

Health Professionals in Mid Eighteenth Century Andalusia: Socio-Economic Profiles and Distribution in the Kingdom of Granada

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Introduction

THE STUDY OF GROUPS of health professionals illuminates important details about health care and the socio-economic structure of the towns in the past. This chapter examines the Kingdom of Granada, an early modern Spanish province situated in the south-east of the Iberian Peninsula, and consisting of the present-day provinces of Almería, Granada, and part of Málaga. In 1752, there were approximately 550,000 inhabitants in the region, a third of which lived in urban areas. The largest towns were Granada, an administrative centre, with the Kingdom's only University and Faculty of Medicine, and Málaga, an important port and commercial centre. The biggest hospitals were also situated in these two cities. There were eleven more towns in the region, considered as one of the most extensively urbanised areas in Europe at that time.¹

The health professionals were united in their pursuance of an activity related to the provision of health care for the population, which was their basic means of earning a living, and a key factor in their social identification.

The seven groups which have been identified (physicians, apothecaries, surgeons, barbers, blood-letter, nurses and midwives) were not the only ones linked with these tasks, but were those which enjoyed greater social recognition, making them visible in the extant sources.²

The present methodology involved the identification of groups, using the nomenclature of occupations recognisable as health-care activities; some, considered doubtful, were excluded and others, perhaps involving some aspect of healing, may have been overlooked.³

The analysis has been carried out using a source of a demographic and a fiscal nature: the *Catastro del Marqués de la Ensenada*, drawn up between 1752 and 1754 in the 22 provinces of the Crown of Castilla, with the object of unifying the wide range of taxes then in force. This tax reform, which was known as *Unica Contribución*, did not come to fruition, but has bequeathed an invaluable and unparalleled source for the study of Spanish society in the mid-eighteenth century.⁴ This source has been little used to provide information on the health providers.⁵

Declarations made by the heads of families (*vecinos*) about their work, income and personal and family property, were authenticated by important local figures (priest, mayor, alderman and notary). The subsequent verification, ordering and systemisation of this data gave rise to, amongst others, two kinds of documents, which contained details on real and personal properties and professional earnings (*Libros de la raíz*) and on demographic information related to each family unit (*Libros de Vecindario*). A third document consisted of *Respuestas Generales*: 40 answers to a questionnaire which summarised, on a local basis, part of the information drawn together from the aforementioned documents.⁶ The analysis is drawn from three types of documents totalling 814 books corresponding to 389 towns, 98% of the total in the Kingdom of Granada, revealing 1,358 health practitioners resident in 273 different localities.⁷ Information is available on the professional earnings of 87% of them, and on the age, marital status, number of children and servants of 63%.

The diversity of documents used has created certain methodological problems, which are worthy of mention. Amongst the surgical practitioners (surgeons, blood-letters and barbers), it is frequent to find the same person indiscriminately named as master or clerk of one or more professions (i.e. blood-letter in one place and barber in another). In these cases, which relate to 39% of the surgeons and blood-letter, the highest hierarchical group has been assigned to the practitioner.⁸ There are health providers who appear in the *Libros de Vecindario* but not in the *Respuestas Generales*, probably because they were not deemed taxable subjects; this affected some

professionals over the age of 60, although still active according to their earnings, but above all the midwives, who were clearly invisible to the majority of officials who carried out the *Catastro de Ensenada*.⁹ Lastly, the economic data could also vary between the different documents as the *Respuestas* tended to unify and round off the figures; in cases of discrepancy, the information in the *Libro de la raíz* was favoured.

The Professions

IN THE MID-EIGHTEENTH CENTURY, the largest group of health providers in the Kingdom of Granada (Table 1) was formed by the barbers and their clerks (43%), the least qualified and with the fewest health-care duties. Together with the blood-letter, the surgeons and their clerks they accounted for more than two thirds of the health practitioners in the Kingdom, the presence of these last three groups being similar to that of the apothecaries and physicians, all of whom represented between 13 and 14% of the total. The smallest groups, the midwives and nurses, amounted to just over 1%. This inter-professional distribution, although comparable to other areas of Andalusia,¹⁰ does not seem to follow a generalised pattern for the whole of Spain. As an example, in the provinces of Castilla and León, the surgeons where the most numerous and accounted for over half of the health providers.¹¹

The physicians were the only group of health providers to be university-trained, although some so-called 'Latin' surgeons could also fall

Table 1: Health professionals in the Kingdom of Granada, 1751-54

	NUMBER	%
Physicians (<i>Médicos</i>)	180	13.2
Apothecaries (<i>Boticarios</i>)	134	9.9
Apothecaries' clerks (<i>Oficiales de boticario</i>)	48	3.5
Surgeons (<i>Cirujanos</i>)	183	13.5
Surgeons' clerks (<i>Oficiales de cirujano</i>)	9	0.7
Bloodletters (<i>Sangradores</i>)	188	13.9
Bloodletters' clerks (<i>Oficiales de sangrador</i>)	14	1.0
Barbers (<i>Barberos</i>)	460	33.9
Barbers' clerks (<i>Oficiales de barbero</i>)	125	9.2
Midwives (<i>Matronas, parteras o comadres de parir</i>)	10	0.7
Nurses (<i>Enfermeros/as</i>)	7	0.5
All professionals	1,358	100.00

Source: *Catastro de Ensenada*

into this category;¹² no such nomenclature has been discovered in the Kingdom of Granada. Medicine in this period was the most powerful profession within the health-care domain, since it controlled all the others, both on a general scale, through the Board of the *Protomedicato*¹³ (the King's Physicians and the highest medical authority), and locally, through the town councils, authorising or refusing the right to practise to all the groups of health providers by setting examinations or by checking and certifying the qualifications.¹⁴

In order to be able to practise anywhere in Spain, all the health practitioners, with the exception of the nurses, and including the midwives from 1750, had to be examined by the *Protomedicato* or its delegations. In addition, it was stipulated that a minimum of two years' practice alongside an authorised professional had to be accredited. Physicians were not exempt and this led to repeated quarrelling and bickering between university staff and the *Protomédicos*, the former arguing that such a measure devalued the university degree.¹⁵ The physicians who undertook this period of practical training, in theory, were not supposed to gain economic benefit from such, and, were thus not liable for taxes. They were called *practicantes*¹⁶ or *pasantes de médico*, and there were at least four in the Kingdom of Granada. One of them, Francisco Gadea, from Granada, supported himself by giving grammar classes¹⁷, whereas Joseph Ramírez, a *pasante* in Pitres, being the only physician in the town, was paid a small salary.¹⁸

This apprenticeship and its duration varied according to profession and province,¹⁹ and was obligatory for the remaining groups of health providers, forming the basis for their training and incorporation in their new trade. This system was common to other trades with a guild structure and had two levels of practical qualifications: clerk and master. The clerks, unlike the *pasantes* could work independently, and only differed from the masters in that they could not take on pupils.²⁰ A clerk working with a master was an employee and received a wage. In the Kingdom of Granada, 40% of clerks were in these circumstances; the majority, evidently carrying out their profession autonomously. Yet, the employee did not seem to be in an unfavourable position as he obtained a slightly higher wage than the self-employed clerks (539 *reales de vellón* -hereafter *r.v.*- and 509 respectively), and he often lived in his master's house.²¹

The apothecaries possessed the most solid guild structure amongst the health providers, and their apprenticeship lasted for four years at the side of another apothecary; the knowledge of Latin was an essential requisite for any trainee.²² The health-care administration, during the eighteenth century, endeavoured to rationalise the principal structures of the profession by

dismantling the guilds and subjecting them to the centralised power of the *Protomedicato*. This was paralleled by their attempt to renew the corpus of pharmaceutical knowledge through the inclusion, at first voluntary but from the middle of the century obligatory, of the study of botany at the Royal Botanical Garden in Madrid.²³ The apothecaries, however, had traditionally controlled themselves, and their submission to the Royal Board of the *Protomedicato*, and consequently to the physicians, was more a formality than a reality. They held a comfortable social and professional position, with many privileges and prerogatives, and, thus, felt that reform was unwarranted. Therefore, it was not until 1799 that a new teaching model came into being in Spain, requiring all apothecaries to have a *bachiller en Artes* and to study for two years in the newly created Pharmacy Colleges.²⁴

The professional duties attributed to the practitioners largely depended on the distinction between 'liberal' and 'mechanical' arts; the origin of a major debate amongst enlightened scholars. A mechanical trade involved manual work and physical effort, and bore negative connotations in the hierarchical and agricultural society of the eighteenth century, where labour ethics were non-existent.²⁵ All the practitioners of the period wished for their professions to be recognised as liberal arts, rejecting the term 'manual', which clearly expressed their desire to improve their standing within a rigidly structured society. Juan Navalón, a blood-letter-surgeon, claimed that the bloodletting profession was:

in itself, extremely worthy and honourable, in spite of the unjust contempt shown by some who have tried to belittle this Liberal Art, attempting to reduce it to the category of mechanical, carried away by their fervour or deceived by their ignorance.²⁶

The professional duties of the physicians centred on the diagnosis and treatment of general illnesses. The most common therapeutic solutions lay in bloodletting, the task par excellence of the blood-letters, and in chemical or natural preparations, which were chiefly based on the works of Galen and Dioscorides,²⁷ and prepared and sold by the apothecaries. External afflictions were entrusted to the surgeons: a clearly expanding group who had also begun to practise midwifery and to take care of all manner of illnesses. Nevertheless, the ideal therapeutic protocol of the mid-eighteenth century was outlined by the surgeon José Jiménez in the case of a woman with advanced venereal scabies: firstly, the physician was called, who diagnosed hysteric affliction and treated the patient; 'the woman free of hysteric disorders, the doctor took his leave, and I was summoned to heal the said herpes, as a surgical case.'²⁸

Lancing and bloodletting were basic techniques belonging to the surgeons and the barbers, and were common to both; indeed, their duties were undoubtedly less well-defined than their different names seem to suggest. The surgeons who treated external illnesses by lancing, cauterising, bloodletting and applying cupping glasses, leeches or *vejicatorios* (special poultices to blister the skin),²⁹ differed little from the blood-letters, who, were not only expert in bloodletting, but also in 'lancing, applying leeches, and extracting teeth.'³⁰ The barbers had been performing this last health-care activity from 1500, along with other therapeutic tasks, such as administering purges and applying balms, oils or poultices,³¹ besides cutting hair and shaving.³²

As has been noted, the surgical practitioners frequently appear with more than one title, as in the case of 31% of the surgeons, 46% of the blood-letters and 14% of the barbers in table 1. This occupational heterogeneity seems to highlight the similarity between the practices of these three groups, as well as the common nature of their own joint practices. This does not question, however, their professional differentiation or identification.

Spanish historiography has not been unanimous in defining the so-called surgical groups. One suggestion, based on the professional duties conferred on these by theoretical works and the prevailing legislation, is that, in early modern Spain, blood-letters and barbers were one and the same profession;³³ another ranks romance surgeons with barbers,³⁴ both diverging from the tripartite distinction.³⁵ There is evidence to suggest that three separate professional groups existed, which were identifiable less by the fuzzy boundaries dividing their practical activities, but more by their socio-economic profiles, which, as will be shown subsequently, perfectly distinguish each group by age, earnings or geographical distribution.³⁶

The midwives, who attended births and took care of the mothers and their new-born, and possibly many other aspects of female and child health care, for the first time in two centuries, found themselves under the supervision of the *Protomedicato*. This intensified, at least on paper, the regulation of their practice, which until 1750 had been controlled exclusively by municipal or ecclesiastical authorities.³⁷ The figure of 10 midwives for the whole of the Kingdom is not credible, and can be explained only by the manner in which the *Catastro* was elaborated, explicitly excluding women from fiscal duties, except those who owned land or a business.³⁸

In general, the regulation of the professions was well-defined and well-known, but what occurred in practice, may have been quite different.

In addition to the unclear divisions between the professional groups, there were exceptions to the regulations, and voluntary transgressions by collectives and/or individuals. For example, the blood-letters, although dependent on the therapeutic indications of the physician to perform their trade, could prescribe in his absence and practise their bloodletting in cases like 'illnesses of pains in the side, erysipelas, sore throats and falls'.³⁹ The barbers 'used the faculties of surgery and phlebotomy', and were denounced for doing so,⁴⁰ like the surgeons who 'meddle in healing, throwing into confusion all that which an intelligent physician ordains, scorning the laws of the Kingdom, which most justly forbid it'.⁴¹ The midwives, who, from 1750, had been trying to limit practise to uncomplicated deliveries, reserving the difficult births for the surgeons, not only had to attend these cases when there was no surgeon present, but did so in the Court itself, where there was a high concentration of all manner of surgeons.⁴² Midwives even prescribed and administered medicines.⁴³

The health professionals, with the exception of midwives, were male, middle-aged (averaging 39) and married, with around two children. The midwives differ from this profile, not only because of their sex, but also because they tended to be widows and older, as the *Protomedicato* demanded, and usually had only one child (see ages in Table 2).

A typical family unit of the practitioners consisted of four members, except for the physicians and surgeons with five and the apothecaries, with the largest families of six. The presence of surgeons in the bosom of the family contributed to these figures, and was noticeably more habitual amongst the physicians and apothecaries, who, on average, had one and two servants respectively (Table 3).

The servants' division by gender is a key factor in understanding the role they played within the household: the duties of the male servants were almost always linked with the professional activity of the head of the family, working as clerks or apprentices; the female servants, however, were restricted to housework, aiding the mistress or the master, if he were a bachelor or a widower.⁴⁴ This domestic structure situates the apothecaries and physicians at the tip of the social pyramid of their time, along with the nobles and the rest of the liberal professions.⁴⁵

Regarding the question of age, apart from the midwives and nurses, the surgeons were the eldest, being, on average, seven years older than blood-letters and nine years older than barbers (Table 3). The age variable places these professions in the same order as that of professional duties or socio-economic status (their incomes will be discussed later). The practitioners with most health-care duties and with greater social status are

the eldest, which could endorse a kind of inter-professional promotion: apart from the guild channel of master and clerk, the health professionals also progressed upwards through the three occupations, passing from the least to the most qualified: a procedure which has already been observed by Sebastián Acuña, a physician of the period.⁴⁶

On the whole, the practitioners were evenly distributed between urban and rural areas. However, when the individual professions are analysed, this only remains true of the barbers. Nurses, midwives, apothecaries and blood-letters were clearly urban-based, while the majority of physicians and surgeons lived in the countryside (Figure 1). In the south-east of Spain, this data contradicts the urban image of the most qualified practitioners, namely the physicians.⁴⁷ Within urban areas, the largest cities (Granada and Málaga) clearly appealed to all the health professionals,

Table 2: Average ages of health professionals by category

	Masters		Clerks		Total age
	n	age	n	age	
Physicians	108	44	0	—	44
Apothecaries	86	43	35	27	39
Surgeons	122	47	6	22	46
Bloodletters	112	40	11	28	39
Barbers	282	38	86	29	36
Nurses	6	55	0	—	55
Midwives	9	50	0	—	50
All professionals	725	41	138	28	39

Source: *Catastro de Ensenada*

Table 3: Presence of servants in health professionals' homes

	% of homes with servants			Average of servants per home	
	n	female	male	female	male
Apothecaries	86	48	44	1	1
Physicians	107	45	24	1	0
Surgeons	125	19	37	0	0
Bloodletters	115	3	21	0	0
Barbers	289	3	9	0	0

Source: *Catastro de Ensenada*

especially the apothecaries and blood-letter, who were polarised between the capitals and the rural areas. The surgeons were the least well represented in the eleven intermediate towns spread throughout the whole of the Kingdom.⁴⁸ The repercussions this had on health-care availability will be discussed shortly.

The majority of practitioners in the Kingdom of Granada were not involved in any other occupation save their own health-care activity, except for a mere 4.7%, who also undertook an additional trade (Table 4).⁴⁹ This was of a purely complementary nature, providing no greater economic benefit than that derived from the health care activity, nor being any more significant in their professional identification. They are identified first and foremost as health practitioners, and then as something else.

There are no great differences between the professions regarding this dual employment, although it does occur more frequently amongst the barbers than the physicians, who found themselves at opposite ends of the scale. As will be seen, the relationship between low income and a secondary occupation, seems to endorse the latter's complementary economic nature.

These secondary occupations were always diverse and the health professionals were distributed between commercial, agricultural, craft, administrative and ecclesiastical activities.⁵⁰ This last category was the

Figure 1: Urban v. rural distribution of health professionals

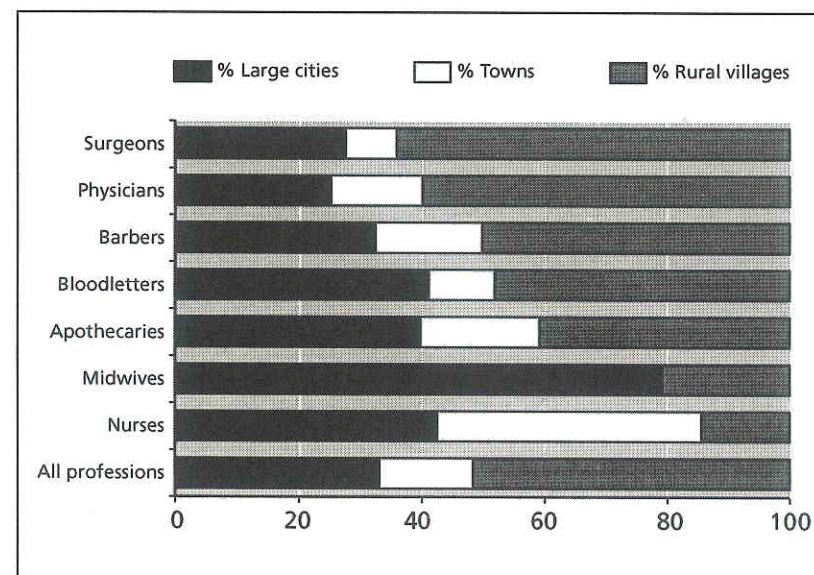


Table 4: Health professionals(*) devoted to medical and non-medical practices

	n	%
Physicians	8	4.5
Apothecaries	6	4.5
Bloodletters	9	4.8
Surgeons	10	5.5
Barbers	27	5.9
All professionals	60	4.7

* Clerks excluded

Source: *Catastro de Ensenada*

exclusive domain of the physicians and the most commonly noted, with three clerical physicians resident in the towns of Málaga, Almería and Ronda, and one in Huerca Overa. Two agricultural labourers (Almuñécar and Barranco de Poqueira), a silk craftsman (Málaga) and a notary (Sedella) complete this short list of physicians with two occupations.⁵¹

Although pharmacy has also been historically an occupation of clerics, none of the apothecaries found in the Kingdom of Granada figure as such. They are linked, however, with agriculture (2 day-labourers in Abta and Puebla de Santa María), and there is also a landowner who obtained a higher income from his land than from his profitable pharmacy in the town of Málaga.⁵² In Baza, another apothecary was the owner of a nitre (saltpetre) boiler, which provided him with considerable economic gain.⁵³

The surgeons, barbers, and to a lesser degree, the blood-letters seem more devoted to non-medical activities. The inhabitants of rural areas, were involved usually in agricultural work, although there were also shopkeepers, bakers, brandy merchants, weavers, bell-ringers and notaries. They were connected with religious activities, but were never clerics, only vergers or acolytes,⁵⁴ a situation which reflects curiously the hierarchy of the health-care professions.

Although these non-medical activities did yield high earnings in a few cases, it is the difference between them which is noteworthy, ranging from 2 to 11,000 r.v. per annum. On average, these incomes were lower than those derived from the professional activity, and never amounted to more than a quarter of the total earnings; blood-letters and apothecaries came closer to this proportion than the others (Table 5). The health-care professions, therefore, represented the main source of income for all the practitioners, substantiating a marked degree of professionalisation within all the groups.

The analysis of their income supports the idea of an inter-professional structure, already suggested by the personal and labour information, and reveals the existence of groups, well-defined in socio-economic terms, which is probably related to their expertise and health-care duties. In this respect, it is clear, that in the mid-eighteenth century in the south-east of Spain, surgeons and barbers were not one and the same profession, even though some surgeons may have practised additionally as barbers, or some barbers may have exceeded their hygienic responsibilities. The blood-letters also formed a group with its own identity and characteristics, although the reality of their practices lies beyond the scope of the available evidence.

The guild structure of each professional body is also reflected in the salaries, these being significantly lower for clerks than for masters (Table 6). Bearing in mind this variable in the breakdown of the salaries for each occupation, it is easier to appreciate the financial position of the average master apothecary, which was more in line with that of the physicians than the joint figures with the clerks in Table 5 indicated originally.

There were other factors which determined the practitioners' incomes, since, from a financial point of view, it was not the same to work in the city as in the country, as the rural villages offered fewer opportunities for financial gain (Table 7). Likewise, the differences in earnings between the professional groups in the villages were less obvious than in urban areas.

In general, the most qualified practitioners in the Kingdom of Granada enjoyed a status similar to that of the other liberal professions.⁵⁵ They occupied an intermediate position with respect to the other health-care professionals in Spain. The average earnings in the capitals were comparable to the amounts stipulated by the *Protomedicato* to remunerate their examiners (4,400 r.v. in 1752),⁵⁶ and were higher than those of physicians in Cordoba (about 2,200 r.v.).⁵⁷ All the practitioners, however, fell far short of the incomes obtained by their counterparts in Cádiz, which were two or three times above those of Granada. This was clearly in keeping with the respective economic situations of both cities: Cádiz, at that time, was experiencing its greatest commercial development and growth, which was reflected in every aspect of city life, rendering it a special case within the Spanish economy of that period.⁵⁸

Health care

IN THE MID-EIGHTEENTH CENTURY, a total of 1,341 health providers (excluding nurses and midwives) carried out their work amongst the slightly more than half a million inhabitants of the Kingdom of Granada; a

Table 5: Earnings of active professionals, including clerks

	<i>reales de vellón per occupation</i>		
	healthcare(1)	other(2)	total(2)
Physicians	2,380	472	3,174
Apothecaries	1,828	575	2,600
Surgeons	1,339	352	1,673
Bloodletters	981	331	1,396
Barbers	662	180	879
All professionals	1,218	321	1,618

(1) Out of a total of 1,152

(2) Out of a total of 537

Source: *Catastro de Ensenada*

Table 6: Earnings of active professionals by guild classification

	<i>reales de vellón per healthcare activity</i>	
	Masters	Clerks
Physicians	2,380	—
Apothecaries	2,088	672
Surgeons	1,374	332
Bloodletters	1,001	397
Barbers	692	490
All professionals	1,308	519

Source: *Catastro de Ensenada*

Table 7: Earnings of active professionals(*) by place of residence

	Large cities	Towns	Rural villages
Physicians	4,805	2,455	1,621
Apothecaries	2,427	1,807	1,365
Surgeons	2,174	1,364	1,028
Bloodletters	1,253	815	789
Barbers	845	865	542
All professionals	1,811	1,253	899

(*) Clerks included

Source: *Catastro de Ensenada*

density of 24.5 practitioners per 10,000 inhabitants, which was somewhat higher than that of other Spanish regions.⁵⁹ The density of physicians and surgeons, which was calculated jointly, as was customary in studies on health care, was 6.8 per 10,000 or 10.5 including the blood-letters (Table 8). This was indicative of a medicalised society, having much in common with that of France in the second half of the eighteenth century (between 5 and 10 physicians and surgeons per 10,000 inhabitants), and with a higher density than that of England and Wales during the same period: 5.7 per 10,000.⁶⁰ The joint density of the surgeons and blood-letters was twice that of the physicians.

These density rates of physicians and surgeons in Andalusia seem to have been maintained throughout the whole of the eighteenth century, and were the highest for two centuries, gradually decreasing in the nineteenth

Table 8: Densities of health professionals per 10,000 inhabitants

	Total	Large cities	Towns	Rural villages
Physicians	3.3	4.9	3.4	2.9
Surgeons	3.5	5.7	2.0	3.3
Apothecaries	3.3	7.7	4.5	2.0
Barbers	10.7	20.2	12.8	7.8
Bloodletters	3.7	8.9	2.7	2.6
All professionals	24.5	47.4	25.4	18.6

Source: Archivo General de Simancas, *Vecindario de Granada*, D.G.R., 1ª rem, leg. 2.046. *Catastro de Ensenada*.

Table 9: Socioeconomic classification of the population centres of the Kingdom of Granada

	Heads of famil.	Tax-payers	Day-Labourers	Paupers (1)	others (2)
Large cities	23,681	72.2	10.4	14.4	3.1
Towns	20,066	57.6	29.9	9.3	3.1
Rural villages	93,118	52.5	37.9	7.7	1.9
Total	136,865	56.7	31.9	9.1	2.3

(1) The miserable poor and poor widows.

(2) Vagabonds and clergymen.

Source: Archivo General de Simancas, *Vecindario de Granada*, D.G.R., 1ª rem, leg. 2.046.

century⁶¹ and not being repeated until the middle of the twentieth century.⁶²

The study of the densities of health professionals in urban areas (large cities and towns) and rural areas enables an elaboration of these characteristics (Table 8). The cities of Granada and Málaga, which exhibited, to a large extent, the poverty and relative prosperity of the Kingdom, and which held less than a fifth of the population, had the greatest density of practitioners, with a total of 47.3 per 10,000 inhabitants, almost double that of the overall rates for the Kingdom.⁶³ The rural centres, on the other hand, which were inhabited by two thirds of the population of the Kingdom and the bulk of the day-labourers, 80.7%, were the worst supplied with health professionals.⁶⁴ The towns, which had a social structure of intermediate characteristics, in contrast to the aforementioned, (and in keeping with that of the Kingdom), revealed a density of practitioners which was slightly above that of the Kingdom. This order of precedence held true

Table 10: Health professionals in the *partidos* of the Kingdom of Granada. Absolute Numbers

	All	Phy.	Sur.	Apo.	Bar.	Blo.
Baza	185	34	35	27	55	34
Granada	304	34	43	45	104	78
Málaga	244	22	27	41	130	24
Ronda	132	22	7	14	83	6
Alpujarras	109	20	24	13	39	13
Almería	70	8	11	5	39	7
Guadix	52	8	13	3	22	6
Vélez Málaga	43	6	4	6	20	7
Las Villas	26	7	2	5	8	4
Loja	42	3	2	5	32	0
Hoya de Málaga	18	4	1	4	5	4
Valle Lecrín	18	2	3	2	7	4
Motril	18	2	4	2	9	1
Alhama	23	2	2	5	14	0
Almuñécar	16	3	4	0	7	2
Marbella	17	2	1	3	0	11
Torvizcón	11	0	6	1	4	0
Orgiva	11	1	3	1	6	0
Temple	2	0	0	0	1	1
Total	1,341	180	192	182	585	202

Note: Phy. (Physicians), Sur. (Surgeons), Apo. (Apothecaries), Bar. (Barbers), Blo. (Bloodletteres).

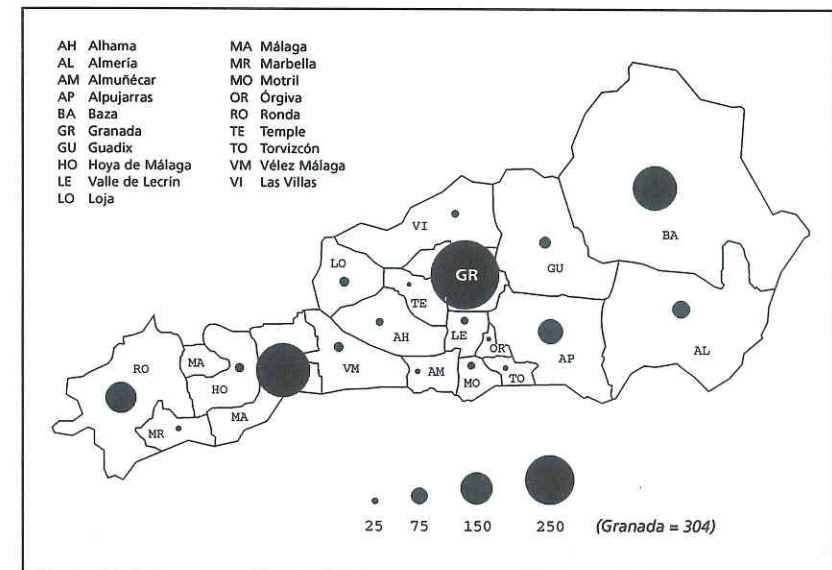
Source: Archivo General de Simancas, *Vecindario de Granada*, D.G.R., 1ª rem, leg. 2.046. *Catastro de Ensenada*.

for the different professional groups. The density of physicians and surgeons in the large cities was almost twice that of the rural villages and the towns: 10.6, 6.2 and 5.4 per 10,000, respectively⁶⁵, although the density of surgeons was greater in the rural centres than in the intermediate towns, and that of the blood-letters was similar in both areas.

The size of the population centres seems to be significant in explaining the territorial distribution of the health professionals as a whole in the Kingdom of Granada.⁶⁶ It would not be inconsistent with such a distribution to find the highest concentration of a potential clientele in urban areas.⁶⁷ Almost three quarters of the inhabitants of the cities of Granada and Malaga were taxpayers, and, therefore, potential patients of the practitioners (Table 9). The vitality of the health-care market, structured within a regime of freedom or induced by the town councils through the creation of public posts for the professionals, could be the key to the professional distribution and to institutional care in eighteenth century Spain.⁶⁸

Some testimonies of the period, which seem to highlight the vigour of the health-care market, lend support to this hypothesis. Benito Jerónimo Feijoo, the well-known Cistercian populariser of the programme of the

Map 1: Health professionals per *partido* in the Kingdom of Granada. Number of physicians, apothecaries, surgeons, bloodletters and barbers



scientific revolution in the first decades of eighteenth-century Spain, claimed that:

the physicians live in great evidence amongst the People. There is scarcely such frequent contact with another group of men ... the frequency of the commerce [is great].⁶⁹

The study of the densities and the distribution of the practitioners by localities grouped into *partidos* (administrative districts) sheds both light and shadows as a result of the variability and the diversity present (Table 10 and Map 1).

The districts of Baza, Granada, Málaga, Ronda and the Alpujarras were the most populated in the Kingdom (almost two thirds of the population were concentrated there), and were served by the bulk of the practitioners: around three quarters of the general contingent and a similar proportion from each of the individual groups. All the above districts had

Table 11: Densities of health professionals per 10,000 inhabitants in the *partidos* of the Kingdom of Granada

	Inhabitants	All	Phy.	Sur.	Apo.	Bar.	Blo.
Baza	91,960	20.1	3.7	3.8	2.9	6.0	3.7
Granada	84,048	36.2	4.0	5.1	5.4	12.4	9.3
Málaga	70,576	34.6	3.1	3.8	5.8	18.4	3.4
Ronda	62,760	21.0	3.5	1.1	2.2	13.2	1.0
Alpujarras	47,812	22.8	4.2	5.0	2.7	8.2	2.7
Almería	32,720	21.4	2.4	3.4	1.5	11.9	2.1
Guadix	27,708	18.8	2.9	4.7	1.1	7.9	2.2
Vélez Málaga	26,952	16.0	2.2	1.5	2.2	7.4	2.6
Las Villas	16,608	15.7	4.2	1.2	3.0	4.8	2.4
Loja	15,928	26.4	1.9	1.3	3.1	20.1	0.0
Hoya de Málaga	13,136	13.7	3.0	0.8	3.0	3.8	3.0
Valle Lecrín	11,192	16.1	1.8	2.7	1.8	6.3	3.6
Motril	10,156	17.7	2.0	3.9	2.0	8.9	1.0
Alhama	8,756	26.3	2.3	2.3	5.7	16.0	0.0
Almuñécar	8,572	18.7	3.5	4.7	0.0	8.2	2.3
Marbella	6,840	24.9	2.9	1.5	4.4	0.0	16.1
Torvizcón	5,564	19.8	0.0	10.8	1.8	7.2	0.0
Orgiva	3,480	31.6	2.9	8.6	2.9	17.2	0.0
Temple	2,692	7.4	0.0	0.0	0.0	3.7	3.7
Total	547,460	24.5	3.3	3.5	3.3	10.7	3.7

Note: See abbreviations in Table 10.

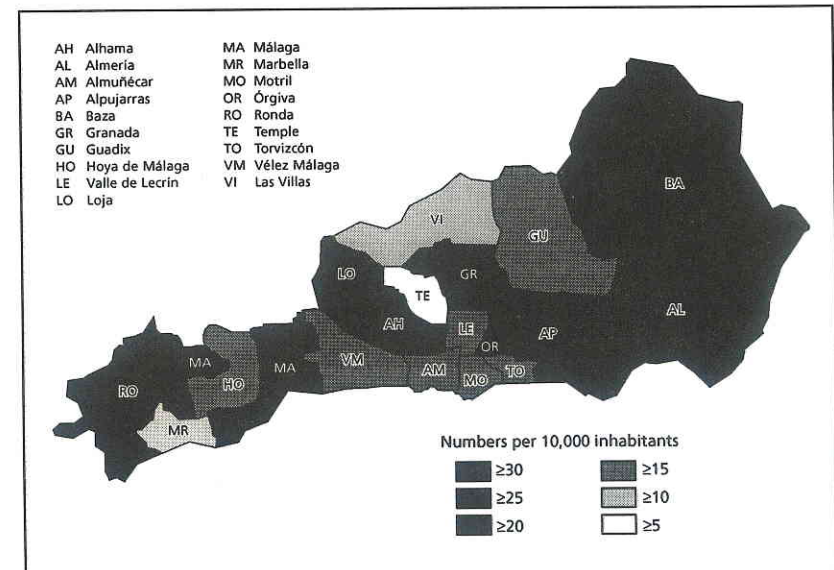
Source: Archivo General de Simancas, *Vecindario de Granada*, D.G.R., 1ª rem, leg. 2.046. *Catastro de Ensenada*.

more than 20 health practitioners per 10,000 inhabitants (Table 11 and Map 2), a density approaching the overall rates for the Kingdom, and which appears inflated due to the contingent districts of Granada and Málaga, containing the two major urban centres. Every *partido* had higher densities of physicians and surgeons than the general rates throughout the Kingdom. Only the density of surgeons in the district of Ronda does not follow this pattern.

The high concentration of health professionals in these districts could be linked with their relatively advantageous socio-economic structures (Table 12): in four of them, the proportion of taxpayers was superior to that in the whole of the Kingdom (in Malaga it amounted to 64.1% of the total). Only the district of Ronda, with its large cereal producing estates, did not surpass this proportion. Nevertheless, apart from the district of Malaga, which, during the eighteenth century underwent major demographic and commercial growth, and to a large extent, the district of Granada, with the capital and bureaucratic and commercial centre, these districts lacked economic and demographic dynamism at that time.⁷⁰

Together with the districts of Granada and Málaga, those of Orgiva, Loja, Alhama and Marbella also showed higher densities of practitioners

Map 2: Health professionals per *partido* in the Kingdom of Granada
Rate of physicians, apothecaries, surgeons, bloodletters and barbers



than was normal for the Kingdom. In socio-economic terms, however, Marbella and Loja present disparate conditions: they had limited proportions of taxpayers, and their respective populations were composed of 5.3% and 17.5% of paupers. This placed them at the bottom of the age-old demographic pattern and economic growth of the Kingdom, representing, respectively, the vitality of the Málaga littoral and the archaism of the cereal producing hinterland. Alhama and Orgiva did not escape from this last condition, although Orgiva did have a considerable number of small properties.

The other districts were supplied meagrely with health practitioners (only Almeria had more than 20 practitioners per 10,000 inhabitants), independent of the demographic and economic growth registered from the beginning of the century. The least populated district in the Kingdom, that of Temple, bore witness to some extreme health-care conditions: it lacked physicians, surgeons and apothecaries, and the density of professionals was the very least in the Kingdom.

Table 12: Socio-economic classification of the heads of families of the Kingdom of Granada – 'partidos'. (percentages)

	Heads of famil.	Tax-payers	Day-Labourers	Paupers	others
Baza	22,990	58.2	32.2	6.9	2.7
Granada	21,012	58.4	22.9	15.8	3.0
Málaga	17,644	64.1	25.2	8.8	1.9
Ronda	15,690	54.5	37.1	6.0	2.4
Alpujarras	11,953	59.7	31.4	6.7	2.2
Almería	8,180	54.6	34.5	8.5	2.3
Guadix	6,927	58.2	30.7	8.6	2.4
Vélez Málaga	6,738	57.2	34.3	7.1	1.4
Las Villas	4,152	47.2	41.6	9.8	1.3
Loja	3,982	45.4	35.6	17.5	1.6
Cuatro Villas	3,284	53.3	37.1	6.8	2.7
Lecrín	2,798	51.9	39.6	7.0	1.5
Motril	2,539	44.4	41.3	11.7	2.6
Alhama	2,189	48.1	42.3	6.9	2.6
Almuñécar	2,143	46.8	44.1	7.3	1.8
Marbella	1,710	52.5	40.1	5.3	2.2
Torvizcón	1,391	50.7	38.2	9.7	1.4
Orgiva	870	49.9	41.6	6.6	2.0
Temple	673	55.9	38.5	4.9	0.7
Total	136,865	56.7	31.9	9.1	2.3

Source: Archivo General de Simancas, *Vecindario de Granada*, D.G.R., 1ª rem. Leg. 2.046.

Meanwhile, examination of Table 13 will enable a development of the hypothesis. In the districts of Baza, Málaga, Ronda and the Alpujarras, a substantial number of localities had one practitioner. This was relevant particularly in the two districts of Baza and the Alpujarras, which had the largest number of population centres in the Kingdom, containing a quarter of the total, and a similar proportion of the population, where more than 90% of the centres were served by a practitioner. In the districts of Málaga and Ronda, the proportion is equally significant: around three quarters of their communities were attended by a practitioner.

Also worthy of mention, is the marked presence of the physicians, who, in Baza, Málaga and Ronda constituted the second largest group in numerical importance after the barbers, and the third in the district of the Alpujarras after the barbers and surgeons. The district of Granada, being the only one with higher densities of the different professional bodies than the overall rates for the Kingdom, diverged from these levels of distribution:

Table 13: Health-care coverage of the *partidos* in the Kingdom of Granada

	Centres		% of towns with				
	Total	HP	Phy.	Sur.	Apo.	Blo.	Bar.
Baza	57	93.0	49.1	47.4	28.1	61.4	33.3
Granada	43	62.8	7.0	23.3	16.3	44.2	20.9
Málaga	22	77.3	36.4	27.3	31.8	59.1	27.3
Ronda	39	74.4	41.0	17.9	25.6	69.2	12.8
Alpujarras	45	91.1	40.0	42.2	22.2	51.1	26.7
Almería	25	76.0	24.0	28.0	12.0	68.0	20.0
Guadix	38	63.2	13.2	26.3	5.3	42.1	13.2
Vélez Málaga	23	47.8	17.4	17.4	8.7	26.1	17.4
Las Villas	15	46.7	33.3	6.7	20.0	26.7	20.0
Loja	6	83.3	33.3	16.7	33.3	83.3	0.0
Hoya de Málaga	5	40.0	40.0	20.0	40.0	20.0	40.0
Valle Lecrín	18	50.0	11.1	16.7	11.1	27.8	11.1
Motril	4	100.0	25.0	100.0	25.0	25.0	25.0
Alhama	6	33.3	16.7	16.7	16.7	33.3	0.0
Almuñécar	12	58.3	16.7	25.0	0.0	33.3	16.7
Marbella	4	75.0	25.0	25.0	25.0	0.0	75.0
Torvizcón	9	66.7	0.0	44.4	11.1	33.3	0.0
Orgiva	7	57.1	14.3	28.6	14.3	42.9	0.0
Temple	20	10.0	0.0	0.0	0.0	5.0	5.0
Total	398	68.3	26.4	27.9	17.8	46.5	19.8

Note: HP (Health Professionals), Phy. (Physicians), Sur. (Surgeons), Apo. (Apothecaries), Blo. (Bloodletters), Bar. (Barbers).

Source: *Catastro de Ensenada*.

fewer than two thirds of its population centres had a practitioner, which was a proportion below that of the Kingdom as a whole. The distribution of its physicians reflects this difference more sharply: 93% of its centres were without a health professional. This demonstrates the strong power of attraction that the capital wielded over the villages of the surrounding plain. The district of Temple, which lay at the opposite end of the socio-economic scale, had only a barber or a blood-letter in 2 of its 20 population centres.

The map of health-care provision in the Kingdom of Granada corresponds to that of the demographic densities.⁷¹ The significant presence of the health professionals in rural areas⁷² (as in the case of the regions of Baza and the Alpujarras) suggests additionally the possibility of frequent contact between the population and the practitioners. The nature of this relationship and the influence that various factors may have borne on it, such as social and professional structures, the standard of the administration and public services⁷³ (including hospitals), the assignation of health-care public posts, the degree of literacy of the population and the impact of the Faculty of Medicine of Granada, amongst others, is, as yet, unknown.

Translated from Spanish by Linda Hollinger.

Notes

- 1 They are Alhama, Almería, Baza, Guadix, Huescar, Loja, Marbella, Motril, Ronda, Vélez Málaga and Vera, according to Bernard Vincent, 'Economía y sociedad en el Reino de Granada, siglo XVIII', in *Historia de Andalucía* (Madrid, 1981), vol. VI, p. 384.
- 2 On other kinds of practitioners see Enrique Perdiguero, 'The popularization of medicine during the Spanish Enlightenment', in Roy Porter (ed.), *The popularization of medicine, 1650-1850* (London, 1992), pp. 160-193.
- 3 In this respect farriers were not included, since they were officially connected with animal care, especially that of horses; their presence in the source is irregular, and frequently confused with that of the blacksmiths; also excluded were the druggists and wax chandlers, who were described as being in competition with the apothecaries by Javier Puerto Sarmiento, 'La profesión farmacéutica: del gremialismo al corporativismo', in José Luis Peset (ed.), *La Ciencia Moderna y el Nuevo Mundo* (Madrid, 1985), pp. 396-400.
- 4 Was not carried out in Catalonia, Aragón, Valencia, Navarra y Vascongadas. The best study published about the *Catastro de Ensenada* is that by Concepción Camarero Bullón, *Burgos y el Catastro de Ensenada* (Burgos, 1989).
- 5 The only two works on the health professionals based on the *Catastro* are those by Juan Manuel Granda Juesas, 'Médicos, cirujanos, barberos, sangradores y boticarios asturianos en el Catastro del Marqués de la Ensenada', *Boletín del Instituto de Estudios Asturianos*, 133 (1990), 97-110; and Margarita Moretón Alonso, *Las profesiones sanitarias en Castilla y León (siglo XVIII). Análisis sociológico y estadístico* (Valladolid, 1993). Previous to this, it is also cited by Luis S. Granjel, *La medicina española del siglo XVIII* (Salamanca, 1979), pp. 79-80; and Antonio Domínguez Ortiz 'Algunos datos sobre médicos rurales en la España del siglo XVIII', *Asclepio*, 25 (1973), 317-321.
- 6 In this *Interrogatorio General* questions 30, 32 and 33 ask about the number and earnings of the health practitioners, as well as the existence and income of the hospitals: such information is not included in this work.
- 7 The total number of towns has been obtained from the document entitled *Vecindario de Granada*, which is conserved in the General Archives of Simancas, D.G.R., 1^a rem., leg. 2.046.
- 8 All the other nomenclatures with which they appear have been retained in order to discuss their professional identity.
- 9 Women were not liable for taxes unless they were obviously rich, according to Camarero Bullón, *Burgos y el Catastro*, pp. 307-310.
- 10 In the city of Cádiz, the barbers are also in the majority (51%), surgeons and bloodletters total 18% and physicians 10%. Antonio García Baquero, *Cádiz 1753 según las Respuestas Generales del Catastro de Ensenada* (Madrid, 1990).

- 11 Moretón Alonso, *Las profesiones sanitarias en Castilla y León*, also uses the *Catastro de Ensenada* but does not refer to the barbers amongst the health professionals, thus stating nothing of their numerical importance. In the city of Murcia, the inscriptions of health practitioners in the XVIII century were principally of bloodletters (34%), and physicians and surgeons amounted to almost 20%, according to José M. Sáez Gómez and Pedro Maset Campos, 'Profesionales sanitarios en la Murcia del siglo XVIII. Número, evolución y distribución', *Asclepio*, 45 n. 2 (1993), 71-101.
- 12 Carmen Calleja Folguera, *La reforma sanitaria en la España ilustrada* (Madrid, 1988), pp. 7-8.
- 13 On the *Protomedicato* see Calleja Folguera, *La reforma sanitaria*, pp. 2-48.
- 14 Proof that this control was carried out can be found in Carmen Mairal Jiménez, *Cargos y oficios públicos en la Málaga de Carlos III* (Málaga, 1990), pp. 88-89; Siro Villas Tinoco, *Málaga en tiempos de la Revolución Francesa* (Málaga, 1979), pp. 331-341; Pedro Maset Campos and P.J. Saturno Hernández, 'Los sanitarios murcianos de 1750 a 1850. Evolución numérica, tipos profesionales y procedencia geográfica', *Asclepio*, 32 (1980), 255-270.
- 15 Sebastián de Acuña, *Disertaciones sobre el orden que los médicos deben observar en las Juntas para evitar discordias y conservar la autoridad y prerrogativa de que goza cada uno...* (Madrid, 1746), pp. 58-59 and 73-74; Luis Menéndez de la Puente, *Notas históricas sobre el ejercicio de las profesiones sanitarias. Médicos, cirujanos y boticarios de Huesca, del S. XV al XVIII* (Zaragoza, 1968), p. 23; Antonio Cardoner, 'La cirugía en Barcelona en el S. XVIII antes de la fundación del Real Colegio de la misma facultad (1700-1760)', *Medicina e Historia*, n. 22 (1973), p. 14.
- 16 'He who practises medicine or surgery to gain experience, trained or taught by some expert physician or surgeon', according to the *Diccionario de la lengua castellana en que se explica el verdadero sentido de las voces...* (Madrid, 1726).
- 17 Archivo de la Real Chancillería de Granada (hereafter ARC), 5^a/CAT/325.
- 18 ARC, 5^a/CAT/551 and 5^a/CAT/552.
- 19 Calleja Folguera, *La reforma sanitaria*, p. 6; Granjel, *La medicina española del siglo XVIII*, p. 87, discusses hospital training for romance surgeons (those who knew no Latin); Cardoner, 'La cirugía en Barcelona', p. v, refers to the apprenticeship alongside another surgeon, who had to be qualified. See also J. Ramos Martínez, *La salud pública y el Hospital General de la Ciudad de Pamplona en el Antiguo Régimen (1700-1815)*, (Pamplona, 1989).
- 20 Siro Villas Tinoco, *Los gremios malagueños, 1700-1746* (Málaga, 1982), pp. 118-119.
- 21 Perhaps an exaggerated proportion, bearing in mind that the clerk sometimes really lived in his parents' house or his own, according to Camarero Bullón, *Burgos y el Catastro*, pp. 259-260, although this situation has not been detected. Regarding earnings, it is not known if they were in cash or in kind, nor whether they included living expenses.

- 22 Carmen Calleja Folguera, *La Farmacia en la Ilustración* (Madrid, 1992).
- 23 Antonio González Bueno and Francisco Javier Puerto Sarmiento, 'Ciencia y Farmacia durante la Ilustración', in M. Sellés, J. L. Peset, and A. Lafuente (eds.), *Carlos III y la ciencia de la Ilustración* (Madrid, 1988), pp. 127-140.
- 24 Calleja Folguera, *La reforma sanitaria*, pp. 36-42.
- 25 Fernando Díez, *Viles y mecánicos. Trabajo y sociedad en la Valencia preindustrial* (Valencia, 1990), p. 3.
- 26 Juan Navalón, *Doctrina moderna para los Sangradores, en la cual se trata de Flebotomía y Arterotomía...*, compuesto en francés por Don Ricardo Le-Preux (Madrid, 1775).
- 27 González Bueno and Puerto Sarmiento, *Ciencia y Farmacia*, pp. 127-140.
- 28 José Jiménez, *Cirugía especial de verdades muchas y de palabras pocas* (Madrid, 1740), p. 5.
- 29 Antonio Carreras Panchón, 'Las actividades de los barberos durante los siglos XVI al XVIII', *Cuadernos de Historia de la Medicina Española*, 13 (1974), 207; Cardoner, 'La cirugía en Barcelona', p. 15.
- 30 Archivo Municipal de Málaga (hereafter AMM), *Protocolos Notariales*, 1775, Leg. 90, f. 739.
- 31 Francisco Puig, *Principios de cirugía* (Barcelona, 1753) quoted in Cardoner, 'La cirugía en Barcelona', p. v.
- 32 Carreras, 'Las actividades de los barberos', p. 207; Antonio Carreras Panchón 'La odontología en España durante los siglos XVI y XVII', *Cuadernos de Historia de la Medicina Española*, 14 (1975), 43-53.
- 33 Carreras, 'Las actividades de los barberos', p. 207.
- 34 Granjel, *La medicina española del siglo XVIII*, p. 87.
- 35 R. Muñoz Garrido, *Ejercicio legal de la medicina en España (S. XV-XVIII)* (Salamanca, 1967).
- 36 Recently, other authors have chosen to exclude barbers from the health professions, although they do recognize their frequent involvement in surgical tasks. José M. Sáez Gómez et al., 'Intrusismo profesional y ejercicio legal de la Sanidad en Murcia 1700-1759', in *VIII Congreso Nacional de Historia de la Medicina. Murcia-Cartagena, 18-21 diciembre 1988. Libro de actas* (Murcia, 1989), vol. II, p. 905. Moretón Alonso, *Las profesiones sanitarias en Castilla y León*, also excludes them from her study.
- 37 Teresa Ortiz, 'From hegemony to subordination: midwives in early modern Spain', in Hilary Marland (ed.), *The art of midwifery. Early modern midwives in Europe* (London and New York, 1993), pp. 95-114.
- 38 Camarero Bullón, *Burgos y el Catastro*, pp. 307-310. Out of the seven midwives, only one appears as a taxpayer, although there are seven female barber-shop owners and two apothecaries.

- 39 AMM, *Reales Provisiones*, 1775, libro 90, f.739. Pedro Abadie expresses himself in a similar manner, *Tratado Odontológico* (Madrid, 1764), pp. 89-90.
- 40 Sáez, 'Intrusismo profesional', p. 905.
- 41 Fernando Ojea, *Justa repulsa de una grosera, falsa calumnia, y descortés precipitado juicio, que izo i manifestó D. José Ortega de Tamayo i Padilla...* (Santiago, 1788), p. 107.
- 42 Teresa Ortiz 'Luisa Rosado, una matrona en la España ilustrada', *Dynamis*, 12 (1992), 323-347.
- 43 Ricardo Conejo Ramilo, 'Los cirujanos y las matronas de Archidona durante la Edad Moderna', *Asclepio*, 22 (1970), 125-129.
- 44 This was probably not the case for the midwives, but no conclusions can be drawn because of the lack of statistical data.
- 45 James Casey and Bernard Vincent, 'Casa y familia en la Granada del Antiguo Régimen', in *La familia en la España mediterránea (siglos XV-XIX)* (Barcelona, 1987), pp. 172-211.
- 46 Acuña, *Disertaciones*, p. 40; this is also suggested by the data of J.M. Sáez Gómez *et al.*, 'Evolución numérica de los sanitarios inscritos en el Ayuntamiento de Murcia, 1700-1750', in *VIII Congreso Nacional de Historia de la Medicina. Murcia-Cartagena. Diciembre 1986. Libro de Actas* (Murcia, 1988), vol. II, p. 846.
- 47 Enrique Perdiguero offers a recent re-examination of this idea, 'The popularization of medicine', pp. 162-168.
- 48 See n. 1.
- 49 Here, only those who appear in the source with more than one occupation are included, but not those who obtained income from their property or land, or earnings of other members of the family, which amount to 41% of the total.
- 50 Moretón Alonso, *Las profesiones sanitarias en Castilla y León*, indicates similar non-medical activities of some of the health professionals in the provinces of Castilla and León.
- 51 ARC, 5^a/CAT/72; 5^a/CAT/104-105; AMM, Catastro de Ensenada, libro 106 and ARC, 5^a/CAT/600.
- 52 His name was Joseph de Medina Campioni, who earned 8,800 *r.v.* from his pharmacy and 10,300 *r.v.* from his properties. ARC, 5^a/CAT/439 and AMM, *Catastro de Ensenada*, libros 109 y 110.
- 53 His name was D. Joseph de Modena, ARC, 5^a/CAT/115.
- 54 There are two barbers vergers in Arenas de Alhama (ARC, 5^a/CAT/88) and Guajar Alto (ARC, 5^a/CAT/345); a bloodletter verger in Instán (ARC, 5^a/CAT/379) and another acolyte in Presidio de Andarax (ARC, 5^a/CAT/557).
- 55 The earnings of the lawyers in the city of Granada were considerably lower, 2,200 *r.v.*; in Cádiz and Córdoba, however, the earnings were practically the same, according to García Baquero, *Cádiz 1753*, p. 117, and Antonio López Ontiveros,

- Córdoba 1752 según las Respuestas Generales del Catastro de Ensenada*, (Madrid, 1990), pp. 179-180.
- 56 Calleja Folguera, *La reforma sanitaria*, pp. 29-31.
- 57 López Ontiveros, *Córdoba 1752*, pp. 175-179.
- 58 García Baquero, *Cádiz 1753*, pp. 15-19.
- 59 According to data from Moretón Alonso, 'Las profesiones sanitarias en Castilla y León', the density for the Kingdoms of Castilla and León was 21.5 per 10,000 inhabitants.
- 60 Matthew Ramsey assessed the situation in France in this manner, *Professional and popular medicine in France, 1770-1830. The social world of medical practice* (Cambridge, 1988), p. 59.
- 61 José María López Piñero *et al.* 'El número y la distribución de los médicos en la España del siglo XIX', *Medicina Española*, 62 n^o 366 (1969), 239-241.
- 62 Teresa Ortiz, *Médicos en la Andalucía del siglo veinte. Distribución, especialismo y participación profesional de la mujer* (Granada, 1987), pp. 93-100.
- 63 The city of Córdoba had a lower density at that time (43,8 per 10.000) according to data from López Ontiveros, *Córdoba 1752*, pp. 175-179. Cádiz, however, with almost 80 health providers per 10.000, was much better supplied: García Baquero, *Cádiz 1753*, pp. 117. In both cases the calculations of densities are calculated from Vincent, 'Economía y sociedad en el Reino de Granada', pp. 385-386. To calculate the number of inhabitants from the heads of families in the Kingdom as a whole, the coefficient 4 was used.
- 64 The joint density of physicians and surgeons was 6.2, higher, however than the densities of the rural areas in the twentieth century, which did not exceed the maximum of the mid-eighteenth century until the nineteen eighties: Ortiz, *Médicos en Andalucía*, p. 106.
- 65 The rates of qualified practitioners in Paris, 1789, and in London, 1783, were 11,5 and 11,9, respectively: Ramsey, *Professional and popular medicine*, p. 60.
- 66 This hypothesis is proposed with the knowledge that it has been shown in the case of France that the size of the population centres did not influence the densities of physicians and surgeons: Jean-Pierre Goubert and Bernard Lepetit, 'Les niveaux de médicalisation des villes françaises à la fin de l'Ancien Régime', in *La médicalisation de la société française 1770-1830* (Waterloo, 1982), pp. 45-68.
- 67 This socio-economic classification has been carried out using *Vecindario de Granada*, General Archives of Simancas, D.G.R., 1^a rem., leg. 2.046.
- 68 Jean Pierre Goubert, 'Réseau médical et médicalisation en France à la fin du XVIIIe siècle', *Annales de Bretagne et des pays de l'ouest*, 86 (1979), 221-229, suggests the existence of a positive relationship between the supply and demand of health professionals and health-care availability within a framework where only a minority could use such services, as a determining phenomenon in the territorial distribution of the practitioners, (p. 227).

- 69 Fr. Benito Feijoo, *Respuesta a los doctores Martínez, Aqueña y Ribera de el Rmo. Pe. Mtro.* – (Madrid, 1726), p. 11. In the same sense, Fray Anselmo Canillejas, *Corrección fraterna del aqueña fingido en obsequio de el Aqueña verdadero. Su autor —, Cirujano Latino* [ca. 1726]: ‘what [Feijoo] claims (as he repeatedly voices) is that the physicians be called and medicines be used less frequently than is customary’, f. 5.
- 70 Gámez Amián, *Transformaciones económicas y sociales*, *passim*.
- 71 In France, the geography of these densities coincides with that of urbanization according to Goubert and Lepetit, ‘Les niveaux de médicalisation’, pp. 45-68), although these authors have pointed out that urbanization and medicalization are not synonymous terms. The high allocation of practitioners in the Kingdom of Granada may be a consequence of its high rate of urbanization, ranking equally with that of the French Midi and with the Italian health-care pattern, Ramsey, *Professional and popular medicine*, p. 61.
- 72 See n. 66.
- 73 Goubert and Lepetit, ‘Les niveaux de médicalisation’, pp. 57-67, have pointed out that in French cities, notably, in those of a second class administrative nature, these types of factors had a positive influence on the densities of physicians and surgeons.

The Professionalisation of Homoeopathy in the Nineteenth Century

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THE GRADUAL EMERGENCE of a schism in the nineteenth-century medical community between those who were adherents of orthodox medicine on the one hand and those, on the other hand, who constituted the so-called ‘medical fringe’¹ (e.g. herbalists, hydro-therapist, homoeopaths and healers practising mesmerism), has so far been considered only from the perspective of a professionalising medical core. The vast majority of historical attempts to follow the occupational development within medicine have merely validated the boundaries imposed by the medicine that became professionally dominant.² Thus, the history of professionalisation has been written essentially as the history of orthodox medicine.³

This means that the history of the medical profession should no longer be treated as if it were a discrete and homogeneous entity. Especially in the case of the most powerful and dangerous challenge to medical orthodoxy in the 19th century, namely homoeopathy, the professional status of the practitioner has been underestimated. Many of those who were labelled quacks or empiricists by the medical establishment were in fact medically qualified colleagues. Writing the history of professionalisation from the perspective of the latter and comparing it with the same process in ‘regular’ medicine helps to avoid simplistic reductions and contributes to a better understanding of the historical variations in occupational development in the field of health and health care during the nineteenth