Catherine the Great and Public Health

JOHN T. ALEXANDER

Except for Empress Catherine II's well-publicized inoculation against smallpox, her interest in public health has received scant attention in general historiography. Most commentators either rhapsodize or demean her role in the formulation and implementation of European standards of professional medical care in Russia. For example, after remarking that Catherine established 'a medical commission' and personally introduced 'vaccination,' Nicholas Riasanovsky disparages her 'feeble measures to help the underprivileged.' The first two assertions are mistaken, and the third is highly questionable. Some nationalistic Russian accounts, by contrast, leave the impression that medical affairs suffered continuous neglect throughout Catherine's reign (1762-96) from the predominance of selfish foreigners in the medical establishment; or, it is implied that public health catastrophes such as the plague epidemic of 1770-72 resulted from governmental negligence and medical incompetence. Other observers attribute virtually all accomplishments either to Catherine personally or to foreign influence alone. Such contradictions stem partly from the sparsity of the historiography concerning public health in Cath-


This paper is a revised version of a presentation made at the annual meeting of the Southern Conference on Slavic Studies in October 1979 at Loyola University in New Orleans. I am indebted to Clifford Foust for organizing the session and to John Duffy and Nancy Frieden for helpful criticism. For research support I am indebted to the National Library of Medicine, United States Public Health Service (grants 1 R01 LM 01664-01 and 1 R01 LM 02359-01), the International Research and Exchanges Board, the American Philosophical Society (grant no. 5890 from the Penrose Fund), and the General Research Fund of the University of Kansas (award 3276). All dates are given according to the Julian calendar, which in the eighteenth century lagged eleven days behind the Gregorian calendar.
erinean Russia. There is no reliable survey of the subject, not even a compilation of data like Richter's on developments to the mid-eighteenth century. All the same, sufficient sources and specialized scholarship exist to produce a fuller picture.

As an individual Catherine possessed a robust physique and enjoyed good health most of her life. She endured some serious bouts of disease and infirmity, however, such as pleurisy or pneumonia soon after her arrival in Russia in 1744, dental abscess, various fevers, and at least two miscarriages. Her reminiscences of the treatment she received on these occasions betray some doubt about the efficacy of professional academic medicine. Still, whatever her reservations about her own treatment, she believed in principle in professional medical care. In this regard Catherine exemplified the new 'enlightened' view of medicine that hailed its rationality, scientific basis, and progressive utility for both individuals and society. If she sometimes poked fun at individual physicians, she did much to promote broader conceptions and more vigorous programs of public health.

Catherine's ideas about public health drew upon contemporary social theory—mainly German cameralism and French physiocracy—Russian precedents and foreign institutional experiments such as foundling homes. All these influences shared strong statist and populationist biases that attracted the politically ambitious, mercantilist-minded government of the huge, underpopulated Russian Empire. As the cameralist theoretician Jacob Bielfeld counseled, rulers must strive to increase the population of their realms because half the world was unsettled. Public health measures seemed an obvious means to boost population growth and economic expansion. Such ideas had been circulating in the tsarist government from at least the 1750s, and had prompted the state medical administration to

undertake regulation of the practice of midwifery. In a private memorandum of 1761, moreover, Mikhail Lomonosov urged medical measures to curtail the tremendous infantile mortality, a subject that several cameralists also expatiated upon. All European states had neglected medical services in the countryside, Bielfeld commented in recommending that a doctor be assigned to the main town of each district to supervise medical affairs, midwifery in particular, and that a surgeon be detailed to each rural district. Johann Justi, another cameralist whose works were valued in Russia, argued the need for local sanitary councils and for a central medical council, both to be composed of officials and prominent practitioners. The local sanitary councils would report all epidemics, investigate the cause of recurrent infectious diseases, and submit annual statistics on the causes of mortality. The central medical administration, or collegium medicum, would regulate all practitioners, testing their qualifications instead of taking their studies at face value; Justi complained that medicine had become the refuge of small minds.

Some of these notions had been tried in various European states. Sweden set up a Social Health Commission in 1737 that investigated epidemics until 1766. Brunswick had formed a council of physicians, and Prussia had established a highly centralized medical administration. Austria and France began organizing networks of provincial practitioners under central guidance by mid-century. Russia, too, had already developed a highly centralized state medical administration.

Presided over by the chief imperial physician or archiater, the Medical Chancery had since 1722 supervised all medical affairs throughout the

11. Bielfeld, Institutions (n. 8), i, 67, 150.
12. J. H. G. von Justi, Die Grundfeste zu der Macht und Glückseligkeit der Staaten, 2 vols. (Königsberg and Leipzig, 1760-61), i, 252-255. This work was also translated into Russian under Catherine by Ivan Bogaevskii, Osnovanie sily i blagosostoyanii tsarstv . . . , 4 vols. (St. Petersburg, 1772-78). The works of the Austrian cameralist Josef von Sonnenfels, who borrowed much from Bielfeld and Justi, were also translated into Russian by Marvei Gavrilo as Iosfa Zommenfelsen nachalnyia osnovania politstii ili blagoschiniia (Moscow, 1787).
empire. In theory it regulated all practitioners, administered training programs at the several surgical schools, and monitored the preparation and distribution of drugs. In practice, however, the Medical Chancery confronted constant problems from inconsistent leadership and confused functions, inadequate financing, and deficient staffing. The archiater— invariably a foreign physician—also served as first personal physician (leib-medik) to the sovereign, and in 1753 the chancery in Petersburg and its Moscow office employed only fourteen officials. Despite the great increases in the number of medical professionals in Russia after 1700, the Medical Chancery could not meet the growing demand for professional care, especially in wartime and in the provinces. To alleviate the dearth of rural practitioners, Archiater James Mounsey in April 1762 proposed the assignment of land-fiziki to the gubernias and their constituent provinces, but this plan was not implemented widely or rapidly, if at all. Such was the situation when Catherine gained the throne through the coup d'état of 28 June 1762.

The new empress had no practical experience in government nor any precise concept of the inchoate field of public health. Nevertheless, she was energetic and well read, quick to learn and politically shrewd. She soon sensed that medical affairs might be one area where government initiatives could capitalize upon the antiwar and antiforeign currents that had facilitated her seizure of power. Within a month of her accession James Mounsey, archiater under Peter III, resigned for reasons of health. Catherine left the position vacant, perhaps to avoid appointing another foreigner and probably from apprehension about the political influence inherent in the office. During her first year of rule, most of which she spent in Moscow (September 1762 to June 1763), Catherine undertook many reforms the main thrust of which was to revive the war-strained economy and to reorganize the government on a peacetime basis. Several commissions were appointed to study changes in all major spheres of state activity, medical affairs included. In the process a number of proposals made under Peter III and Elizabeth were retrieved.

Catherine’s personal interest in public health appears to have derived

17. Senatskii arkhiv (St. Petersburg, 1904), xi, 206.
from her reading of cameralist and physiocratic literature, from her rec-
ognition of specific institutional deficiencies, and from various advisers.
Her concern for increasing the empire’s population drew upon cameralism
and physiocracy, both of which favored general welfare and public health
measures for that purpose. Scattered notes from her reading indicate that
Catherine early perceived the problem of high infantile mortality, as she
remarked:

If you go into a village and ask a peasant how many children he has had, he will
tell you (usually) 10, 12 and often even twenty. How many of them are living?
He will answer one, two, four, rarely a fourth part; one ought to remedy this
mortality, to consult with physicians more philosophical than they usually are
in that field, and to establish some general rules which the estate owners might
introduce little by little, for I am convinced that the lack of care for very small
infants is the principal cause of this evil; they run about naked, in only a shirt
over snow and ice. There are those who remain robust, but nine-tenths die, and
what a loss for the state!

From this general concern, and from Ivan Betskoi’s survey of British
and European foundling homes, emerged the plan for the Moscow Found-
lng Home and lying-in hospital. Like its foreign prototypes, this institu-
tion was supposed to curtail the high rate of infant mortality and abandon-
ment, and to assist unwed or indigent mothers. It was also hoped that the
children thus saved would learn useful skills enabling them to become
exemplary members of the new ‘middling rank’ of people that Russia’s
socioeconomic evolution required.\footnote{Announced in September 1763 and
opened on 21 April 1764—Catherine’s birthday—the institution received
more than 500 babies by the end of the year. Soon its annual intake from
Moscow and the neighboring provinces exceeded 1,000, and births sur-
passed 100. A doctor was assigned to the home and was supposed to pro-
vide the poor with free medical advice and prescriptions, but so many
sought these services that the home established a public pharmacy in 1769.
As with comparable foreign institutions, the death rate among foundlings
in Moscow was awesome, often over 50% annually; less than 20% attained
adulthood. Nevertheless, the home received generous patronage from
Catherine throughout the 1760s and built a huge new masonry complex
in 1764–72 in central Moscow—a symbol of the Europeanization and

(St. Petersburg, 1867–1916), vii, 86–87—hereafter cited SIRIO.}

\footnote{19. P. M. Maikov, Ivan Ivanovich Betskoi: opyat ego biografii (St. Petersburg, 1904), pp. 119–137.
secularization of Russian public health and welfare policies. Similar institutions appeared in Petersburg in 1770–71 and in several provincial towns.²⁰

Another product of Catherine’s personal interest in public health was Paul’s Hospital (Pavlovskaya bol’nitsa), the first permanent public hospital in the empire. While en route to Moscow for his mother’s coronation in September 1762, Grand Duke Paul fell dangerously ill and a few weeks later suffered such an alarming relapse that Catherine vowed to dedicate a new hospital to his recovery.²¹ The new facility with twenty-five beds and a four-man professional staff opened a year later on the outskirts of town. Financed entirely by the empress, Paul’s Hospital expanded to fifty beds in 1767 and offered free treatment for the curable poor of both sexes. In 1770–71 it released about twenty-eight patients per month, according to statistics in the local gazette; the death rate was not reported and is not known. Although Paul’s Hospital burned in 1784, it was rebuilt, then rebuilt again in 1802–07, and still functions today. In 1763–64 Catherine also provided for permanent medical services at the Smol’nii Institute, the new educational facility for young women, for colonists at Mozdok in the Caucasus, and for the Astrakhan garrison school.²²

On another plane the empress followed cameralist notions and foreign precedents in 1764 by seeking to collect vital statistics for the population of St. Petersburg and to have such data published and analyzed. Standard categories were suggested to classify causes of death, with the evident intention of investigating patterns of disease and of compiling ‘medical topographies.’²³ Academician Kraft later analyzed the Petersburg data in print, and similar statistics were collected in Moscow but were not systematically published or studied.²⁴

Catherine’s initial interest in medical reform did not neglect the military, either. In November 1762 she framed a special instruction to the


²² N. A. Zhivopisnev, Bol’nitsa Imperatora Pavla I-go v Moske (Moscow, 1914), pp. 3–7; Moskovskie vedomosti, 1 February, 4 March, 8 April, 3 May 1771; Polnoe sobranie zakonov rossiiskoi imperii, 1st series (St. Petersburg, 1830), XVI, no. 12, 134 (5 May 1764) and no. 12, 286 (22 November 1764); vol. XIII, pt. 1: Kniga shiatov, p. 77, appendix to no. 12, 174 (5 June 1763)—hereafter cited PSZ.

²³ PSZ (n. 22), XVI, no. 12, 661 (29 February 1764).

²⁴ Pukhova, Ocherki (n. 13), pp. 322–330; mortality tables for Moscow gubernii in 1774–75 in Tsentral’nii gosudarstvennyi arkhiv drevnikh aktov, f. 199, portfeli Miller, no. 385, pt. 2, no. 10: 12–14, 16–18—hereafter cited TsGADA.
commission for reorganizing the army that called for the improvement of medical services. The lack of sufficient skilled surgeons had caused unnecessary suffering and loss of life during the Seven Years’ War, the empress lamented; she recommended increasing surgical cadres and improving their status.25 Perhaps Catherine did not foresee the implications of this proposal, which in effect called into question the entire medical establishment dominated by military practitioners since the Petrine era.26 With the empire at peace, military practitioners might be shifted to the long-neglected civilian sector. Besides, with Peter III’s ‘emancipation’ of the nobility from compulsory state service in peacetime, a policy that Catherine could not afford to countermand, it behooved the medical authorities to upgrade the conditions of service for all practitioners if they were to remain voluntarily in military or civilian employment. All these trends and problems were soon brought to Catherine’s attention by officials of the Medical Chancery and other advisers. The longer the archiarchership remained vacant, the more directly the empress became involved in the reorganization of medical affairs.

Early in 1763 Catherine began collecting information about medical affairs preparatory to a general reform of the state medical administration. Dr. Johann Lerche, acting head of the Medical Chancery and a former military practitioner with three decades of experience in Russia, described the current status and needs of the medical profession. More and better practitioners were the first priority, Lerche stressed, proposing to increase the numbers of students at the surgical schools and at the military hospitals by recruiting aspirants from seminaries and universities. To facilitate instruction by native practitioners, Lerche suggested sending up to six students abroad for advanced training as surgical and anatomical instructors. Finally, to boost morale among practitioners in state service, Lerche advised reconfirmation of the ranks, salaries, and pensions proposed earlier by Archiarcher Mounsey.27

One anonymous critic, apparently a practitioner at court, decried the Medical Chancery’s cramped quarters and its lack of a library and archive; he wished it moved to a special building and made independent of other

27. ‘Pro-memoria meditsinskoi kantseliarii,’ 5 February 1763; J. Lerche, ‘Pribavlenie o sposobakh k priumnozheniiu v Rossiskoi imperii obsoblivo zh dlia upotreblenia k voinskoi sluubhe iskusnykh lekarei’ (1763), TsGADA (n. 24), f. 16, d. 322, pt. I: 140-151.
central administration, reporting directly to the Senate. Like Lerche, this commentator advocated greater financial support for the surgical schools and hospitals, which he estimated to have a current enrollment of 200 students, and he recommended that students and instructors receive salaries only through the Medical Chancery. Hospitals should be reimbursed for medicaments sent to the army, and the civilian population of Petersburg should have a public hospital or lazaret and an insane asylum. If similar institutions were founded in Moscow together with surgical schools and the requisite numbers of students, 'then in time there will no longer be a deficit of capable surgeons in the state.' In addition, this adviser thought the Medical Chancery should acquire a press to publish useful medical works and should set up a facility in Voronezh guberniia for the preparation of medicinal plants.28

Such criticism, when combined with Catherine's reservations about the archiarchership, convinced her that the Medical Chancery needed fundamental reform. She delegated two advisers familiar with medical affairs, Baron Alexander Cherkassov and state secretary Grigorii Teplov, to plan a new medical administration capable of pursuing more vigorous public health policies. In formulating the new institution Cherkassov and Teplov adopted Justi's model of a centralized collegium medicum under the joint supervision of state officials and medical professionals. Indeed, they abolished the office of archiater and even stipulated that the president of the medical collegium be a Russian layman conversant with the natural sciences. To foster efficient administration, the collegium would have a bifurcated structure, with separate medical-scientific and administrative-accounting departments.29 On 18 October 1763, a panel of eight high-ranking practitioners approved the draft proposals of Cherkassov and Teplov that also urged a policy of multiplying professional cadres and bringing them into closer association with the central medical administration. Practitioners should periodically submit journals of their practice so that the Medical Collegium could evaluate skills and assign personnel on the basis of demonstrated merit instead of chance recommendations, self-seeking, 'and sometimes (as reported) for bribes, with the bad ones taking precedence over the good.' Furthermore, as an incentive to research and initiative the collegium might publish original medical treatises in Latin, the traditional language of European medical scholarship.30

Alexander: Catherine the Great and Public Health

Catherine approved most of these proposals, but altered several significantly. For example, apparently to conciliate the many foreign-born practitioners, she dropped the stipulation that the Medical Collegium have a Russian president, but then she named Cherkassov to the post and had him choose the first professional members, who were all of foreign ancestry. Having adopted the bifurcated collegial structure in place of the archiater, the empress excluded all court practitioners from the collegium’s purview and placed them under her personal jurisdiction. Presumably she made this last change to insulate court operatives from professional and political rivalries, and to lessen the financial obligations of the Medical Collegium. Moreover, Catherine added an expanded preface to the decree of 12 November 1763 establishing the Medical Collegium that reiterated its primary tasks and lauded its restoration of Petrine collegial principles. Despite sixty years of medical advance begun by Peter the Great, the preface complained, Russia still possessed ‘an extremely small number of doctors and surgeons who are Russians’ and continued to hire expensive foreigners of questionable competence. Meanwhile most of the empire lacked practitioners, and remote areas lacked even apothecaries. Catherine directed the Medical Collegium to cooperate with Moscow University in training Russian physicians. Following cameralist prescriptions she also charged the collegium to formulate proposals for hospitals in the provinces.31

The Medical Collegium quickly took shape under Cherkassov’s direction (he served as president until 1775) and lasted until absorbed into the Ministry of Internal Affairs in 1803.32 The collegium signaled the end of the Petrine medical administration and the start of a broader and more elaborate conception of public health under state supervision—‘a new and important epocha in the history of physic in Russia,’ declaimed one contemporary.33 That Catherine and her advisers formulated these institutions and policies so rapidly, and so early in her reign, indicates the ideas were prevalent; besides, the new institutions easily fit into the Russian tradition of centralized state medical administration. If the collegium signified a greater state commitment to the provision of professional medical services to the population at large, it was endowed with no magic formula to conjure commitment into reality. Indeed, the Medical Collegium en-

31. PSZ (n. 22), XVI, no. 11, 965 (12 November 1763).
countered the same dilemmas that had haunted its Petrine and Muscovite forbears.

The staff and budget of the Medical Collegium—ninety-two persons including twenty-eight in the Moscow office, with total salaries of 13,655 rubles per year—represented a substantially larger commitment of resources than the Medical Chancery could boast. Though the medical members all came from foreign backgrounds, they represented the main ranks and functions of the profession: military and civilian, doctors and surgeons, and one apothecary. At least one, Dr. Georg von Asch, had been born in Russia; the others had all served there many years, and some had presumably become somewhat russified.\(^34\) Moreover, Catherine and Cher-
kassov figured prominently in the new institution's early policy initiatives. Six months after founding the Medical Collegium, in fact, Catherine authorized it to award the M.D. degree to qualified candidates after exami-
nation, whether or not they had studied at foreign universities.\(^35\) This ruling opened the way for native practitioners to receive all their pro-
fessional training in Russia, and with the creation in 1764 of the empire's first full-fledged medical faculty at Moscow University, the accelerated formation of a native medical elite appeared in prospect. Furthermore, the empress badgered Cherkassov to facilitate the employment of a contingent of Slavic physicians who returned from training abroad in the mid-1760s.\(^36\) The number of physicians practicing in Russia rose sharply during Cath-
ervative's reign, as evidenced by Brückner's tabulation of biographical data.\(^37\)

<table>
<thead>
<tr>
<th>Decade</th>
<th>Total Number of Physicians</th>
<th>Russians and Ukrainians</th>
</tr>
</thead>
<tbody>
<tr>
<td>1760–70</td>
<td>94</td>
<td>21</td>
</tr>
<tr>
<td>1770–80</td>
<td>124</td>
<td>25</td>
</tr>
<tr>
<td>1780–90</td>
<td>229</td>
<td>34</td>
</tr>
<tr>
<td>1790–1800</td>
<td>236</td>
<td>38</td>
</tr>
</tbody>
</table>

These data are not comprehensive and do not distinguish russified indi-
viduals, whose numbers were surely multiplying. There are no comparable statistics measuring the growth of the more numerous practitioners who held lower degrees—staff-surgeons, surgeons, surgeons' aides, and apothe-
caries. Yet official reports for 1803 counted over 2,000 practitioners as com-

\(^{34}\) Chistovich, \textit{Istoriia} (n. 32), pp. 509–511.
\(^{35}\) PSZ (n. 22), XVI, no. 12, 179 (9 June 1764).
\(^{36}\) A. Cherkassov to G. Teplov, 2 March 1767, TsGADA (n. 24), f. 16, d. 322, pt. I: 309.
\(^{37}\) A. Brückner, \textit{Die Ärzte in Russland bis zum Jahre 1800: Ein Beitrag zur Geschichte der Europäisierung Russlands} (St. Petersburg, 1887), pp. 13, 68.
pared to a rough estimate of 800 in 1760.\textsuperscript{38} Rapid population growth and territorial gains after 1750 combined to keep the ratio of practitioners per capita quite low, however, and heavily concentrated in urban areas. Russian citizens, Ukrainians in most cases, continued to be sent abroad for advanced training, and foreigners continued to be hired, especially in time of war. But the Medical Collegium itself rarely granted the M.D. Catherine and Cherkassov had to override the stubborn opposition of the professional members before the collegium awarded its first M.D. to Gustav Orraeus in 1768.\textsuperscript{39} Meanwhile, the medical faculty of Moscow University developed so slowly that it only won the right to confer the degree in 1791 and awarded its first in 1794.\textsuperscript{40} The surgical schools, though reorganized in 1786, also increased their enrollments quite slowly. New schools could not fill the void, either. Potemkin sponsored a surgical school at Elizavetgrad, in the Ukraine, that graduated 153 practitioners during its short existence from 1788 to 1796.\textsuperscript{41} Another attempt at founding a new training institution, the so-called Kalinkin Institute organized in Petersburg in 1783 to train German surgeons for service in the Baltic provinces, never amounted to much before its merger with the Medical-Surgical Academy in 1802.\textsuperscript{42}

Russian historians sometimes blame the slow growth of professional medical cadres upon the alleged machinations of the foreign-dominated medical elite in collusion with the noble-dominated tsarist government, both of which supposedly impeded the increase of native practitioners in order to feather their own nests. Such simplistic notions hardly do justice to the situation. If nationalist-tinged tensions and antagonisms colored some incidents, more basic dilemmas permeated the whole context of the time. Fundamentally Russia lacked the educational institutions, scientific tradition, and pool of skilled manpower needed to create a medical profession of the European type; hence its dependence on foreign physicians and foreign medical faculties. The government recognized the disadvantages and costs of such dependence—witness Catherine’s critique of the

\textsuperscript{38} Tabeli k Otechetu Ministerstva vnukrennikh del za 1803 (St. Petersburg, 1804), table N; Alexander (n. 15), p. 121.

\textsuperscript{39} Ia. A. Chistovich, Ocherki iz istorii russkikh meditsinskikh uchebnykh ustanov Tsaristskoi Rossi (St. Petersburg, 1870), pp. 326–345.

\textsuperscript{40} D. M. Rossiskii, 200 let meditsinskogo fakul’teta Moskovskogo gosudarstvennogo universiteta (Moscow, 1955), pp. 40, 42.

\textsuperscript{41} B. N. Palkin, Russkie gosipal’nye shkoly XVIII veka i ikh vospitanniki (Moscow, 1959), pp. 21–23.

Medical Chancery in the foundation decree of the Medical Collegium—but progress required much time and expense. In the 1760s native-born, foreign-educated physicians began to teach at the Moscow surgical school and at Moscow University, foreign medical treatises and practitioners’ public lectures began to be translated into Russian, and in 1764 the Medical Collegium summoned all practitioners to submit medical histories of remarkable cases in Latin, German, French, English, Italian, or Russian, the best accounts to be published in a collection called Russian Medical Commentaries. Hundreds of manuscripts were submitted in the next several decades, but only one volume of the proposed publication ever appeared, in Latin in 1805.\(^{43}\) Catherine’s reign can thus be credited with the inauguration of a modest tradition of medical research and data gathering—one dimension of the expanded conception of public health and medical affairs that the empress cultivated.

On a more mundane level the Medical Collegium encountered immediate financial problems: a project of 1765 to increase the salaries of military surgeons could not be implemented and, three years later, Catherine appointed a commission to investigate the collegium’s tangled finances.\(^{44}\) No improvement resulted. Moreover, the Russo-Turkish War of 1768–74 and the plague of 1770–72 depleted the treasury further and dramatized the glaring deficit of practitioners with the armed forces and in the provinces. The latter problem had assumed higher visibility because of Catherine’s own public encouragement of reform at the Legislative Commission of 1767–68.

The deficiencies of public health and the need for medical reforms received much comment in Catherine’s Great Instruction to the commission, in the numerous cahiers (nakazy) submitted by all free estates and government offices, and in debates at the plenary sessions. All of these sources called for increased cadres of skilled practitioners (in the countryside above all) and for the organization of hospitals and pharmacies in all gubernias. The primary aims were to lessen infant and maternal mortality, and to contain infectious diseases. Several laymen suggested that the clergy receive basic medical instruction so they could assist the peasantry of localities without professional practitioners; but Baron Dr. Georg von Asch, deputy from the Medical Collegium, rejected that proposal as unnecessary and

\(^{43}\) Palkin, Russkie gospit’nye shkoly (n. 41), pp. 119–131.
\(^{44}\) Catherine to Z. Chernyshev, N. Chicherin, and G. Teplov, 19 September 1768, TsGADA (n. 24), f. 16, d. 322, pt. I: 315.
potentially harmful because of the clergy's lack of medical skills. Some nationalist Russian historians have derided Asch for blind obstructionism, but such charges ignore the Medical Collegium's extensive reform proposals, which unfortunately were not published with its nakaz. It appears likely that subsequent policies and legislation drew upon these proposals. At any rate, Catherine responded to such criticisms and proposals by directing Cherkassov to assign more apothecaries and pharmacies to provincial towns, where medicaments were in short supply, and to inquire whether the provincial nobility would agree to finance a doctor in each gubernia. Closer to home, moreover, she appointed a Greek physician to assist the Petersburg city-physician in watching for epidemics in the metropolitan area.

With the cameralists Catherine took a direct interest in communicable diseases, and three diseases in particular: syphilis, smallpox, and bubonic plague. In the eighteenth century syphilis, usually called French disease, denoted a much larger and vaguer concept than it does today. The term was often applied to all venereal disease inasmuch as gonorrhea was not differentiated until the late eighteenth century. Besides, venereal affections were frequently confused with other skin diseases, and many maladies were seen as merely alternative manifestations of a general infective process. Thus the Portuguese physician António Ribeirão Sanchez, who served many years in Russia (1731–47) and wrote a popular tract about steam-baths, saw in syphilis the source of all sorts of afflictions, whereas Dr. Johann Schreiber's account of the plague epidemic in the Ukraine in 1738–39 branded syphilis 'slow plague' and plague 'fulminant syphilis.' Venerable disease might affect any social stratum, it was recognized, but the lower orders were thought to be afflicted more readily than their social betters. Furthermore, since treatment was available in the form of mercurial compounds, syphilis was one of the first diseases to become the object of special treatment facilities—'secret' clinics or hospitals.

46. Nakaz of the Medical Collegium, SIRIO (n. 18), xliii, 215–217.
47. PSZ (n. 22), xvii, no. 13, 045 (10 January 1768).
mended by cameralist theorists as a means to conserve population by limiting infection, these institutions appeared in Russia under Catherine II.51

At the end of 1762 while the court was still in Moscow for Catherine’s coronation, the empress and the Senate took special cognizance that 'in many Russian towns no small number of people suffer from contagious and infectious diseases, as much from the lack of skillful doctors and surgeons in those localities, and even more from the shame of harboring those diseases, and consequently such exceedingly harmful diseases infiltrate whole families and thereby prematurely shorten the life of the innocent, more especially even babies.' The Medical Chancery was directed to plan a network of 'homes' near towns that would provide professional medical care for a fixed payment without questions. The medical authorities responded with proposals for pilot facilities in Petersburg, Novgorod, and Moscow gubernias where the poor and the infirm should receive free treatment, but estimated the cost at 10,656 rubles the first year for salaries and medicaments alone. In reply, the Senate postponed construction of new facilities and assignment of practitioners, ordering the Medical Chancery to have practitioners already in the towns perform such duties at existing buildings or to assign such personnel, the medicaments to be paid for from state funds. Surgeons should report such diseases to the Medical Chancery, which would provide instructions and practitioners without delay to prevent further propagation in towns or nearby hamlets.52 Whether such a survey of venereal patients was ever made is not known, unfortunately, but the Petersburg General Infantry Hospital reported that 20% of its 671 patients were afflicted.53 Syphilitic homes sponsored by the police were opened in Moscow and Petersburg by 1765. Both were impromptu institutions housed in secluded quarters on the outskirts and served by practitioners from nearby military hospitals.54 Few if any provincial facilities appeared, and venereal disease did not abate noticeably. In 1766, for example, Dr. Lerche and staff-surgeon Johann Chemnitzer visited Finland to assist surgeon Johann Wilckens in the treatment of ninety-six persons suffering from venereal disease.55 Perhaps this was the incident that prompted

51. Bielfeld, Institutions (n. 8), 1, 65; Justi, Die Grundfeste (n. 12), 1, 250.
52. PSZ (n. 22), xvi, no. 11, 728 (19 December 1762); no. 11, 821 (20 May 1763); Chistovich, Istoriia (n. 32), pp. 560–568.
53. PSZ (n. 22), xvi, no. 11, 826 (20 May 1761).
55. J. Lerche and J. Chemnitzer to Medical Collegium, 8 August 1766, TsGADA (n. 24), f. 16, d. 322, pt. 1: 263–268v.
Catherine's reference in her *Great Instruction*: 'This Disease spreads *wide* its *mournful* and *destructive* Effects in *many* of our *Provinces*. The utmost Care ought to be taken for the Health of the Citizens. It would be highly prudent, therefore, to stop the Progress of this Disease by the Laws. Those of Moses may serve here as an Example.'

Such sentiments availed nothing, however, and venereal disease persistently impaired public health, particularly among the armed forces. There is little solid evidence about the incidence of such maladies, but in September 1769 the Moscow General Infantry Hospital classified 45 of 417 patients as syphilitics, a higher proportion than at the Kronstadt Naval Hospital where the 1,070 patients included only 49 with venereal disease. Although no network of treatment facilities materialized, the empress maintained a special interest in combating the disease locally, when she ordered the hospital for infectious diseases operated at her expense, to preserve the patients' anonymity by assigning them numbers, and to submit weekly registers of admissions and recoveries. In subsequent decades several tracts on venereal disease were published in Russian, others remained in manuscript, and Alexander Radishchev made some damning remarks about the spread of such maladies in the countryside. In brief, the significance of syphilis to Catherine's involvement with public health was twofold: it attracted her attention to some of the medical obstacles to population growth, and it whetted a desire for interventionist 'medical police' policies entailing special treatment facilities and more practitioners in the provinces.

Smallpox became the target of a much better publicized and, possibly, more effective public health campaign under Catherine's direct sponsorship. Because this subject has been much discussed in general and specialist historiography, the present reconsideration will skip many of the details in favor of concentrating upon questions of motivation, context, and social impact. Smallpox was perhaps the most dreaded affliction of the

---

58. *PSZ* (n. 22), xxxi, no. 15, 399 (8 May 1782).
era because of its virtually universal incidence, considerable mortality—notably among infants and young children—and disfigurement of many survivors. Indeed, Catherine was quite exceptional in having attained adulthood without contracting the scourge, for which she preserved a vivid horror that extended as well into a lively concern for her sole heir and political raison d'être, Grand Duke Paul. From fear of smallpox Empress Elizabeth had issued repeated prohibitions against attendance at court or church by anyone with exanthemata, a prohibition that the Petersburg police had reaffirmed as recently as November 1765.\(^6\) \(^1\) Variolation or inoculation with matter from the pustules of a mildly afflicted smallpox patient, an ancient folk practice rediscovered and popularized in Britain and her American colonies early in the eighteenth century, was discussed in Russian periodicals in 1732 and 1755, and a German practitioner performed many inoculations in Livland in the late 1750s. In Petersburg in 1763 Dr. Avram Ens had special responsibility under the Medical Chancery for the care and treatment of smallpox victims, some of whom he may have inoculated.\(^6\) \(^2\) If the concept of variolation was reasonably well known in Russia at the start of Catherine’s reign, it was not practiced widely, probably because of the commonly held suspicion that the procedure was dangerous to the individuals who underwent it, to the donors of the inoculant, and to society at large, the nonimmune segments of which might be artificially infected.

Several events and developments combined to persuade Catherine to undergo the controversial operation. Virulent outbreaks in Petersburg and Moscow in the mid-1760s reawakened her fears for herself and for her son. In the spring and summer of 1768 she reacted sharply to the death from smallpox of Countess Sheremeteva, a young lady-in-waiting and fiancee of Paul’s governor, Count Nikita Panin; so she journeyed with Paul from one suburban palace to another to avoid the scourge, which in Moscow contributed to the death of 98% of the infants brought to the foundling home in 1767.\(^6\) \(^3\) Amid such terrors word arrived from abroad of a momentous improvement in the technique of variolation. British practitioners

---


\(^6\) \(^1\) Gubert, *Ospa i osopriviwanie* (n. 60), pp. 195–198; *PSZ* (n. 22), xvii, no. 12, 505 (8 November 1765).


\(^6\) \(^3\) Catherine to Friedrich II, 5 December 1768, *SIRIO* (n. 18), xx, 246–248; Catherine to I. P. Elagin and N. I. Panin, 4 May–8 June 1768, *SIRIO* (n. 18), x, 290–293.
Robert Sutton and his sons and Thomas Dimsdale perfected a new form of inoculation which, by using a superficial scratch on the skin and much shorter periods of preparation and confinement, rendered the procedure much safer, simpler, and cheaper. Sutton and his sons began to inoculate hundreds of people, sometimes whole communities at once, and Dimsdale published a best-selling book on the subject.64 Hence the decision of Catherine and her ministers to invite a British inoculator to introduce the new technique, starting with the empress herself.

On 12 October 1768, Dr. Dimsdale inoculated Catherine secretly. The empress announced the success of the operation nine days later, declared the date a national holiday thenceforth, and lavishly rewarded Dimsdale, who soon inoculated Grand Duke Paul and some 140 aristocrats in Petersburg and Moscow. His tract explaining the technique was issued in Russian translation in 1770.65 Dimsdale and other physicians also established variolation clinics in both capitals and some provincial towns. According to one estimate, more than 20,000 persons in the Russian Empire had been inoculated by 1780, and the practice may have spread even more rapidly after that date.66 The practical effects of variolation remain debatable wherever it was introduced, but some recent scholarship has stoutly defended its efficacy and has argued that in Britain the procedure spread far more widely than previously thought, either substantially diminishing mortality or, at worst, doing 'more good than harm.'67 Similar evidence has yet to be assembled for Russia, but one may hazard the guess that it might show the same pattern. Whatever the practical application and social impact of Catherine's sponsorship of variolation, she gained favorable publicity at home and abroad to embellish her image as the enlightened sovereign of a progressive nation. Then, too, variolation dramatized the potential of new interventionist medical practices in the service of state-sponsored public health policies.

It was tragically ironic that smallpox inoculation, Catherine's greatest triumph in the sphere of public health, should receive official sponsorship on the eve of her empire's most catastrophic encounter with the principal

67. Razzell, Conquest of smallpox (n. 64), pp. 157–158; Van Zwanenberg (n. 64), p. 82.
pestilential peril of the past—bubonic plague. Because my recent monograph details her involvement in the antiplague efforts of 1770–72, only summary remarks will be offered here.68 Suffice it to note that Catherine played an active role in the vigorous, albeit unsuccessful, effort to contain the catastrophe. She closely followed the puzzlingly sporadic course of the epidemic, constantly consulted various medical authorities, mobilized unprecedented numbers of medical professionals against it, and sponsored institutional innovations of a ‘medical police’ persuasion such as a network of district supervisors and a plague council in Moscow. In addition, she suggested a new form of therapy (ice massages), proposed to defuse the peril by removing large-scale manufactories from Moscow, and even announced her intention to visit the empested metropolis at the height of the plague. Once the epidemic was over, the empress sought to turn its effects to the improvement of Moscow and to incorporate lessons from the experience in the Guberniia Reform of 1775, which codified many of the public health proposals of the 1760s and provided for the systematic extension of professional practitioners and treatment facilities to the provinces. Finally, she encouraged and rewarded the publication of several plague tractates in Russian that endeavored to explain the disaster and to guard against its recurrence. Whatever her private doubts about the prudence of the policies used against the plague, she publicly supported the practitioners’ rationalizations that blamed the disaster upon ignorance, panic, and failure to adopt the authorities’ benevolent guidance.69 All in all, the plague helped convince Catherine of the need to invest more resources in public health institutions, medical education, and recruitment of practitioners, who were encouraged to assume greater initiative in the areas of treatment, prevention, and research.

Implementation of the Guberniia Reform after 1775 gradually introduced or increased practitioners and treatment facilities in the provinces. This process required several decades and comprehensive data are lacking for the empire as a whole, but scattered reports indicate that Kharkov, for instance, received a permanent city physician in 1778, whereas Voronezh only got a pharmacy in 1778, a hospital in 1780, and permanent practi-

tioners in 1788.\textsuperscript{70} New public facilities opened in Moscow in 1775 (Catherine’s Hospital) and in Petersburg in 1779 (the Obukhov Hospital, which was expanded in the 1780s on the model of the Vienna General Hospital).\textsuperscript{71} Catherine personally ordered the foundation of a hospital, workhouse, and madhouse in Novgorod in 1783; ten years later she directed the Holy Synod to provide hospitals for sick monks in twenty-two eparchies.\textsuperscript{72} Evidently such institutions appeared in many other towns by the end of her reign. Consequently the concept of public health emerged with greater clarity and higher governmental priority under Catherine, as formulated in Russian adaptations of European ‘medical police’ teachings. Johann Peter Frank’s system early migrated to Russia, where the master himself taught from 1805 to 1808.\textsuperscript{73}

The evolution of public health in Russia under Catherine the Great may be seen as the continuation or acceleration of trends already begun before her reign. The number of professional practitioners multiplied even faster, and they were employed in a greater variety of positions, thereby upgrading the status of medical professionals in civilian service. Practitioners were assigned permanently to all regions of the vast empire. Medical services for foundlings, indigent mothers, the poor, and the insane were all increased. Special facilities for the treatment of venereal disease were organized. Preventive medicine in the form of variolation against smallpox was introduced on a substantial scale. An enormous, albeit largely unsuccessful, effort was made to prevent the terrible plague of 1770–72. The state medical administration was fundamentally reorganized and granted much greater resources. Greater efforts were made to train native practitioners of all types, the first M.D. degrees were awarded on Russian soil, and medical research and publication were stimulated and rewarded. By the end of Catherine’s reign Russia had a fair-sized medical profession trained according to European standards, and, under the guidance of a centralized medical administration run by lay officials and medical professionals, this profession aspired to offer medical care of European quality.

\begin{flushright}
\end{flushright}

\begin{flushright}
\end{flushright}

\begin{flushright}
\textsuperscript{72} \textit{PSZ} (n. 22), \textit{XXI}, no. 15, 670 (23 February 1783); \textit{XXII}, no. 17, 124 (17 May 1793).
\end{flushright}

\begin{flushright}
\textsuperscript{73} Erna Lesky, ed., \textit{A system of complete medical police: selections from Johann Peter Frank} (Baltimore, 1976), pp. xiii–xiv.
\end{flushright}
to all segments of the population. Public health was understood to be an important component of modern society and of national prosperity, power, and progress. In the Petrine tradition Catherine accentuated the state’s interest in public health by her personal example. She also fostered a broader, more flexible conception of public health and a more active notion of medical assistance, preventive and curative alike.

*Department of History*

*University of Kansas*