

The Medical Practice and Licencing of Women in the Late Medieval Kingdom of Naples

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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ABSTRACT

This paper analyzes the medical licences of women from the Angevin Kingdom of Naples between the late thirteenth to early fifteenth century. While the Kingdom of Naples was home to the first known medical regulatory measures and to an extensive amount of surviving medical licenses, little else is known about the medical profession and practices within Naples and even less of women's practices. This paper makes up for the deficit by examining Neapolitan women's medical practice and licences against the late medieval medical practice and regulatory measures of the wider western European world.

The examination of the wider social context of late medieval medicine and medical regulation finds that the marginalization of women as legitimate and legal members of the medical profession was a byproduct of larger tensions that were introduced during the professionalization of healthcare. Primarily, cases of conflict occurred between academic practitioners who preferred to maintain the literate, text-based medical standards against empirics and other healers, who found support in local and royal authorities, as well as their communities. Often, the conflict boiled down to providing available and accessible medical care.

Although this demand for practitioners ensured the continued survival of women's medical practice, despite the growing rhetoric and legislation against it, women rarely reached the same degree of professional success as their male counterparts. As the comparison against the medical practices of Jews and clerics illuminates, the gendered differences in literacy played a strong role in hindering women's acceptance within the medical profession, rather than any prejudices.

The additional analysis of the social concept of gender against education, upbringing, economics, professional biases, cultural norms, and authoritative power, also reveals how pervasive gender was in influencing the types of medical licences and practices that state allowed Neapolitan women to have.

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CHAPTER I

Sources and Methods

1.1 Genesis of the Research

In September 1309, the Neapolitan royal court issued a licence to Maria Gallicia to practice surgery throughout the kingdom. Maria's licence was one of thousands preserved from the Angevin ruled, late medieval Kingdom of Naples. Maria's surgical licence was unique within the kingdom as it was one of twenty-four the crown granted to women, and the only one granted to a woman without territorial limitations. Perhaps the uniqueness of her licence had to do with her surgical speciality: the cure of wounds, abscesses, and hernias of the womb.¹ A particularly gender-specific specialty, the lack of territorial limitations within Maria's licence suggested a demand within the kingdom for doctors skilled in "women's diseases." As there are few surviving records on medical practice within the late medieval Kingdom of Naples, these licences offer a rare view into women's participation in medical care during a period of increasing medicalization.

Around the same time that the Angevin Neapolitan royal court granted licences to prospective doctors, the medical profession throughout western Europe was undergoing a major shift. As Joseph Shatzmiller explained, the medicalization of society meant that, "instead of clerics, old men, experienced women, or other well-meaning volunteers, we now see the emergence of professional, secular practitioners, mostly male, who wished to be remunerated for the expertise they possessed and for the effort they exhibited and who were expected to take responsibility for misdeeds and failures."² Thus, the medical licenses, granted within the Kingdom of Naples and outside, became a requirement for practice in this

¹ Mention of Maria's licence appears in the inventory contained in 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), p.141 no. 1165.

² Joseph Shatzmiller, *Jews, Medicine, and Christian Society* (Los Angeles: University of California Press, 1994), 5.

new world. While the scholarship of medieval healthcare by, and the medical education of, (Christian) men is, more or less, consistent, throughout Europe, women's "official" presence within the profession varied from one region to the next and found a limited engagement in the legal sectors of medieval medicine. This study attempts to recreate women's engagement within the sparsely documented Kingdom of Naples.

By analysing the documentation of medical licences granted by the royal courts of the Kingdom of Naples against the wider surviving records of medical regulations, rhetoric, licenses, and other related documentation throughout the western Europe, this study aims to understand the factors that dictated women's legal status within the late medieval Neapolitan medical profession. There is little doubt that medieval women of all walks of life practised some sort of healing, be it domestic, empirical, or religious, but comparatively few women appeared as full-fledged, licenced (or gilded) members of the profession. As this study is based primarily on the *licenced* women of Naples, it emphasizes the regulatory aspect of medieval medicine. Therefore, this study is less about the totality of women's medical contributions and more about how the professionalized, "legitimate" medical community viewed and reacted to women's practice. As such, this study establishes a few, interconnected points: First, that the professionalization of health care brought with it a series of diverse tensions that influenced all members who participated in the medical profession. Tense interactions such as that between learned doctors and "empirical" practices; between maintaining medical standards and providing enough practitioners to meet the demands of a community; between the demands of a community and medical authorities;³ and between medical, local, and royal authorities, all had some say. Second, and overlapping with the previous point, the demand for doctors often overruled the legal and rhetorical moves meant

³ When referring to "medical authority," this study is referencing practitioners in a position of power and influence over healthcare. Ie. examiners, university professors, guild members with political power, influential medical authors.

to exclude certain practitioners that the medical and ecclesiastical authorities deemed as undesirable. Lastly, and under the influence of the previous two points, the social force of gender, rather than any exclusionary laws and rhetoric, played a powerful role in affecting Neapolitans women's participation into "legal" medical practice, through their entrance into the profession, upon whom they were able to practise, and as to the type of medical care they could provide.

1.1.1 Survey of Existing Corpus of Scholarship

The scholarship of women's medical practice in medieval Western Europe is beset by challenges due to the scarcity of factual information available. The details that are available, as Monica Green remarked, give "the general impression that women constituted no more than the tiniest percentage of medieval medical practitioners."⁴ What scholarship exists began as a result of the rise of early twentieth-century feminism.⁵ First-wave feminist scholars aimed to document the various practices and, more importantly, to capture the long-standing existence of learned female practitioners. This body of work gradually evolved in the 1960s through the second-wave feminist movement, wherein scholars argued that biological "sex" factored in the changing role of women's medical practice. By this time, scholars maintained that while women were considered the "natural" caretakers of women's health, men had historically and intentionally excluded women from the medical profession. Most recently, beginning in the 1980s, scholars have nuanced these earlier approaches by analysing the scholarship of women in medieval medicine through a gendered lens. By gendering practitioners and patients, current approaches find women's exclusion from medical practice to be the unfortunate side effect of the professionalization of medicine, rather than the

⁴ Monica H. Green, "Documenting Medieval Women's Medical Practice," in *Practical Medicine from Salerno to the Black Death*, ed. Luis García-Ballester, Roger French, Jon Arrizabalaga, and Andrew Cunningham, (Cambridge: Cambridge University Press, 1994), 322.

⁵ Judith M. Bennett and Ruth Mazo Karras, "Women, Gender and Medieval Historians," in *The Oxford Handbook of Women and Gender in Medieval Europe*, ed. Judith M. Bennett, (Oxford: Oxford University Press, 2013), 3.

deliberate, malicious, or planned work of men. Third-wave scholars, moreover, advocate against a narrow definition of “medical practitioner,” resist highly gendered professional labels, and prefer instead to broaden the scope of investigation thereby capturing many more women’s involvement in healthcare.

The historiography of first-wave feminist scholarship focused on documenting the various aspects of women medical practitioners. Mélanie Lipinska’s 1900 publication, *Histoire des femmes médecins depuis l’antiquité jusqu’à nos jours*, laid the groundwork for the scholarly field of women in medicine. Lipinska traces the medical professions of women across a wide geographical range, from “*les attributs du médecin primitive*,” to the present day. In regard to medieval Italy, Lipinska found the region much more tolerant of women doctors than had the men of her time period. She notes “*il n’est donc plus surprenant de voir de nombreuses femmes médecin en Italie au XIIIe et au XIVe siècle*,”⁶ as the education of upper-class Italian women became more aligned to men. To bolster her observation, Lipinska lists a few notable women practitioners granted permission to practice medicine throughout the regions of Italy. Lipinska, however, failed to consider that women with a sufficiently high status to receive a “man’s education” did not need to learn medical knowledge to make a living.

Following closely in Lipinska’s footsteps, Kate Campbell Hurd-Mead’s 1938 publication, *A History of Women in Medicine*, traced women’s medical practice from antiquity to the present day. Containing her study within Europe and Russia, Hurd-Mead situated women’s medical roles within the greater social and medical community, taking care to include the practices of men, and the social and private lives of women. Hurd-Mead organized her research primarily century- by- century and took care to note any significant

⁶ Mélanie Lipinska, *Histoire des femmes médecins depuis l’antiquité jusqu’à nos jours*. (Paris: Librairie G. Jacques & C., 1900), 148.

and influential medical work created by women. In a deviation from her organisation, Hurd-Mead devoted an entire chapter on the Salernian author Trotula, and to the creation and distribution of her gynaecological texts, in an attempt to present the wide-ranging influence which Trotula, a learned woman doctor, maintained throughout medieval Europe. Of thirteenth-century Italy, Hurd-Mead notes “the wives and daughters of doctors, or other learned men, also studied at the universities and led very independent lives.”⁷ She further claimed, as did Lipinska, “that properly prepared women have always been admitted to Italian universities, where some of them became professors.”⁸ When describing the medical atmosphere of the fourteenth century, Hurd-Mead repeats the common belief that women patients preferred female doctors over male, and that occasionally “men resorted to the remedies of “old women” and barbers to help their patients.”⁹ She claimed that, “because [Italy’s] universities were never closed to women students the medical schools at Salerno and Bologna continued to draw both men and women from every civilized quarter of the globe.”¹⁰ Hurd-Mead viewed the absence of a restriction as proof of the Italian universities’ acceptance of women, however, she failed to identify a single woman who matriculated in an Italian university. Furthermore, as Monica Green noted in her 2008 publication *Gendering the History of Women’s Healthcare*, neither Hurd-Mead nor Lipinska attempted to “assess quantitatively how significant women’s presence was in what historians now call the “medical marketplace.”¹¹ Rather, their goal was to simply present the existence of women in the medical profession and to mark the ways women’s work and remedies influenced men’s practices.

⁷ Kate Campbell Hurd-Mead, *A History of Women in Medicine*. (Haddam: The Haddam Press, 1938), 224.

⁸ Hurd-Mead, *A History of Women in Medicine*, 225.

⁹ Hurd-Mead, *A History of Women in Medicine*, 265.

¹⁰ Hurd-Mead, *A History of Women in Medicine*, 277.

¹¹ Monica H. Green, “Gendering the History of Women’s Healthcare,” *Gender and History*, Twentieth Anniversary Special Issue, 20. 3 (2008): 494.

Nearly a decade after Hurd-Mead, Muriel Joy Hughes published *Women Healers in Medieval Life and Literature*, the first monograph on medieval women medical practitioners. Hughes utilized both history and literature to discern women's practice and social status as healers. She observed that the conditions in which both men and women learned and practised medicine in the late Middle Ages depended on the development of universities. Prior to "the organization of universities, men and women learned a smattering of theory and treatment from experienced physicians, surgeons, or barber-surgeons, and then carried out their own practices with almost no restrictions whatsoever upon their activities."¹² On her chapter devoted to women practitioners, Hughes acknowledges that women practitioners' fortunes "did not improve with the development of universities" and "wherever the universities were closed to women, laws tended to be more strictly enforced."¹³ Nevertheless, Hughes also conceded that thirteenth and fourteenth century European cities and universities found it difficult to enforce their regulations over the population. Of all the European countries, Hughes, like Lipinska and Hurd-Mead, found that Italy offered women "the most satisfactory conditions for both study and practice,"¹⁴ but that, overall, women remained "excluded from the front ranks of medicine."¹⁵ Hughes exemplified this point with the oft-cited French trial of Jacoba Felicie, wherein the Faculty of Medicine at Paris charged Felicie with the illicit practice of medicine and a court found her (along with two men and three other women) guilty, fined her sixty *livres*, and excommunicated her despite positive testimony from her patients. The case, documented only in Henri Denifle's edition of the *cartulairium universitatis parisiensis* and first revived by Lipinska, led Hughes to conclude

¹² Muriel Joy Hughes, *Women Healers in Medieval Life and Literature* (Freeport: Books for Libraries Press, 1943), 62.

¹³ Hughes, *Women Healers*, 82.

¹⁴ Hughes, *Women Healers*, 83.

¹⁵ Hughes, *Women Healers*, 135.

that university-trained physicians conducted attacks against empirics, a category most women practitioners fell under, as a result of professional jealousy.¹⁶

This notion of intentional and concerted sabotage of women's medical practice by "learned" men became a focus of the second-wave feminist historical studies of the 1960s. Growing out of the women's health movements and the modern political concern over birth control and female bodily autonomy, Barbara Ehrenreich and Deirdre English's published the pamphlet, *Witches, Midwives, and Nurses*, in which they argue that the authority of women's bodies and health remained the biological birth right of women.¹⁷ According to Ehrenreich and English, it was once commonplace in the Middle Ages for women to be the sole healers for both women and the poor. This was so until, at least, the "active take-over by male professionals" suppressed their work.¹⁸ The authors framed this take-over as an attempt by the Church, through a partnership with university trained male physicians, to reform the medical profession and its methods.¹⁹ By the early modern period, midwives and other women healers became associated with witches, and the witch-hunts, according to the authors, were sexist campaigns funded in part by church and state to gain control of the medical profession and its training. The denunciation of women as healers eventually culminated into the witch-trials wherein the Church "explicitly legitimized the doctor's professionalism, denouncing non-professional healing as equivalent to heresy."²⁰ All women healers fell under the stigma of "non-professional," as they did not have a route to study medicine as the Church required, and were thusly condemned. Ehrenreich and English judge that "the present system was born in and shaped by the competition between male and female

¹⁶ Hughes, *Women Healers*, 92.

¹⁷ Green, "Gendering the History of Women's Healthcare," 489- 490. Barbara Ehrenreich and Deidre English, *Witches, Midwives, and Nurses: The History of Women Healers* (New York: Feminist Press, 1973), 3-4.

¹⁸ Ehrenreich and English, *Witches, Midwives, and Nurses*, 4.

¹⁹ Ehrenreich and English, *Witches, Midwives, and Nurses*, 15-16.

²⁰ Ehrenreich and English, *Witches, Midwives, and Nurses*, 19.

healers” and “the sexism of the health system is not incidental...it is historically older than medical science itself; it is deep-rooted institutional sexism.”²¹

The current wave of feminist historiography challenged the authority of Ehrenreich and English’s thesis by incorporating the social aspect of gender into the history of women’s medicine, as both practitioners and patients. Monica Green argues against the notion that men intentionally excluded women from the “medical marketplace,” and posits that culturally-constructed gender identities pushed women from the healthcare profession. As Green notes in her article, “Gendering the History of Women’s Healthcare,” the battle over medicine during the high Middle Ages was not “between men and women per se but rather between empiricism and book learning.”²² As not only universities, but notarial and grammar schools, excluded women, book learning and Latin literacy became a highly gendered process that shut women out from access to the authoritative knowledge that defined the medieval physician. Moreover, Green discovered that among the few female institutions where a literate culture existed, such as religious enclosures, there is little evidence of their relationship to learned medical literature.²³ Similarly, while women’s vernacular literacy grew during the High Middle Ages, women did not engage in widespread medical reading until well after male domination of the professionalized medical field.²⁴ The empirical, hands-on aspect of medical practice is the characteristic which prevented the profession from becoming exclusively male dominated and allowed women to stake a claim, no matter how small.²⁵

²¹ Ehrenreich and English, *Witches, Midwives, and Nurses*, 41.

²² Green, “Gendering the History of Women’s Healthcare,” 495.

²³ Monica H. Green, “Books as a Source of Medical Education for Women in the Middle Ages,” *Dynamis: Acta Hispanica ad Medicinam Scientiarumque* 20 (2000): 343.

²⁴ Green, “Gendering the History of Women’s Healthcare,” 495.

²⁵ Monica H. Green, *Making Women’s Medicine Masculine: The Rise of Male Authority in Pre-Modern Gynaecology* (Oxford: Oxford University Press, 2008), 300.

Katherine Park's work, *Secrets of Women: Gender, Generation and the Origins of Human Dissection*, analyses through a gendered perspective, how knowledge of the inside of the human body was understood and disseminated between the sexes. The interior of women's bodies, more specifically the uterus, became the object of focus in medical imagery of the human body, as women's reproductive organs represented the secret internal workings of the body.²⁶ Learned men understood women as the owner of this secret knowledge and who "stood for an earlier way of doing things," where this secret knowledge passed only between themselves.²⁷ As the world of medicine grew competitive, Park notes that the "interior of women's bodies became a matter of interest to medical scholars and practitioners as well as to literate laymen,"²⁸ and when this knowledge became "public", through Latin script, the authority over women's bodies and health no longer remained exclusively among women.

Beyond revising the intentions or arguments of women's medical history, third-wave feminists have also called into question prior methodologies. The foundational works by first-wave historians in recording the names and practices of women practitioners have been indispensable, but Green argues that "women have another, separate history created by the gendered divisions of medieval society," and, "until we set aside the androcentric perspective on the world" their history will remain hidden.²⁹ Prosopographical data allow historians to note the various practices of women but it also pointed to their rather lacklustre participation within the field. Only when we are given extraordinary civil or court cases, such as that of Jacoba Felicite, are we allowed a glimpse into a richer history. Green, thus, calls for a new technique through which to collect and interrogate data. One such approach involves

²⁶ Katharine Park, *Secrets of Women: Gender, Generation, and the Origins of Human Dissection* (New York: Zone Books, 2006), 80-81.

²⁷ Park, *Secrets of Women*, 87-88.

²⁸ Park, *Secrets of Women*, 92.

²⁹ Green, "Documenting Medieval Women's Medical Practice," 323.

broadening the definition of what it meant to be a medical practitioner, resisting and problematizing common English terminology such as physician, surgeon, barber-surgeon, and apothecary.³⁰ Montserrat Cabré takes up this task in her study of health care in late medieval Iberia. Cabré reasons that “the labels identifying women’s practices differ from those for men” such that men are more likely to be marked by occupational markers.³¹ As caring for the sick often took place in the home, usually by friends or relatives of the sick, Cabré found that women often used the medieval language of kinship and love to describe their caretakers. Thus, “mother” often became a term used to describe the women who took charge of the health of the sick. This semantic use of the word extended into court records as well, where Cabré found among the Iberian documents that “mother” and “women” were frequently synonymous with “midwife” and “wet nurse.”³² The acknowledgement of the gendered use of language allowed Cabré to provide a richer picture of women’s medical practice, usually ignored for a legally-defined and public practice.

1.2 Parameters of the Research

1.2.1 Spatial Boundaries

This study into women medical practitioners focuses on the Angevin Kingdom of Naples, which encompassed the lands just south of the papal states along the Italian peninsula. The choice of the Kingdom of Naples is for two major reasons. The first is the survival of thousands of medical licences, considered “the most copious source of information about licensing anywhere.”³³ The second reason is the lack of scholarship dedicated to medical history in this region and time period, despite the abundance of

³⁰ Monica H. Green, “Women’s Medical Practice and Health Care in Medieval Europe,” *Signs: Journal of Women in Culture and Society* 14 (1989): 444-445.

³¹ Montserrat Cabré, “Women or Healers? Household Practices and the Categories of Health Care in Late Medieval Iberia,” *Bulletin of the History of Medicine* 82 (2008): 23.

³² Cabré, “Women or Healers,” 31- 35.

³³ Shatzmiller, *Jews, Medicine, and Christian Society*, 19.

licences.³⁴ I hypothesize that the cause of this is due to the lack of surviving complimentary source material created in this region at this time period. For this reason, this study makes frequent comparisons with northern and central Italy, as well as with western Europe, to fill in any gaps caused by an absence of corroborating Neapolitan sources.

1.2.2 Temporal Boundaries

The temporal boundaries of this study, dictated by the availability of source material, in this case extant medical licences, span the twelfth to the end of the fifteenth centuries. The earliest of the licences comes from the Archives of Naples and is dated 1273. It accredited the surgeon, *magistro Johanne de Baro*. The latest licence is from the surgeon *donna Bella di Paija*, who was licenced 6 September 1414. The numerous licences between these two permits the study of the development of the medical profession up to the Black Death, a development that witnessed the height of scholastic medicine and placed university physicians firmly at the top of the medical hierarchy,³⁵ and after. A period which Michael McVaugh sees as formative: the “transitional period in which medicine was taking firm shape as a secular occupation, developing concurrently with a social awareness of the benefits of healthcare and with a perception that learned or scientific medicine was most desirable.”³⁶ While the bulk of this study, however, takes place between the periods mentioned above, it also, from time to time and for context, references earlier Angevin regulatory legislation and practices that occurred after the last licence was granted.

³⁴ So far, I have found that the PhD dissertation, Ronald Doviak, “The University of Naples and the Study and Practice of Medicine in the Thirteenth and Fourteenth Centuries,” (PhD diss., City University of New York, 1974) the only scholarship that focused on the medical history of the Angevin Kingdom of Naples. Many other studies do reference the licences, but never as the main focus of their work.

³⁵ Roger French, “Introduction: The “Long Fifteenth Century” of Medical History,” in *Medicine from the Black Death to the French Disease*, ed. Roger French, Jon Arrizabalaga, Andrew Cunningham, and Luis García-Ballester (Aldershot: Ashgate, 1998), 1-2.

³⁶ Michael R. McVaugh, *Medicine before the Plague: Practitioners and their Patients in the Crown of Aragon, 1285-1345* (Cambridge: Cambridge University Press, 1993) 71. More specifically, McVaugh notes the period as 1285- 1335.

1.2.3 Primary Sources & Methodology

This paper relies primarily on Raffaele Calvanico's 1962 work, *Fonti per la Storia della Medicina e della Chirurgia per il regno di Napoli nel periodo Angioino*, which contains summaries and copies of around 2769 acts³⁷ from between 1273 to 1414. The documents originated from the Angevin registries located in the Archivio di Stato di Napoli. In 1943, German soldiers destroyed 31,606 volumes and 54,372 parchments belonging to the *Archivio*, including the original Angevin registries.³⁸ Only 29 documents survive from before 1500, none of which benefit the history of medicine.³⁹ Knowledge of the licences pertaining to this study exists thanks only to Calvanico, who had been working with and recorded the data prior to its destruction.

In medieval Naples, the licensing of individuals fell under the jurisdiction of the royal physicians or surgeons, depending on the type of licence. One or two masters examined candidates, and if deemed competent, the officials signed documentation detailing the parameters or scope of the licensee's practice. Less commonly, officials sometimes also accepted letters of credentials by teachers indicating an individual's qualifications in order to grant a licence. The masters granted licences for the medical practice of physicians or surgeons, however none pertained to barber-surgeons or apothecaries.

The use of the licences to recreate the social history of medicine and women is, admittedly, problematic. These records present a normative insight to the practice of medicine. They tell us the conditions, scope, and standards of the Kingdom of Naples's medical practice, without recording actual practice. I noted above that scholars argued that by widening the definition of medical practitioner we receive a clearer view of women's medical practice, but among Calvanico's sources the definitions are narrowed even further. It is

³⁷ While the final act is officially numbered at 3670, the author made a numerical error on page 213 where he jumps from licence # 2099 to licence #3000,

³⁸ Doviak, "The University of Naples," 6-7.

³⁹ Doviak, "The University of Naples," 7.

within these limitations that this study focuses primarily on the “legal” and “ideological” form of medical practice though references to the “illicit” were made.

1.3 Theoretical Framework: Gender

This paper’s primary form of analysis is rooted in constructed gender. The concepts of third-wave feminism maintain that the social concept of gender affected women’s role and visibility in the “medical marketplace” and among documents. The concern towards female modesty, additionally, impeded better study and techniques into the medical care of women’s bodies but may have allowed the greater visibility of women within the documents themselves. Notorious of concern for women’s morality exist in many of the Neapolitan licences even, in some cases, almost bewilderingly, within licenses that do not treat “women’s diseases.”

This study follows the approach to gender adopted by authors such as Monica Green, Katherine Park, and Susan Broomhall. Building on an approach advanced by Judith Butler, they believe that gender is “performed.” More specifically, the actions of men and women were not reliant on biological sex but, instead, influenced by social norms.⁴⁰ However, these norms could be contradictory. During the process of medicalization, regulatory bodies required a medical licence or a medical degree to enter into the medical profession, processes which were either difficult or impossible, respectively, for women to achieve, due to their upbringing. In contrast, the social norms toward female modesty required the hands of a woman to complete certain medical tasks which would otherwise have been shameful to the female patient and damage the reputation of the male practitioner. Gender, then, restricted women’s access to the medical arts but also required it. Finally, Broomhall remarked, that while “gender was not always the most relevant element in some medical contexts for women,” as were other social factors- religion, class, wealth, family, region- she,

⁴⁰ Green, *Making Women’s Medicine Masculine*, 31.

nevertheless, conceded that “gender [was] certainly always in play at some level, and if this is the case, there can be little justification to ignore the rich possibilities offered by gender as an analytical tool in the production of histories of medicine.”⁴¹

⁴¹ Susan Broomhall, *Women’s Medical Work in Early Modern France*, (Manchester: Manchester University Press, 2004), 259.

Chapter II

Regulation, Licences, and Practice

2.1 Introduction

To frame Neapolitan women's presence within the medical milieu, this study first explores the general state of the medical profession in southern Europe which they inhabited. As mentioned previously, the Angevin licences, while numerous, do not provide a complete picture of the medical profession, and there were very few sources that described the practice as it was within the late medieval kingdom. What the records do convey is that by the late thirteenth century, medicine was on its way to becoming professionalized and stratified. The late medieval Neapolitan medical community, like in much of Europe, was primarily composed of lay male Christian practitioners, but women, clerics, and Jews are found scattered throughout, as well. There came a clear line drawn between the practice of physicians and surgeons, as well as subdivisions within the practice of surgery, and the earliest Neapolitan legislations paralleled the enactment of similar regulations within neighbouring regions.

As the main objective of this study is to understand the elements behind Neapolitan women's entrance in "official" and legal medical practice, the first half of this chapter examines the medical profession, particularly the implementation of regional and state regulations, both *as they ought to have been* and *as they were*. This reveals a dynamic relationship between the enforcement of legal code, the enforcing authorities, legal and "illegal" practitioners, and what medical authorities considered acceptable medical knowledge and skill. As there are few surviving documents that describe the specificities concerning Neapolitan practices, or how their communities regarded them, this chapter introduces the common pressures and tensions of regulation and licensing that troubled Naples' neighbours, and which, presumably, troubled Naples as well. The documents

illustrate that in the choice between upholding medical examinations and regulations or receiving available, accessible, but not technically “legal” medical care, many towns, communities, and individuals chose the latter rather than receiving no medical care at all. Social need overrode the structural and institutional factors which hindered women’s medical practice.

The second half of the chapter analyses what medical faculties and authors viewed as an “acceptable” baseline of knowledge and skill. Academic, text-based medicine arose during the twelfth century with great support from medical faculties and learned authors, but its role in medical examinations differed between physicians and surgeons. A physician’s examination demanded knowledge of the medical texts, while the surgical examination focused more on technical skill. This distinction between the two will have played an important role in women’s acceptance into the medical profession.

2.2 Regulation

2.2.1 Implementation of Legislation

Studies have found no surviving record prior to the twelfth century of any laws that regulated the medical profession against the ignorant and untrained.⁴² Early Western European medical practitioners' access to patients depended on reputation and skill rather than legal legislation and theoretical knowledge. Men and women, clerical and lay, literate and illiterate, all had access to the “medical marketplace”; the lines that defined the different categories of healers were fluid and overlapped.⁴³ The consumer population, as well, relied on a mixture of methods and healers to receive the best possible care, occasionally mixing secular healing (medicine and surgery) with faith healing (incantations and charms).⁴⁴ The

⁴² Pearl Kibre, “The Faculty of Medicine at Paris, Charlatanism, and Unlicensed Medical Practices in the Later Middle Ages,” *The Bulletin of Medical History* 27.1 (1953): 4.

⁴³ Katherine Park, “Medicine and society in medieval Europe, 500- 1500,” in *Medicine in Society: Historical Essays*, ed. Andrew Wear, (Cambridge: Cambridge University Press, 1992), 65, 75.

⁴⁴ Park, “Medicine and society,” 65-66.

circumstances of medieval medical practice began to change with the arrival of the “twelfth-century Renaissance.” Population growth, urbanization, economic prosperity created a demand for a more sophisticated medical service,⁴⁵ which, in turn, led to an increased interest in learned medical literature. This demand and expectation by medieval society for better quality medical care cumulated in 1140 within the Kingdom of Sicily⁴⁶ when Roger II passed the earliest known legislation that introduced a universal baseline of knowledge, and punishments for illicit practice.

The Kingdom of Sicily became the first region to set a standard for medical care and practice. Southern Italy comprised many thriving urban communities, Naples the largest, its location geared toward international trade.⁴⁷ Located on the western shore of the kingdom lay Salerno, which, by the twelfth century, possessed an impressive reputation for both its medical centre and for its physicians.⁴⁸ By virtue of its position, Salerno had not only access to Latin medical work, but also came to Greek and Arabic medical knowledge. Translations abounded and Hippocratic, Galenic, and Aristolian science, medicine, and philosophy became a part of the Salernitan curriculum.⁴⁹ As Salerno’s medical corpus grew and circulated through western Europe, the reputation of its theoretical medical practitioners lured both the wealthy within Salerno and foreigners from without. In this, geography and market demand no doubt stimulated the need for Roger II’s medical legislation.⁵⁰

⁴⁵ Park, “Medicine and society,” 75.

⁴⁶ Under Hauteville and Hohenstaufen rule, as well as within the Angevin licences, the Kingdom of Naples was in fact called the Kingdom of Sicily. Due to the War of the Sicilian Vespers during the late thirteenth to early fourteenth century, the Angevins lost the island of Sicily to the Aragonese, creating two Kingdoms of Sicily. To maintain consistency, Angevin rule will consistently be called the Kingdom of Naples, even when referencing licences dated prior to the loss of Sicily.

⁴⁷ Patricia Skinner, “Urban Communities in Naples, 900- 1050,” *Papers of the British School at Rome* 62 (1994): 294.

⁴⁸ Vern L Bullough, *The Development of Medicine as a Profession* (Basel: S. Karger, 1966), p.40-42. Monica H Green, tran., *The ‘Trotula’: A Medieval Compendium of Women’s Medicine* (Philadelphia: University of Pennsylvania Press, 2001), p.9.

⁴⁹ Nancy Sirasai, *Medieval and Renaissance Medicine* (Chicago: University of Chicago Press, 1990), 58.

⁵⁰ Sirasai, *Medieval and Renaissance Medicine*, 17. Green, *The ‘Trotula’*, 4.

When the Norman Roger of Hautville seized control of southern Italy in 1130, he not only claimed the lands, but also a variety of ethnic groups, many of which came accompanied by their own customary laws. As Roger II of the Kingdom of Sicily, his rule encompassed the mainland of Italy, just south of the Papal states, and the island of Sicily. Within the Kingdom, the duchies of Benevento, Capua, and Salerno maintained a dominant Lombard population, subject to Lombard law; the Greek-speaking communities throughout the mainland and the principalities of Gaeta, Naples, and Amalfi followed Roman Law; Jewish communities, bound by Mosaic law and rabbinical tradition, existed throughout the kingdom; Muslim communities also lived in Sicily, tied to Islamic law codes; and of course, Roger II's Normans established their own communities.⁵¹ The people themselves were further categorized into either the nobility, *milites*, *equites*, or common people.⁵² These communities came with their own, contradictory customary laws, a situation Roger II hoped to alleviate. To maintain consistency throughout his Kingdom, in the 1140s Roger II passed a series of laws, the so called the Assizes of King Roger. The very first assize acknowledged and respected the cultural diversity within his kingdom and confirmed that "the usages, customs and laws which have existed among them up to now are not abrogated" except in situations where "what is observed in them is clearly in contradiction to our edicts here."⁵³

This first assize is revealing. It confirmed the rights of the assorted customary laws while outlining contradictions the state deemed too important to stand. Most of the assizes concerned themselves with treason, violence, and the rights of the Crown, Church, and individuals, however, an assize regarding medical regulation ruled:

Whoever in the future wishes to become a physician (*mederi voluerit*) should present himself to our officials and judges, for an examination according to their judgement (*eorum iudicio discutiendum*). But if he should rashly take for

⁵¹ Green, *The 'Trotula'*, 7. Graham A Loud, tran., *Roger II and the Creation of the Kingdom of Sicily* (Manchester: Manchester University Press, 2012), 5.

⁵² Benedetto Croce, *History of the Kingdom of Naples*. trans. Frances Frenaye. (Chicago: The University of Chicago Press, 1970), 84.

⁵³ Loud, *Roger II*, 315.

granted, let him be consigned to prison and all his property confiscated. For this had been arranged so that subjects of our kingdom shall not be put at risk through physicians' inexperience (*imperitia medicorum*)⁵⁴

This legislation is not only the first to recognize, officially, medical practice as a profession, to be regulated by the state, but also the first to introduce the concept of “illegal” practice. The particularly harsh punishment implied the seriousness and danger in which the state considered unchecked medical practice, as well as the responsibility of examination the state felt they must take on to ensure the safety of its people. The assiz, furthermore, introduced an approved universal baseline of knowledge within the medical profession, an examination left to the state-appointed examiner to assess and approve. The assiz itself does not tell us exactly what that criteria entailed, but it is almost certain to be a grasp of the “fixed corpus of medical writing” taught at Salerno.⁵⁵ As Garcia-Ballester et al. observed of the 1329 Valencian *fuero* that similarly regulated medical licensing in Valencia, the assiz became “a public acknowledgment of the growing influence of medical learning. The view was emerging that medical science was responsible for health, man’s most precious possession, and was hence an important factor in social equilibrium and stability.”⁵⁶ The creation of this medical legislation, and legislations that followed, suggested that society viewed the medical profession now as a bestowed privilege, rather than an innate right;⁵⁷ a privilege, as the Angevin licence of Margarita de Ruga agreed, that can only be granted by the authorities.⁵⁸ Finally, Roger II’s legislation was one of few to give licensing authority over to the state

⁵⁴ Cited in Loud, *Roger II*, 327, and Dionysios Stathakopoulos, “On Whose Authority? Regulating Medical Practice in the Twelfth and Early Thirteenth Centuries,” in *Authority in Byzantium*, ed. Pamela Armstrong (Surrey: Ashgate Publishing Limited, 2013), 232.

⁵⁵ Luis Garcia-Ballester, Michael McVaugh, and Agustín Rubio-Vela. *Medical Licensing and Learning in Fourteenth-Century Valencia. Transactions of the American Philosophical Society*, vol. 79, pt.6 (Philadelphia: American Philosophical Society, 1989), 1.

⁵⁶ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 3-4.

⁵⁷ Edward F. Hartung, tran., “Medical Regulations of Frederick the Second of Hohenstaufen,” *Medical Life* 41 (1934): 596

⁵⁸ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3620, p. 271. “*Margarite de Ruga de Botonto privilegium chirurgie pro medendis vulneribus, apostematibus et fistulis.*”

rather than to regional councils, guilds, or to other physicians.⁵⁹ This type of state control made it harder for masters and physicians of Naples later to effect change within the regulation without direct approval from the state.

The novel Norman introduction of state control of medical regulation continued to carry through and evolve within the Hauteville and Hohenstaufen monarchies, and remained in practice during Charles II's rule of Naples. About a century after the end of Roger II's rule, his grandson, the Emperor Frederick II, promulgated a new collection of laws based on Roger II's collection of assizes, the Constitutions of Melfi. Among the Constitutions were updates to the previous medical regulation. The state continued to maintain control over the licensing of practitioners but implemented a few additions and added more detail in the regulation of their practice. Liber III, Titulus LXV, once again, reasserted the state's concern of "the heavy loss and irreparable harm that can result from the inexperience of doctors," and that "the penalty of confiscation of goods and a year's imprisonment shall await those who in future venture to practice in defiance of this ordinance."⁶⁰ The legislation further stipulated that "no one alleging the title of doctor shall dare practice in any other manner, or even to heal unless he shall first be certified by the judgment of the masters in the public convention at Salernum," as well as by royal examiners.⁶¹ The requirements for practice and the penalty of illicit practice are almost identical to Roger II's assiz, but the additional presence of the "masters at Salerno" is notable. Paul Oskar Kristeller points out that by stipulating that the examinations proceed at Salerno, it paralleled changes that occurred a few years prior in Paris and Bologna universities in 1220 where university professors granted degrees after an examination by masters.⁶² While state control over licensing in Naples meant that a university

⁵⁹ Stathakopoulos, "On Whose Authority?" 232.

⁶⁰ Hartung, "Medical Regulations of Frederick the Second of Hohenstaufen," 594.

⁶¹ Hartung, "Medical Regulations of Frederick the Second of Hohenstaufen," 594.

⁶² Paul Oskar Kristeller, "The School of Salerno: Its Development and Its Contribution to the History of Learning," *Bulletin of the History of Medicine* 17 (1945): 528.

degree did not necessarily equate a medical licence, it cannot be denied that the influence and prestige of university-trained physicians and their “scholastic, text-based, learned medicine” rose to such prominence that the king required them to oversee the medical examinations, alongside his appointed officials. Any further extant legislations that regulated medical licensing in southern Italy seemed to end with Frederick II’s rule, and aside from the licences, there are very few direct sources which can attest to any great changes or the direct medical practice of Neapolitan men and women. Nevertheless, there is little evidence that the examinations for prospective physicians and surgeons changed much between the end of Frederick II’s rule and the beginning of Charles of Anjou’s Angevin rule.⁶³ In fact, neighbouring regions seem to have mimicked similar modes of examination and licensing. The regulation itself showed a growing professionalization and greater confidence toward academic medicine, but little hinted at a growing distrust towards women’s continued practice. Additionally, the severe punishment was meant to discourage illicit practice, but there are not many extant sources detailing how well the Hauteville and Hohenstaufen legislation was implemented throughout the state. Fortunately, the neighbouring regions that adopted a similar process of professionalization and medical licensing provide both normative and descriptive sources from which this study may extract a general idea about the strength of the implementation of the medical regulation.

2.2.2 Regulation Vs. Reality

The late medieval Kingdom of Naples did not transmit many sources that reveal the mundane realities of healthcare, but scholars have found similar legislation from neighbouring European regions, as well as the reactions by their communities to the implementation of such legislation. As mentioned, southern Italy’s implementation of a medical licensing examination became the standard that neighbouring regions applied. In

⁶³ Doviak, “The University of Naples,” 35.

1239, the Montpellier region announced its new licensing procedure by declaring that, “no one would henceforth be allowed to practise medicine before being examined and approved by two masters selected from the Montpellier faculty” or face excommunication,⁶⁴ while in Paris the university’s faculty of medicine assumed medical licensing responsibility and between 1271 to 1272 and “took occasion to define more clearly the requirements for obtaining the license.”⁶⁵ The *cortes* of Monzón within the Crown of Aragon passed its first *fueros* regarding medical care in 1289, that similarly and simply, ordered that no physician or surgeon shall practice unless examined by councillors and physicians of the town.⁶⁶ In 1310, the city of Florence passed its own legislation asserting that no new healer, physician or surgeon, man or woman, was allowed to practice before being examined,⁶⁷ four years before Florence’s Guild of Doctors, Apothecaries, and Grocers released its first surviving statute.⁶⁸ These early, introductory, legislations, similar to southern Italy, introduced the concept of overseeing and regulating medical practice, but their effectiveness varied from region to region.

These structural changes introduced new tensions into the profession throughout western Europe, the first, and most pressing, being providing enough medical services to comfortably support the local population. The medicalization of society effectively reduced the number of medical practitioners permitted to practice “officially.” Although authorities intended to ensure the safety of their patients, Shatzmiller lists many, from numerous regions,

⁶⁴ McVaugh, *Medicine before the plague*, 69.

⁶⁵ Kibre, “The Faculty of Medicine at Paris,” 5.

⁶⁶ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 2-3.

⁶⁷ Piero Giacosa, *Magistri Salernitani Nondum Editi: Catalogo Ragionato Della Esposizione Di Storia Della Medicina Aperta in Torino Nel 1898* (Torino: Fratelli Bocca, 1901), 660. “Nullus medicus novus, physicus vel cirugicus, undecumque fuerit, possit exercere artem phisice vel cirugie in civitate Florentie, qui non sit conventatus, nisi fuerit examinatus per Consules huius Artis...Et si aliquis medicus inveniretur in civitate vel comitatu Florentie ydeota vel imperitus, femina vel masculus, contra ius medicans, quod a societate huius Artis repellatur, ita quod in civitate vel comitatu Florentie medicare non possit.

⁶⁸ Katharine Park, *Doctors and Medicine in Early Renaissance Florence*, (Princeton: Princeton University Press, 1985) 18.

who complained about the lack of doctors throughout the fourteenth and fifteenth century. In 1350, the Valencian city of Xativa expressed its dissatisfaction with the lack of both physicians and surgeons in both their city and other large cities. The governor of Dauphiné, too, lamented the daily suffering of his populace due to this scarcity, in 1370. The counsel for the Italian city of Pistoia complained that “there are not enough doctors to satisfy the needs of the city,” in 1359, and twenty-five years later, in 1384, demand continued.⁶⁹ As the desperation for medical practitioners grew, many regions employed various tactics to attract physicians and surgeons or to prevent them from leaving. Many Italian cities promised a public salary/contract, as well as tax exemptions and grants of citizenship to lure more doctors,⁷⁰ while a royal official in the city of Barcelona attempted to procure a royal order from the queen to prevent its Jewish physician, Benvenisti Ismeal, from leaving their city in the mid-fourteenth century.⁷¹ The complaints and strategies still could not successfully provide enough “qualified” doctors, as per the standards of the medical legislations, and so made it difficult to enforce restrictive legislations.

García-Ballester, McVaugh, and Rubio-Vela, in their work describing medical licensing in fourteenth-century Valencia, describe the tricky relationship between regulating medical practice and the strength of enforcement common throughout Europe. McVaugh argues that the first *fueros* of 1289 appear not to have been enforced heavily, if at all. Instead, they were meant primarily to ensure a certain level of expertise among the medical practitioners who gave expert testimony in court cases, rather than monitoring the general

⁶⁹ Shatzmiller, *Jews, Medicine, and Christian Society*, 6-7.

⁷⁰ Katherine Park, “Stones, Bones and Hernias: Surgical Specialists in Fourteenth- and Fifteenth- Century Italy,” in *Medicine from the Black Death to the French Disease*, ed. Roger French, Jon Arrizabalaga, Andrew Cunningham, and Luis García- Ballester (Aldershot: Ashgate, 1998), 116-118. Vivian Nutton, “Continuity or Rediscovery? The City Physician in Classical Antiquity and Mediaeval Italy,” in *The Town and State Physician in Europe from the Middle Ages to the Enlightenment*, ed. Andrew W. Russell (Wolfenbuttel: Herzog August Bibliothek, 1981), 26- 30.

⁷¹ Shatzmiller, *Jews, Medicine, and Christian Society*, 7.

medical community.⁷² The updated medical *furs* of 1329, on the other hand, exhibited a growing concern with unchecked medical practice. The *furs* of 1329, more thorough than its predecessor, differentiated and regulated the practices of physicians, surgeons, and barbers, as well as introduced limitations to women's practice. Similar to southern Italy, the *furs* of 1329 introduced the implementation of fines toward anyone charged practising illegally, to be split between the court, the town, and the accuser. Unlicensed physicians and surgeons paid 100 gold morabatins, and barbers paid 50, for every occasion they broke the law. Women who practised medicine or gave potions faced the "penalty of being whipped through the town."⁷³ Despite the *furs*, however, medical authorities sometimes found it difficult to enforce the prescribed medical standards and found themselves in conflict with royal and local authorities. Often growing out of the difficulties in supplying medical services to the populace, "unqualified" practitioners sometimes found local and royal support and protection against medical authorities and their attempts at prosecution. Take, for example, the cases of the apothecaries Ramon Sa Lena from Borriana, Pere Morades from the town of Castellón, and Francesc Martí of Vilafranca del Penedès. Under the 1329 *furs*, the justiciar charged, and subsequently acquitted, Ramon Sa Lena of practising medicine without a licence. The details of his acquittal remains unknown, but the lord of Nules, Guilabert de Centelles, defended Ramon's practice to the king by claiming "in the town of Nules and in your other towns and villages there is no physician or surgeon or other skilled person from whom you and the inhabitants of these towns and villages can receive advice and assistance and medicine for sickness and other afflictions." Guilabert's defence came in response to Ramon's request to the king for royal support to his practice as a precautionary measure against future accusations. The king granted his request.⁷⁴ Pere Morade's town faced a similar scarcity of

⁷² McVaugh, *Medicine before the plague*, 71.

⁷³ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 60.

⁷⁴ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 19- 20.

physicians, and in 1378 their *consell* granted Pere leave to treat the poor and patients in the hospital as they searched for a qualified physician in Valencia.⁷⁵ Francesc Martí, too, received a royal exemption from Joan I to treat others as a physician would without having to present himself for the required examination, due to either the lack of licenced physicians or their high costs.⁷⁶ That is not to imply that all reputable, but unlicensed, doctors received an exemption. During the mid-fourteenth century, the examining physicians of Valencia declined to examine a practitioner from Alzira until he paid 200 *sous*, despite the town entreating that they had no one to care for its sick.⁷⁷

Women, too, skirted licensing regulations. Within the Crown of Aragon, the king continued to prefer to grant exemptions rather than immediately punish the perpetrators, if they proved skilled.⁷⁸ In 1338, a female Barcelonan surgeon's practice came to the attention of Pere III. The king received complaints that the surgeon, having treated both men and women, had been harming her patients. Pere III ordered that her punishment be held back until after she underwent an examination. If she passed, she was free to practice, if not, then she would be punished.⁷⁹ In three other instances, between 1341-1342, the king directly interceded in court proceedings that attempted to punish unlicensed female surgeons and demanded no action taken against the women. The king reasoned that proven skill, of which he had direct testimony, trumped the "illegality" of their practice and did not appear concerned over the gender of the practitioner.⁸⁰ Similarly, in December 1394, Joan I stated, after granting the Valencian woman, Bevinguda, a surgical licence, that "contrary *furs*,

⁷⁵ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 21.

⁷⁶ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 49.

⁷⁷ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 22.

⁷⁸ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 30-31.

⁷⁹ McVaugh, *Medicine before the plague*, 106.

⁸⁰ McVaugh, *Medicine before the plague*, 106-107.

privileges, uses and other practices of the kingdom of Valencia shall in no way interfere,” with Bevinguda’s practice because of her skill and success in treating men and children.⁸¹

These examples illustrate a dissonance between enforcement and need, as well as the tension that erupted between the learned doctors and medical authorities against municipal authorities, the authority of the crown, and the lay population. Within the Crown of Aragon, such interference by the crown became so commonplace that the “legal” community of physicians and surgeons protested against the crown’s actions twice, once in 1347 and failing that, in 1356.⁸² Licensed physicians became concerned over the proliferation of “empirics” and unqualified practitioners, both for the public’s safety and for the economic threat they posed, and sought to control and monopolize the practice through their corresponding statutes and legislations, whereas the crown granted exceptions to both men and women, due to the scarcity. The medical regulations enacted to test and license the medical knowledge of practitioners was not an evil practice, in and of itself. In fact, as McVaugh notes in the Crown of Aragon, “in the late thirteenth century it was becoming widely accepted among the public that medical learning made for better medical care,” which these examinations tested for.⁸³ Rather, the reduction of available “legal” practitioners as well as the cost of their practice placed a strain, particularly in smaller and more remote towns and communities, leading to interventions and exceptions by higher authorities. Furthermore, we must not forget that these interventions arose from communities that came into contact with the regulatory bodies. Likely, there remained many more communities that primarily relied on the “empirical” and “unlearned” to care for their sick that never came to light, many of which included women.

Parisian experts maintained an even tighter control of the medical profession. The medical faculty in the city obtained the right not only to set licensing and examination

⁸¹ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 49.

⁸² Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 48.

⁸³ McVaugh, *Medicine before the plague*, 241.

standards, but to prosecute illegal practice as well. With support from the Church and the king, they threatened any person caught practising without approval with excommunication.⁸⁴ The threat of excommunication were not empty words either as the Parisian medical faculty repeatedly carried it through. Even so, its effectiveness remained minimal, which is seen by the number of times the pope addressed the situation. In quick succession, on 1325, 1330, 1340, 1347, and 1350, the reigning pope was either sought after for support by the city or addressed the continuing illegal medical practices himself (perhaps by some prodding), and on 1340, even extended the threat of excommunication toward patients.⁸⁵ Women's medical practice and the illicit practices of men, became targeted by the medical faculty, due to its "unlearned" characteristic.⁸⁶ Nonetheless, the punishment of excommunication and oral denunciation to illicit medical practice, as given to both Clarice de Rothomago and her husband, Peter Faverel, in 1312, did very little to deter other unlicensed medical practices.⁸⁷ Men and women had come forth to defend Jacoba Felicie's medical practice in her 1322 trial, and in 1410, Perette Pétone came under investigation by the university for her surgical practice. By the time of Perette's trial, "*Perette était assez populaire auprès de ses patients puisqu'il est dit qu'ils vinrent au Châtelet pour demander son élargissement,*"⁸⁸ and to further cement the normality of her practice and other women's, prior to her trial, Perette's practice had been publicized with a banner, and the defence had argued, "*que ces ordonnances quelque-elles fussent ne furent pas gardées car plusieurs autres femmes se mêlent de chirurgie à Paris à qui l'on ne demande rien.*"⁸⁹ Thus, as the trial records show, patients continued to

⁸⁴ Kibre, "The Faculty of Medicine at Paris," 5.

⁸⁵ Kibre, "The Faculty of Medicine at Paris," 12- 14.

⁸⁶ Danielle Jacquart, *Le milieu médical en France du XIIIe au XVe siècle* (Geneva: Librairie Champion, 1981), 53.

⁸⁷ Kibre, "The Faculty of Medicine at Paris," 7.

⁸⁸ Geneviève Dumas, "Les femmes et les pratiques de la santé dans le 'Registre des plaidoiries du Parlement de Paris, 1364-1427'," *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 13 (1996): 15-16.

⁸⁹ Dumas, "Les femmes et les pratiques de la santé," 16-17.

seek out the best care they could, legal or illegal, male or female, as “illicit” practices continued on within the city.

Between the widely different cases of the Crown of Aragon and Paris, there is the implication that when the authoritative power rested in the hands of a collective medical institution, unlicensed practitioners faced a profession hostile to their presence. Nevertheless, what both cases do illuminate is that as long as practitioners were available, the sick and their families sought them out. While there was a general belief that the best medical care came from the best educated, this section does note that the availability, fees, and reputation of the practitioner played a role for patients. These cases of conflict in maintaining medical standards between learned doctors and empirics, and between medical, local, and royal authorities, not only demonstrated the tensions that erupted in the process of professionalization, but also that there was a general demand for doctors within many communities throughout western Europe. This demand, in turn, facilitated the continued presence of “unlearned” and “empirical” doctors, a category which women were commonly sorted into. Many patients sought out the skills of “illicit” practitioners without inquiring too deeply about the legality of their practice, which this study can only assume this to be just as true within the Kingdom of Naples. Just as with the cases in the Crown of Aragon, the Parisian cases highlighted the blind spots in medieval healthcare documentation, particularly in regards to women’s medical practices. As Peretta’s defence argued, there were many more women practicing medicine that the courts did not pursue, and who did not leave behind documented evidence of their practice.

2.3 Licensing and Practice

2.3.1 Angevin Licences

The Angevin medical licences, as mentioned, at least as preserved in Calvanico’s edition, give a limited view into the social aspect of medical practice and care in southern

Italy. Characteristically formulaic, as are so many medieval legal documents, they present little variation. Generally, the documents provide the identity of the practitioner, the identity of the examiners, the region(s) in which the practitioner may perform their work, the field of medicine (*medica/fisica* and/or *chirurgica*) in which they were authorized to practice, and the location in which the state granted the licence. Aside from the introductory customary greeting by the reigning monarch and confirmation of the subject's oath and loyalty, little more were added. Only with irregularities were the formulaic altered to present new information. These irregularities appeared only among the surgical licences.

There existed four different types of licences within the Angevin kingdom. The first was granted to physicians (*medica/fisica*), with very little variation among the specifics of their practice. The rest, and more variant, were awarded to surgeons. This thesis sorts the surgical licences into three categories: general, specialized, and restrictive. The general surgeon's practice belonged to licences that authorized the individual to practice surgery, without any clarification as to the specifics of their practice. Specialized licences are those which indicated that the individual had a particular, and, as we will see, highly lauded, skill in a specific area of surgery not found among general surgeons. Many common examples included the treatment of *apostimatibus*, *crepaturarum*, *vulneribus*, *lapidibus*, *fracturarum*, *dislocationibus*, and *hernie/ernie*. Finally, restrictive licences are so called because they specify, like specialized licences, that the practitioner is skilled enough to heal a specific illness or wound, but, unlike the specialized licences, they denote that the surgeon had only the most rudimentary of skills. These licences permitted them to heal apostemes, wounds, fissures and the rest, but only the "simple," "old," "small to medium," or some other lesser, and less dangerous, variants.

2.3.2 Physicians and Text-Based Knowledge

Of the licences reported in Calvanico regarding *medici* and *fisici* we can observe two key features. The first is that all the physician licences were granted to men. The second feature is that the requirements for practice among the licences for *medici/ fisici* had no differences between one another. Unlike surgical licences, the Neapolitan *fisici* examinations seemed to leave no room for any variation or limitations within the practice, likely because of the university influence and their corresponding medical curriculum. Frederick II, in 1231, provided his prescribed curriculum. First, the study of medicine must be preceded by a three year study of logic. Once completed, the medical student must study and practice medicine and surgery for five years, made up by the *Aphorisms*, *Prognostics*, and *Regimen of Acute Diseases* of Hippocrates and the *Tegni* of Galen. The student must also have participated in a one-year internship under a practising physician.⁹⁰ Under Angevin rule, the mandatory medical books became more similar to Paris' curriculum, which, as Karger notes, was likely due to Charles' French origins,⁹¹ though the curriculum preserved its original Arabic and Greek influences.⁹² Nonetheless, the standards of the medieval medical profession and the rise of formal academic training became greatly influenced by universities because the translation and proliferation of the Greek and Arabic texts created a greater connection between medicine and natural philosophy.⁹³ The new theoretical and "rational" medicine's connection to natural philosophy, and the popularity of the School of Salerno, in turn, "supported medicine's claim to a place in the new universities."⁹⁴ Although the university-trained graduates faced competition among the non-university trained physicians, medical

⁹⁰ Doviak, "The University of Naples," 24- 25.

⁹¹ Bullough, *The Development of Medicine as a Profession*, 51.

⁹² The list of assigned medical texts for the University of Paris is found in Faith Wallis, editor. *Medieval Medicine : A Reader* (Toronto: University of Toronto Press, 2010), 194- 195.

⁹³ Nancy Sirasai, "The Faculty of Medicine," in *A History of the University in Europe*, ed. Walter Rüegg, (Cambridge: Cambridge University Press, 1992), 360.

⁹⁴ Wallis, *Medieval Medicine*, 129.

faculties held the highest position of importance in the public, and in creating medical standards. A few universities, Paris and Montpellier, even maintained both the rights to examine and to license any future medical candidate.⁹⁵ Thus, the standards of a physician's examination were based upon the Latin medical treatises of the university curricula, and, perhaps to maintain the prestige of physicians, as Charles II lamented the falling medical standards of Salerno,⁹⁶ "officially," any variation or acceptance of a limited education among physicians was not permitted within Naples.

2.3.3 Surgeons and Skill

Lanfranc defines surgery as,

"that medical science by which we teach how to operate manually on the human body: making incisions, restoring wounded tissue to its original conditions as far as possible, and removing growths..."⁹⁷

Surgeons, unlike physicians, relied principally on technical and manual skills over text-based medical theories and commentaries. As such, under the medieval medical hierarchy, surgeons fell beneath physicians but above barber-surgeons.⁹⁸ Prominent medical authors, Roger, Bruno, Teodorico, Lanfranc, and Guy de Chauluc, increasingly attempted to connect surgical practice as an academic, theoretical, and text-based profession,⁹⁹ as displayed by Lanfranc's qualification, "...following the guidance of medical theory."¹⁰⁰

Italian universities took to this view relatively quickly, presumably because many of the aforementioned authors originated in Italy, provided lectures, and awarded degrees in

⁹⁵ Kibre, "The Faculty of Medicine at Paris," 13.

⁹⁶ Bullough, *The Development of Medicine as a Profession*, 51.

⁹⁷ Cited in Michael McVaugh, *The Rational Surgery of the Middle Ages* (Firenze : SISMELE/ Edizioni del Galluzzo, 2006), 59.

⁹⁸ This study ignores the role of barber- surgeons and apothecaries as the Angevin records do not contain the licences of either. We do know, however, that among Frederick II's medical regulations, there included stipulations toward the practice of apothecaries. More on Frederick II's edicts towards apothecaries can be found in, Hartung, Edward F., trans. "Medical Regulations of Frederick the Second of Hohenstaufen." *Medical Life* 41 (1934): 587–601.

⁹⁹ For more information on these surgical authors and their work, see McVaugh, Michael. *The Rational Surgery of the Middle Ages*. Firenze : SISMELE/ Edizioni del Galluzzo, 2006.

¹⁰⁰ McVaugh, *The Rational Surgery of the Middle Age*, 59.

surgery.¹⁰¹ The master of the medical faculty at Montpellier, too, saw the value of academic learning for surgery. The university at Montpellier provided some instruction in surgery, surgical author, Henry de Mondville was one of its more prominent lecturers, but did not count it toward a medical degree.¹⁰² The Paris medical faculty viewed the surgical art with less respect, as competition, left surgeons under the control of the municipality, and only allowed surgeons to access university lectures in the fifteenth century.¹⁰³ The Crown of Aragon, in contrast, enthusiastically adapted the Italian view in the early fourteenth-century. Their university at Lerida hired a professor of surgery, in addition to a professor of medicine, and, when the surgeon died in 1330, the king took a personal interest in his replacement.¹⁰⁴ Most surgeons throughout Europe, however, received their training through apprenticeships.¹⁰⁵

Despite the growing popularity of a text-based, literate surgical education, the idea did not catch on as easily among the general population. Empirical and illiterate surgeons still flourished in their communities, and academically trained surgeons attempted to warn the population of the dangers of accepting help from such uneducated and illiterate surgeons. As Niccolò Falducci, author of the influential *Sermones medicinales*, declared,

“From what I have said, you can see how wrong people are who call anyone who treat illnesses a surgeon. For we should not call just any lay practitioner [*operator idiota*] or little woman [*muliercula*] a surgeon, even though they lance abscesses, stitch up wounds, and do similar work. We should rather utterly bar them from these operations, wherever they practice, and flee their treatments, for they operate wrongly and inappropriately, and if occasionally they perform successful cures, it is not due to their competence but to luck... A great host of these ignorant people and empirics flourishes at present...especially in the treatment of broken bones and dislocated joints.¹⁰⁶

¹⁰¹ Sirasai, “The Faculty of Medicine,” 381. Michael M. McVaugh, “Surgical Education in the Middle Ages,” *Dynamis* 20 (2000):289. Bologna, Padua, Naples/Salerno, and Siena had lectures on surgery by the first half of the fourteenth century.

¹⁰² Sirasai, “The Faculty of Medicine,” 380- 381. McVaugh, *Medicine before the plague*, 114.

¹⁰³ Kibre, “The Faculty of Medicine at Paris,” 17.

¹⁰⁴ McVaugh, “Surgical Education in the Middle Ages,” 289.

¹⁰⁵ Park, “Medicine and society,” 79.

¹⁰⁶ Cited in Park, “Stones, Bones and Hernias,” 110.

The issue with the argument, however, rested in convincing the populations that there was a palpable difference between academics and non-academics. Surgeons healed physical and tangible injuries, a skill that required dexterity and anatomical knowledge. When an individual became physically injured, be it by a deep cut, by a blade, or a broken bone, the surgeon physically altered the body (incisions, bone fragments removed, stitches applied, etc.), avoided infection, and dressed the wound. Different surgeons had different styles of addressing the wound, aggressively or conservatively, but, overall, surgical “procedures offered relatively little incentive or opportunity for technical or theoretical elaboration.”¹⁰⁷ Thus, greater emphasis was placed on the surgeon’s experience and medical successes than on their theoretical knowledge, but it remained that it was their theoretical knowledge the academics were promoting as superior. As a result, academically trained surgeons faced great competition against empirical and non-literate surgeons. Greater, in fact, because these academically trained surgeons hoped they could count on, like their *fisici* counterparts, a demand for their knowledgeable services and, therefore, higher payment from their patients. It must have been a great surprise when they found the opposite to be true. As Henri de Mondeville observed on 1306,

It is the habit of all princes, prelates, and ordinary people these days in all western lands - it may not be so in hotter regions- not to trust any medically learned surgeon [*medico cyrurgico scientifico*] very far, for they say that a surgeon ought not to be a cleric because, while a cleric is in the school, the layman is learning the technique of manual operation.¹⁰⁸

¹⁰⁷ Sirasai, *Medieval and Renaissance Medicine*, 155.

¹⁰⁸ Cited in Michael R. McVaugh, “Royal Surgeons and the Value of Medical Learning: the Crown of Aragon, 1300- 1350,” in *Practical Medicine from Salerno to the Black Death*, ed. Luis García-Ballester, Roger French, Jon Arrizabalaga, and Andrew Cunningham, (Cambridge: Cambridge University Press, 1994), 236.

Literacy, we find, did not become a major barrier in the surgical practice as it did in the physician's.¹⁰⁹ In surgery, experience was king, and even devoting oneself to one area of specialty was not a detriment to their practice.

It was not just the patient population that ignored the warnings against “illiterate” and “rustic” surgeons, but regional authorities as well. The earliest “specialized” licence within the Kingdom of Naples was awarded to magistro Pascale de Vivencia on April 8, 1278.¹¹⁰ Magistro Pascale's skill was found in “*curandi homines prodevotos et ruptos in femoralibus circa visilia sit plene sufficiens et instructus*” and the examination further judged him to be exceptionally talented as his licence allowed him to practice throughout the Kingdom.¹¹¹ Between the years 1305- 1306, the state granted Benedetto de Citro the licence to heal apostemes and wounds as it found him skilled yet uneducated.¹¹² Angevin Naples granted many such surgical licences to general, restricted, and specialized surgeons, to both the illiterate and literate. From 1301 to 1346, Naples rarely went a year without granting at least one restrictive or specialized licence. The more popular skills among the licences, as mentioned previously, came to be healing apostemes, fissures, wounds, and kidney and bladder stones, though there were also a significant number skilled in dislocated joints and broken bones.¹¹³ Katherine Park, too, observes the dissonance between academically trained physicians' and surgeons' advice and the lay population's behaviour in her study of surgical specialists in the fourteenth and fifteenth century Florence. She finds, despite repeated warnings by university-trained physicians and surgeons, Florence's advisory and legislative

¹⁰⁹ The case of Peretta Perone of Paris, argues differently. For more on Peretta's trial see, Geneviève Dumas, “Les femmes et les pratiques de la santé dans le ‘Registre des plaidoiries du Parlement de Paris, 1364-1427’,” *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 13 (1996): 3-27.

¹¹⁰ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 226, p.20.

¹¹¹ *Similies universis per Regnum Sicilie constitutis presentibus et futuris presentes etc.*

¹¹² Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 753, p.99. “*peritus tamquam ydiota in cure egritudinum apostematum et vulnerum*”

¹¹³ Within Calvanico's records, 222 surgeons are granted “specialized” or “restrictive” licences. 102 refer to *apostimatibus*, 64 to *crepaturarum*, 62 to *vulneribus*, 57 to *lapidibus*, 29 to *fracturarum*, 24 to *dislocationibus*, and 16 to *hernie/ernie*.

council deemed the empirically trained surgical specialist “an important community resource, whose presence in the city was worth one of its extremely rare lifetime tax exemptions,”¹¹⁴ as well as citizenship. Specialists in hernias, bones, teeth, eyes and poultices were the most commonly found among Florentine society,¹¹⁵ which overlapped with the findings within the Angevin licences. Valencia, too, endorsed granting restrictive or “specialized” licences over theoretical knowledge. Valencian municipal authorities allowed Bernat Giner and the Muslim, Maymó Abdochaxis, to practice “minor surgery,” and Tommaso de Maestre Tone on hernias, but more telling is Johan de Sena’s licence.¹¹⁶ De Sena’s licence permitted him to heal cataracts, hernias, and bladder stones, but added their reasoning as that “the said things pertain more to experience and manual activity than to scientific understanding,” outlining clearly the common view by authorities that it was preferable to have a skilled surgeon over an academically educated one.

The cause for demand for surgical specialists and the proliferation of empirics and rustics is obvious. It has already been noted that a “medical crisis” existed due to the dearth of “qualified” practitioners. For regional authorities, attempting to limit the acceptance of surgeons into the profession, due to their literacy and academic knowledge, would inevitably have compounded that crisis, especially in the more remote locations. Physical health played an important role in the economy of many families. Injuries, debilitating illnesses, and possible blindness could be the line between poverty and economic stability, so the popularity and need by the lay population to obtain the services of bone, eye, cancer, and hernia specialists, legal or illegal, overruled any other advice. Then, if we take into consideration the much higher likelihood of minor injuries that would occur in both an agricultural and urban society, which explains the licensing of individuals with even the most minimal medical

¹¹⁴ Park, “Stones, Bones and Hernias,” 111.

¹¹⁵ Park, “Stones, Bones and Hernias,” 113.

¹¹⁶ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 17.

skills, we observe the cracks in the system that allowed women's practice to continue, even marginally.

Chapter III

Targeted Legislation: Women Doctors, Jewish Doctors, Clerical Doctors

3.1 Introduction

The implementation of regulatory measures in southern Italy signified the end of the open and easy access into the “medical marketplace.” To claim medical expertise, doctors needed to qualify for their region’s set of medical standards. The previous chapter demonstrated that, occasionally, social need trumped the established regulations, but overall, “a certain level of medical learning was being assumed as, in principle, a necessary prerequisite for practice.”¹¹⁷ As a result, the medicalization of society saw “the emergence of professional, secular practitioners, mostly male, who wished to be remunerated for the expertise they possessed and for the effort they exhibited and who were expected to take responsibility for misdeeds and failures,”¹¹⁸ and, in that vein, attempted to monopolize the medical profession. Thus, in this changing medical landscape, women practitioners, already infrequently documented, as well as Jewish and clerical doctors, found increasing rhetoric and legislation against their practice.

While this thesis is primarily focused on the medical practice of women under regulation, to highlight the unique aspects of women’s practice, and to round out the medical milieu of Naples, it contrasts it against other targeted medical practices, primarily those of Jews and clerics. Of the three groups of healers, women, comparatively, found the least amount of documented success. While this thesis acknowledges that there existed many more undocumented, “empirical” women healers, overall, women’s “range of practice had shrunk to the same degree that male practitioners’ professional identities had grown.”¹¹⁹ The licences of Angevin Naples exhibited this point. Women in the Kingdom of Naples may have

¹¹⁷ McVaugh, *Medicine before the Plague*, 241.

¹¹⁸ Shatzmiller, *Jews, Medicine, and Christian Society*, 5.

¹¹⁹ Green, *Making Women’s Medicine Masculine*, 294.

appeared, numerically, more often than Jews and clerics, but they were, primarily, granted the less prestigious surgical licences, most of which were restricted into the humbler sectors of surgical practice.

Why were Christian women's practices treated most severely when both Jews and clerics, as this chapter will show, faced similar restrictions? The Jewish population, like Christian women, faced similar difficulties into their integration within the medical profession. Unlike Christian men, neither their female coreligionists nor Jews could receive a prestigious and valuable university degree; both were negatively impacted by medical regulations and authorities against their practice, and both faced suspicion to their practice due to the perceived untrustworthiness of their respective religious and gender groups. Nonetheless, male Jewish doctors appeared to experience greater success and influence within Christian communities and the ruling class, almost equal to Christian male practitioners.¹²⁰ To compare, the Jewish population comprised less than 1 percent of the overall Mediterranean European population, and, at best, 5 percent to 8 percent of the population in great cities, yet, Jews could make up to more than 50 percent of the medical population.¹²¹ Conversely, women made up, more or less, about 50 percent of the population, but, if we take sources at face value, they comprised, at best, 1.5 percent of the medical population.¹²² Clerical orders, too, were underrepresented numerically within the medical profession, but many clerics were still found in positions of power and medical authority, despite ordinances to the contrary.

Thus, this chapter is two-fold. First, by highlighting the ineffectiveness of targeted medical legislation, it weakens the notion that the regulations were the prime factor in

¹²⁰ Luis Garcia-Ballester, "A Marginal Learned Medical World: Jewish, Muslim and Christian Medical Practitioners, and the Use of Arabic Medical Sources in Late Medieval Spain," in *Practical Medicine from Salerno to the Black Death*, ed. Luis García-Ballester, Roger French, Jon Arrizabalaga, and Andrew Cunningham, (Cambridge: Cambridge University Press, 1994), 367-368.

¹²¹ Shatzmiller, *Jews, Medicine, and Christian Society*, 1.

¹²² Green, *Making Women's Medicine Masculine*, 121.

women's eventual exclusion from (scientific) medicine. Primarily comparing the practice of Jewish doctors against women doctors, it highlights the factors that marginalized women's practices, both within the Kingdom of Naples and outside.¹²³ Parallel limitations are often found in both Christian women and Jewish men's entrances into the medical profession. In fact, within medical legislations, it can be argued that they were much more outwardly aggressive toward Jewish doctors than women. The last section of this chapter focuses on clerical doctors of Naples, noting that while there were little secular legislations against their practice, clerics did face ecclesiastical sanctions against their medical practices. Nonetheless, it appears that these sanctions did little to affect the professional career of clerics, both in the ecclesiastical and medical sense. In the analysis of all three practices, this chapter finds that a key point of divergence between the women's path, and the Jewish and clerical paths was their access and understanding of the medical texts. Literacy, as a highly gendered practice, played the pivotal role between "legitimate" medical success and failure.¹²⁴

3.2 Popular Suspicion

3.2.1 "*He Kills Gentiles*"

Jewish practitioners found great success as the doctors of Christians and Christian communities, but they were also well aware of the environment in which they lived. No matter their successes, prejudice continued to follow as accusations of the ritual murder of Christian children, desecrating the Host, and poisoning wells became popular throughout the high and late Middle Ages.¹²⁵ Jewish doctors accused of malpractice or the wrongful death of Christian patients risked facing a court predisposed against and fearful of their true intent. Fear of poison by Jewish physicians, in particular, seemed to be a common threat.

¹²³ When discussing "Jewish doctors," this study is primarily referring to *male* Jewish doctors. Much of the information about Jewish medical practice relies primarily on Joseph Shatzmiller's conclusions in *Jews, Medicine, and Medieval Society*.

¹²⁴ Green, "Documenting Medieval Women's Medical Practice," 495.

¹²⁵ Steven Beller, *Antisemitism: A Very Short Introduction*. Second edition. (Oxford: Oxford University Press, 2015) 13- 14.

Ecclesiastical and secular legislation frequently referred to the threat of poison by Jewish doctors. The regional council of Trier (1227) instructed

...the lords of the land to compel their Jews, and force them to do this by some punishment, not to occupy themselves with medicine, nor to give any kind of potion to Christians.¹²⁶

A century later, the councils of Valladolid (1322), and Salamanca (1335) explicitly stated the threat of Jewish doctors purposely killing their Christian patients through their prescribed medication.¹²⁷ Other legislation, perhaps seeing the futility in completely denying Jewish medical practice, attempted to ensure Christian safety. The thirteenth-century Castilian code of Alfonso X, *Las Siete Partidas*, allowed Jewish physicians to see and prescribe medicine to Christian patients but the actual preparation of the prescription was left to Christian doctors.¹²⁸ So, too, did a 1349-1350 Provençal legislation demand Jewish surgeons to taste the wine prior to giving it to their sick.¹²⁹

These suspicions may have been in the minds of the courts when Jewish physicians were brought forth in cases of poisoning. In 1317, a French court suspected that a Jewish French surgeon, David “the Young,” and his Jewish accomplice, Abraham, had poisoned many Christians, including a priest.¹³⁰ In 1404, a Florentine court executed a Jewish doctor for providing a Christian woman with poison to kill her husband.¹³¹ It is difficult to say with certainty whether prejudice played a part in the accusations and final verdict of Jewish doctors, since Shatzmiller also finds cases of impartiality and leniency by the courts toward Jewish doctors, as well.¹³² In the 1348 case of Balavignay, surgeon of Thonon, and 1416 case

¹²⁶ Solomon Grayzel, *The Church and the Jews in the XIIIth Century: a Study of Their Relations During the Years 1198-1254 Based on the Papal Letters and the Conciliar Decrees of the Periods* (Philadelphia: The Dropsie College for Hebrew and Cognate Learning, 1933), 319.

¹²⁷ Shatzmiller, *Jews, Medicine, and Christian Society*, 88.

¹²⁸ McVaugh, *Medicine before the Plague*, 59.

¹²⁹ Shatzmiller, *Jews, Medicine, and Christian Society*, 88.

¹³⁰ Jacquart, *Le milieu médical*, 167. Shatzmiller, *Jews, Medicine, and Christian Society*, 87.

¹³¹ Park, *Doctors and Medicine*, 74.

¹³² Shatzmiller, *Jews, Medicine, and Christian Society*, 81- 83.

of Abraham, doctor of the Duchess of Burgundy, however, there are clear hints of anti-Semitism in their charges of poisoning wells and fountains.¹³³

The height of fear and prejudice against Jewish practice came during the fifteenth-century Inquisition. Inquisitions extracted many “confessions” from Jewish and *converso* doctors where they admitted their conscious involvement in the poisoning and deaths of their Christian patients, as well as, consorting with the devil, necromancy, and desecrating Christian graves.¹³⁴ These “guilty” men were then promptly executed. Such was the risk of treating Christian patients that the Hebrew moral treatise, *Sefer ha-Yosher*, cautioned against it. Of the practice, the *Sefer* warned that if Christians

...discover any ignorance on our part they say, “He kills gentiles.” This is the reason I advise each and every Jew not to [even] touch a gentile if he is not able to answer [the questions of those Christian doctors] in natural sciences.¹³⁵

3.2.2 The *Vetula*

For women, the threat to patients was not merely religious in nature but biological. In 1253, Bruno of Longobucco published his work on surgery, the *Cirurgia Magna*. Within his work he described his ideal, and less than ideal, surgeon, arguing that,

[Surgeons] should be literate men, or at least should have learned the art from a literate teacher; I believe scarcely anyone can master this art if he cannot read. Yet today not only the illiterate [*ydiote*] but, what is deemed even more horrible, women, presume to usurp this art and abuse it; they have neither skill nor understanding, though they believe they do. *Almansor* says that for the most part those who practice this are *ydiote*, rustics and dullards [*stolidi*], and on account of their dullness the most serious illnesses arise by which the sick may die, since they practice not wisely nor on the basis of principles but haphazardly, and they completely fail to understand the causes and names of the illnesses they claim to be treating.¹³⁶

In Bruno’s description, we see that by the thirteenth century, surgery was, or at least purported to be, more than a mere manual and technical craft and increasingly a learned art.

¹³³ Jacquart, *Le milieu médical*, 167

¹³⁴ Shatzmiller, *Jews, Medicine, and Christian Society*, 86-87.

¹³⁵ Shatzmiller, *Jews, Medicine, and Christian Society*, 85.

¹³⁶ Cited in McVaugh, *The Rational Surgery*, 53.

More importantly, we can see that in Bruno's hierarchy of doctors, women's medical practice fell to the bottom, as the most perilous and ignorant, and that any success likely came from luck rather than any true understanding of their procedures. This view comes as the reverse of the century prior, when "in the twelfth-century Salerno male medical writers could refer to the empirical practices of Salernitan women with acknowledgment and even respect,"¹³⁷ not only in their care of women and children, but towards men as well.

The reversal of opinion came about as the by-blow of growing medicalization of European society. As medicalization gained traction, "medical services had to depart from the realm of Christian charity and become part of the marketplace, where not only goods but services were sold."¹³⁸ As health care transformed into a commodity, competition between practitioners arose too. The growing need to differentiate one practice as more skilled, and therefore, better, became a point to clarify within medical treatises and a common tactic had been to target "unlearned" and "empirical" medical practices, and as Bruno's summary displayed, by the late medieval period, women grew to become synonymous with such practices.

Jole Agrimi and Chiara Crisciani discovered that the term, *vetula*, or, "old woman," became a common derogatory reference of women's empirical practice. Agrimi and Crisciani noted of the *vetula* that, "il s'agit d'une figure qui, dans la réalité comme dans les textes, se trouve placée à l'intersection de la féminité, de la vieillesse et de la simplicitas, et qui porte ces trois données de la conditions humaine à leur point d'incandescence, ou plutôt à l'incandescence de leur négativité," and that the term became interchangeable with that of *mulieres*, *simplices*, and *empirici*.¹³⁹ As the "experts" attempted to gain a monopoly on the profession, their primary criticism against the medical practice of women lay in the

¹³⁷ Green, *Making Women's Medicine Masculine*, 14.

¹³⁸ Shatzmiller, *Jews, Medicine, and Christian Society*, 5.

¹³⁹ Jole Agrimi and Chiara Crisciani, "Savoir médical et anthropologie religieuse : Les représentations et les fonctions de la *vetula* (XIIIe-XVe siècle)," *Annales: E.S.C.* 48 (1993): 1282.

transmission and understanding of their information, which is to say, none at all. To the “experts” of the craft, “la *vetula*, pas plus que d’autres profanes, ne conçoit la vraie raison d’être des thérapies qu’elle adopte, parce qu’elle ignore tout de leurs causes, et qu’elle ne peut en aucune façon généraliser l’expérience concrète; elle ne sait ni identifier, ni distinguer les maladies; elle n’entend rien au langage technique du médecin, ni souvent rien non plus aux mots qu’elle emploie elle-même,”¹⁴⁰ which would then, undoubtedly, put the unknowing common man’s health in danger. Just as dangerous to the “experts”, and related to the aforementioned ignorance of the *vetula*, was the *vetula*’s lack of literate transmission of medical knowledge. To academic doctors, empirical knowledge did not equate to real knowledge, was “vouée à n’être qu’un rituel répétitif fondé sur le secret,”¹⁴¹ and a perversion of “real science.”¹⁴² Thus, as Agrimi and Crisciani question, “ce n’est pas par hasard que le premier barrage qu’il dressent contre la *vetula* et ce qu’elle représente est l’arme commune de la *doctrina*?”¹⁴³

3.3 Legal Implementations

3.3.1 Explicit Exclusion of Jews

Like lay Christian male doctors, Christian women and Jewish men were subject to medical licensing and regulation. As the previous chapter exhibited, many of the initial secular legislations focused predominantly on ensuring competent practice rather than excluding any particular group from the profession. Nevertheless, the perceived “otherness” and “danger” of the Jewish population persisted within Christian society and quickly coloured Christian views on Jewish medical practice. Just as Church legislation against

¹⁴⁰ Agrimi and Crisciani, “Savoir médical et anthropologie religieuse,” 1285.

¹⁴¹ Agrimi and Crisciani, “Savoir médical et anthropologie religieuse,” 1288.

¹⁴² Agrimi and Crisciani, “Savoir médical et anthropologie religieuse,” 1289.

¹⁴³ Agrimi and Crisciani, “Savoir médical et anthropologie religieuse,” 1305.

clerical medical practice derived from concern over the Christian soul, so too was there a concern of Christian health and spirit while under Jewish care.

Regulation ordering the limitation and elimination of Jewish practice began as early as the thirteenth century. The Church, through its councils and popes, promoted the idea that Jews generally wished to kill all Christians and plotted against Christianity.¹⁴⁴ They believed that while under the care of Jewish doctors, there remained the risk of both physical death and spiritual, through the prevention of their last ordinances.¹⁴⁵ Church councils, then, as mentioned above, attempted to warn against and limit Jewish medical practice. The Council of Tarragona in 1243, condemned and restricted the entirety of the Crown of Aragon, clerics and laymen alike, from receiving Jewish medical care,¹⁴⁶ and many like Béziers (1246) and Albi (1254), threatened that Christians “shall be excommunicated who because of illness, entrust themselves for healing to the care of Jews.”¹⁴⁷ The Church councils of the fourteenth century continued in a similar fashion. The previously mentioned synods of Valladolid (1322), and Salamanca (1335) made their stance toward Jewish doctors clear and the council of Avignon (1337) ordained that no Christian of any rank “should approach and ask, or make us ask, any Jewish physician or surgeon for any medicine, medicament, or cure” unless “imminent danger to the patient exists and it is impossible to appeal conveniently to Christian doctors or surgeons.”¹⁴⁸

Secular legislation, too, attempted to curtail Jewish practice. The faculty of Paris’ 1271 legislation, introduced in the previous chapter, ordered “no Jew or Jewess may presume to operate surgically or medicinally on any person of the Christian faith.”¹⁴⁹ Count Charles II

¹⁴⁴ Grayzel, *The Church and the Jews*, 72- 75.

¹⁴⁵ Shatzmiller, *Jews, Medicine, and Christian Society*, 91.

¹⁴⁶ McVaugh, *Medicine before the Plague*, 59.

¹⁴⁷ Grayzel, *The Church and the Jews*, 333, 337.

¹⁴⁸ Shatzmiller, *Jews, Medicine, and Christian Society*, 92.

¹⁴⁹ Shatzmiller, *Jews, Medicine, and Christian Society*, 16.

of Provence and the King of Naples, goes as far as attempting to negate previous valid licences, in an act passed in Provence, in 1306, ordering,

“that no one, when stricken by a sickness, should turn to a Jewish doctor or any other infidel or get from him, or through his counsel, any medicine. Neither in the future, will any license to practice among the faithful be awarded to any Jew by the senechal or any other official. And if [a license] was awarded to anyone before this date we revoke it and declare it not valid. A Jew called upon [by a Christian] will pay a fine of ten pounds of the new money [*reforsas*] if he tends him against the [tenets] of the present ordinance. If he refuses to pay it, we order his body to be scourged. As for the faithful [Christian] who called upon him, he will be punished according to the decision of the judge under whose jurisdiction he lives.”¹⁵⁰

South of Naples, Frederick III of the Kingdom of Sicily as well, passed a similar law in 1310 promising imprisonment for both the Jewish doctor and Christian patient.¹⁵¹ For Charles II’s legislation, if successfully implemented throughout his domain, it would imply that the Jewish licences granted in the Angevin Kingdom of Naples to Matteo Ebreo, physician,¹⁵² Mosè Ebreo, physician,¹⁵³ and Giuseppe di Venafro, surgeon,¹⁵⁴ were at risk of becoming defunct. As will be seen below, the strength of Charles’ anti-Jewish legislation, as well as neighbouring secular and ecclesiastical legislation, remained for a time, almost non-existent, and so too the threat against Jewish medical practice.

Prior to the fifteenth century, legislation against Jewish medical practice remained largely unsuccessful. The repeated variations of anti-Jewish legislation imply that there was, at least on the surface, a general feeling of fear toward Jewish doctors claiming a position of authority over Christian health. However, it can additionally be argued that the aggressive punishment toward both Jewish doctors and their Christian patients meant that the practice of hiring out Jewish doctors remained both distressingly common and required a powerful deterrent. Previous regional studies have found that Jewish doctors continued to treat both the

¹⁵⁰ Cited in Shatzmiller, *Jews, Medicine, and Christian Society*, 93.

¹⁵¹ Shatzmiller, *Jews, Medicine, and Christian Society*, 92-93.

¹⁵² Calvanico, *Fonti per La Storia Della Medicina*, no. 39, p. 4.

¹⁵³ Calvanico, *Fonti per La Storia Della Medicina*, no. 80, p.7.

¹⁵⁴ Calvanico, *Fonti per La Storia Della Medicina*, no. 223, p.20.

Jewish and Christian members of their communities, and were able to rise to great height and prominence within both ecclesiastical and secular powers. McVaugh noted that in the Crown of Aragon, “such prohibitions had few observable social consequences... [in] the early fourteenth century.”¹⁵⁵ Katherine Park, too, finds that the Florentine Guild of Doctors, Apothecaries, and Grocers “placed no special restrictions on Jewish doctors” and that “the thirteenth and fourteenth centuries witnessed the growth of deep respect for the Jewish medical tradition,” specifically in Spain, southern France, and Italy.¹⁵⁶

Just as societal pressures persuaded regional and state authorities to allow for exceptions within the medical profession and in granting medical licences, so too, did these similar pressures supersede religious prejudice. The retroactive cancellation of previous licences and subsequent punishments in the 1306 anti-Jewish Provençal legislation denoted the ferocity in which it wanted to eliminate Jewish medical practice, however, the legislation itself did not last more than a few months. Although there is no explanation for its retraction, the following select instances in Provence’s neighbours showcase the high likelihood that it was either due to overwhelming public pressure or a widespread disregard of said legislation. Perhaps too many exceptions to the regulation were granted for the legislation to carry any weight. In 1301, Jaume II of the Crown of Aragon, allowed a Jewish physician to treat the Franciscans of Valencia, and in 1309, in Zaragoza, granted its *probi homines* permission to allow both a Jewish physician and Jewish surgeon to practise within their city.¹⁵⁷ The city of Marseilles, in a statement released in 1381, announced its “urgent need for Jewish doctors,” while the citizens of the fifteenth-century Catalan city of Cervera presented a petition advocating city councillors to invite an acclaimed Jewish doctor to work in their city.¹⁵⁸ The

¹⁵⁵ McVaugh, *Medicine before the Plague*, 60.

¹⁵⁶ Park, *Doctors and Medicine*, 72- 73.

¹⁵⁷ McVaugh, *Medicine before the Plague*, 60, 61n.

¹⁵⁸ Shatzmiller, *Jews, Medicine, and Christian Society*, 112- 113.

council of Avignon (1337) had hinted at the discomfort the Church had toward male Jewish doctors treating female Christian patients for fear of sexual misconduct.¹⁵⁹ However, in 1464, within the Italian city of Gravedona, its citizens sided with their Jewish doctor, Master Angelo de Cesena, when his romantic connection to a Christian woman became public. Shatzmiller, further, hypothesized that Gravedona's citizens pressured the Christian woman to retract her statement so that Cesena could safely return and continue his practice.¹⁶⁰ The Avignon synod itself was overturned in 1341, due to a lack of available Christian doctors.¹⁶¹ As noted in the previous chapter, the exceptions to the medical profession came about from a scarcity of "qualified" practitioners, therefore, accepting medical care from "qualified," but Jewish, practitioners, became more palatable to the Christian community. As Shatzmiller observed, "...people in medical distress: they tend to overlook religious differences."¹⁶²

3.3.2 Implicit Exclusion of Women

Despite the growing distrust by academic authors, initially, regional laws neither immediately, nor explicitly attempted to dissuade women's medical practice. As Monica Green observed, "these first attempts to control non-university-trained practitioners are notable in that they were sexually egalitarian."¹⁶³ A few initial legislations even expected that women would present themselves for a licensing examination. The 1310 Florentine legislation included the stipulation that no *femina vel masculus* could practice medicine until examined,¹⁶⁴ and the faculty Paris, which arguably became the area with the most outspoken denunciation of women's medical practice, referred to in their 1271 decree of the medical practices of "*cirurgicus seu cyrurgica, apothecarius seu aptothecaria, herbarius seu*

¹⁵⁹ Shatzmiller, *Jews, Medicine, and Christian Society*, 88-89.

¹⁶⁰ Shatzmiller, *Jews, Medicine, and Christian Society*, 113.

¹⁶¹ Shatzmiller, *Jews, Medicine, and Christian Society*, 93.

¹⁶² Shatzmiller, *Jews, Medicine, and Christian Society*, 120.

¹⁶³ Green, "Gendering the History of Women's Healthcare," 447.

¹⁶⁴ Giacosa, *Magistri Salernitani Nondum Editi*, 660.

herbaria.”¹⁶⁵ Both regions did update their licensing regulations to place more importance on academic medicine, and, further, gave the power of licensing into the hands of the region’s governing medical body, but they still did not outright condemn women’s medical practice. Nevertheless, that did not mean the regulating bodies did not attempt to dissuade female medical practice, nor open up the profession for their entrance.

In fact, whether or not medical legislations explicitly excluded women from the profession, it appears that medical authorities throughout western Europe attempted to keep the keep the profession closed to women, except when demand necessitated their inclusion. As found in Florence, its Guild of Doctors, Apothecaries, and Grocers released a new statute in 1349, which prescribed,

That no doubt can arise over who are doctors, we declare that all persons in the city or countryside of Florence who practice physic or surgery, set bones, and treat mouths, whether they use writing or not, are understood to be doctors, and are to be held and considered doctors, and must swear obedience and submit to the guild and consuls...no new doctor, whether physician or surgeon, who does not have a doctorate may practice the art of medicine or heal in physic or surgery in the city or district of Florence, unless he has been examined by those consuls who are doctors, along with four doctors selected for the purpose by the consuls who are doctors, and approved as competent...¹⁶⁶

This statute left the responsibility of examination, for women’s only route into the guild was by examination, to doctors chosen by the guild, but it, nonetheless, did leave it open for women and Jews.¹⁶⁷ It, additionally, created special provisions to protect the reputation and livelihood of its doctors and that included reducing competition, as “the guild’s branch of doctors included people of widely differing social classes and medical training, from the physician with a doctorate from Padua to the shoemaker who couched cataracts; all, however,

¹⁶⁵ Henri Denifle, ed., *Chartularium universitatis parisiensis*, I (Paris : Delalain, 1889), 489. Although, there is no mention of *fisici seu fisica*, as such a distinction comes from the University of Paris, from which women were barred.

¹⁶⁶ Cited in Park, *Doctors and Medicine*, 20.

¹⁶⁷ Park, *Doctors and Medicine*, 21.

were fully licensed practitioners.”¹⁶⁸ The concern by medical authorities over the threat of competition likely negatively impacted women’s medical practice and is explored further in the following chapter, but, in short, very few women have been “officially” identified as practitioners. Katherine Park had been able to unearth only six women that practiced in Florentine, four that matriculated in the guild, and the other two from tax records, all between 1353 to 1408. This confirmed “the impression left by the guild statutes and by contemporary accounts that the medical profession was relatively open in the decades immediately following the first epidemic of plague.”¹⁶⁹ Therefore, even without explicitly excluding women from the profession, obtaining “official” standing as a medical practitioner was rare, and in the case of Florence, came about in response to the demand created by an extreme health crisis.

The medical authorities in Paris explained their reasoning in refusing to grant legitimacy to women’s medical practices. In 1311, the medical faculty in Paris obtained the right to prosecute unlicensed medical practice, and successfully exercised their right the year after in the case of Clarice de Rothomago’s illicit medical practice.¹⁷⁰ Later, in 1322, the medical faculty once again prosecuted a group of both men and women for illicit and unlearned medical practice. In the case of Jacoba Felicie, her sex became the point in which the arguments centred upon.¹⁷¹ The faculty connected literacy with medical knowledge and accused Jacoba of, “*totaliter est ignara artis medicine et non litterata,*” although Jacoba insisted she knew medical theories. Following their accusation of Jacoba’s illiteracy, and despite her witnesses confirming her competence, they furthermore argued, “*tum quia prohibitum est in jure ne mulier possit esse advocatrix et testis in causa criminali, et quod*

¹⁶⁸ Park, *Doctors and Medicine*, 23.

¹⁶⁹ Park, *Doctors and Medicine*, 71- 72.

¹⁷⁰ Kibre, “The Faculty of Medicine at Paris,” 7.

¹⁷¹ Wallis, *Medieval Medicine*, 366.

multo fortius potest sibi de jure inhiberi, ne practicet dando infirmis intra corpora eorum potus, cibos et clisteria, cum nullum causam infirmitatis infirmorum per litteram vel artum medicine cognoscat, cum multo fortius sit periculosum occidere hominem per tales potus et clisteria, quam causas civiles perdere per ignorantiam et inscientiam advocatorum."¹⁷² Thus, to the Parisian medical faculty, women, through their ignorance, had no business nor claim within either of these professions.

It was in Valencia, in 1329, that a state promulgated its first legislation explicitly against women's medical practice. The Valencian *furs* 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.¹⁷³

Garcia-Ballester, McVaugh, and Rubio-Vela, suggested that the passage of this law was not aimed at women, specifically, but as a "response to a regional phenomenon that was perceived as a cultural and religious threat" to prevent Muslim *metgesses* from treating Christian women in obstetric and gynaecological matters.¹⁷⁴ Even so, Monica Green countered, "we should not, however, overlook the fact that it is simultaneously excluding them (and all other women) from other forms of practice."¹⁷⁵ Especially as it pushed healthcare further into the hands of men since an important element of medieval medical care involved administering "potions."¹⁷⁶

Despite the overall lack of *explicit* restrictive legislation, barring Valencia, as this study showed, there was an *implicit* gendered connotation within the various legislations throughout western Europe that prevented women, as a whole, from the level of documented success that Christian and Jewish (male) doctors enjoyed. As observed, the legislation against

¹⁷² Henri Denifle, ed., *Chartularium universitatis parisiensis*, II (Paris : Delalain, 1889), 266.

¹⁷³ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 62.

¹⁷⁴ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 32.

¹⁷⁵ Green, "Women's Medical Practice," 449.

¹⁷⁶ Green, "Women's Medical Practice," 449, n.46.

Jewish medical practice, while anti-Semitic, never attacked their intellectual capabilities as physicians and surgeons. Of course, Jewish (male) doctors, like their Christian counterparts, were brought forward on cases of illicit and “ignorant” practices but these were not charges that defined, or negatively impacted, their medical practice, as a whole. Women’s practice, on the other hand, was usually lumped with the “empirics,” and the “unlearned.” Thus, while regional laws were hypothetically open to women’s medical practice, the available documentation suggests that either women were not reaching the prescribed qualifications, or they did not present themselves for documentation as men did. In regard to the former hypothesis, McVaugh found through his observation of fourteenth-century Catalanian medical practice that there was, “no systematic animus against women,” but even so, of the four women he found practicing medicine, all were surgeons.¹⁷⁷ In one of the cases, in 1342, the king prevented the royal justiciar from acting against the unlicensed surgical practice of the Jew Astruga “on the grounds that Astruga was practicing surgery alone, not medicine.”¹⁷⁸ As a result, McVaugh placed forth the question that perhaps women found it both easier to pursue a surgical profession and that women were tolerated in surgery because “it did not presume the academic training from which women were debarred?”¹⁷⁹ The records from Naples certainly endorsed this hypothesis, as will be seen further down. However, the Jewish were also excluded from the same academic training, and explicitly targeted, yet they were granted leave to practice as physicians in Naples and elsewhere. The pivotal difference, then, was in their access and understanding of the medical texts.

¹⁷⁷ McVaugh, *Medicine before the Plague*, 107.

¹⁷⁸ The king also did not see Astruga as a danger because she was only treating Jews.

¹⁷⁹ McVaugh, *Medicine before the Plague*, 107.

3.4 Literacy

3.4.1 Establishing a Jewish Medical Literary Tradition

Monica Green noted that an absence of a medical literary tradition among medieval women played a part in the decline of women's medical participation¹⁸⁰ but, as Shatzmiller found, the Jewish population managed to avoid this pitfall. The medieval western European Jewish population owed a great deal of their success to their Arab and Arabic-speaking counterparts. While the medicalization of western Europe gained traction during the thirteenth century, the Jewish communities of Christian Europe did not have an established medical literary tradition.¹⁸¹ As noted previously, medical licensing authorities based their examinations on a set of medical texts, which were known to the public. The examination involved a *lectio* portion that consisted of a technical reading of the assigned medical texts, and could additionally, include providing an analysis of words and phrases, and a series of questions and responses to test the candidate on the "principles of medical science."¹⁸² Since a university education was by and large closed off to them, the Jewish population's only recourse to enter the profession depended on private tutoring and an access to the medical works. Scholars in Muslim controlled lands translated a great many Greek scientific texts into Arabic throughout the eighth and ninth century, and by the twelfth century, Jewish doctors of the Islamic world had been well integrated into the medical profession. Point of fact, many Jewish libraries of the Islamic world have been found to contain the Greek and Arabic scientific and medical texts of Galen, Averroës, Avicenna, Hippocrates and Razes.¹⁸³ Spain's earlier Islamic rule, in particular, became a great boon for Jewish medical practice, as when Islamic Spain fell under Christian control, many Jews owned and understood the Arabic

¹⁸⁰ Green, *Making Women's Medicine Masculine*, 316- 317

¹⁸¹ Shatzmiller, *Jews, Medicine, and Christian Society*, 10.

¹⁸² Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 13. Shatzmiller, *Jews, Medicine, and Christian Society*, 37.

¹⁸³ Shatzmiller, *Jews, Medicine, and Christian Society*, 13, 39-40.

medical books in their possession. Additionally, since the Jews of Italy had little trouble learning Latin, in the late thirteenth to fourteenth century they were proactive in translating Latin medical and scientific texts into Hebrew.¹⁸⁴ Thus, once it became clear that certain medical texts and theories became vital to a successful medical career, Jews “had the primary task of investing talent, money, and effort in translating an entire medical library into Hebrew, mostly from Arabic.”¹⁸⁵

The well-established and well-regarded Jewish “reputation for medical learning,”¹⁸⁶ and the reality of medieval university matriculation rates, thus, allowed Jewish medicine to thrive. A university education was desired by many prospective doctors, since graduates would be placed at the top of the medical hierarchy. Nevertheless, as well regarded as a university education was, its high cost of tuition ensured a low number of graduates that could not meet societal demands.¹⁸⁷ Private tutorship, then, for both Jews and Christians, provided the rest, and comparatively more numerous, supply of doctors. In choosing one or the other, McVaugh observed, “the choice of physician by patients of *any* religion had really been determined primarily by personal considerations. There was in general little to distinguish practice from Christians from that by Jews...”¹⁸⁸ As seen in the case of Peter the Ceremonious, the fourteenth-century King of Aragon, noble households commonly hired multiple doctors and arranged them into ranks of seniority based on title. If a physician held a university title, he would immediately be placed higher than his privately- educated counterpart. However, if they both held the same title, the one hired first was granted the senior position,¹⁸⁹ and, thus, we can presume that the doctor, Jewish or Christian, with the better reputation would have been approached first. Skill, not religion, then, played a

¹⁸⁴ Shatzmiller, *Jews, Medicine, and Christian Society*, 52.

¹⁸⁵ Shatzmiller, *Jews, Medicine, and Christian Society*, 54-55.

¹⁸⁶ McVaugh, *Medicine before the Plague*, 62.

¹⁸⁷ Shatzmiller, *Jews, Medicine, and Christian Society*, 7.

¹⁸⁸ McVaugh, *Medicine before the Plague*, 63.

¹⁸⁹ Shatzmiller, *Jews, Medicine, and Christian Society*, 55.

deciding factor in the success of a medieval doctor. Thanks to the equalizing effect of the Jewish medical literature, Jewish physicians had access to the scientific medical texts from which to successfully build their medical practice. As Shatzmiller found, many Jewish doctors achieved great medical success throughout the late medieval period. Occasionally, Jewish doctors obtained reputations so great they were granted highly esteemed positions within both secular and ecclesiastical circles, as well as tax exemptions, influence, and leadership positions within their communities, among other privileges.¹⁹⁰ In one extreme instance, a thirteenth-century Jewish, Aragonese oculist, master Vidal Esperçero was kidnapped en route to treat a nobleman's wife and held for ransom.¹⁹¹

Additionally, the common practice, by both ecclesiastical and secular authorities, in hiring Jewish doctors took a lot of the teeth out of the anti-Jewish legislation. The frustrated Arnau de Vilanove wrote to both Jaume II of Aragon and his brother, Frederick III of Sicily, about this concern and urged them both to prohibit Jews from treating Christians. Arnau found more success in Frederick III than Jaume II, and influenced the creation of the 1310 Sicilian anti-Jewish legislation, mentioned above.¹⁹² Nevertheless, popes, archbishops, bishops, low-ranking clergy members, convents and nunneries all have been observed obtaining the services of Jewish doctors throughout the late medieval period. In fact, only a few popes during the late medieval and Renaissance period did not employ a Jewish doctor.¹⁹³ As Arnau complained in his letter to Frederick III, "... the custom is for no other physician to enter cloisters unless he is Jewish, such is the case not only of cloisters for men but for women as well,"¹⁹⁴ Furthermore, as mentioned briefly above, records from royal and

¹⁹⁰ Shatzmiller, *Jews, Medicine, and Christian Society*. Shatzmiller's fourth chapter "Reputation: Brilliant Medical Careers," provides numerous examples of the various privileges, royal favours, and grand medical reputations many Jewish doctors achieved.

¹⁹¹ Shatzmiller, *Jews, Medicine, and Christian Society*, 67.

¹⁹² McVaugh, *Medicine before the Plague*, 60.

¹⁹³ McVaugh, *Medicine before the Plague*, 94.

¹⁹⁴ McVaugh, *Medicine before the Plague*, 94-95.

noble households of England, Spain, France, and Italy, show that many continued to request and hire the services of Jewish doctors, especially those of international repute.¹⁹⁵ King Pedro IV of Aragon, and Queen Johanna of Naples both included Jewish doctors as part of their “consortium of doctors,” in the fourteenth and fifteenth centuries, respectively.¹⁹⁶ Meanwhile in 1349, another Johanna, this time the queen of Navarre, was not above begging the neighbouring kingdom of Castile to force a reputable Jewish doctor named Salomon to treat her, after the doctor’s initial refusal.

3.4.2 Women’s Education

Literacy proved to be the important key factor in the creation of professional medical identities, regardless of class or religion,¹⁹⁷ but for women, access to similar medical books, literary tradition, and training proved to be a different matter. As the previous section demonstrated, in their proactive efforts in creating a Jewish medical literary tradition, the Jewish community closed the gaps towards their medical education in an attempt to keep up with the Christian university tradition. Examinations for a surgeon’s licence in the Kingdom of Naples did not view literacy as a cause for dismissal from the profession, which, in part, explained women’s presence, but the physician’s examination, as observed, placed a great deal of importance on the *lectio* portion of training. As seen among Neapolitan licences, none of the thousands of licences granted to physicians in Naples described the candidates as an *ydioita*. However, women’s absence as physicians in the late medieval Neapolitan licences suggest that women’s lack of book-learning may still have been an impediment. As Monica Green finds, “women’s engagement with medical literature- not just gynaecology, but medical works of any sort - had not been extensive in the Middle Ages.”¹⁹⁸

¹⁹⁵ Specific examples can be found in Shatzmiller, *Jews, Medicine, and Christian Society*, 65- 70.

¹⁹⁶ Shatzmiller, *Jews, Medicine, and Christian Society*, 58, 60.

¹⁹⁷ Green, *Making Women’s Medicine Masculine*, 129.

¹⁹⁸ Green, *Making Women’s Medicine Masculine*, 301.

First, identifying how literate the documented female practitioners were is impossible, unless the records make explicit mention of it. From the Kingdom of Naples, of the nearly thirty documented licences granted to women, all but one were for surgery. This harkens back to McVaugh's earlier theory that there existed a higher tolerance for women as surgeons, rather than physicians. Despite the growing popularity of surgical lectures within the Italian universities, surgical practice in Italy did not place a great deal of importance in theoretical knowledge over proven technical skill. The state granted full, "specialized," and "restrictive" surgical licences to both the learned and *ydiota*. As the licences show, a third of those that were awarded to women, those to Isabella da Ocre,¹⁹⁹ Lauretta, wife of Giovanni dal Ponte da Saracena,²⁰⁰ Margherita da Venosa,²⁰¹ Polisenia de Troya,²⁰² Francesca, wife of Matteo dal Romano da Salerno,²⁰³ Raymunda de Taberna,²⁰⁴ Sabella di Orco,²⁰⁵ and Vigorita da Rossano,²⁰⁶ stated that these women were *perita ut ydiota* or *chirurgia idiota*. The rest did not offer any information toward their literate status, but, as Monica Green asserted, there is nothing that indicated that the rest of the women had any book learning either.²⁰⁷

Monica Green produced a comprehensive study that detailed the gendered differences in the ways men and women interacted with literate medicine.²⁰⁸ The early education of young boys and girls was the first divergence that impacted women's presence within the medical profession. From childhood, the type of learning young boys and girls were offered differed. A young girl's education remained informal and homebound although, in certain

¹⁹⁹ Calvanico, *Fonti per La Storia Della Medicina*, no. 3195, p.229.

²⁰⁰ Calvanico, *Fonti per La Storia Della Medicina*, no. 1413, p.156. Duplicates in no. 2023 and 2026, p.208.

²⁰¹ Calvanico, *Fonti per La Storia Della Medicina*, no. 3226, p.232.

²⁰² Calvanico, *Fonti per La Storia Della Medicina*, no. 3598, p.268. Duplicate in no. 3610, p. 269- 70.

²⁰³ Calvanico, *Fonti per La Storia Della Medicina*, no. 1451, p.159. Duplicate in no. 1872, p.194.

²⁰⁴ Calvanico, *Fonti per La Storia Della Medicina*, no. 3643, p.277- 78.

²⁰⁵ Calvanico, *Fonti per La Storia Della Medicina*, no. 3071, p.219.

²⁰⁶ Calvanico, *Fonti per La Storia Della Medicina*, no. 3512, p.254.

²⁰⁷ Monica H. Green, "Medicine in Southern Italy: Six Texts (twelfth–fourteenth centuries)," in *Medieval Italy: Texts in Translation*, ed. Katherine L. Jansen, Joanna Drell, and Frances Andrews, (Philadelphia: University of Pennsylvania Press, 2009).

²⁰⁸ Green, *Making Women's Medicine Masculine*.

instances, they may have obtained some elementary form of schooling, taught in the vernacular, but hardly anything more advanced than that.²⁰⁹ For young boys, after their elementary education they could move onto a more formal style of secondary education: grammar schools, which taught Latin literacy, grammar, rhetoric, and logic. Afterwards, if the men could afford it, university medical education remained open to them.²¹⁰ The advantages did not end there either. Three years study of logic was a requirement of medical education according to Frederick II's Constitutions, as well as Aristotelian natural philosophy, which were both skills men received through their secondary education.²¹¹ Men who were trained in other literacy dependent, women- exclusionary professions, such as clerics and notaries, could just as well interact with the medical texts,²¹² and as Green discovered, many of these very same men claimed the theoretical, medical texts among their possessions.²¹³

In a similar search among high and late medieval women's possessions, there is less evidence of women interacting with the medical literate culture. Both the number of medical books owned by women and the medical texts written for women's use was extremely small, which was "directly indicative of the limited engagement that women had with medical writings, even writings on topics specific to women."²¹⁴ That is not to say women did not own books at all. Often "works of religious instruction (books of hours, psalters, breviaries, saints' lives, guides for moral living, and so forth) will hold pride of place in female- owned collections followed, as a distant second, by romances and other belletristic literature...but it

²⁰⁹ Barbara A. Hanawalt and Anna Dronzek, "Women in Medieval Urban Society," in *Women in Medieval Western European Culture*, ed. Linda E. Mitchell (New York: Garland Publishing Inc., 1999), 33.

²¹⁰ Monica H. Green, *Women's Healthcare in the Medieval West: Texts and Contexts*. (Aldershot: Ashgate, 2000), 41.

²¹¹ Hartung, "Medical Regulations," 592. Green, *Women's Healthcare in the Medieval West*, 41.

²¹² Green, *Making Women's Medicine Masculine*, 130.

²¹³ Green, *Women's Healthcare in the Medieval West*, 40.

²¹⁴ Green, *Women's Healthcare in the Medieval West*, 5.

is unusual rather than normative for medical books to be in their hands.”²¹⁵ Of the medical texts created for women, they were “works intended to help women maintain their health or works that offer basic information on self- treatment but no rationalized explanations of how the body functions or why medicinal substances work,”²¹⁶ none of which would be sufficient in passing the licensing examination. Nevertheless, even if women had access to the theoretical readings, be it through their fathers or husbands, their educational upbringing made it difficult for them to truly interact with the texts. In a very clear example of how, within the same family, gender determined literacy, the surgeon, Raymunda de Taberna, was noted to be a *ydiota*, yet, her licence took care to note that her brother was a notary.²¹⁷ Even the catalogues and inventories of female religious institutions, where literacy levels were expected to be high, found that their best documented and best supplied libraries held, at best, a couple medical texts.²¹⁸ Thus, the literacy women obtained, including cloistered religious women, was not enough to obtain a scholastic medical education through the theoretical texts, as women’s literacy was kept “below the level where they could readily engage with technical literature.”²¹⁹ As Monica Green expressed, “it is a question of the basic intellectual skills that one would have in order to read, comprehend, *and appreciate* medical works that aspired to any theoretical sophistication.”²²⁰ Thus, according to Green, “[w]omen’s limited literacy, therefore, combined with the cultural beliefs in women’s minimal intellectual capacity and social norms that constrained the public behaviour of women, set clearly *gendered* boundaries to how women could interact with the culture of learned medicine.”²²¹

²¹⁵ Green, *Women’s Healthcare in the Medieval West*, 10-11.

²¹⁶ Green, *Women’s Healthcare in the Medieval West*, 24.

²¹⁷ Calvanico, *Fonti per La Storia Della Medicina*, no. 3643, p.277-78.

²¹⁸ Green, “Books as a Source of Medical Education,” 345.

²¹⁹ Green, “Books as a Source of Medical Education,” 356.

²²⁰ Green, *Women’s Healthcare in the Medieval West*, 41.

²²¹ Green, *Making Women’s Medicine Masculine*, xiv.

As such, since surgery was not dependent on literacy, it clarifies why women appeared more prominently among surgical licences in late medieval Naples, than as physicians.

3.5 The Suppression of Clerics

To further cement the notion that gender, literacy, and skill played the prominent role in a professional medical practice, rather than the effectiveness of regulation or access to universities, we can briefly turn to clerical medical practice. This study mentioned earlier that the growing professionalization of medical care and the “nascent money economy” that arose during the twelfth century transformed medicine into a lucrative profession.²²² As a result, ecclesiastical authorities began to voice their growing concern that monks and clerics practiced and provided medical care for others to the detriment of their religious duties.²²³

3.5.1 A Changed Opinion

The first note of concern arose from the regional Council of Clermont’s edict of 1130, closely followed by the Council of Rheims’ edict of 1131. As regional council edicts, they could, at best, affect their area of jurisdiction and did not speak for all of European Christendom.²²⁴ Nonetheless, they introduced the first of many sentiments against their practice such that in 1139, Pope Innocent III passed a general decree during the Second Lateran Council about the medical study by monks and canons regular, nearly identical in writing to the former two but applicable to all of Christendom. The decree begins by outlining their most pressing concern that,

“an evil and detestable custom, we understand, has grown up in the form that monks and canons regular, after having received the habit and made profession, despite the rule of the holy masters Benedict and Augustine, study jurisprudence and medicine for the sake of temporal gain. Instead of devoting themselves to psalmody and hymns, they are led by the impulses of avarice to make themselves defenders of causes and, confiding in the support of a splendid voice, confuse by the variety of their statements what is just and unjust, right and wrong. The imperial constitutions, however, testify that it is

²²² Wallis, *Medieval Medicine*, 363.

²²³ Kibre, “The Faculty of Medicine at Paris,” 4. Shatzmiller, *Jews, Medicine, and Christian Society*, 8.

²²⁴ Darrel W. Amundsen, “Medieval Canon Law on Medical and Surgical Practice by the Clergy,” *Bulletin of the History of Medicine* 52 (1978): 26.

absurd and disgraceful for clerics to seek to become experts in forensic disputations. We decree, therefore, in virtue of our Apostolic authority, that offenders of this kind be severely punished...”²²⁵

Unlike the regional laws mentioned in the previous chapter, it is clear that it was not the medical capabilities of clerics that concerned the Church authorities, but rather the temptation of greed that came from practicing medicine and secular law. The Church authorities believed that this avarice led to “the care of souls being neglected and the purpose of their order being set aside” by monks and canons regular, and, further, that monks and canons regular “promise[d] health in return for detestable money and thus make themselves physicians of human bodies,” over that of the spirit.²²⁶ Despite its firm stance, David Amundsen concludes that the Church directed this warning just to monks and church regulars, and that secular clerics continued to remain free to study and practice medicine.²²⁷ Following the Second Lateran Council, the regional councils of Montpellier in 1162, Tours in 1163, and Paris in 1213, enacted updates and clarified their punishment. The canon of Tours and Paris asserted that the guilty clerics were to be excommunicated if they left the cloister to study medicine and failed to return within two months. If they should return, they were essentially to become *persona non grata*, last in all aspects of the community.²²⁸

Pope Honorius III enacted his own prohibition into the practice of medicine in 1219 in his rescript, the *Super specula*. He reiterated the same threat of excommunication and punishment as Tours and Paris. After, he followed with his own additions:

...we wish and order that this [prohibition] be extended to archdeacons, deacons, rural deans, priors, cantors and other clerics having benefices, and also to priests, unless they desist from these things within the prescribed period, and that [this order] be firmly enforced, with the right of appeal having been rescinded.”²²⁹

²²⁵ Cited in Wallis, *Medieval Medicine*, 363.

²²⁶ Wallis, *Medieval Medicine*, 363.

²²⁷ Amundsen, “Medieval Canon Law,” 30.

²²⁸ Amundsen, “Medieval Canon Law,” 31- 35.

²²⁹ Cited in Amundsen, “Medieval Canon Law,” 34-35.

Honorious' enactment now widened the pool of clerics forbidden to study medicine from "regular clergy", that is those that lived under a rule, to any cleric whose "major functions were spiritual and to those who possessed ecclesiastical benefices to which they owed their primary responsibilities."²³⁰ This edict denoted the Church's continued concern that, just as the earlier decree of the Second Lateran Council worried over the "care of souls", this ignorance now evolved into devaluing theological study for the more profitable medicinal studies. The repeated promulgation of the Church edicts imply that this remained an ongoing problem.

While the edicts prevented the monks and regular clergy from *leaving* the cloister to study medicine, it did not necessarily prevent them from the knowledge nor the practice of medicine. Latin- medical texts obtained their start within monasteries, and they continued to be housed among the libraries of cloistered men. Large cloisters' libraries commonly possessed dozens of medical volumes, which had the capability to bring the men "into the same intellectual universe that university men...participated in throughout Europe."²³¹ The very same intellectual universe charged high fees for their medical services, and so clerics teaching other clerics medicine became viewed as a matter of Christian charity; a means for the poor to receive free healthcare.²³² More importantly to this study, the clerics drew upon their clerical education to engage with the literate medical works.

The practice of surgery by regular clerics and monks, too, became a point of contention, though, once again, it was not all encompassing. The edict passed at the Fourth Lateran Council, in 1215, ordered that "no subdeacon, deacon, or priest shall practice the part of surgery involving burning or cutting," but other aspects of surgery presumably remained

²³⁰ Amundsen, "Medieval Canon Law," 36.

²³¹ Monica H. Green, "Books as a Source of Medical Education," 357- 358.

²³² Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 22.

fair game.²³³ Once more, the Church was not concerned about the medical skill of the cleric but his spiritual responsibilities. In a rescript written in 1212, Pope Innocent III gave his ruling on whether a monk, who was also a priest, should be found responsible and “lawfully exercise the priestly office” after the surgical death of a woman with a tumor in her throat.

The monk

...acting as a surgeon, opened the tumor with a knife. When the tumor had healed somewhat, he ordered the woman not to expose herself to the wind at all lest the wind, stealing into the incision in her throat, bring about her death...

The woman ignored his order, her incision opened, and she died. Before she died, however, she took full responsibility for her actions and absolved the monk-priest from any wrongdoing. Innocent III ruled that

...although the monk himself was very much at fault for usurping an alien function which very little suited him, nevertheless he did it from piety and not from cupidity, and was an expert in the exercise of surgery and was zealous to employ every diligence which he ought to have done, he must not be condemned for that which happened through the fault of the woman against his advice.²³⁴

Thus, even with the monk’s expert surgical skill acknowledged by Innocent III, he still viewed the monk’s actions as “ill- suited.” The reason being that had the woman died as a result of his intervention, no matter how well-intentioned, the monk would have been barred from fulfilling his priestly office. Amundsen argues the later legislation of the canonical surgical restriction arose from the Church’s attempts to prevent regular clergy from being “severely affected by incurring canonical irregularity.”²³⁵ Thus, Church concern in medical care lay in the fulfilment of spiritual responsibilities and the vice of greed, and not towards the competence of their care .

²³³ Amundsen, “Medieval Canon Law,” 40.

²³⁴ Amundsen, “Medieval Canon Law,” 39.

²³⁵ Amundsen, “Medieval Canon Law,” 41.

3.5.2 Success and Failure

With Amundsen's conclusions in mind, how were the licensed clergy found within the Neapolitan records affected by the Church doctrine? For one, Shatzmiller notes that while the prohibitions did not necessarily eliminate clerical medical practice, they did severely reduce their numbers.²³⁶ Among the thousands of Neapolitan records, not many members of the Church received licences. Pietro da Sulmona, a cleric examined between 1292 to 1293²³⁷, *magistro* Iohanne de Tocco, a *phisico et canonico* examined on 1295,²³⁸ and Simone di Nicola, a cleric examined between 1302 to 1303,²³⁹ were the few to be identified as belonging to a religious order. Unfortunately, one of the many disadvantages of going through the licences is that the lack of clerical title does not mean the title did not exist. Iohanne de Tocco appeared within his own licence as a *phisico et canonico*, but he also appeared in over a hundred other licences as the state examiner. As the medical examiner, Iohanne was labelled interchangeably as a mix of *clericum*, *phisicum*, and *medicinalis scientie doctorem*. In many licences, his affiliation to the Church was not mentioned, so it would be incorrect to assume the labels granted to each individual captured their religious affiliation. However, when considering the patterns that occurred in neighbouring European regions into consideration, the observation that Christian lay practitioners increasingly outnumbered their clerical counterparts proved to be common.²⁴⁰

Comparatively speaking, we find more members of the Church as state examiners than as candidates. Of the about forty examiners, five are identified in the licences as clerics, regular or secular, and one more is identified by Ronald Doviak in his study. The first is Adam de Braya, *clericum*, who examined *magistro* Jacobo de Suessa in 1274.²⁴¹ Next,

²³⁶ Shatzmiller, *Jews, Medicine, and Christian Society*,

²³⁷ Calvanico, *Fonti per La Storia Della Medicina*, no.1161, p.141.

²³⁸ Calvanico, *Fonti per La Storia Della Medicina*, no. 259, p.25.

²³⁹ Calvanico, *Fonti per La Storia Della Medicina*, no. 724, p.96.

²⁴⁰ McVaugh, *Medicine before the Plague*, 75.

²⁴¹ Calvanico, *Fonti per La Storia Della Medicina*, no. 41, p.4.

Abbatem Symonem was the *archpresbiterum* of the San Giovanni Maggiore of Naples as early as 1290, a *medicinalis sciencie doctorem*,²⁴² and an instructor at Naples between 1278 to 1306.²⁴³ *Magister* Iohannis de Tocco, *canonico, clericum, phisicum, and medicinalis sciencie doctorem*, previously mentioned, promoted to state medical examiner, can be found in many licences between 1295 to 1304. Tocco, too, instructed at the University of Naples between 1294 to 1308, and in 1304 practiced as a priest at the Church of S. Croce di Bari.²⁴⁴ Guglielmo di Sandonnino was labelled as a physician, cleric, and “familiar to the king” on a licence granted on 1296,²⁴⁵ and known to have received a tonsure.²⁴⁶ In 1300, *frater* Bernardus, was the only licensed surgeon within the Neapolitan records visibly affiliated with a holy order, and became a surgical examiner himself.²⁴⁷ Finally, Matteo di Platamone is identified within Calvanico’s documents only as a *fisici* examiner on 1319,²⁴⁸ but was also, according to Doviak, the Archdeacon of the Cathedral of Cappaccio, Rector of the Church of S. Salvatore di Fundicario of Salerno, and a professor of medicine at Naples as early as 1309.²⁴⁹ As examiners, university graduates, and, for some, university professors, they “represented the highest degree of medical competence available in the kingdom.”²⁵⁰ The annual salary of a professor of medicine at Naples could range between twelve to thirty- six ounces of gold, as well as bonuses, such as, a noble title and land grants.²⁵¹ Some, however, reached this level of prestige seemingly against Church regulation. According to Honorius’s *Super specula*, *Magister* Iohannis de Tocco, the *abbatem* Symonem, and Matteo di

²⁴² Calvanico, *Fonti per La Storia Della Medicina*, no.204, p. 18.

²⁴³ Doviak, “The University of Naples,” 48.

²⁴⁴ Doviak, “The University of Naples,” 48.

²⁴⁵ Calvanico, *Fonti per La Storia Della Medicina*, no. 297, p. 30. “*Esaminato da Guglielmo di Sandonnino medico, chierico e familiare del re.*”

²⁴⁶ Doviak, “The University of Naples,” 49.

²⁴⁷ Calvanico, *Fonti per La Storia Della Medicina*, no.413, 415, p.50.

²⁴⁸ Calvanico, *Fonti per La Storia Della Medicina*, no.1757, 1766, p.184, 185

²⁴⁹ Doviak, “The University of Naples,” 49.

²⁵⁰ Doviak, “The University of Naples,” 46.

²⁵¹ Doviak, “The University of Naples,” 28- 29.

Platamone, as a priest and archdeacons of their respective churches, should not have been as heavily involved in the study of medicine as they appeared to be. Even as professors rather than students, they violated the spirit of the regulation as the contention reminded them that they were 1) leaving their cloister for medical study and 2) earning a wage from the profession. Matteo di Platamone, appearing among the records in 1309, at the earliest, may have been granted clemency, as Boniface VIII passed a decree, in 1298, that loosened the previous medical restrictions so long as

...permission is first given to depart for study by his prelate with the consent of his religious house or the majority of its members...²⁵²

The same cannot be said of Iohannis de Tocco and the *abbatem* Symonem, having both worked prior to Boniface's dispensations and in violation of Honorius' edict.

Nevertheless, the prohibitions by the Church did not appear to be effective outside of Naples, either. Prior to his ascension as pope in 1276, Pope John XXI studied medicine in Siena and Paris, an action that evidently did not impact his advancement within the Church hierarchy.²⁵³ In 1298, Pope Celestine V prohibited clerics with ecclesiastical benefices from practicing for profit, but Danielle Jacquart finds "un grand nombre de médecins (15,6%), principalement parmi les universitaires, obtinrent une ou plusieurs prébendes."²⁵⁴ Jacquart concludes that "cette injonction soit restée lettre morte."²⁵⁵ Even among members of major orders, receiving a papal exemption was not unusual as "parmi les médecins bénéficiés, il est attesté que 44,5% (soit 6,9% du total des médecins) parvinrent au sacerdoce."²⁵⁶ Finally, Theodoric of Lucca published his well-received *Chirurgia* while the bishop of Bitonto in the

²⁵² Amundsen, "Medieval Canon Law," 37.

²⁵³ Shatzmiller, *Jews, Medicine, and Christian Society*, 11.

²⁵⁴ Jacquart, *Le milieu médical*, 155.

²⁵⁵ Jacquart, *Le milieu médical*, 155.

²⁵⁶ Jacquart, *Le milieu médical*, 156.

mid- thirteenth century, and received a papal licence to keep his medical earnings for himself.²⁵⁷

Thus, the Angevin case studies here provide a few quick conclusions: the number of clergy to lay practitioners was minimal; the threat of excommunication and demotion toward regular clergy and priests if they left to study (or in this case, teach) medicine was either subject to exceptions or not regarded with any real seriousness; and finally, canonical restrictions did not prevent clergy, both regular and secular, from a position of high medical authority. Their clerical training may have even helped them. Nevertheless, their low numbers do point that their practice was uncommon and correlated to the general consensus by other scholars that the Church campaign to curb clerical medical practice was, somewhat, effective.²⁵⁸

Overall, clerics continued to practice medicine, though not as numerically, because they could slip between the cracks within the Church's anti-medical regulations. Leaving to study medicine was prohibited, but there was no restriction of learning the craft within their walls. As this study previously mentioned, the clergy's libraries, unlike the libraries of cloistered women, contained enough written medical works for clerics to earn a similar university education. We do not know for certainty where the clerics among the Neapolitan licences received their education, the few identified as *medicinalis scientie doctorem* likely from the nearby University of Naples, but undoubtedly, their background in clerical training allowed for a level of success women could not emulate. Secular clergy, as long as they did not earn ecclesiastical benefices, could continue to study and practice as they will. By 1298, the Church restrictions loosened up enough that acquiring Church dispensations to practice became an option, though prior to this exemption, clerics had disregarded the Church

²⁵⁷ Nancy G. Siraisi, *Taddeo Alderotti and His Pupils: Two Generations of Italian Medical Learning* (Princeton, N.J.: Princeton University Press, 1981) 15- 17.

²⁵⁸ Shatzmiller, *Jews, Medicine, and Christian Society*, 8-10, Park, "Medicine and society," 76-77.

regulations with little long-term consequence. The consumer population, of course, remained interested insofar as they could “consult physicians in whose competence and technical knowledge they had reason to believe.”²⁵⁹

3.6 Conclusion

The unlettered, the empiric, the Jew, the monk, the actor, the barber, the old woman- each pretends to be a doctor, as does the alchemist, the maker of cosmetics, the bath keeper, the forger, the oculist. While they seek profit, the power of medicine suffers...²⁶⁰

...at least according to a section of the thirteenth-century poem, *Regimen sanitatis Salernitanum*. The reality, however, was a little less black and white. The records from the Kingdom of Naples presented a diverse medical world, both in practice and practitioners, despite the criticism made in *Regimen* and by other medical authorities. Medical, royal, regional, and ecclesiastical authorities all had an opinion on who should be granted the privilege to heal, and they attempted to solidify their opinion through legislation with varying degrees of success. Previous scholarship, incorrectly, suggested that these very same male-controlled institutions conspired together to keep women from practicing,²⁶¹ but, as the *Regimen*, and this chapter illustrated, women’s practice had not been the only one viewed with suspicion, just the one least likely to have a literate background to draw on.

If polemics and legislative limitations played a large part in women’s marginalization in the medical profession, then this study should have found a similar result in the practices of others similarly targeted. Instead, the results were the opposite; Jewish practices remained successful, as long as there was a Jewish community in the region, and although clerical practices did decline, both, nonetheless, continued to be found in positions of medical authority within Naples and outside. Monica Green asserted it was “their participation in a

²⁵⁹ McVaugh, *Medicine before the Plague*, 75.

²⁶⁰ Cited from Park, “Medicine and society,” 76.

²⁶¹ Ehrenreich and English, *Witches, Midwives, and Nurses*.

shared literate culture that gave them access to theoretical principles of medical knowledge,”²⁶² which in turn gave them the *authority* to continue to practice medicine, despite the negative legislative stances. An authority that was, more often than not, denied to women. As the literacy of Jewish women appeared to be higher than that of Christian women,²⁶³ that may additionally explain the appearance of the Jewess, Virdimura, wife of Doctor Pasqual, as the only licensed female physician (so far) in the Kingdom of Naples.²⁶⁴ The demand for doctors, noted in the previous chapter, also played a role in the acceptance of Jewish doctors,²⁶⁵ and this chapter observed, briefly, how it facilitated Florentine women’s legitimization, as well. Overall, however, Monica Green found that, “because of [women’s] general exclusion from cultures of book learning, [women] could not play the game men did. Or to put it another way, instead of targeting knowledgeable women for suppression, learned masculine culture effectively prevented such women from coming into existence at all.”²⁶⁶

²⁶² Green, *Women’s Healthcare in the Medieval West*, 43.

²⁶³ Green, *Making Women’s Medicine Masculine*, 131.

²⁶⁴ Pierro, “Nuovi contributi,” 239.

²⁶⁵ Shatzmiller, *Jews, Medicine, and Christian Society*, 141.

²⁶⁶ Green, *Making Women’s Medicine Masculine*, xiii.

Chapter IV

By An Unspoken Rule Of Law

4.1 Introduction

In examining women's medical practice against the wider medical world, the previous chapters have illuminated the overarching conflicts that existed in healthcare during the late medieval period. Chapters Two and Three revealed a few of the pressures that resulted in the attempt to control and regulate the medical profession: the conflicting needs between upholding medical standards and providing available doctors for the community, between the municipal and royal authorities against medical authority, between community needs and prejudice, and between "empirics" and "learned" doctors. Often, of the few women documented practicing medicine, we find them situated in the middle of one or more of these conflicts.

While the previous chapters discussed how literacy, generally, excluded women from learned medical practices, this chapter takes the sparse data from Naples and situates them within these existing conflicts to find that there were additional social, economic, and professional factors that influenced (positively and negatively) the legitimization of women's medical practice. Sexual modesty, upbringing and training, economics, and conflicting authority, all exerted their influence in the type of medicine women were licensed to practice, and like literacy, can be traced back to the gender systems at play.

4.2 "*By their honesty of character*"

Jacoba Felice's defence argued in her 1322 trial that her presence as a doctor in Paris was required because,

it is better and more becoming that a woman clever and expert in the art should visit a sick woman, and should see and look into the secrets of nature and her private parts, than a man, to whom it is not permitted to see and

investigate the aforesaid, nor to feel the hand's, breast, belly, and feet, etc., of women.²⁶⁷

Monica Green observed that this defence did not carry much weight as there was “an inherent flaw in Jacoba’s argument.” Jacoba’s practice, “...as evidenced by the witnesses (all but one of whom are uniformly supportive of her competence), belies her claim that she specializes in “secret” diseases.” She is clearly treating both sexes (four of the eight witnesses are men) and none of the witnesses articulates any concern about shame nor are any of them being treated for gynaecological or andrological diseases.”²⁶⁸ As it stood, the Parisian courts, too, did not see the merits of Jacoba’s argument, finding them “frivolous” and “worthless,” declared her guilty, and excommunicated her for her medical practice.²⁶⁹

Despite the conclusion by the Parisian courts, the fact that the defence presented “women’s shame” and “women’s modesty” as a viable argument meant that there was at least some sort of rhetoric and concern around the dangers of male doctors with female patients. In Italy, a “strongly patriarchal and patrilineal society,” a woman’s sexual conduct and her family’s honour were intrinsically linked.²⁷⁰ This was due to the fact that “women had the greater potential to wreak symbolic violence through sex,” particularly in regard to inheritance. Consequently, courts, as well, intervened in cases of sexual misconduct and treated accusations of female adultery more severely than male adultery.²⁷¹ As Florentine patrician and humanist Matteo Palmieri declared in his sixteenth-century publication, *Vita Civile*,

Wives must exercise the greatest and most extraordinary guard not only against uniting with another man, but even to avoid all suspicion of such filthy

²⁶⁷ 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: A Journal of Gender and Sexuality* 42.1 (2006): 54.

²⁶⁸ Green, "Getting to the Source," 54.

²⁶⁹ Green, *Making Women's Medicine Masculine*, 114.

²⁷⁰ Michael Rocke, "Gender and Sexual Culture in Renaissance Italy," in *Gender and Society in Renaissance Italy*, ed. Judith C. Brown and Robert Davis, (New York: Longman, 1998), 151-152.

²⁷¹ Steven Bednarski, *Curia: A Social History of a Provençal Criminal Court in the Fourteenth Century* (Montpellier: Presses universitaires de la Méditerranée, 2013), 130.

wickedness. This error is a supreme disgrace to decency, it effaces honour, destroys union, renders paternity uncertain, heaps infamy on families and within them brings dissention and hatred and dissolves every relationship; she no longer deserves to be called a married woman but rather a corrupt wench, worthy only of public humiliation.²⁷²

Matteo's view was not limited to wives either, as a young unmarried woman's chastity reflected back and threatened the political standing of the men responsible for her upbringing.²⁷³ Since medicine and healthcare were usually a private affair that took place in the patient's home, there always remained the risk that something unseen and untoward could take place.²⁷⁴ When the medical condition of the woman involved their genitalia, the risk and concern of a compromised honour increased.

These concerns did not remain in the realm of hypotheticals either. In 1308, in the town of Manosque, *magister* Antoni allegedly entered into an adulterous relationship with the daughter of one of his patients. The courts never charged Antoni, but his wife, Isnard, and his "mistress", Doucette, were prosecuted for complicity and adultery, respectively. Antoni was nonetheless implicated in the affair.²⁷⁵ How his practice suffered afterwards is unclear, but it was these types of sexual encounters, imagined and real, that medical writers warned other practitioners as threats to their professional reputation.²⁷⁶ To further add suspicion to the dangers of male doctor and female patient medical encounters, we look to another case in Manosque that occurred on September 15, 1341. On that date, Alaxia Collard sought out the services of Crescas de Nîmes, *judeus qui est medicus*, for her daughter. Alaxia, herself, fell ill as well, and Crescass, knowing she could not afford his services, pressed her for sex in leu of payment. After Crescass persisted despite Alaxia's refusal, Alaxia contacted the authorities. The Manosquan court set a trap and subsequently caught Crescas in the act. Crescas was

²⁷² Roche, "Gender and Sexual Culture in Renaissance Italy," 152.

²⁷³ Roche, "Gender and Sexual Culture in Renaissance Italy," 151.

²⁷⁴ Green, *Making Women's Medicine Masculine*, 115.

²⁷⁵ Caley McCarthy, "Midwives, Medicine, and the Reproductive Female Body in Manosque, 1289-1500," (Master's thesis, University of Waterloo, 2011), 49.

²⁷⁶ Green, *Making Women's Medicine Masculine*, 115.

tried, found guilty, and punished with the loss of his member.²⁷⁷ These encounters, Caley McCarthy noted, “reflects the apprehensions regarding relationships between various groups of medieval society – those between men and women, but also between Jews and Christians.”²⁷⁸

Additionally, even within respectable and professional medical encounters between men and women, there remained certain limitations within the practice that both men and women were wary to cross. Inspection and touch of the genitalia became a complicated region of care for doctors, and “necessitated leaving open a space for women’s continued involvement as caretakers of other women.”²⁷⁹ In 1410, the Barcelonan court accused a knight, Arnau Alberti, of repeatedly raping three young girls. To get to the heart of the matter, the court hired several women, *madrina*, to examine the girls. From their examination, the women confirmed the accusations. Throughout Arnau’s trial, the court had physicians brought before the court to speak in the trial, but their presence remained unrelated to the medical inspection of the girls, as the court preferred to use women instead.²⁸⁰ Even Bruno of Longobucco, a strong proponent against women’s medical practice, acknowledged the need for male doctors to recruit “any woman sufficiently learned in the affairs of women,” when dealing with gynaecological and obstetrical illnesses, and fourteenth-century English surgeon, John Ardene, counselled against touching the breasts, hands, and private parts of women, “lest he anger the lord of the house.”²⁸¹ A similar threat to “women’s modesty” is found in the interplay between a female doctor and male patient as well. In 1321, Fava, a surgeon from Manosque, treated Poncius Porcelli with “plasters and

²⁷⁷ Bednarski, *Curia*, 132. McCarthy, “Midwives, Medicine, and the Reproductive Female Body,” 47- 50.

²⁷⁸ McCarthy, “Midwives, Medicine, and the Reproductive Female Body,” 48- 49.

²⁷⁹ Green, *Making Women’s Medicine Masculine*, 116.

²⁸⁰ Cabré, “Women or Healers,” 34- 35. Of course, the Barcelonan court may have also had the wherewithal to understand that the young girls, through their trauma, would be more comfortable being inspected by women. Nevertheless, the courts did trust the medical capabilities of the women to correctly proceed with the examination and provided a space for female practitioners.

²⁸¹ Green, *Making Women’s Medicine Masculine*, 118- 119.

other medicaments” after his “member” had been injured by Andreus Raynaudi. When the Manosquean court called Fava to testify on Poncius’ injury, the judge questioned Fava on whether she touched him. In an inverse of Bruno’s suggestion to male practitioners, Fava responded that her son Bonafos, also a surgeon, had done so in her stead.²⁸²

Thus, the gendered dynamics and perceived risks involved in an interaction between male doctors and female patients prompted a sexual division of medical labour within the Kingdom of Naples that left a space open in the medical profession for women. As the Neapolitan licences show, about half of the known surgical licences granted to women restricted their practice to the care of other women with a few of the surviving documents laying bare the state’s rationale for licensing women. On May 7th, 1343, Maria Incarnata presented herself to the Royal Court and “proved that [she] is competent in the principal exercise of surgery, in the treatment of wounds and apostemes [tumors].” The court, accepting her skill, granted her permission to continue her practice, but only to attend to female patients. According to Maria’s licence, the court reasoned that,

[a]lthough it should be alien to female propriety to be interested in the affairs of men lest they rush into things abusive of matronly shame and for this reason they risk the sin of forbidden transgression, [nevertheless] because the office of medicine is expediently conceded to women by an unspoken rule of law, it being noted that females, by their honesty of character, are more suited than men to treat sick women, especially in their own diseases...²⁸³

A similar justification was expressed in the 1321 surgical licence of Francisca, wife of Mathei de Romano of Salerno,²⁸⁴ the 1343 surgical licence of Margarita de Ruga,²⁸⁵ and the 1345 licence of Raymunda de Taberna.²⁸⁶ The rationale resurfaced again in the Kingdom of

²⁸² McCarthy, “Midwives, Medicine, and the Reproductive Female Body,” 95.

²⁸³ Translated in Green, “Medicine in Southern Italy,” 324-45. Original in Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3671, p.261. Monica Green wonders within “Getting to the Source,” whether Maria Incarnata’s licence, granted the year before Jacoba Felicie’s trial, was the basis behind Jacoba’s defence on the need for female doctors for female patients.

²⁸⁴ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 1872, p.194.

²⁸⁵ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3572, p.262.

²⁸⁶ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3643, p.277- 78.

Naples as late as 1404, in the licence of Donna Cusina di Filippo who was cleared, “*in medicandis vulneribus, ulceribus, apostematibus, doloribus, languoribus, egritudinibus et infirmitatibus ac aliis diversis morbis et passionibus*” of women because, “*ad mulieres curandas femine sunt viris aptiores*”²⁸⁷

The Kingdom of Naples was unique in that it used the rhetoric of “women’s modesty,” as a force behind granting women legal access into the profession. No other region throughout western Europe had been documented to employ the sexual division of labour as a justification to license women.²⁸⁸ This secured women’s continued, albeit small and limited, presence within the profession in Naples as late as the fifteenth century, but whether they followed the restrictions and kept their practice limited only to women is unknown. What is remarkable about the licences is that only two of them referred to directly treating the gynaecological matters of women. Maria Gallicia, licensed between 1309 to 1310, was skilled “*in arte chirurgie et ad curandum et practicandum in ea, videlicet in vulneribus apostematibus et crepaturis et in apostematibus matricis et aliis accidentibus matricis*,”²⁸⁹ and Margherita di Napoli da S. Maria, licensed between 1313 to 1314, was skilled “*in curandis vulneribus et apostematibus periculosis in mamillis et matrice*.”²⁹⁰ Both Maria Gallicia and Margherita di Napoli’s licences were one of the few granted to women that did not limit their practice to the “simple” or “external” forms of injuries, likely because of the sex and nature of their practice. Maria’s had the additional honour of being allowed to practice throughout the entirety of the kingdom, indicating either to her skill and/or the demand of her specialty.²⁹¹ The rest of the women were licensed for various other surgical

²⁸⁷ Francesco Pierro, “Nuovi contributi alla conoscenza delle mediche nel regno di Napoli negli ultimi tre secoli del medioevo,” *Archivio Storico Pugliese* 17, fasc. 1-4 (1964): 239.

²⁸⁸ Green, *Making Women’s Medicine Masculine*, 113.

²⁸⁹ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 1165, p.141.

²⁹⁰ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3534, p.256.

²⁹¹ Monica Green notes that a uterine prolapse, a condition unique to women, was “almost always mentioned, at least perfunctorily, in gynecological writings and general medical textbooks from the Salernitans on,” but that a, “uterine prolapse remained decidedly untheorized well into the fifteenth century... Instead, the kinds of

skills, the most peculiar licence belonging to Clarice di Durisio da Foggia. It was not Clarice's licence as an ophthalmologist that was strange, but that she was an ophthalmologist *only* for women.²⁹²

While the gendered and cultural notion of women's modesty allowed the continued inclusion of women in medicine, that did not suggest that "women's healthcare was women's business." Throughout the Neapolitan licences that were awarded to men in the late medieval period, not one had their medical practice restricted by gender, under concerns over "modesty," nor did men exclude themselves from caring for female patients. Instead, the only Neapolitan licensee whose practice was restricted to men was Stoyo di Sclamonia, *chirurgo*, who was "skilled in the incision and extraction of stones formed in the testicles and bladders of men and boys."²⁹³ This "restriction," of course, was not mandated by the state but rather, by the nature of Stoyo's surgical specialty; a specialty that was deemed essential enough that, just like Maria Gallicia, Stoyo was given no territorial restrictions to his practice.

Additionally, male doctors found ways to circumvent any implication of wrongdoing within their interaction with female genitalia, whether it be receiving permission and chaperones from the male head of household, or employing female assistants to look and manually intervene on his behalf.²⁹⁴ Furthermore, as this study has exhibited, patients, for the most part, were unbothered by the sex and religion of their doctors. Monica Green expressed that, "in fact female modesty was not the overwhelming motive force behind the social structuring of women's medical care throughout the rest of Europe."²⁹⁵ It seems then that the state

treatments male practitioners recommended continued to stay on the level of potions, abdominal massages, and other hands-off treatments that characterized men's gynaecological practice in general." Green, *Making Women's Medicine Masculine*, 315.

²⁹² Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3127, p.224.

²⁹³ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3405, p.245.3405 "perito 'ad incisionem et extractionem lapidum que nascuntur in testiculis seu vescicis hominum ac etiam puerorum.'"

²⁹⁴ Green, *Making Women's Medicine Masculine*, 115- 116.

²⁹⁵ Green, *Making Women's Medicine Masculine*, 113.

preferred to have licensed women available, on the chance that a female patient, or her family, preferred for her to be seen by the hands of a woman rather than a man.

4.3 Women's Work

Despite the prominence of gender-restricted surgical licences, a few women did receive licences that allowed them to practice on both sexes. However, many of the licences granted to women carried gendered differences, as well, in that most were limited surgical licences. Francisca, *mulier de Vestis*,²⁹⁶ licenced in 1307, and Margherita,²⁹⁷ licenced in the beginning of the fifteenth century, received general surgical licences without any limitations, and Sibilie de Afflicto de Benevento, was cleared to heal *bubonibus apostematibus et similia*.²⁹⁸ The rest, however, were allowed only to heal a combination of *vulneribus, apostimibus, veteribus, ulcerarum* and/or *lapidis* but only if they were “simple,” “external,” and/or of the “healthy” variety. Of the one physician's licence awarded to a woman, Viridimura, even that was restricted to treating the poor only.²⁹⁹

As the previous chapter illuminated, women's upbringing and their lack of a literate education was a factor in hindering women's medical practice, and one cause for their absence as *fisica* within the Neapolitan licences. However, a lack of literacy was not a strong justification for women's relegation into what were clearly the marginal positions of surgical care, as there was plenty of evidence among the Neapolitan documents that *illiteratus* and *ydiote* men received general, limited, and specialized surgical licences. If this study assumes that the medical examinations of men and women were identical, then women's medical training, not literacy, should have played a part in their marginalization.

²⁹⁶ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 916, p.119.

²⁹⁷ Pierro, “Nuovi contributi,” 238.

²⁹⁸ Calvanico, *Fonti per La Storia Della Medicina e Della Chirurgia*, no. 3407, p.245.

²⁹⁹ Pierro, “Nuovi contributi,” 239.

Apprenticeships were a non-university route into healthcare. For men, apprenticeships were a way to establish their lifelong career, but for women, if they partook, it was seen more as an attractive economical bonus to bring into their marriage.³⁰⁰ More often, women numbers among apprenticeships were low, and they rarely became independent after their training.³⁰¹ Instead, women commonly remained homebound, and were taught by their parents the skills they deemed essential. Thus, as Maryanne Kowaleski concludes about women's work in the fourteenth century Exeter, "women rarely benefited from formal training in the workplace."³⁰² Rather, women's work identity depended on their relationship to a man. While women lived in their father's household, they joined in their father's occupation. Once women entered their husband's household, they would learn and take part in their husband's trade.³⁰³ As Kowaleski observed, "the intermittent nature of women's work may well have contributed to women's low status within individual trades."³⁰⁴ This instability in their work identity, then, could have influenced women's parents to decide against investing in any type of in-depth, broad medical training. The prevalence of limited licences among women certainly gives the impression that they learned their surgical skill at the side of their husbands or fathers, assisting and observing their practice, but never took part in, or taught, the more difficult and technical aspects of surgery.

4.4 Professional and Economic Motivation

Kowaleski also observed that "even if women did receive some skilled training, they still tended to hold low-status marginal positions within individual trades,"³⁰⁵ a pattern from

³⁰⁰Hanawalt and Dronzek, "Women in Medieval Urban Society," 34.

³⁰¹ Maryanne Kowaleski and Judith M. Bennett, "Crafts, Gilds, and Women in the Middle Ages: Fifty Years after Marian K. Dale," *Signs* 14. 2 (1989): 477.

³⁰² Maryanne Kowaleski, "Women's Work in a Market Town: Exeter in the Late Fourteenth Century," in *Women and Work in Preindustrial Europe*, ed. Barbara A. Hanawalt, (Bloomington: Indiana University Press, 1986), 155.

³⁰³ Hanawalt and Dronzek, "Women in Medieval Urban Society," 42.

³⁰⁴ Kowaleski, "Women's Work," 157.

³⁰⁵ Kowaleski, "Women's Work," 155.

which the medical profession was not exempted from. As medical care grew increasingly professionalized throughout the late medieval period, Monica Green discerned that, “women’s medical practice seems to have been entirely subsumed into the context of the patriarchal family, where it remained in a ‘grey area’ of both law and custom.”³⁰⁶ Women continued to practice medicine, but official recognition and legitimization by medical authorities appeared to be heavily influenced by gender, even with proven skill. As Green discovered in fifteenth-century Paris, women’s authority in healthcare was not legally recognized, though the knowledge and skill they passed on was. A widow could inherit and run the workshop of her gilded husband, after his death, but it was done so under the stipulation that she could not remarry and had to employ an accredited male colleague. More notable, however, is that the son, learning the craft from his widowed mother, was permitted the same exemption from guild entrance fees as one who learned under his father.³⁰⁷ This indicated that there existed an unspoken acknowledgement that the widowed wife practiced medicine and had the same skill to impart as her husband, yet could not claim the same benefits. Green argued that as women “had no claim to the *authoritative knowledge* that distinguished the now professionalized, institutionally sanctioned practices of male physicians, surgeons, barbers and apothecaries,” their contribution did not carry the same weight men’s did.³⁰⁸ However, there appeared to be an additional self-serving motive in the marginalization and exclusion of women from the medical profession. As medicine became more masculinized, “one invested not only the time of education but also the material goods of tools and books.” Thus, there is some indication that the exclusion of women from healthcare was a professional and economic move by learned doctors to protect their investment into - and profit from - the medical profession.

³⁰⁶ Green, *Making Women’s Medicine Masculine*, 295.

³⁰⁷ Green, *Making Women’s Medicine Masculine*, 295.

³⁰⁸ Green, *Making Women’s Medicine Masculine*, 299.

It is difficult to state definitively that an individual's practice was targeted by other practitioners because of economic motivation and monopolistic self-interest rather than genuine concern over their medical knowledge. Both McVaugh and Green find that the general population supported the implementation of medical regulation and according to McVaugh, the general population "seems to in fact to have believed quickly in the promise offered by learned medicine, and to have tried to institutionalize that learning in various ways by delegating responsibility over matters of health to practitioners who might possess specialized knowledge."³⁰⁹ The previous chapter demonstrated that the new attitudes towards learned, literate medicine hindered women's entrance into "legal" medical practice, although it did not necessarily stop their practice. While this study does not deny that there was a general, growing belief that academic medicine provided better healthcare, it does propose that literacy was not all that excluded women from the medical profession, but the threat "empirical" practices, a category women were largely found in, posed to the "superiority" of the male gendered academic and literate medicine.

Certainly, while the courts punished and banned legitimate threats to the population's health and safety, a few trials hint that a few practitioners' goal was to remove displeasing competitors. As will be observed later, strong corporate medical identity hid women's medical practice more often than it revealed them, but, when women did appear in the Neapolitan licences, their practices were filled with limitations. From the evidence gathered from the Kingdom of Naples, are we to assume that the licences truly reflected the medical talents of women? This study believes, instead, that there was, at some level, a professional and economic decision to relegate women to the more rudimentary sectors of medical practice.

³⁰⁹ McVaugh, *Medicine before the Plague*, 242. Green, *Making Women's Medicine Masculine*, 7-8.

4.4.1 A Doctor's Fee

There is very little information available about the fees charged to physicians and surgeons in Naples. Of the physician's services there is an extant legislation by Frederick II which ordered that,

A doctor shall visit his patients at least twice a day, and at the request of the patient, once during the night; he shall receive from the patient for a day-visit, provided he has not been called beyond the city or village limits, not more than half a tarenus of gold. If he has been summoned beyond the city limits, he shall receive not more than three tarenì if the patient pays the expenses. A physician may not make contracts with pharmacists or receive any of them under his patronage for the payment of a fixed sum, nor may he have his own shop³¹⁰

While indicative of the abuses that must have occurred when physicians profited off of the pharmaceuticals they prescribed, it tells little about the wages of the doctors based on gender, skill, and education. Previous scholarship found that full-time workers received public contracts and salaries from the town or institution that employed them, private contracts ensuring the health of households, as well as, single treatment payments as the need arose.³¹¹ From the scholarship of the surrounding regions we know the general idea toward payments; university-trained physicians expected the highest income, although physicians, in general, received a higher income than surgeons and empirics, from which we find most of our women doctors.³¹²

Surgical treatments, a sector of medical practice into which Neapolitan women made easier inroads, with their corresponding fees, varied in both the required level of skill for each type of surgery and in the severity of the examining injury itself. As the licences show, there remained different types of surgical care, and the seriousness of injuries and illnesses varied from healing "simple wounds," to bone fractures, to stones. Due to the variety of the severity

³¹⁰ Hartung, "Medical Regulations," 592.

³¹¹ Chapters Three and Four of Park's *Doctors and Medicine in Early Renaissance Florence*, Chapter Six and Seven of Shatzmiller's *Jews, Medicine, and Christian Society*, and Chapter Six of McVaugh's *Medicine before the Plague* go into detail about the fees and services offered by doctors to their communities.

³¹² Sirasai, "The Faculty of Medicine," 361- 362. Park, *Doctors and Medicine*, 152-8.

of injuries, the cost of each procedure shifted from patient to patient. In 1429, the Kingdom of Sicily took these factors into account and attempted to proportionally price common surgical procedures. The least expensive came out to be wounds that required sutures at 1 *tari* per stitch. Bone injuries went as high as 1 ounce and 6 *tari* for the femur and decreased in value from the tibia (1 ounce), to humerus radius, or elbow of the arm (24 *tari*), to all the other types of bone injuries not named at 18 *tari*. Sprained joints followed a similar pattern, the humerus and thigh at 1 ounce and 6 *tari*, decreasing to the elbow and knee, then to the foot, tibia, and arm sprains, once again ending at “other” at 18 *tari*. The costliest treatments, at 2 ounces, were cauterizing a hernia, extracting a stone from the bladder, restoring correct urinary functions, and treating scrofula and cataracts,³¹³ most of which have appeared as specializations within the Neapolitan licences. Ophthalmology, in particular, emerged as a specialization that women favoured and from which they could charge their patients particularly high fees.³¹⁴

While the Sicilian prices were not standard throughout Europe, they do allow us to infer which injuries required a more skilled hand, or, alternatively, the list reflected the procedures that the community placed a high value on.³¹⁵ Surgical treatment of hernias and cataracts, in particular, “was more or less forced on surgeons...because patients wanted it, believed it should work, and were willing to pay.”³¹⁶ Established academic surgeons found themselves in a frustrating competition against “empirics,” because the established surgeons promoted a conservative approach to healing that did not necessarily cure the ailment, nor the

³¹³ Daniela Santoro, “Surgeons in Late Medieval Sicily: Education, Activities, Regulation,” in *Medieval Urban Identity: Health, Economy and Regulation*, ed. Flocel Sabaté, 110–26 (Newcastle: Cambridge Scholars Publishing, 2015), 121.

³¹⁴ Shatzmiller, *Jews, Medicine, and Christian Society*, 111.

³¹⁵ According to McVaugh, Italy, and its municipal authorities, was the only area to regulate medical treatment fees, depending on illness, wealth, and status of the patient. Often the poor were treated for free. McVaugh, *Medicine before the Plague*, 199.

³¹⁶ Michael McVaugh, “Cataracts and Hernias: Aspects of Surgical Practice in the Fourteenth Century,” *Medical History* 45 (2001): 335.

accompanying pain, and only ensured that it did not get worse. Established surgeons dared not risk death or disfigurement because it would impact their professional reputation, but in doing so, they could not improve their technique either.³¹⁷ “Empirics,” specifically travelling ones, did not have these same concerns over their medical reputation nor over the difficulty of the operation, as an anonymous thirteenth-century medical student complained, because they could leave town before they had to face any real consequences for their failure. Eventually, the empiric, McVaugh reckons, “could profit from their failures and become increasingly dexterous,” surpassing the skill and treatment of the established surgeons.³¹⁸ The problem that arose then was that established surgeons could not promote the superiority of their learned medical education, nor reap the economical rewards, if the “empirical” surgeon offered a better treatment.

It is this high value and demand placed toward optical procedures, among the other surgical procedures, that make the restriction toward Clarice di Durisio da Foggia’s surgical practice, licensed between 1329 to 1330, curious. Skilled ophthalmologists were viewed positively, regardless of sex. Katherine Park noted in her study of Florence that eye doctors were one of the favoured surgical specialists to receive the city’s rare tax exemptions, with little regard as to whether they were empirics or not.³¹⁹ In 1350, Judah, son of Rabbi Asher, praised the skill of a female Jewish doctor, after the failure of a female Christian doctor, in saving some of his eyesight and confidently noted that “[h]ad she lived another month, I might have recovered my sight fully. As it were, but for the two months’ attention from her, I might never have been able to see at all.”³²⁰ In 1391, the municipality of Castellón observed of a female Muslim ophthalmologist, “that she had been only a short time in the town and had

³¹⁷ McVaugh, “Cataracts and Hernias,” 324- 25.

³¹⁸ McVaugh, “Cataracts and Hernias,” 336.

³¹⁹ Park, “Stones, Bones and Hernias,” 116.

³²⁰ Shatzmiller, *Jews, Medicine, and Christian Society*, 111.

brought about marvellous cures of the eyes,” and, despite the 1329 Valencian legislation against women’s medical practice, the municipality both requested her presence and expressed that, “if she came [the *consell*] would be thankful because of the good she would do.”³²¹ None of these exchanges expressed women’s - nor Jewish and Muslim - practices as out of the ordinary. Furthermore, it should be noted that all of these positive encounters and opinions were made by those whose professional activities were not impacted by empirical and female healing, but rather benefited from it. In Clarice’s di Durisio da Foggia’s case, the medical examiners found her ophthalmological knowledge up to par, and the practice, itself, ran little risk of sexual compromise, yet, Clarice’s surgical licence limited her practice only to women.³²² If *all* the extant Neapolitan licences granted to women had restricted their practices *only* to women, then the argument could be made that the state saw the worth of women’s medical practice exclusively as a barrier to protect other women’s modesty, no matter the surgical operation. However, the point stands that the Kingdom of Naples granted medical licences to women without the gender restriction, as well.

By how much, if at all, were the Neapolitan medical authorities influenced by or even aware of the economic threat and competition women’s practices posed? As this study found, women scarcely received the same level of investment in education and training that men did. Could it then be assumed, as Monica Green wondered, that “women healers charged less than

³²¹ Cited from Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 31-32.

³²² Other ophthalmologists that appeared within Calvanico’s records include, *magistro* Nicandro de Vayrano, skilled “*in curandis vulneribus apostematibus et curis oculorum*,” p.112, no.860. Iohanne de Policastro and Giovanni da Policastro, both licensed “*in cura egritudinum ocularum et simpliciorum vulnerum*,” p.129, no.997 and p.154, no.1365, respectively; Andrea di maestro Paolo di Riccardo, an eye surgeon (*chirurgo oculista*), p.164, no.1491; Ragone da Arienzo, *chirurgo idiota*, “*in curis vulnerum, scilicet in medendis unguis et carnositatibus crescentibus supra oculos*,” p.168, no.1546; Sindo da Arena, licensed throughout the entire kingdom as an “expert in eye diseases,” (*perito nelle malattie degli occhi*), p.218, no.3062; Nicola di Bartolomeo di Savino, skilled “*in vulneribus apostematibus et etiam in curis oculorum*,” p.229, no.3195; Odino da Gragnano, *chirurgo idiota*, skilled “*in curandis antracibus apostematibus et ocalmiis oculorum simplicibus tunc sine periculo*,” p.230, no.3204; Giacomo di notar Palmiero da Messina, skilled “*in crepaturis et morbis oculorum exceptis (?)*,” p.235, no.3270; and Giacomo de Contio de Servis, *chirurgo idiota*, “*in curis oculorum*,” p.236, no.3282. All were men, literate and illiterate, without gendered restrictions.

men, either because of the simple fact they were women or because, being viewed as less skilled, more empirical in their knowledge, their services were seen as worth less?”³²³ If so, then women’s medical practice constituted an economical risk to men, which may have factored into the types of licences the Neapolitan state granted. Since the Neapolitan licences do not reveal much in terms of motive, this study looks to cases outside of Naples, to better understand the view medical authorities had toward unlearned and empirical practices, a category which often defined female practitioners.

4.4.2 Before the Law

Unlicensed practitioners, male and female, as well as their patients, have argued that licensed practitioners denounced their practice due to their success and the threat to “learned” practices they posed. In 1338, Ramon Roquer of Socarrats complained to King Pere, that “some surgeons envious of him have maliciously caused royal officials to order him not to practice surgery until he has been examined *per medicos*,” despite the claim that he already had a well-known medical reputation within his district.³²⁴ Bevinguda, introduced in Chapter Two, too, claimed that Valencian physicians attacked her practice, “more from malice or envy than from a desire for justice.”³²⁵ However, it is the 1421 Parisian trial against the illicit practice of Jean Domrémi that presents how economic and professional motivations came into play to restrict an otherwise well-regarded, competent, but “illicit” medical practice. Jean’s medical practice was perceived to be a threat to the Faculty of Medicine in Paris as he appeared to have a learning that was equivalent to the university-educated doctors without the university education, treated patients from the Parisian elite, and, overall, contested the Faculty’s monopoly of the title *medicus*.³²⁶ Jean repeatedly cured patients that had first been

³²³ Green, “Documenting Medieval Women’s Medical Practice,” 334.

³²⁴ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 8-9.

³²⁵ Quote from Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 50.

³²⁶ Geneviève Dumas and Faith Wallis, “Theory and Practice in the Trial of Jean Domrémi, 1423-1427,” *Journal of the History of Medicine and Allied Sciences* 54.1: 61.

unsuccessfully seen by the graduates of the Faculty, and, worse, he charged much less than his fellow Faculty members, making Jean's practice a threatening competition.³²⁷ Most telling of the Faculty's view of Jean's practice, the Faculty suggested that Jean "should practice elsewhere where the statutes and edicts are not so strict."³²⁸ The problem, university's suggestion implied, was not that Jean's medical care was a danger to his patients but that his "illicit" practice was casting doubt on the superiority of the university-trained men's medical practice and taking away their potential clients, through both his skill and fees. As Geneviève Dumas and Faith Wallis observed, the Faculty wanted Jean punished either, "because it was seen as a displeasing competition or because the university felt it held a moral and scientific responsibility inside the city of Paris."³²⁹

The rural population of the town of Angers certainly believed that the interference by urban physicians in Jeanne Lescallier's medical practice was a result of greed rather than a concern for public health. In the late sixteenth century, the presidal court at Angers prohibited Lescallier from continuing her medical practice, a decision Lescallier appealed to the *Parlement* of Paris to reverse. The university-trained physicians of Angers argued that as Lescallier had no academic training she was not suitable to heal her patients, while Lescallier's patients and lawyers countered that the physician's suit came as a result of avarice, because Lescallier took work from them. According to Lescallier's defence, the town physicians had no altruistic interest or concern over the rural population's health as they were more concerned in treating "the greatest [people]" of the town. Should the rural community be forced to call on the town's physicians instead of Lescallier, her defence argued, the physicians would arrive in the countryside "with such great expense that it would be

³²⁷ Dumas and Wallis, "Theory and Practice," 71-72.

³²⁸ Dumas and Wallis, "Theory and Practice," 70.

³²⁹ Dumas and Wallis, "Theory and Practice," 71.

impossible for the said habitants to provide it.”³³⁰ Lescallier, on the other hand, allegedly offered her treatments for free.

Susan Broomhall used Jeanne Lescallier’s trial and the above narratives put forth by the prosecution and defence to discover how female healing was viewed through the law.

Broomhall found that,

[i]t was clear that there were important restrictions implied in how much medical knowledge physicians expected women to acquire, and in the ways they used it. Firstly, women were to exercise their expertise only out of the spirit of charity... Secondly, the majority of women whose medical contributions was praised by doctors belonged to the upper levels of society or to the nobility... Thirdly, women were only to nurse the sick and not diagnose their illnesses by themselves... In doing so, noble ladies were not in competition with medical professionals.³³¹

According to Lescallier’s lawyer, the law should then have permitted Lescallier’s practice as it was both out of charity and came about due to the absence, and high fees, of available physicians.³³² Just as well, Lescallier’s lawyer also added that her practice was in no way a direct competition to the town’s physicians. However, Lescallier, not being of noble birth and more outrageously, acting as a physician rather than a nurse, was denied leniency. As Broomhall explains, university-trained practitioners preferred the practice of noble ladies because they were, in their own way, learned, and acknowledged a university education as superior, but more so, putting aside the effects of class and social status, it appears that learned physicians approved of women’s practice when it was conducted as an extension to their own. The nature of many of the Neapolitan surgical licences granted to women, in treating simple wounds and protecting other women’s modesty, attested to a similar view, as well. Both the noble women’s “accepted” type of healing the French physicians approved of, and the wounds the women of Naples were licensed to treat reflected the role of a nurse more

³³⁰ Broomhall, *Women’s Medical Work*, 102- 05. Cited from pp. 103.

³³¹ Cited from Broomhall, *Women’s Medical Work*, 99-100.

³³² Broomhall, *Women’s Medical Work*, 103.

than a physician. Meanwhile it is clear that Lescallier's perceived sin involved healing and prescribing medicine like that of a physician, as observed in Lescallier's second encounter with the *lieutenant criminel* of Angers; In 1571, Lescallier was ordered to end her medical practice, with a concession by the courts that she could continue to heal the sick "by simple plants and herbs and not by compositions...as physicians and apothecaries do."³³³

A similar economic motive is seen in Doreen A. Evenden's study of the gendered differences in the licensing of seventeenth-century London surgeons. While Evenden's findings are outside the geographical range and timeframe of this study, the similarities between the female practitioners of early modern London and those granted to the women of late medieval Naples were too great to ignore. More importantly, Evenden's study had the benefit of surviving written patient testimonials that attested to and gave first-hand accounts into the illnesses and injuries that the women treated, which this thesis on Naples lacked. This allowed Evenden to give a more comprehensive and assertive analysis on both the English women's medical practices and the motives behind the medical licences English women were granted. In her study, Evenden attested that the gendered differences of education and literacy were the primary force behind women's exclusion among the licences, as was the case in Naples and the rest of late medieval western Europe. Medical apprenticeships in London required Latin literacy, though at times, it was lightened to a minimum of basic literacy. All the same, either option was too high a barrier for most of the female population to overcome.³³⁴ Fortunately for women, testimonial certificates, written by "expert persons" who examined the candidate, as well as their patients, were another avenue to become licensed, although there continued to be gendered differences in the outcome.³³⁵ In comparing the differences in the surgical licences of men and women, this thesis finds parallels between

³³³ Broomhall, *Women's Medical Work*, 107.

³³⁴ Doreen A. Evenden, "Gender Differences in the Licensing and Practice of Female and Male Surgeons in Early Modern England," *Medical History* 42 (1998): 198- 201.

³³⁵ Evenden, "Gender Differences," 207.

the seventeenth- century English licences and the late medieval Neapolitan licences. In her study, Evenden found that English women were granted licences,

in what can only be described as exceptional circumstances: a family connection to male practitioners in surgery and/or physick, as well as an understanding that the woman's practice would be limited to certain specialities such as female "complaints", bone setting, or distasteful, chronic ailments requiring prolonged treatments for which many sufferers could not afford substantial payment if any at all. In three cases licences were granted to practitioners working far beyond the areas jealously guarded by London medical monopolies thereby removing any possible threat of competition to male practitioners.³³⁶

The trait of limiting women to treat certain specialties, particularly female "complaints," was very common among the Neapolitan women's licences, as well. Moreover, Evenden remarked that the women in her study needed to demonstrate extraordinary medical talent to receive equal recognition as men. Evenden's study discovered that even when women produced proof of higher empirical successes than men through the certificates, women's practice continued to be restricted in some form or another, as noted above, and relegated to illnesses that male practitioners had very little (economical) interest in.³³⁷ Christian men, on the other hand, often received unrestricted access in all aspects of surgical care with minimal training and qualifications, without needing to provide the type of documentation women did.³³⁸ Just as well, one of the common features of the Neapolitan surgical licences granted to women was that they were permitted to treat nothing more difficult or dangerous than "simple," "external," and "healthy" injuries. Basically, these injuries required little broad training, a characteristic common in women's urban work identities. However, it should also be noted that just like the women of London, "simple," "external," and "healthy" injuries were very unlikely to fetch much, economically speaking. For an explicit indication, however, that the Neapolitan medical authorities similarly

³³⁶ Evenden, "Gender Differences," 212.

³³⁷ Evenden, "Gender Differences," 194, 213.

³³⁸ Evenden, "Gender Differences," 205-06.

preferred to relegate women into the sectors of healthcare that posed little to no professional threat of competition, this thesis needed to look no further than the licence of Viridimura, Jewess, wife of Doctor Pasquale. Presently, no known Neapolitan physician's licence, granted to men, contained any special instruction or restriction for their practice. They were, presumably, free to treat anyone, of any age and gender. Viridimura, on the other hand, as the only known Neapolitan woman to receive a physician's licence, was permitted *ad praticandum in scientie medicine, circa curas phisicas coprporum*, but on the condition that she only cure the physical or internal diseases of, "the poor who find it difficult to pay back the immense fees of medics and physicians."³³⁹

4.5 A Question of Authority

Without the detailed testimonials, trial records, and first-hand accounts, there is little to tell us if the medical licences granted to women reflected the true expanse of medical care Neapolitan women offered their communities. Were women in the Kingdom of Naples relegated to the less prestigious, and less profitable aspects of surgical care due to economic and professional motives, or was it a reflection of women's medical talents? Very likely, the answer is neither simple nor singular, but rather the dependant on a mix of changing factors dependent on upbringing, location, demand, personal motives and biases, and who had the overall authority to police and grant legitimization within the profession. Medieval women commonly worked in "low-skilled, low-status, and low-paid occupations,"³⁴⁰ so their prevalence in healing mainly "simple" and "external" injuries and illness among the Neapolitan surgical licences may just be a reflection of a lack of overall broad training. However, the various regional scholarships noted in this study indicated that it was highly unlikely. Studies conducted of western European medieval medical practices have found

³³⁹ Pierro, "Nuovi contributi," 239.

³⁴⁰ Kowaleski and Bennett, "Crafts, Gilds, and Women," 480.

women in all levels of the “medical hierarchy,” both officially and unofficially, as physicians, surgeons, and barbers, a few with their own workshops.³⁴¹ In focusing on the legal and documented aspects of medieval medicine, this study touched upon the motivations in either prosecuting or permitting women’s medical practices, but only briefly on the patterns found in the authoritative power itself. The power to regulate the medical profession fell into different hands in different western European regions, and as this study finds, the less ties (and investment) the regulatory body had to the medical profession and its monopolization, the more authority women appeared to receive in medical care.

Medical guilds and universities were especially concerned in monitoring the medical profession, and women were often the victims of their monopolization. As Patricia Skinner observed, “[g]uilds did not so much as exclude women from work as hide the evidence of it and marginalize women’s role as membership was denied to them.”³⁴² Kowaleski and Bennett extended the point further, adding that,

although male-dominated guilds offered women important protections and privileges, they also severely restricted women’s full involvement in guilds and women’s work opportunities overall. The secondary status of women in such guilds, for example, left them particularly vulnerable when trade diminished or competition increased. Guilds often responded to adverse economic developments by placing further restrictions on the employment of women in the craft, in some instances prohibiting masters from employing any women at all (except for their wives and daughters).³⁴³

We see evidence of this point briefly in the previous chapter, in the case of Florence’s Guild of Doctors, Apothecaries, and Grocers. Katherine Park found that the medical guild in Florence became increasingly professionalized, and in 1349, the guild implemented many special provisions, “aimed to reduce competition, establish licensing requirements and standards for practice, and multiply opportunities for consultation” although Park found that,

³⁴¹ Green, “Women’s Medical Practice,” 434-473.

³⁴² Patricia Skinner, *Women in Medieval Italian Society 500- 1200*, (Harlow: Longman, 2001), 170.

³⁴³ Kowaleski and Bennett, “Crafts, Guilds, and Women,” 479- 480.

“[i]n practical terms, however, the very breadth of the licensing requirements must have served to limit medical collegiality,” particularly between university-trained physician and empirics, a categorization women were often linked with.³⁴⁴ Nevertheless, Park asserted that the matriculation rate of medical practitioners in Florence was “extremely high.”³⁴⁵ While the discovery was true, it did not seem to imply an openness to women’s practice. Florentine women were only granted official status during a short, unique period, between 1353 to 1408, in the aftermath of the plague, and even then, many of the women had a familial medical connection. Furthermore, during the same time period, “doctors with influence” within the guild, unhappy with the new laxity and “influx of ‘idiots’ and ‘mechanicals’,” introduced reforms that tightened the standards for admission, once more so that they could “reduce competition from new practitioners outside the established profession,” while additionally, “[aiming] to restore their authority and reputation.”³⁴⁶ While not completely successful, Park’s finding that women did not matriculate in the guild after 1408, confirmed Kowaleski and Bennett’s theory that in times of increased competition, women’s place in the guild was the first to go.

A connection to a university presence also did not look too favourably towards women’s medical practice. As the previous section revealed, it was the physicians from the Faculty of Medicine at Angers who brought forward the suit against Jeanne Lescallier’s practice, rather than any of her former patients, and the medical faculty in Paris had a particularly well-established control over the medical profession, as they “sought the protection of ecclesiastical, royal and papal authority to define the legitimacy of the university’s product and to limit the role of others in their domain.”³⁴⁷ It had already been

³⁴⁴ Park, *Doctors and Medicine*, 23.

³⁴⁵ Park, *Doctors and Medicine*, 26-27.

³⁴⁶ Park, *Doctors and Medicine*, 36-37..

³⁴⁷ Broomhall, *Women’s Medical Work*, 47.

noted that the marginalization did not necessarily stem from their sex, but rather because women usually fell under the umbrella of “unlearned,” during a period that “learned” practitioners, often university graduates, attempted to establish the superiority of their practice. As a result, women’s medical practice in Paris faced a greater difficulty as, “the medical faculty’s control over the guilds which, in other countries, civic authorities oversaw, linked medicine more intimately with the literate knowledge to which women were denied access.”³⁴⁸ Thus, while Perette Pétone complained during her trial that there were many women who were practicing in Paris that were not being prosecuted by the university, Danielle Jacquart found in her scholarship of the medical milieu in France that the Paris medical faculty had attacked all but one documented women’s medical practices within the city during the late medieval period.³⁴⁹

Thus, as it has been put forth throughout this thesis, women generally appeared to have had an easier time establishing legitimacy when licensing examinations and upkeeping medical standards were not under the control of a medical guild, university, or council of doctors, as they were excluded from participating as members. It is even more apparent when we turn to the late medieval town of Manosque. Between the years 1292 to 1342, the court of Manosque identified three women as *sirurgica* or *fisica*, one of whom, Fava, had been introduced earlier in this chapter. Fava, as seen earlier, was called to the court to give medical testimony to the injury sustained by Poncius Porcelli after he was attacked.³⁵⁰ In 1292, another woman, Laura, *habitatrix Manuasca*, was a part of a group of physicians and surgeons that were called to treat a man’s son. The courts demanded that the man, Betrandus, pay all the medical practitioners’ fees. According to the court verdict, Laura’s fee was no different to her male counterparts, indicating that, “women practitioners were respected by

³⁴⁸ McCarthy, “Midwives, Medicine, and the Reproductive Female Body,” 43.

³⁴⁹ Jacquart, *Le milieu médical*, 54, n.1.

³⁵⁰ McCarthy, “Midwives, Medicine, and the Reproductive Female Body,” 41.

their communities and deemed equally competent with men.”³⁵¹ The third woman, Mayrona, *fisica*, appears among the court documents many times but never in any medical capacity.

Nonetheless, “[t]he repeated references to Mayrona as *fisica* underscores the social acknowledgement of her professional identity.”³⁵² As Caley McCarthy argued,

[t]he relative ease with which women appear to have practised medicine in Manosque... can be explained, in part, by the absence in Manosque of corporative medical identities, generally, – that is, guilds – and a medical faculty that regulated them... the court could only regulate *externally* to uphold licensing requirements. Guilds, on the other hand, regulated *internally*, through their monopoly of the profession.³⁵³

Ladislao Münster’s study on the medical practice of the fourteenth century Republic of Venice also appeared to hint at a similar theory, according to Monica Green. In his analysis, Münster found six women practicing in Venice, during the first half of the fourteenth century. Although they were not officially licensed, the state granted women a special dispensation, “per grazia,” that for all intents and purposes made their practice equal to men’s. These women could treat any gender, both adults and children, and were not limited only to the lower strata of healthcare. Rather they practiced as physicians or surgeons, with one female physician even given the honorary title of *Magistra*.³⁵⁴ Green observed that “the city of Venice, although not the seat of a university, was excelled by no other Italian region (except Sicily and the Republic of Florence) in having so many female practitioners.” Green further mused towards “the possibility that it was precisely *because* Venice did not yet have a university that women practitioners could thrive.”³⁵⁵

How, then, can these broad generalizations about the relationship between gender and power structures be used for the medical practice and licensing of women in the Kingdom of Naples? As observed, the presence of a medical university and/or a corporate medical identity

³⁵¹ Green, “Documenting Medieval Women’s Medical Practice,” 346- 347.

³⁵² McCarthy, “Midwives, Medicine, and the Reproductive Female Body,” 42.

³⁵³ McCarthy, “Midwives, Medicine, and the Reproductive Female Body,” 43.

³⁵⁴ Green, “Documenting Medieval Women’s Medical Practice,” 342- 343. Park, “Medicine and Magic,” 136.

³⁵⁵ Green, “Documenting Medieval Women’s Medical Practice,” 343.

made it difficult for women to find legitimacy within their profession. Conversely, when the regulative power rested among those without a strong tie into the profession, women found more leniency. The Kingdom of Naples housed a medical university within the city of Naples, and to the south, in Salerno, there existed a tie to the learned and literate medical knowledge that took hold throughout Europe. However, unlike in Paris and Florence, there also existed a degree of separation between the medical faculty in Naples, and the licensing authority. While in Paris, Florence, and Valencia, a university medical degree automatically equated to a medical licence, in Naples, both the university graduate and the privately trained practitioner needed to present themselves for the licensing examination. The overt authoritative licensing power rested in the hands of the Royal Curia, which indicated that neither the university nor any guilds had the authority (and monopoly) over health care that was observed in its neighbouring regions. Nevertheless, as the Royal Curia still needed to assign the state's examiners, Ronald Doviak found that "the most prestigious of the examiners were probably those associated with the University of Naples."³⁵⁶ The question that arises is how much did personal and professional biases of the examiners influence the licensing process and results?

The closest comparison this study can make to the situation in Naples is the one found within the Crown of Aragon, although, of course, there are just as many regional differences as well. Nonetheless, the Crown of Aragon is the best candidate as it had presented the tension that existed between the kings of Aragon and the local municipal *examinadors*, as both had a vested interest and influence, but different goals, towards medical licensing.³⁵⁷ In regards to women's practice, the differences between the royal and medical authorities are made clear: every known licence awarded to the Valencian *metgesses* were awarded by the

³⁵⁶ Doviak, "The University of Naples," 46.

³⁵⁷ See Chapter Two

king rather than by their municipal *consull*, against the recommendation of the 1329 *furs*, and in the known cases of Catalonian women facing disciplinary action, introduced in the previous chapter, it was the king who intervened on their behalf. Monarchs appeared to have a more sympathetic view towards women's medical practice, as well as providing skilled medical practitioners, than toward any monopolistic control the regional medical authorities hoped to exert.³⁵⁸

Unfortunately, in the absence of further documentation, it is speculative to contemplate how much influence the examiners had on the licensing of women and how much was the influence of the Neapolitan royal court. Rather, the purpose of this overview of medical authority is to acknowledge that although we do not know exactly *how* they affected medical licensing in Naples, *who* had the authority to permit and prosecute medical practices was a factor in influencing women's practices. In areas such as university towns and major cities, where healthcare was mostly institutionalized and gendered as male, and where it was largely influenced by learned doctors and guilds, women's medical practices were rarely granted legitimacy. While it can be assumed that healthcare within the city of Naples, as the location of a medical university, may not be so welcoming to female practitioners, the entire territorial range of the Kingdom of Naples should also be taken into consideration. The city of Naples was but one city of many within the *Iusticiariatum* of Terra di Lavoro. Terra di Lavoro, in turn, was but one of twelve *iusticiariatum* that made up the entirety of the Kingdom of Naples, and of which the Royal Curia needed to supply with practitioners to meet with demand.³⁵⁹ How professionalized, and therefore, masculinized, medicine was

³⁵⁸ Garcia-Ballester, McVaugh, and Rubio-Vela, *Medical Licensing and Learning*, 30-31. This point refers to the women that received "official" identification as practitioners, despite the *furs* of 1329. There were many more women, mostly Muslim, in Valencia, during the fourteenth and fifteenth century that, "practice[d] medicine as a more or less normal occupation, often without bothering to seek formal exemption from the *fur*," which, "indicate that the prohibition of 1329 was essentially a dead letter."

³⁵⁹ Despite the low number of licensed female practitioners as well as the predominance of limited licences, many of the women licenced within the Kingdom of Naples received a wide territorial range in which they could practice: Vigorita da Rossano (no. 3512) could practice within five *iusticiariatum*; Sabella di Ocro (no.3071), Clarice de Rothomago (no.3127), and Margarita de Ruga (no.3572/3620) within four; Margherita da

throughout the many cities and *iusticiariatum* of Naples remains a question, but, as Green observed, the continued licensing of women into the fifteenth century implied that healthcare was not fully professionalized.³⁶⁰ Thus, the Kingdom of Naples was an amalgamation of the factors noted in this section: a medical university presence from which the royal examiners were drawn from, but no overt monopolistic control of the profession by learned doctors, as well as, royal interest, authority, and control over medical licensing. As a result, we have women that continued to be recognized and licensed by the Curia as late as the early fifteenth century, but whose practices were, more often than not, in no competition with men's. Furthermore, women continued to be assisted in entering the medical profession by the Royal Curia. When Donna Cusina di Filippo could not travel to Naples for her surgical examination, the royal court allowed Cusina to take her oath at a local court, as well as, issued a royal decree on May 1, 1404, that assigned Benedetto de Roma, a Jewish doctor from Costenza, to conduct her examination.³⁶¹

4.6 - Conclusion

The licensing of men and women in Naples, as elsewhere in western Europe, favoured men, not only numerically, but professionally. While the differences in educational opportunities remained a strong element in excluding Neapolitan women from the profession, in the rare cases where the authoritative power conceded to allow women's legal entrance, the Neapolitan documents found that the medical authorities preferred to relegate women into positions that were, by and large, no threat to their own.

Venosa (no.3226) within three; Costanza da Barletta (no.1168/1209), Lauretta, wife of Giovanni (no.1413/2023/2026), Francesca, wife of Matteo (no.1451/1872/1874), Gemma da Molfetta (no.1981), and Maria Incarnata (no.3571) within two; and Maria Gallicia (no.1165) who we already know to be the only woman who could practice throughout the entire kingdom. Almost all the surgical licences restricted to treating only women were allowed more than one *iusticiariatum* in which they could practice medicine in. Principato counted as two *iusticiariatum* (Principato Ultra and Principato Citra), Val di Crati and Terra Giordana counted as one *iusticiariatum*. *Iusticiariatum* borders are based on the map of the Kingdom of Naples provided in Samantha Kelly, *The New Solomon: Robert of Naples (1309-1343) and Fourteenth-Century Kingship* (Leiden:Brill, 2003), xviii.

³⁶⁰ Green, *Making Women's Medicine Masculine*, 297.

³⁶¹ Shatzmiller, *Jews, Medicine, and Christian Society*, 110.

Susan Broomhall remarked that there were many elements at play when considering medical contexts for women.³⁶² By focusing primarily on the details found in the Neapolitan licences, this chapter surmised that the cultural and patriarchal norms about modesty ensured that women had a right to practice medicine, whilst the neglect in “women’s work identity” and education stunted their medical talents. Widening the territorial and social range of analysis, however, and comparing the Neapolitan documents against the patterns found throughout western Europe revealed that there were additional factors at play that have influenced the medical practices of women, beyond what was discernible within the licences. Specifically, by looking into the patterns of licensing and legitimization espoused by learned doctors, and by those with, objectively, less stake in the profession, this study finds that local authoritative power and economics factored into the extent of women’s marginalization.

In the same vein, Broomhall also conceded that we must not forget the role gender systems played, even when it does not seem obvious. It is displayed in Naples’ concern over male-female doctor-patient interactions, in the differences in upbringing between men and women, in the value placed on women’s work, in women’s practice often being (or viewed as) “empirical” in nature, all of which came together to dictate the licence the state granted women. Gender, as Katherine Park asserted, “dramatically shaped the kinds of healing offered by, and available to, both men and women, as it shaped the careers, working conditions, and social and economic prospects of the healers themselves.”³⁶³ That’s not to say some men's practices were not viewed similarly to how women’s were - there were many limited Neapolitan licences awarded to men that had the same characteristics as women - only that the label of “empiric” and “unlearned” it did not *define* their practice.

³⁶² Broomhall, *Women’s Medical Work*, 259.

³⁶³ Katherine Park, “Medicine and Magic: The Healing Arts,” in *Gender and Society in Renaissance Italy*, ed. Judith Brown and Robert Davis, (New York : Longman, 1998), 131.

Chapter V

Conclusion

Until and unless new evidence comes to light, analysis into the medical practice of women in the Kingdom of Naples is limited and dependent upon the patterns found in the wider western European context. As Monica Green observed, “most of the sources that we use to document medieval practitioners are those produced when the individual steps into ‘public’ life,” and as such, medical licences, court cases, and widowhood were a few of the avenues for women into documented visibility. Unfortunately, “identification by occupation was the exception rather than the rule for women,” Green continued, and women offered more frequently, and less visibly, informal care within their communities.³⁶⁴ Nevertheless, the details from the documents allowed this study to build a partial picture of the medical milieu in Naples. In particular, this study uncovered the factors that dictated the licensing of Neapolitan women.

By focusing on the wider social contexts of medieval medicine, as well as, the fruits of medicalization -institutionalized medical knowledge, upholding regulatory standards and laws, the creation of professional organizations and corporate medical identities, and, of course, medical licences - the study arrives to a few conclusions, regarding both the medical practice of women in the Kingdom of Naples and the wider western European world. First that the implementation of regulatory measures introduced a series of tensions and conflict of interests into the medical world. While, by the fourteenth century, academic medicine grew to become the gold standard, there simply were not enough learned practitioners to meet the needs of the populace. Several instances demonstrated the attempts made by medical authorities to maintain medical standards and who, as a result, faced resistance by not only the “unqualified” practitioners they attempted to eradicate, but by local and royal authorities,

³⁶⁴ Green, “Documenting Medieval Women’s Medical Practice,” 329.

and by members of the local community. In fact, the paucity of available (and affordable) healthcare ensured the continued presence of female (and male) practitioners that the medical authorities viewed as “undesirable,” and who often worked outside the established legal parameters with the support of their community and with little repercussion.

Second, that despite the growing legal and polemical moves made against women’s medical practice in the fourteenth century and onward, these moves were not the main force behind their marginalization. As observed in the cases of Jewish and clerical practitioners, the targeted secular and ecclesiastical sanctions did little to prevent Jews and clerics from rising to impressive heights within the profession. Rather it was the ability by Jewish men and clerics – and the inability by women- to interact with the learned and literate medical culture that determined success within the institutionally sanctioned medical profession. As a physician’s licence depended on knowledge of the text-based medical treatises but a surgical licence did not, we found Neapolitan women primarily excluded from the former but not the latter.

Lastly, the social force of the medieval gender system was a great influencing factor on Neapolitan women’s legitimacy within the medical profession. Although the effect of gender was never static, and shifted based on context, nevertheless, it played a role by many means. Gender influenced women’s upbringing, education, and professional training. As noted in the previous point, more often than not, women did not receive the same training men did and so could not keep up with the educational and technical standards imposed. Additionally, this reinforced the idea that healthcare was a masculine profession. Even in instances where women appeared to have sufficient training, the unlearned and empirical nature of women’s practice, and the economic and professional motives and biases by the medical authorities ensured that women remained at the bottom of the “medical hierarchy,” in marginalized positions. Only the “looser” requirements for surgery, the demand for doctors,

and the concern over women's modesty were a few factors that ensured the continued legitimate acceptance for female practitioners in Naples.

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