Public Health and the Civilizing Process

JOHAN GOUDSBLOM

Sociological Institute,
University of Amsterdam

MANY MODERN SOCIAL PRACTICES, WHEN compared to medieval practices, seem to emanate primarily from concerns about health and hygiene. Think of the contrast between a modern restaurant and a medieval tavern. The guests at the inn ate from a common dish without any other utensils than a knife, and the cup from which they drank passed from mouth to mouth. Having no handkerchief, they would blow their noses directly into their fingers—the same fingers with which they helped themselves from the common dish. Whenever the need was felt—and it was felt frequently—they would spit on the floor. Guests who wished to stay overnight had to be prepared to share their beds with one or more strangers.

Although such or similar practices may still be encountered in some parts of the world today, they run counter to the prevailing trends in contemporary culture. Our standards of conduct have changed; and the most obvious explanation of this change appears to be that the modern standards are due to a better understanding of hygiene. We regard our own manners as more sanitary, and we tend to assume that they have come about in a rational way as the result of scientific or practical knowledge about the prevention of disease. This idea

serves at once to explain and to justify our manners. We postulate an autonomous development of "hygienification" impelled by an increasingly enlightened concern for health.

It may well be, however, that this view, which sounds so plausible and commonsensical, is anachronistic, that, instead of fitting the historical facts, it only represents the projection into the past of our contemporary impressions. Such, at least, is the conclusion at which Norbert Elias arrives in his two-volume historical-sociological study *The Civilizing Process* (1978, 1982; see also Goudsblom 1977a, 1977b, 143–50). To conceive of the changes in manners since the Middle Ages as propelled primarily by hygienic motives is, according to Elias, a fallacy. A major part of the taboos that people gradually impose upon themselves in their dealings with each other, a far larger part than is usually thought, has not the slightest connection with "hygiene" but is concerned even today merely with "delicacy of feeling" (Elias 1978, 115). Actually, Elias maintains, the development of manners in the direction of contemporary standards has proceeded "in a way that is exactly opposite to what is commonly assumed today." First, the way people conduct themselves toward one another has changed, and so has their sense of shame and delicacy. Only afterwards have the new codes of conduct been recognized as "hygienically correct," that is, as justified by medical knowledge (Elias 1978, 115–16).

Elias's thesis forms a good starting point for reexamining the part played by concerns for health in the development of contemporary social practices. First, I shall summarize his evidence and arguments for concluding that reasons of hygiene have served mainly as rationalizations a posteriori for changes in manners brought about by other social forces. Next, in search for the most likely counterevidence to Elias's thesis, I shall look briefly into the social responses to four major diseases by which Europe was successively visited during the period under consideration: leprosy, the plague, syphilis, and cholera. In the conclusions, I shall first assess how these four test cases relate to Elias's theory of the civilizing process. Finally, I shall bring some of the conclusions of my historical-sociological inquiry to bear upon the social responses to AIDS in our time.

Norbert Elias on Changes in Manners and Hygiene

Elias's evidence on the transformation of manners since the Middle Ages is drawn from etiquette books and other historical sources. It

covers a series of activities concerned with such elementary human needs as eating, drinking, sleeping, and body care. The general trend which emerges during this stage of the civilizing process in Europe between, say 1500 and 1900, is that an "invisible wall of affects" has risen between one human body and another, repelling and separating, a wall "which is often perceptible today at the mere approach of something that has been in contact with the mouth or hands of someone else, and which manifests itself as an embarrassment at the mere sight of many bodily functions of others, and often at their mere mention, or as a feeling of shame when one's own functions are exposed to the gaze of others" (Elias 1978, 69–70).

Until the end of the eighteenth century, Elias notes, the changes in conduct in the general direction of greater self-restraint were hardly ever motivated by hygienic reasons. On the contrary, if the etiquette books made any mention of health at all, it was usually to caution the reader not to sacrifice his health to politeness. As Erasmus, who wrote some very influential treatises on good manners, remarked: "It is not pleasing, while striving to be urbane, to contract an illness"; only "fools who value civility more than health suppress natural sounds" (quoted by Elias 1978, 58, 130).

For a long time, the decisive argument with which the etiquette books called for greater self-restraint was not the reader's health but the impression he would make upon others, particularly on his social superiors. This was the recurrent theme: Avoid anything that others, and most of all those to whom you owe respect, will find unpleasant and disgraceful. It was on these grounds that Della Casa in the *Galateo* urged the reader "*not* to wash his hands on returning to decent society from private places, as the reason for his washing will arouse disagreeable thoughts in people" (1609 edition, quoted by Elias 1978, 131 [emphasis added]).

How fear of embarrassment, rather than a concern for health, was the prime reason for the refinement in table manners is clearly shown by the spread of that peculiar eating instrument, the fork. In the early Middle Ages, the fork was unknown in western Europe; when it was first introduced at a Venetian palace in the eleventh century it was was looked upon as an extravaganza. However, eating with a fork soon became fashionable. It required a dexterity which not only expressed a certain measure of restraint but which also served as a means of distinction (Elias 1978, 151). This, as Elias demonstrates, was the prime function of the fork; people became accustomed to its

use, not because they found it more hygienic but because they feared social degradation if they would not use it. The fork thus became "the embodiment of a specific standard of emotions and a specific level of revulsion" (Elias 1978, 127).

What has changed is the social standard of delicacy. "People, forced to live with one another in a new way, become more sensitive to the impulses of others. Not abruptly but very gradually the code of behavior becomes stricter and the degree of consideration expected of others becomes greater" (Elias 1978, 80). This trend is also reflected in the attitudes toward spitting. In the Middle Ages, spitting was a widespread habit among men, apparently arising out of a generally felt need. The steps by which it became more and more restricted and eventually altogether prohibited reflect, again, changes in social sensitivity; the motivations of health that to us today sound so comprehensible and convincing did not appear before the nineteenth century.

Even with regard to the standards of personal cleanliness, considerations of health were for a long time secondary to social considerations. At first, it was taken for granted that people should wash themselves regularly only out of respect for others, especially social superiors. Gradually, social relations were transformed so that compulsions exerted by people on one another were converted into more and more automatically functioning self-controls in the individual; these were then, in the nineteenth and twentieth centuries, increasingly backed up by more "rational" explanations about the dangers of dirt to health (Elias 1978, 305–7).

Social Responses to Epidemics in European History

The Struggle against Lepers

As is evident from Elias's study, the psychological "danger zone" that people try to avoid in their social contacts has widened considerably in the course of a few centuries. We may well wonder whether this trend is not related to a growing awareness that intimate contacts may be *physically* dangerous—dangerous not in the sense that others may suddenly draw a knife or a pistol, but that they may be carriers of an infectious disease.

It is William McNeill (1976, 3) who has drawn our attention to this dimension of human history—the history of humanity's encounters

with infectious diseases, and the far-reaching consequences that ensued whenever contacts across disease boundaries allowed a new infection to invade a population that lacked any immunity to its ravages. The Black Death of the fourteenth century, as McNeill points out, was a shattering experience that has never been expunged from European memory. Before this traumatic first outbreak of the plague in medieval Europe, leprosy was a disease that filled the imagination with horror. Similar lasting fears were provoked by syphilis in the sixteenth century, and by cholera in the nineteenth.

Of these four diseases, leprosy, in a sense, represents only a negative case with regard to our problem, for it virtually disappeared from Europe before the transformation of manners, as documented by Elias, began. In the early Middle Ages it was the most feared malady but, from causes still unknown, it ceased to be common soon after the first onset of the plague in 1347 (McNeill 1976, 175–77). Nevertheless, it offers an interesting example from which we may draw some inferences about the way in which the fear of contagion operated in medieval society.

Of course, in gauging the responses to diseases in the past we have to guard against anachronisms. We may all too easily attribute reasons, based on modern scientific insight into the mechanisms of contagion and infection, to people who could not possibly have this knowledge. Even such a notable historian of medicine as George Rosen (1958, 63–66) tends to write about the medieval treatment of lepers— isolation—as if it were guided by a well-informed attempt to reduce the risks of infection:

> The need for action to control leprosy was recognized early, and it is out of this awareness that there developed a form of public health action that is still with us, namely, the isolation of persons with communicable diseases. . . . Leprosy . . accomplished the first great feat in direct prophylaxis, namely, methodical eradication of disease by consistently making the affected individuals harmless as carriers of the causative element. The analogy with the more recent campaigns against tuberculosis and venereal disease is clearly evident.

It seems to me that in this quotation twentieth-century ideas and motives are projected into medieval society. We may well doubt whether in the Middle Ages any organized "struggle against leprosy" was waged at all; it may be more appropriate to speak of a "struggle

against lepers." Crude though it may sound, this probably comes closer to what actually took place. The evil of leprosy was regarded as a punishment sent by God, against which human resistance was of no avail. Whoever was struck by this punishment was considered impure and sinful, and was treated as such—with stigmatization and ostracism.

According to present-day medical knowledge the risks of contagion of leprosy are, certainly in mild climates, relatively small. Individual susceptibility varies greatly, and the incubation period may extend over a number of years (Richards 1977, 91). In the Middle Ages these facts were unknown. The treatment of lepers was not based upon any precise knowledge of the nature and transmission of the disease but rather on disgust and fear. Although the decentralized structure of medieval society allowed for many local variations, the same rule applied everywhere: lepers were regarded as unclean, and treated as outcasts. Leprosy was, therefore, as much a social as a physical condition. People were relegated to this condition by a commission of churchmen in a special religious ceremony which culminated in the person's official banishment from the community of the living, sealed by the celebration of a requiem mass for his soul.

The physical injuries a leper had to suffer were thus greatly augmented by the social fate that was forced upon him, and that inevitably added to the horrors of the disease—both for those who were and for those who were not afflicted by it. The lepers were reminded time and again that they had been hit by "the most loathsome disease" and that they therefore ought to show themselves, as the regulations of an English hospital put it, "only at special times and places, and in their manner and dress more contemptible and humble than other men" (Richards 1977, 131). In practice this meant that they were banished from their dwelling places, and were only allowed to enter the streets in a clearly recognizable attire of hood and dress, announcing their coming with a bell or a clapper. Churches, inns, and markets were forbidden them; they could only eat and drink in the company of other lepers. In conversation with a healthy person they had to speak against the wind because of the foul air they exhumed, and they had to maintain a distance of six feet. All these measures reflected a great fear of contamination, and their very severity was likely to increase this fear even more. It is no wonder that those suffering from leprosy or a similar affliction often tried to hide their symptoms as

long as possible; discovery would bring no relief but only add further misery.

In keeping with the ritual treatment of lepers, their ban was lifted on certain holy days, when they could move about freely and mix with everybody else. In other respects, too, they were not always treated with unrelenting harshness. It has often been noted that medieval people tended in their emotions to oscillate between extremes (cf. Huizinga [1924] 1955, 9–30). This tendency was also displayed toward lepers. Over against the routine of ostracism and defilement stood feats of commiseration and charity, in gifts to hospitals and in spontaneous acts of love and care. There are many stories in medieval literature about people who were stricken with leprosy as a punishment for some deadly sin, and who were cured, or rather rescued, either through penance or because a pure and innocent soul took pity on them (Brody 1974, 147–97). Saints were said to have cured lepers by their embrace; the extreme repugnance was overcome by an equally extreme act of charity. Sometimes the theological imagination went so far as to see leprosy as a holy disease; it was believed that God had elected the lepers, like Job, to their singular anguish. Thus, leprosy also evoked—besides abhorrence—pity and even glorification. The configuration of medieval society, in which the lepers were outcasts, offered little scope to their fellow men for the expression of more moderate and subtle feelings.

The Plague: Panic and Countermeasures

The plague arrived in Europe via a Black Sea port in 1347. Its ravages continued at irregular intervals until the beginning of the eighteenth century. In the first wave, it is estimated that approximately one-third of the European population died. In later waves, the death toll per city or region usually varied between 20 and 50 percent (Cipolla 1981, 100–1). It would seem unlikely that such a terrible scourge could have failed to affect people's conduct. Did they not learn to become more cautious in their dealings with each other, and to suspect everyone of being a carrier of this lethal illness?

In examining the reactions, we have to realize, of course, that the plague was a disease with an entirely different character from leprosy. It struck far greater numbers, and took an incomparably quicker course. In contrast to leprosy, the plague was always a temporary

threat. It was not continuously present; it came, it was rampant for several months, and then went away again, for years or even decades.

From the start, there could be no mistake about the highly contagious nature of the disease, but the actual way in which it was transmitted remained a mystery (cf. Nutton 1983). Physicians had no way of finding out whether the disease was passed on by skin-to-skin contact or through the air or by another means; fleas and lice were so common that their omnipresence was taken for granted and their possible contaminating role completely overlooked (Cipolla 1981, 7–18, 97). Contemporary accounts, such as the famous first chapter of Boccaccio's *Decameron,* as well as historical reconstructions, such as William Bowsky's (1964) study of the impact of the Black Death in Siena or Elisabeth Carpentier's (1962a) book on the plague in Orvieto in 1348, convey a general sense of helplessness, agony, and horror. Boccaccio has given us a poignant description of all-pervading misery and social regression, telling how people abandoned their neighbors and relatives, and, "even worse, and almost incredible," how "fathers and mothers refused to nurse and assist their own children, as if they did not belong to them" (Boccaccio [1353] 1972, 55)—words that correspond almost literally to the observations by the Sienese chronicler, Agnolo di Tura del Grasso: "Father abandoned child, wife husband, one brother another" (Bowsky 1964, 15). In Orvieto the inhabitants of the stricken town knew only one defense: to close the city gates to all visitors, and to avoid anyone inside the walls who had, or was suspected of having, the disease. Since the plague was, for sound reasons, regarded as something that came from outside, it easily aroused fear and hatred of strangers, expressed most violently in flagellant movements and in the persecution and burning of Jews (cf. Tuchman 1978, 109–16).

Needless to say, none of these spontaneous reactions of flight, avoidance, and aggression had anything in common with a tendency toward more all-round self-control and greater refinement in manners. However, in addition to panic and terror the plague also sparked more rational responses. In the cities of northern Italy in particular, city magistrates sought, from early on, to counteract the disruptions brought about by the epidemic and to stem its tide. It is striking how, amid all the personal anguish, and in spite of the profound demographic and economic shocks caused by the plague, the political institutions remained unimpaired and were often strengthened rather than weakened by the calamity. In Orvieto almost all members of

the highest city board, the Council of Seven, succumbed to the disease; yet, except for an interlude of a few weeks, the Council continued to function. In Florence and Venice the city magistrates immediately appointed a special committee to deal with the emergency.

These provisional committees were the forerunners of the health boards that, since the late fifteenth century, became a regular institution in all the major cities of northern Italy and served as a model for similar developments elsewhere in Europe (cf. Cipolla 1976, 11–66). The permanent health boards continued to be staffed not by medical men but chiefly by administrators; since the etiology of the disease was unknown and no remedy was available, they concentrated their efforts upon generally preventive measures such as the institution of strict quarantine regulations for all incoming ships and of required health certificates for travelers. When an emergency arose, their powers were extended to confiscating merchandise, closing markets, forbidding processions, burning furniture and clothes, and confining people in their homes or (if they happened to live in crowded quarters) locking them away in pest houses. Thus, in contrast to leprosy in the preceding centuries, the plague evoked organized attempts not just to ostracize the victims but indeed to combat the disease.

Expectedly, the measures of the health boards were none too popular, and they met with a great deal of evasion and obstruction. As Carlo Cipolla (1976, 39) remarks, "In addition to waging their impossible fight against the invisible enemy, the Health Officers also had to fight selfishness, carelessness, ignorance, and stupidity—which were no less formidable than the microbes." Yet, in spite of all opposition, the health boards became increasingly powerful agencies of government. They succeeded, in the course of the sixteenth and seventeenth centuries, in building up a far-reaching network of communications through which they could report to each other on the incidence of contagious disease anywhere—including in their own territory. The latter kind of information was especially delicate, for it was bound to have disastrous consequences for trade and employment. The temptation and the political pressure to conceal a pestilence at home were always strong; yet, as Cipolla (1976, 53) notes, these short-term interests were outweighed by the long-term interest that all health boards had in maintaining the network of communications in a trustworthy state— a clear example of what Elias (1982, 229) calls "the social constraint toward self-constraint." Thus, in the long run the plague, the visitations

of which were the result of increased long-distance traffic and trade in European society, served as a catalyst in bringing about new ties of interdependence and, accordingly, new standards of self-control among the city magistrates responsible for the exchange of reliable information.

The population at large, however, was not prompted toward more "civilized" behavior, neither by the plague itself nor by the public health regulations. Although these regulations were backed by the state monopoly of military force and taxation, they were met with continuous attempts at evasion and obstruction. The rich felt increasingly safe from the plague because, whenever it flared up, they could retreat to their country estates (cf. Thrupp 1966, 482). The poor generally did not have the means to abide by the sanitary laws, and they were surely not inclined to collaborate with an agency that appeared to have little more to offer them than enforced evacuation to a pest house (cf. Cipolla 1973, 15–32). Thus, apart from such specific measures as the quarantine for ships, the routine of life in ordinary times, when the plague was not rampant, does not seem to have been much affected by it.

It may run contrary to what we would expect that the experience of such a disastrous sequence of epidemics as the waves of the plague that swept over Europe between 1347 and 1721 would have influenced the development of manners only indirectly: not by people voluntarily altering their habits but at most through the, only partially successful, enforcement of city ordinances. On closer reflection, this is not so surprising. As Elisabeth Carpentier (1962b, 1074) points out, epidemics seldom lasted longer than half a year, and they took place in a society that was thoroughly familiar with want and disease and a high mortality—a society in which "incessantly, catastrophes kept reminding people of the precariousness of existence."

Syphilis in Erasmus's Colloquies

Syphilis arrived in Europe in the late fifteenth century. As a new disease, it caused extremely violent afflictions, much more so than in later generations, when its presence had become endemic. From the start, syphilis was associated with debauchery, vice, and well-deserved punishment; this, together with the abominable physical symptoms, soon gave it the reputation of being "the new leprosy." It differed

significantly from the plague in the way it was propagated. The plague
was a disease which one could see coming slowly, as it were. Certainly,
in the sixteenth century the population of a city or region had always
been warned when an epidemic was on its way. Such men as Erasmus
and Montaigne, who had some freedom in choosing their residence,
were able to avoid hotbeds of the plague, and even those who were
in no position to leave their own locality could be certain that the
epidemic would eventually spend itself and disappear. The only remedy
against the plague was said to consist of the ingredients *cito, longe,*
and *tarde,* meaning that one did best to run swiftly, go far, and
return tardily (Cipolla 1973, 23). Against the new disease this pre-
scription was of no avail. It spread in a far more surreptitious manner,
and it seemed that everyone, poor and rich alike, had to guard against
it all the time.

The advent of syphilis in Europe took place during the lifetime of
Erasmus. His writings contain several references to it which have a
direct bearing upon our problem, the relation between fear of contagion
and changes in manners. An interesting allusion is found in the
description of a German inn, in one of the *Colloquies,* written in 1523.
The theme of the dialogue is a comparison between inns in different
countries. One speaker sings the praises of French inns: Service is
gracious and polite, the food is excellent, everything is done to please
the guest and to make him feel at home. What his companion has
to report about German inns sounds less attractive: The guest has to
spend most of his time in the crowded and overheated public room
or stove room, food is only served after waiting a long time and it
is of poor quality, the wine is sour, the owner is rude, the guests
stink and make rowdy noises far into the night, the linen has not
been cleaned in six months. Then, the speakers touch upon the subject
of disease:

> *William.* But nothing seems to me more dangerous than for so
> many persons to breathe the same warm air, especially when their
> bodies are relaxed and they've eaten together and stayed in the
> same place a good many hours. Quite apart from the belching of
> garlic, the breaking of wind, the stinking breaths, many persons
> suffer from hidden diseases, *and every disease is contagious.* Undoubtedly
> many have the Spanish or, as some call it, French pox, though it's
> common to all countries. In my opinion, there's almost as much
> danger from these men as from lepers. Just imagine, now, how
> great the risk of plague.

Bertulf. They're brave fellows. They laugh at these things and pay no attention to them.
William. But all the while their bravery endangers the public.
Bertulf. What would you do? This is their custom and they're resolved not to depart from established ways.
William. Twenty-five years ago nothing was more customary among the Brabanters than public steam baths. Now these are out of fashion everywhere, for the new pox has taught us to let them alone (Thompson 1965, 150 [emphasis added]).

William's last remark appears to be in accordance with the historical facts; public baths were indeed rapidly disappearing from European cities at the beginning of the sixteenth century. "Flee sweating-rooms and baths, I beg you, or you will die!," advised a doctor in 1513, expressing not only a generally mounting fear of water as an alleged agent of illness but also the increasing distaste on the part of the more well-to-do for any intimate mingling with the poor (cf. Elias 1978, 307).

In the work of Erasmus, syphilis is treated as a central theme in another dialogue, "A Marriage in Name Only, or The Unequal Match," of 1529 (Thompson 1965, 401–11). The speakers discuss the marriage of a beautiful sixteen-year-old daughter of a patrician with a nobleman who is known for two things: "lies, and the pox that doesn't yet have an exclusive name, since it goes by such a variety of them." The bridegroom is depicted as a monster: "nose broken, one foot dragging after the other . . . , scurvy hands, a breath that would knock you down, lifeless eyes, head bound up, bloody matter exuding from nose and ears"; "there's no corpse you wouldn't rather be bound to than such a stinking one, for his breath is sheer poison, his speech a plague, his touch death." The disease that this man carries is worse than leprosy, for it progresses more quickly and causes more hideous disfigurement; moreover, it is communicated in the most elusive ways, spreading to other persons "by a kiss, by conversation, by touch, by having a little drink together. And we observe that this disease is accompanied by a mortal hatred, so that whosoever is in its clutches takes pleasure in infecting as many others as possible, even though doing so is no help to him."

So great is the horror of both speakers that they describe the disease in well-nigh demoniacal terms. Toward the end, their conversation gets a lighter touch, as they throw out some suggestions to combat

Lepers making their round, copper engraving by Nicolaas Visscher, 1608. At special feast days, lepers were allowed to come into towns to beg for money. This illustrates the, in our view, very inconsistent treatment of lepers, i.e., isolation which was suspended on feast days.

Cholera Morbus, by Honoré Daumier, from *Némésis Médicale*, 1840.

the dangers of contagion. Every man should cut his own hair and beard in order not to be touched by barbers; a law should be passed to prohibit the common drinking cup; innkeepers should not be allowed to let their guests sleep in sheets anyone else has slept in; the custom of greeting with a kiss should be abolished. These proposals, made in a playful manner, seem to indicate unmistakably that Erasmus was well aware of the risk of contagion, and tried to avoid it by keeping other people at a safe distance.

Certain details in the dialogues, however, speak against ascribing to Erasmus the sort of view of infection and hygiene with which we are familiar today. According to our contemporary notions, "hygiene" refers very specifically to the preservation of physical health, as the more recently coined concept of "mental hygiene" only underlines. But in the world of Erasmus, hygiene was not such a specific and distinct concern. The German inn aroused feelings of displeasure because of its entire ambience: the stench, the filth, the mingling of ranks and estates, the insolence, the noise, the hidden diseases, they were all part of one complex. The speakers do not condemn sanitary conditions separately; they find the whole situation vulgar and offensive. The traveler with whom Erasmus identifies finds himself in a company not of his own choosing; it is a forced togetherness about which the speaker reports, an interdependence which he has not sought and which he experiences as threatening.

The theme of contagion is treated more explicitly in "The Unequal Match." The issue here is not the latent risk of infection but a clearly visible hideous case. Still the portrait drawn of the sufferer from syphilis is much more than a medical diagnosis; the man is not only shown to be sick but also thoroughly wicked. As a depraved nobleman whom a nice burgher girl is forced to marry, he represents a social stereotype. His repulsiveness is total and beyond redemption: he is unclean in body and soul, the words he speaks are as dangerous as his touch.

The proposals at the end of the dialogue do indeed suggest a connection between fear of contagion and a tendency toward greater reservedness in social interaction. Yet, they do not appear to have been inspired by specifically medical considerations, but rather by a general repugnance of the throng of people crammed together in a narrow space. Erasmus was a hypochondriac, always complaining about the food, the wine, the air, the climate; but he was no less obsessed

by contempt for the stupidity and vulgarity of most of his fellow men. Fear of contamination did play a part in his cultivation of more refined and reserved manners; but the very idea of "contamination" was for him less clearcut and more diffuse than the modern medical notion. It included the idea of social pollution; his physical delicacy was part of a more general social delicacy.[1]

Cholera and Public Health in the Nineteenth Century

After the most virulent outbursts at the beginning of the sixteenth century, syphilis remained in Europe as an endemic infection. It continued to differ from the plague in its "social range." Whereas plague epidemics at a later stage infested almost exclusively the common people, syphilis reached into the highest circles. It was not fortuitously that Erasmus in "The Unequal Match" depicted a nobleman suffering from syphilis; from the start it affected commoners and aristocrats equally. As its virulence diminished, it even acquired the reputation of a "gallant disease" about which a courtier needed to feel no embarrassment.

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[1] Very far-reaching effects are ascribed to syphilis by Stanislav Andreski (1980, 724) who, taking up an idea of D.H. Lawrence ([1929] 1956) argues that "it seems exceedingly likely that the spread of puritanism was mainly due to the arrival of syphilis in Europe." Andreski bases his argument on the following grounds: (1) chronological congruence, (2) psychological plausibility, and (3) the complete inadequacy of alternative explanations. In the conclusions of his essay he goes on to say that if Max Weber's thesis about the relationship between puritanism and capitalism is essentially correct— as Andreski assumes it to be—the coming of syphilis to Europe has also played a major part in the development of industrial capitalism and, consequently, of Western science and technology.
    Andreski's thesis has the advantage of being simple and clear. I find it intriguing but unconvincing for several related reasons. First of all, the chronological fit is too loose; the peak of puritanism began in the seventeenth century, when the most terrible first phase of syphilis was long a thing of the past. Moreover, to my knowledge syphilis does not play the eminent part in the literature of puritanism that one would expect if the connection was as tight as the thesis suggests. Puritans were concerned with the well-being of the soul, not with the well-being of the body. Altogether, Andreski's thesis seems too strongly couched in the modern idiom of what William James has called "medical materialism," ascribing as it does a highly specific concern with matters of bodily health to an age when the knowledge informing such concerns today was not yet available.

The last time the plague raged in western Europe was in Marseilles in 1720–1721. The causes of why it disappeared are still unknown. Quarantine measures are likely to have contributed, but they cannot have been effective enough fully to explain the termination of the plague (cf. Appleby 1980; Slack 1981).

The system of quarantine continued to function in Mediterranean ports for many decades after 1720. It found medical support in the theory that the plague was transmitted through a *contagium vitum,* an animated particle invisible to the naked eye which passed from one person to another by touch or by breath. Since no microscope could reveal these particular organisms their existence had to remain hypothetical. When around 1800 advanced medical researchers began to insist on stricter codes of empirical proof, the idea of contagion through invisible creatures was thrown into doubt and replaced by a modern version of the time-honored view that infection occurred by inhaling putrefied air or, as it was called, "miasma." Not only did the miasma theory sound more scientific as it did not imply the belief in any unseen living substance, it also served the practical purposes both of businessmen interested in unimpeded free trade and of advocates of sanitary reform eager to clean the squalor of the slums (cf. MacLaren 1977). Throughout the nineteenth century, the medical profession remained divided over the issue of "contagionism" versus "miasmism"; in 1892, nearly ten years after Robert Koch had identified *Vibrio cholerae,* Max von Pettenkofer, who had been the leading German hygienist for several decades, and a group of his pupils were still trying to prove through self-exposure to cholera cultures that the bacillus itself could not cause the disease without other factors being present (cf. Winslow 1943, 311–36).

No other disease had a more terrifying impact in the nineteenth century than cholera. It reached Europe from Asia around 1830, and immediately unleashed panic as well as determined efforts to combat it. As in the cities of Italy at the time of the plague, the pacesetters of the sanitary movement were administrators, among whom Edwin Chadwick was to become the most famous. At first it was widely believed, by rich and poor alike, that cholera was a disease which, like the plague and typhus, would find its victims almost without exception among the poor (cf. Briggs 1961). Even after experience had taught otherwise, many well-to-do citizens persisted in the attitude voiced by an editorial in *The Times* in August 1854: "We prefer to

take our chance of cholera and the rest rather than be bullied into health" (Rosen 1958, 224). The champions of sanitary reform could easily rejoin that the chance was very real indeed, and that cholera did not show any respect for social distinctions:

> Don't think that the foul air of the street, propelled by the wind, turns around and humbly recedes when it meets windows adorned with marble and sculpture. Be assured that the germs of disease from the dwellings of the proletarians can be easily transmitted through the air to the parlour and the bedroom of the first servant of the state (Reclam 1880, 105).

These words by a popular German writer and physician appealed to a more general fear of the working class as a dangerous class. Increasingly, it dawned upon the rich that they could not ignore the plight of the poor; the proximity of gold coast and slum was too close. In the Middle Ages, lepers had literally been placed outside ordinary society; intercourse with them was limited to a ritually fixed minimum. In the nineteenth century, the numbers of the poor and sick, suffering from many diseases of which cholera was only the most spectacularly fatal and contagious, had swollen to a degree where they could no longer be contained in leper hospitals and pest houses. From their quarters emanated a threat of squalor, illness, and disorder. The public health campaigns fitted into a more encompassing movement to meet this threat by raising the level of "civilization" in society at large (cf. De Regt 1984).

The strong emphasis in this movement upon sanitation may be explained in the first place, I think, as a function of the "affect structure" in the upper middle classes out of whom the initiatives sprang forth, and of the means they had at their disposal. In the nineteenth century, as Elias (1982, 307) points out, the "civilizing process" in Europe entered a new phase, as leading groups of what used to be the third estate became the most powerful section of society. These groups continued to carry on professional and commercial functions, with the corresponding division of human existence into work and private spheres. They were not terribly interested in any further refinements of table manners and other forms of gracious social behavior. In this respect they were content to take over, with some accommodations, the pertinent standards of conduct developed in courtly

society, which subsequently spread to increasingly wider social circles. The novelty that came with the ascent of the professional and commercial groups was that they brought along with them the bourgeois propensity to cultivate a sphere of privacy and intimacy and to mould the personality accordingly, as, in the eighteenth century, aristocratic groups also began to show signs of picking up something of this tendency. As a typical indication of the shift, toward the end of the century, bedrooms in English country houses ceased to be used to receive visitors, and soon they began to be fitted with an adjoining bathroom and water closet (cf. Girouard 1978, 231–62). To be able to retreat and refresh oneself in such privacy and comfort became an ideal that in the next two centuries was to capture the fancy of ever larger groups.

The crowded and filthy conditions in which the urban working classes throughout most of the nineteenth century had to live formed a stark contrast to this ideal. For those who had been brought up with middle-class standards of their time it was a revolting experience to come into contact with these conditions, and yet they could hardly avoid such contact, if only through their nostrils, as the notorious Great Stench that plagued London in the summer of 1858 made painfully clear. It is impossible to tell whether the atmosphere in 1858 was objectively worse than it had been one or more centuries earlier; all we know is that the public entering the city from the suburbs in the summer of 1858 found the odor unbearable. As George Orwell ([1937] 1962, 112) was to observe a few generations later, the middle classes grew familiar with the idea that "the lower classes smell"—an idea that reflected on the emotional standards of the bourgeoisie as much as it did on the standard of living of the poor.

It would seem, then, that the campaigns for sanitary reform, conducted as a struggle against cholera, were also waged in order to make life at close quarters with the expanding working classes less uncomfortable and less dangerous, in more than one respect. The fact that hygiene was singled out as the major target (cf. Gauldie 1974, 85) also had to do with the increasing confidence that the epidemics could be handled as a technical problem, to be tackled by a combination of technology and administration. Even if medical knowledge did not yet provide a therapy, the reformers firmly believed that sanitation would at least bring about prevention. They found their belief confirmed by a series of successful cases where the introduction of modern water

and sewage systems saved a city or a district from the disease. By
1910 every major European city possessed its subterranean "arterial-
venous system of water supply and sewage disposal" (McNeill 1976,
273), and cholera epidemics no longer occurred. The ceramics industry
furnished the pipes for the new sanitary infrastructure, and public
boards or, occasionally, private firms saw to its functioning smoothly
day and night. When toward the end of the century *Vibrio cholerae*
was isolated and inoculation became possible, the disease was already
in retreat. Whereas the earlier maladies of leprosy, the plague, and
syphilis had receded through causes that remained essentially unknown,
cholera had been brought under control by engineering.

Conclusions

Public and Personal Hygiene, External and Internal Compulsions

No one who has read William McNeill's *Plagues and Peoples* can fail
to have been impressed by the tremendous influence that epidemics
have had upon human history. Time and again when the precarious
balance between microbes and their human hosts was upset, the human
population had to go through severe demographic, economic, and
military crises. And yet, when we examine the effects of some major
epidemic diseases upon another aspect of social development, namely
the changes in conduct and sentiment studied by Norbert Elias in
The Civilizing Process, we find relatively little evidence for a direct
influence of epidemics.

    Instead, we are drawn toward another conclusion: that the impact
of epidemics, the fear of contagion, and the development of public
and personal hygiene are all to be seen *within the context* of the civilizing
process. The reactions evoked by leprosy, the plague, syphilis, and
cholera were determined not only by the nature of these diseases but
at least as much by the prevailing social structure (including class
differences) and personality structure (in its combined cognitive and
affective aspects).

    Thus, the sanitary-reform movement of the nineteenth century was
undoubtedly stimulated by the advent of cholera. However, in all

probability the cholera scare only speeded up a process that already had a momentum of its own, propelled by disgust of stench and filth, on the one hand, and by the rise of a class of engineers and administrators—of technocrats—on the other (cf. Gleichmann 1979a, 1979b). It is most unlikely that no sanitary reforms would have taken place had cholera not come to Europe. In that case there might have been some delay; but society was veering toward the removal of dung heaps from cities all the same. Fear of cholera helped to accelerate the process; it certainly was not the sole mover.

The question remains why, in the twentieth century, concern with physical health has apparently become so overriding that considerations of hygiene have gained pride of place among the reasons given for a variety of rules of conduct pertaining to such elementary activities as eating, drinking, sneezing, and spitting. The explanation, I suggest, may be found in some long-term trends that are closely related to the general drift of the civilizing process during the last centuries. I am thinking in particular of individualization and democratization.

Since the days of Hippocrates and Galen, physicians had known that only a privileged few people could afford regularly to spend a great deal of attention to the preservation of their health. As Galen advised the readers of his treatise on personal hygiene, only those who had sufficient financial means and leisure would be able to put his precepts into practice (cf. Sigerist 1956, 13). Moreover, they should also be able to produce the inner rest and wisdom to follow a life of temperance and moderation. In other words, a favorable class position and a personality structure that would keep the individual from indulging in excesses of any kind were, for Galen, indispensable prerequisites for a healthy life. And, as he also knew too well, very few people met these preconditions.

This was to remain so for a long time. Typically, the *Regimen* of the school of Salerno, one of the most influential treatises on personal hygiene of the Middle Ages and early modern times, addressed itself in the opening lines to a royal patron:

> The entire School of Salerno writes to the English monarch: If you want to make yourself healthy and sound, remove from you the pressing cares. Regard as wicked and profane any display of anger. Abstain from strong, undiluted wines. Let frugality reign at your supper. It is important for you not to tarry at your table when the

meals are over. Rise, but avoid the noonday sleep. Do not retain any urine, or force your anus beyond necessity (Parente 1967, 63).[2]

Throughout most of European history, regular medical attendance and personal health care remained the prerogatives of a privileged minority. In contrast, the sanitary measures issued by the magistrates of Italian cities during the epidemics of the plague, as well as those introduced locally and nationally in the nineteenth century were directed toward the population at large. They represented external constraints, backed up by the state monopoly of organized force and taxation, to which all subjects were, at least in principle, equally exposed.

In the twentieth century, as Paul Starr has documented for the United States, the public health movement has shifted "from the environment to the individual" (1982, 189–94). With the aid of bacteriology it became possible to do away with indiscriminate interventions and to restrict health programs to specific measures aimed at specific groups or individuals. Regular individual health examinations helped in locating the targets. Great emphasis was put on the efficacy of personal hygiene. As Charles V. Chapin wrote in 1917:

> Wash the hands well before eating and always after the use of the toilet. Teach this to children by precept and especially by example. Modern sanitary science enables the individual to protect himself even if his health department is inefficient (quoted by Starr 1982, 190).

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[2] The medieval candor of the last sentence was gradually subdued in later editions of the *Regimen*. While the tenor of the message did not change, the words in which it was couched became more prudish and vaguer. On the whole, the *Regimen* does not appear to have added anything to prevailing standards of conduct; it merely reflected them. This is brought out nicely in the following quotation, one of the few that refer to table manners: "If you wish to be healthy, wash your hands frequently. Washing after a meal has a double reward for you: your hands are made clean and your eyes are made keener" (Parente 1967, 64). What is striking with regard to our problem is not so much the assumed connection between hand washing and vision (a piece of medical lore of which I have not been able to trace the origins) but the casual recommendation to wash one's hands *after* the meal. This, of course, was entirely in keeping with medieval eating habits. People ate with their hands, and while considerations of health did not prompt them to wash their hands before the meal, propriety demanded of them that they did so afterwards, when their fingers had become greasy and sticky.

In this quotation we can see both democratization and individualization epitomized, as it were. Regular health care has come within everybody's reach; it is now a task that each individual can and must perform for himself. The analogy to "the social constraint toward self-constraint" described by Elias (1982, 229–47) for a much wider range of activities is obvious. "The individual is compelled to regulate his conduct in an increasingly differentiated, more even and more stable manner. . . . The more complex and stable control of conduct is increasingly instilled in the individual from his earliest years as an automatism, a self-compulsion that he cannot resist" (Elias 1982, 232–33). The regular and automatic concern for personal hygiene forms a striking example of this more general pattern of socially induced (sociogenetic) inner compulsions.

Responses to AIDS and the Civilizing Process

The preceding discussion may give rise to some, admittedly speculative, thoughts about the social responses to AIDS. Our inquiry has shown that the responses to epidemic diseases are influenced by a variety of conditions including the proportion of the population struck—both in its totality and according to social class divisions; the length of the course of illness; the length of the course of the epidemic; the mode of communication; knowledge and beliefs about communication; the effectiveness of local and national public health organizations; attitudes to health, illness, and death; and standards of delicacy and shame. The list could be extended and differentiated; the main point is that it does not consist of isolated variables; each of these conditions is interdependent with others. Even those variables that might appear as autonomous medical factors, such as the proportion of the population struck by an epidemic, are, in fact, influenced by that population's history, culture, and social organization. The rule of thumb implied in the writings of Elias and McNeill that epidemics and the responses they evoke need to be understood in an historical-sociological or "sociogenetic" framework applies to AIDS as much as to any epidemic disease of the past.

A conclusion that emerges very clearly from our inquiry is that epidemic diseases in themselves are unlikely to exert any "civilizing" influence. On the contrary, as long as epidemics remain beyond people's control, their primary effect is for people to treat victims and others

suspected of carrying the disease with unrestrained callousness and hostility. This basic pattern of response in a community which finds itself helpless against an epidemic was expressed well by a member of the Tiv tribe in Nigeria when he told the anthropologist, Laura Bohannan, about an onset of smallpox: "Who does not know the terror and the death and the hate it brings?"(Bowen 1954, 266). The anthropologist has given us a tragic account of how the first victim of the disease, a boy, was expelled from his village by the village priest who shouted at him: "I forbid you to enter. I forbid evil to enter. You, our child, have brought evil to the land of your fathers. . . Go to the farms! You shall walk alone and sleep alone. Let all men shun you, for you have brought evil among us. . . . Go! Go alone to the farms. None shall visit you nor speak to you. Go!" (Bowen 1954, 269). As Bohannan makes clear, the community was thoroughly disrupted. Social bonds were severed brusquely, to be mended again only after the disease had taken its toll and the danger for the survivors had passed.

There is no reason to expect that the responses to patients suffering from AIDS, if left free rein, would have been much different from the way the Tiv villagers reacted toward the smallpox victims in their midst. As Elias (1978, 307) points out, "The armor of civilized conduct would crumble very rapidly if, by a change in society, the degree of insecurity that existed earlier were to break in upon us again, and if danger became as incalcuble as it once was. Corresponding fears would soon burst the limits set to them today."

There are, however, strong forces at work in American and European society today counteracting both the dangers and the fears. Foremost among these mitigating forces is organized medical opinion. At the time of the bubonic plague, the most powerful attempts to curb responses to the epidemic into a more "civilized" direction were those enforced by city governments. In our days, medical experts, although at the moment still unable to develop a cure, are actively combatting reactions that they judge hysterical. Over against the endeavors by groups of "moral entrepreneurs" (Becker 1963, 147–63) to turn the struggle against AIDS into a crusade against homosexuals, the medical profession has maintained firmly that the disease should be defined in strictly medical terms. Even if physicians cannot yet offer a therapy for the patients, they can, and do, provide information about the

nature of the disease, its mode of communication, and the most effective ways of halting its spread. The struggle between "medicalists" and "moralists" is still going on; but there can be no doubt that the "civilizing" appeal against moralizing and scapegoating—an appeal that is in most cases backed up by public, city, and state authorities—has succeeded in restraining, at least to some degree, the tendencies toward demonizing the disease and its carriers.

AIDS has come to the Western world at a time when epidemic diseases were supposed to have been brought under control. This very fact helps to account for some of the severity of the shock it has caused. As late as the eighteenth century in Europe, as John McManners (1981) and others have made vividly clear, ill health and early death were the rule rather than the exception. In industrial societies today, by contrast, average life expectancy has become so high that for the majority of the population it is a quite realistic goal to strive to live into old age in good health. Public health is at a much higher level than it was even a century ago; personal health, therefore, depends to a much larger extent than ever before upon the individual's own initiative, upon his or her willingness to "invest" in it by leading a regular life, with sufficient exercise and rest, and without gluttony or other forms of self-indulgence. What Galen, as a matter of course, considered the privilege of a few, has now come within the reach of many. The chances that a person's life will suddenly be ended by an uncontrollable epidemic are small. While our affluent societies indeed abound with temptations toward excessiveness, these temptations are far outweighed by the omnipresent countervailing pressures toward moderation and self-restraint.

Making care of one's health into an ordinary routine is more "rational" when life expectancy is high than when it is low. In a society that may be struck by an outbreak of the plague at any time the incentives to follow a regular health regime for the sake of longevity are much weaker than in a society in which the hazards of catching a deadly infection have been reduced to a minimum. The social conditions of regular personal health care may be compared to the social conditions for thrift. As W.F. Whyte (1955, 141) has pointed out in his study of an Italian slum during the Depression, poor people are unlikely to get rich by saving; if they have a little money left at the end of the week it makes more sense for them to spend it betting at the

horse races than to save it. Gambling offers at least some chance of winning a large amount, whereas the prospect that the savings will soon be dissipated in one way or another is only too real.

Social conditions in contemporary industrial societies no longer favor a "gambling" attitude toward health. Instead, the prevailing trend goes toward "hygienification" and an increasing concern about physical health. The great priority given in our culture to hygiene and health and the wholly unanticipated inability of the medical profession to deal with AIDS effectively appear to have strengthened the tendency to respond to the new disease with fear-inspired actions that, by the standards of informed medical experts, could only be judged as excessive and needlessly cruel. At the same time, however, both the present concern about health and the authority of medicine also make it likely that, faced with the danger of AIDS, people will be inclined to adjust their conduct in a more reasonable fashion. We have every reason to expect that the fear of AIDS nowadays will sooner prompt people to change some of their ways than the fear of syphilis, although equally formidable, could induce Erasmus's contemporaries to do so. The increasing likelihood that the promise of a long and healthy life may be fulfilled has made it more sensible for people to accept medical authority and to arrange their lives according to the precepts of hygiene. The increasing power of medicine has made "medical materialism" come closer to being true.

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