Women's Medical Practice and Health Care in Medieval Europe

Monica Green

It is a commonplace—both in histories of medicine and histories of women—that throughout the Middle Ages "women's health was women's business."¹ Midwives, it is claimed, were the sole providers of women's health care, and they maintained an unchallenged monopoly on this specialty of medicine until it was gradually wrenched away from them by so-called man-midwives in the course of the seventeenth and eighteenth centuries. At least two assumptions lie embedded in statements such as these: first, that "midwife" is necessarily synonymous with "caretaker of all of women's health

My thanks to the many colleagues who brought to my attention both their own and others' recently published works, and to the Interlibrary Loan staff at Duke University who performed wonders in tracking down the more elusive books and articles. I am particularly indebted to Michael McVaugh, Katharine Park, and the late John F. Benton for their suggestions and especially for sharing their research-in-progress with me. Very special thanks go to Kate Cooper for seeing the glimmer of light in my cloudiest thoughts. Dedico questo contributo a Marta e Saro.

¹ For example, Beryl Rowland, Medieval Woman's Guide to Health: The First English Gynecological Handbook (Kent, Ohio: Kent State University Press, 1981), xv, who uses the formulation "women's illnesses were women's business."

[Signs: Journal of Women in Culture and Society 1989, vol. 14, no. 2] © 1989 by The University of Chicago. All rights reserved. 0097-9740/89/1402-0002$01.00
concerns," and, second, that in the Middle Ages there existed a sexual division of medical labor so absolute that men did not concern themselves with women’s medical conditions (particularly gynecological or obstetrical matters), nor (as some would suggest) did women medical practitioners concern themselves with men. These assumptions are enticing in their simplicity, yet it is astounding how little historical evidence has been brought forth to substantiate them.

Since the purpose of this essay will be to challenge assumptions such as these, let me be clear about an assumption of my own: that most women in the Middle Ages required medical care at some point in their lives. Reproduction was one of the most taxing labors a woman’s body had to bear, and it brought with it all manner of risks of infection and other complications. Even women neither gestating nor lactating—whether for reasons of age, infertiltiy, circumstance, or personal choice—may have been subject to innumerable afflictions of the reproductive organs, including menstrual difficulties, infections, and cancers, all of which might be further complicated by malnutrition (which was almost certainly a chronic factor of medieval life). And all women, of course, may have been subject to the same general diseases and injuries that afflict men and children. I assume, therefore, that women’s need for health care was more or less constant and that at least some of this need was addressed by specialized caretakers.

2 Actually, there is a pernicious ambiguity with which “women’s health” is discussed. Although the term is not usually defined explicitly, in actual use “women’s health” is generally discussed solely in terms of childbirth or other matters directly concerned with it. There may be many reasons for this almost exclusive focus on the birth event (evident in the primary as well as the secondary sources), e.g., patriarchal concern over ensuring women’s capacity to reproduce or the fact that birth is one of the few points in a woman’s life when her health becomes a matter of public concern. However, if our interest is in the history of women rather than the history of childbirth, we should be asking how women’s health as a whole was attended, not simply how the few hours of birth were supervised. Thus, even if we do find that midwives did not treat all of women’s diseases, it is still legitimate (indeed imperative) to ask who did.


4 I am by no means suggesting that morbidity patterns are historically unvarying (as any study of plague, puerperal fever, syphilis, AIDS, or countless other diseases will show). Nevertheless, I do assume that the biomedical experience of medieval women was close enough to that of twentieth-century women to permit comparison.
But precisely who were these caretakers of women? Was the division of medical labor in the Middle Ages so simple and straightforward that the history of women’s health care can be considered coextensive with a history of women medical practitioners? The history of the medical treatment of women in fact extends far beyond the question of whether it was provided exclusively by other women; likewise, the history of women’s medical practice is by no means limited simply to determining whom they treated. Nevertheless, the history of women patients and the history of women practitioners in medieval Europe are inextricably interwoven: to understand what sort of health care women received, we also need to know what sort of health care they were allowed to give.

Only two monographs have been written on medieval women healers and women’s health care, and the few articles published thus far on specific issues do not, even when taken together, constitute a comprehensive history of the subject. Nevertheless, by analyzing the findings of these disparate studies together with the results of recent work on the general social history of medieval medicine, the outlines of a composite picture of women’s medical care and medical practice in the Middle Ages begin to emerge. This picture, sketchy as it may be, shows that the assumptions we have accepted so uncritically about women’s health care and the sexual division of medical labor in the Middle Ages have masked a reality far more complex than hitherto imagined. It also suggests directions that future research will have to take if we are to see past the prejudices that have

---

rendered this fundamental aspect of women’s history into a topic so trivial as to be unworthy of critical investigation.\footnote{Barbara Brandon Schnorrenberg (“Is Childbirth Any Place for a Woman? The Decline of Midwifery in Eighteenth-Century England,” \textit{Studies in Eighteenth-Century Culture} 10 [1981]: 393–408) notes that the Victorian stereotype of the midwife as a “fat, dirty, drunken old woman” has “passed from fiction into fact to encompass all midwives in all periods in many serious works” by even the most respected historians (393). This attitude might also be part of the reason why there are few serious, comprehensive histories of gynecological and obstetrical practice. A welcome indication of change is Yvonne Knibiehler and Catherine Fouquet, \textit{La femme et les médecins: Analyse historique} (Paris: Hachette, 1983).}

broadly: geographically, to include all of western Europe; chronologically, to include some pertinent research from the early modern period (which can often only be separated from the medieval period by arbitrary and ultimately unhelpful boundaries); and categorically, to include discussion of female medical practitioners in general for reasons that will soon become apparent.

**Women as medical practitioners**

When it concerns the Middle Ages, a simple (but hardly insignificant) equation is often made between “woman medical practitioner” and “midwife.” The danger of such an equation is not merely semantic inaccuracy, for such a blurring of categories frustrates any attempt to grasp the realities of the gynecological and obstetrical care women received or the expectations made by medieval society of both women and men in medical practice. More important, it is simply not true. Several major prosopographical studies provide a preliminary body of data on medieval medical

---

8 For example, in her study of a fifteenth-century gynecological text, Helen Lemay occasionally uses the terms “midwife” and “old woman” (i.e., “old woman medical practitioner”) as if they were completely interchangeable; see Lemay, “Anthonius Guainerius and Medieval Gynecology,” in Women of the Medieval World: Essays in Honor of John H. Mundy, ed. Julius Kirshner and Suzanne F. Wemple (Oxford and New York: Blackwell, 1985), 317–36, esp. 326–27. See also C. H. Talbot and E. A. Hammond, The Medical Practitioners in Medieval England: A Biographical Register (London: Wellcome Historical Medical Library, 1965), 211, where they describe Matilda la Leche as “probably the ‘sage femme’ of Wallingford” (emphasis added). This may be mere assumption rather than a fact supported by the evidence. “Leech” was a generic term for “healer,” and it is unwarranted to assume that just because Matilda was a woman, her practice must necessarily have been limited to midwifery. (Since writing this, I have found that A. L. Wyman makes the same point in a letter to the editor, History Today 36 [October 1986]: 59, suggesting that the interpolation was on the part of the Victorian editor of the document.)
practitioners, data that demonstrate that numerous medical specialties were recognized in the High and late Middle Ages, as evidenced both by the terminology used to designate different practitioners and by legislation and guild organization. Although they were not represented on all levels of medicine equally, women were found scattered throughout a broad medical community consisting of physicians, surgeons, barber-surgeons, apothecaries, and various uncategorizable empirical healers. Midwives, then, were part of a much larger community of women practitioners, and it will be useful to discuss female healers in general in order to set a context for the specific historical details of women's medical care.

The distinctions between these categories of healers were roughly as follows: physicians, who could often boast of a university training, claimed as their province the general business of diagnosis and treatment of internal diseases; surgeons carried out most of the manual aspects of the medical art (bone setting, amputations, etc.), while barber-surgeons were largely confined to more minor surgical procedures, particularly bloodletting. Apothecaries would be responsible for dispensing medications, though this role took on real medical import when advice was dispensed as well. "Empiric" is a generic term used loosely to signify all those individuals who took up medical practice on their own, independent of university sanction, state licensure, or guild regulation. It should be emphasized, however, that these categories were much more fluid and subjectively defined than in the modern, highly regulated medical industry of Westernized societies. (Indeed, even the vocabulary to distinguish these specialties does not begin to take shape until the tenth and eleventh centuries.) The possibility of overlap in function was enormous, hence the intensity with which certain practitioners fought to solidify hazy boundaries.

I should stress that I am limiting the following discussion to women who can in some sense be called medical specialists or "professionals"—i.e., women who at some point in their lives would have either identified themselves in terms of their medical practice or been so identified by their communities. "Professional" should be understood in its loosest sense. On this point, see the important insights of Margaret Pelling, who has recently stressed that in preindustrial times few medical practitioners relied solely on medicine for their livelihood: Pelling, "Medical Practice in Early Modern England: Trade or Profession?" in The Professions in Early Modern England, ed. Wilfrid Prest (London: Croom Helm, 1987), 90–128. Furthermore, I do not pretend to be discussing all the situations in which women gave or received health care (e.g., in hospitals); on the contrary, I imagine that most of the medical care women gave and received in the Middle Ages would probably have been in a familial context where few of the issues discussed here would have come into play. For some indication of what this familial context looked like in a later period, see Adrian Wilson, "Participant or Patient? Seventeenth Century Childbirth from the Mother's Point of View," in Patients and Practitioners: Lay Perceptions of Medicine in Pre-industrial Society, ed. Roy Porter (Cambridge: Cambridge University Press, 1985), 129–44. Findings from anthropological studies of modern nonindustrial societies might be of comparative value; see Sheila Cosiminsky, "Cross-cultural Perspectives on Midwifery," in Medical Anthropology, ed. Francis X. Grollig and Harold B. Haley (The Hague and Paris: Mouton, 1976), 229–48. A final limitation of this essay is the omission of miraculous cures and religious healers, which, though important elements of medieval medical practice, involve issues too complicated to be properly addressed here.
Although in all the prosopographical studies conducted thus far women’s numbers are remarkably small, the data nevertheless demonstrate conclusively that women’s medical practice was by no means limited to midwifery. For example, of the 7,647 practitioners documented by Ernest Wickersheimer and Danielle Jacquart in France for the twelfth through fifteenth centuries, 121 (approximately 1.5 percent) were women. Of these, forty-four are identified by terms we might translate as “midwife” (matrone, sage-femme, ventrière, mère-aleresse), while the rest (close to two-thirds) practiced as barbers, surgeons, trained physicians, or untrained empirics. Three are referred to as sorcières.

As sparse as the data for France are, the silence of the records for England is positively deafening. C. H. Talbot and E. A. Hammond’s biographical register of medical practitioners in England, Scotland, and Wales covers the period from Anglo-Saxon times up to the beginning of the sixteenth century. In these eight centuries, the authors found records of only eight women: six identified as physicians, or more literally, “healers” (medica or leche), one as a surgeon (la surgiene), and one as a midwife (obstetrix). Although Edward Kealey’s in-depth study of medical practitioners during the Norman period (1100–1154) has not added any new entries to Talbot and Hammond’s list of women for that period, he has identified three more names to add to the roll of women practitioners in later twelfth- and thirteenth-century England: the two sisters, Solicita and Matilda, each of whom is designated medica, and Euphemia (d. 1257), abbess of Wherell, whom Kealey describes as “an active physician.” Talbot and Hammond’s register has recently been supplemented for the later medieval period (1340–1530) by Robert Gottfried, who claims to have found evidence for a total of twenty-eight women practitioners (eight “leeches,” sixteen barbers, and four apothecaries) in the

11 Aside from those of Danielle Jacquart and, to a limited extent, Robert Gottfried, none of the following studies have attempted quantitative analyses of the data on women. Most of the figures and interpretations that follow reflect my own tabulations drawn from indices and a rapid survey of the compiled data.

12 Danielle Jacquart, Le milieu médical en France du XIIe au XVe siècle: En annexe 2e supplément au “Dictionnaire” d’Ernest Wickersheimer (Geneva: Librairie Droz, 1981). To this total of 121 can be added the six (not five as stated on p. 47 of her work) additional women whom Jacquart lists in her app. C.

13 Ibid., 47–54.

14 Talbot and Hammond (n. 8 above). See the index (502) under “Women Practitioners,” though note that Pernell (241) was inadvertently omitted here.


two centuries of his survey. Yet even these women constitute only 1.2 percent of the 2,282 entries in Gottfried’s “doctor’s data bank.”

No comprehensive survey of female practitioners has yet been made of medieval Italy, though several localized studies of individual cities or regions provide evidence of women’s varied medical practice. Alcide Garosi, for example, has documented 550 Sienese medical practitioners between 774 and 1555, two of whom are women—both physicians (mediche). Ladislaù Münster has found documents regarding seven women who practiced medicine in Venice in the first half of the thirteenth century, including a physician who was accorded the title “master” (magistra); a surgeon’s widow (no specific practitioner label is attached to her own name) who was fined for malpractice on “many people, men and women”; and a specialist of gout and eye problems. None of the documents suggest that these women concentrated on women’s diseases. Katherine Park, in her study of the late medieval Florentine Guild of Doctors, Apothecaries, and Grocers, explicitly acknowledges that midwives, barbers, and other practitioners on the medical periphery have not been included in her research. Park finds only four women doctors who were members of the guild and only two others who are documented in contemporary tax records.

17 Robert S. Gottfried, *Doctors and Medicine in Medieval England, 1340–1530* (Princeton, N.J.: Princeton University Press, 1986), esp. 87, 89, and 251. Gottfried’s study is of little use in learning more about women’s medical practice since he gives no specific information on these women (he does not even provide their names and dates) nor does he include midwives among his categories of practitioners.

18 Ladislaù Münster, “Women Doctors in Mediaeval Italy,” *Ciba Symposium* (English ed.) 10, no. 3 (1962): 136–40, is the only available survey. Unfortunately, Müns ter’s brief study was published without any documentation, and his findings, therefore, need to be rechecked against the original sources.

19 Alcide Garosi, *Siena nella storia della medicina (1240–1555)* (Florence: Leo S. Olschki, 1958); see 356–98 for his biographical list. The two women were Chattelana (fl. late fourteenth century) and Giovanna di Paolo (fl. ca. 1410). One wonders how Garosi focused his research, however, for the absence of barbers and apothecaries (not to mention midwives) from his list suggests that he did not define “healer” very broadly.


21 Katherine Park, *Doctors and Medicine in Early Renaissance Florence* (Princeton, N.J.: Princeton University Press, 1985), 8, 71–72. Park (personal communication, December 10, 1986) informs me that she has since found one, perhaps two, additional women doctors in the guild. Other women in the guild were grocers, apothecaries, leatherworkers, metal workers, painters, etc.
Women practitioners in the south of Italy were, if not more numerous, at least more visible in the documents that have been examined. Salvatore De Renzi’s nineteenth-century study of the famous medical center of Salerno mentions several women practitioners: the so-called Salernitan women (mulieres Salernitanae) who are frequently mentioned in Salernitan medical literature of the twelfth century, as well as four other women (who are known by name) who not only practiced medicine but also are said to have written learned treatises. Of these, the most famous is the eleventh- or twelfth-century physician Trota, whose existence and authorship have been the subject of a centuries-long, largely sterile debate that, as Susan Mosher Stuard has observed, has told us more about the prejudices of the disputants than about the woman herself. Happily, the controversy has been brought to a close by John Benton’s recent discovery of Trota’s genuine work (a practical book of medicine) and his demonstration that the texts which circulated under her name were falsely attributed.

Licenses of women who practiced between the thirteenth and fifteenth centuries also provide important evidence. Raffaele Calvanico’s study of medicine in the Kingdom of Naples from 1273 to 1410 provides evidence for a total of twenty-four women surgeons, thirteen of whom were explicitly licensed to practice on women. Most interesting is the fact that some of these thirteen were not limited to treating women’s peculiar diseases (i.e., those of the

---


24 Benton, esp. 41–46. Only one manuscript of Trota’s genuine work, the *Practica secundum Trotam*, is now known to exist. Although the three other works that circulated widely under her name (the Trotula treatises) are spurious, that they were attributed to her is palpable evidence of her fame—much the way Hippocrates is associated with the ancient Greek Hippocratic Corpus even though he probably did not author any part of it.
breasts and genitalia) but seem to have been expected to perform a whole variety of surgical operations on women.25

The mass of documentation for the social history of medieval Spanish medicine has only begun to be studied, yet some preliminary results are available. Michael McVaugh has been undertaking an exhaustive study of the archives of the Crown of Aragón between 1285 and 1335. As rich and complete as these archives are, McVaugh has not been able to document a single woman medical practitioner attached to the royal household.26 In contrast, studies of the wider medical community in fourteenth-century Valencia by Luis Garcia Ballester, McVaugh, and Augustin Rubio Vela reveal several women who were practicing both as unofficial, empirical healers (curanderas) and as licensed physicians (metgeses), the latter often being Muslim women who practiced within the ruling Christian community.27 Like their Italian counterparts, it is clear that their practice was not limited exclusively to gynecological and obstetrical problems, and they may even have had more freedom to treat both men and women than did their Italian sisters.28

To my knowledge, no comprehensive archival study has yet been done of medical practitioners in the medieval German prin-

25 Raffaele Calvanico, Fonti per la storia della medicina e della chirurgia per il regno di Napoli nel periodo angioino (a. 1273–1410) (Naples: L’Arte Tipografica, 1962). Since these women cannot all be readily identified in Calvanico’s index, I list them here with their entry numbers: Adelicia da Capua (3006); Bona di Guglielmo di Odorisio da Miglionico (3119); Clarice di Durisio da Foggia (3127); Costanza da Barletta (1168, 1200); Francesca, wife of Matteo di Romano da Salerno (1451, 1872, 1874); Francesca, wife of Vesti (916); Gemma da Molfetta (1981); Isabella da Ocre (3195); Lauroeta, wife of Giovanni dal Ponte da Saracena (1413, 2023, 2026); Letizia di Manso da Friano (3072); Mabilia di Scarpa da S. Maria (3327, 3371, 3406); Margherita di Napoli, da S. Maria (3534); Margherita de Riga (3572, 3620); Margherita da Venosa (3226); Maria Gallica (1165, 1234); Maria Incarnata (3571); Polisena de Troya (3598, 3610); Raymunda de Taberna (3643); Sabella di Ocro (or de Erro) (3071); Sibilia d’Afflito di Benevento (3407); Sibilla da S. Giovanni Rotondo (3227); Trotta di Troya (966); Venturella Consinata (1875); Vigorita da Rossano (3512). Calvanico’s notes on Clarice indicate that she was licensed to practice as a surgeon for women’s eye problems (chirurga oculista per le donne).

26 Michael McVaugh, personal communication.

27 Luis Garcia Ballester, Michael McVaugh, and Augustin Rubio Vela, Licensing, Learning and the Control of Medical Practice in Fourteenth-Century Valencia (Philadelphia: American Philosophic Society, in press). Although a full tabulation of all the known Spanish women practitioners has not yet been made, McVaugh has indicated to me that most appear only after 1350.

28 One woman, Bevenguda, was licensed by the king in 1394 with the explicit recognition that she already had experience “treating and curing many men and children of both sexes of serious conditions and illnesses” (Garcia Ballister, McVaugh, and Rubio Vela).
cialities, though here again the few data that have been assembled indicate that women performed a variety of medical functions, not simply midwifery. Walther Schönfeld, for example, has found evidence for fifteen women practitioners (most of them Jewish) in Frankfurt am Main between 1387 and 1497, several of whom specialized in eye diseases. None is referred to as a midwife. 29

These data on medieval Europe as a whole thus offer us tangible evidence for the existence of all kinds of women healers. 30 Still, we are left wondering why the evidence for these women—and especially for midwives—is so sparse, forming (in those instances where percentages can be tabulated) no more than the tiniest fraction of the medical populace as a whole. Is it really possible that there was only one midwife in the whole of England or that there were none at all in Italy? Obviously, beyond the general poverty of sources all medieval researchers must face, there is need to acknowledge the special limitations of the historical record for research on women, for apart from medical licenses, the principal sources used have been wills, property transfers, court records, and similar documents, all of which traditionally underrepresent women. 31 Indeed, it is generally the unusual woman—the one who has acquired enough personal wealth to leave a will or be taxed, the one who is brought to court on civil or criminal charges—that finds her way into the historical record, not her less conspicuous colleague. 32 The absence of women may also be due to the parameters by which some researchers themselves have chosen to define their investigations. Focusing on the upper echelons of "learned" medicine, sometimes to the complete exclusion of empirics and other healers on the legal and social fringes of medical practice (where most women would have been found), these studies by their

29 Schönfeld (n. 5 above), 75. Schönfeld’s list and other documents on German women’s medical practice have been collected by Peter Ketsch in Frauen im Mittelalter, Band 1: Frauenarbeit im Mittelalter, Quellen und Materialien, Studienmaterialien Band 14: Geschichtsdidaktik, ed. Annette Kuhn (Düsseldorf: Schwann, 1983), 1:259–307.

30 Gundolf Keil (n. 5 above, 204–6) suggests that women who translated, copied, and illustrated medical texts should also be included in assessing women’s involvement in medicine. Keil would also include women for whom special tracts were written or to whom treatises were dedicated, since, in those cases where they actually commissioned the works to be written, these women were very obviously displaying an active interest in women’s health care.

31 Werner Gerabek has recently suggested the potential value of letter collections as a source for the history of medicine; see “Consolida maior, Consolida minor und eine Kräuterfrau: Medizinistorische Beobachtungen zur Reinhardbrunnern Briefsammlung,” Sudhoffs Archiv 67, no. 1 (1983): 80–93, esp. 92.

32 Even these women often only surface in the records as widows or unmarried women, i.e., only when they are no longer legally “covered” by a husband or father.
very nature offer limited hope of documenting the existence of women practitioners.

The advantages of broadening the definition of "medical practitioner" are immediately apparent in Margaret Pelling and Charles Webster's study of sixteenth-century London and Norwich. Instead of focusing solely on officially recognized and licensed physicians, barbers, and surgeons, Pelling and Webster use as their working definition "any individual whose occupation is basically concerned with the care of the sick." The dramatic increase in the number of women practitioners who can thus be identified cannot be attributed solely to demographic or social changes in the early modern period. In London, Pelling and Webster have found an estimate made circa 1560 of sixty women practitioners in the city at that time (only thirty years after the ending date of Gottfried's survey). Although this may be a slightly exaggerated figure, it still poses a striking contrast to Gottfried's total of twenty-eight women throughout the whole of England for the two previous centuries. In Norwich in the two decades between 1570 and 1590, ten women practitioners are known by name, again a high figure compared to the sparse medieval data gathered thus far (though still seemingly low for a town of 17,000 people).

Clearly, then, the definition of "medical practitioner" used in such studies must be as broad as possible if we are to catch more than a handful of women in our analytical net. Yet prosopography


34 Obviously, changes in the type and amount of records available for the early modern period would contribute to these differential findings. This, however, does not warrant (and if anything, it counterindicates) drawing arguments from the silence of the medieval records.

35 Pelling and Webster, 183–84, 222–26. Seven of the Norwich women were employed by the city corporation to perform a variety of cures; one was a licensed surgeon. Only one was explicitly referred to as "obstetrix," though one other woman was described more vaguely as a spinster "that helped women."

36 A similar critique was made by Luke Demaitre in his review of Jacquart's, Le milieu médical (Speculum 58, no. 2 [April 1983]: 486–89, esp. 488), where he notes the complete absence from Jacquart's study of any vetulae ("old wives") who appear so frequently in the literature." See also Jole Agrimi and Chiara Crisiciani, "Medici e ‘vetulæ’ dal duecento al quattrocento: Problemi di una ricerca," in Cultura popolare e cultura dotta nel seicento: Atti del convegno di studio de Genova (23–25 novembre 1982) (Milan: Franco Angeli, 1983), 144–59. An example of such vetulae is "a certain old woman" I discovered who had been called before King William (William the Conqueror or William Rufus?) to explain one of her cures. Cambridge, Trinity College MS 903 (R.14.30), 13th or 14th cent., fol. 121r (olim fol. 227r): "Quidam quattanarius a nullo medico liberari potuit cui quedam uetula succum
may have limitations even more fundamentally rooted in the method itself, which usually restricts the admissible data to persons known by name in order to properly individuate and identify them. The problem this poses for any study of women in the medieval period is obvious, for even when they are introduced into the historical record women are all too often nameless (witness the otherwise indistinguishable “Salernitan women”).

In sum, while the prosopographical data do demonstrate the variety of women’s medical practice in medieval Europe, because of their paucity they tell us little more. Indeed, such meager data have encouraged an unsatisfactory, anecdotal sort of history that unfortunately is still characteristic of the field.\textsuperscript{37} There is, nevertheless, still hope of bringing greater nuance and sophistication to our understanding of medieval women healers. For this, we need to bring analyses developed in other areas of women’s history into play as we explore the wider social context of women’s health care and medical practice. We need, in short, to raise questions of power, of economic rivalry, of literacy and the control of knowledge. When these are set into a chronological framework, certain striking patterns emerge.

Professionalization and the restriction of women’s medical practice

In her recent book on women’s work in early modern Germany, Merry Wiesner argues that women’s participation in health care was seen as “natural and proper, part of women’s sphere.” She goes on to claim that women working in health care were rarely viewed as economically, socially, or politically threatening.\textsuperscript{38} Whether or not Wiesner’s idyllic picture is accurate for sixteenth- and seventeenth-century Germany,\textsuperscript{39} the medieval data for the rest of Europe present no such uniform image of a clearly defined sexual division of labor that allowed women complete freedom of movement within their “natural

tapsi barbati tribus diebus ante accessionem dedit et statim liberatus est. Quam rex Williamus iussit uocari et confessa est quomodo fecit.”

\textsuperscript{37} See, e.g., Rowland (n. 1 above), introduction; and the works by Hughes and Labarge (n. 5 above).


\textsuperscript{39} Some of the evidence Wiesner presents calls her own picture into question. In Working Women, Wiesner recounts the persecution of female physicians, sur-
sphere” or that freed men from any threat of competition. On the contrary, medieval Europe was a battleground for all medical practitioners—women being caught in the crossfire—and it is here, not in the seventeenth or eighteenth centuries, that the foundations were laid for the eventual (though hardly inevitable) exclusion of women from independent medical practice.

Although its timing and degree of effectiveness varied greatly, most of western Europe witnessed the implementation of medical licensing by secular and religious authorities between the twelfth and sixteenth centuries. Moreover, medical practitioners themselves often banded together to form guilds or protective societies that attempted to control who could practice and under what conditions they could do so. These developments resulted in fierce tensions between physicians trained in the universities, surgeons and apothecaries trained by apprenticeship, and empirics with no formal training at all.40 Viewed from the perspective of women, these first attempts to control nonuniversity-trained practitioners are notable in that they were initially sexually egalitarian. Why, then, at a certain historical moment should women have been explicitly singled out and excluded?

In France from the late thirteenth century on, physicians of the Parisian faculty of medicine made concerted efforts to control the medical practice of surgeons, barbers, and empirics. This led in 1322 to the oft-recounted trial of several unlicensed healers, including one Jacoba (or Jacqueline) Felicie who clearly was treating both women and men.41 A principal argument used by the prose-geons, barbers, and empirics, noting that “during the course of the sixteenth century, many [German] cities passed regulations expressly forbidding ‘women and other untrained people’ to practice medicine in any way” (49–55, esp. 50).

40 For a general discussion of these developments, see Vern Bullough, The Development of Medicine as a Profession: The Contribution of the Medieval University to Modern Medicine (Basel and New York: Karger, 1966); and Park, “Medicine and Society in Medieval Europe, 500–1500” (n. 3 above). How the process of the professionalization of medicine in late medieval Europe specifically affected women has never been thoroughly analyzed.

ution against Jacoba was that as it was forbidden for women to practice law, so much the more should they be barred from practicing medicine where their ignorance might result in a man’s death rather than the simple loss of his case in court. Yet the statute of 1271 which Jacoba allegedly violated said nothing that restricted women more than men from medical practice. On the contrary, the statute was phrased in such a way that put the female surgeon, apothecary, or herbalist under the very same restrictions as her male counterpart—a formulation that assumes both that these women exist and that they have the possibility of meeting the same requirements as men in order to practice legally.

In Valencia, Luis Garcia Ballester and his colleagues have shown that prior to 1329 (and in some cities, even afterward) all the ordinances regulating medical practice simply applied to anyone “who has not learned the science of medicine, be they men or women, Christian, Jew, or Saracen.” As they note, this precedent of “egalitarianism” makes the new law of 1329 all the more curious. It stipulated that “no woman may practice medicine or give potions, under penalty of being whipped through the town; but they may care for little children and women to whom, however, they may give no potion.” Garcia Ballester and his coauthors suggest that this severe and unprecedented prohibition of women’s practice may have been motivated by a simple desire to control the practice of


43 It is, of course, conceivable that the inclusive phrasing of the statute was motivated by a formulaic need to cover all possibilities rather than by a straightforward recognition of current realities; nevertheless, other sources leave no doubt that women were in fact practicing in these fields. The one field that was virtually closed to women was the practice of “physic” (general internal medicine), which was generally limited to those having attended a university, which normatively women could not do. Neither, however, could Jews or (in Spain) Muslims or even (in practical terms) most Christian men, so the emphasis on university education cannot be seen as a restriction directed solely toward women.

44 Garcia Ballester, McVaugh, and Rubio Vela (n. 27 above). The text quoted is from an ordinance from the town of Valls, redacted in 1299 and again in 1319. Religious diversity did raise its own complications, however. In 1338, concern over the potentially corrupting influence of intimate contact between religious groups prompted a regulation that “any Saracen woman who acts as metgessa to women” could not bring a Christian woman into her house for treatment.

45 Ibid.
gynecology and obstetrics by Muslim metgesses. We should not, however, overlook the fact that it is simultaneously excluding them (and all other women) from other forms of practice.46

In England, where the physicians became organized only much later, it was not until 1421 that a petition was put before Parliament requesting, among other measures to ensure the physicians’ hegemony, “that no Woman use the pruytyse of Fisyk [medicine] undre the same payne” of “long emprisonement” and a fine of forty pounds.47 That this measure was ultimately ineffectual does not diminish the fact that the desire to prohibit women’s medical practice was obviously real.

Interestingly, the one area of medicine generally thought of as “women’s work,” midwifery, was affected by the trend toward licensing only at the very end of the Middle Ages.48 Currently there

46 This law does not guarantee women a monopoly in gynecology and pediatrics, however, since the stipulation that women could not administer “potions” would, theoretically, have severely limited their independence of practice; any internal medicines (which were a major component of all medieval medical care) would have to be administered by a (male) physician.

47 Power (n. 41 above), 23. Wiesner, Working Women (n. 38 above), argues that restrictions on women’s practice in Germany came only in the sixteenth century.

48 By “licensing” I mean the granting of official permission to practice according to prescribed regulations on training and ethical principles, which were usually assessed by means of examinations and/or oaths. This needs to be distinguished from other forms of official recognition of a practitioner’s competence and/or right to practice. For example, the employment of midwives by municipal authorities to provide free or subsidized services to women of the city is known in Frankfurt am Main from 1302, in Nuremberg from 1381, in Basel from 1455, and in other German municipalities; see Gordon P. Elmeer, “The Regulation of German Midwifery in the 14th, 15th and 16th Centuries” (M.D. thesis, Yale University School of Medicine, 1964), esp. 8. Isaac De Meyer has similarly documented the employment of municipal midwives in Bruges from 1312; see Isaac De Meyer, Recherches sur la pratique de lart des accouchements à Bruges depuis le XIVe siècle jusquà nos jours (Bruges: 1843), 9–11. In France, the Hôtel Dieu of Paris was appointing midwives to work at its maternity hospital from at least 1378; see Richard L. Petrelli, “The Regulation of Midwifery during the Ancien Régime,” Journal of the History of Medicine and the Allied Sciences 26, no. 3 (July 1971): 276–92, esp. 279. In the absence of licensing, however, criteria that might have been used to appoint these individuals would not necessarily have applied to other practitioners. In Frankfurt am Main, e.g., municipal midwives were first examined for their medical knowledge only in 1491, 189 years after the office was instituted; examination of other midwives began eight years later (Elmeer, 9). Licensing also needs to be distinguished from the employment of midwives as “expert witnesses” in legal proceedings to determine pregnancy or virginity. Indeed, it is not clear that it was only publicly recognized (let alone licensed) midwives who performed this function. In England from the early thirteenth century, legal determinations of pregnancy were conducted by juries of matrons, “lawful and discreet women,” no mention being made of their medical knowledge; see Thomas R. Forbes, “A Jury of Matrons,” Medical History
is no indication that medieval midwives attempted to organize or control themselves by means of guilds or other formal associations in the same way that many male practitioners did. On the contrary, all currently available data show that licensing, which apparently began in the mid-fifteenth century (the earliest known example is from Regensburg in 1452), was imposed on midwives from the outside, either by local municipal or ecclesiastical authorities, or by both.49 Most of these early regulations were meant to control not the midwives’ medical skills but, rather, their moral character. When these regulations do focus on strictly medical matters, they usually reflect an attempt to monitor, restrict, and control midwives’ practice, often requiring them to turn first to other midwives and then to male physicians and surgeons for help.50


49 Histories of midwifery have mostly been limited to local or regional studies. For England, see J. H. Aveling, English Midwives: Their History and Prospects (1872; reprint, London: Hugh K. Elliott, 1967); and Thomas R. Forbes, The Midwife and the Witch (1966; reprint, New York: AMS Press, 1982). More recently, see the introductory chapter of Jean Donnison’s excellent study, Midwives and Medical Men: A History of Inter-Professional Rivalries and Women’s Rights (New York: Schocken, 1977), which has in no way been superseded by Jean Towler and Joan Bramall, Midwives in History and Society (London: Croom Helm, 1986). The first known English midwife’s license dates from 1588; see James Hitchcock, “A Sixteenth-century Midwife’s License,” Bulletin of the History of Medicine 41, no. 1 (January–February 1967): 75–76. Studies on German-speaking territories abound: in addition to Elmeer, see Georg Burckhard, Die deutschen Hebammenordnungen von ihren ersten Anfängen bis auf die Neuzeit (Leipzig: W. Engelman, 1912), which prints the texts of many early German midwife ordinances; Elseluise Haberling, Beiträge zur Geschichte des Hebammenstandes, vol. 1, Der Hebammenstand in Deutschland von seinen Anfängen bis zum Dreissigjährigen Krieg (Berlin: Elwin Staude, 1940); Katharina Meyer, Zur Geschichte des Hebammenwesens im Kanton Bern, Berner Beiträge zur Geschichte der Medizin und der Naturwissenschaften, Neue Folge, 11 (Bern: Hans Huber, 1985); and Merry Wiesner’s studies (n. 38 above). Popular overviews can be found in Wolfgang Gubakle, Die Hebamme im Wandel der Zeiten: Ein Beitrag zur Geschichte des Hebammenwesens (Hannover: Elwin Staude, 1964), and Jean-Pierre Lefftz, L’art des accouchements à Strasbourg et son rayonnement européen de la Renaissance au Siècle des Lumières (Strasbourg: Editions Contades, 1985). In addition to De Meyer, data on midwives and women’s medical care in the late medieval Netherlands can be found in Myriam Greilisammer, “The Condition of Women in Flanders and Brabant at the End of the Middle-Ages” (Ph.D. diss., Hebrew University, Jerusalem, 1984).

50 The controlling function of midwifery regulations has been pointed out with particular clarity by Dagmar Birkelbach, Christiane Eifert, and Sabine Luken, “Zur
The timing of these midwifery regulations, which coincide with the first stirrings of the early modern wave of witch persecutions, has prompted several theses that argue for a direct connection between the two phenomena. These arguments suffer from numerous shortcomings, not least of which is the failure to distinguish between midwives and female medical practitioners in general or to recognize that midwives seem to have constituted no more than a minority of the women convicted of witchcraft. Richard and Ritta Jo Horsley have recently stressed the importance of distinguishing between "wise women" and midwives, and especially of distinguishing between official formulations of witchcraft theory and the actual beliefs of the people who made accusations against individual women. What little evidence for the medieval period that has been brought forward seems to support their conclusions, for despite the vitriolic accusations made against midwives in Jakob Sprenger and Heinrich Kramer's *Malleus Maleficarum* ("The Hammer of Witches") in 1486, the rhetoric of witchcraft seems to have been used not so much against midwives as against *vetulae* ("old women") and empirics, and even here it is not clear how widespread such accusations were.

---


53 For a summary of Jakob Sprenger and Heinrich Kramer's accusations against midwives in the *Malleus Maleficarum*, see Towler and Bramall (n. 49 above), 33–39. Although they place their discussion of witches in a chapter entitled "The Dark Ages and Medieval Period," none of the texts Towler and Bramall cite associating witches and midwives predates Sprenger and Kramer's 1486 tract; most are from the sixteenth century. Although Wiesner (Working Women, n. 38 above) does not really tackle this issue directly, the rarity of prosecutions for witchcraft among the
This rapid survey of legislation and other attempts to restrict and control women's medical practice demonstrates the complexity of the tensions within the wider community of medical practitioners to which women belonged: tensions not only between male and female, but also between Christian and Jew (and in Spain, Muslim as well), between those in positions of political power (the physicians and, to a lesser extent, guild members) and those relatively lacking in power (empirics and "old women"). To these must also be added the often conflicting needs and goals of municipal, royal, and ecclesiastical authorities. These multiple axes of tension and rivalry make it particularly difficult to determine the true motives and causes of developments affecting women's medical practice. There is, however, one strand of this complex tapestry that makes the question of professionalization unique for women—the sexual division of labor. This is itself a difficult issue, but in order to address it briefly, let me explore one deceptively simple question: Who was responsible for the care of women?

legal cases involving midwives in early modern Germany suggests that the rhetoric of witchcraft was not normally used against midwives, who on the whole were a well-respected community. Wiesner mentions in passing some cases in Württemberg but stresses that "these are really witchcraft cases in which the woman accused _happened_ to be a midwife" (69; emphasis added). On the association of _vetulae_ and witchcraft, see Agrimi and Crisciani (n. 36 above); and, in the same volume, Paola Zambelli, "Vetula quasi strix?" 160–63. For documents on several such women, see Josep Perarnau i Espelt, "Activitats i fòrmules supersticioses de guarcio a Catalunya en la primera meitat del segle XIV," _Arxiu de Textos Catalans Antics_ 1 (1982): 47–78, which includes the case of Geralda Codines, who was brought in for questioning in 1304, 1307, and again in 1328 in Barcelona. Clearly quite knowledgeable about general medical theory, Geralda was questioned about her use of religious charms and prayers in her medical practice. (I am indebted to Michael McVaugh for bringing this article to my attention.) Other studies on women's medical practice provide only random incidents of alleged magical practices: Charles Talbot ("Dame Trot and Her Progeny," _Essays and Studies_ [The English Association], n.s., 25 [1972]: 1–14, esp. 13–14) cites the case of a Viennese woman who in 1470 was forced to confess that she had practiced medicine "having been deceived by the devil." A. L. Wyman, "The Surgeoness: The Female Practitioner of Surgery, 1400–1800," _Medical History_ 28, no. 1 (January 1984): 22–41, cites the Act of 1511 in England, by which physicians tried to limit the practice of empirics (27). The preamble to the act condemns "Women [who] boldly and accustomedly take upon them great Cures, and things of great difficulty, in the which they partly use Sorcery and Witchcraft." Wyman notes, however, that a later act in 1542 removed many of these restrictions, allowing "divers honest men and women" to carry on their practice unimpeded. Only two witches, Margaret Neale and Elizabeth Clerke, are mentioned in Pelling and Webster's survey of sixteenth-century London and Norwich practitioners (n. 33 above, 231–32).
The care of women and the sexual division of labor

Up till now, the standard answer, as I stated at the outset of this essay, has been unequivocal: “women’s health was women’s business.” In this vein, Charles Talbot has argued that at least in the case of the women practicing at Salerno, “It seems quite clear that [women’s medical practice] was restricted to the fields of gynecology and paediatrics, in which medical men showed no interest.”

Talbot thus envisions a simple sexual division of labor: women treated women, men treated men—the unambiguous line of sex (of both the patient and the practitioner) defining whose turf was whose, with neither men nor women desiring to cross that divide. (How Talbot imagined women’s nongynecological problems were treated is unclear.) Obviously, the evidence for women practitioners surveyed above already casts serious doubt on these assumptions. To judge from Trotta’s genuine work, for example, her practice was not so limited as Talbot imagines, for only about one-quarter of it deals with gynecological or obstetrical concerns, the rest of the text being devoted to various ailments such as fevers, wounds, and internal disorders. Similarly, the Italian and Spanish data indicate that, even for those female physicians and surgeons who were restricted by their license to treating only women, their practice was rarely limited to just gynecological or obstetrical problems.

But even if we restrict our discussion to gynecological and obstetrical care, can we still maintain that “women’s health was women’s business” and particularly that it was midwives’ business? Let me return to the issue of definition I addressed briefly above. Thus far, I have been treating the term “midwife” as if its definition were commonly agreed upon and unproblematic. Yet if “midwife” was

54 Talbot, 2.
55 See Benton (n. 22 above), 41. Professor Benton was kind enough to share with me his transcription of Trotta’s Practica which he was in the process of editing at the time of his death. Of the other Salernitan women noted for their writings, Abella was said to have written On Black Bile and On the Nature of the Seed, Rebecca Guarna On Fevers, On Urines, and On the Fetus, and Mercuriaide On Critical Days, On Pestilential Fever, On the Care of Wounds, and On Unguents; see De Renzi (n. 22 above), 1:372–73. As with Trotta, these attributions need to be reconfirmed in accordance with modern scholarly standards.
56 It is important to stress, however, that modern Western medical beliefs about what does or does not constitute a condition or disorder of the reproductive system were not necessarily shared by medieval people. Work on medieval theories of female physiology and disease (as represented in medical literature) suggests that the spectrum of diseases thought to have their origin in the reproductive system was very broad indeed; see Green, “Transmission” (n. 7 above).
not simply a generic name for any female practitioner, how did medieval people actually define it? Was it someone who assisted women with all their medical problems or just with those having to do with the reproductive organs? Or was this role even more narrowly defined as someone who assisted only with birth itself, leaving all prenatal and postpartum conditions to the care of others? Was the midwife a woman who functioned independently, or was she subservient to another (perhaps male) practitioner? Was she, indeed, always a woman? Was her role exclusive, that is, did she have a monopoly on whatever it was she did, or did she face competition from other healers? Was “midwife” a term used to refer to someone formally trained as a healer, or was it used more loosely to designate a woman who, in a specific situation, merely performed the function of “standing by” at birth (the original sense of the Latin term, obstetrix)? Was there, in fact, any single definition of “midwife” in medieval Europe, or was it, rather, a variable concept whose definition changed in different social and medical contexts?

Michel Salvat, one of the few scholars to have raised the question of definition, found the following description of the midwife’s function in the thirteenth-century Latin encyclopedia of Bartholomew the Englishman (which was subsequently translated into various

57 Michel Salvat (“L’accouchement dans la littérature scientifique médiévale,” Senefance 9 [1980]: 87–106) distinguishes between midwifery as a simple activity that would be the shared responsibility of kinswomen and neighbors, and midwifery as a true craft or profession in which certain women would specialize and on which they would rely for income. In other words, this distinction would be between midwives (i.e., acknowledged specialists) and midwifery (i.e., a simple stock of skills and knowledge that was freely and informally shared among the whole community of women—and perhaps even some men). Salvat argues that informal, familial traditions of medical care predominated throughout most of the Middle Ages, whereas the midwife strictly defined cannot be found before the second half of the thirteenth century and then only as an urban phenomenon. This proposed chronology (which is based solely on French evidence) is probably a conservative estimate since it refers to when professional midwives first appear in the historical records. Nevertheless, Salvat is probably right to stress the urban aspects of midwives’ practice, since any type of specialization requires a minimum concentration of population to support it. A profitable contrast might be made with the abundant evidence for professional midwives in the highly urbanized world of antiquity; see, e.g., the literature cited in Valerie French, “Midwives and Maternity Care in the Greco-Roman World,” in Rescuing Creusa: New Methodological Approaches to Women in Antiquity, a special issue of Helios edited by Marilyn Skinner, n.s. 13, no. 2 (1987): 69–84; and Green, “Obstetrices” (n. 7 above).

vernacular languages): "A midwife [Latin, obstetrix; Italian, obstetris; Provençal, levayритz; Spanish, partera; French, ventriere] is a woman who possesses the art of aiding a woman in birth so that [the mother] might give birth more easily and the infant might not incur any danger... She also receives the child as it emerges from the womb."59 This would seem to conform with the most narrow definition above, yet Salvat does not mention that Bartholomew's passage occurs within the context of a larger discussion of the "ages of man" where there is no reference whatsoever to women's general health care.60 Nor does Salvat examine the profound implications of this definition for the actual treatment of women. Looked at from the perspective of the patient, the midwife of Bartholomew's definition (if taken literally) provides an extremely limited service: both before and after the baby is born, the woman must call on some other health care provider for all her medical needs.

One might contrast Bartholomew's concept of the role of the midwife with that found in the sixth-century gynecological work of Muscio, which circulated throughout the Middle Ages. Here it is assumed that midwives (obstetrices) would be responsible for all gynecological and obstetrical concerns—a definition that would consequently have radically different ramifications for the woman patient.61

Neither of these definitions may be fully representative of medieval understandings of the term (Muscio because he reflects late antique realities more than medieval, Bartholomew because of the limited context of his discussion), yet their agreements and disagreements are instructive. Both take it for granted that the midwife is a woman,62 and both identify the midwife as a trained healer who specializes in the care of other women's reproductive concerns. They disagree, however, on how extensive that province of specialty is. Most interestingly, neither definition either states or implies that the midwife's province of medical practice is exclusively hers,63 an


60 "Man" as Bartholomew uses it is ostensibly meant to refer to humans, though the specificity of most of his discussion suggests that he is really just talking about the male.

61 Valentin Rose, ed., Sorani Gynaeciorum vetus translatio latina (Leipzig: Teubner, 1882), 6: "What is a midwife? A woman learned in all the diseases of women, and also expert in medical practice" (Quid est obstetrix? femina omnium muliebrorum causarum docta, etiam medicinali exercitacione perita).

62 The grammatical gender of all the terms for "midwife" in the various European languages is feminine.

63 There are other indications in Muscio's text that obstetrics and gynecology are definitely not the exclusive monopoly of midwives; see Green, "Obstetrices" (n. 7 above).
issue of monopoly that is important for a proper historical understanding not only of midwives’ practice (which might have faced competition from or subordination to other practitioners) but also of the options available to women patients when they had to choose a medical attendant.\textsuperscript{64} If midwives did not have a monopoly on the whole field of obstetrics and gynecology (and if my assumption is accepted that a constant need for this care existed), then obviously there must have been other practitioners caring for women. Who, then, were they?

Those who argue that “women’s health was women’s business” assume that the treatment of women, especially for “women’s diseases,” constituted the exclusive domain of women practitioners either because of social convention or because (as Talbot would argue) male practitioners simply lacked interest in such matters. There is, in fact, evidence to support both these views. Many of the Italian licenses that limited women to a female clientele stipulated that this was done for reasons of propriety, as it was more seemly that women be treated by other women than by men.\textsuperscript{65} As for male practitioners’ lack of interest in women’s affairs, Beryl Rowland cites the statement of the fourteenth-century French surgeon, Guy de Chauliac, who remarked on the topic of multiple births that “because the matter requires the attention of women, there is no point in giving much consideration to it.”\textsuperscript{66}

Yet despite certain indications to the contrary, women were not immune to male competition even in the field considered “naturally” theirs. When Jacoba Felicie argued that she should be allowed to continue her practice on the grounds that as a female she would not threaten women’s modesty, the court dismissed her arguments as “worthless” and “frivolous.”\textsuperscript{67} That the medical faculty refused to engage in a debate about sexual “propriety” strongly suggests that they were not willing to so easily cede the treatment

\textsuperscript{64} The choice of medical attendant may, of course, have been made not by the woman herself but by her husband or male guardian; this is another question in need of study.

\textsuperscript{65} See Münster, “Women Doctors” (n. 18 above), 139; and Talbot (n. 53 above), 11–13. While it could be argued that this enforced specialization would have the benefit of encouraging practitioners to learn the peculiar anatomy and physiology of their female patients better, in the case of many practitioners (e.g., the woman eye surgeon mentioned by Calvanico [n. 25 above] who worked in a field where sex specialization would hardly seem relevant or medically useful), it must have simply limited their potential clientele and hence their economic viability.

\textsuperscript{66} Rowland (n. 1 above), 24.

\textsuperscript{67} Denifle, ed. (n. 42 above), 2:267. Jacoba may have used this argument simply for its rhetorical force since obviously it would not have justified her practice on male patients.
of female patients to women practitioners. Indeed, contrary to Talbot's claim that gynecology was a field "in which medical men showed no interest," there is abundant evidence that male practitioners were interested in the care of women's reproductive health. This becomes readily apparent from an examination of medieval gynecological literature.

Texts and audiences

Toward the end of the sixteenth century, Scipione Mercurio received advice on how to ensure a successful career as a physician in Venice. All he needed to know, he was told, were two things: how to get on well with pharmacists and how to make women fertile. The potential for profit in gynecological practice was not lost on Mercurio's medieval predecessors. In her superb study of the medical careers of a group of north Italian male physicians of the late thirteenth and early fourteenth centuries, Nancy Siraisi has found evidence that the treatment of gynecological problems was often a fundamental part of their practice. In the writings of a leading Bolognese physician, Taddeo Alderotti, Siraisi notes a "large number of gynecological remedies and cosmetics . . . [which] perhaps implies an extensive practice among women and a situation in which upper-class males were prepared to spend frequently and generously for the medical treatment of their wives and daughters."

Another recent work that demonstrates the gynecological activity of male physicians is Helen Lemay's study of the Treatise on the Womb by a fifteenth-century Pavian professor of medicine, Anthonius Guainerius. Lemay convincingly argues that Guainerius was actively involved in the medical care of women, diagnosing and treating them for a variety of gynecological ailments both di-

68 Although it is unlikely that this ever happened (though compare Clarice, the Italian eye surgeon mentioned in n. 25 above), the argument of modesty could, if carried to its logical extreme, preclude men from treating any of women's medical problems, not simply those of "the shameful parts."


71 Lemay (n. 8 above).
rectly and through the use of midwives as his assistants. Lemay’s reading of Guainerius’s treatise does not, however, exhaust the questions that need to be asked if this fascinating document is to tell us all it can about women’s medical care and practice in this period.

For example, the question of rivalry between different medical practitioners could be addressed with far greater nuance. Lemay writes that “Guainerius clearly recognizes the necessity of distinguisghing himself from the lay healer”—a concern Lemay attributes to “professional decorum.” To treat a certain disorder, Guainerius recommends that whereas “old women” use burned hair and feathers, the physician ought instead to use asafetida or castoreum. What Lemay does not realize (but which Guainerius clearly did) is that the distinction between these two sets of medicinal substances is solely economic: hair and feathers are valueless yet readily available, while asafetida and castoreum can be obtained only at considerable cost; all of these substances had been recommended in virtually every medical account of this disease from antiquity on. Guainerius’s innovation was to use something as seemingly neutral as materia medica to construct a social distinction between himself and a “lower” class of healers who in reality practice a medicine not so very different from his own.

Also crucial to understanding Guainerius’s text is an analysis of its intended purpose and audience. The title itself is revealing: it is called a “Treatise on the Womb,” not “On the Diseases of Women.” This reductive focus is clearly evident in Guainerius’s dedicatory preface to Filippo Maria, the duke of Milan: this is a treatise motivated not by a concern for the suffering of women (though Guainerius is not indifferent to this) but by an explicitly male desire for progeny. Guainerius’s treatise, obviously written with the self-serving goal of his own social advancement, is rife with subtle

---

72 Lemay notes a similar relationship between male physician and female midwife in her study of the thirteenth-century physician, William of Saliceto (Helen Lemay, “William of Saliceto on Human Sexuality,” Viator 12 [1981]: 165–81). I do not see, however, how the midwife’s role as manual assistant to the physician demonstrates that she had “ultimate responsibility for the practice of gynecology and obstetrics in thirteenth-century Italy” (181). As Lemay herself notes, according to William, the midwife even had to be taught the anatomy of the vagina by the physician (180).

73 Lemay, “Anthonius Guainerius” (n. 8 above), 326–27.

74 Compare Green, “Transmission” (n. 7 above).

75 I have examined a microfilm copy of Milan, Biblioteca Ambrosiana, MS A 108 inf., at Notre Dame University. The apparent popularity of the work suggests that Guainerius struck a responsive chord among the patriciate of fifteenth- and sixteenth-century Italy. There are at least fourteen extant manuscripts dating from the fifteenth and sixteenth centuries. The work was also printed at least three times before 1500.
polemics that, though they make interpretation more difficult, have a great deal to tell us about why male practitioners were interested in reproductive medicine. My point, then, is that Guainerius was writing within the context of a specific social and cultural environment that subtly pervaded even the most technical aspects of his work; understanding that environment is crucial to making proper sense of his medicine and of the way he describes his relations with other practitioners and his own patients.

Peter Biller offers other examples of male interest in gynecological and obstetrical matters, bringing up many of the complex issues of the relations between medieval males (scientific writers, practicing physicians, and even clergy) and midwives. Biller refers (somewhat hyperbolically) to "the massive presence in the west of learned books" that describe how birth ought to be handled, noting, however, the possible disjunction between such learned discussions (of which there is abundant evidence) and orally transmitted midwifery (about which there is virtually none). Even so, male medical literature was not simply scholastic speculation, Biller argues, but was derived at least in part from actual practice or discussion with midwives and was intended, in its turn, to be used to instruct them. He cites the Dominican friar Thomas of Cantimpré (d. ca. 1280), for example, who included discussion of midwifery in his general encyclopedia of learning "because of the danger of still-births and the ignorance of midwives. . . . We exhort therefore . . . that they [those with care of souls] should call together some more discerning midwives, and train them in secret, and others may be trained by them" (my emphasis).

There are many other instances in medieval medical literature that prove the active interest in gynecological matters among male practitioners. Even obstetrics was not beyond the pale of male


77 Ibid., 45–46.

78 Much of this material has been collected in the undeservedly neglected article of Carl Oskar Rosenthal, "Zur geburthilflichen gynaekologischen Betätigung des Mannes bis zum Ausgange des 16. Jahrhunderts," Janus 27 (1923): 117–48. For the text of a criminal inquest, held in 1326, against a male practitioner accused of gynecological malpractice, see Joseph Schatzmiller and Rodrigue Lavoie, "Médecine et gynécologie au moyen-âge: Un exemple provençal," Razo: Cahiers du Centre d'Études Médiévales de Nice, no. 4 (Nice: Université de Nice, Faculté des Lettres et Sciences Humaines, 1984), 133–43. The story of a miracle at St. Thomas à Becket's shrine involves a parish priest who personally observed a difficult birth and gave technical advice to the midwife; cited in Peter Biller, "Birth-Control in the West in the Thirteenth and Early Fourteenth Centuries," Past and Present, no. 94 (February 1982), 3–26, esp. 19, n. 69. Biller also cites evidence of priests' manuals which depict the priest as a source of advice on breast feeding and child care.
interest, as indicated by the quotation from Thomas of Cantimpré. Indeed, despite his dismissive statement that there was "no point" in giving attention to certain matters of birth, Guy de Chauliac himself nevertheless saw it as his duty to advise both the mother and the midwife on what they ought to do in case of difficulties.\textsuperscript{79} However, as I already suggested in the case of Anthonius Guainerius, it must be kept very clearly in mind that this is, after all, literature, and if we are to treat it as historical evidence we need to subject it to the same analyses as any other form of literary material meant to inform and persuade its audience, keeping in mind all the various ways in which language can hide or misrepresent reality. How much, for instance, do these writings reflect real experience, and how much are they simply reiterating beliefs and practices the authors have found in other writings? How much, in other words, of what we find in these texts is merely "armchair gynecology"? What role do rhetoric and polemic play, and how are we to filter out their influences? Who wrote this literature? And even more important, who read it?

John Benton has argued that the gynecological treatises ultimately attributed to "Trotula" were written both by and for men. Further, he argues that the false attribution to a woman author was equally an indication of and an aid toward the takeover of "women’s medicine" by male physicians and the gradual exclusion of women themselves from medical practice.\textsuperscript{80} I believe, however, that the "victimization" of women both as practitioners and as patients was not so absolute as Benton supposes; particularly, I believe it is incumbent upon us to distinguish between the purpose with which a text is written and the purpose to which it is later put. This distinction is absolutely crucial if we are to determine the relationship women—either as practitioners or patients—had to gynecological literature.

One critical problem in Benton’s thesis that the "Trotula" texts were written for men is that he does not explain the meaning of the preface to the longest of the three works, the \textit{Cum auctor} (or \textit{Trotula major}). In that preface, the author (who very well may have been male) states her or his reasons for writing. Recounting the numerous reasons why women are afflicted with diseases of their reproductive organs, she or he adds that "shame-faced on account


\textsuperscript{80} Benton (n. 22 above), esp. 48–52.
of their fragile condition and the diseases which afflict them in such a private place, women do not dare reveal their distress to a male physician.” It was out of recognition of their misfortune (and particularly “for the sake of a certain woman”) that she or he was impelled to write the book.81

If women “do not dare reveal their distress to a male physician,” how could the author possibly intend that this work be solely for the use of male physicians? While it is conceivable that the work was meant to educate male physicians so that they would not have to press a woman patient with questions she was too embarrassed to answer, it is also conceivable (and to my mind quite plausible) that the author meant her or his work to be read by women themselves; who actually did read it and who controlled its later transmission is an entirely different matter. Benton notes the condescension and distancing with which the author speaks of both women patients and midwives, yet these same features can be found in the sixth-century work of Muscio that was very clearly intended to be used by midwives.82 Furthermore, Benton himself concedes that the short work on cosmetics also attributed to “Trotula” was written explicitly for women.83 If, as this one instance suggests, men were willing to write texts specifically for women and women were eager (and able) to read them,84 why could this not be true of the gynecological texts as well? This problem of intended audience becomes all the more difficult when we turn to the multitude of vernacular gynecological treatises dating from the fourteenth and fifteenth centuries.

An anonymous late medieval Flemish translation of the “Trotula” texts has recently been edited by Anna Delva, who argues that the translation was made by a practicing midwife critical of

---

81 Paris, Bibliothèque Nationale, MS lat. 7056, fol. 77r: “Et ipse conditionis fragilitatis rubore faciei egritudinum suarum que in secretiori loco eis accidit, medico angustias reuelare non audent. Earem igitur miseranda calamitas et maxime cuiusdam mulieris gratia animum meum sollicitans impulit ut contra egritudines earum eidentius explanarem.” Although this passage was subject to frequent scribal alteration in the manuscripts, its sense remains substantially the same.

82 Benton, 46; compare Green, “Obstetrices” (n. 7 above).

83 Benton, 48.

84 Little is known about women’s literacy in the Middle Ages, especially among women outside the cloister. On one hand, it would be presumptuous simply to assume, without positive evidence, that women were illiterate. On the other hand, even in the case of a woman author such as Trota, we cannot be sure that she was literate, since it is possible that she dictated her work rather than writing it herself. Still, we should not dismiss this realm of “quasi-literacy”; even if women “wrote” only by dictating and “read” only by having works read to them, they were still functionally participating in literate culture.
male university masters. Various translations of “Trotula” and other Latin sources were also made into Irish, French, English, German, and Italian, and at least one entirely new gynecological tract was composed in Italian. The English translator of the “Trotula” makes explicit the value of the vernacular: “Because whomen of our tongue donne bettyr rede and undyrstande thys langage than eny other and every whoman lettyrde rede hit to other unlettyryrd and help hem and conceyle hem in her maledyes, withouthyn shewyng here dysese to man, i have thys drauyn and wryttyn in englysh.”

How are we to explain the contemporaneous appearance of “men’s texts” such as Guainerius’s and “women’s texts” like these vernacular ones? Are the vernacular texts addressed to women an active response, as Delva would argue, by women themselves to the increasing male intrusion into gynecological affairs? If so, did only women read them?

Anna Delva, Vrouwengeneeskunde in Vlaanderen tijdens de late middeleeuwen, Vlaamse Historische Studies 2 (Brugge: Genootschap voor Geschiedenis, 1983). This edition is not without its defects; see the (excessively hostile) review by Albert Derolez in Scriptorium 38, no. 1 (1984): 175–77. Delva provides a French résumé of her conclusions on 201–6. Here she repeats the argument that “women’s health was women’s business”: “Enfin notre étude a établi avec certitude que jusqu’à environ [!] 1550 tous les aspects de la médecine pour les femmes étaient confiés à des femmes” (205). Male involvement, she argues, was solely theoretical or in the guise of counsel offered in emergency situations.

See Benton, nn. 12 and 52, for references to these works. To this list can be added B. Kusche, Das Frauenbild in Gebrauchspratexten aus dem 15. Jahrhundert (3 mittelniederländische Handschriften gynäkologisch-obstetrischen Inhaltes) (Stockholm: Deutsches Institut, 1982). An unedited Italian text on the diseases of the breasts exists in MS 38 of the Boston Medical Library. Another Italian text (mistakenly identified in the catalog as a translation of pseudo-Cleopatra) is found in London, Wellcome Institute Library, MS misc. med. II; like the English text it, too, is intended “maximamente per le donne [sic]” (fol. 64r). On the general question of the use of the vernacular for gynecological texts, see Audrey Eccles, “The Early Use of English for Midwiferies, 1500–1700,” Neuphilologische Mitteilungen 78, no. 4 (1977): 377–85. Faye Marie Getz (“Gilbertus Anglicus Anglicized,” Medical History 26, no. 4 (October 1982): 436–42) has some useful cautions about assuming too much about the class or even the profession of the readers of vernacular medical literature. The problematic question of male vs. female audiences is also addressed in the recent editions of two early modern German translations of the Secreta mulierum (falsely attributed to Albertus Magnus), which seems to have been intended, not as a practical gynecological text, but as a “natural history of women” to inform curious male audiences. (One, the version of Hartlieb, was definitely intended for the use of the aristocracy, while the other was probably intended for the urban bourgeoisie.) See Kristian Boselman-Cryan, ed., “Secreta mulierum” mit Glosse in der deutschen Bearbeitung von Johann Hartlieb (Pattensen/Hannover: Horst Wellm, 1985); and Margaret Schleissner, “Pseudo-Albertus Magnus: Secreta mulierum cum commento, Deutsch. Critical text and commentary” (Ph.D. diss., Princeton University, 1987).

As cited in Rowland (n. 1 above), 14.
One of the fifteenth-century Middle English works, transcribed by Beryl Rowland, begins with a preface which, like that of the *Trotula major*, mentions women’s reluctance to bare their ills to a male doctor, although in this case the intended audience is explicitly declared: "Because there are many women who have numerous illnesses—some of them almost fatal—and because they are also ashamed to reveal and tell their distress to any man, I therefore shall write somewhat to cure their illness. And so to assist women, I intend to write of how to help their secret maladies so that one woman may aid another in her illness and not divulge her secrets to such discourteous men." 88 In addition to its intriguing preface, the intended audience of this anonymous text is further indicated, Rowland argues, by the inclusion of material on obstetrics—a topic that (she believes) was of little interest to men and was not usually found in standard medical texts. 89 From this, Rowland suggests that at this time "women were the sole obstetricians," arguing further that "the debt to the experience of women, whether such material was originally recorded orally or written down, is obvious throughout the work." 90

Rowland edited her text from only one of at least six manuscripts now extant, two of which are identical to the copy she used in all substantive details. 91 The other three are exemplars of a second version of the text; a transcription of one of these latter manuscripts has now been produced by M.-R. Hallaert. 92 Although both Row-

---

88 Ibid., 59. This edition is marred by numerous errors of presentation and interpretation. The reader wishing to make use of it should refer to the important critiques in the reviews by Jerry Stannard and Linda Voigts, *Speculum* 57, no. 2 (April 1982): 422–26; Nancy Siraisi, *American Historical Review* 87, no. 2 (April 1982): 435–36; and Faye Marie Getz, *Medical History* 26, no. 3 (July 1982): 353–54. For some reason, Rowland insists on calling her text an "English Trotula" even though she knew it was not an English translation of the Latin *Trotula* texts (48). Peter M. Jones (*Medieval Medical Miniatures* [London: British Library, 1984], 54) has now demonstrated that Rowland’s text is for the most part a translation from the Latin of a general book on practical medicine by Roger Baron. Copies of the "genuine" Middle English translation of *Trotula* (actually, a compilation made from *Trotula* and other texts) can be found in Oxford, Bodleian Library, MSS Bodleian 438 and Douce 37; and London, British Library, MSS Additional 12195 and Sloane 421A. All have an incipit more or less as follows: "Our Lord God when he had stored the world" (cf. *Trotula major*: "Cum auctor universitatis deus in prima mundi origine").

89 Rowland, 23–26.

90 Ibid., xvi.

91 Rowland transcribed London, British Library MS Sloane 2463. Other manuscripts with the same text are London, British Library, MS Sloane 249, and London, Royal College of Physicians and Surgeons, MS 129 a.i.5.

land and Hallaert knew of the existence of these other manuscripts, neither made any attempt to compare them systematically with the copy each transcribed. 93 Had they done so, they might have realized that the two versions of this text together have a lot more to tell us about the creation and dissemination of gynecological knowledge than a superficial reading would suggest.

The second version of this Middle English text (which for convenience I will call "Hallaert’s version") not only is rearranged in parts and substantially "abbreviated," but it also lacks much of the obstetrical material (including the illustrations of the fetus in utero) and other sections found in the first version ("Rowland’s version"; see table 1). 94 Most important, Hallaert’s version lacks the poignant, almost feminist preface that was the sole explicit indicator in Rowland’s version that women were the intended audience. Without the preface, the text becomes superficially "neutral." The scribe of one manuscript in Hallaert’s version, however, had a very clear idea of who his (or her) audience would be and emended the text accordingly: she or he simply began "Sirs, we shall understand that women’s bodies have less heat" (emphasis added). 95

How are we to explain the simultaneous existence of the two versions of this text, one (Rowland’s) ostensibly a "women’s version," the other (Hallaert’s) a neutral or "men’s version"? Which came first, and who appropriated from whom? These, unfortunately, are questions that must wait until a competent specialist in Middle English can produce a critical edition of all the manuscripts and determine the text’s origins. 96 It is not necessary to know which version was prior, however, to see that Rowland’s claim that "the debt to the experience of women . . . is obvious throughout the work" is unfounded, for the obstetrical material, no less than many other parts of the text, clearly derives in large part from previous Latin sources—all of them (in those cases where authorship can be de-
<table>
<thead>
<tr>
<th>Middle English Text</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>For as much as there ben manye women [preface]</td>
<td>58</td>
</tr>
<tr>
<td>Therfore ye schal understonde [text of treatise proper]</td>
<td>58</td>
</tr>
<tr>
<td>Witholdyng of this blode</td>
<td>60–64</td>
</tr>
<tr>
<td>For to helpe women of these sekenesses</td>
<td>66–70</td>
</tr>
<tr>
<td>Good electuaries for this sekenesse</td>
<td>70</td>
</tr>
<tr>
<td>Also a worshipfull serip</td>
<td>70–74</td>
</tr>
<tr>
<td>To moche flowynge of blode</td>
<td>74–86</td>
</tr>
<tr>
<td>Suffocacion of the moder is when</td>
<td>86–96</td>
</tr>
<tr>
<td>The precipitacioun of the moder</td>
<td>98–104</td>
</tr>
<tr>
<td>Moch wynde ther is also in the moder</td>
<td>104–8</td>
</tr>
<tr>
<td>Ydropsie of the moder</td>
<td>108–10</td>
</tr>
<tr>
<td>A good suppositorie to purgen the moder</td>
<td>110–12</td>
</tr>
<tr>
<td>The moder semyth ofte layne &amp; rawe</td>
<td>112–14</td>
</tr>
<tr>
<td>Apostume of the moder</td>
<td>114–18</td>
</tr>
<tr>
<td>Ache of the moder</td>
<td>118–20</td>
</tr>
<tr>
<td>Yff a woman be with child</td>
<td>120–22</td>
</tr>
<tr>
<td>Greuances that women haue in bering [includes 17 figures of fetus in utero]</td>
<td>122–34</td>
</tr>
<tr>
<td>And the greuances that women have in beryng</td>
<td>134–38</td>
</tr>
<tr>
<td>Mola martrics is in two maners</td>
<td>140–44</td>
</tr>
<tr>
<td>Seconbine is a litell skynne</td>
<td>144–46</td>
</tr>
<tr>
<td>Fyrst, yf she be repleted</td>
<td>146</td>
</tr>
<tr>
<td>The women that bleden otherwhiles</td>
<td>146–48</td>
</tr>
<tr>
<td>Woundes of the marice</td>
<td>148–50</td>
</tr>
<tr>
<td>Cancryng and festres of the marice</td>
<td>150–52</td>
</tr>
<tr>
<td>Women when they ben with child</td>
<td>152</td>
</tr>
</tbody>
</table>
TABLE I (Continued)

<table>
<thead>
<tr>
<th>Middle English Text</th>
<th>Page Numbers</th>
<th>Rowland</th>
<th>Hallaert</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Several pages of Latin text on such topics as provoking the menses, anaphrodisiacs, tumors of the breasts)</td>
<td>152–62</td>
<td>[lacking]</td>
<td></td>
</tr>
<tr>
<td>(Several more pages of Middle English recipes)</td>
<td>162–72</td>
<td>[lacking]</td>
<td></td>
</tr>
</tbody>
</table>


M.-R. Hallaert, *The “Sekenesse of wymmen”: A Middle English Treatise on Diseases of Women*, Scripta: Mediaeval and Renaissance Texts and Studies, no. 8 (Brussels, 1982), a reproduction and transcription of the text in New Haven, Connecticut, Yale Medical Library, MS 47. Two other copies also exist of this version: London, British Library, MSS Sloane 5 and Royal 18A.VI.

The Middle English chapter incipits (i.e., opening phrases) cited are those of Rowland’s text.

Although it lacks a preface, Sloane 5 nevertheless makes its intended audience explicit: “Sires, we shulle vndersonde” (fol. 158r; emphasis added).

terminated) written by men. Aside from two unnamed women said to have cured their own illnesses, no women are ever mentioned as authorities in the text. Nor, aside from the preface, is the text in any way addressed to either women patients or midwives; both are referred to solely in the third person. All second-person references and imperatives are reserved for the practitioner reading the book who, apparently, is assumed to be neither laywoman nor midwife. In what sense, then, whether we talk about its audience or its sources, can we unambiguously speak of this work as a “medieval woman’s guide to health”? Clearly, this was a text shared (fought over?) by men and women, and it reflects men’s accumulated knowledge of gynecological and obstetrical medicine as much as (if not more than) women’s. Even if the text was originally intended for women, the fact that the manuscript Rowland edited is known to

97 Rowland, 110/111 and 144/145. Although “Trotula” is mentioned (168/169), it is not clear whether the author understood the word to be a woman’s name or simply the title of a text; the name “Lilie” on 102/103 is not a woman but rather a reference to the *Lilium medicinae*, a general textbook of medicine by Bernard of Gordon. The male authorities cited are not merely the traditional figures (e.g., the Arabic authors, Avicenna and Rhazes); on pp. 76/77, e.g., a remedy for uterine flux is described which was taught to a woman by the prior of Bermondssey!

98 Although, as I suggested earlier in reference to the *Trotula major* and Muscio, this does not entirely exclude the possibility that women (either practitioners or patients) were the original intended audience, it does raise serious doubts.

99 If the argument that “whomen . . . donne bettyr rede and undyrstande” English than Latin is to be accepted, then the presence in this text of an extended section
have been owned by a male surgeon within a century after its cre-
ation underscores how tenuous women's possession of texts might have been.\textsuperscript{100}

In light of all the apparent male involvement in this Middle English text, what is to be made of the rhetoric of the preface of this or, for that matter, any of the other vernacular translations ostensibly addressed to women? Should it be dismissed as false and meaningless on the assumption that the content of these works, because it came from texts either written or transmitted by men, could not possibly have reflected the gynecology and obstetrics practiced by women themselves?

Some scholars, in discussing both modern and premodern times, have suggested that men and women lived in such completely separate cognitive universes that gynecological theories formulated by men would in no way correspond to the "female medicine" practiced by women. Helen Lemay suggests that such an assumption is inappropriate. Granted, she relies for her argument on a comparison of the text Rowland edited (which as I have just argued can only tenuously be said to represent "women's medicine") and Guaimierius's work (which, as I have also suggested, presents a very biased view of what "women's medicine" was). Nevertheless, Lemay's observation that medieval women as well as men may have fully accepted the cultural and scientific assumptions of their time is a point worth heeding.\textsuperscript{101}

Benton, in contrast, believes that there is such a difference and that the "Trotula" texts, despite their (false) attribution to a woman, nevertheless reflect "male medicine," which he assumes was both less effective and more harmful than that practiced by women. Benton argues that male physicians took comfort in the thought that they were reading what a woman, speaking as a woman, had to say about gynecology, though he suggests that if medieval male physicians had really wanted to know "what women think," they could have looked at the medical writings of the twelfth-century German abbess, Hildegard of Bingen.\textsuperscript{102} While studies of these works show

\textsuperscript{100} See Rowland (46) for the later history of this manuscript. The other contents of the codex (which was created as a unit) are surgical, suggesting that it was intended to be used by a surgeon. There is no evidence to indicate whether the original owner was male or female, though the "de luxe" quality of the codex suggests at the very least that she/he was well-to-do.

\textsuperscript{101} Lemay, "Anthonius Guaimierius" (n. 8 above), 325–26.

\textsuperscript{102} Benton (n. 22 above), 51–52.
that Hildegard was indeed a remarkably innovative thinker (particularly with regard to notions of female nature), her writings still evince a fundamental dependence on the dominant medical theories of her day. Furthermore, if Delva is correct in arguing that women themselves were responsible for and used at least some of the vernacular translations of the "Trotula," this would suggest that they viewed the contents of the texts as an acceptable interpretation of their diseases.

The connection (or disjunction) between literature and reality is also relevant when interpreting rhetoric. Despite the hoary antiquity of the theme of women's modesty in gynecological and other literature, this topos may still have been meaningful to medieval people, both male and female. Carl Rosenthal notes that, although male physicians considered themselves competent to treat the full range of gynecological disorders (even to the point of instructing the midwife!), he was able to find no instance of a man manually examining a woman's vagina for a gynecological disorder. This deeply ingrained social taboo would have insured women a place in the medical care of other women, if only in the role of manual assistant to the male physician (as can be seen in Guainerius and other writers) and in the rarely challenged role of birth attendant.

103 See Gertrude M. Engbring, "Saint Hildegard, Twelfth Century Physician," Bulletin of the History of Medicine 8, no. 6 (June 1940): 770–84; Bernhard W. Scholz, "Hildegard von Bingen on the Nature of Woman," American Benedictine Review 31, no. 4 (December 1980): 361–83; Michela Pereira, "Maternità e sexualità femminile in Ildegarda di Bingen: Proposte di lettura," Quaderni storici, no. 44 (August 1980), 564–79; and Joan Cadden, "It Takes All Kinds: Sexuality and Gender Differences in Hildegard of Bingen's 'Book of Compound Medicine.'" Traditio 40 (1984): 149–74. Cadden writes that "Hildegard of Bingen's views on the physical constitution of men and women were generally consistent with the scientific outlook of twelfth-century male medical and philosophical authors" (150). What is fascinating is how Hildegard used and manipulated those ideas in such a different fashion from that of her male contemporaries.

104 It would be interesting to know whether in the vernacular translations of "Trotula" addressed to women emphasis was given to the fact that the author was (allegedly) female, leading women readers (as it had led men) to believe they were reading a woman's own theories and practices. Other than Trotula's Practica, no other extant gynecological text is known to have been composed by a woman until the early modern period. The later texts show that women did accept many prevailing views of their physiology and diseases; see Natalie Zemon Davis, "Women on Top," in her Society and Culture in Early Modern France (Stanford, Calif.: Stanford University Press, 1975), 124–51, esp. 125. Perhaps class needs to be used as an analytical variable as well as gender.

105 See Green, "Obstetrics" (n. 7 above).

106 Rosenthal (n. 78 above), esp. 146–47.

107 There is a very long tradition (which itself needs to be explored) of surgeons being called in in cases of difficult labor when the child often had to be sacrificed.
The rhetoric of women's modesty is not used by Jacoba Felicie and the authors of the vernacular prefaces to support these merely ancillary roles, however. Rather, their employment of the rhetoric of modesty might be seen as a conscious attempt to actively turn the taboo to their own advantage and thereby resist the increasing circumscription of women's sphere of medical practice. Their desire may have been to make women's health women's business because it was women's interests that there be a sexual division of medical labor that would ensure them a field of practice where men could neither claim competence nor offer competition. The rhetoric of modesty could equally have served the purposes of women patients who may very well have preferred to be treated by attendants of their own sex. Indeed, in this sense, to speak of modesty in terms of "rhetoric" may be slightly misleading, for it is at least possible that women really felt the shame these statements attribute to them. Unfortunately, since we do not yet have any testimony from women patients themselves telling us how they perceived this complex world of medical practice, for now we can only guess whether the sentiments we find in the vernacular gynecological literature addressed to women—having passed through who knows how many filters—do not in some way truly reflect women's desire "to help and conceal themselves in their maladies, without showing their diseases to men."

to save the life of the mother. It would be interesting to know whether, when there was a female surgeon at hand, she would be preferred to a male. If so, what would her relationship to the midwife be? Besides the traditional use of surgeons as the attendant of last resort in difficult labors, men apparently assisted births only of the upper classes. Labarge (n. 5 above) notes this but then quickly dismisses it as a relatively insignificant indicator of male obstetrical practice (179). Its rarity may not be the sole criterion with which to assess its importance, however. Because of concern over succession, the births of royalty and the nobility are great matters of state; for kings and nobles to consider university-trained male physicians competent to supervise these births indicates faith that they were indeed the best available attendants. For example, Michael McVaugh has demonstrated that King Jaime II of Aragón/Catalonia placed such high faith in university training that he went to great lengths to make sure that his wife, Blanca, was attended by a (male) physician at almost all of her ten births; see Michael McVaugh, "The Births of the Children of Jaime II," *Medievalia* 6 (1986): 7–16. Whether these physicians acted alone or in concert with an assisting midwife is not clear; there are no traces of any female midwives in the royal archives. Male involvement in gynecological surgery is also documented. The fifteenth-century anatomist, Berengario da Carpi, recalls a hysterectomy performed by his father, a barber surgeon; see R. K. French, "Berengario da Carpi and the Use of Commentary in Anatomical Teaching," in Wear, French, and Lonie, eds. (n. 69 above), 42–74, esp. 43.

The social inculcation of shame would be well worth exploring, particularly from an anthropological perspective.
Other sources, other questions

Awareness of the deep tensions between men and women might help us decipher other aspects of women’s health care and medical practice in medieval Europe. Here we are especially in need of interdisciplinary studies, such as Grethe Jacobsen’s exemplary analysis of pregnancy and childbirth in medieval Scandinavia.109 Jacobsen has taken virtually every sort of evidence imaginable—archaeological findings, laws, sermons, folk ballads, theological and scientific literature, even language itself—to reconstruct a picture of how women themselves experienced pregnancy and childbirth. Sensitive both to the different perspectives of what she terms “women’s sources, men’s sources, and common [or neutral] sources” and to the limitations of traditional periodization, Jacobsen describes among other things the Kvindegilde (Women’s feast), a postpartum gathering of women which, “in its most raucous form, . . . ended with a tour of the village where women upset carts, split wagons, knocked over gates, destroyed haystacks, stripped the men they encountered and forced them to dance.”110 This may at first sight seem to show women’s power and control of their reproductive capacities, yet as Natalie Zemon Davis has demonstrated for the sixteenth century, such ritualized reversals of the sexual order—as dramatic, even violent, as they may be—in fact can have very ambiguous meanings.111

As with Davis’s work on inversion rituals, methodological techniques developed in other areas of women’s history have tremendous potential to inform the history of medicine. For example, Merry Wiesner’s discussion of female healers in her study of women in early modern Germany has the inestimable virtue of placing these women in the context of workers, where questions of economic rivalry, guild regulations, and municipal and state control can properly be addressed.112 Alison Klarmont Lingo’s study of charlatans


110 Ibid., 106–7.

111 Davis (n. 104 above).

112 Wiesner, Working Women (n. 38 above). Wiesner’s admirable reconstruction of the training, practice, and social position of midwives in early modern Germany, one hopes, will serve as a model for similar regional studies; see also Natalie Zemon Davis, “Women in the Crafts in Sixteenth-century Lyon,” in Hanawalt (n. 38 above), 167–97. Although she does not discuss women healers specifically, the general conclusions of Martha Howell, Women, Production and Patriarchy in Late Medieval
in sixteenth-century France shows how potentially useful the concept of "Otherness" can be to assessing the development of professionalization in medicine. Such conceptual approaches might also be used to explore many other important questions, such as the development of a rhetoric about the ignorance of midwives and other women practitioners, or the role of women’s literacy in determining their access to certain areas of medical knowledge, or the possible impact of the vernacular translations of gynecological literature. Literate sources are of only limited utility, however, in chronicling the history of a society that was predominately illiterate. One particularly fruitful form of evidence not yet fully exploited is artistic depictions of childbirth and other medical encounters, though

_Cities_ (Chicago: University of Chicago Press, 1986), might usefully be set against the developments of women’s increased restrictions in medicine, their access to medical guilds, and questions of the sexual division of medical labor. For example, in her study of the effects that the Black Death had on late fourteenth- and early fifteenth-century Florentine physicians, Katharine Park (n. 21 above) notes that she could find no evidence of women matriculating as physicians in the Guild of Doctors, Apothecaries, and Grocers before 1353 or after 1408; between those two dates, however, Park documents a notable opening-up of the profession to otherwise marginal practitioners. By contrast, women’s access to guilds of surgeons and especially barbers in England seems always to have been quite free; cf. Gottfried (n. 17 above), 50–51. Although Gottfried’s explanation for the relative freedom in the barbers’ guilds is hardly satisfactory, he is nevertheless quite right to note that attention should be paid to whether these women gained access to the guild in their own right or only because, as widows, they were allowed to take the place of their dead husbands; see also Wyman, “The Surgeoneess” (n. 53 above), 26–27.


114 Ignorance had always been an argument used by university-trained physicians to distance themselves from other practitioners, but this theme seems to take on particular virulence when applied to women. This is noted briefly by Biller, “Childbirth in the Middle Ages” (n. 76 above), 44. While some would argue that for all their elaborate theories university physicians were in no better position to cure their patients than empirical healers, great caution is needed when addressing questions of medical efficacy, for it is both presumptuous and simply unhelpful to criticize medieval healers for not having thought and acted in ways that only make sense in light of modern medical discoveries.

115 For example, when Ferretta Petonne was prosecuted in 1411 by the master surgeons of Paris for unlicensed practice, she was ordered to deposit her books on surgery with the provost for examination by the physicians; cf. Wyman, “The Surgeoneess,” 25; and DeMille, ed. (n. 42 above), 4:198–99. Thomas Benedek (n. 48 above) cites a late fifteenth-century German ordinance that also assumes women’s literacy: “So that the midwives be better informed in all aspects [of their practice] they should read their professional books diligently and, when necessary, make use of the information of a physician” (554; emphasis added).
here, too, we need to beware mistaking topoi (in this case, iconographic ones) for historical realities. ¹¹⁶

These desiderata could be continued ad infinitum. Clearly, the most pressing need is for extensive work based on the primary sources themselves. Benton’s discovery of the genuine work of Trota (after more than four hundred years of empty speculation about her existence) could not have been accomplished without extensive manuscript research. Critical editions of medical texts are also essential if we are to avoid the danger of premature generalizations drawn from insufficient information. In all of this, we must remain sensitive to chronological, regional, religious, and class distinctions—in short to all the factors that create historical specificity and diversity.

Paying attention to such diversity allows us to realize how far we have been misled by simplistic assumptions, seeing uniformity where there may in fact have been much variety: in the roles midwives played, in the ways other women practiced medicine, in the medical needs women had beyond assistance at birth, and in the sources from which they obtained that medical care. Even though such findings do not radically alter the accepted view that the majority of births were probably attended by women up until the eighteenth, perhaps even the twentieth century, or that an all-female world of birthing ritual did exist,¹¹⁷ once we move beyond a reductive focus on the birth event, we see that there was also a world of interface between male practitioners and female patients—a world where women practitioners were gradually being restricted to a role as subordinate and controlled assistants in matters where, because of socially constructed notions of propriety, men could not practice alone. Women’s health was women’s and men’s business, the latter being interested if for no other reason than their concern

¹¹⁶ See Loren MacKinney, “Childbirth in the Middle Ages, as Seen in Manuscript Illustrations,” Ciba Symposium 8, nos. 5/6 (December 1960): 230–36; Volker Lehmann, Die Geburt in der Kunst: Geburtshilfliche Motive in der darstellenden Kunst in Europa von der Antike bis zur Gegenwart (Brunswick: Braunschweiger Verlagsanstalt, 1978); Danièle Alexandre-Bidon and Monique Closson, L’enfant à l’ombre des cathédrales (Lyon: Presses Universitaires de Lyon, 1985); Jones (n. 88 above), esp. 123–24; and Biller, “Childbirth in the Middle Ages.” A study on the history of medieval illustrations of caesarian sections by Renate Blumenfeld-Kosinski is forthcoming from Cornell University Press. An index of medieval medical images is now being created at the Medical History Division, Department of Anatomy, University of California at Los Angeles.

¹¹⁷ See, e.g., Wilson, “Participant or Patient?” and “William Hunter” (nn. 10 and 58 above); and Nadia Maria Filippini, “Levatrici e ostetricanti à Venezia tra Sette e Ottocento,” Quaderni storici, no. 58 (April 1985), 149–80, and the literature cited therein.
as husbands and fathers for the production of healthy (and legitimate) heirs or, as medical practitioners, for the potential profit to be made in treating the wives and daughters of their wealthier clients. As many other studies in the history of women have shown, the superficially simple dichotomies of sex and gender often mask very complex and tension-fraught realities of the relations between women and men. Making sense of such complexity is no easy task, but it is one that will inevitably enrich and deepen our understanding of the history of women’s medical practice and health care in medieval Europe.

Department of History
Duke University