Proceedings of The National Conference
On Undergraduate Research (NCUR) 2016
University of North Carolina Asheville
Asheville, North Carolina
April 7-9, 2016

Magic and Medicine in a Man's World: The Medieval Woman as both Healer and Witch

Abigail Casey
Honors Program
Cedar Crest College
100 College Drive
Allentown, Pennsylvania 18104 USA

Faculty Advisors: Carol Pulham, PhD and K. Joy Karnas, PhD

Abstract

Medieval women live in the shadows of literary remembrance. Primary literature, much of it written by men, does little to give us an intimate knowledge of women's work and lives. Nonetheless, they were an integral part of medieval life, particularly in the delivery of health care. Operating within the sphere of the home or the nunnery, women were largely responsible for tending to common ailments, treating childhood diseases, and attending to women in labor. With no formal education, they based their medical care in the practical application of botanical compounds, and religious and secular superstition. Towards the end of the Middle Ages, universities began offering medical education to male students, and formally-trained male physicians began practicing alongside nurses and midwives with informal training. This paper intends to show that a new combination of competition and deeply rooted antagonism towards the female sex tilted the public perception of women healers from well-respected necessities to witches and charlatans. This project explores the conflicting images of women as healers and women as charlatans, in reference to medieval gender conflicts, through a collective analysis of primary literature, including texts by Trotula, Hildegard of Bingen, and Jacqueline Felicie, as well as art from the Middle Ages.

Keywords: Medieval medicine, witches, gender-conflict

1. Introduction

In twenty-first century America, with a pharmacy in every town and a remedy for nearly every malady, it is hard to imagine the extent of the gulf of knowledge that separates modern medicine from medieval medicine. Medieval medicine was often a guessing game, a mixture of heuristics, oral traditions, practical remedies and grossly ineffective treatments. Just as the poor efficacy of medieval medicine contrasts drastically with modern medicine, so does the difference in accessibility to professional healthcare. A well-trained, reasonably-priced physician was often impossible to find, and thus much of medieval healthcare was delivered and developed by empirical practitioners: mothers, nuns, midwives, and 'wise women.' Unfortunately, most medieval women live in the shadows of literary remembrance. Primary medieval literature, much of it written by men, significantly underrepresents the work and influence of the medieval woman. As a result there are few direct accounts to give us an intimate knowledge of women's work and lives. Despite a disproportionate lack of individual accounts from medieval women, their collective influence upon history confirms that they were an integral part of the delivery of practical and essential healthcare. This paper intends to show that a combination of competition and strong medieval gender roles contributed to the tilting of the public perception of women healers from well-respected necessities to witches and charlatans, ultimately leading to the professionalization of medicine. This shift in perception towards women healers led to the general exclusion of women from advanced medical practice for the next five centuries, and the depersonalization of medicine that has only now been corrected within the last fifty years.

2. Medieval Health Practitioners

It is valid to claim that medieval women healers played perhaps the most significant role in delivering healthcare during the Middle Ages[1]. But the historical records from this time give us little direct evidence to support that claim due to the scarcity of documents about individual people. To compound the problem, there was minimal interest in recording the daily actions and influences of women. Fortunately, the increase in literary expositions and translations of historical documents over the last seventy years have provided enough information to support the claim that women were providing the majority of practical medical services throughout the Middle Ages. In order to draw a clear picture of their work and influence, it is helpful to discuss the practice of both male and female healers; the distinction between the sexes and their influence becomes clear with such an analysis. As such, it seems appropriate to first discuss the work of the medieval physician, or medicus, who was nearly always male, before discussing the work of less formally trained, but more ubiquitous, female healers.

2.1 Medici: Male Physicians

Why did medieval healers and physicians not continue to advance and build upon Galen's theory extensively, and why did medical treatment remain mostly unchanged for over one thousand years during the Middle Ages? The answer seems to lie in the way medieval healers classified themselves and performed their work. During the early Middle Ages, between approximately the 6th and 10th centuries, an educated man would have studied, in some measure, three fundamental stones of learning: law, liturgy, and medicine[2]. If he chose to study medicine further, and to practice it, he would have approached it much like any other academic study. Intellectual philosophizing, rather than practical discovery, was the pinnacle of learning and academic work during this time. There was an emphasis on theory over experience.

Rather than explore the causative agent of a disease, or even pursue rudimentary clinical applications of novel treatments, many formal physicians were satisfied with restricting their practice to the theoretical study of disease, unaltered since the Greco-Roman philosophers first wrote[3]. According to Major, "the ambition of a learned physician was not to study disease itself but to study the writings of great physicians and to write commentaries on their works"[4], a fact which led to the stagnation of medical advancement after the earlier work of the Greeks and Romans. Unfortunately, their commentaries and treatises were not only restricted to the exposition and analysis of previous medical knowledge, for if that were true perhaps some faulty thinking would have been exposed and corrected; instead, the early male physician was encouraged to bind previous medical knowledge to celestial and spiritual concepts of sin, astrology, or Church dogma. As a result, their medical advancement was often stunted. Without an understanding of the physical cause of disease, they could only hope for an immediate cure of a disease. Attempts at the management of pain or discomfort were seldom made by *medici*, for they thought of disease as a physical state that could be switched on or off, rather than a process that could be modified, lessened, or aggravated. Should their treatments be ineffective, and a cure unattainable, it was not necessarily considered to be due to the failure of a treatment but rather to the overpowering nature of the cause of the disease: sin. Brody writes in regards to leprosy that "For the physician, the mere presence of the disease might well bespeak the possibility of sinful acts,"[5] and that "many writers equated the cardinal sins with diseases"[6]. Given that many illnesses and diseases were not treatable with a few applications of medicine, the physicians would often only counsel their patient in spiritual changes, and devote the remainder of their time to writing and theorizing.

Gleaning solid names and histories of well-respected male physicians during this period of the Middle Ages can be convoluted and indefinite; between the years 400 A.D. and 1066 A.D., only eight physicians are identifiable without doubt in the British Isles, and few more add to the list across Europe[7]. Nonetheless, historians do find a significant number of records, names, and histories of physicians in the Arabic world during this period of time. While Arabic physicians were hindered by religious regulations on the dissection of human bodies, they were less determined to fit science and observation into philosophical and religious confines. George Sarton, having compiled a succinct list of twenty-five early Middle Age Arabic physicians, writes that they are but a "few glorious names, without contemporary equivalents in the West"[8]. While Sarton's assertion is perhaps an unfair assessment, history does not indicate that Western physicians were ever as sought after nor as well-respected as Arabic physicians practicing during the early Middle Ages. Their reliance on previously written theories meant that they were liable to place blame for failed treatment on the state of their patient's soul, rather than the inefficacy of their medical services, which is not a desirable trait in a healer.

With the advent of the high Middle Ages (11th-13th centuries), and the beginning of the Crusades, fairly little of the Arab world's medical knowledge was brought back to Western culture and introduced to European physicians. While

there are accounts of both Western and Arab physicians traveling to learn medicine from one another, the resulting exchange of ideas was poor. Western physicians, considering the lack of Church doctrine in Arabic medical treatment, chose to adhere to their preferred methods of treatment rather than use Arabic knowledge[9]. Thābit was an Arabic physician working near Jerusalem in the 11th century who was famed for healing wounds with salves and poultices and was well-known for refusing payment unless treatment was effective. Following one battle in which there were mass casualties on both sides, he was horrified to find an itinerant Frankish friar and physician who was amputating the limbs of recovered Crusaders, claiming the remedies used by Thābit were the result of pagan magic and would poison the souls of the Crusaders[10]. Similar stories, in which the religious convictions of the two worlds collided, explain the lamentably poor exchange of medical ideas between cultures.

Given the poor flow of medical knowledge from the Arab world, it seemed there was little hope for medical improvement in medieval Europe. However, the Crusades did lead to the greater exploration of Europe and the freer movement of books and manuscripts. Treatises and remedies began to flow through Europe from the school at Salerno, in Italy. Founded in 1075 A.D., Salerno was a medical school and health retreat based on a very different kind of medicine than was regularly practiced in Western Europe. Medicine was taught with little emphasis on books and humorist theory, being instead rooted in practical knowledge and observation[11]. It was a school at which patients could expect a fair chance at being cured with minimal theoretical babbling and philosophizing. Out of this school, practical medical treatises and texts began to be more widely circulated. While they did not change the fundamental humorist theory of medicine that underpinned all medical treatment, they outlined practical remedies and approachable treatments that often were effective. Certainly medieval physicians were invested in the philosophical aspects of practicing medicine, but some were truly interested in ministering to their patients. With practical knowledge at their fingertips, they began to place a heavier emphasis on treatment than they had previously done, and as such, much of the credit for any advancement of medieval medicine through the Middle Ages is attributed to the dissemination of medical information from the center at Salerno.

A trained *medicus* became an increasing necessity at court during the high Middle Ages, progressing through the late Middle Ages (13th-15th centuries). Patrons of the sciences, notably King Henry I and King Stephen of England, began to place an emphasis on having the most successful and prominent physicians placed in their court[12]. Indeed, between 1100 A.D. and 1154 A.D., the number of recorded *medici* jump from eleven to ninety, a clear indication that a trained physician was seen as a necessity, and a hint that their medical prowess, through experience and significant trial-and-error, was improving[13]. Even within this brief, fifty-year period, it is clear that an increasing emphasis on formal training begins to take hold across Europe. Within a few years of 1154 A.D., records begin to show the start of the broad, continental licensing campaign that would lead to marked increases in the number of practicing male physicians, and the resulting "professionalization" of medicine[14].

2.2 Healers: Women Healthcare Workers

Before analyzing the role of a medieval woman healer, it is important to highlight the difference, in this paper, between "healer" and "physician." While modern medicine is increasingly pressing that there be a less definitive line between the two roles (in the form of complementary, holistic medicine), the roles of medieval healers compared with medieval physicians were very dissimilar. While physicians are healers by trade, there is an important distinction to be made between the individuals who delivered healthcare according to the current medical theories of the Middle Ages (and were formally trained), and those who delivered healthcare with less theoretical and more practical knowledge. The latter are, in this study, considered healers; this term encompasses those who practiced medicine without licensure, without theoretical training, but with practical or domestic training. As such, it seems reasonable to assign the term "healer" to the majority of historical women who delivered medical care throughout medieval Europe, and reserve the term "physician" for those who were formally-trained, and thus often male.

Women were not entirely missing from the ranks of medieval healthcare, nor were they confined to midwifery or vague domestic medicine. Records indicate there were *some*, though very few, women in all the ranks of medicine, from physician to barber-surgeon to nurse[15]. However, their presence was markedly poor. Out of the entirety of known healthcare practitioners in France during the Middle Ages, only 1.5 percent of them were women; compounded research has yet to indicate more than fifty formally-trained women healers within England's historical record for the entirety of the Middle Ages[16]. The pattern is striking similar throughout the rest of Europe, but as Green argues, is highly impractical.

It is impossible that there would have been "[…] only one midwife in the whole of England"[17]. The understanding then must be that the women whose names were remembered in the historical record were either of other historical or religious renown (e.g. Hildegard of Bingen, Heloise, Jacqueline Felicie de Almania), or were notably wealthy. Pelling

and Webster broadened their search for women healers to those living on the margins of legal medical practice, and found a significantly higher number of women contemporaneous with one another and operating within the same general region of England[18]. Ultimately, this suggests that though women were in some small measure found in varying areas of formal medical practice throughout the Middle Ages, the majority were delivering medical care outside of the bounds of legality, or at the least, formality. From this, two questions arise. First, what kinds of medicine were medieval women practicing, and second, how were they learning to practice medicine if few of them were trained professionally?

The paucity of records by medieval women, or by medieval men concerning the work of women, makes solid conclusions about the types of medicine they practiced difficult to support. Nonetheless, most medieval historians assert – in the words of Eileen Power – that "all women were expected to know something of family medicine"[19]. Some of this argument is based on evidence found in personal testimony or personal correspondence, and some from second-hand accounts or local records. Personal accounts that make mention of medical treatments or specific cases are rare. The correspondence and personal papers of the Paston women, for example, provide some information about medical care provided at home[20]. For example, Katherine Paston, who lived just after the end of the Middle Ages, cites 'family' remedies for illness in several letters to her son[21], indicating that these were treatments maintained and used by her family for some generations, and thus allowing us to extrapolate that these were remedies used by Paston women throughout the Middle Ages. In one instance, she prescribes licorice brews to moderate back pain, and the application of the bezoar stone to avoid contraction of the plague[22]. Correspondence from John Paston indicates he commissioned a copy of *The Myrour*, a physic book, for family use[23]. Unfortunately, such individual records of medical care delivered within the home are uncommon, and historians have had to rely on other records to confirm the role of women in the practice of domestic medicine. *Le Menagier de Paris*, a guidebook to women's domestic conduct written in 1393, provides remedies and medical care suggestions; this affirms that women were expected to bear the weight of most domestic healthcare[24]. Domestic guidebooks, such as *The English Huswife*, written after the Middle Ages, also reference medical care as 'wifely duties;' this indicates the continuing tradition of domestic healthcare among women in medieval Europe throughout the Middle Ages and extending even into the Renaissance.

Given that most women were practicing some form of practical medicine, in the absence of convenient or reliable professional medical care, it seems most intuitive to suggest that the medical knowledge was disseminated mostly through oral tradition. Throughout the Middle Ages, there is evidence that some women were literate – Christine de Pizan, Hildegard of Bingen, the Paston women, to name a few. However, given the education limitations in medieval Europe, most women were unable to read medical texts even if they were available for use. Perhaps the most accurate depiction of how medical information was disseminated and taught among the women in medieval Europe relies on the understanding that most knowledge was taught from mother to daughter, and maintained in an unrecorded, and consequently unprovable, oral tradition. However, some medical knowledge – especially knowledge stemming from institutions in the Middle East or Italy – was read by educated women and presumably taught to those who were illiterate. For example, Power and Postan cited the introduction of a 14th century English translation of *Trotula*, a gynecological handbook, which reads:

> "[in order to] let every woman lettered read it to others unlettered and help them and counsel them in their maladies withouten showing their disease to man, I have this drawn and written in English"[25].

This quotation leads us to infer that some literate women were studying academic texts on medicine and simultaneously participating in this oral tradition of medical knowledge, and serves to strengthen the evidence for a diverse and dynamic domestic healthcare system of women healers.

Certainly, women were the predominant force for the invention and delivery of practical medicine. However, some women were actively involved in the exploration and publication of scientific medicine. Notably, the work of Trota of Salerno and Hildegard of Bingen provide strong examples of women who pursued academic medicine, their influence on medical knowledge throughout medieval Europe having been of lasting impact. During the 11th century, a gynecological treatise began circulating throughout Europe by the name of *De Passionibus Mulicrum*, or "On the Diseases of Women." It became widely known that the author of the text was a female physician by the name of Trota, or Trotla, and hence the text became known as *The Trotula*. The complete treatise, composed of three volumes, has been heavily analyzed by historians (starting in the 20th century), and there was a large and heavily divided pool of academics who argued for nearly a century over the details of its authorship. Some attributed the entirety of the treatise to Trota's hand, while others suggest she only wrote the second portion of the text, "Treatments for Women"[26]. With the discovery of a medical work - *Practica Secundum Trota* – whose style is mirrored in "Treatments for Women" and whose provenance strongly indicates that it can be assuredly linked back to her, John Benton laid the argument to rest. He concluded that a real woman, possibly named Trota, did indeed write the second section of *The*

Trotula, and determined that its favorable reception across Europe is testimony to her intelligence and astounding influence on medieval medical practice[27]. The lasting impact of her gynecological advice is evidence of the efficacy of her treatments.

One other female healer is worth mentioning, before further discussion of the role of women healers. Hildegard of Bingen, a German abbess with a penchant for prophecy, is credited with writing a significant amount of material on practical medical cures. Her medical volumes, *Causae et Curae* and *Physica*, were widely circulated; *Physica* was even used as a principle text at the medical school in Montepelier[28]. The reception of Hildegard's contributions to the medical community was often tempered by her equally famous and often controversial writings on spirituality and theology. Nonetheless, her scientific observations – though heavily built on theological principles and often proved incorrect – were widely read following their publication.

3. Physician Vs. Healer: Artistic Representations

The historical record and primary literature provide a number of ways to study and analyze the roles of men and women in the delivery of medieval healthcare. However, perhaps the most telling and objective representations of gender roles in healthcare are found in art. Illuminated manuscripts and illustrations can provide representations of medieval activities without the constraints of gender bias in historical record keeping or the anecdotal twist of personal correspondence.

Depictions of male physicians in illuminated manuscripts and illustrations tend to follow the same construction. The illustration entitled "Miniature of a seated physician with a scroll" is found in the *Medical Miscellany of a Pharmacopeial Compilation*[29]. There are several aspects of the image that strengthen what the historical record seems to indicate about the function of male physicians. First, it is notable that this male physician is not portrayed with any patients. While many portraits of male physician do include patients[30], a nearly-equal number of portraits portray physicians as singular entities rather than healers interacting with patients. This seems to set the male physician apart from his patients – one might even say as a professional – rather than a healer intent on treating a patient. Another interesting feature of this portrait is the engagement of the physician. He is not actively producing a medication, setting a bone, or even preparing an incantation or charm. Rather he is sitting with a scroll, a pose which implies meditation, not action. This is the essence of the role of a male physician, the embodiment of the philosophizing doctor, the physician-scribe.

In comparison, depictions of female healers tend to have a more active component. Because most female healers were interested in the treatment of their patients rather than an understanding of the history of a disease or perpetuation of medical thought, many depictions of female healers include patients. The 14th illustration entitled "Compounding a potion" from *Historia Scholastica*, is a standard portrayal of a female healer[31]. Again, the portrayal is a telling indication of the functions of a female healer. This illustration is decidedly communal, with the patient nestled in the background and a female servant attending. No philosophizing, research, or recording is being done in this instance; rather, the healer is intent on preparing a remedy for the injured individual.

Compared with the illustration of the male physician, this depiction indicates the practical, domestic nature of medieval medicine as practiced by women. There is a connection here between the brewing of the medicine, and the application of this medicine to an ill person. There is a sense of immediacy in this image of the female healers; the patient is waiting in the bed, the servant is waiting to deliver the potion, and the healer is actively preparing it. In contrast, the male physician's services do not appear to be in demand; he is not engaged in the preparation of a treatment, but rather the academic considerations of his profession. Both images, as representatives of a larger whole of similarly structured artwork, serve to illustrate the vastly different nature of medicine as practiced by male physicians and female healers.

4. Changing Dynamics: Licensure and Universities

Through primary literature, historical records, and even medieval art, it is evident that there are stark differences between male and female healthcare roles in medieval Europe. And while the advancement of medical knowledge was frustratingly slow, the number of trained healthcare workers (abbesses, nuns, midwives, physicians) inadequate, and the education of women lamentably nonexistent, the system was functional enough to continue as it did for over five hundred years. In fact, its relative efficacy combined with the stagnation of scientific advancement could have

led to its continuing to function in exactly the same way throughout the entirety of the Middle Ages. But this was not the case.

Prior to 1140 AD, there was no licensure requirement placed upon practicing healthcare professionals. Domestic healers were often successful in treating minor illnesses, and often the more complex ailments eluded treatment by even the most renowned physicians. Excusing a few notable physicians, most practitioners were providing the same level of care to their patients regardless of education level. In some regions of medieval Europe, notably Germany and major Italian cities, women continued to practice medicine without harassment or regulation throughout the entire Middle Ages[32], leading to a continuity of knowledge and maintenance of medical tradition that historians attribute to the renown of their hospitals and medical treatment facilities. Unlike Italy and Germany, however, most of Europe would be touched by the growing professionalization of medicine. In 1140, King Roger of Sicily enacted a law requiring any healthcare practitioner to purchase a license from his government, or suspend all practice[33]. This led to a constriction of healthcare positions available for women healers in Sicily and the surrounding territory. By the early 13th century, Roger's example had set a precedent for medical licensure across much of the Continent.

Medical universities had been growing in Europe since the establishment of the University at Salerno (1231 A.D.), and increasingly rigorous medical education programs had been established at the University of Paris (1150), Bologna (1158) and Oxford (1167). Programs based solely in medical education were improvements upon previous medical training opportunities, for they required a directed study exclusively in medicine (rather than allowing the student to study a variety of topics) and often maintained a practicum portion of the curriculum for practical skills training. But into these educational advancements crept the snake of gender conflict that reared its head repeatedly throughout the Middle Ages. Concerns of opportunity and financial competition led university leaders to bar women from entering universities at all or at least from embarking on medical studies[34]. This effectively excluded most women from participating in advanced medical study, and required them to limit their practice to the domestic and practical knowledge previously associated with women healers. It was this turning point that led to the intense schism between male and female healers. While a university education was desirable, the actual results of a university medical education were not always superior to a practical education gained from tutelage under a skilled mentor. As a result, university physicians were often out-competed in their practice by equally effective and often more financially-reasonable women healers. And thus the practice of licensure, conceived by King Roger of Sicily and borne to the corners of the European Continent, took hold.

The motivations behind widespread licensure practices and the resulting "professionalization" of medicine are widely debated among scholars. Some suggest that licensure was imposed to standardize medical practices, which were often varied in application and efficacy[35]. Others suggest this was done to appease the public over medical damages caused by unlicensed and poorly trained physicians[36]. However, historians over the last twenty years have begun to attribute these severe licensure regulations to deeply held medieval gender conflicts. Some women were permitted to purchase and maintain medical licenses, specifically to treat gynecological illnesses and assist with deliveries, and even join guilds for collaboration and legal protection[37]. Nonetheless, the majority of women were prohibited from attending universities, and thus from purchasing medical licenses at all. Consequently, the argument that the target of licensure was the prohibition and regulation of women healers seems feasible, given that the divisions were based on sex rather than ability[38].

The effects of licensure on the practice of female healers were widespread. Perhaps the most famous example, in the trial of Jacqueline Felicie, illustrates the distinct gender bias that resulted from licensure practices. Having been summoned to court for practicing without a license, Jacqueline Felicie was tried for her crime, and sentenced by an all-male jury to excommunication[39]**.** While some historians make the argument that this was a common pattern of punishment for anyone practicing without a license, there are two aspects to her case that point to gender-conflict reasoning rather than law-based reasoning for her conviction. First, in order to be tried for practicing without a license – and in order to receive a license – a practitioner was required to undergo oral examinations by a board of physicians. According to Iona McCleery, during normal licensure applications "[…] examiners questioned candidates about their knowledge as well as observing their practice"[40]. However, though Jacqueline Felicie should have been extended this option[41], she was refused an oral examination and sentenced without a defense[42]. While this is the most cited incidence of licensure-against-women due to its thorough record in Parisian courts, Jacqueline Felicie's case was certainly not the only one to be brought to court, nor the only one to end in the excommunication and punishment of the accused.

Licensure regulation became increasingly strict in its application to women practitioners following Jacqueline Felicie's trial. In 1329, a Valencian law was enacted which ordered 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"[43]. This, among other laws and treatises penned through the 1300s, led scholars to suggest that most stringent licensure practices were implemented to prevent female healers from out-competing university educated males. The implication, then, is that healthcare became regulated out of medieval gender conflicts

rather than movement towards a unified medical practice or safer and more effective treatments. Indeed, "The licensed had no monopoly of skill or virtue"[44]; their only real qualification was being male.

Limiting female healer's practices through licensure ultimately meant that their skills and treatments became harder to secure. Patients in need of a trusted female gynecologist, reliable midwife, or knowledgeable herbalist were required either to forgo these trusted sources and seek licensed male physicians, or to seek out female healers who practiced on the fringes of society. Historians who support the gender-conflict theory of licensure development have little trouble assigning similar reasoning to the persecution of midwives and women healers that followed licensure practices across Europe. Seeking those who practice on the outskirts of society – the quiet women at the edge of town, the Jewish women, the unlicensed herbalists – became necessary after many reputable female healers closed their doors[45]. How does one regulate these healers who live in the shadows, who refuse to stop practicing? The answer, for them, was found in the public's reliance on religion and fear of religious deviance.

5. Witches and Charlatans

Beginning in the late 1300s, there is an increase in the recorded number of female healthcare workers accused of practicing witchcraft. As with most medieval historical records concerned with women, the number and reliability of manuscripts recording directed attacks on healthcare workers are few. Nonetheless, two arguments have been made, suggesting that these campaigns were in some measure directed towards eliminating unlicensed midwives and healers. First, the increase in witch hunts across Europe directly followed the licensure attacks against female healers, a fact which some historians attribute to a widespread campaign to eliminate female healers entirely. The evidence for this argument throughout the literature seems to rely on personal interpretations of accounts and anecdotal evidence in drawing conclusions. For example, the strong denunciation of midwives as witches, as written by Jakob Sprenger and Heinrich Kramer in *Malleus Maleficarum* in 1486, is often taken as evidence for a tenacious campaign against midwives[46]. They wrote, "The greatest injuries to the Faith as regards the heresy of witches are done by midwives; and this is made clearer than daylight itself by the confessions of some who were afterwards burned"[47]. *Malleus Maleficarum* was a staple text for churches from its publication through the 17th century, and is often taken as evidence for a consciously targeted campaign against midwives, with the intention of eliminating their practice[48].

However, the other theory on the connection between midwives and witch-hunt campaigns suggests that while the Catholic (and eventually Protestant) church did not specifically target midwives for their execution, the church did direct a moral campaign against midwives and healers, which led to a change in the public's perception of the necessity of midwives[49]. This argument seems more feasible than the first, in that it is both tempered by the understanding that not all midwives were targeted as witches, and supported by existing church and secular documents connecting midwives with a predisposition for engaging in witchcraft but not denouncing the entire profession[50]. In 1987, Ritta and Richard Horsley re-evaluated church records and found a number of instances in which village midwives were recorded as being pagan, having a sexual relationship with the devil, or purposefully interacting with the demon world to deliver or harm infants[51]. Their concluding arguments from this research were two-fold. First, they suggested that much of the campaign directed against witches were meant for "wise women," not "midwives." The fact that the wise women did sometimes practice midwifery was, in their analysis, not the primary reason for their conviction. Second, they argued that convictions were often made against practitioners who regularly used advanced charms and superstition in their treatment, rather than convictions made indiscriminately among all midwives.

This second argument by the Horsleys is the most convincing given the nature of medieval European society. Recall that the medieval conception of disease was not one solely of physical illness, but rather the result of a disruption of the intrinsic connection between body and spirit. Consequently, it follows that in a society steeped in religious understanding, any healer accused of bringing an unholy component into the healing process was to be feared. Now, we know that many medieval remedies had some superstitious, astrological, or even entirely pagan components that were essential to the successful application of the remedy[52]. However, the forms of 'practical' magic employed by housewives and domestics were very different than the types of magic associated with witchcraft. Witchcraft, in the medieval conception, required a distinct and often sexual relationship with the Devil or demons, and thus was condemnable by death[53]. As a result, the argument that women who practiced this level of magic in conjunction with medical treatment were specifically targeted for punishment seems appropriate. And indeed, a shift in the way many medieval healers were considered – from medical necessities to witches – by society led to their removal from medical practice. The church's campaign against pagan medical practices (which hindered private practice by women healers), and the licensure regulations (which prevented women from practicing publicly), caused a significant reduction in the number of women practicing empiric medicine. Women no longer practiced medicine as independent entities or

private practitioners; instead they were often resigned to the janitorial aspects of medical care, as male physicians began to dominate the healthcare field.

Understanding the results of both licensure regulation and the religious and secular persecution of witches through a gender-conflict lens may seem questionable, but interpretations of the historical events that unfolded seem to support this approach. In some measure, women - the primary providers of healthcare in medieval Europe – were displaced by men eager to have their work and compensation. As a result, by the end of the Middle Ages and moving forwards until the 19th century, medicine became less patient-centered[54]. As men replaced women in the medical field, science-based medicine replaced medical magic. The brilliant and necessary scientific advancements that followed the Middle Ages (and the male physician take-over) replaced empiric care, and the outcome was a slow progression towards amazing medical innovation and a loss of healer-patient interaction.

6. Conclusion: Medieval and Modern Magic

This skim through the development of medieval medicine and the complex shift in perceptions and roles of women healers leads us to ask one final, overarching question. What were the long-term ramifications of the elimination of independent women healers and women practitioners in the Western world? An entire society of practically-educated, patient-centered healers was lost due to witch-hunts, academic exclusion and licensure practices. As a result, much of the oral tradition that defined their practice was lost, and the medieval magical practices that accompanied medicine were abandoned, when women stopped practicing. Now, to be clear, this paper neither argues that medieval magical practices (charms, incantations, spells, etc.) were effective treatments in themselves, nor that they should be reinstated as part of modern medical treatment. Indeed, the advancements of modern medicine in identifying and successfully treating diseases – starting at the end of the Middle Ages and still accelerating today – do not require the application of lodestones nor the reading of astrological charts to increase their efficacy.

The real magic behind medieval medicine as practiced by women healers were the "soft skills" they practiced, the "non-material, invisible, inaccessible, (and perhaps unmeasurable)"[55] interactions between healer and patient. The heart of every encounter between a medieval healer and medieval patient required an interpersonal interaction: a charm for the spirit, a prayer for the soul, a song for the heart[56]. *Le Menagier de Paris* instructs women on cures from dog bites to headaches – it is notable that most of these remedies incorporated some charm or recitation. Did those elements banish infection or set bones? No. But they were a verbal affirmation of treatment, and provided a connection of hope and healing between the healer and patient. The very heart of medieval medicine – in a time where treatment was a guessing game and cures were few and far between – relied on a relationship of trust between the healer and patient, and a mutual bond of hope.

With the removal of women healers from most medical practice, and the resulting "professionalization" of medicine, the practice of medicine lost its personalization. No longer was healthcare provided by a "healer," but rather a qualified physician. The soft skills – the "magical" components of medicine – were lost in favor of the progress of medicine. The argument here is not that rapid, modern advancement in medicine is wrong, or that those advancements should have been avoided in favor of maintaining traditional medical practices. Instead, it is a suggestion that – had women not been excluded from formal medical practice – modern medicine would not have developed as a sterile, results-driven profession, but as a well-rounded practice requiring a synthesis of personal connection and scientific analysis for the successful treatment of patients.

While medicine has, over the last fifty years, been increasingly focused on delivering holistic care and aspiring towards patient-centered medicine, a gap of nearly five hundred years (13th-18th centuries) during which women were excluded from advanced medical practice, led to the delay in such essential and effective care practices. Eventually, with an increase in the number of women returning to medical practice in the early 1900s, there was a shift back towards holistic medical care and the re-personalization of medicine – lamentably though, this re-introduction of women into medical practice and new appreciation for holistic medicine occurred centuries (and hundreds of thousands of excluded women) after licensure regulations.

In conclusion, this paper has attempted to illustrate both the complexity and necessity of the roles of female medieval practitioners in comparison with male physicians, and the complex changing dynamics that led to their exclusion from formal medical practice following the Middle Ages. The result not only meant that women were hindered in the pursuit of a lucrative and necessary occupation, but that the characteristics of medicine as practiced by women healers – the 'soft skills,' or magic they employed as the foundation of the healer-patient relationship – were lost to the professionalization of medicine. While the remembered value and importance of having women practitioners has led to the encouraging return of women into advanced medical practice, and a social shift in reception to women healthcare

practitioners, the history of their exclusion leads us to wonder what advances in care might have been made if their practice had continued to develop following the Middle Ages.

7. Works Cited

1. Eileen Power and M.M. Postan, Medieval Women, (Cambridge: Cambridge UP, 1975), 9.
2. Edward J. Kealey, Medieval Medicus: A Social History of Anglo-Norman Medicine (Baltimore: Johns Hopkins UP, 1981), 11.
3. Ibid, 15.
4. Ralph Hermon Major, A History of Medicine (Springfield, IL: Thomas, 1954), 224.
5. Saul N. Brody, The Disease of the Soul; Leprosy in Medieval Literature (Ithaca: Cornell UP, 1974), 145.
6. Ibid, preface.
7. Edward J. Kealey, Medieval Medicus: A Social History of Anglo-Norman Medicine (Baltimore: Johns Hopkins UP, 1981), preface-2.
8. George Sarton, “Tribute to Muslim Scientists” in Introduction to the History of Science (Baltimore: Carnegie Institution of Washington by the Williams & Wilkins, 1953).
9. Ralph Hermon Major, A History of Medicine (Springfield, IL: Thomas, 1954), 266.
10. Eliakim Littell and Robert S. Littell. “A Contemporary of Saladin,” Littell's Living Age 208, no. 2690 (1896): 271.
11. Ralph Hermon Major, A History of Medicine (Springfield, IL: Thomas, 1954), 271.
12. Edward J. Kealey, Medieval Medicus: A Social History of Anglo-Norman Medicine (Baltimore: Johns Hopkins UP, 1981), preface.
13. Ibid, 2.
14. John F. Benton, "Trotula, women's problems, and the professionalization of medicine in the Middle Ages," Bulletin of the History of Medicine 59, no. 1 (1983): 40-41.
15. Monica Green, "Women's medical practice and health care in Medieval Europe," Signs 14, no. 2 (1989): 440.
16. Ibid, 439-440.
17. Ibid, 444.
18. Margaret Pelling and Charles Webster, Health, Medicine and Mortality in the Sixteenth Century, ed. Charles Webster, (Cambridge: Cambridge University Press, 1979).
19. Eileen Power, “Some women practitioners of medicine in the middle ages,” Proceedings of the Royal Society of Medicine 15 (1921): 22-23.
20. Elaine E. Whitaker, "Reading the Paston letters medically" English Language Notes 31, no. 3 (1993):19-27.
21. Raymond A. Anselment, "Katherine Paston and Brilliana Harley: Maternal Letters and the Genre of Mother's Advice," Studies in Philology 101, no. 4 (2004): 439.
22. Ibid.
23. George R. Keiser, "Two medieval plague treatises and their afterlife in early modern England," Journal of the history of medicine and allied sciences 58, no. 3 (2003): 306.
24. Georgine E. Brereton and Janet Mackay Ferrier, Le Ménagier de Paris: A Critical Edition. (Clarendon Press, 1981).
25. Eileen Power and M.M. Postan, Medieval Women. (Cambridge: Cambridge UP, 1975), 86.
26. Monica H. Green, The Trotula: a medieval compendium of women's medicine, (University of Pennsylvania Press, 2013), 12.
27. John F. Benton, "Trotula, women's problems, and the professionalization of medicine in the Middle Ages," Bulletin of the History of Medicine 59, no. 1 (1983): 5-34.
28. Margaret Alic, Hypatia's Heritage: A History of Women in Science from Antiquity through the Nineteenth Century, (Boston: Beacon, 1986), 64-67.
29. "Miniature of a seated physician with a scroll," Medical Miscellany of a Pharmacopeial Compilation, including a Herbal and Bestiary Illustrating the Pharmocopeial Properties of Animals, (The British Library Catalogue of Illuminated Manuscripts).
30. “Medical miscellany,” Pseudo-Macer's De viribus herbarum. (The British Library Catalogue of Illuminated Manuscripts).

31. "Compounding a potion," Comestar's Historia Scholastica, (The British Library Catalogue of Illuminated Manuscripts).

32. William L. Minkowski, "Women healers of the middle ages: selected aspects of their history," American journal of public health 82, no. 2 (1992): 293.

33. Iona McCleery, "Medical Licensing in Late Medieval Portugal," in Medicine and Law in the Middle Ages, ed. WJ Turner and SM Butler, (Leiden: Brill, 2014), 199.

34. Leigh Whaley, "New Medical Regulations and their Impact on Female Healers" in Women and the Practice of Medical Care in Early Modern Europe, 1400–1800, (Palgrave Macmillan UK., 2011), 26-47.

35. Toby Gelfand, "The History of the Medical Profession," in Companion Encyclopedia of the History of Medicine, ed. W. F. Bynum and Roy Porter, (London and New York: Routledge 2, no. 2, 1993): 1119–1150.

36. Pearl Kibre, "The Faculty of Medicine at Paris: Charlatanism and Unlicensed Medical Practice in the Later Middle Ages," Bulletin of the History of Medicine 27, (1953): 20.

37. Monica Green, "Women's medical practice and health care in Medieval Europe," Signs 14, no. 2 (1989): 439.

38. Leigh Whaley, "New Medical Regulations and their Impact on Female Healers" in Women and the Practice of Medical Care in Early Modern Europe, 1400–1800, (Palgrave Macmillan UK., 2011), 26-47.

39. Monica H. Green, "Getting to the source: the case of Jacoba Felicie and the impact of the portable medieval reader on the canon of medieval women's history," Medieval Feminist Forum 42, no. 1 (2006): 22-23.

40. Iona McCleery, "Medical Licensing in Late Medieval Portugal," in Medicine and Law in the Middle Ages, ed. WJ Turner and SM Butler, (Leiden: Brill, 2014), 203.

41. Monica H. Green, "Getting to the source: the case of Jacoba Felicie and the impact of the portable medieval reader on the canon of medieval women's history," Medieval Feminist Forum 42, no. 1 (2006): 49-52.

42. Eileen Power, "Some women practitioners of medicine in the middle ages," Proceedings of the Royal Society of Medicine 15 (1921): 22-23.

43. Lynn Thorndike, University Records and Life in the Middle Ages, (New York: Columbia University Press, 1944), 84.

44. Margaret Pelling and Charles Webster, Health, Medicine and Mortality in the Sixteenth Century, ed. Charles Webster, (Cambridge: Cambridge University Press, 1979), 216.

45. Monica Green, "Women's medical practice and health care in Medieval Europe," Signs 14, no. 2 (1989): 448.

46. H. Kramer and J. Sprenger, Malleus Maleficarum,(London: Pennthome Hughes Folio Society, 1968).

47. Ibid, 128.

48. William L. Minkowski, "Women healers of the middle ages: selected aspects of their history," American journal of public health 82, no. 2 (1992): 294.

49. Monica Green, "Women's medical practice and health care in Medieval Europe," Signs 14, no. 2 (1989): 448.

50. Ibid, 450.

51. Ritta J. Horsley and Richard A. Horsley, "On the Trail of the 'Witches': Wise Women, Midwives and the European Witch Hunts" in Women in German Yearbook III: Feminist Studies and German Culture, ed. Mariane Burkhard and Edith Waldstein (Washington, D.C.: University Press of America,1987), 1-28.

52. T. R. Forbes, The Midwife and the Witch, (New Haven, Conn: Yale University Press, 1996).

53. Keith Thomas, Religion and the decline of magic: studies in popular beliefs in sixteenth and seventeenth-century England (UK: Penguin Classics, 2003), 436-438.

54. Rob Buckman and Karl Sabbagh, Magic or Medicine?: An Investigation of Healing & Healers, (Amherst, NY: Prometheus, 1995), 25.

55. Ibid, 7.

56. Debra L. Stoudt, "Medieval German Women and the Power of Healing" in Women Healers and Physicians: Climbing a Long Hill, ed. Lillian R. Furst, (Lexington, KY: University of Kentucky, 1997), 22.