# Women's Informal Medicine, Experience, and Authority in Medieval and Early Modern Europe

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## Abstract

In this thesis, women's involvement in medicine in the medieval and early modern periods will be read through the lens of "experience" and "experiment" as sources of validation. "Experience" was a contested term and concept in this period, and my thesis is devoted in large part to studying the changing nature of experience. "Experience" connoted both something *thought* or *known*, and something *done* or *performed*. This perspective is important because during these periods, the value and definitions of experience and experiment changed among intellectual and professional elites, effectively reframing the traditional identification of women with experimental knowledge. Rather than viewing and demoting women's expertise as "only" experience, men claimed experience as a privileged characteristic of the "new science" of experimental philosophy, excluding women from experience.

The case of the Royal Society is the subject of chapter one. In the process, women's experience of their own bodies as privileged knowledge is demoted, and the idea of female "secrets" was revealed to men through science, printing, and dissection. Women were declared ignorant even of their own bodies. In chapter two, I deal with this subject through the idea that female knowledge of the body could be obtained only through female touch. Alternately, embodied knowledge was protected to some degree by its association with elite women performing Christian charity, a subject which will be explored in chapter three. Finally, in chapter four I discuss women's entry into publication through recipe collections, which illustrates the ambivalence of their authority. Even as they seem to gain a public voice, printing undercut the personal, domestic, and charitable associations that had empowered and protected women's medical work. The long chronological period of my thesis allows me to illuminate themes of continuity and uncertainty in the history of experience. In my four chapters, I have presented cases where female authority was compromised, mediated, disregarded, or appropriated by professional men, and yet retained or relocated through social and cultural forces outside the control of the profession, notably religious expectations

and printing**.** My research demonstrates the uncertain coexistence of different types of authority, and the fluctuating power attributed to women as sources of knowledge and owners of experience.

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Cette mémoire porte sur l'implication des femmes dans la médecine durant le Moyen Âge et le début de l'Époque moderne, en faisant référence à l' « expérience » et à l' « expérience scientifique » comme sources de validation de la connaissance. Comme concept, l' « expérience » faisait sujet de controverse et a connu des changements dont traite une importante partie de cette thèse. À l'époque, l'expérience désignait à la fois ce qui est connu ou pensé et ce qui est fait. L'importance de cette perspective ne peut être négligée lorsqu'on considère le développement des notions de l'expérience et de l'expérience scientifique au sein du cadre professionnel et intellectuel, et comment les changements de signification ont effectivement reformulé l'identification traditionnelle des femmes par rapport à la connaissance expérimentale. Au lieu de minimiser les compétences féminines à que des « expériences », les hommes ont revendiqué l'expérience comme concept particulier à la « nouvelle science » de la philosophie expérimentale, dont les femmes étaient forcément exclues.

Cette mémoire se présente en quatre parties. Le premier chapitre traite du cas de la Royal Society, et le processus par lequel la méthode scientifique, l'imprimerie et la pratique de dissections ont dévoilé les secrets féminins aux hommes. Par conséquent les femmes ont été proclamées ignorantes de leurs corps. Dans le deuxième chapitre, on examine la conviction que le corps féminin ne peut être compris que par la main féminine. Le troisième chapitre porte sur la connaissance incarnée et l'implication de l'élite féminine et leurs bonnes oeuvres chrétiennes dans la protection de cela. Finalement dans le quatrième chapitre on examine les livres de recette et comment ces premières publications des femmes servent à illustrer l'ambivalence de l'autorité des auteurs féminins. Au même temps que celles-ci réclamaient la sphère publique, l'instrumentalisation de l'imprimerie a mené une érosion des relations de la sphère privée, telle que les

oeuvres caritatifs, qui ont jusque-là servit à promouvoir l'implication des femmes dans la médecine. La période d'analyse, y compris le Moyen Âge et le début de l'Époque moderne, nous permet d'illustrer les thèmes de continuité et d'incertitude le long de l'histoire de l'expérience. Les analyses présentées au cours des quatre chapitres illustrent l'affaiblissement, la réinterprétation, le mépris et la réappropriation de l'autorité féminine par les hommes professionnels. En même temps que l'autorité féminine a subi ces attaques, son intégrité était retenue ou transférée par des forces sociales et culturelles hors de la sphère de la profession, notamment à travers les attentes religieuses et l'accès à l'imprimerie. Les conclusions présentées dans cette mémoire démontrent la coexistence incertaine entre différentes manifestations d'autorité et la puissance floue des femmes comme sources de connaissance et d'expérience.

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First and foremost, thank you to my advisor, Dr. Faith Wallis. This thesis would not be possible without your knowledge, attention, and support. Additional thanks to Mitali Das, who has been invaluable in providing me with information about the thesis process. I am also grateful for my friends' patience and willingness to discuss my thesis over these past two years. Particular thanks Kathleen Gudmunsson and Lianne LaFrance for French translations and to Nicole Belej-Corrigan, Peter Hynd, Eliza Wood, and Raminder Saini for their reading and corrections. All remaining errors are my own.

I am very fortunate for the love of my family, particularly my parents. You believed in me and gave me strength. This work—hopefully the first of many—is dedicated to you.

## Introduction

Western Europe has a conflicted relationship with the idea of experience. This is particularly true in England, where from 1200 to 1700 the female relationship with experience was transformed in relation to expectations of what constituted knowledge through the foundation of the Royal Society. Experience as the collection of information based on concrete events, which encompassed both the passive concept of "experience" and the active "experiment" were used as an educational tool and method of garnering authority daily. As a result of the accessibility of experience, male physicians associated this concept with women and the uneducated. Learned society, however, struggled to define the relevance of experience and empiricism as pathways to knowledge that bypassed the necessity of intellectual training and rhetoric. As experiments became increasingly significant in the epistemology of science, the concept of experience was colonized and masculinized by men. Ideas about experience and experiment were gendered, with men placing greater authority on the now masculine concept of experiment. The subject of male experimentation shifted away from the passive "experience," or acquired practical knowledge, to a purposeful and designed testing, the "experiment." This thesis examines how elite perceptions of the nature and value of expertise and experience shifted in relation to gender through interaction with women's informal medical practice.

"Experience" was a contested term and concept in this period, and will be utilized as a lens to view the changing role of women. In the period under consideration here, "experience" connotes both something *thought* or *known*, and something *done* or *performed.* The Oxford English Dictionary defines experience, starting in 1377, as "the actual observation of facts or events, considered as a source of knowledge." The definition became more nuanced by 1533, when experience was defined as "knowledge resulting from actual observation or what one has undergone."[1] Experience implied a degree of passivity, experiencing

[1] "experience, n.". OED Online. March 2013. Oxford University Press. http://www.oed.com.proxy2.library.mcgill.ca/view/Entry/66520?rskey=OBIAgf&result=1&isAdvanced=false (accessed June 02, 2013).

events like the sensations of pain and childbirth without controlling them. Related to this idea is "embodied experience," pertaining to the information collected through the possession of a body and the observations pertaining to that body. Again, this could either be passive, by having a body and observing what goes on in it, or active, by using one's body to carry out certain actions. Experiment is "the action of trying anything, or putting it to proof; a test, trial" or "an expedient or remedy to be tried."[2] Experiment was an elevated, purpose driven experience, a concept that became concrete with the "experimental science" of the Scientific Revolution. Experiments within the Royal Society were enacted and interpreted, with the implication that prior knowledge was required to understand cause and result. During this period, active and passive experience formed a complicated nexus of ideas about knowledge and the merit of personal experience.

Women's involvement in medicine in the medieval and early modern periods is read through the lens of "experience" and "experiment" as sources of validation. This perspective is important because during these periods, the value and definitions of experience and experiment changed among intellectual and professional elites, effectively reframing the traditional identification of women with experimental knowledge. Rather than viewing and demoting women's expertise as "only" experience, men claimed experience as a privileged characteristic of the "new science" of experimental philosophy, excluding women from experience. In the process, women's experience of their own bodies as privileged knowledge is demoted, and the idea of female "secrets" was revealed to men through science, printing, and dissection. Women were declared ignorant even of their own bodies.

In chapter two, I deal with this subject through the idea that female knowledge of the body could be obtained only through female touch. Alternatively, embodied knowledge was protected to some degree by its association with elite women of the landed gentry performing Christian charity, a subject which will I will explore in chapter three. The final chapter discusses

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[2] "experiment, n.". OED Online. March 2013. Oxford University Press. http://www.oed.com.proxy2.library.mcgill.ca/view/Entry/66530?rskey=vpMoEG&result=1&isAdvanced=false (accessed June 02, 2013).

women's entry into publication through recipe collections, which illustrates the ambivalence of their authority. Even as they seemed to gain a public voice, printing undercut the personal, domestic, and charitable associations that had empowered and protected women's medical work.

This introduction will frame my argument and the terms of my discussion. My thesis is divided into four chapters, each with a distinct selection of sources. I will introduce each chapter and indicate both my range of sources, and some reasons for their selections. First, I define and discuss the subject matter, distinguishing between occupational and informal medicine. I also deal with the terms used to describe medical care and experience. I justify my use of a broad time period in my thesis, which ranges from the years 1200 to 1700. Doing so allows me to explore issues of continuity and discontinuity, a subject that I will discuss further in this introduction in regards to the English Reformation and the rise of publishing.

The expansion of the social history of medicine in recent decades has similarly expanded ideas about who performed medicine in medieval and early modern Europe. These studies frequently focus on figures who are identified by profession, which for women means that medical practitioners like midwives, nurses, and empirics now populate studies in the history of medicine.[3] Even when medical practitioners who worked for profit are eliminated, there remains a broad range of health and medical care that occurred in the medieval and early modern periods. Many women performed medicine[4] informally, without identifying it as their occupation and without receiving remuneration, as part of their charitable and gendered roles. They were also generally excluded from the formal arenas in which formal medical knowledge was acquired, namely universities and guilds

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[3] For example, *Early Modern Midwives in Europe,* ed. Hilary Marland (London & New York: Routledge, 1993), Doreen Evenden, *The midwives of seventeenth-century London* (Cambridge: Cambridge University Press, 2000), or Lianne McTavish, *Childbirth and the display of authority in early modern France* (Hampshire: Ashgate, 2005). While texts like Susan Broomhall's *Women's Medical Work in Early Modern France* (Manchester: Manchester University Press, 2004) and Leigh Ann Whaley's *Women and the practice of medical care in early modern Europe, 1400-1800* (New York: Palgrave MacMillan, 2011) devote chapters to informal care, the brunt of their research is also into identified medical roles.

[4] This is not an actor term. I use it to indicate women preparing cures, providing care, and interacting with ideas about diagnosis and treatment.

though that exclusion did not necessary have an impact on their domestic and charitable medical activities. Women could educate themselves by accessing and reading texts available to male academics, but the informal nature of their educations meant that they were not acknowledged as authorities by medical institutions. Focusing solely on women who acted informally, I use informal female medical activity as a lens through which to examine the meanings of experience and expertise in medicine, and how changes in the value placed on experience gendered experience in new ways. I examine cases where women practiced in concert with or beneath the radar of male practice, and observe how experience and information were collected and utilized by women and contested by male professionals and members of the new scientific communities. This aligns with my demonstration of how printing and the appetite for published recipes opened up a new domain of experience and expertise.

This focus demonstrates the uncertainty of the place and value of experience in medieval and early modern Europe. It examines how the female experience of the body impacted the way women discussed disease and interacted with practitioners. I also raise the issue of class, and how station impacted the type of medical roles and responsibilities provided to and expected of women. The medical historian Susan Broomhall argues that the status of women who practiced medicine was determined through a mediation of class and gender factors.[5] This meant that upper-class women had the potential to transcend their gender and state their opinions, particularly when talking to men of lower classes, which almost inevitably included physicians. Conversely, medicine practiced as an occupation by members of lower classes was still frowned upon and associated with profit and danger to patients, with the argument that their illiteracy and lack of "suitable knowledge" that would be provided by reading and formal training made it impossible for lower class women to provide appropriate care.[6] The

[5]Susan Broomhall, *Women's medical work in early modern France* (Manchester: Manchester University Press, 2004) 7.

[6] The cases of Jacoba Felicie, Faith Wallis, trans. "The Faculty of Medicine of Paris vs. Jacoba Felicie" in *Medieval Medicine: a Reader,* ed. Faith Wallis (Toronto: University of Toronto Press Inc., 2010) 366-369, and Jean Domremi, Faith Wallis, trans. "The Faculty of Medicine of Paris vs. Jean Domremi" in *Medieval Medicine: a Reader,* ed. Faith Wallis (Toronto: University of Toronto

issues of class and freedom demonstrate the problem of differentiating social value and social experience.

This thesis is a synthesis of broad research and historiographic trends. I have chosen to sacrifice comprehensiveness to any one field in pursuit of an original and interesting question. My research is interdisciplinary, and unites the origins of scientific thought with the informal medical scene and academic ideas about power and experience. I am heavily indebted to Monica Green, who has researched the balance of power between male and female practitioners and ideas about female access to medical texts.[7] Additionally, I relied on Katharine Park and her concept of "secrets of women," both as concealed ideas and personal knowledge of the hidden interior of female reproductive organs, in crafting an image of women as authorities on female bodies was invalidated as male practitioners colonized the female body throughout the medieval and early modern periods.[8] These perspectives are united in my research by the emphasis on female experience. My perspective on female bodily authority is also influenced by the works of Barbara Duden, Cathy McClive, and Ulinka Rublack, who examine the female perception and interpretation of signs and signals from their bodies.[9] Recipe collections have traditionally been an under-researched field of study, and I have relied on the works of Laura Lunger Knoppers and Elaine Leong, and the unpublished thesis of Jennifer Kay Stine to structure my knowledge of recipe collections.[10] My reconstruction of the origins of the Royal Society has been

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Press Inc., 2010), 369-379, demonstrate some of the ways that institutions criticized the methods of gaining authority and practices of empirics.

[7] Monica Green, *Women's Healthcare in the Medieval West* (Burlington: Ashgate Publishing Company, 2000) and *Making Women's Medicine Masculine* (New York: Oxford University Press, 2008).

[8] Katharine Park, *Secrets of Women: Gender, Generation, and the Origins of Human Dissection* (New York: Zone Books, 2006).

[9] Barbara Duden's *The Woman beneath the Skin* (Cambridge & London: Harvard University Press, 1991) reconstructs early modern German women's relationships with the physician Johannes Storch through his case records, with an emphasis on how women described their bodies and illnesses. Both Ulinka Rublack's "Pregnancy, Childbirth and the Female Body in Early Modern Germany," *Past and Present* 50 (February, 1996) and Cathy McClive's "The Hidden Truths of the Belly: The Uncertainties of Pregnancy in Early Modern Europe," *Social History of Medicine* 15 (2002) 209-227, deals with the difficulty of understanding the female body and pregnancy.

[10] Jennifer Kay Stine's "Opening Closets: The discovery of household medicine in early modern England," PhD Diss. (Standford University, 1996) explores the situations that allowed for the rise and fall of the early modern recipe collection, focusing on manuscript sources. Laura Lunger

informed by William Eamon's work on the developing idea of secrets literature, Pamela Smith's reconstruction of the process of validating experience, and Steven Shapin and Simon Schaffer's exploration of "experimental science" in early modern England.[11] Each chapter serves as an entry both to secondary literature and primary sources, indicating the importance of the unifying theme of experience while leaving room for further research.

This study spans medieval and early modern Europe but focuses on England, encapsulating a time period of roughly 1200 to 1700. Previous studies that separate the medieval and early modern periods have overstated the divisions between the two, particularly in terms of the life of the domestic and informal practitioners that are the focus of my study. By stepping back and viewing informal healing as a coherent, continual transition, I shift away from ideas about dramatic transitions and reconstruct the continuity of the female medical experience.[12] Additionally, the point of transition between "medieval" and "early modern" was a turbulent period in which ideas about experience and authority were destabilized and reconstructed. By taking this uncertainty as the crux of my argument, rather than the beginning or ending, I am able to identify points of continuity and discontinuity more effectively.

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Knoppers investigates the political implications of *the Queen's Closet Opened* in "Opening the Queen's Closet: Henrietta Maria, Elizabeth Cromwell, and the Politics of Cookery," *Renaissance Quarterly* 60 (2007): 464-499, and expands on the same theme in *Politicizing Domesticity from Henrietta Maria to Milton's Eve* (Cambridge: Cambridge University Press, 2011.) Elaine Leong explores the practice of preparing medicines in the home in "Making Medicines in the Early Modern Household," *Bulletin of the History of Medicine* 82.1 (Spring, 2008): 145-168.

[11] William Eamon, *Science and the Secrets of Nature: books of secrets in medieval and early modern culture* (Princeton: Princeton University Press, 1994); Pamela H. Smith, *The body of the artisan: art and experience in the scientific revolution* (Chicago: University of Chicago Press, 2004); Steven Shapin and Simon Schaffer, *Leviathan and the air-pump: Hobbes, Boyle, and the experimental life: including a translation of Thomas Hobbes, Dialogus physicus de natura aeris by Simon Schaffer* (Princeton, N.J.: Princeton University Press, 1985).

[12] Examples of books that capitalize on strict chronological divisions include Doreen G. Nagy, *Popular Medicine in Seventeenth-Centruy England* (Bowling Green: Bowling Green State University Popular Press, 1988) and Lucinda McCray Beier, *Sufferers and Healers: the experience of illness in Seventeenth-Century England* (London & New York: Routledge & Kegan Paul, 1987), which prioritize the reconstruction of a specific period over the long history of themes. Although they are excellent resources, I believe it is also important to identify long trends to see how and why the medical culture of early modern Europe emerged. I feel my work is more in the style of William Eamon, who takes a long approach in *Science and the Secrets of Nature: books of secrets in medieval and early modern culture* (Princeton: Princeton University Press, 1994) in studying the formation of the scientific revolution.

One of the features that has traditionally been used to establish the chronological break between the medieval and early modern periods is the rise of printing and the corresponding expansion of literacy. With the introduction of the printing press, literacy rates began to increase and society shifted away from manuscript and oral transmission of knowledge. Publications offered expanded dispersal of uniform ideas, increasing the geographic and intellectual scope of shared thoughts. The theme of publication is particularly important in my fourth chapter, which deals solely with published recipe sources and some of the implications of this method of information transmission. Printing also played into the Renaissance humanist revival. This can be seen in the obstetric text *the Birth of Mankind,*[13] which was part of the revival of Soranus' method of educating midwives on the art of midwifery. Beginning prior to the introduction of printing and continuing through the transition demonstrates the ways in which experience was shaped and changed by literacy and printing. Features like publishing became points of transition through which to view themes of continuity and discontinuity in experience, rather than historical breaks. Publishing is one of the methods through which female and male experiences were demonstrated and clarified.

My thesis is also impacted by the unique social and religious context of the English Reformation, which differed from continental reforms of both Protestantism and Catholicism due to its unique origins and trajectory. In 1529, King Henry VIII convened the reformation parliament to remove papal authority but remain nominally Catholic, with the intention of consolidating his power and securing an annulment for his first marriage to Katherine of Aragon. A. G. Dickens argues that the reformers "sought first and foremost to establish a gospel-Christianity, to maintain the authority of the New testament evidence over mere church traditions and human inventions masquerading as universally approved truths and 'unwritten verities'."[14] Prominent features of the developing Anglican

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[13] Thomas Raynalde, *The Birth of Mankind: Otherwise Named, The Woman's Book Newly Set forth, Corrected, and Augumented. Whose Contents Ye May Read in the Table of the Book, and Most Plainly in the Prologue,* ed. Elaine Hobby (Burlington: Ashgate Publishing Company, 2009.
[14] A.C. Dickens, *The English Reformation, Second Edition.* (University Park: Pennsylvania State University Press, 1989) 13.

Church were the elimination of the doctrine of purgatory,[15] dissolution of monasteries,[16] dismantling the cult of the saints, and institution of an English bible and book of prayers. Additionally, Henry VIII's 1535 "10 articles" reduced the number of sacraments from seven to three: baptism, Eucharist, and penance.[17] Linda Pollock argues that reformation measures were not popular with the "majority of the ordinary people; instead formal national conversion occurred over thirty years with the backing of a tiny, powerful elite consisting primarily of the landed gentry.[18]

These measures had significant repercussions for medicine and charitable practices in England. By 1539, after the initial reforms, the emphasis was placed on worldly and secular behavior, rather than traditional Catholic pious acts like church donations and veneration of the saints and Mary.[19] The new focus was on good deeds as a demonstration of piety in itself, without the intention for spiritual or physical return.[20] The base of power shifted away from the clergy and religious orders to the gentry who profited through the void in clerical wealth and territorial influence.[21] The deconstruction of monasteries removed a traditional site of informal medicine, scattering the texts and removing the authority of monks. Additionally, reforms dismantled hospitals, almshouses and other ecclesiastical institutions of charity that had hitherto been the focus of donations by the elites. Although many institutions were re-founded under Edward VI, the focus of charity had already shifted away from donations to the church, to more private and personal methods, particularly bequests to friends and family.[22] Additionally, the Reformation dismantled nunneries and lay charity groups such as confraternities, giving women in particular few opportunities for public charity.[23] Protestant perspectives also focused on the fear of idleness, constructing both campaigns

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[15] Claire S. Schen, *Charity and Lay Piety in Reformation London, 1500-1620* (Burlington, Vermont: Ashgate Publishging Company, 2002) 68.
[16] Dickens, *The English Reformation*, 167.
[17] Schen, *Charity and Lay Piety in Reformation London*, 22.
[18] Linda Pollock, *With Faith and Physic: The life of a Tudor Gentlewoman, Lady grace Mildmay 1552-1620* (Knightsbridge: Collins & Brown Ltd., 1993) 49.
[19] Schen, *Charity and Lay Piety in Reformation London*, 68.
[20] Schen, *Charity and Lay Piety in Reformation London*, 115.
[21] Dickens, *The English Reformation*, 189.
[22] Schen, *Charity and Lay Piety*, 101.
[23] Schen, *Charity and Lay Piety in Reformation London*, 242.

against the idle poor and idle gentry.[24] This emphasized the significance of noble women and informal medicine, as they both supplanted the absent monasteries, and demonstrated their activity and charitable intentions by providing care. The Reformation changed the terms of charitable practice, putting more emphasis on individual piety and noblesse oblige, rather than almsgiving and support of religious institutions.

Although I argue that female medical practice was widespread during this period, discussing informal and unpaid care is difficult due to the absence of early modern categories of description. I have done my best to clearly differentiate between formal or occupational, and informal practice, and will in particular use the word "physician" to indicate university trained, literate men engaging in internal treatment of the humoural system. Defining healing terms to describe the work of women is doubly problematic because of the absence of strict labour categories for female workers. Thus, I refer to midwives, as distinct from unpaid "birth attendants," empirics, and professionals to indicate women who received pay or social acknowledgement explicitly for their healing work. The majority of my paper deals with women not formally associated with their healing, and in this case I have referred to them as "informal practitioners" or "healers."

When referring to the work done by these informal healers, I have used words like "treated," "cared," and "cured" to refer to the provision of medical care. This category itself is broad, including diagnosis, attendance at sickbeds and childbeds, and the use of medicines and surgical techniques. Most of the surgical work performed by the women in this paper involves wound care. The word "nurse" has also been used as a verb, not an occupational label. During the sixteenth and seventeenth centuries, the word was expanding in definition from wetnurses to those who attended ill persons.[25] Unless otherwise stated, all these terms are labels I apply to the activities of the women, not user terms. When practicing informal medicine, women rarely applied explicit terms to their

[24] Schen, *Charity and Lay Piety in Reformation London*, 119, 236.
[25] "nurse, n.1". OED Online. March 2013. Oxford University Press. http://www.oed.com.proxy2.library.mcgill.ca/view/Entry/129240?rskey=9EX5tL&result=1&isAdvanced=false (accessed June 02, 2013).

activities. As a result, I have been obligated to use modern terms to describe their actions rather than relying on actor terms.

Related to the contested definition of "experience" is the nature and definition of "knowledge" in this period. Physicians felt that they had a monopoly on medical knowledge,[26] even including "experiential" medical knowledge, due to their literate tradition and explanations of causation, or in the case of *experimenta*, their intellectual and social "credibility."[27] They dismissed women and empirics as being associated with chance and uninformed observation. To respect this divide in perception, I have attempted to avoid using the term "knowledge" without indicating to which group it belonged. Thus, I refer to female traditions as "information" or "embodied knowledge," and to "academic knowledge" to indicate the tradition of male physicians. For the "experimental science" of the Scientific Revolution and Royal Society, I try to use the actor terms as outlined by Robert Boyle in his works, most specifically the idea of "experimental science" itself. This concept is integral to my first chapter, demonstrating the exclusion of women and their experiential information from experiments and "experimental science."

Each chapter of my thesis deals with a discreet situation of female participation in medicine. The difficult process of reconstructing this informal form of medicine, which was primarily unrecorded in terms of case records, statements of intent, or bodies of knowledge, required me to use a broad range of sources. Because each chapter deals with a different situation in which women interacted with medicine and male authority, it has been beneficial for me to focus on different types of primary sources in each chapter. I begin with the scientific revolution and the valorization of experience, which exemplifies the problems that women faced in asserting experiential authority. I develop this theme in the following chapters by exploring the ways that women interacted with the subject of experience within bodily experience, in chapter two on the subject of

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[26] Medical knowledge in this period included the principles of physics and physiology that explained the workings of the body, the processes of illness and the effect of therapies

[27] See, for example, Arnau of Vilanova's experimenta, trans. Faith Wallis, in *Michael McVaugh*, "The *experimenta* of Arnald of Villanova," *the Journal of Medieval and Renaissance Studies* I (1997): 107-18.

gynecology, and as healers in chapter three on noble women and chapter four on recipe books. In each chapter, I deal both with the types of authority women experienced, and the ways it was problematized or contested.

The formation of the Royal Society of London signified a shift in the academic, masculine perception of empirical evaluations. In my first chapter, I evaluate the ways that artisanal and scientific shifts in the value of experience impact popular ideas about the definition and usefulness of empiricism. I use the work of Robert Boyle, one of the preeminent members of the newly founded Royal Society, to outline the expectations of the society in terms of how information should be collected and presented, and who would be an authority.[28] This form of experience conflicted with informal methods practiced by women. The Royal Society's definition of experience is examined in light of the implicit exclusion of women from membership. Additionally, I utilize three cases in which women were in contact or collaboration with members of the Royal Society and were excluded despite ideas of their proficiency. This conflict between female proficiency in experiment and experience, and the realities of gendered exclusion, demonstrates the tenuousness of female authority based on experience.

In chapter two, "Unperceived hands: the role of the female assistant in gynecological literature," I take a broad chronological stance to view the relationship between female patients and male physicians in relation to gynecological and obstetric complaints. I use texts ranging from the early medieval *Trotula* corpus[29] and the fourteenth century *De Secretis Mulierum*[30], to the early modern period with studied two Middle English versions of *The Knowing of Woman's Kind in Childing* edited by Alexandra Barratt,[31] and the sixteenth century physician Thomas Raynalde's *The Birth of Mankind: Otherwise*

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[28] Robert Boyle, *The Works of the Honourable Robert Boyle. In five volumes. To which is prefixed the life of the author (*London: Printed for A. Millar, 1774).
[29] Monica H. Green, trans., *The* Trotula: *A Medieval Compendium of Women's Medicine* (Philadelphia: University of Philadelphia, 2001).
[30] Helen Rodnite Lemay, *Women's Secrets: A Translation of Pseudo-Albertus Magnus'* De Secretis Mulierum *with Commentaries* (Albany: State Unviersity of New York Press: 1992).
[31] *Alexandra Barratt, ed., The Knowing of Woman's Kind in Childing: A Middle English Version of Material Derived from the Trotula and Other Sources* (Belgium: Brepols Publishers, 2001).

*Named, the Woman's Book*[32]. These sources are evaluated in light of the troubled relationship of patients and professional healers, who had to mediate issues of tactility and propriety in their interactions. I will demonstrate the maintenance of physical space in the diagnosis and treatment of female ailments, specifically uterus complaints and childbirth complications. This space, combined with expectations of female embodied knowledge and relationships of touch between women, leads me to explore the realm of the unpaid and informal female intermediary. The presence of women acting in a descriptive and treatment capacity for other women is key to understanding the importance of experience in allowing a spectrum of medical behaviours in this period.

Chapter three, "Noble Ladies and Healing in Early Modern England," focuses on the unique situation of noble women, who were expected to provide treatment in both a charitable capacity, and in their role as the manager of an estate. In this chapter, I have drawn from the recollections and letters of Ann Fanshaw,[33] Anne Halkett,[34] Anne Clifford,[35] Jane Cornwallis,[36] Grace Mildmay,[37] and Mary Rich.[38] Each of these women recorded their participation in private, informal medicine, beginning with concern for the illness of their family and friends, and then stretching from wound care, to the treatment of their own children, to the preparation and exchange of medicines. I investigate why the subject of charity protected noble women from criticism about their medical practice and how religious and caring motivations could be used to justify active

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[32] *Thomas Raynalde, The Birth of Mankind: Otherwise Named, The Woman's Book Newly Set forth, Corrected, and Augumented. Whose Contents Ye May Read in the Table of the Book, and Most Plainly in the Prologue*, ed. Elaine Hobby (Burlington: Ashgate Publishing Company, 2009.

[33] Ann Harrison Fanshaw, "The Memoirs of Ann, Lady Fanshawe" in *The Memoirs of Anne, Lady Halkett and Ann, Lady Fanshaw,* Ed. John Clyde Loftis, John Cough Nichols, and Samuel Rawson Gardiner (Oxford: Clarendon Press, 1979)

[34] Anne Halkett, "The Memoirs of Anne, Lady Halkett" in *The Memoirs of Anne, Lady Halkett and Ann, Lady Fanshaw,* ed. John Clyne Loftis, John Cough Nichols, and Samuel Rawson Gardiner (Oxford: Clarendon Press, 1979).

[35] Anne Clifford Herbert Penbroke, *The Diaries of Lady Anne Clifford,* ed. D.J.H. Clifford (Wolfeboro Falls, NH: Alan Sutton, 1991).

[36] Jane Cornwallis Bacon, *The private correspondence of Jane Lady Cornwallis, 1613-1644 from the originals in the possession of the family,* ed. Richard Griffin Braybrooke (London: London: S&J Bentley, Wilson, & Fley, 1842)

[37] Linda Pollock, *With Faith and Ph*ysic: *The Life of a Tudor Gentlewoman, Lady Grace Mildmay 1552-1620* ( London: Collins & Brown, 1993).

[38] Mary Rich Warwick, *Autobiography of Mary countess of Warwick,* ed. Thomas Crofton Croker (London: Printed for the Percy Society by Richards, 1848).

medical involvement. From the diaries, I reconstruct the extent of their practices, demonstrating the interest and involvement of women in medicine.

Finally, chapter four is entitled "Female Experience and Authority in the Publication of Recipe Books" and deals with published recipe books as potential acknowledgments of female authority and skill. I use the three most popular published recipe books of the seventeenth century, *A Choice Manual of Rare and Select Secrets in Physick and Chyrurgery; Collected, and Practised by the Right Honourable, the Countesse of Kent, late deceased. Also most Exquisit ways of Preserving, Conserving, Candying, etc*, published by "W.I., Gent" and printed by "G.D." in 1653;[39] *The Queens Closet Opened. Incomparable Secrets in Physick, Chirurgery, Perserving, Candying, and Cookery; As they were presente to the Queen by the most Experienced Persons of our Time, many whereof were honoured with her own practice, when she pleased to defend to these more private Recreations*, by "W.M.";[40] and Hannah Woolley's *The Queen like Closet, Or Rich Cabinet: Stored with all manner of Rare Receipts for Preserving, Candying, and Cookery. Very Pleasant and Beneficial to all Ingenious Persons of the Female Sex. To which is added, A Supplement, presented To all Ingenious Ladies, and Gentlewomen. (3rd edition)*[41]. I approach the recipe books in two ways. First, there is the issue of publication ownership and male appropriation of texts, with two of the three authors being men who are publishing without the permission of the purported female compilers. However, I also believe that these sources reflect the popular manuscript tradition of recipe books in England. They can be used to see how the female compilers, Henrietta Maria, Elizabeth Grey, and Hannah Woolley, understood and described medical practice. The structure of the recipes can also be analyzed to see what sorts of skills would be expected of readers who

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[39] W.I., *A Choice Manual of Rare and Select Secrets in Physick and Chyrurgery; Collected, and Practised by the Right Honourable, the Countesse of Kent, late deceased. Also most Exquisit ways of Preserving, Conserving, Candying, etc. (*London, 1653).

[40] W.M., *The Queens Closet Opened. Incomparable Secrets in Physick, Chirurgery, Perserving, Candying, and Cookery; As they were presente to the Queen by the most Experienced Persons of our Time, many whereof were honoured with her own practice, when she pleased to defend to these more private Recreations (*London, 1655).

[41] Hannah Woolley, *The Queen like Closet, Or Rich Cabinet: Stored with all manner of Rare Receipts for Preserving, Candying, and Cookery. Very Pleasant and Beneficial to all Ingenious Persons of the Female Sex. To which is added, A Supplement, presented To all Ingenious Ladies, and Gentlewomen (*London, 1675).

wished to utilize the texts. Ultimately, publishing of female texts displays the extent of ambiguity around female experience. Recipe books were removed from the realm of the personal and charitable, becoming transferable, impersonal, and financially motivated. Female authority was established at the price of evacuating the traditional sources of female authority from the personal realm of the domestic and charitable.

Collectively, these chapters demonstrate how women integrated themselves or were integrated into issues of health and experience. Across Europe, and within England specifically, women utilized and were evaluated by their use of experience. I deal with the ways in which experience was used to construct authority, and the relationship that this authority had with formal medical practitioners, scientists, and the industry of publishing. Experience and class interacted and were utilized for both authority and profit, by women or by men appropriating the idea of women's authority. I will demonstrate how female authority was compromised, mediated, disregarded, or appropriated by men. Ultimately, this thesis shows how women remained active despite these limitations

## Chapter 1: Women, Experience, and the Rise of the Royal Society

In his preface to "A Defense of the Doctrine touching the *Spring* and *Weight* of the *Air*," Robert Boyle informed his reader that

> "it was not my chief design to establish theories and principles, but to devise experiments, and to enrich the history of nature with observations faithfully made and delivered; that by these and the like contributions made by others, men may in time be furnished with a sufficient stock of experiments, to ground hypotheses and theories on."[42]

In so doing, Boyle emphasized a new philosophy that departed severely from the traditional hierarchy that contrasted handiwork and experience with ratiocination and "scientific thought."[43] Instead, Boyle contributed to a movement that translated techniques of observation into a system of experiments that emphasized "intuitive, concrete, context-embodied experience." and that foregrounded the scientist's ability to "faithfully make and deliver" his observations to his audience. [44] Wolf and Gal indicate that this system was an "open, collaborative experimental practice, mediated by specially designed instruments, supported by civil, critical discourse, stressing accuracy and replicability."[45] Robert Boyle and his definition of experiment were part of a broader European movement that stressed experience and the relationship with nature as keys to understanding and explaining knowledge. In examining the changing comprehension of how to obtain and interpret scientifically valid and authoritative information, it is possible to perceive the shifting relationship between women's medical empiricism and formal, academic knowledge.

Starting with Robert Boyle and the scientific revolution is, in some ways,

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[42] Robert Boyle, "A Defense of the Doctrine touching the *Spring* and *Weight* of the *Air*, proposed by Mr. *Robert Boyle* in his new *Pysico-Mechanical* Experiments, against the Objections of *Franciscus Linus,* wherewith the Objector's *Funicular* Hypothesis is also examined" in *The Works of the Honourable Robert Boyle. In five volumes. To which is prefixed the life of the author (*London: Printed for A. Millar, 1774): 237.

[43] Pamela H. Smith, *The body of the artisan: art and experience in the scientific revolution* (Chicago: University of Chicago Press, 2004) 147.

[44] Smith, *The body of the artisan,* 147.

[45] Charles T. Wolfe and Ofer Gal "Embodied Empiricism Introduction," in *The body as object and instrument of knowledge: embodied empiricism in early modern science,* Ed. Charles T. Wolfe and Ofer Gal (New York: Springer, 2010): 1.

beginning at the end of the story of experience. In this chapter, I will demonstrate how elite scientific and medical men constructed a new philosophy that prioritized experience, and how the women who had previously been excluding from the realm of "knowledge" *because* their knowing was only "experimental" were now excluded from the newly defined and valorized category of experience. This process took place without formal acknowledgement of exclusion; instead, the creation of a designated research space with limited access and the new structures for communication of knowledge implicitly excluded female experience. The Scientific Revolution made experience masculine. This chapter is significant in my thesis because it begins near the chronological end of my thesis, demonstrating just how the terms that female experience gained power could be appropriated and deconstructed. By beginning with this inherent instability in the idea of experience and who experience "belonged" to, I set the stage for other points of conflict between female knowledge and male evaluation or control of women. I will demonstrate that because the construction of an ideal practitioner and desired now results in "experimental philosophy," women have to be banished from utilizing the skills they shared with experimental philosophers, including their familiarity with distillation and chemistry, to contribute to the new body of experimental knowledge. The exclusion of women from the formal institutions of "experimental philosophy" is demonstrated through the comparison of two peripheral female figures. Mary Evelyn was the wife of John Evelyn, an active member of the Royal Society. Although she was acknowledged as a proficient experimenter, she remained physically separate from the institution of experimental philosophy. Margaret Cavendish, Duchess of Newcastle attempted to penetrate into the masculine sphere of the Royal Society, both through self publication and physical visits. Despite her class, which normally allowed women access to politics, medicine, and science that were otherwise restricted by gender, and her persistent efforts to be integrated into the scientific community, she remained external to the procedure and self-definition of the Royal Society. These two examples demonstrate both how women perceived themselves in relation to experimental philosophy, how elite scientific men understood this relationship,

and the ways in which men eliminated women from experiments. Knowledge of natural philosophy, experimental technique and even "gentle" birth were not sufficient qualification for women to gain access to the Royal Society.

The necessary element of tactility in amassing personal experience impacted its relationship with formal, university medicine. Prestige in medicine was distinguished by the practitioner's extent of work along a spectrum stretching from head to hand, where male surgeons were subordinate to doctors, yet still superior to midwives.[46] Physicians, who were associated with the theoretical knowledge, logic and familiarity with classical texts that structured knowledge of the four humours and the techniques necessary to manage health, assigned themselves the position of hierarchical superiority compared to surgeons, apothecaries, and informal or unregistered practitioners who were deemed to work outside this epistemological framework. Within this medical system, techniques of observation and accurate representation had not been considered the site of philosophy and theory, but instead were considered lesser due to the nature of apprenticeship and rote learning and "slavish imitation."[47] Additionally, sense knowledge was regarded as less reliable than rationcination because it was less universal; each person perceived and interpreted sensory information differently.[48] However, during the early modern period, an epistemological shift occurred relating to the definition, collection, and distribution of knowledge. This involved a new perception of the relationship between knowledge and experience that was emerging in disparate groups. Pamela Smith identifies the self-conscious representation of European artists as an early demonstration of the valuing of a tactile and sensory relationship with nature. Similar themes can be identified in the foundational principles of the Royal Society. Collectively, these figures initiated a process through which activity and experience were redefined and prioritized in the search for knowledge.

Empiricism can be traced to the treatises of the prominent classical medical authority, Galen, who set empiricism in opposition to rationalism in his

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[46] Smith, *The body of the artisan*, 196.
[47] Ibid.
[48] Smith, *The body of the artisan*, 200.

claim that "some say that experience alone suffices for the art, whereas others thing that reason, too, has an important contribution to make."[49] His ideal approach mixed theory and empiricism. Although he appreciated empiricism as one of the two primary sects, alongside rationalism, he continued to rank it lower than reason for acquiring medical knowledge.[50] Empiricism was used by medical figures to study symptoms, and then use their memory and the process of inductive reasoning to recall past circumstances where a relevant treatment succeeded or failed.[51] This perspective persisted the medieval and early modern periods, with physicians claiming that empiricism should only be appreciated in conjunction with and in subordinate to reason.

Figures that used empiricism exclusively, without the benefit of reason and formal training, were denigrated in anti-empiric tracts by dominant intellectual groups like the Royal College of Physicians.[52] This can lead to the construction of a misleading dichotomy, in which the categories of formal and informal training, or academic and rhetorical training versus empirical acquisition of information, could be placed as two opposing groups. This construction is faulty, relying on attempts by physicians to situate themselves as primary medical authorities by denigrating their financial rivals. It was thus necessary to construct a cohesive opposition in order to denigrate economic rivals, despite the claims of these "empirics" that they were the same as physicians. Physicians strove to demonstrate that their skills were better than economic and social rivals. In reality, empirics could only be loosely classified as a collective because of their shared, allegedly exclusive reliance on the value of experience, and more

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[49] Galen, *Three treatises on the nature of science,* trans. R. Walzer and M. Frede (Indianapolis: Hackett Pub. Co., 1985) 3.
[50] Ibid. Galen proclaimed both sects superior to Methodism, which diagnosed illness through the disease alone, without taking into account the patient's history or theoretical knowledge of the body.
[51] AnikWaldow, "Empiricism and its roots in the ancient medical tradition" in *The body as object and instrument of knowledge: embodied empiricism in early modern science,* Ed. Charles T. Wolfe and Ofer Gal (New York: Springer, 2010): 291.
[52] See, for example, the cases of Jacoba Felicie, Faith Wallis, trans. "The Faculty of Medicine of Paris vs. Jacoba Felicie" in *Medieval Medicine: a Reader,* ed. Faith Wallis (Toronto: University of Toronto Press Inc., 2010) 366-369, and Jean Domremi, Faith Wallis, trans. "The Faculty of Medicine of Paris vs. Jean Domremi" in *Medieval Medicine: a Reader,* ed. Faith Wallis (Toronto: University of Toronto Press Inc., 2010), 369-379.

accurately on the fact that they existed outside the ranks of learned physicians. Instead of a group that presented coherent treatises on medicine and authority, the opinions of empirics emerged sporadically and disparately, in defenses against persecution or personal advertisements. This changed in the sixteenth and seventeenth centuries, when new descriptions of experience began to be used as a qualification for academic and professional integrity in larger circles. What was novel about groups like the continental artisans and the members of the Royal Society was their unembarrassed self-identification as empirics or experimentalist, and the fact that this knowledge was essential in the construction their group identity.

Pamela Smith argues that these intellectual changes can be understood as an epistemological shift in the understanding of what knowledge was and how it was to be pursued. In place of the traditional emphasis on syllogism, authors and philosophers now emphasized the observation of nature alongside continual practice and the active accumulation of practice.[53] The defining characteristic of this new approach to knowledge was the prioritization of experience. This inverted the traditional hierarchy of knowledge, in which textual and logical learning was prioritized over sensory knowledge. This shift in knowledge creation was accompanied by a move away from preexisting systems of theoretical knowledge. Experiential information was particular and obtained by the senses, unlike the general structures of theory. The new system required new methods of information collection and dispersal. Instead of reading and debating classical works and appropriating the records of experience they contained, authors turned to the writing of history, geography, and natural history, and the associated ideas of personal interpretation of facts, for models of active gathering knowledge. New techniques valued the recovery of data, recording of inscriptions, searching for locations, and observation of nature and natural exempla. Importantly, the art of experiencing also became linked to the practice of experiment. As a result, rhetorical systems like Aristotelean and Galenic medicine were supplanted and this philosophy was increasingly identified as a

[53] Smith, *The body of the artisan*, 217.

body of "facts" that had been sought by active work of the senses. In this period, the key words of empiricism acquired new meanings. Observation changed from the concept of custom, practice, performance or rite, to the idea of scrutiny and painstaking attention to a thing.[54] This redefinition allowed a new concept of a valid way to interact with nature, and provided the terms for the rise of experimentalism.[55]

One of the earliest groups to systematically emphasize their empirical knowledge of nature was the continental artisans. Pamela Smith argues that, particularly in Northern Italy, southern Germany, and the Netherlands, artists articulated and published their desire to espouse and make record of their skill.[56] Artists used their work to link claims about their elevated social status with their ability to accurately witness and represent nature; only true artistic skill and integrity could effectively replicate nature in art.[57] Artists indicated their skill and effectiveness at producing art through a relationship with "all-bearing nature," which they understood as an entity that was prolific, copious, and imbued with creative force. Most importantly, however, was the potential for imitability. Artists in this school saw their role as going further than earlier art, which mimicked nature but did not possess inherent truth, to imitate, reproduce, and harness the inherent creative power of nature itself. [58] Beyond this construction of indications of success, artisans made efforts to disseminate their perspective through publication. These books departed from the traditional style of artisanal manuals, which served more as lists of memory aids, rather than instructions. New treatises were explicit and attempted to synthesize theory, mathematics, and

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[54] Alan Salter, "Early Modern Empiricism and the Discourse of the Senses," *The body as object and instrument of knowledge: embodied empiricism in early modern science,* Ed. Charles T. Wolfe and Ofer Gal (New York: Springer, 2010.) 59.

[55] It is not my intention to re-trace the reasons that these changes were taking place, the work has been treated in monographs like A Rupert Hall, *The scientific revolution, 1500-1800; the formation of the modern scientific attitude* (London: Longmans: 1954); Steven Shapin *The scientific revolution* (Chicago: University of Chicago Press, 1996); and Deborah E. Harkness, *The Jewel House: Elizabethan London and the scientific revolution* (New Haven: Yale University Press, 2007).

[56] Smith, *The body of the artisan,* 31.

[57] Smith, *The body of the artisan,* 47.

[58] Smith, *The body of the artisan,* 54.

experience.[59] Experience became theorized through this process. This style implied a certainty and legitimacy to the work of artisans and crossed the divide between labour and scholar through an attempt to construct shared language.

Similar trends are visible in the field of academic medicine. Cynthia Klestinec indicates that "empiricism" can have a variety of meanings, including practical knowledge, knowledge of contingent effects, or the non-theorized perception of phenomena accessible to the senses. In the field of anatomy, "experience" during this period became associated with manual operative skill and expertise in dissection.[60] Kelstinec perceives a trend in Italian schools in which "peritia," or the manual experience gained from the accumulation of experiences, was perceived as a virtue. Because it ceased to be connected to lower-order experience, it became an elite value; "peritia" was achieved through the technical expertise in medical and dissection practice.[61] Katharine Park perceives the results of this new emphasis on practical and experiential knowledge as impacting the relationship of female privacy to medicine. The rising prestige of anatomy in the sixteenth century leant practitioners confidence in describing the texture and detail of the female body.[62] She observes that, despite the difficulties of access to body, academic perception indicated that the anatomist's experience outweighed erudition and verbal descriptions of the working of the female body.[63] The emphasis on personal experience, once the hallmark of inferior "female" forms of knowing, thus ironically removed women from their position as implicit assistants and interpreters within early texts on the female body. Because experience and experiment were now considered factors of male knowledge, women's organic interactions were no longer demonstrations of their right to proficiency and confidence, a subject that I will discuss in greater length in chapter two. In early gynecological and obstetrical manuals, women had been available to provide their

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[59] Smith, *The body of the artisan,* 73.
[60] Cynthia Klestinec, "Practical Experience in Anatomy" in *The body as object and instrument of knowledge: embodied empiricism in early modern science*, ed. Charles T. Wolf and Ofer Gal (New York: Springer, 2010): 33.
[61] Kelstinec, "Practical experience in anatomy," 37.
[62] Katharine Park, *Secrets of Women: Gender, generation and the origins of human dissection* (New York: Zone Books, 2006) 169.
[63] Park, *Secrets of Women,* 182.

experiences as an unacknowledged supplement to male rhetoric, but the new system of anatomical involvement and its resulting increased empowerment in masculine knowledge eliminated the traditional sphere of women as having a unique access to the female body and experience.

The emphasis on men experiencing nature did not stop at minimizing the significance of women's relationship to knowledge of their own bodies. Their new perspective penetrated deep into social consciousness about nature, changing expectations about the role that nature itself played in knowledge. Lorraine Daston explains that in the medieval period, "nature" was defined in contrast to the non-natural entities of supernatural, preternatural, artificial and unnatural events.[64] The most important shift inspired by artisanal self-promotion was the relationship between the natural and the artificial. The artificial was an ontological category that indicated that manufactured objects lacked an essence or internal nature, "in the sense of an inner essence that defined an authentic kind or species."[65] The criterion was seen as outweighing agency; human art and nature could create similar effects by similar procedures, but art could not create or alter essences. However, the artisan's claim of replication of nature as an indication of mastery compromised this divide. If they could replicate nature accurately, then the categories of definition began to collapse together. This problem was exacerbated by the rise of Cartesian mechanistic theory, which indicated that nature functioned through divine design, as if God had created a system of preorganized mechanisms that followed patterns without involvement or interruption.[66] If nature was a machine and absolutely obedient to cause and effect, then it lost its own creative power and was "reduced to brute, passive, stupid matter."[67] This certainty in the structure of nature indicated that it would be possible to construct a new natural history with a comprehensive knowledge of causes. If nature was mechanistic and divinely structured, then it was in turn possible to isolate and explain causes in the pursuit of unity with god. The self-

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[64] Lorraine Daston, "The nature of nature in early modern Europe," *Configurations* 6.2 (1998): 154.
[65] Daston, "The nature of nature in early modern Europe," 156.
[66] Daston, "The nature of nature in early modern Europe," 166.
[67] Daston, "The nature of nature in early modern Europe," 151.

promotion of artisans began the transition to experimental philosophy.

Even as it created the space for methodical exploration of nature, artisanal claims to knowledge based on experience compromised the power dynamic between academics and labourers. In the sixteenth and seventeenth centuries, Pamela Smith perceived a shift in academics' understanding of how nature could be known. The existing access to nature was achieved through manual labour and hard work. As a result, manual labour lost its stigma and experience was promoted as an integral component of knowledge making. This compromised the system by which academics had previously achieved authority through their dissociation from manual labour. Rather than exclusive access to information based on literacy and education, knowledge of nature in this system was theoretically available to any person willing to commit the time and labour. This system penetrated society and provided legitimacy to large numbers of practitioners who were previously excluded by their illiteracy.[68] The new universality of knowledge compromised the claims of academics, challenging systems of authority and allowing for questions about the necessity of university knowledge, which featured Aristotelan logic and natural philosophy. In order to retain exclusivity to knowledge construction, natural philosophers reframed their criticism of the expectation that bodily access alone provided knowledge, and instead suggested limitations to "raw" experience in order to refine and structure the transmission of experiential knowledge. Pamela Smith argues that "bodily involvement in the gathering of experience and the construction of knowledge came to be viewed as problematic."[69] One of the concerns that they vocalized about the new idealization of sensual experience was the fear of frailty and fallacies of the body. Although the senses were privileged, they were also wrecked by passions.[70] Therefore, experiences could be compromised due to the flaws of human nature, and were exacerbated in women because frailty and passion were gendered female.

The concern of inadequate or inaccurate observation was central in the

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[68] Smith, *The body of the artisan,* 185.
[69] Ibid.
[70] Smith, *The body of the artisan,*226.

appropriation redefinition of experience and nature by traditional academic groups. To combat fears that knowledge had been remade to allow any person access to enlightenment through the language of unity with nature, despite their qualifications or the accuracy of their knowledge, philosophers began to codify the language and techniques of "experience". The ideal became a dispassionate scientia, which could guarantee that experiential knowledge had not been aversely affected by passions.[71] In order do this, it was necessary to construct a new "objective" method of investigation, paired with a distinctive identity that was composed of formality and authority as well as experience. The new figure constructed by natural philosophers valued experience, but only through the perception of a moderate, chaste, disinterested, impartial observer. These qualities had traditionally been gendered masculine, with men associated with reason and the spirit and women with emotion and the body.[72] By defining an ideal observer as a masculine figure, women were implicitly eliminated from experiential authority. Pamela Smith argues that, as a result of this restructuring, "artisanal bodily experience was absorbed into the work of the natural philosopher at the same time that the artisan himself was excised from it."[73] Ultimately, these new philosophers proclaimed that they had reversed the relationship of instruction between academics and artisans. In his "History of the Royal Society" in 1667, Thomas Sprat indicated that one of the benefits of the Royal Society's program was that "the weak minds of the *Artists* themselves will be strengthen'd, their low conceptions advance'd, and the obscurity of their shops inlighten'd … the flegmatick imaginations of men of *Trade*, which used to grovel too much on the ground, will be exalted."[74] Far from acknowledging the role of artisans in elevating experience and nature, formal literature returned active and physical artists to a lower role through implying that they did not understand the actions they performed, and could be educated by philosophers. Philosophers described artisans as "low," weak, and phlegmatic, feminizing their characteristics.

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[71] Smith, *The body of the artisan,* 228.
[72] Horowitz, "Aristotle and Woman,"186-187.
[73] Smith, *The body of the artisan,* 186.
[74] Smith, *The body of the artisan,* 228.

Philosophers, describing themselves as masculine, situated themselves to be the educational and powerful authority.[75]

This development is important in appreciating the relationship of women in medicine to experimental knowledge. During the period of artisanal experience in the fifteenth and early sixteenth centuries,[76] it could be argued that the emphasis on experience accurately mirrored the relationship that women structured with medicine. Both groups utilized the idea that, through repeatedly accessing nature and amassing bodily experience, authority and truth could be achieved. This process occurred without formal education for both groups, instead knowledge was gained from the peer group, or through apprenticeship. Ultimately, however, to become authoritative in art or in medicine as a woman, one needed experience. Women were expected to have a basic and working knowledge of medicines but not provided with formal training, making them rely more heavily on experience in the absence of other forms of education. This was particularly true in women's health care, where the possession of a female body was seen as a source of knowledge.[77] While women were not expected to demonstrate their knowledge in concrete ways, as with artisans and works of art, there was the same expectation that the information they had collected through observation and experience would translate into practical benefits.[78] However, the new ideas of natural philosophers restricted the methods in which information collected through experience would be considered valid, emphasizing rationality, impartiality and moderation.[79] In this case, impartiality's definition as a lack of vested interest focused on the ideal that an experimenter would not have expectations about the results, leaving them free to observe and accurately record effects. This isolated women, who had previously been associated with information gained from experience, as a group

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[75] For more information about medieval and early modern gendering of traits, see Maryanne Cline Horowitz, "Aristotle and Woman," *Journal of the History of Biology* 9.2 (Autumn, 1976).
[76] Smith, *The body of the artisan,* 20.
[77] See the works of Horowitz, Lemay, or Green in the bibliography for more information.
[78] Because women were associated with the body and perceived to be less capable of intellectuality, as seen in Maryanne Cline Horowitz, "Aristotle and Woman," *Journal of the History of Biology* 9.2 (Autumn, 1976), they were also associated with the home. During the scientific revolution, women were associated with publishing practical recipe books, while men published philosophical tracts, a subject that will be discussed later in this chapter.
[79] William Eamon, *Science and the Secrets of Nature: books of secrets in medieval and early modern culture* (Princeton: Princeton University Press, 1994) 337-339.

particularly incapable of participating in the philosophy of experience. "Women, who are in excluded from the sphere of rationality, are declared to be unfit to participate in the activity of science, the highest expression of rationality."[80] Prevailing expectations of gender and body norms defined women as inherently weak and susceptible to emotion.[81] This eliminated them from the ranks of observers because their innately feminine traits, which had previously associated them with nature, eliminated their impartiality. In academia and rhetoric, women were allowed access to experience because of this bodily weakness; the transition to impartial experience removed their ability to participate in empiric observation.

In England, the validation of experience and experiment were forwarded by the figure of Francis Bacon. In his work, Bacon created and consciously associated himself with the early days of a new philosophy. William Rawley explained in his introduction "That his Lordship (who thinkth hee deserveth to be an Architect in this building,) should be forced to be a Work-man and a Labourer; And to digge the Clay, and burne the Brick; … For he knoweth, that except hee doe it, nothing will be done"[82] Bacon used the language of labour to indicate the status of his new philosophy and the work necessary to expand it. He considered his philosophy to be in the early stages and devoted himself to the structure that would enable it to continue on the path towards inclusive knowledge. On one level, this sharp division is accurate in the academic community, as the elevation of experiment contrasted sharply to traditional methods of rhetorical practice and complete knowledge systems. However, there were broader implications to Bacon's creation of a "new" philosophy. The decision to frame his philosophy as a clean break from tradition meant that Bacon could also disempower previous cases of empiricism. As a result, his philosophy integrated aspects of artisanal and informal medical practice into his methods of obtaining knowledge, but limited references to existing systems. He could appropriate techniques while applying

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[80] Susan Hekman in Sarah Hutton, "The riddle of the Sphinx: Francis Bacon and the Emblems of Science" in *Women, Science and Medicine 1500-1700,* ed. Lynette Hunter and Sarah Hutton (Thrupp: Sutton Publishing Ltd.: 1997): 9.
[81] Horowitz, "Aristotle and Woman," 188.
[82] Francis Bacon, *Sylva sylvarum, or, A natural historie/written by the Right Honourable Francis Lo Verulam Viscount St. Albans: published after the author's death by William Rawley.* London, 1626. *The Making of the Modern World (*Web): 8.

his own expectations for methods and results.[83]

Francis Bacon's status as an intermediary can be seen in his acceptance of inductive reasoning. His system would allow both the validation of traditional techniques of analysis, and the expansion of more certain knowledge through exploration of nature. In the publisher William Rawley's introduction to Bacon's *Sylva sylvarum*. Rawley states that Bacon's intention was "to write such a *Naturall History*, as may be Fundamentall to the Erecting and Building of a true *Philosophy*: For the Illumination of the *Understanding*; the Extracting of *Axiomes*; and the producing of many Noble *Works*, and *Effects*."[84] Although Bacon continued to use the traditional genre of natural history, his selection of purposes varied from tradition. Rather than an informative work, Bacon indicated that the composition of natural history was a tool to further ends. Instead, natural history must be accumulated until it produced understanding of cause and function in nature, eventually producing rules. Bacon indicated with this philosophy that current systems of understanding nature were inadequate, but made the drastic step of consciously choosing not to supply a new system of his own. Instead, he provided a suggestion that it was necessary to collectively and gradually construct information in a different way to produce true knowledge. Knowledge was now dependent on collective empirical and experimental intellectual labour over time, resulting in the collection of power.

One of the results of the gathering of experience was the creation of "matters of fact." Barbara Shapiro explores the rhetoric of this concept through its origins in the legal system. This is particularly relevant to England, as Francis Bacon was a lawyer and would have access to the legal culture of fact. She indicates that legal terms that emphasized truth and impartiality through firsthand accounts were disseminated from courts to the general public, where they were appropriated by natural philosophers.[85] In *A Culture of Fact: England, 1550-*

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[83] In his natural history, Bacon refers to a "rule" which states "a short stay in this liquor recevyeth the Spirit; And a longer stay confoundeth it;" but does not indicate the origins or justification of the rule. It exists as if in a vacuum. (Bacon, *Sylva sylvarum, 5.)*

[84] Francis Bacon, .*Sylva sylvarum,* 6.

[85] Barbara Shapiro, *A Culture of Fact, England: 1550-1720* (Ithaca and London: Cornell University Press, 2000): 7.

*1720.*, she outlines the origins of necessary assumptions of "matters of fact" in a legal setting. First, it must be possible to gain accurate knowledge of events that had not been personally seen or heard, making them "transient things" that were transmitted through oral or written testimony. Second, there was a necessary faith in the validity of the observer's testimony and the ability of the juries to judge the credibility of the fact.[86] This concern was evident in the codification of the artisanal relationship with nature by the natural philosophers. The origins of artisanal theory indicated that the performance of art was the demonstration of qualification; a successful relationship with nature translated into a level of artistic accuracy. However, it also allowed any member of society to claim knowledge of nature through experience. Natural philosophers indicated that experience was not sufficient, and instead proposed the additional necessity of an impartial observer who could perceive and record without bias. This perspective was a product of legal discourse and cultivated suspicion towards artfulness, partiality, and ornament.[87] However, "facts" could still be personal experience and were considered to be knoweable even if not directly observed, constructed by trustworthy witnesses as testament to past events and accepted by a community.[88] The qualifications of the impartial witness allowed them to stand in for any viewer through the transmission of their knowledge. Truth was mediated by credibility.

"Matters of fact" were taken up as the central premise for the Royal Society of London, a group of men lead by figures like Robert Boyle who proposed that conscious and methodical experiments, with regulated techniques, procedures and spaces, could reveal essential natural causes. Nature could not be understood passively, even though repeated exposure. Instead, it had to be investigated and critiqued. The two perspectives are evident in the philosophy of Robert Boyle, who claimed that

> "For some men care only to know nature, others desire to command her; or, to express it otherwise, some there are, who desire but to please themselves by the discovery of the causes of the known phaenomena; and

[86] Shapiro, *A Culture of Fact,* 13.
[87] Shapiro, *A Culture of Fact,* 3.
[88] Shapiro, *A Culture of Fact,* 9.

> other would be able to produce new ones, and bring nature to be serviceable to their particular ends."[89]

Boyle acknowledged that simple experience was one route of interaction with nature. This philosophy can be related to the earlier continental artisans, who demonstrated their intimate knowledge of nature through convincingly reproducing it. Boyle's adherence to the new, more codified system of experience is evident in the second half of his statement. He indicated that others would interact with nature in order to produce a knowledge exacting enough that it could be utilized exert control over nature, making it "serviceable" through intensive understanding of causes. This was one of the roots of the new "experimental philosophy;" although intellectuals were careful to indicate that they were not surpassing their current knowledge and emphasized the necessity of collection of information, they believed that the practice would lead to a more relevant end. Ultimately, through their collection of information, these philosophers believed that they would be able to construct rules that allowed them a degree of control over nature. The subject of potential control was integral to the new "experimental science."

One of the features of the new Royal Society was its exclusively male membership, which was implicit but unsurprising due to social and intellectual norms of the period, like the male-only university, which precluded female membership. One of the reasons women were excluded involved the construction of a relationship between knowledge and power. When Boyle discussed how some men "desire to command"[90] nature, he implicitly related his new philosophy with the idea of control. This was a masculine idea, as men were more associated with power than women. However, the choice to exclude women from formal organizations of experimental philosophers is surprising when the relationships of founding members prior to the establishment of the Royal Society are investigated. Lynette Hunter explains that until the mid-seventeenth century, men

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[89] Robert Boyle, Certain Physiological essays, and other tracts; written at distant times, and on several occasions" in *The Works of the Honourable Robert Boyle. In five volumes. To which is prefixed the life of the author (*London: Printed for A. Millar, 1774): 199.
[90] Ibid.

and women practiced science in the same place and using the same equipment.[91] In this case, her use of the concept of "practicing science" is problematic because it awards the same intentions to the two genders. Household science and household medicine had similar features, including distillation, cookery techniques, and adherence to recipes. Men used their experiments to drive knowledge of causes, eventually coming together in scientific communities like the Royal Society. Women like Mary Evelyn appear to have focused on the concrete results of experiments, prioritizing the benefits to the household over abstract discovery.[92] Men and women shared a workspace and tasks, and women like Katherine Jones were included in debates about technique and intention. Before the expectations and experimental space of the Royal Society were codified, women were involved in meetings and correspondence about experiments.

Female participation in science can be seen in both Katherine Jones, the sister of Robert Boyle, and Mary Evelyn, the wife of Society member John Evelyn. Katherine Jones shared facilities with her brother and had contact with other experimentalists like Thomas Willis and John Wilkins. These men recognized her skill in "using her receipts" and the appropriateness of female activity in chemistry.[93] Mary Evelyn was the wife of Royal Society member John Evelyn, who was known for his knowledge of trees. As a result, she existed in what Frances Harris refers to as the "neighbourhood of science;" although John Evelyn had a separate laboratory on their property, he worked in conjunction with Mary in the stillroom and kitchen and shared information and resources with his wife. Harris observes that during the 1650's, books produced in the Evelyn household contained both their handwriting, a sign that he respected her skill

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[91] Lynette Hunter, "Women and science in the sixteenth and seventeenth centuries -- different social practices, different textualities, and different kinds of science." in *Men, Women, and the Birthing of Modern Science.* Ed. Judith P. Zinsser. (DeKalb: Northern Illinois University Press, 2005): 123.

[92] Frances Harris, "Living in the neighborhood of science: Mary Evelyn, Margaret Cavendish and the Greshamites" in *Women, Science and Medicine 1500-1700.* Ed. Lynette Hunter & Sarah Hutton (Thrupp: Sutton Publishing Limited: 1997): 199.

[93] Lynette Hunter, "Sisters of the Royal Society: The Circle of Katherine Jones, Lady Ranelagh" in *Women, Science and Medicine 1500-1700,* Ed. Lynette Hunter & Sarah Hutton. (Thrupp: Sutton Publishing Limited: 1997): 186.

enough to allow her to make contributions to his stock of information.[94] With the creation of the Royal Society, John Evelyn physically removed his experimental process from their home, but Mary remained acknowledged as uniquely qualified for a female to participate and mediate in discussions on experiment.

Hunter indicates that one of the reasons for female exclusion may have been concerns about the gendering and authority of the new society. Because women were expected to provide care for their households, they were expected to obtain a set of skills related to the making of medicines and foods. These skills focused on chemistry and distillery, which were also techniques utilized in the pursuit of experimental knowledge by men. Because women were associated with these skills, chemistry and medicine were demoted from classic areas of "learning."[95] In order to continue using these techniques, men had to sustain the argument that their skills were not trivial and could be publically legitimized. Although the shift from kitchens to laboratories needed minimal change in procedure, the new space could be designated as masculine and divorced from the implications of housewifery.[96] Associating their work with a public space meant that men divorced themselves from women to redefine themselves and their work as masculine and academically acceptable according to traditions of exclusively male intellectual fields. To do so, they emphasized that their practices were supported by a coherent philosophical argument. However, there is another side to the story. It is possible that the women who had participated in the early days of experimental philosophy had little interest in following their male peers to the public and theoretical arena. The feature distinguishing female scientific practice from the new techniques of the Royal Society was its usefulness; their skills developed cures and treated their families. There was little to be gained in moving away from kitchens and household distilleries, as they would be departing from feminine roles and sterilizing the use of their practices in becoming philosophers.

Another way that men distinguished themselves from the practices leading

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[94] Harris, "Living in the neighborhood of science," 202.
[95] Margaret P. Hannay, "'How I these studies prize': the Countess of Pembroke and Elizabethan Science" in *Women, Science and Medicine 1500-1700*, Ed. Lynette Hunter & Sarah Hutton. (Thrupp: Sutton Publishing Limited: 1997) 109
[96] Hunter, "Sisters of the Royal Society," 188.

to the creation of the Royal Society was their dissemination of knowledge. Rather than using letters or discoursing in person, discoveries were transmitted through detailed experimental reports and essays. One of the features of this type of document was the ideal of replication; readers were encouraged to perform the experiments themselves with the intention of perfect replication, thus "ensuring distant but direct witnesses"[97] Even for those who could not replicate the experiments, the exacting nature of the documents allowed for a form of "virtual witnessing." Shapin and Schaffer describe virtual witnessing as the production in a reader's mind of an image of the experimental scene that "obviates the necessity for either direct witness or replication."[98] Through explicit detail of the technology and process, it would become possible to imagine the experiment through digestion of the text.[99] This technique changed the types of information remembered, placing an emphasis on remembering the experience of learning, seeing, doing and touching. Richard Yeo refers to this as "personal memory," as opposed to the "non-personal" memory of facts, dates, and theorums.[100] Emphasizing the importance of the experience made "virtual witnessing" all the more important, because it was the experience and not the resulting data that was to be transmitted for approval. Robert Boyle acknowledged the necessity of the technique of "virtual witnessing" for the dispersal of his new philosophy. Boyle's experiments focused on pneumatics and air pressure, using a device he named referred to as the air pump. The success of these experiments relied on the creation and maintenance of an air pump with a tight seal. To possess the equipment required time and high financial freedom, both of which Boyle possessed as a member of the aristocracy. However, he was conscious that the same resources were not available to all his readers and

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[97] Steven Shapin and Simon Schaffer, *Leviathan and the air-pump: Hobbes, Boyle, and the experimental life: including a translation of Thomas Hobbes, Dialogus physicus de natura aeris by Simon Schaffer (*Princeton, N.J.: Princeton University Press, 1985): 59

[98] Shapin and Schaffer, *Leviathan and the air-pump,* 60.

[99] This intention differed from recipe books, which did not aim to have readers imagine the results of the first experiment, but create a functional product with similar effects.

[100] Richard Yeo, "Memory and Empirical Information: Samuel Hartlib, John Beale and Robert Boyle" in *The body as object and instrument of knowledge: embodied empiricism in early modern science,* Ed. Charles T. Wolfe and Ofer Gal (New York: Springer, 2010): 198.

> "thought I might do the generality of my readers no unacceptable piece of service, by so punctually relating what I carefully observed, that they may look upon these narratives as standing records in our new pneumatics, and need not reiterate themselves an experiment to have as distinct an idea of it, as may suffice them to ground their reflexions and speculations upon."[101]

Boyle acknowledged the unique limitations of his experiment and utilized the exchange of letters, and publishing more broadly, to navigate the divide between the desire to experience and the ability to perform experiments. These letters were different than those exchanged by women due to the style and degree of detail and intention of transmission, a subject that will be discussed later in this thesis. It was important that he did not indicate that there was a degree of insufficiency to the agreement of those who did not personally witness experiments. He emphasized instead that that having a distinct idea of the event, constructed through reading detailed texts, sufficed as an experience. These readers could still contribute valuable ideas that resulted from their consideration of the experiments of others.

The communicative structure of empiricism within "experimental philosophy" excluded female medical practitioners. The male tradition of publishing responses contrasted with female communication, which was primarily oral through familial and friendship circles, but was also supplemented by the unique genre of the recipe book. Even when women began to be affiliated with the publication of recipes, women continued the private and personal exchange of recipes, supplemented by published sources. It was only in unique situations, which will be discussed further in chapter four, that women's literature was published. Lynette Hunter indicates that women's communication about interaction with physical world, pertaining to domestic medicine and household technology, "may have been oral, but there is no record of formal disputation or their education in it."[102] Women primarily communicated and exchanged

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[101] Robert Boyle, "New Experiments Pysico-mechanical, touching *the Spring* of the *Air*, and its Effects; made, for the most part,in a new Pneumatical Engine; written by way of Letter to the Right Honourable *Charles* Lord Viscount of *Dungarvan*, eldest Son to the Earl of *Cork*" in *The Works of the Honourable Robert Boyle. In five volumes. To which is prefixed the life of the author (*London: Printed for A. Millar, 1774): 163.

[102] Hunter, "women and science in the sixteenth and seventeenth centuries," 123.

information personally, or within private correspondence.[103] This system of communication was also problematic in the way that women constructed their knowledge, because the open process of sharing and oral communication of private results did not follow the rigorous descriptive methods that ensured replication that were found in the Royal Society. Additionally, the texts of the Royal Society had persuasive intentions, while female texts were intended to communicate information. Therefore, their information could not be subject to the same processes that created "matters of fact." Additionally, Lynette Hunter indicates that women perceived an important inadequacy in the act of replication. In their medical work, women perceived the necessity of recreation, producing a new product that would stimulate the same curative results. What "virtual witnessing" intended was exact replication, which was technically impossible due to the minute variables of each situation. The intentions were minutely different. Men indicated that through "virtual witnessing," an exact copy would be produced that would allow the observer to replicate the experience of the original experimenter. Women did not aim for the same degree of precision implied by replication, but instead used recipes to create the same results, rather than an exact duplicate of the original. A successful recreation of a medical recipe would produce the same cure as the original, even if the contents or methods were slightly varied. The masculine ideal of representation and replication could not adequately express an interaction with the natural world.[104] Women practiced and communicated without the vital ideal of communicated replicability in the Royal Society, isolating themselves from the published and self-aggrandizing practice of their former peers.

The difference between these ideas of male and female can be seen in contrasting scientific publications, like that of Robert Boyle, with recipe collections like *the Queen's Closet Opened* which we discuss in greater depth in chapter four below. Boyle devoted a high level of detail to his description of

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[103] Lynette Hunter, "Women and Domestic Medicine: Lady Experimenters, 1570-1620" in *Women, Science and Medicine 1500-1700*, Ed. Lynette Hunter & Sarah Hutton (Thrupp: Sutton Publishing Limited: 1997): 103.
[104] Hunter, "Women and science in the sixteenth and seventeenth centuries," 135.

experiments. In "New Experiments Pysico-mechanical," his descriptions of experiments last at least a page each, with lengthy sentences such as "that we have not mis-aligned the cause of this phaenomenon, seems evident enough by this, that as air is suffered by little and little to get into the receiver, the weigth, that a man fancies his hand supports, is manifestly felt to decrease…"[105] Boyle is also careful to describe the devices he uses in his experiments. Experiment VII indicates that "we caused to be blown with a lamp a round glass bubble, capable of containing, by guess, about five ounces of water, with a slender neck about the bigness of a sqan's quill; and wit was purposefully blown very thin, .. that the thinness of the matter might keep the roundness of the figure…"[106] These details demonstrate the desire to make total reproduction possible.

In contrast, recipe books presented a more minimal format, presenting the ingredients and basic steps for creation of the medicine. Examples of recipe instructions include "Take blue Lilly-roots sliced small and bruised, and steep it in as much Vinegar as will cover them;"[107] Take powder of Cinamon, one dram, powder of Amber half a dram finely beaten, mingle it with eight spoonfuls of Claret Wine, and so let her drink it,"[108] and "distill them in a Limbeck"[109] Recipe collections did not go into detail about the types of equipment, or even deconstruct the use and preparation of ingredients. A recipe recreated from a book was intended to have the same curative power as the implicit original preparation that had been recorded by the author. It was not expected to be an exact duplicate of that earlier preparation. Even an individual user, making the same recipe multiple times, could vary the content and preparation, experimenting further to nuance the results. The methods of recording results and the expectations about how results would be achieved varied between the two genres.

The difference between recipe books and experimental tracts cannot be

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[105] Boyle, "New Experiments Pysico-mechanical ," 16.
[106] Boyle, Boyle, "New Experiments Pysico-mechanical ," 23.
[107] W.M., *The Queens Closet Opened. Incomparable Secrets in Physick, Chirurgery, Perserving, Candying, and Cookery; As they were presente to the Queen by the most Experienced Persons of our Time, many whereof were honoured with her own practice, when she pleased to defend to these more private Recreations (*London, 1674) 55.
[108] W.M., *The Queen's Closet Opened* (1674), 84.
[109] W.M., *The Queen's Closet Opened* (1674), 19.

used as an absolutely divide between male and female science. During the early, days of the Royal Society, women did interact with the male members though they were eventually marginalized. The contrast of Mary Evelyn and Margaret Cavendish can demonstrate the problematic relationship women had with the new experimental philosophy. Both women existed in the periphery of the Royal Society. Where Mary Evelyn had participated in science with her husband before the formulation of the Royal Society, Margaret Cavendish, Duchess of Newcastle, stimulated her own fame. Cavendish wrote and self published books on natural philosophy, personally sending copies to academic institutions including Cambridge and Oxford. Cavendish was motivated by a desire to have her theories publically expounded and constructed relationships with intellectuals of her day. She was the only woman to enter the Royal Society in the seventeenth century, in a much heralded ceremonial visit in 1667.[110]

Margaret Cavendish's position as the Duchess of Newcastle made her exempt from many of the limitations on female interaction with male academics. Cavendish was active in the natural philosophy community, and comfortable in criticizing what she perceived as flaws in the experimental method. She was particularly critical of experimental philosophers' use of tools in experiment, claiming that "I have but little faith in such Arts, and as little in Telescopical, Microscopical, and the like inspections, and prefer rational and judicious Observations before deluding Glasses and Experiments.[111] Indeed, Cavendish dismissed many of the central precepts of the Royal Society, considering nature to be embued with essences and distrusting the experimental practices. In her book, *Observations upon experimental philosophy : to which is added the description of a new blazing world*, Cavendish makes no mention of personally practicing experiments, instead presenting a rhetorical work that was not rigorously

[110] Harris, "Living in the neighborhood of science," 198.
[111] Margaret Cavendish, *Observations upon experimental philosophy : to which is added the description of a new blazing world / written by the Duchess of Newcastle. 1st ed. London: 1666.* (Providence, RI: Brown University Women's Writers project, 1999): B1v.

organized and dealt with a broad range of subjects.[112] In regards to experiment, she indicated that "However, although it be the mode, yet I for my part ſhall not follow it, but leaving to our Moderns their Experimental or Mode-Philoſophy built upon the deluding Art, I ſhall addict my ſelf to the ſtudy of Contemplative-Philoſophy, and Reaſon ſhall be my guide."[113] She used the traditional academic discourse, not the new discourse of experimental science, to frame her new argument. Sarah Hutton indicates that Cavendish also had a tendency to expound her opinions, rather than explaining how she arrived at them.[114] These opinions placed her at odds with the theories of the community of new natural philosophers, but Cavendish did not indicate an awareness of this conflict. She continued to ruminate and self-publish.

Cavendish had to work hard to justify her qualifications and solicit-respect for her work. In her letter "to the most famous University of Cambridg," Cavendish said that "by your civil respects, and undeserved commendations, you were pleased to cherish rather, than quite to suppress or extinguish my weak endeavors."[115] She perceives herself in a relationship with the university in which they supported her philosophy, and desires further and more formal acknowledgement. Sarah Hutton thinks that it is likely, in analyzing the letters of response from academic institutions, that Cavendish' works were never read. [116] This is an important factor in analyzing her relationship with the Royal Society and experimental philosophers more generally. Cavendish's status allowed her access to masculine spaces, but did not assure her their respect or acknowledgement. Instead, she was tolerated and privately dismissed. Without her status as a Duchess, it is probable that Cavendish would never have been acknowledged as a participant in the community, let alone gain access to the space

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[112] Sarah Hutton, "Anne Conway, Margaret Cavendish and seventeenth-century scientific thought" in *Women, Science and Medicine 1500-1700*, Ed. Lynette Hunter & Sarah Hutton (Thrupp: Sutton Publishing Limited: 1997): 223.
[113] Cavendish, *Observations upon experimental philosophy*, Aa2r. The "deluding Art" to which Cavendish refers is, according to Anna Battigelli, optical lenses, which Cavendish disliked because they interposed between the object and personal experience, and could not be verified by plain sight.
[114] Hutton, "Anne Conway, Margaret Cavendish and seventeenth-century scientific thought," 224.
[115] Cavendish, *Observations upon experimental philosophy*, B2v.
[116] Hutton, "Anne Conway, Margaret Cavendish and seventeenth-century scientific thought," 222.

of the Royal Society. She was given the benefit of access due to the role of aristocratic women in the scientific community, but she was never acknowledged as a member.[117]

The case of Mary Evelyn is very different, as she had been active with her husband in the creation and recording of science he had done at home. Mary Evelyn was acknowledged as proficient in the skills that were transcribed into the community of the Royal Society, and sustained close relationships with active members, including her husband. However, Evelyn never strove to cross the boundary into the public sphere of experiment. Instead, she took pains in her correspondence to demonstrate her prioritization of traditional female duties. In a letter to Ralph Bohun she indicated that

> "Women were not born to read authors, and censure the learned, to compare lives and judge of virtues, to give rules of morality, and sacrifice to the muses. We are willing to acknowledge all time borrowed from family duties is misspent; the care of children's education, observing a husband's commands, assisting the sick, relieving the poor, and being serviceable to our friends, are of sufficient weight to employ the most improved capacities among us."[118]

What was important to Mary Evelyn was her home life. She contrasted herself and her duties with the figure of Margaret Cavendish, indicating after meeting Cavendish that "Never did I see a woman so full of herself, so amazingly vain and ambitious."[119] Evelyn criticized the effrontery of Cavendish' ambitions, including her acceptance of compliments "which she took to be so much her due that she swore if the schools did not banish Aristotle and read Margaret, Duchess of Newcastle, they did her wrong and deserved to be utterly abolished."[120] Evelyn established a clear divide between the work she saw fit to perform herself, and the procedures of Cavendish, which violated sense and decency.

Although she focused on her home life and the raising of her children, Mary Evelyn sustained prolonged correspondence with her son's tutor, Ralph

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[117] Hunter, "Women and domestic medicine," 93.
[118] Harris, "Living in the neighborhood of science,"199.
[119] Ibid.
[120] Ibid.

Bohun, on subjects including the practice of experiment. He considered her decision to remain private to be a waste of her skill, indicating that it was "odd" that a woman of her skills

> … should now wholly be abandon'd to the conduct of her domestic affairs, And her most important concerns either to make laws in the nursery, or pyes and tarts in the kitchen, or serve under Mrs Turner in the stilhouse. These are employments that degrade from her self, & render her mortal as other women."[121]

Mary eventually dismissed this by saying, "I find the slight cares of a family are great hindrances to the study of philosophy, and that one grows less and less capable of improvements by books, as one grows more acquainted with the world."[122] However, it is clear from Bohun's admiration of her skills that she had proficiency and technique enough to exceed her role as a housewife. In prioritizing "assisting the sick, relieving the poor" and other charitable duties, Evelyn emphasized that her practical skills were associated with a duty to care. In this way, her choice was an active dismissal of the public community in favour of traditional female roles.

Both Cavendish and Evelyn had their sense of relationship with the Royal Society unhappily terminated. Despite extended attempts to be integrated into the male community, Cavendish complained of "the carelesse neglects and despisements of the masculine sex to the effeminate, thinking it impossible we should have either learning or understanding, wit or judgement, as if we had not rational souls as well as men."[123] The less active and aggressive figure of Mary Evelyn eventually experienced "the teasing, inhospitable and potentially hostile display of masculine learning and science, professing only 'admiration.'"[124] Harris deals more explicitly with the silencing of Cavendish, indicating that faced with the "formidable display of experimental technique by Boyle and Hooke, she retreated professing herself 'all admiration' and afterwards muted her criticism of

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[121] Harris, "Living in the neighborhood of science," 208.
[122] Harris, "Living in the neighborhood of science," 211.
[123] Hutton, "Anne Conway, Margaret Cavendish and seventeenth-century scientific thought," 222.
[124] Harris, "Living in the neighborhood of science," 213.

the new science."[125] This intellectual bullying does not emerge in the publications of Boyle, who professed to be interested in converting everyone to his "new philosophy."[126] Although women played a role in distancing themselves from the new experimental philosophy, men also actively dissuaded their participation. Particularly in the case of Cavendish, her interest and participation appears to be met with a concerted effort to indicate her insufficiency on the subject, rather than interact or persuade her to adjust her theories to be in line with those of the natural society. From shared roots, the Royal Society began to distinguish and suppress the involvement of interested and peripheral women.

The rise of empiricism was informed by a gradual redefinition of terms of practice and expectations of knowledge. In elevating experience from the disparate justification of qualification of scattered medical practitioners, to the indicative feature of artisanal success, to the necessary qualification in creation of new knowledge, the relationship of experience to women was shifted. Both women and nature were removed from being sites of knowledge unavailable to men. Instead, men began to assert themselves as possessing and defining experiential knowledge. This is evident in the development of the Royal Society and its decision to construct the experimental space as masculine. Despite the availability of women with the technical skill and social relationships to participate in experimental philosophy, men emphasized means of communication and self-definition that shifted experience from being a non-gendered domain to a space that was publically occupied by men following a precise behavioural code. This process was not solely through exclusion of women by men. Although women had skills that were relevant to the work of the Royal Society, a mutual process of women's general, if not entirely genuine disinterest in participation in the "new philosophy" and an effort by men to differentiate themselves from the feminine implications of their experiments resulted in the exclusion of women from the Royal Society. Women like Mary Evelyn chose to remain differentiated and use their skills for practical purposes within their homes and communities. When elite women did try to penetrate the arena of experimental philosophy, like

[125] Harris, "Living in the neighborhood of science," 210.
[126] Boyle, "Certain physiological essays," 312.

Margaret Cavendish, they were socially tolerated but intellectually dismissed. Women were not moved from their traditional use of experience in medicine, but they were disqualified from using experience as a claim to knowledge and prestige. The power associated with the practice of experiment was codified and relocated

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## Chapter 2: Unperceived Hands:
## The role of the female assistant in gynecological literature

In the sixteenth century, physician Thomas Raynalde announced to his literate audience that he would inform them of "the reason of many diseases which happen peculiarily to woman, and the causes thereof; by which perceiverance, again, ye shall have the readier understanding how to withstand and remedy the said infirmities or diseases."[127] Raynalde had assumed authorship of the gynaecological text *The Making of Mankind* and intended for his treatise to benefit and educate English women. He informed these ideal female readers that he intended that "your wits and understanding shall be illuminated and lightened, the better to understand how everything cometh to pass within your bodies in time of conception, of bearing, and of birth."[128] Raynalde claimed authority to educate women in ascertaining treatments and distinguishing the proper time to call in a male physician. He justified this information as necessary to help women understand the treatment offered by male practitioners, because "the answer of the physician ... is many times obscure, dark and strange to be comprehended by the woman, for lack of due knowledge."[129] However, the treatise did not explain how he had procured this information, and assumed the existence of a functional, medically involved female audience. Despite this perceived female independence, he indicated that information in his text would teach women how to interpret male knowledge and apply it to their own bodies. There was an implicit divide between natural and practical female knowledge of their own bodies and needs, and the necessity of the masculine intellectual tradition. Through this publication, Raynalde entered into the tradition of masculine academic descriptions of the female body, presenting academic knowledge for the consumption of a presumptive audience who had personal physical experience with the described

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[127] *Thomas Raynalde, The Birth of Mankind: Otherwise Named, The Woman's Book Newly Set forth, Corrected, and Augumented. Whose Contents Ye May Read in the Table of the Book, and Most Plainly in the Prologue*, ed. Elaine Hobby (Burlington: Ashgate Publishing Company, 2009), 12.
[128] Raynalde, *The Birth of Mankind,* 12.
[129] Raynalde, *The Birth of Mankind,* 13.

conditions. Raynalde simultaneously appropriated and proclaimed himself an authority on the female body, and in doing so he disregarded the potential for independent female forms of knowledge.[130]

The participation of male authors and physicians in the sphere of female gynaecological and obstetric complaints raises questions about access to information and patient bodies. *The Birth of Mankind* entered a community of literate medicine produced almost exclusively by male authors, and controlled primarily by a larger male audience limited to those literate in Latin and frequently academically trained in a university setting. Raynalde claimed that his transition into the vernacular was a tool to broaden the access to medical information, particularly for women who were not trained in Latin. Earlier texts like the *Trotula* and *De Secretis Mulierum* had been composed in Latin, but the high medieval and early modern eras saw a transition to presenting gynaecological and obstetric literature in the vernacular for the consumption of both male and female audiences. In doing so, authors presented information that they gained obliquely or hypothesized according to academic methods, with which they claimed to educate women who, as pregnant and parturient women or as midwives, had knowledge through experience and touch related to these same conditions. The techniques were of greater benefit to male readers than to the stated female audience. These physicians relied on the construction of intellectual structures, supplemented by uncited sources of practical knowledge, to explain female diseases. I infer in this gap between knowledge and practice an intermediary female who existed in the text as an active agent of investigation in the professional physician's passive art, but was undefined in the literature. She existed marginally within the gap between the patient's body and the physician's diagnosis, then again between professionally recommended treatment and application of healing techniques.

In the introduction to *Making Women's Medicine Masculine*, Monica

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[130] Raynalde's statement was part of the Renaissance phenomenon that saw a revival of the Soranus tradition. Soranus' gynecology (Trans. Owesei Temkin, Baltimore: Johns Hopkins University Press, 1991) sought to educate midwives in the art of delivery during the classical period. In reviving this tradition, Raynalde claimed rights of the physician to be involved in the previously non-medical subject of childbirth.

Green indicates the probable "employment of female surgeons, midwives, or untrained assistants to do the needed manual observations and operations" on female patients.[131] Female assistants can indeed be perceived in the margins of professional medical literature. Lemay's work on Anthonius Guainerius, a fifteenth century professor at the University of Padua who left a *Treatise on the Womb* containing "constant references to his personal experience"[132] observes that his in his writings, treatments "seem to involve a female assistant, or midwife"[133] because Guanarius indicated that propriety necessitated avoiding touching the patient.[134] The first, male authored book of the *Trotula*, "On the Conditions of Women," which was composed in the twelfth century in Salerno, was written with passive verbs; physician readers were instructed to "let [the woman] be bathed,"[135] "let juice of great plantain be inserted by means of a pessary,"[136] or "let the woman be girded with a snake's skin."[137] The author also recommended that "the hands and feet of the woman be rubbed" and "their vaginas ought.... also to be anointed inside and out with oils and ointments."[138] Monica Green has analyzed this passive voice and determined that it was indicative of physicians recommending treatment but not directly practicing on their female patients.[139] These actions could be completed instead by a female intermediary figure or the patient herself who obeyed the instructions of the physician and performed the active insertions, anointment, and assistance on the female body. The separation between physician and patient raises questions about the specific role of this assistant figure and her power in the professional medical relationship.

In this chapter, I have utilized literature that can be classified either as

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[131] Monica Green, *Making Women's Medicine Masculine: the Rise of Male Authority in Pre-Modern Gynaecology* (New York: Oxford University Press, 2008), xii.
[132] Helen Rodnite Lemay, "Anthonius Guainerius and Medieval Gynecology," in *Women of the Medieval World: Essays in Honour of John M. Mundy*, ed. Julius Kirshner and Suzanne F. Wemple (New York: Basil Blackwell, 1985), 320
[133] Lemay, "Anthonius Guainerius and Medieval Gynecology,"), 323.
[134] Lemay, "Anthonius Guainerius and Medieval Gynecology," 321.
[135] Monica H. Green, trans., *The* Trotula: *A Medieval Compendium of Women's Medicine* (Philadelphia: University of Philadelphia, 2001), 75.
[136] Green, trans., *The* Trotula, 83
[137] Green, trans., *The* Trotula, 103.
[138] Green, trans., *The* Trotula, 85.
[139] Green, *Making Women's Medicine Masculine*, 43.

obstetric or gynecological literature. What is important in my analysis is the uncertain relationship between male physicians and the female genital area, which is central in both fields. . This chapter deals with the idea of the female body as a site of privileged female knowledge, displaying one of the ways that experience could be used to create female authority. It also displays the growing uncertainty of this authority, with the shifting boundaries between female patients and male physicians, dictated by strictures against touch. In this chapter**.** I have chosen not to focus on the distinctions between the two genres, but instead observed both categories for the similarity of the problematic nature of the treatment. The male authored works I have surveyed all feature a professional perspective that does not explicitly reference the problems of interaction with the patient. This area was occupied instead by the figure that I hope to illuminate. She was an active but invisible female agent within the texts and a figure who was not identified by the authors of the gynaecological and obstetric treatments with a title or an explicit role. This balance was significant because, despite the rhetoric of male separation from the female medical experience, male practitioners throughout the medieval era participated in the treatment of females. Monica Green observes that this was partially because there was a high profit potential in the field of fertility treatments.[140] Katharine Park offers another significant theme in male exploration of female sexuality and genitals through the theme of "secrets of women." She defined secrets as either knowledge unavailable to men because of their gender, or the actual "topological inaccessibility" of the female reproductive organs, hidden inside the body.[141] The use of the term "secret" implied a withholding of knowledge, and Park tracks the development of dissection as cases of male exploration and reclamation of female anatomy throughout the medieval period.[142] This genre of literature was another attempt for men to possess and in some cases appropriate authority on the subject of female health. The difference between the ideals of information and the reality of proprietary interactions demonstrated an

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[140] Monica Green, "Women's Medical Practice and Health Care in Medieval Europe," *Signs* 14.2 (Winter, 1989): 457.
[141] Katharine Park, *Secrets of Women: Gender, Generation, and the Origins of Human Dissection* (New York: Zone Books, 2006): 26.
[142]Park, *Secrets of Women*, 89.

imbalance between the desire for and assumption of knowledge.

In my research, I drew information from medieval and early modern gynaecological and obstetric texts. Chronologically earliest was the twelfth century *Trotula,* which can be more properly classified into three separate texts entitled "On Conditions of Women," "On Treatments for Women," and "On Cosmetics;" and the fourteenth century *De Secretis Mulierum,* which was erroneously attributed to the Saint Albertus Magnus the Dominican philosopher and theologian despite the fact that it was composed after his death. For the late medieval and early modern period, I have studied two Middle English versions of *The Knowing of Woman's Kind in Childing* edited by Alexandra Barratt, who refers to them as the "Douce" and "Cambridge" texts; and the sixteenth century physician Thomas Raynalde's *The Birth of Mankind: Otherwise Named, the Woman's Book.* Monica Green has argued convincingly that of the three *Trotula* texts, "On Conditions of Women" and "On Cosmetics" were composed by male authors, while "On Treatments for Women" had a female author, perhaps the titular healer "Trota."[143] Because this chapter will focus on how male authorship impacted the relationship between males and females, I will avoid discussion of "On Treatments for Women," dealing with it instead in chapter three when I discuss the female medical community. *De Secretis Mulierum* was written by a man, as evidenced by the "author's preface," which stated that it was written "Since you asked me to bring to light certain hidden, secret things about the nature of women,"[144] with the hope that "we might be able to provide a remedy for their infirmities, and so that in confessing them we might know how to give suitable penance for their sins." In this declaration, the author did not indicate the significance of his own experience, but instead relied on classical authors in the style of academia. In her transcription of *De Secretis,* Helen Lemay indicates that the style "is more philosophical than medical."[145]

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[143] Monica H. Green, "Obstetrical and gynaecological Texts in Middle English," in *Women's Healthcare in the Medieval* West, ed. Monica Green (Burlington: Ashgate Publishing Company, 2002): 56.
[144] Helen Rodnite Lemay, *Women's Secrets: A Translation of Pseudo-Albertus Magnus'* De Secretis Mulierum *with Commentaries* (Albany: State Unviersity of New York Press: 1992) 59.
[145] Lemay, *Women's Secrets,* 4.

Both versions of *The Knowing of Woman's Kind in Childing* were by male authors who indicated that the reason for composition was "be-cause whomen of oure tongue cvnne bettyre rede & vndyrstande þys language þan eny oþer"[146] The author presented himself as the teacher figure, providing information for women who had inferior access to knowledge and information.[147] Finally, both the first translator Richard Jonas, who created the earliest version of *the Birth of Mankind* from the German text by Eucharius Rosselin, entitled *"T'he Rose Garden for Pregnant Women and Midwives'"*, and the editor of later editions Thomas Raynalde, who tailored the work to later, hypothetically female audiences, are known male authors of the English *The Birth of Mankind.*[148] Raynalde explained that the original translation was "at the request and desire of diverse honest and sad matrons being of his acquaintance."[149] As with *The Knowing of Woman's Kind in Childing*, he presented himself as aiding ignorant women in the practice of childbirth.

Despite these explicit references to intended audiences, these texts would still have been read and utilized by male practitioners. To explain this disparity, Monica Green makes the distinction between intended audience and identified audience.[150] Although these texts directly address women, she has not concretely identified a female owner of a medieval manuscript.[151] Instead, texts on female conditions were integrated into the academic corpus of literature that was predominantly masculine. This essay does not seek to understand how women interacted directly with the literature, but instead focuses on these sources as providing information to the male physician in understanding and directing gynaecological and obstetric work. In the case of sources with intended female

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[146] *Alexandra Barratt, ed., The Knowing of Woman's Kind in Childing: A Middle English Version of Material Derived from the Trotula and Other Sources* (Belgium: Brepols Publishers, 2001): 42.
[147] This establishment of the author as teacher differs from the *Trotula* texts, which spoke to male audiences. *On the Conditions of Women* begins with the author informing his reader that women "out of shame and embarrassment do not dare reveal their anguish over their diseases… to a physician." (Green, trans., *The* Trotula, 71.) With the shift in audience came a shift in intention, from informing men about the health of women, a subject that would be inherently personally unknowable, to educating women about themselves from the perspective of an outsider.
[148] Elaine Hobby, ed. "Introduction." *The Birth of Mankind,* xv.
[149] Raynalde, *the Birth of Mankind,* 11.
[150] Green, "Obstetrical and gynaecological Texts in Middle English," 58 .
[151] Ibid.

audiences, Green has demonstrated that systematic edits of procedures into the passive voice did not occur; instead, medieval men would have engaged in simultaneous translation, reading the texts as an outsider and adjusting the contained directions to reflect their social and practical restrictions.[152] It is important that these men did not appear to be concerned with the issues of audiences and genders. Despite the textual intention of a female audience, male physicians demonstrated a generally unconcerned attitude towards their right to obtain access to the field of gynecology.

Green argues that the history of medieval women's healthcare can be understood through investigations of how knowledge was produced and who "owned" it.[153] This concept is particularly relevant in the case of the female intermediary figure in gynaecological literature. When I was first alerted to the existence of power dynamics between female patients, male physicians and female assistants, I was reminded of the ethnographic work of Stefan Hirschauer. He observed and analyzed the imbuing of the physical space in the surgical operating room with symbolic meaning, and perceived a "functional extension" of the head surgeon to his nurses and assistants.[154] The aids become extensions of his vision and sight, exploring and relaying information back to him for processing.[155] At first, this model seemed applicable to the role of the female assistant, who would be responsible for seeing and touching the female patient and describing these observations to the physician for interpretation. However, as I began reading medieval gynaecological literature and the historiography about doctor-patient relationships, I realized the untenability of this paradigm because the realities of medieval and early modern healthcare contained entirely different constructs for power, authority, and treatment.

Physiological knowledge was understood through the primacy of the humoural system, in which the body was understood as a site in which black bile, phlegm, blood, and yellow bile were balanced to create a state of health. The

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[152] Green, *Making Women's Medicine Masculine*, 80.
[153] Green, *Making Woman's Medicine Masculine*, viii.
[154] Stefan Hirschauer, "The Manufacture of Bodies in Surgery," *Social Studies of Science* 21 (1991): 296.
[155] Hirschauer, 298.

imbalance of these humours lead to disease, and treatment was therefore heavily biased towards reinstating internal balance. Physicians claimed exclusive knowledge of this field, as opposed to the manual and exterior work performed by contemporary surgeons. However, the perception of physician supremacy in interpreting illness was not shared uniformly by the population of their potential patients. Nicholas Jewson's evaluation of the pre-eighteen hundreds medical structure as being "patronage based" is important to perceive medieval power relationships.[156] Physicians were in a position of inferiority to their patients because they were reliant on them for pay, although there was uncertainty about authority in the case of female patients, whose status was mediated by both gender and class. Physicians had to perform and demonstrate their knowledge in order to gain trust and fees. Because of their dependence on patients, physicians functioned persuasively rather than domineeringly. The sense of touch was thus influenced by patient perspectives on appropriate interactions, rather than physician requirements. In order to mediate the impropriety of male physicians touching women, the female assistant was incorporated into the medical relationship. Some authors, like Anthoinus Guarianus, stated the existence of assistants, but frequently the figure was only implied in texts.[157] To define the role of the physician's assistant, I had to construct the significance of touch, the role of the physician and the intentions of the patient, and then examine the spaces between, into which this female practitioner would fit.

Female medical intermediaries occupied the physical space between the physician and patient. To understand their role, it was necessary to understand why touch was such a loaded issue in medieval medicine. Universally accepted injunctions dictating the impropriety of touch by physicians towards their female patients[158] were influenced in part by intellectual and theoretical discussions on the sense of touch. Medieval thinkers struggled to classify and locate the sense of touch because unlike senses like vision, which could be clearly associated with the

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[156]Nicholas Jewson, "Medical Knowledge and the Patronage System in Eighteenth Century England. *Sociology* 8 (1974): 378.
[157] Lemay, "Anthonius Guainerius and Medieval Gynecology,"323.
[158]See for example Lucille B. Pinto, "The Folk Practice of Gynecology and Obstetrics in the Middle Ages," *Bulletin of the History of Medicine* 47.5 (1995): 520.

eyes, touch was the action of the entire body.[159] Touch was also a sense that did not have a contrary, instead it was "clearly able to discern between many" sensations, making it more difficult to define.[160] Although touch was necessary, it was also often classified as "coarse and base" because of the association with animals and the earth.[161] The universality of touch made it essentially uncontrollable and unknowable as a subject of study. While touch distinguished animals from plants and stones, scholars struggled to perceive how the human experience of touch differed from other animals. The "coarse" nature of touch also carried the stigma of work and activity that was so unpalatable to the professionally situated physicians, who described themselves in relation to academic and theoretical knowledge. Physicians defined their separation from other spheres of medical practitioners through distinctions about the degradation of manual labour and tactile contact that described empiric practice and surgery.[162] Emphasizing the contemplative and intellectual nature of their art was the key to their prestige.

The act of touching and being touched was also problematic because it was a venue for social interactions and power definition. Laura Gowing argues that in seventeenth century England, the act of touch contained assumptions about vulnerability, property, and possession.[163] To touch someone was to assume a right of proximity to their person, particularly in the case of matrons who investigated and testified about virginity and pregnancy in legal cases.[164] Touch was also an action that necessitated mutual responses. In the medical cases of the eighteenth century German physician Johannes Storch, Barbara Duden demonstrated that when it was necessary to expose their bodies to the physician's

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[159] Salmon, "A Medieval Territory for Touch," 60.
[160]Elizabeth Sears, "Sensory perception and its metaphors in the time of Richard of Fournival" in *Medicine and the five senses,* ed. W.F. Bynum and Roy Porter (New York: Cambridge University Press, 1993): 24.
[161] Salmon, "A Medieval Territory for Touch," 63-64.
[162] See for example Ghislaine Lawrence, "Surgery Traditional," in *Companion Encyclopedia of the History of Medicine* vol 2, ed. W. F. Bynum and Roy Porter (London & New York: Routledge, 1993): 968, or Jewson "Medical Knowledge and the Patronage System in Eighteenth Century England," 374.
163 Laura Gowing, *Common Bodies: Women, Touch and Power in Seventeenth-Century England* (New Haven and London: Yale University Press, 2003): 1.
[164] Gowing, *Common Bodies,* 71.

sight, women looked away.[165] They were looked upon, but did not engage the physician. However, since touch always involved the mutuality of touching and being touched, both parties participated in and acknowledged the interaction. Being touched implied either consent to exposure, or a relative powerlessness to refuse contact. Right of contact was based on familial and social relationships, making access to the body an issue of permissibility as well as accessibility. The physician was external to these relationships and the propriety of his contact was thus also questionable from the perspective of the patient. Although touch was commonly permitted to determine pulse, temperature, and abdominal palpitation, these actions all involved peripheral and brief contact.[166] To be touched was to allow intimacy with a man who was not related to a woman by marriage or kinship. The nature of female medical conditions' association with their reproductive organs exacerbated the sensitivity of the action. When women initiated contact with the physician, they had the power as patient and patron to dictate permissible interactions, and touching was an activity that was removed from the scope of appropriate diagnosis.

Touch and knowledge of the female body were linked to the theme of shame. The *Trotula* "On the Conditions of Women" began with the observation that "women, from the condition of their fragility, out of shame and embarrassment do not dare reveal their anguish over their diseases ... to a physician."[167] This "shame and embarrassment" limited their willingness to discuss their conditions, and was extended to and subsumed the shame of exposure and implied possession associated with touch. The rhetoric that these treatises were necessary due to shame and modesty of women survived various translations and reformations of the texts. Injunctions against misbehaviour by male readers occurred in both *The Knowing of Woman's Kind in Childing* and T*he Birth of Mankind.* The author of the Douce manuscript of *The Knowing of Woman's Kind in Childing* informed male readers that the author "pray hym &

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[165] Duden, *The Woman beneath the Skin,* 84.
[166] Vivian Nutton, "Galen at the bedside: the methods of a medical detective," in *Medicine and the five senses,* ed. W.F. Bynum and Roy Porter (New York: Cambridge University Press, 1993): 22.
[167] Green, trans., *The* Trotula, 71.

scharge hym in ovre Lady be-halue þat he rede it not in no dsypyte ne sclanvndure of no women."[168] Similarly, in "A Prologue to the Women Readers," Raynalde feared that "men it reading or hearing shall be moved thereby the more to abhor and loathe the company of women."[169] Knowledge of the female body was seen as compromising respectability of both involved parties. However, instead of explicitly ordering men to avoid reading, all the sources acknowledged male readers and indicated that the sensitivity of the subject necessitated delicacy in the presentation of male knowledge and treatment. Rather than presenting a taboo, treatises claimed that they sought to adapt to or undermine feminine shame and privacy.

Medieval perceptions of the female body exacerbated and emphasized the problems of hidden knowledge, shame of transmission, and the sanctity of touching. The female body appeared as inherently unknowable in medieval literature. In *Secrets of Women*, Katharine Park indicated that the female figure was associated with the "body's hidden interior," and appeared as the subject of desire fore exploration and understanding because of this opacity.[170] Laura Gowing confirms this belief, explaining that because the uniqueness of the female body focused on the "opacity of the stomach" and female generative organs,[171] there was no normative figure by which to apply treatment. The mystery of femininity was emphasized by the nebulous condition of all pre-twentieth century pregnancies, which was "felt internally and apprehended gradually rather than seen."[172] However, despite the lack of accessibility for intellectual verification, the male understanding of intellectual power presented women's knowledge as a source of information that required professional verification.[173] Therefore, although women could present knowledge about medical conditions that had been directly obtained, they could not be perceived as authorities because they were not professionally and academically trained. Their information, based on touch, was

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[168] Alexandra Barratt, ed., *The Knowing of Woman's Kind in Childing*, 42.
[169] Raynalde, *The Birth of Mankind,* 17.
[170] Park, *Secrets of Women*, 27.
[171] Gowing, *Common Bodies,* 112.
[172] Park, *Secrets of Women*, 113.
[173] Park, *Secrets of Women*, 86.

subsumed precisely because of its association with experience.

The academic and social dialogues about touch, privacy and the female body impacted the relationship between male physicians and female patients. In the eighteenth century, Johannes Storch treated a woman for pain in her privates. Duden observes that "Storch, whom she later consulted through her mother, was never allowed to see or touch. His prescription was entirely based on the mother's report about the "strange" thing a woman had found."[174] In this case, there were two degrees of separation between Storch and his patient. She was physically examined by a woman who in turn transmitted information about what she had perceived to the patient's mother. It was the mother who described her daughter's condition to Storch, and the daughter was not present for his diagnosis. Storch was temporally and physically separated from his patient, but still felt confident in making a diagnosis and recommending treatment. Indeed, Storch often functioned through intermediary methods, including letters, oral reports, requests, and written messages.[175] A woman's method of contacting him could depend heavily on her means, which meant that noble women communicated via letters, while lower class women were more likely to send a messenger.[176] The reliance on indirect diagnosis was critical in understanding the relationship between physicians and patients. For medieval and early modern medical interactions, physical physical contact was not only not necessary in treatment, but physical proximity was not a necessary condition for the interaction.

Methods of professional diagnosis for female conditions could be gleaned from the gynaecological and obstetric texts produced throughout the period. The diagnoses rarely required direct contact, but instead relied either on the woman's description of her bodily experience, or a visual analysis of her body. In the *Trotula* "Conditions of Women," the author discussed signs of the lesions of the womb with the explanation, "the woman feels heaviness in the hips, buttocks, and thighs."[177] These were not measurable signs for a physician or assistant to

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[174] Duden, *The Woman beneath the Skin,* 76.
[175] Duden, *The Woman beneath the Skin,* 81.
[176] Duden, *The Woman beneatth the Skin,* 82.
[177] Green, trans., *The* Trotula, 91.

investigate, but rather necessitated the female description of her experience. A more active diagnosis instructed the reader that movement of the womb from its place was indicated when "the woman experiences pain on the left side, retention of the menses, contortion of the limbs, difficulty of urinating, [and] twisting and rumbling of the belly."[178] In this case, the woman's experience of pain, retention and difficulty must be transmitted, but the contortion of the limbs and stomach and the noise of the belly can be perceived by the physician. Pseudo-Albertus Magnus demonstrates a similar range of female perception and non-tactile physician diagnoses. He indicates that the signs of conception include "If a woman feels cold and has pain in her legs immediately after coitus with a man, this is a sign that she has conceived." Because "when the kidneys are deprived of heat, they become cold and painful,"[179] "if the woman after coitus continually wants to have more,"[180] and "if after coitus the menstrual period does not arrive in its accustomed way and there is a titillation in the mouth of the womb."[181] Externally, he indicated that "Another sign is if the color of the face is changed from its usual appearance ... Also, if unusual foods are desired."[182] The author primarily indicated self-perceived signs relating to the act of copulation, but also indicated that a change in complexion could be indicative of conception. Thus, although the author maintains his focus on reproduction, there was also the opportunity for physicians to perform visual observations for their diagnoses. These sources consistently presented an ideal of female self-diagnosis supplemented by visible external signs.

The trend of physical separation continued in early modern publications. In the Douce version of T*he Knowing of Woman's Kind in Childing*, the author provided signs of uterine suffocation. He stated that the signs were "yf sche draw here breth with dyffyculte & chortly & lythyll, for þan þe matrys rysyth to þhe hert, [hyr ionitis, hyr handis, hir feet, her brestys] been sore & suellynge a-bowte

[178] Green, trans., *The* Trotula, 89.
[179] Lemay, *Women's Secrets,* 120.
[180] Lemay, *Women's Secrets,* 121.
[181] Lemay, *Women's Secrets,* 121.
[182] Lemay, *Women's Secrets,* 122.

here hert..."[183] To diagnosis uterine suffocation, the reader would need to hear of the female patient's personal discomfort, but could also supplement this information with perception about the swelling of extremities and state of breathing. Both investigative tools could be performed without engaging the patient physically. However, both versions of *the Knowing of Woman's Kind in Childing* also necessitated superficial touch to determine uterine swelling. In the Cambridge version, the author indicated that "yif ye smyte on the wombe, it soundith lyke a tabour."[184] The same directions were found in the Douce version, which informed readers that "yf ye smythe on the wowbe with yowur hand, hit will sond as hit were a tabure."[185] In this case, the touch was external and relied also on hearing. The action was brief and did not engage with the female genitals directly. Finally, in *The Birth of Mankind*, Thomas Raynalde presented his information "not only in words, but also in lively and express figures."[186] The inclusion of images emphasized the visual nature of medieval diagnosis, as the reader could compare the images of the treatise to a female patient's disease symptoms. Raynalde focused on the physiological structure of the female body, but included information on symptoms in the section on childbirth. To ascertain if a woman was near death, he indicated that signs included "if the woman being in the labour sound, or fear, as though she were in a trance; if her rememberance fail her, and she wax feeble and scant able to move or stir herself..."[187] These signs could be perceived by surrounding members of the party, particularly his idealized female reader, and incorporated into a prognosis. Despite the envisioned female audience of the late medieval and early modern texts, the level of physical contact required for diagnosis remained superficial.

Physicians also separated themselves from the activity of treatment. In the *Trotula* "On Conditions of Women," the author recommended treatments including "let one little sack be filled with finely carded wool ... and placed warm

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[183] Barratt , ed., *The Knowing of Woman's Kind in Childing,* 76.
[184] Barratt , ed., *The Knowing of Woman's Kind in Childing,* 99.
[185] Barratt , ed., *The Knowing of Woman's Kind in Childing,* 98.
[186] Raynalde, *The Birth of Mankind,* 12.
[187] Raynalde, *The Birth of Mankind,* 143.

on the belly"[188] for blocked menses and "if we wish to bring the lesions to sanies, let maturatives be applied."[189] This passive voice conformed with the intended audience of male physicians indicated by the author's statement that the fragility of women had "impelled [him] to give a clear explanation regarding their diseases."[190] Because the male physician was prohibited from touching the woman, it was strongly implied that an unnamed person must be performing the active verbs recommended by the treatise. In the female "On Treatments for Women," active verbs were instituted to describe this practical element. Monica Green has compared this language to the tone of a teacher instructing students.[191] The author indicated in one case that "we give aid to such women by repositioning [the womb]... diligently we foment it until the womb has been rendered soft, and then we gently replace it."[192] This was drastically different in the level of activity expected from male readers, and the theme of interaction between the reader and the female body continued throughout the text. In *The Knowledge of Woman's Kind in Childing*, the intended audience was female, and the activity of the treatments reflected their right to contact with other females. The author recommended that his readers put herbs "in a lynyn bag & put hit in at here wyket"[193] or "make a pissary therof & put in at here priuite and it shal do here gret ese."[194] The access to the genitals of the female patient were physically available to the reader who was treating her. By the sixteenth century, *The Birth of Mankind* assumed a middle ground by eliminating the action of the reader from its descriptions. Raynalde indicated that the woman "may receive a clyster"[195] and that the reader "must take diligent heed that [the woman] be exactly and utterly purged."[196] Thus, the reader was in a supervisory role, responsible for directing but not interacting with the patient's genitals.

Treatment in the form of self-care was necessary for women in all of the

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[188] Green, trans., *The* Trotula: 77.
[189] Green, trans., *The* Trotula: 93.
[190] Green, trans., *The* Trotula: 71.
[191] Green, *Making Women's Medicine Masculine,* 57.
[192] Green, trans., *The* Trotula, 125.
[193] Barratt, ed., *The Knowing of Woman's Kind in Childing,* 82.
[194] Barratt, ed., *The Knowing of Woman's Kind in Childing,* 77.
[195] Raynalde, *The Birth of Mankind,* 104.
[196] Raynalde, *The Birth of Mankind,* 120.

gynaecological and obstetric books I have surveyed. Although the physician provided a diagnosis and suggested treatment, his involvement or presence did not seem to be necessary for the enactment of the cure. Instead, the *Trotula* "Conditions of Women" observed an important degree of self-treatment on the periphery of physician practice. In regards to pregnancy, the author indicated that the physician should "let the woman herself see to it that in the last three months her diet consists of light and digestible foods" and that during labour he should "let the woman prepare herself as is customary, and likewise the midwife should do the same with great care."[197] Advice was general and non-intrusive, it was expected that women were conscious of appropriate methods and that this knowledge was socially diffused to the point where explicit statement in treatises was unnecessary. Attention was also drawn to women's self-care in the cosmetics section of the *Trotula*. The passive voice emerged, as it did in "Conditions of Women," but the intended actor was made explicit. In the application of treatments, the woman became the active agent. The author instructed that the physician should "let her also anoint herself all over,"[198] or "let her adorn her hair, and first of all let her wash it. ..."[199] This practice acknowledged the personal applicability of treatment. Being a patient did not always equate to being an invalid, so it was feasible for women to prepare and apply treatments rather than rely on the person of the physician for all their care. In *The Knowing of Women in Childing,* the author of the Douce version also indicated that pregnant women should "kepe hem well in þe viij monyth, for þan be þey heuy & grettj lett hem than kepe hem & reste & ete measurably & kepe here wombe at large & anoynt hit with oyle..."[200] *The Birth of Mankind* provided similar advice during pregnancy, explaining "how a woman with child shall use herself" and that "the woman with child must keep two diets."[201] Pregnancy was a particular area in which women were seen to have experiential authority about procedures that aided their health, and physicians ordered women to practice in ways that would

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[197] Green, trans., *The* Trotula, 105.
[198] Green, trans., *The* Trotula, 167.
[199] Green, trans., *The* Trotula, 169.
[200] Barratt, ed., *The Knowing of Woman's Kind in Childing,* 58.
[201] Raynalde, *The Birth of Mankind,* 103.

encourage and reinforce their safety.

Academically trained physicians thus rarely required physical examinations to diagnose or treat female medical conditions. Instead, power remained with women to distinguish their conditions and request medical assistance. Barbara Duden describes Storch as "a guest in the realm of self-treatment,"[202] responsible for recommendations but without authority to enforce either his diagnosis or treatment regimen. This is a useful phrase for comprehending the significance of physicians in the health care process, particularly for women. Women entered the relationship with physicians with set desires, explaining and describing ailments with minute precision to sensation and physical conditions. Duden observes that Storch used these descriptions to formulate his own perceptions of the women, relating their encounters with grammar indicators including "she sent word," "she sensed," or "she felt."[203] Women frequently conceived of their condition and expected results, using Storch as professional confirmation of their diagnosis and access to prescriptions.[204] Lemay's evaluation of Anthonius Guainerius conforms with the implications of Storch's practice. She observes that Guainerius' practice involved consulting and discussing symptoms with women, supplemented by "examinations" that appear to rarely have necessitated touch.[205] Guainerius instead relied heavily on information gleaned from the women, indicating that although he could gain information by sight and touch, his diagnosis was gained "more decently, by the testimony" of his female patients.[206] Although the physician claimed himself as an authority, the information provided by the female patient was integral to the medical interaction.

Female testimony was supported by popular assumptions that women had a unique form of knowledge based not in academic training, but in the possession

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[202] Duden, *The Woman beneath the Skin*, 76.
[203] Duden, *The Woman beneath the Skin*, 83.
[204] Duden, *The Woman beneath the Skin*, 92.
[205] Lemay, "Anthonius Guianerius and Medieval Gynecology," 321.
[206] Lemay, "Anthonius Guainerius and Medieval Gynecology," 321

of a female body and the experience of marriage and childbirth.[207] This knowledge was constructed through custom, tradition and guesswork, and practiced through the figure of the wise woman who physically investigated women testing for virginity and pregnancy.[208] Instead of occupying professional roles, women practitioners used this innate knowledge to perform medicine in a casual and unlicensed style. [209] The female medical role was dictated by the marital state, rather than formal occupations. Monica Green argues that this and the activity of women in multiple "jobs" resulted in a weak work identity; women's work was dependent on their husbands and their marital status.[210] Few women identified themselves in the category as medical professional, which makes it more difficult to construct the history of their practice.

The differentiation between male and female implicit medical knowledge was constructed in part through dialogues about female and male traits. In the gender binary, women were associated with the body, while men were aligned with the soul. Estelle Cohen argues that this contributed to longstanding assumptions of female inferiority and biological passivity.[211] Similarly, Merry Weisner observes that the academic discourse on gender was constructed through a consensus of "revered authorities" including the Bible and Greek philosophers.[212] She observes that arguments like that of Aristotle, that women were "a deformity, but one which occurs in the ordinary course of nature," were accepted and arguments about the nature of humanity featured questions like "what is man" versus "what are women for?"[213] Women were inherently underqualified to perform professional work or discuss knowledge because God and nature did not give them "learned reason and understanding."[214] Since

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[207] Susan Broomhall, "'Women's Little Secrets': Defining the Boundaries of Reproductive Knowledge in Sixteenth-century France," *Social History of Medicine* 15.1 (2002): 2.
[208] Gowing, *Common Bodies,* 41.
[209] Monica Green, "Documenting Medieval Women's Medical Practice," in *Women's Healthcare in the Medieval West,* ed. Monica Green (Cambridge, 1994): 335.
[210] Green, "Documenting Medieval Women's Medical Practice," 332.
[211]Estelle Cohen, "'What the Woman at All Times Would Laugh At': Redifing Equality and Difference, Circa 1660-1760," *Osiris* 2.12 (1997): 123.
[212]Merry E. Wiesner, *Women and Gender in Early Modern Europe* (Cambridge: Cambridge University Press, 2000), 14.
[213]Wiesner, *Women and Gender in Early Modern Europe,* 18.
[214]Beier, *Sufferers and Healers,* 43.

women were perceived as physically and intellectually weaker, they were ideal for serving the higher thoughts and purpose of man.[215] Their primary asset was their ability to nourish.[216] However, this tight association with the body was seen as giving women high levels of information about their bodies. Because they were incapable of reason, their knowledge focused on tangible experience.

Susan Broomhall summarizes this expectation of information as the understanding that the lived experience of female bodies translated to authority.[217] This was particularly true in the case of childbirth. Childbearing was a rite of passage for medieval and early modern women.[218] Failing to produce children was an abnormal state, both in terms of the possession of a female body and authority, and practical issues of the marriage union. Thus, the majority of women experienced and participated in childbirth rituals with members of their family, their friends, and their neighbours. Maintenance of labour was nearly exclusively a female domain until the mid-to-late early modern period. Medieval and early modern communities generally accepted the premise that childbirth was not pathological.[219] Instead, the common knowledge of women informed labour.

Low figures of identification are due in part to the permeable nature of categories for female care. Women were expected to aid in household tasks including feeding and caring for the ill[220] and expected to aid women "without any basis other than the solidarity of gender."[221] Female medical roles assumed medical connotations due to the medical significance of the six "non-naturals," which included sleep, exercise, retention and evacuation.[222] Women provided

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[215]Wiesner, *Women and Gender in Early Modern Europe,* 18
[216]Wiesner, *Women and Gender in Early Modern Europe,* 22
[217]Broomhall, *Women's Medical Work in Early Modern France,* 7.
[218]Laura Gowing, *Common Bodies: Women, Touch and Power in Seventeenth-Century England* (New Haven and London: Yale University Press, 2003), 114.
[219] Monica H. Green, trans, *The* Trotula: *A Medieval Compendium of Women's Medicine* (Philadelphia: University of Philadelphia, 2001), 43.
[220] Montserrat Cabre, "Women or Healers? Household Practices and the Categories of Health Care in Late Medieval Iberia," *Bulletin of the History of Medicine* 82.1 (Spring, 2008): 33.
[221] Teresa Ortiz, "From hegemony to subordination: midwives in early modern Spain," in *The Art of Midwifery: Early Modern Midwives in Euorpe,* ed. Hilary Marland (London & New York: 1993), 95.
[222] Cabre, "Women or Healers?", 23.

"most of the direct, bedside care of other women,"[223] and could thus monitor patterns of sleep, consumption and evacuation. Because this was seen as a natural female task, their function in these roles did not indicate their professionalization. The assumption that women could and would understand and care for other women was a powerful factor in the integration of women in general, not an assistant in particular, into the areas of inactivity within male gynaecological practice. Women formed networks of medical advice that were readily available for any female patient, and their knowledge was seen as innate and thus required no specific training to prepare them for interaction with female genital illnesses.

This control of female health processes was not unobserved by male medical professionals. Although physicians appeared to be interest in the process of childbirth and published on the subject, including books like *The Birth of Mankind* and *The Knowing of Woman's Kind in Childing,* Susan Broomhall argues that there was a perception that the gender stratification of labour superseded medical authority. Because childbirth was seen as women's work, it was difficult for men to access the information.[224] Concerns about the way women possessed and transmitted information were translated in academic language to systems of withholding and deception.[225] The genre of "secrets of women" featured both the issue of topological inaccessibility of the female genitals, and a male perception that women had knowledge that was unavailable to men, or even that women purposefully withheld knowledge from men.[226] She argues that particularly in northern Italy, this issue was significant because of the social emphasis on paternity. Patrilineal genealogy was crucial, yet there was a physical tie between mothers and their children due to the site of conception in the "dark, inaccessible" uterus.[227]

This lead to fears about the potential infidelity of women, and fed into concerns that women had knowledge that they withheld from male counterparts.

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[223] John F. Benton, "Trotula, Women's Problems, and the Professionalization of Medicine in the Middle Ages," *Bulletin of the History of Medicine* 59.1 (Spring, 1985): 30.
[224]Broomhall, *Women's Medical Work in Early Modern France,* 53.
[225]Park, *Secrets of Women,* 81.
[226]Park, *Secrets of Women,* 26.
[227]Park, *Secrets of Women,* 25.

This fear expanded to incorporate academic discussions about how to obtain knowledge about the female interior and effective treatments. Park argues that understanding of the body was structured through religious, familial, and kinship lenses before the medical perspective.[228] This enhanced the perspective that women possessed information that men, particularly physicians, lacked due to the social and physical inaccessibility of the body. In this narrative emerged the trope of "secrets" as a collective, group property, indicating the boundaries of learned expertise. This metaphor can be considered a "trope of communication," demonstrating the divide between textual knowledge and experienced based practice. Importantly, Park observes that this genre was attributed to, not claimed by women. [229] The language of concealment used to describe female knowledge indicated a desire by males, particularly physicians, to reveal secrets, not the female effort to maintain them.[230]

The conception of "secrets of women" indicated one of the problems with the way that men pursued medical and physical knowledge, compared to the way that women interacted and assumed authority based on their experiences. Possessing concrete medical knowledge was difficult because the early modern body was inherently unstable. Because health was conceived as a state of humoural balance and illness as imbalance and change, the expectation of applying mediating and allopathic treatments distinguished medical treatment. The experience of the female body was even less stable because of the significance of the uterus. Physiologically, the interior female genitals distinguished women from their male counterparts. However, the significance of the uterus extended past practical differences and was considered the central site of female illness. The weakness of women was associated with their colder nature, and menstrual blood was seen as a necessary purgation because women lacked the heat to naturally burn off excess blood. Barbara Duden explains that the womb "embodied this constant danger of stagnation by virtue of its shape as a collecting basin for

[228]Park, *Secrets of Women*, 23.
[229]Park, *Secrets of Women*, 81.
[230]Park, *Secrets of Women*, 92.

blood."[231] Stagnated blood brought upon hardenings that "spread and 'devoured' the healthy tissue inside," leading to decay.[232] The female body was always poised to become corrupted by nature of the excess blood. This situation was exacerbated because the ambiguity of the body extended to issues of flow and stoppage. Retained menses could either signal pregnancy, or sign of illness in the form of a "message of stagnation."[233] Only experience and patience could reveal distinctions between the two physical changes. The preoccupation of women with the movement of their bodies qualified them to decide what techniques were necessary to restore movement.

The uncertainty of the female body lent credence to information provided by women, who had experience with their own bodies and those of their peers through illness and childbirth. Katharine Park describes the female body as characterized by malleability and impressionability.[234] In the cases of the German physician Johannes Storch, he and his female patients knew the body through experience processes, and therefore could not be universalized.[235] Instead, the patients of Storch perceived the body in terms of "flux" and "flow." This movement could be understood through the perception that bodily fluids, including the humours, menses, and milk, were all essentially similar and thus capable of transforming into other fluids. This was combined with the existence of a porous body that allowed fluids to shift internally and exit through multiple orifices.[236] Flux was the sensation of internal movement, and could be associated with pain that served as a reminder that the body continued to function and balance itself.[237]

Because of the continual importance of this movement, the greatest concern for women was the stagnation of this flow, and internal hardening

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[231]Barbara Duden, *The Woman Beneath the Skin: A doctor's patients in eighteenth-century Germany* (Cambridge & London: Harvard University Press, 1991), 140.
[232]Duden, *The Woman Beneath the Skin,* 139.
[233]Duden, *The Woman Beneath the Skin,* 159.
[234]Park, *Secrets of Women,* 75.
[235]Duden, *The Woman Beneath the Skin,* 107.
[236]Duden, *The Woman Beneath the Skin,* 109.
[237]Duden, *The Woman Beneath the Skin,* 140.

indicated that the body was not responding and adapting in expected ways.[238] Therefore, women interacting with Storch expected healing to occur through the removal of viscous and hardening matter, and the regular expulsion of fluids.[239] This preoccupation with expected movements created a body that was perpetually in flux, impacted by the periodic expulsions of the mentrual cycle that purged the body of corrupted blood.[240] The female system of information was an effective way to interact with the body because it relied on observation and experience, perceiving the changeability of the body and constructing a history of bodily experience. This collected knowledge was amassed until women constructed ideas about the expected behaviour of female bodies. This information would then be applied to further healing techniques. Personal experience with the body and its changes could be compared between women to construct norms of bodily reactions, leading to a sense of ownership and knowledgeability about the way female bodies functioned.

The "secrets of women" narrative is particularly evident in the case of the pregnant female body. Cathy McClive argues in "The Hidden Truths of the Belly: The Uncertainties of Pregnacny in Early Modern Europe" that the "female body conceals 'truths' in ways that the male body does not."[241] This deception occurred due to uncertainty about the traits of pregnancy and the inaccessibility of the uterus. Laura Gowing explains that her sources viewed the pregnant stomach as an opaque object,"felt internally and apprehended gradually, rather than seen."[242] Authoritative statements about the pregnant body could be made only by the mother, who was capable of differentiating the changes in her body due to conception from those caused by disease and blockage. This involved a degree of uncertainty during the early stages; the mother herself could not confirm conception until the quickening, or early movements of the child. This minute initiation of movement was prone to subjective interpretation, because only the

[238]Duden, *The Woman Beneath the Skin,* 132.
[239]Duden, *The Woman Beneath the Skin,* 153.
[240]Duden, *The Woman Beneath the Skin,* 113.
[241]Cathy McClive, "The Hidden Truths of the Body: The Uncertainties of Pregnancy in Early Modern Europe," *Social History of Medicine* 15 (2002): 201.
[242]Gowing, *Common Bodies,* 113.

mother could distinguish this initial change from the normal rhythm and movement of her body.[243] Additionally, women in the work of Cathy McClive demonstrate uncertainty about their interpretation of internal signs. Women sought advice and assistance in the interpretation of their bodies, allowing physical access to other women and discussion of experience to determine the condition of their own bodies.[244] Seen in this light, women fail to appear as sole owners of authority on the female body. Rather, information was obtained on a graduated scale, with women closer to information and thus more knowledgeable than their male counterparts, who could not partake in and understand the experience of the female body. McClive argues that communities of women participated in touching of the stomach of breasts and making evaluations about pregnancy; anyone and everyone could become an "expert" based on her own experience.

Traditional scholarship on the subject of women in medicine has conflated these practical medical female tasks into the title of midwife. Montserrat Cabre argues that this may be a problem of identification. Midwife is the most, and in some cases only, identifiable female vocation in records; other female healers must be identified by narrative descriptions or context rather than professional title.[245] It is important to acknowledge that, rather than being a formal medical practitioner, the figure of the midwife described in gynaecological texts was essentially considered a non-medical position in the majority of cases. Monica Green argues that childbirth was not pathological in the medieval period, but instead was informed by the common knowledge of female attendants.[246] She explains that this is the reason for the absence of information on normal birth, and it also explained the separation of childbirth from medical men until the early-modern emergence of the English man-midwife. This informality contributed to the problem of non-evidence for the existence of formal or professional midwives before the fourteenth century. Their role can more properly be defined in the work

[243]McClive, "The Hidden Truths of the Body," 215.
[244]McClive, "The Hidden Truths of the Body," 217.
[245] Cabre, "Women or Healers?," 25.
[246] Monica Green, "Introduction," *The* Trotula, 43.

of Michael J. Wright, who has found that early Anglo-Saxon words for midwives correspond to the Latin *obstetrix*. "Obstetrix," in turn, was defined as a "(female) attendant on childbirth."[247] Instead of "midwife" as an occupational identifier, Kathryn Taglia indicates that evidence towards the existence of the formal practice of midwifery did not emerge until after regulating policy has been produced.[248]

Montserrat Cabre's findings in medieval Iberia corroborates Green's suggestion. Cabre finds that although there is documentary evidence of professional midwives in thirteenth century Iberia, the number of practicing midwives would not have supported the number of births per year, indicating that many women either could not or did not access the services of an official midwife during labour.[249] If midwives were figures associated explicitly with the birth process, lacking in congruent practice or a sense of community, how can we understand their role in medieval medical life and literature? David Harley's perspective is a beneficial replacement for the conception of midwife as occupation; he argues that medieval midwifery was a skill, not a trade.[250] This explains the system of apprenticeship under supervision of more senior women to gain practical experience in assisting births.[251] Midwifery as a skill that was obtainable to all women and particularly accessible to mothers adhered to the trends of authority of married women observed in Gowing[252] and explains the evidentiary deficiencies and gaps.

The emphasis on the figure of midwives as specifically related to birthing skills is supported by my research into gynaecological and obstetric texts. In the *Trotula* "Conditions of Women," the author recommended that in cases of malpresentation of the foetus, the physician should "let a midwife assist with a small and smooth hand ... and let her replace the child in its place and let her put it

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[247] Monica Green, "Bodies, Gender, Health, Disease: Recent Work on Medieval Women's Medicine," *Studies in Medieval and Renaissance History* 3.2 (2005): 15.
[248] Ibid.
[249] Cabre, "Women or Healers?", 22.
[250] David Harley, "Provincial midwives in England: Lancashire and Chesire, 1660-1760," in *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland (London & New York: Routledge, 1993): 28.
251 Doreen Evenden, "Mothers and their midwives in seventeenth-century London," in *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland (London & New York: Routledge, 1993): 9.
[252] Gowing, *Common Bodies*, 41.

in its correct position."[253] The midwife thus was responsible for delivery of the child, and her contact with the female genitals was in direct relation to the task of assistance in labour. *De Secretis Mulieum* contained fewer explicit references to the practice of medicine, but similarly referred to the case of malpresentation with the injunction that "in these cases the midwives carefully thrust back the hand or feet"[254] The author also observes that in cases of ruptures in the vulva "experienced midwives use a certain unguent .. Therefore it is necessary that the women who assist in childbed be skillful, and expert in their work."[255] The issue of experience as a defining agent of midwife skill was particularly important, because there was no formal training institution. Instead, women served as apprentices, either formally to another midwife, or gaining knowledge from the female collective knowledge in the birthroom.[256] Again, the midwife appeared as the assistant of a woman in birth; the authority of the reader or physician was in emphasizing the significance of a well trained woman. However, the author also draws from popular female knowledge, adding that "I have heard from many women that when the fetus presents the head during birth, then the operation goes well, and the other members follow easily."[257] He also claims that "women and doctors know well how to take care of" the rupture of membranes prior to birth.[258] Expectations about normal birth procedures are gathered from "many women," not a particular profession or group. In both middle English versions of *The Knowing of Woman's Kind in Childing*, the midwife appeared again in relation to the specific act of childbirth. In the Douce version, the reader was told to "let þe myddewyffe whete hare [handys] in watyre þat fenygrek & lynnesede haue be sodon in; þan sese þe hede & draw hym so forth."[259] This advice was similarly presented in Cambridge, where the reader should "lete the mydwyf wete her

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[253] Green, trans., *The* Trotula, 101.
[254] Lemay, *Women's Secrets,* 107.
[255] Ibid
[256] Lucinda McCray Beier, *Sufferers and Healers: the experience of illness in Seventeenth-Century England* (London & New York: Routledge & Kegan Paul, 1987) 16; Doreen Evenden, "Mothers and their midwives in seventeenth-century London" in *the Art of Midwifery: Early Modern Midwives in Europe,* ed. Hilary Marland (London & New York: Routledge, 1993), 99.
[257] Ibid.
[258] Lemay, trans. *Women's Secrets,* 108.
[259] Barratt, ed., *The Knowing of Woman's Kind in Childing,* 66.

handis in watir of senigreue that lyne-seede hath been soden in, and than sese the hed and drawe hym forth."[260] Emphasis was not placed on the midwife's action in the diagnosistic act, but her function of assistant in labour. Finally, in Raynalde's *Birth of Mankind*, he indicated that "it shall be the midwife's part and office with her nails easily and gently to break and rend" the secundine.[261] In all the cases, the midwife was demonstrated entering the area of the female genitals with a specific task and the focus is on their contact with the child, rather than the female genitals.

The existence of explicit references to the midwife in relation to childbirth practices leads to questions about the nature of the assistant figure in the rest of the gynaecological and obstetric literature. Each author demonstrated a tendency to refer specifically to the midwife in relation to her practice, yet not all instances of physician passivity are associated with childbirth. This silence indicates that the figure of the "midwife" would not be a universal assistant to the physician. Instead, this intermediary sphere would be filled by a female figure who was not explicitly defined by the physician authors as a possessing unique skill. All women had a form of knowledge founded in the "accumulated personal experience of touching and noticing,"[262] and were thus were uniquely positioned to act as intermediaries between the words and diagnoses of the physician, and the body of the female patient. The existence of a female assistant was demonstrable due to social and medical requirements of the period, but she was likely not a midwife and the authors neglected to give her an official title. This silence, which also omitted traditional terms for female practitioners like "wise women," spoke to the unprofessional nature of this assistant. The silence of the physician authors also reflected their perception that the female intermediary had a silent role in their interactions. Despite her exploratory task, she was not described as vocally transmitting information to the physician. This is significant in medical treatment, because the interaction between physicians and female patients was characterized by words.

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[260] Barrett, ed. *The Knowing of Woman's Kind in Childing*, 67.
[261] Raynalde, *The Birth of Mankind*, 108.
[262] Broomhall, "Women's Little Secrets," 45.

Peregrine Horden observes that "in treating the sick, medieval healers of all kinds... probably said much more than they did" and that "talk is not necessarily a prelude to action."[263] Talk was also necessary for women who needed to explain their pain, vocalize their concerns, and indicate the diagnosis and treatment that they suspected would be necessary. The necessary area of control for the physician in this medical structure was very small. Their formal training informed a knowledge of intangible factors through the emphasis on the humoural system, and their task was limited to non-intrusive recommendations of treatment including scenic and dietary changes and prescriptions to correct perceived imbalances. It was not a physician's duty to physically investigate or actively treat women, but instead to act as a fixed point through which information was processed and applied academic meaning. That the assistants were voiceless in the texts could indicate that the author did not have set proscriptions for what the examination would reveal. A further clue to their relationship between patient and physician can be found in the significance of touch.

Touching indicated relationships and power, and the exemptions of physicians from relationships of touch with females also lead them to broadly avoid discussions of the significance of this power structure. The threat of power was instead implied through the physician's unwillingness to perform active examinations or treatments for women in these texts because it would challenge the power of other men, notably the husbands of these women. However, the significance of these power structures remained between the women performing the examination and the female patients. The case of Storch and the mother's testimony on her daughters condition seems to me a more accurate example of the relationship of these invisible intermediary women with female patients. Because touch was so powerful, rights to access of the body were limited to family and friends. Thus, the female "assistant" figure described by Monica Green would be more closely associated with the female patient than the male doctor. This dovetails neatly with the methods of expression seen in the gynaecological texts

[263] Peregrine Horden, "A Non-natural Environment: Medicine without Doctors and the Medieval European Hospital," in *The Medieval Hiospital and Medical Practice,* ed. Barbara S. Bowers (Aldershot: Ashgate, 2007): 138.

and the practices of both Storch and Guainerius. Women were seen acting on behalf of other women, helping each other interpret physical signs to construct their own depictions of illnesses. Their knowledge was experienced and their role was intimate, they were a product of female society and not professional medicine.

When I began my research, I wondered how women who were pivotal in the formation of diagnosis and application of treatment did not appear as threats in gynaecological and obstetric literature. Part of the answer is that they were not associated with the authority of male academia, but instead assisted the female transmission of information. Broomhall indicates that male physicians devalued the corporeal sensations of female patients as "subjective and unreliable" in comparison to their own academic medical knowledge and techniques, which were classified as "objective."[264] This relationship can be seen in the works of Anthonius Guainerius, which featured the appropriation of the hands of his assistant. In the event of suffocation, "Guainerius instructs the operator to anoint her hands and the mouth of the vulva" and "comments that the midwife will be more successful in this procedure if the patient is not a virgin."[265] While she does the touching, he claims that it is his knowledge that informs the diagnosis and treatment. In reality, the midwife would have to have an established knowledge base of her own in order to navigate treatments, knowing what the proper placement and feel of the internal organs was in order to respond to his instructions. Additionally, the knowledge of the woman would be necessary to translate her findings back to Guainerius. Even as he establishes himself as an authority, he is relying on and working within a system of information provided by women. This binary of objective versus subjective was broadly applied to enforce the superiority of university training and male knowledge. John Benton also provides a useful explanation of the relationship between male practitioners and female patients, which plays into the role of the assistant figure. He observes that, despite the activity of female healers, healthcare was "supervised" by academically trained men, who also monopolized the theoretical understanding

[264] Broomhall, "Women's Little Secrets," 14.
[265] Lemay, "Anthonius Guainerius and Medieval Gynecology,"232.

and scientific knowledge of women's bodies.[266] These assistants did not appear as threatening because they were not part of the professional end of the medical relationship, but instead structured female knowledge that was, by inclusion of the physician into the realm of female care, reconstituted as male knowledge. They were sources of raw knowledge that required refinement by the art of the physician.

The medieval medical relationship between male physicians and female patients was structured to incorporate a degree of physical distance. Physicians both denigrated the action of touch in relation to their academic art, and were socially restricted from initiating relationships of touch with patients. Instead, the process of professional diagnosis and cure was informed by the exchange of words. This context was informed by the marginalization of bodily exploration and the primacy of self-description for the female patient. Because of the structure of medical interactions, the female intermediary who existed on the periphery of medical literature could not be seen as an extension of the physician; he could and did perform his work without proximal interaction with the patient. Instead, these women helped the female patient to articulate and describe her situation through providing assistance in the physical exploration of the internal and poorly accessible genital conditions. They emerged again to aid in treatment after the physician had indicated cures, replacing the hands of the female patient in preparation of mixtures, spreading of poultices and insertion of pessaries. These women were invisible to physician writers because they were nonentities in the professional medical community; they were not required to have formal practices and they were not always midwives. Instead, their role was informed by the requirements and behaviour of the female patient. Invisibility was due to the exclusion of physicians from this female community, not the lack of a female presence.

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[266] Benton, "Trotula, Women's Problems, and the Professionalization of Medicine in the Middle Ages," 29.

## Chapter 3: Noble Ladies and Healing in Early Modern England

The letters of Jane, Lady Cornwallis (1581-1659) are punctuated by information about court life, familial relationships, and religious devotion. They are also an invaluable source of information about the methods that women communicated their narratives about health and illness. In 1614, Cornwallis received a letter from her friend Lucy, Countess of Bedford, who indicated she "extreamly desier to hear wheather your ill health this sommer have had so happy an issue as I hoped it wold,"[267] The request was one of many Cornwallis received through thirty one years of surviving correspondence. Letters between family and friends, as well as autobiographies are punctuated by references to health and healing, demonstrating a popular preoccupation with issues of illness. Noble women in these letters serve both as sufferers and healers, both recounting their own experiences with injury and illness, and acting to heal and reassure others. Their reminisces demonstrate authority over wellness in their homes and lands. Situating women within the noble and charitable healing tradition is important in understanding one of the ways that women's medical practice and experience were seen as valid demonstrations of feminine skill. This chapter will explore how charity protected female medical practice by making it a necessary feature of female charitable behavior. In this way, experience was made necessary for good behavior.

In this chapter, I will move from the relationship between physicians and female patients in explicitly female conditions to reconstruct more broadly the role of women in the informal performance of medicine. My conclusion in chapter two indicated that the women most involved in the mediation of the patient body were not considered medical professionals or acknowledged as a source of authority by male physicians, despite the significance of their descriptions and experiences. As a result, I have chosen to remain primarily in the realm of non-professional practice to show how how domestic and charitable

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[267] Jane Cornwallis Bacon, *The private correspondence of Jane Lady Cornwallis, 1613-1644 from the originals in the possession of the family*, ed. Richard Griffin Braybrooke (London: London: S&J Bentley, Wilson, & Fley, 1842) 29.

medicine could be defended as a domain of limited female medical "expertise", notably when allied to social prestige. Additionally, I have limited this chapter to explicitly upper class women, who possessed a unique relationship with the medical institution while serving as the providers of care within the home and exemplars for society at large. I have relied on the letters, diaries, and autobiographies of Ann Fanshaw, Anne Halkett, Anne Clifford; Jane Cornwallis; Grace Mildmay; and Mary Rich, to demonstrate the methods of providing care and the accompanying attitude towards medicine. Their recollections focus on the necessity of providing care, competence in the discussion of illness, the provision of medicine, and healthy relationships with physicians. These works display important expectations about the structure of health in the patrician home and the role of female experience and expertise in those expectations.

All of the women used in this chapter were members of the landed gentry who lived away from court life and major cities. Lady Grace Mildmay (1552-1620) resided in Northamptonshire, where she recorded 85 folios of autobiographical recollections and 250 folios on diseases, medicines and treatments, which are analyzed and extensively quoted in Linda Pollock's monograph, *With Faith and Physic: the life of a Tudor Gentlewoman*.[268] Her father was a member of a minor gentry family, knighted by Queen Elizabeth in the late sixteenth century. She married Anthony Mildmay in 1654, but he was opposed to the union and spent little time at home.[269] Mildmay had only one daughter, fifteen years into the marriage, but does not record details of the birth or childhood. She devoted most of her time and attention to religious meditations and medical work, as evidenced by her extensive collection of medical papers. Lady Jane Cornwallis Bacon (1581-1659) was descended "from an ancient and respectable family"[270] and married twice; first as the second wife of Sir William Cornwallis of Brome, and then in 1614 to Nathaniel Bacon. Her correspondence collection spans the years 1613-1644, primarily with her husband and family

[268] Linda Pollock, *With Faith and Ph*ysic: *The Life of a Tudor Gentlewoman, Lady Grace Mildmay 1552-1620* ( London: Collins & Brown, 1993) 1.
[269] Pollock, *With Faith and Physic,* 9.
[270] Cornwallis, *The private correspondence of Jane Lady Cornwallis,* ix.

members or her friend at court, Lucy, Countess of Bedford, and covers a broad range of topics on the health and financial interests of her friends and family. Lady Anne Clifford (1590-1676) was descended from the "illustrious northern branch of the Cliffords," her father the third earl of Cumberland.[271] She married Richard the third earl of Dorset, and Philip the fourth earl of Pembrooke. Clifford devoted extensive passages to her concerns about her inheritance and property rights in her early life, accompanied by concerns the health of her child. Her later diaries focus on her family and issues of her own health during her decline at home in Westmoreland.

Lady Anne Halkett (1623-1699) wrote between 1677 and 1678, focusing her memoirs on her frustrated love life prior to her marriage at the age of thirty three. John Loftis indicates that she "apparently wrote for herself alone, as she wrote many of her religious mediations."[272] She was descended from a Provost of Eton College, and claimed to have served as a Lady of the Bedchamber to Henrietta Maria.[273] In her later life, she lived away from court, in Scotland. Lady Ann Fanshaw (1625-1680) recorded her memoirs with the intention to "discourse to your (my most dear and only son) the most remarkable actions and accidents of your family."[274] As a result, a great deal of the content deals with the genealogy, deeds of her husband, and the family's close relationships with Charles I and Charles II.[275] Fanshawe resided primarily at Hertfordshire. Finally, Mary Rich (1625-1678) likely recorded her memoirs between 1671 and 1674, although she was a noted diarist.[276] Her father was Richard Boyle, Earl of Corke. Rich secretly married Charles Rich, fourth Earl of Warwick prior to his inheritance of the title, and devoted her autobiography to a basic narrative of her life, with trials and

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[271] Anne Clifford Herbert Penbroke, *The Diaries of Lady Anne Clifford,* ed. D.J.H. Clifford (Wolfeboro Falls, NH: Alan Sutton, 1991) x.
[272] Anne Halkett, "The Memoirs of Anne, Lady Halkett" in *The Memoirs of Anne, Lady Halkett and Ann, Lady Fanshaw,* ed. John Clyne Loftis, John Cough Nichols, and Samuel Rawson Gardiner (Oxford: Clarendon Press, 1979) ix.
[273] Halkett, "The Memoirs of Anne, Lady Halkett," 9.
[274] Ann Harrison Fanshaw, "The Memoirs of Ann, Lady Fanshawe" in *The Memoirs of Anne, Lady Halkett and Ann, Lady Fanshaw,* Ed. John Clyde Loftis, John Cough Nichols, and Samuel Rawson Gardiner (Oxford: Clarendon Press, 1979) 102.
[275] Fanshaw, "The Memoirs of Ann, lady Fanshaw," 103.
[276] Mary Rich Warwick, *Autobiography of Mary countess of Warwick,* ed. Thomas Crofton Croker (London: Printed for the Percy Society by Richards, 1848)

illnesses framed as tests of her devotion.

The medieval and early modern medical marketplace allowed room for the functioning of women in healing roles provided that they acted in a domestic and charitable capacity, without claims to occupational status or expectations of remuneration. Lucinda McCray Beier argues that there was a wide dissemination of knowledge, with no clear demarcations between professional and lay. Instead, medical skill was perceived as a shared spectrum of knowledge.[277] Physicians could be identified on the academic and formal end of this spectrum, gaining their knowledge in a university setting and working in the more theoretical field of internal, humoural medicine. However, despite their claims to superiority, they were not the only source of care provided to sufferers. Indeed, Beier argues that there was no consensus on "expertise," and that the consumer, or in the case of informal medicine simply the patient, was in charge of evaluating appropriate care in the open medical market.[278] Instead, the patient procedure of selecting medical assistance can be understood as a "hierarchy of resort." Sufferers considered and worked within constraints of issues of accessibility, geography, personal income, and the nature, phase, and circumstances of their illness.[279] For many, particularly in rural areas, access to physicians and other formal practitioners was a geographic impossibility. Lucinda McCray Beier observes that even middle and upper class families who had the financial ability to obtain medical care, like the Josselin family, had only brief and sparing relationships with physicians; only one of the five children who died before the age of ten was assisted by a physician.[280] Josselin references consulting healers in only twenty one cases out of 762[281]. Of these cases of external aid, only one was a physician.[282] Selection of medical care was influenced by social conceptions about the services provided by practitioners. Doreen Nagy argues that physicians were associated with upper class services,

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[277]Lucinda McCray Beier, *Sufferers & Healers The experience of illness in Seventeenth-Century England* (London & New York: Routledge & Keegan Paul, 1987)*:* 4.
[278]Beier, *Sufferers and Healers,* 5.
[279]Susan Broomhall, *Women's medical work in early modern France* (Manchester: Manchester University Press, 2004) 5.
[280]Beier, *Sufferers and Healers,* 188.
[281] In Beier's work, a case is an incident in which Josselin recounts the illness of himself or his family.
[282]Beier, *Sufferers and Healers,* 203.

despite offering accessible prices that should have appealed to artisans and even lower class sufferers.[283] The illness itself dictated the necessity of external involvement, and frequently was not seen as severe or appropriate for external assistance. Rather than rely on formal medical institutions, it was common for both genders of all classes to experience self-treatment, or use the assistance of friends, relatives and neighbours.[284] Medicine had an important social aspect, and was performed within the home with friends and family present, which is one reason why women could observe and "pick up" medicine when professionals were brought in. Indeed, physicians engaged the women of the house to do the nursing and carry out the doctor's order after the doctor left.[285]

Medical authors frequently discussed and dismissed the authority of female medicine.[286] However, there is one group of healers that functioned with relative success in relation to formal medical professions. Upper class women were in a unique position of power in relation to the academically trained physician, and as such were not subject to the same critiques as their lower class equivalents. As I mentioned in the previous chapter, Nicholas Jewson has proposed a theory of the patronage-based early modern medical system, in which physicians were socially subordinate to their patients. This limited their ability to enforce medical recommendations, but also had broader implications on their authority. Their ability to criticize the charitable medicine of upper class ladies was constrained because these same women were prominent patrons of physicians. Instead, popular literature attempted to control female medicine by indicating that care was only to be provided in a charitable context.[287] This strongly suggests that the issue of "authority" was in fact largely economic, rather than intellectual. Susan Broomhall observes that social level impacted the

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[283]Doreen G. Nagy, *Popular Medicine in Seveenth-Century England* (Bowling Green: Bowling Green State University Popular Press, 1988): 50.
[284]Beier, *Sufferers and Healers*, 4.
[285]Beier, *Sufferers and Healers*, 5.
[286] See, for example, Helen Rodnite Lemay, "Anthonius Guainerius and Medieval Gynecology," in *Women of the Medieval World: Essays in Honour of John M. Mundy*, ed. Julius Kirshner and Suzanne F. Wemple (New York: Basil Blackwell, 1985). Lemay discusses Guainerius' perception of the dangers of practitioners, particularly old women who were seen as having potentially dangerous powers.
[287]Broomhall, *Women's Medical Work in Early Modern France*, 99.

propriety of providing medical care out of Christian charity.[288] Noblewomen were expected to display a benevolent interest in those nearby, as well as providing funding and services to hospitals. Additionally, Broomhall indicates that women were instructed to only nurse patients, not diagnose. This meant that physicians were trying to place women at the fringes of medical practice, dealing with patients who had already seen physicians and now needed only maintenance or the application of prescribed medicines.[289]

The participation of noble women in the realm of informal medicine was linked to fundamental ideas of gift giving and charity in medieval and early modern England. One facet of right Christian living was dictated by enacting the seven works of mercy, which enjoined Christians to feed the hungry, give drink to the thirsty, clothe the poor, welcome the stranger, care for the sick, help prisoners, and bury the dead.[290] Schen argues that in medieval Catholic England, charity and bequests fulfilled the works of mercy through a structured intended to benefit of the donor's soul. In exchange for charity, the recipient was expected to pray for the donor's salvation, thus minimizing their time in purgatory.[291] Ben-Amos describes this as a reciprocal relationship with God, in which the performance of works during one's life was an expression of faith and piety that benefitted them after their death.[292] This system was compromised during the English Reformation. The concept of purgatory was eliminated from the literature of the Church of England, and with it was removed the motivation for performing charity and religious bequests.[293] Some historians have indicated that, in doing so, the English Reformation divided religion and charity.[294] However, Ben-Amos does not perceive in this division a loss of the ideal of charitable giving. Instead,

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[288]Broomhall, *Women's Medical Work in Early Modern France,* 98.
[289]Broomhall, *Women's Medical Work in Early Modern France,* 100.
[290] Ilana Krausman Ben-Amos, *The Culture of Giving: Informal Support and Gift-Exchange in Early Modern England* (Cambridge: Cambridge University Press, 2008) 242.
[291] Claire S. Schen, *Charity and Lay Piety in Reformation London, 1500-1620* (Burlington, Vermont: Ashgate Publishging Company, 2002) 21 .
[292] Ben-Amos, *The Culture of Giving,* 242 .
[293] Schen, *Charity and Lay Piety in Reformation London* 68.
[294] Ben Amos references authors like Max Weber, *The Protestant Ethic and the Spirit of Capitalism* (New York: 1920); Christopher Hill, *Society and Puritanism in Pre Revolutionary England* (London, 1971) and Lawrence Stone, *The Family, Sex and Marriage in England, 1500-1800* (London, 1977).

new language and incentives were used to continue the ideal of charitable behavior.[295] The link between the performance of works and the concept of salvation was severed. In its place was a focus on the spiritual, social and material effects of good works.[296] Good works became beneficial as acts necessary of a Christian person, rather than protection against spiritual problems.

This transition in the intention of charity was further examined in Claire Schen's study of post-reformation London. Schen perceives two major shifts in the provision of gifts and charity. First, Reformation England limited the opportunities of all women, and noble women in particular, to participate in charitable endeavors. Traditional routes of Catholic charity, which for women included lay orders and nunneries, or gifts and bequests to hospitals and almshouses, were dissolved. Unlike French noble women, the English gentry had no organization like the French Daughters of Charity to allow women contact with the public poor.[297] The venues in which women had acted publically in a charitable spirit were minimized, resulting in a growing emphasis on personal and private charity. Growing classifications of "worthy" and "unworthy" poor dictated the figures who were acceptable as the beneficiaries of charity. This dovetailed with increased concern about morality and right behavior, leading London women to increasingly separate themselves from the giving of alms and the hosting of doles.[298] Perhaps due in part to this issue of morality, Schen argues that the second social shift related to the type of bequests. Before the Reformation, a high percentage of funds had been directed towards pious matters, including church upkeep and funding for masses and prayers. Increasing limitations on church decoration and the elimination of purgatory and perpetual masses eliminated traditional religious routes of financing. Schen argues that as a result, there was an increase in familial "non-pious bequests," which included tokens, inheritance, and dowries within the donor's kin group.[299] This tightened expectations of reciprocity and care within households.

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[295] Ben Amos, *The Culture of Giving*, 243.
[296] Ben Amos, *The Culture of Giving*, 246-7.
[297] Schen, *Charity and Lay Piety in Reformation London* 242.
[298] Schen, *Charity and Lay Piety in Reformation London* 243.
[299] Schen, *Charity and Lay Piety in Reformation London* 21, 68.

These transitions are particularly important for the women of my own study, who were expected to care for family and the residents of their estate, and were therefore limited to "worthy" poor by dint of their geographical isolation. Additionally, the "poor" on a noblewoman's estate were likely her tenants, and therefore dependents. This folded them into the woman's extended of family, creating expectations that she would care for them. When noble women cared for the sick, they fulfilled two expectations of Christian women. They both acted out one of the seven works of mercy, and demonstrated their attempt to combat the idleness that accompanied wealth. Protestant concerns about the activities of Christians enhanced the situations in which women could act in caring roles, with the important caveat that they gained nothing substantial in return. This meant that for noble women, both the explicit desire for prayers in exchange for care, and money or equivalent gifts, were eliminated from the caring equation. Charity became more fundamental because the Church of England strove to eliminate benefits while maintaining requirements of charitable work. Women were expected to provide care for their kin and servants in their roles as good Christians and as ladies of the household.

Strictures against the refusal of fees and the situations in which noblewomen could perform medicine were prescriptive alone. Sources like the diary of Margaret Hoby reference dressing patients, distillation, offering advice to suffering parties, and caring for children.[300] This knowledge was often gained through collective experience and embodied knowledge, as with lower class women. However, literate gentlewomen were in a position to extract medical knowledge from reading as well as surrounding oral traditions, and communicated with physicians to increase their practical knowledge.[301] This relationship with physicians could be extensive; Lucinda McCray Beier describes the practice among physicians of utilizing noncharging acquaintances to provide medical recipes and "devoted nursing care."[302] Beier indicates that some physicians, like John Symcotts, "respected such amateur female healers as colleagues" and

[300]Beier, *Sufferers and Healers,* 172.
[301]Beier, *Sufferers and Healers,* 167.
[302]Beier, *Sufferers and Healers,* 43.

"sometimes he shared his patients," indicating an informal referral system. In these cases, the relationship between physicians and gentlewomen was indicative of mutual respect and the exchange of recipes and knowledge.[303] This relationship contrasted sharply with the derogatory style physicians referred to empiric healers, and hinged on both the importance of personal interactions and the status of gentlewomen as non-professional.

Ladies frequently supplemented their own practice with the use of physicians for both consultation and treatment. Grace Mildmay's medical recipe collection includes "An approved course for the same by Doctor Poe, practiced upon a gentlewoman who had a very foul red face"[304] and "Another approved course for the same [falling sickness] by Doctor Athill for children betwixt 3 and 10 years old."[305] This is indicative of both her trust in the work of physicians, and the extent of their confidence in her skills. Physicians were willing to supply Mildmay recipes with detailed treatment records, allowing her to act in their stead. Anne Halkett recalls that "I fell into a feaverish distemper… so that I found it necessary to send for Dr. Cunningham."[306] During her husband's illness, Ann Fanshaw stated that "At last, after all that the doctor and surgion could do, it broke."[307] Similarly, Mary Rich claimed that "God was pleased in the year 1648 to make me fall dangerously ill of the small-pox. My distemper at the first made Dr. Wright, my physician, believe I would die, but it pleased God, by his means, to save my life."[308] Although she never neglected to acknowledge the healing power of God, Fanshaw also relied on the knowledge and skill of the physician to act as a divine instrument. In some cases, professional medical authority even supplanted familial healing ties. Anne Clifford remembered, "was my Grandchilde the Lady Frances Tufton sente…. Ofer see into Utrecht in Holland to be cured of the Ricketts, which she had in great extremitie …" travelling without

[303]Beier, *Sufferers and Healers,* 107.
[304] Pollock, *With Faith and Physic,* 125.
[305] Pollock, *With Faith and Physic,* 114.
[306] Halkett, "The Memoirs of Anne, Lady Halkett," 78.
[307] Fanshaw, "The Memoirs of Ann, Lady Fanshawe," 135.
[308] Warwick, *Autobiography of Mary countess of Warwick,* 24-25.

her parents.[309] The extreme situation and regional availability of the cure separated parents and child in order to maintain her health. However, women also maintained autonomy in choosing when and how to use physicians. When Anne Clifford fasted during her brothers illness, "my Lord persuaded me and Mr Smith[310] wrote unto me so as I was content to break it, besides I looked very pail and ill and was very weak and sickly."[311] It was not only their advice, but her assessment of her condition that led her to return to a normal diet. In their position as authority within the home, women both chose when to call for external medical aid, and the extent to which this advice would be applied.

The centrality of the home is one factor explaining the relationship between women and healing. Because households were both primary sites of care and the private domain of women, the responsibility for tasks relating to basic care was frequently relegated to female housemates.[312] The birthchamber, sickroom, and deathbed were dominated by women because relatives had a familial responsibility to nurse and watch over the ill.[313] Lucinda McCray Beier observes that women were expected to be capable of prescribing and nursing, with their duty to care so socially engrained that the absence of an invitation to a birthroom was seen as a slight.[314] The expectations of women as providers of care in their homes and those of their neighbours and friends structured reciprocal relationships focused on homes as sites of illness and treatment. This centrality of the home during illness was a feature of medicine prior to the rise of the "modern" hospital. Medieval and early modern hospitals were sites for long term care, particularly for the poor or for diseases like leprosy. Treatment for diseases experienced by the majority of the population were diagnosed and treated at home, surrounded by family. Homes were hospitable sites in which feeding and nurturing took on

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[309] Penbroke, *The Diaries of Lady Anne Clifford*, 125.
[310] Smith has a recurring presence in Clifford's diaries, providing medical advice, although he is never identified as "doctor."
[311] Penbroke, *The Diaries of Lady Anne Clifford*, 70.
[312]Montserrat Cabre, "Women or Healers? Household Practices and the Categories of Health Care in Late Medieval Iberia" in *Bulletin of the History of Medicine* 82.1 (Spring, 2008): 25.
[313]Katharine Park, *Secrets of Women: Gender, Generation, and the Origins of Human Dissection* (New York: Zone Books, 2006), 139.
[314]Beier, *Sufferers and Healers*, 5.

primary significance.[315] Medicine focused on regimen through the control of the six non-naturals, described by Carole Rawcliffe as "agents necessary to life": environment, motion, nourishment, sleep, evacuation, and mental equilibrium.[316] These were factors of daily life that could be controlled to influence health. Women's control of the homes also gave them power to contribute to the balance of environment, nourishment, and sleep in particular. The task of providing care allowed access to the remaining non-naturals.

In their memoirs, women frequently refer to their provision of care towards ailing persons, with a particular focus on caring for siblings or children. Anne Clifford's autobiography narrates both her experiences with her daughter's prolongued Ague, and Clifford's later reminisces on the same subject. Clifford states that "Upon the 25 I spent most of my time in working and in going up and down to see the child. About 5 or 6 o'clock the Fit took her which lasted 6 or 7 hours."[317] The incident made a lasting impression, during her final months Clifford recounts returning to her daughter after an absence, saying "I thank God I found her alive though extreamly weak and ill with her long Ague, of which shee had been in great danger those 4 nights I was from her."[318] Anne Halkett similiarly remembers the final illness of her brother, recording "The constant attendance I gave my brother" and his final moments in which "My brother's feaver increasing and his strength decaying…"[319] In her autobiography, Mary Rich stated "till my sister Boyle's taking sick of the measles (and by my lying with when she had them, though I thought at first it might be the small-pox, I got them of her) my kindness being then so great for her, that though of all diseases the small-pox was that I most apprehended, yet from her I did not anything, and would have continued with her all her illness,"[320] Her fear of the disease was combatted by her affection, and she maintained to provide comfort and attention until her father separated her and she contracted an illness of her own. Although

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[315]Cabre, "Women or Healers?," 27-29.
[316]Carole Rawcliffe, *Medicine & Society in Later Medieval England* (Glouchestershire: Alan Sutton Publishing Ltd., 1995) 37.
[317] Penbroke, *The Diaries of Lady Anne Clifford,* 47.
[318] Penbroke, *The Diaries of Lady Anne Clifford,* 241.
[319] Halkett, "The Memoirs of Anne, Lady Halkett," 31.
[320] Warwick, *Autobiography of Mary countess of Warwick,* 8-9.

Mildmay does not refer to specific incidents in her memoirs, she recollects that "also every day I spent some time … ministering to one or other."[321]

For friends and family outside the home, the practice of visiting the sick is a recurring theme in these sources. Mary Rich records that during several of her own illnesses, "my dear sister Raneleigh came down to see me."[322] When travel was not feasible because of distance, friends included multiple inquiries about health in their letters. The letters to Cornwallis are punctuated by remarks like "I AM not a little troubled that I have heard nothing since my departure from Broome concerning your health,"[323] and "Itt wold have eased me of a great deale of care if I might by your servant have heard that you had recovered better health."[324] Although these letters do not include recommendations, they demonstrate a prolonged interest in the health of friends. Although this was not a distinctively female phenomenon, women devote more recollections to visiting and being visited by women than by men. Anne Halkett had extensive recollections of her own illness. In one case, she remembered that "During my sicknesse I was much obliged to the frequent visits of most of the ladies thereabouts."[325] In another case, Halkett "had sent for my woman, who came the next day after I fell sicke and present much my sending for a phisitian…"[326] Notably in this case, Halkett dismisses this suggestion due to the unavailability of the physician, and it is her woman who treats her. Although there is no alternative, Halkett is also confident in receiving care from her servant. Halkett's personal authority is emphasized in another anecdote regarding her own sickness, when she remembers that

> "Mrs. Cullchetch seeing, came to mee and told mee if I saw another in that condition I could prescribe what was fitt for them, and therefore itt were a neglect of duty if I did nott use what meanes I thought might conduce to my recovery. Her discourse made me recollect what I had by mee that was

[321] Pollock, *With Faith and Physic,* 35.
[322] Warwick, *Autobiography of Mary countess of Warwick,* 25.
[323] Bacon, *The private correspondence of Jane Lady Cornwallis,* 200.
[324] Bacon, *The private correspondence of Jane Lady Cornwallis,* 48.
[325] Halkett, "The Memoirs of Anne, Lady Halkett," 74.
[326] Halkett, "The Memoirs of Anne, Lady Halkett," 73.

proper for mee."[327]

The incident features many facets of the female medical relationship, including the visit of a friend, confidence in diagnosis, and the application of a cure. It is Cullchetch who removes Halkett from her position as a victim of disease, reminding her that she has the skills to determine a proper course of treatment. Halkett proceeds to use medicines from her own household to heal herself.

Noble women were expected to have a degree of both medicinal and surgical proficiency. Ann Fanshaw, Grace Mildmay, and Anne Halkett also referred to surgical practices in their autobiographies. In Anne Fanshaw's recollections of her mother, one of the distinguishing noble features was that she "drest many wounds of miserable people when she had health."[328] This action of providing care is associated with her mother's other positive traits, including "loving wife and most tender mother, very pious, and charitable."[329] Grace Mildmay avoided perfoming surgery herself, but described her governess fondly when she called her a "good lady" and said that "she had (also) good knowledge in physic and surgery."[330] Wound dressing fit both under the category of motherhood and charitability, providing aid and caring for family, servants, and the poor. Anne Halkett was particularly proud of her treatment of soldiers during her travels, claiming, "I cannot omit to insert here the opertunity I had of serving many poore wounded soldiers … I believe threescore was the least that was dressed by me and my woman"[331] Halkett demonstrated through the extended anecdote that she was comfortable dealing with grim cases, including one in which the "head was cut so that the [ ] was very visibly seene and the water came bubling up," and other spectators stated "thou at butt a dead man."[332] The extent of her proficiency is emphasized in her choosing to handle these cases, and the successful treatments she applied. Halkett continues, "And the King was pleased to give mee thankes for my charity. I have made this relation because itt was the

[327] Halkett, "The Memoirs of Anne, Lady Halkett," 33.
[328] Fanshaw, "The Memoirs of Ann, Lady Fanshawe," 109.
[329] Ibid.
[330] Pollock, *With Faith and Physic*, 26
[331] Halkett, "The Memoirs of Anne, Lady Halkett," 55.
[332] Ibid.

occation of bringing mee much of the devertissements I had in a remoter place.*"*[333] The reference to "devertissements" is particularly revealing, indicating that Fanshaw did not view her behavior as either a duty or an isolated event, but instead a hobby that she practiced in her own home. Her skills were refined by private practice and included a broad level of confidence in treating physical ailments.

The idea of "Devertissements," characterized as charitable hobbies, characterized noble women. Their unwillingness or disinterest in claiming payment was an important feature in distinguishing these women from those employed in medicine. Their privileged status and its associated wealth meant that upper class women performed medical services as either a familial or charitable obligation. Women like Grace Mildmay made this daily obligation explicit in their memoirs, referring to the daily practice of spending "some time in the herbal and books of physic and in ministering to one or other."[334] This distinction is beneficial in separating their services from the professions of medical men and women. The distinction between women as practitioners and women as providers of care and healers often seems to be simply the reception of payment. Women performed similar tasks for their families and for their clients, shifting between the two roles due to necessity. When women engaged in paid work, their jobs were consistently viewed as having less prestige and deserving of lower pay.[335] Women also had less stable working lives, often playing different roles at different points in their lives or changing jobs in order to assist their husbands in formal male professions.

Additionally, women had the physiological deterrent of pregnancy and childcare, leading to extended periods of time in which they had roles to prioritize above working, and peaking with the lying-in period. Women emerged as rivals to medical institutions like university trained physicians only when their medical treatments intersected with the internal, humoural medicine that physicians considered to be their personal domain. Susan Broomhall observes that when

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[333] Halkett, "The Memoirs of Anne, Lady Halkett," 56.
[334] Pollock, *With Faith and Physic,* 35.
[335]Broomhall, *Women's Medical Work in Early Modern France,* 23.

women were providing medical aid and care to the elderly, dying, young or pregnant, this was not perceived as interfering with male practice.[336] The dying were removed from the domain of physicians because there was no successful treatment left for physicians. The elderly and young were seen as needing more care for chronic or innate illnesses. It was the female treatment of paying customers, particularly the internal diseases of men, that troubled physicians and other medical practitioners.

This figure of the non-threatening gentlewoman, possessing both a relationship to academic medicine and access to the female community and embodied knowledge, became important through the later early modern period. In the medical community, changes occurred that shifted the balance of knowledge and authority between men and women. In the seventeenth and eighteenth centuries, efforts to colonize female bodily experience become evident. Particularly in England, the figure of the male-midwife aimed to supplant the traditional female role in the birth chamber. This altered the dynamics of power in what had previously been an exclusively female affair, diffusing procedural knowledge and creating tension between midwives and physicians. Similar attempt to demystify pregnancy can be found in childbirth literature. Mary Fissel argues that after 1650, childbearing manuals incorporated masculine metaphors for the process of reproduction.[337] In doing so, the power of women to produce children, as a trait that was considered unique and unknoweable, was given common traits and made understandable.[338] The genre of "secrets of women" was being gradually redefined to focus on the female body, rather than the mystery of female medical secrets. This recasting of inaccessible female's knowledge into inherently secret bodies produced a potential subject of learned inquiry for professionals.[339] The body as a concrete object could be examined, particularly through dissection, and understood by men.

In "Women's Little Secrets," Susan Broomhall acknowledges that there

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[336]Broomhall, *Women's Medical Work in Early Modern France,* 53.
[337]Mary Fissel, "Gender and Generation: Representing Reproduction in Early Modern England," *Gender and History* 7.3 (November, 1995): 439.
[338]Ibid.
[339]Park, *Secrets of Women,* 256.

was a particular attribution of knowledge of female health to women."[340] This sentiment is broadly echoed among historians of women in history. The general consensus is that women treated like due to an expectation of shared experience.[341] General features of this communal information were structured around female bodies, familial expectations, and gender roles. Montserrat Cabre observes that in late-medieval Iberia, nursing was described by the practitioners in terms like "as if I was her mother" or "like a daughter." This related health to kinship, which structured relationships to incorporate love, reciprocity, and trust.[342] Lucinda McCray Beier presents a similar argument for women's nearly universal role in healing.[343] She argues that female authority was due to the centrality of the family, as demonstrated by Alice Clark.[344] Additionally, Katharine Park argues that women possessed "orally transmitted, experience-based, concrete and bodily oriented therapeutic knowledge."[345] This was knowledge that arose from specific communities, experiences, and interactions.

Female authors frequently recorded the occurrence of birth in their memoirs.

Anne Clifford makes frequent but perfunctory references to childbirth in her autobiography, using statements like "About this time Lady Rich was brought to Bed of a Son, her 6th child. [She] should have christened it but it died in 3 or 4 days"[346] and "My Coz. Russel's wife was brought to bed of a son."[347] Personal experiences with successful childbirth are also described minimally, as in the case of Mary Rich, who indicated that "God was pleased to give me a safe delivery of a girl, which I lay in with at Warwick House. And soon after the second year, I was brought a bed of a boy."[348] Although these are minimal descriptions, the formulaic description indicated the normalcy of the process. Casual references to

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[340] Broomhall, *Women's Medical Work in Early Modern France* (2.
[341]Helen Rodite Lemay, "Anthonius Guainerius and Medieval Gynecology" in *Women of the Medieval World: Essays in Honour of John M. Mundy*, ed. Julius Kirshner and Suzanne F. Wemple (New York: Basil Blackwell, 1985), 318.
[342]Cabre, "Women or Healers?," 30.
[343]Beier, *Sufferers and Healers*, 211.
[344]Beier, *Sufferers and Healers*, 213.
[345]Park, *Secrets of Women*, 83.
[346] Penbroke, *The Diaries of Lady Anne Clifford*, 65.
[347] Penbroke, *The Diaries of Lady Anne Clifford*, 67.
[348] Warwick, *Autobiography of Mary countess of Warwick*, 17.

childbirth and nursing indicate that these women had established ideas about the process. Mary Rich remembered that "At my son's death, I was not much more than thirty-eight years old and therefore many, as well as my Lord and myself, entertained some hopes of my having more children"[349] Her expectations reflect assumptions about the extent of fertility among early modern women, although she does not add further details about the methods of establishing fecundity.

Frequently, the births women referenced in their autobiographies were challenging or unsuccessful. In a letter to Cornwallis, Bedford wrote that "because by your brother I hear you have binne ill since your being delivered; but I truste itt is no other then som indisposition incident to childe bed, and that I shall hear you have recovered better health."[350] The reference to illness as "incident to childe bed" indicates that a degree of risk was accepted as part of the process of pregnancy, but Cornwallis' case was relatively mild. Of more severity was Anne Clifford's granddaughter, who "dyed … in a hyred house… being then in labour of her first Childe which was a Sonne of whom she could not be delivered, for the childe was dead within her a few hours before her owne death."[351] In a similar case, Halkett records that "For within 3 or 4 days my Lady Moray took her paines, butt they all struck up to her hart, and all meanes being unsuccessful she died" with the child undelivered.[352] In both cases, these women had unsuccessful deliveries; in Clifford's autobiography it related to the extraction of the child, and for Halkett it was a blockage of the natural progression. Rather than moving downwards, Moray's pain moved up and "struck up to her hart." These cases indicated an irregular progression of a natural process. However, the emphasis was on the fatality, with minimal details on the process of childbirth.

Roles of marriage and motherhood contexualized female experiences. Teresa Ortiz argues that female care was provided "without any basis other than that of solidarity of gender and their own experience as mothers."[353] This sense of

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[349] Warwick, *Autobiography of Mary countess of Warwick* 32.
[350] Bacon, *The private correspondence of Jane Lady Cornwallis*, 87.
[351] Penbroke, *The Diaries of Lady Anne Clifford*, 178.
[352] Halkett, "The Memoirs of Anne, Lady Halkett," 69.
[353]Teresa Ortiz, "From hegemony to subordination: midwives in early modern Spain" in *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland (London & New York:

solidary and experience were keys to understanding the way women possessed and applied bodily information and health care. However, this sense of uniqueness is not reflected in the upper-class autobiographies and letters. Women appear to treat it as a given that they will provide care, with statements like that of Mary Rich, who indicated that I had been a constant nurse to him, and had never neglected night or day my attendance upon him when he needed it."[354] Similarly, Ann Halkett refered to incidences like her visit to her amour, "C.B.," in which "when I went to see him I found him lying upon his bed, and asking if hee were not well…"[355] Perhaps the most powerful indicator is the normalcy of the inclusion of medical incidences in the narrative. The emphasis is placed on unusual diseases, like when "My Lady Bedford had the Small Pox and had them in that extremity that she lost one of her Eyes,"[356] not Halkett's own confidence in describing and dealing with ill persons.

Even when correspondence and memoirs do not deal explicitly with the author's interaction with illness, these women demonstrate a high degree of confidence in describing and diagnosing illness. During her youth, Anne Clifford remembered, "There I fell extremely sick of a Fever, so as my mother was in some doubt it might turn to the Plague."[357] The reliance on women to diagnose their family is also apparent in the recollections of Ann Fanshaw. During their travels, they sleep in a bed infested in fleas and when they wake, her husband asks "My heart, what great spots are these on my legs? Sure, this is the plague, but…"[358] It is Ann who discovers the true cause, in contrast to his immediate reaction of asking for her assistance. In a letter from lady Cramond to Cornwallis, "Yo$^{r}$ La$^{p's}$ good daughter & mine was latlie here: she gott leaue for one night to come see her husband, who indeed made great moane for you, & tels me she feares you are inclined to a dropsie, my olde disease, w$^{ch}$ for your comfort, sweet

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Routledge, 1993): 95.
[354] Warwick, *Autobiography of Mary countess of Warwick,*34.
[355] Halkett, "The Memoirs of Anne, Lady Halkett," 27.
[356] Penbroke, *The Diaries of Lady Anne Clifford,* 78.
[357] Penbroke, *The Diaries of Lady Anne Clifford,* 25.
[358] Fanshaw, "The Memoirs of Ann, Lady Fanshawe," 126.

Madam, I thinke is a easie to be cured, if you take it in time.[359] Despite the geographical distance, Cornwallis' daughter felt confident in describing and recommending a treatment for her mother. The case of Grace Mildmay's papers is the most extreme example of this obligation. In *With Faith and Physic,* Linda Pollock presents Mildmay's memoirs, religious meditations, and excerpts from her expansive medical papers, which include recipes for apoplexy, falling sickness, melancholy, and eye pain. The degree of preparation that went into such a collection, along with the surviving letters that contain requests for ingredients or instructions on preparation from Mildmay to her housekeeper, Bess, indicated that Mildmay maintained a medical arsenal for treatment of those around her.[360]

Women frequently indicated familiarity with ascribing causality and diagnosis. Grace Mildmay included in her medical papers a section on "disease and regimens" that included a theoretically based goal of care. She includes advice like "it is [a] dangerous thing to wear and distract the humours in the body by extreme purges or extreme cordials" and "Then this is the difficulty, how to cure the one and not to hurt the other."[361] Mildmay demonstrated an advanced knowledge of theory that she was able to coherently record, demonstrating her familiarity with diagnostic concepts that would help her utilize her recipe collections. Other women demonstrated a more integrated or discreet knowledge of causation and their bodies. In one of her pregnancies, Fanshaw records that "This winter I fell sick of an aguish distemper, being then with child, but I believe it was with eating more grapes than I am accustomed to eat."[362] She recounts the pregnancy but does not establish cause, instead it is her diet that related to the illness. Clifford similarly recorded her expectations of cause and effect during her final months when she recorded that "And this morning after I was out of my Bed I had 7 or 8 great loose stooles downwards, which I thought did me much good, but withal weakened my Body so much that it cast me into a swooning fit."[363] Clifford's relief in evacuation reflects common perceptions about the importance

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[359] Bacon, *The private correspondence of Jane Lady Cornwallis,* 297.
[360] Pollock, *With Faith and Physic,* 140.
[361] Pollock, *With Faith and Physic,* 110-111.
[362] Fanshaw, "The Memoirs of Ann, Lady Fanshawe," 147.
[363] Penbroke, *The Diaries of Lady Anne Clifford,* 233.

of purging, but she also records the failure of this process to relieve her illness. The same confidence was ascribed to diagnosing others. Lady Bedford was surprised at the death of the Lord Steward, explaining to Cornwallis that "God knows, I conceived it to be but a melancholy aprehension, seeing his health better to my thinking than it had beene a year or two before, for his spleene seemed to trouble him lesse."[364] Bedford afforded her own opinion more significance than the associated physicians. Instead, she interpreted the signs and reached her own conclusions. Anne Clifford demonstrated a similar authority when, after her daughter's prolongued illness, Clifford claimed that "After Supper the Child's Nose bled, which I think was the chief cause she was rid her Ague."[365] The incident had nothing to do with medical treatment; instead, Clifford indicated her familiarity with natural expulsions and their ability to restore health.

Gendered expectations about the ability to supply treatment enhanced the female desire for the possession of information. This in turn lead to trends in the collection and exchange of recipes. Montserrat Cabre indicates that in Iberia, household recipes, oral knowledge, and cosmetics were areas of primarily female communication.[366] Recipes were short, anonymous, nonconceptual, nonnarrative and repetitive, indicating the ease of flexibility and modification of recipes to tailor to the women's patients.[367] She argues that the range indicates what women viewed as plausible, possible, useful or desirable cures.[368] These recipes were exchanged orally and textually. The possession of recipes empowered women because a diversity of recipes indicated that they possessed the means of self-help for future disease.[369] Women with broad collections of recipes were prepared to provide care regardless of the presentation of the ill persons in their proximity. This tool supplemented communities of oral and kinaesthetic knowledge, and, as I will argue in a later chapter, grew to be a significant representation of female medical information in the seventeenth century. The possession of recipes,

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[364] Bacon, *The private correspondence of Jane Lady Cornwallis*, 129.
[365] Penbroke, *The Diaries of Lady Anne Clifford*, 49.
[366] Cabre, "Women or Healers?," 37.
[367] Cabre, "Women or Healers?," 38.
[368] Cabre, "Women or Healers?," 39.
[369] Cabre, "Women or Healers?," 40.

verified by trusted relations or medical authorities, enhanced the female ability to provide care. Embodied experience was a tool for understanding disease that women supplemented as much as possible through communally pooled knowledge of cures.

Evidence of female participation in the creation and distribution of medicine is apparent in autobiographies and correspondence of the sixteenth and seventeenth centuries. Grace Mildmay is a popular source for medical historians due to the high degree of preservation in her recipe collection. In a letter to her housekeeper, Mildmay demonstrated the practical use of her collection, instructing the woman expansively on preparative techniques including "strain and wring out hard the gums and spices from the liquor and put them to the extracted liquor of the herbs" in Mildmay's absence.[370] In a letter to Cornwallis, her daughter Eliza said that "I haue sente yo$^{r}$ La$^{e}$ a littill barrell of Seffill oullifs: thay say thay are uery good for the spleene, if thay bee eaten in a morning fasting, and disgested by sum exsersise."[371] Her letter contained both information about the type of cure enclosed, and the accompanying treatment regime. Most cases are more minimal, as with Ann€ Clifford, who remembered that "My Aunt of Warwick sent us medicines from a House near Hampton Court where she then lay with Sir Moyel Finch and his Lady."[372] A letter to Cornwallis from her brother-in-law, Thomas Meutys, included the information that "I have hearwithall sent some of that syropp of ela campane, of my sister's making, which I have myself, and some other of my friends, found so much good of, and have withall sent the receipt herinclosed by which it is made; and if thear bee any thing in it hurtful to my cosin's infirmity."[373] Although it was a male sending the syrup, it was prepared by a woman and Meutys indicated that further correspondence would be between the two women. During her own illness, in the absence of a physician Anne Halkett used her own premade medicines when she "called to Crew (who served mee) for itt, and with the use of some cordials I siencibly grew better"[374] Anne Fanshaw similarly

[370] Pollock, *With Faith and Physic,* 141.
[371] Bacon, *The private correspondence of Jane Lady Cornwallis,* 272.
[372] Penbroke, *The Diaries of Lady Anne Clifford,* 25.
[373] Bacon, *The private correspondence of Jane Lady Cornwallis,* 180.
[374] Halkett, "The Memoirs of Anne, Lady Halkett," 33.

described her cure as being "By the help of God, with these cordials …"[375] These passing references indicate a culture of self-treatment that would become increasingly prominent throughout the seventeenth century.

Embodied knowledge and shared traditions were associated with expectations about the kinds of treatment that women could perform. The experience of childbirth and child-rearing indicated innate specialties for female healers. David Harley argues that women were "expected to be expert in the common diseases peculiar to women and children."[376] This is evident in Lucinda McCray Beier's evaluation of the medical practices of the Josselin family, which demonstrated the treatment of childhood illnesses being mediated by multiple female voices [377] Similarly, many of Anne Clifford's most extensive reminisces on illness deal with her eldest child, who had an extended fit of Ague.[378] Due to their nurturing roles as mothers and the experience of witnessing childhood diseases, both growing up with the advice of their mother and through caring for their own children, women were assigned capability over the health care of children. As a result, women felt confident making personal diagnoses and administering treatment for children.[379] More broadly than maternal duties Muriel Joy Hughes observed that there was a perception that "women are better suited for the treatment of women's diseases."[380] This related to the narrative of female modesty and male distrust of the female body.[381] The specific female diseases were rarely described, but assumptions existed that women were capable of privately handling gynecological debates. Women were seen as possessing accute bodily sensitivity during pregnancy, their bodies "unfinished" and thus exposed to external experiences.[382] Communal knowledge about this fragility constructed

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[375] Fanshaw, "The Memoirs of Ann, Lady Fanshawe," 114.
[376]David Harley, "Provincial midwives in England: Lancashire and Chesire, 1660-1760," *The Art of Midwifery: Early Modern Midwives in Europe,* ed. Hilary Marland (London & New York: Routledge, 1993): 29.
[377]Beier, *Sufferers and Healers,* 189.
[378] Penbroke, *The Diaries of Lady Anne Clifford,* 47.
[379]Beier, *Sufferers and Healers,* 238.
[380]Muriel Joy Hughes, *Women Healers in Medieval Life and Literature* (New York: King's Crown press, 1943), 83.
[381]Beier, *Sufferers and Healers,* 144.
[382]Ulinka Rublack, "Pregnancy, Childbirth and the Female Body in Early Modern Germany," *Past and Present* 150 (February, 1996): 84-86.

communities of care to protect and assist pregnant women.

Noble women interacted with medicine as both clients and experts. Susan Broomhall argues that women were expected to acquire caregiving techniques within an oral and kinaesthetic tradition. Although they are seen as undocumented and unchanging, they must be structured, influenced, and engaged in trends, events, and mentalities of the time.[383] In letters, diaries, and autobiographies, women express confidence in choosing physicians and deciphering the worth of their treatment, providing care for families, and even administering surgical procedures. They do not defend their competence, but work as caregivers with implicit authority. Much of this was likely based on experiential knowledge that was discussed and refined in a community of women. The majority of female reminisces about illness and medicine feature women active in the lives of their friends, family, and servants. They prepared and administered medicine, but did not reflect on the extent of their services. Noble women also demonstrated a high awareness of the pregnancies of their peers and servants. The physiology of women, with the centrality of the uterus and the visual inaccessibility of the reproductive process, aided the primacy of female experience in dictating body functions and defining illness. However, both the privacy of the female body and the academic perspective on information gained by experience were shifting. The rise of empiricism in early modern Europe changed the context of gaining knowledge and created doubt about the gendering of experience. Women's role as keepers of embodied knowledge and members of a community of information fluctuated as male expectations about the possession of information expanded. The relationship between women and medicine was changing.

[383]Broomhall, *Women's Medical Work in Early Modern France*, 2.

## Chapter 4: Female Experience and Authority in the Publication of Recipe Books

In 1653, a man identifying himself as "W.I., gent." initiated a new trend in medical literature by publishing a text entitled *A Choice Manual of Rare and Select Secrets in Physick and Chyrurgery.*[384] This text fit into the narrative of self-help manuals and interest in personal care in the seventeenth century, but was a strong departure in one significant way. *A Choice Manual* was originally compiled by a woman, Elizabeth Grey the Countess of Kent, for her personal use. Additionally, it was her name and authority as a female medical practitioner that facilitated the popularity of the genre, despite the fact that it was published posthumously and without reference to her permission for distribution. In fact, the absence of her involvement with the text may have played a part in transcending norms of noble female avoidance of paid work, allowing the publication of the text. This was a drastic departure from the traditions of disregarding female authority in medicine; rather than vocalizing concerns about female practice, the skills of women were the selling point of these recipes. The popularity of these texts are evidence of shifting expectations of the parametres of women's experiential knowledge. Instead of focusing on the female body, recipe books demonstrate how women managed medical concerns in their household,, and perhaps more significantly, they "represent" to society at large women's "expertise" in these roles, displaying a spectrum of authority in diagnosis, preparation of cures, and treatment. They serve simultaneously as demonstrations of the scope of female knowledge, and how expectations about these skills were popularized and commodified in the seventeenth century. However, using a woman as a figure of authority is not equivalent to a woman printing her own authoritative text, or using her knowledge to gain financial profit. Analysis of these texts will reveal the degree to which authority was appropriated from charitable household medicine, and repackaged as obtainable public skills.

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[384]W.I., *A Choice Manual of Rare and Select Secrets in Physick and Chyrurgery; Collected, and Practised by the Right Honourable, the Countesse of Kent, late deceased. Also most Exquisit ways of Preserving, Conserving, Candying, etc. (*London, 1653) img 1.

Women's authority was both demonstrated and qualified by the publication of their personal sources.

Above all, this chapter demonstrates the ambivalence of female authority. As female medicine was made more public through publishing, traditional protections like domestic and charity were compromised. This chapter ties back into chapter one, showing how women and men interacted when experiment and informal medicine became public commodities. In order to examine the relationship between female experience and public acknowledgement in the seventeenth century, I have chosen to analyze the three most popular printed recipe books produced between 1650 and 1700. The earliest published is *A Choice Manual of Rare and Select Secrets in Physick and Chyrurgery; Collected, and Practised by the Right Honourable, the Countesse of Kent, late deceased. Also most Exquisit ways of Preserving, Conserving, Candying, etc,* published by "W.I., Gent" and printed by "G.D." in 1653. Next is *The Queens Closet Opened. Incomparable Secrets in Physick, Chirurgery, Perserving, Candying, and Cookery; As they were presente to the Queen by the most Experienced Persons of our Time, many whereof were honoured with her own practice, when she pleased to defend to these more private Recreations,* which was "transcribed from the true Copies of her Majesties own Receipt Books, by W.M. one of her late servants" and printed for Nathaniel Brook in 1655.[385] This book initially included two separate texts: "The Queens Cabinet Opened: or, the Pearl of Practise; Accurate, Physical, and Chirurgical Receipts," which contained the majority of medical recipes, and "A Queens' Delight, or the art of preserving, conserving, and candying; as also A right knowledge of making perfumes, and Distilling, the most Excellent Waters." Finally, Hannah Woolley published *The Queen like Closet, Or Rich Cabinet: Stored with all manner of Rare Receipts for Preserving, Candying, and Cookery. Very Pleasant and Beneficial to all Ingenious Persons of the Female Sex. To which is added, A Supplement, presented To all Ingenious Ladies, and*

[385] W.M., *The Queens Closet Opened. Incomparable Secrets in Physick, Chirurgery, Perserving, Candying, and Cookery; As they were presente to the Queen by the most Experienced Persons of our Time, many whereof were honoured with her own practice, when she pleased to defend to these more private Recreations (*London, 1655) Img. 1.

*Gentlewomen. (3rd edition)* printed for Richard Lowndes in 1974.[386] All three books claim to focus on providing their readers with skills in physic, distillation, and food preparation through the provision of receipts. *A Choice Manual* and *The Queens Closet Opened* also indicate in their titles that they are printed from pre-existing recipe collections. Hannah Woolley makes a similar argument in her introductory letter to her readers.

*The Queens Closet Opened* was the most successful of the three books, being published eighteen times in the late seventeenth century. The printing run spanned Henrietta Maria's banishment and return to England, and continued after her death in 1669. The long printing run allowed me the opportunity for comparison to study the stability and additions to the text through various reprints. Each new edition was accompanied by claims like "with additions,"[387] "The Fourth Edition corrected, with many Additions together with three exact Tables, one of them never Printed,"[388] "Corrected and Revised, with many Additions: together with three exact Tables."[389] Despite this claim, my analysis of the recipe content indicates a high level of content stability.[390] Instead, the changes made to the text are peripheral, including updating the methods of attributing authority to the text, changing tables, acknowledging new printers, or, in 1674, the addition of an entirely new text. These changes will be discussed further below. *The Queens Closet Opened* can then be compared to *A Choice Manual* and *The Queen Like Closet* in order to identify the common themes and techniques in these books.

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[386] Hannah Woolley, *The Queen like Closet, Or Rich Cabinet: Stored with all manner of Rare Receipts for Preserving, Candying, and Cookery. Very Pleasant and Beneficial to all Ingenious Persons of the Female Sex. To which is added, A Supplement, presented To all Ingenious Ladies, and Gentlewomen (*London, 1675) img 1.
[387] W.M., *The Queen's Closet Opened* (1656) img 1.
[388] W.M., *The Queen's Closet Opened* (1658) img 1.
[389] W.M., *The Queen's Closet Opened* (1659) img 1.
[390] I completed a page by page comparison of the earliest version of *the Queen's Closet Opened,* and the 1674 version where the text gained its final textual addition, "The Compleat Cook." In "The Queens Cabinet Opened: or, the Pearl of Practise; Accurate, Physical, and Chirurgical Receipts," only two recipes are added between the 1655 and 1674 editions. On the final page, "For the teeth" and "to cure the Toothache" are added. Additionally, a section entitled "Distillings" is added to A Queens' Delight, or the art of preserving, conserving, and candying; as also A right knowledge of making perfumes, and Distilling, the most Excellent Waters." with seven additions. Several recipes' titles are changed, including "for Sweating in the face" in 1654 became "Dr Friers Recipe for Sweating in the face" in 1674, both on page 54. The content of the recipes remained constant.

Recipe books are relatively underused as sources to understand female medical practice in early modern Europe. Jennifer Kay Stine indicates that they are problematic due in part to the degree of information missing from the texts. Recipe books did not state how often the preparations were used, list trial subjects, or indicate if recipes were to be used in conjunction with other treatments. In addition, information on prescription and preparation were minimal.[391] However, although these absences can be viewed as weaknesses in sources, I believe the content, and implications about its use both by the authors and readers, is indicative of the scope and expectations of female practitioners. Therefore, rather than trying to use my sources to reconstruct the practice of their users, I perceive them as an opportunity to examine how female authority was constructed and utilized in this genre by both female compilers and male publishers. Through examining how they were composed and the context and implications of the recipes, a picture emerges of the expectations of female practice and the public transmission of this knowledge. Recipe books serve as a source to access the culture of household medicine, in which women were expected to provide for family well-being.[392]

The popularity of these books was made possible by the rise of the printing press in England and the acceptance of printed literature as a valid communicative form. Printing significantly impacted the nature and dispersal of literature. The creation of manuscripts was expensive and costly, and the personal nature of hand copying lowered the likelihood of exact copies. Indeed, one of the benefits of manuscript culture was the ability to draw and recombine multiple sources to create a personalized text.[393] The printing press produced multiple exact copies of texts, which allowed for wide dissemination of uniform ideas. The potential audience to be impacted by a particular tract was exponentially multiplied. For recipes books, this changed the communicative parametres of the genre. Rather

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[391] Jennifer Kay Stine, "Opening Closets: The discovery of household medicine in early modern England," PhD diss., Standford University (1996) 18.
[392] Elizabeth Lane Furdell, *Publishing and Medicine in Early Modern England* (New York: University of Rochester Press) 96.
[393] William Eamon, *Science and the Secrets of Nature: books of secrets in medieval and early modern culture* (Princeton: Princeton University Press, 1994) 131 .

than individual recipes distributed in an oral or private context, collections could be consolidated and, in the case of texts like *the Queen's Closet Opened, A Choice Manual,* and *The Queen Like Closet,* consumed on a national scale.

The rise of publishing can be correlated to a shift in the intention of medical author's work. This period saw a proliferation of works for the "common man" that translated or summarized classics, professed to offer do-it-yourself acquisition of trade and technological secrets, or provide remedies, prognostications, and almanacs for home use.[394] The initial proliferation of do-it-yourself medical texts indicated a new sense of responsibility and a new venue for profit and publicity in medical practitioners to make their knowledge public.[395] To this end, Stine perceived a dramatic increase in the diversity and number of books on medical topics between 1580 and 1690.[396] This genre was supported and controlled by readers through the purchase and consumption of do-it-yourself literature. Whether or not they reproduced the information in the books was less important than their willingness to accept the genre and perpetuate its usefulness through buying the books. This process was an active negotiation between authors, publishers, and readers.[397] It required authors to produce information in a unique style that was designed to be accessible and realistic; they had to collect information that could be seen as useful to an imagined audience of capable laypersons. Then, publishers had to agree to the profitability of this genre and produce it. Indeed, Chrisman argues that it was the interest of printers in vernacular scientific publication that inspired the expansion of the genre. She states that printers capitalized on the existing intense curiousity in technology and interest in technical skills, as well as the desire to disseminate practical knowledge, as a viable printing specialization.[398] In the case of my sources, the long publishing runs of *the Queens Closet Opened* and *A Choice Cabinet* are indicative of an extended interest in the subject and a readership willingness to

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[394] Eamon , *Science and the Secrets of Nature,* 111.
[395] Miriam Usher Chrisman, *Lay Culture, Learned Culture: Books and Social Change in Strasbourg, 1480-1599* (new Haven: Yale University Press, 1982) 129.
[396] Stine, "Opening Closets," 14.
[397] Eamon, *Science and the Secrets of Nature,* 112.
[398] Chrisman, *Lay Culture, Learned Culture,* 52.

continue purchasing the texts.

Limitations constructed by calculations of literacy rate, like those performed by David Cressy, do not fully define the parametres of access to these texts. Peter Murray Jones indicates that the potential audience of these newly published texts was very broad. Reading was taught before writing in the early modern period, and he argues that by 1600 the gentry and professions were nearly fully literate.[399] Even for those who were not personally literate, traditions of reading aloud to broadcast information were widespread. He argues that achieving competence was not the same thing as being denied access;[400] therefore even lower class figures could potentially access texts through the skill of a singular individual. As a result, the literary skill necessary to utilize recipe books would be divorced from the practical skills, particularly involving cookery techniques, necessary to make the medicine. Due to this range of access to the texts, I will not focus on defining the actual audience of the sources, distinct from the alleged audiences created in the prefaces. Laura Lunger-Knoppers covers this territory in her monograph when she argues that "most of the early responses [to the text] are literally inscribed in the margins or on the endpapers of the text itself."[401] Both men and women recorded ownership of the text, but all the explicit examples of recipe modification that Lunger-Knoppers cite feature the names and handwriting of women.[402] This indicates to me that although ownership was mixed, women made more use of the text than men. With this in mind, I will consider what the construction of the sources says about expected skills and the way information was presented to the public, and particularly to women.

In the conclusion to *Making Women's Medicine Masculine,* Monica Green indicates that the fifteenth century consolidation of recipes and proliferation of

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[399] Peter Murray Jones, "Medical Literacies and medical culture in early modern England" in *Medical Writing in Early Modern English,* ed. Irma Taavitsainen and Paivi Pahta ( Cambridge, Cambridge University Press, 2011) 33.
[400] Cressy, *Literacy and the social order,* 33.
[401] Laura Lunger Knoppers, *Politicizing Domesticity from Henrietta Maria to Milon's Eve* (Cambridge: Cambridge University Press, 2011) 107.
[402] Knoppers, *Politicizing Domesticity,* 108.

domestic medicine could be indicative of a female sphere of medical authority.[403] Household medicine was one of the most acceptable methods of charity and behavior for women. Lady Anne Howard, Countess of Arundel, supervised the preparation of her treatments and (broad geographical range relied on??? Check)[404] Hannah Woolley treated members of her household and her husband's school as well as patients up to ten miles away.[405] This work necessitated familiarity with basic physick and surgery, and often included the personal preparation and application of treatments. The need for skilled ladies was emphasized by geographic factors; Susan Broomhall describes "simple domestic recipes" as the "only hope of usual aid" for members of isolated French communities.[406] These recipes were often preserved orally in a mnemonic structure designed to preserve and transmit information in a familiar formula. Jennifer Stine perceives a continuation of this technique during the early stages of publishing. She argues that recipe texts gained authority from the consistent language and tradition of their use.[407] Recipes were utilized for charitable and household purposes in the application of care, and as such were not strictly gendered female. Instead, clergy like Ralph Josselin and even interested independent parties like Sir Kenelm Digby utilized recipes to maintain their health, provided they acted out of good-will or informal interest, not profit.[408]

During the seventeenth century, there is evidence of a transition away from an exclusively oral system of female medical knowledge. Stine indicates that most personal recipe books were written during the same period that the publication of my three sources, particularly *the Queen's Closet Open*, thrived.

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[403] Monica H. Green, *Making Women's Medicine Masculine: the Rise of Male Authority in Pre-Modern Gynaecology* (New York: Oxford University Press, 2008) 308.
[404] Doreen G. Nagy, *Popular Medicine in Seventeenth-century England* (Bowling Green: Bowling Green State Unviersity Popular Press, 1988) 61.
[405] Nagy, *Popular Medicine in Seventeenth-century England,* 64.
[406] Susan Broomhall, *Women's medical work in early modern France* (Manchester: Manchester University Press, 2004) 105.
[407] Stine, "Opening Closets," 42.
[408] Sir Kenelm Digby was also the subject of a posthumous publication by a servant. The work, *The closet of the eminently learned Sir Kenelme Digbie Kt. Opened whereby is discovered several ways for making of metheglin, sider, cherry-wine, &c: together with excellent directions for cookery, as also for preserving, conserving, candying, &c. / published by his son's consent*, primarily features detailed distillation instructions.

Seventy three percent of her surveyed manuscript sources were written after 1650.[409] This is evidence that during this period, women began to see an increased value in recording and consolidating collections of cures. As a result of the unusually high visibility of female participation, the genre has been associated with female activity across class boundaries. The title pages and attributions of the published recipe books appear to support this theory by indicating a higher level of female participation in the genre. *The Queen's Closet Opened*'s extended title indicated that the collector of the receipts was Queen Henrietta Maria, and the extended title claimed that the book included "many [recipes] whereof were honoured with her own practice." Similarly, the title of *A Choice Cabinet* claimed that the contained works were "*Collected, and Practised by the Right Honourable, the Countesse of Kent."* Hannah Woolley indicated in her title that the work would be "Very Pleasant and Beneficial to all Ingenious Persons of the Female Sex," specifying the expected gender of her audience. The title pages of these books thus utilized female practice as a means to demonstrate authority on the subject.

However, a closer analysis demonstrates the continued male involvement in the genre. *The Queen's Closet Opened* was organized for publication by "W.M.," likely Henrietta Maria's confident and servant, Walter Montagu.[410] The earliest publications were completed while Henrietta Maria was in exile, and W.M. claims that one of his hopes was that "shee may smile at the happy recovery of those papers, which perhaps these troubles and her travels might utterly have deprived of had not my diligent care preserved them for her Majesties review." He situates himself in this phrase as sharing information as a gift to its original compiler. W.M. goes further by claiming involvement in the creation of the recipes in his initial preface, telling his "generous reader" that "there being few or none of these receipts presented to her Majesty, which were not transcribed into her book by my self, the Original papers being most of them preserved in my own hands…"[411] Similarly, Elizabeth Grey's receipt collection was published

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[409] Stine, "Opening Closets," 110.
[410] Laura Lunger Knoppers, "Opening the Queen's Closet: Henrietta Maria, Elizabeth Cromwell, and the Politics of Cookery" in *Renaissance Quarterly* 60 (2007): 480.
[411] W.M., *The Queen's Closet Opened (*1655), img. 4.

postmortem by "W.I.," who identifies himself as "gent."[412] In this case, W.I. does not describe the methods by which he came into possession of Grey's texts. His only reference to Grey herself is that the manual "was once esteemed as a rich cabinet of knowledge, by a person truly Honourable." There are no indications of a personal relationship. W.I. chooses to dedicate the book to "the Vertuous and most Noble Lady, Lettita Popham," whose husband is a colonel. He thus appropriates the work of one woman and dedicates it to another, maintaining the centrality of women to the text while absorbing the profit of publication himself.

Hannah Woolley is thus the only source in this period who provides recipes both written or recorded, and prepared for publishing by a woman. Historians also recognize her as the first women to make a living through publishing, further emphasizing her uniqueness in the field.[413] Therefore, despite the popularity of recipe books as a "female genre," in reality the field of publication remained a masculine domain. Female medicine remained more permissible as a charitable than a profitable endeavor. These recipe books demonstrate an incongruity between the attribution of authority and the motivation for publication. This can be partially explained through the dichotomy of female's expected authority in medical recipes, versus social norms of privacy and discretion. Women's medicine became socially acceptable as long as it was divorced from financial gain. Women who charged for their services were denigrated as empirics and pursued by the regulatory powers of the College of Physicians; but women who acted in the spirit of charity were ignored or even supported by physicians. The collection and use of recipes was an appropriate female pastime, the sale of the same recipes would be socially unacceptable. Additionally, Henrietta Maria and Elizabeth Grey were socially established to the point where there was no fiscal reason to publish.[414] Hannah Woolley, as a lower class woman who had to support herself as a widow, disregarded these social expectations explicitly to support herself. The buried motivations for profit seen in W.I. and W.M. align with Hannah Woolley's publishing.

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[412] W.I., *A Choice Manual*, img. 1.
[413] Stine, "Opening Closets," 202.
[414] Stine, "Opening Closets," 186.

Introductory sections by W.M., W.I., and Hannah Woolley discuss their purported intentions in publication, emphasizing the rhetoric of charity in place through the genre of works "for the common man." "W.I." addressed his work first "to the Vertuous and most Noble Lady, Letitia Popham," dedicating and offering the work to her service.[415] In so doing, W.I. emphasized the nature of the text as a gift and boon to its readers, indicating that "what to tender unto your acceptance worthy your Patronage, nothing occurred more probable, than this small Manuall."[416] Additionally, he addressed a more general "Courteous Reader" with the intention of emphasizing his charitability in publishing. He begins his second letter by stating "that ye are all born for the weal-publique good: I here tender to thy person all this small, and yet most excellent Treatise."[417] The remainder of his letter emphasizes that "that nothing is absolutely perfect, and withal, that the richest and most sovereign Antidotary be often misapplied."[418] His concerns are honouring Popham and deflecting criticism. As the earliest of the three recipe texts, it is possible that W.I. was concerned about the risks of publicizing private collections; his decision to use the word "misapplied" indicates that he is aware of the lack of qualifications necessary for access to the book. His emphasis on charity and self-defense demonstrate the vulnerability of turning recipe collections into a financial venture.

Hannah Woolley divided her introduction into three sections; a letter "To the truly Virtuous and my much Honoured Friend Mrs. Grace Buzby,"[419] a more general letter addressed "To all Ladies, Gentlewomen, and to all other of the Female Sex who do delight in, or be desirous of Good Accomplishments,"[420] and a short poem of intent.[421] Woolley states, ": I am not ashamed nor do I disown what I have already Printed, but some of you being so perfect in your Practices and I very desirous still to serve you, do now present you with this Queen-Like

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[415] W.I., *A Choice Manual,* img. 2.
[416] Ibid.
[417] W.I., *A Choice Manual,* img. 4.
[418] W.I., *A Choice Closet,* img. 4.
[419] Woolley, *The Queen Like Closet,* img. 5.
[420] Woolley, *The Queen Like Closet,* img. 6.
[421] Woolley, *The Queen Like Closet,* img. 8.

Closet."[422] The title cashed in on the still-popular text, *the Queen's Closet,* while also emphasizing Woolley's humility and the scope of skill she shared with her readers. She refers to herself as Buzby's "most Observant Servant"[423] and the readers' "faithful and humble servant."[424] In her poem of intent, Woolley concludes with the lines "But I'm content you should to feed, / So I may have to serve my need."[425] Although her work has a price, her introduction emphasizes the assistance she provides her reader, mimicking a spirit of charity and humbleness. Woolley does not capitalize as extensively on the language of gift giving. By situating her work in her publication history, she alludes to the business aspect of her continual publications. She is a servant providing recipes to clients, choosing to appear as a subordinate rather than a gift giver.

The *Queens Closet Opened* addressed his introduction first to "those Persons of Honour and Quality that presented many of these admirable Receipts at the feet of the Queens Majesty"[426] and then generally to the "Generous Reader."[427] In the first edition, W.M. claimed that his primary intention was maintaining the integrity of the text. He argued, "I found no lesse than two other copies abroad, the sad consideration whereof inforced mee to consult with my friends, who all of them advised me to dispatch my Original copy to the Presse to prevent those false ones."[428] The original preface presents W.M. as a servant who aimed to please his mistress, the absent Henrietta Maria, through the preservation and publication of her text. Like W.J, W.M. disclaims errors, stating, "I must ingeneously confesse some receipts are disordered in their placing, other false printed, which kinde of dealing I must impute to the most unfortunate customes of Printers." His writing centres around the validity of the text, his reasons for publication, and dismissal of potential errors. Henrietta Maria is the central focus of his intention, and only a token reference to charity is made when he concludes by saying that ". Reader, I am sorrowfull that I have detained thee for so long

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[422] Woolley, *The Queen Like Closet,* img. 7.
[423] Woolley, *The Queen Like Closet,* img. 6.
[424] Woolley, *The Queen Like Closet,* img. 7.
[425] Woolley, *The Queen Like Closet,* img. 8.
[426] W.M., *The Queen's Closet Opened,* img. 3.
[427] Ibid.
[428] W.M., *The Queen's Closet Opened,* img. 4.

from thy more beneficial use of this Book."

However, by 1659, *the Queens Closet Opened* was given a new introduction. In so doing, W.M. imposed charitable intentions on his early publications, stating that "It being at first the general good which caused us to publish this useful and compleat Piece, we could not chuse but for the same end give it a new Birth."[429] He went further, asking, "what can be more noble that that which gives the rich such an opportunity of spending upon good works, while they succor the poor, and give comfort to them in their greatest distresses."[430] References to Henrietta Maria and her favour are completely removed from this version. Instead, W.M. focuses on the elevation of the contents. He renames the contents to be more in line with the popular scientific terminology of the period, stating that the contents "we shall now rather call Experiments than Receipts."[431] Departing from the image of the faithful servant, W.M. reflects on the benefits and praise of the text, claiming, "If we have given it too narrow a praise, for too large an Encomium, I am sure we cannot attribute to it, considering its true value." He speaks of the text as if it is his own creation, no reference to the labour or pleasure of Henrietta Maria is maintained in the text. W.M. preserves the charitable conclusion of the work, imploring his readers, "now we hope your Ingenuity will the rather forgive us and them, and with more diligence seek to amend what is amiss, if not for our sakes, yet out of Charity to a Work which is so charitable to your selves." What emerges is a very different author who has laid claim to the work and emphasizes the broader charitable implications and successes, rather than defending the publication and his personal relationship with the queen.

Lunger-Knopper argues that the most significant intention of *the Queen's Closet Opened* was the assimilation of Henrietta Maria into the English tradition in response to the Cromwell reign.[432] She believes that in style and title, the book is a rebuttal of *the King's Cabinet Opened*, published in 1645. This work published the private correspondence of the dethroned royals, focusing on

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[429] W.M., *The Queen's Closet Opened* (1659) img 2.
[430] W.M., *The Queen's Closet Opened* (1659) img 3.
[431] W.M., *The Queen's Closet Opened* (1659) Img 2-3.
[432] Lunger-Knopper, "Opening the Queen's Closet," 467.

Henrietta Maria's "domineering behavior" and the threats to England of a foreign, potentially Papist woman.[433] As a response, *the Queen's Closet Opened* emphasized Henrietta Maria's links to the English nobility through extensive use of approvals and names of recipe creators and users. Lunger-Knopper argues that the text itself further indicated Henrietta Maria's association with the English tradition of charity and medical care, forging connections to her new home through the practice of physic. To make her argument, she contrasts *the Queen's Closet Opened* with *The Court and Kitchen of E, Commonly Called Joan Cromwel, the Wife of the Late Usurper,* published in 1664. *The Court and Kitchen of E* emphasized the country habits, frugality, and stinginess of Elizabeth Cromwell, casting her as "alien" to English traditions despite her birthplace.[434] By casting Cromwell as an "upstart" and bad housewife, the image of Henrietta Maria as assimilating to English traditions of home care and charity is emphasized.[435] Their identities are constructed and contrasted through demonstrations of their alleged domestic practices.[436]

This perception of *the Queen's Closet Opened* as an explicitly political tool does not explain the lengthy publishing run of the text. I also believe that the low degree of recipe organization and the level of attributions to known members of Henrietta Maria's court speak to the validity of an original manuscript of medical recipes. W.M. himself says that he has published recipes that "few or none of these receipts presented to her Majesty, which were not transcribed into her books by my self."[437] He is utilizing an existing collection for a new purpose. The recipes of Henrietta Maria, like Elizabeth Grey and Hannah Woolley, were chosen for publication because the implications of her practical experience made her into an authority, and her authority due to status implied experience and knowledge. The interest in Henrietta Maria and Elizabeth Grey was likely compounded by their status. Queen Henrietta Maria was wife to Charles I and queen of England from 1625 to 1649. Furdell indicates that she was a member of the "cross-

[433] Lunger-Knopper, "Opening the Queen's Closet," 477.
[434] Lunger-Knopper, "Opening the Queen's Closet," 484.
[435] Lunger-Knopper, "Opening the Queen's Closet," 488.
[436] Lunger-Knopper, "Opening the Queen's Closet," 490.
[437] W.M., *the Queen`s Closet Opened,* img. 4.

disciplinary or pre-disciplinary culture of the Renaissance," active in social, artistic, and scientific pursuits in England.[438] Elizabeth Grey was Countess of Kent and wife to Henry Grey. During her lifetime, she was renowned for her charitable endeavours and piety.[439] Elizabeth Grey's sister, Alethea Talbot, was also renowned for her skill in physick, and published a book entitled *Natura Exenterata*. Excluding the lower class Hannah Woolley, popular recipe books emerged from the same community that had produced the Royal Society. Henrietta Maria patronized a broad circle of innovators including John Evelyn, the husband to Mary Evelyn, who was discussed in chapter three. Henrietta Maria was also in contact with the circle of noble ladies renowned for their medical skills, including the sisters, Elizabeth Grey and Althea Howard, Countess of Arundel. These recipes thus emerge from a coherent community with similar skills and values.

Hannah Woolley therefore emerges as distinct in both her publication of multiple unique self-help books, and her lower class status. Little is known about Hannah Woolley beyond the information she provided in the prefaces to her published works. In her series of publications, Woolley constructed her persona as an authority in female skills. Woolley dedicated *the Queen Like Closet* to Grace Buzby, who would be of the middle class, with a husband who was employed as a "wollen draper."[440] Without the authority of status, Woolley emphasized her personal skill and charisma; In *A Supplement to the Queen-like Closet, or, A Little of Everything*, Woolley claims, "I have been Physician and Chirurgion in my own house to many, and also to many of my Neighbours, eight or ten miles round."[441] She establishes her authority in the field not because of her social or religious status, but as a personal statement of competence and skill. Woolley reemphasizes these elements in the *Ladies Directory in Choice Experiment & Curiousities*, as she assured her readers, "I have not taken upon the credit of others; but do

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[438] Furdell, *Publishing and Medicine in Early Modern England,* 98.
[439] John Considine, "Grey, Elizabeth, Countess of Kent (1582-1651)" in *Oxford Dictionary of National Biography* (Oxford University Press: 2004) online edn, Oct 2006 [http://www.oxforddnb.com/view/article/11530, accessed 20 March 2013]
[440] Woolley, *The Queen Like Closet,* img. 5.
[441] Hannah Woolley, *A supplement to the queen-like closet, or A little of everything Presented to all ingenious ladies, and gentlewomen.* (London, 1684) Img 5

commend them to you from my own Practice…"[442] Although status was a factor, the texts emphasized the practicality of the texts.

Stine observes that these sources became commodities based on assumptions about their compiler's social and medical authority.[443] For both Grey and Henrietta Maria, the benefits of a compilation associated with nobility would be a powerful motivation, but Laura Lungers-Knoppers observes that the texts were also used and modified by their readers.[444] They must thus have had merit for their content as well as their attributions. The effort to construct and enforce authority can also be seen through the use of approval words. In this section, I study the authority applied to particular recipes by associations with names, success words, and anecdotes. Therefore, a recipe attributed to a named figured like "Dr. Friers receipt for sweating in the Face,"[445] statement like "proved," "perfectly cured," "very medicinal," or "very good," or a narrative like "A drink for the Plague or Pestilent Fever, proved by the Countess of Arundel, in the Year, 1603," which claimed that "Also this medicine saved 38 Commons of Windsore the last great Plague, 1593"[446] all indicated the origins and perceived validity of the recipe. In the case of recipes that were "proved," it could both mean tested by or upon, the significance was in the enactment of a cure. They could be used as a measure to evaluate the usefulness of the text, acting as a shortcut to testing the recipes personally. Approvals are particularly important in *the Queens Closet Opened*, which contains both a high level of approvals generally, and high level of attribution. Over fifty percent of the recipes in *the Queens Closet Opened* contained some sort of approval or indication of origin. Thirty four recipes were attributed to doctors, fourteen to men, and sixteen to women. An additional two recipes were attributed to royalty, including Queen Elizabeth. The most common type of approval was a guarantee of success, that the recipe would "perfectly cure" or is "excellent" or "very good." Many recipes compound success words with

[442] Woolley, *The Queen Like Closet*, img 4.
[443] Stine, "Opening Closets," 186.
[444] Knoppers, *Politicizing Domesticity*, 108.
[445] W.M., *the Queen's Closet Opened,* 54.
[446] W.M., *the Queen's Closet Opened,* 24-25.

attributions, like "The Bishop of Worchesters admirably curing Powder"[447] and "The Lady Drury's Medicine for the Colick, Proved."[448] A high proportion of recipes carried some guarantee of efficacy.

The difference is striking when the attributions and approvals of *The Queens Closet Opened* are compared to *the Queen Like Closet* and *A Choice Manual of Rare and Select Secrets.*

*A Choice Manual* contained fifty six cases of approval, a total of sixteen percent. Approvals were indicated both by words of approval like "very good" and "most excellent," and by guarantees of success like "and that will heal it" and "will cheer the heart." Nine recipes were attributed to a male author, including "Dr. Steven's Sovereign Water," a "Paracelsus Salve," and a recipe attributed to Mr. Bendlow. Three recipes were attributed to females, all ladies. "Receipts for bruises" was "approved by the Lady of Arundel,"[449] "An Ointment for any Swelling" was from Lady Pawlett,[450] and a panacea cure was entitled "The Countesse of Kents Powder."[451] One recipe was attributed to "A.T.," who was not defined by gender or class.

*The Queen Like Closet* contains twenty four cases of approvals, a total of twelve percent. Woolley indicated approval through phrases like "ought to be prized,"[452] "it is very rare"[453] and "approved by many."[454] Additionally, three recipes were attributed to male doctors. No sources were attributed to women or non-professional sources more generally.

Lunger Knopfer observes that *the Queen's Closet* has an "unusually high" number of attributed recipes. This argument is supported by my research; *the Queen's Closet* has an attribution rate of eighteen percent, compared to three percent in *A Choice Manual* and two percent in *The Queen Like Closet.* She indicates that this could be a political tool, indicating the generational bonds and

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[447] W.M., *the Queen's Closet Opened* (1674) 18.
[448] W.M., *the Queen's Closet Opened* (1674) 43.
[449] W.I, *A Choice Cabinet,* 74.
[450] W.I, *A Choice Cabinet,* 110.
[451] W.I, *A Choice Cabinet,* 175.
[452] Woolley, *The Queen Like Closet,* 11.
[453] Woolley, *The Queen Like Closet,* 334.
[454] Woolley, *The Queen Like Closet,* 27.

social links that qualified Henrietta Maria as an English queen despite her foreign birth.[455] I believe this tells only part of the story of Henrietta Maria's collection. As a result of her social circle, she would have access to a higher proportion of recognizable names for her sources, and the same social expectations would require attribution of successful cures to friends and family. Additionally, her time restrictions as a ruler and may have lead her to rely more heavily on the recipes of others, trusting their experience in lieu of her own trials, and trusting that notions of class propriety ensured it was more appropriate for them to perform medicine than for the queen. The same tendency to attribute recipes to friends and neighbours is found in the private recipes of lower status women, as demonstrated by Jennifer Stine.[456] It is also possible that the lower number of attributed recipes in Woolley's collection is because she relied more heavily on oral traditions and advertised her personal competence in formulating and testing recipes, and therefore did not have external sources to acknowledge in her publishing. Indeed, because of her proficiency Woolley implies that attributions were not necessary, she acted as the primary authority within her writing. Lower levels of attributions did not disqualify a source, but they also strengthened the authority of the text.

Despite the heavy emphasis on male authority in attributions, there are a series of recipes that remain gendered female. None of the recipes in *the Queens Closet* relating to the female body were attributed to men. Only two recipes are described as "an approved Medicine",[457] or state that "this is proved," [458] and two more recipes are given attribution to noble women: "The Lady Nevil for a sore Breast, by cold festering milk."[459] and the Lady Arundel is attributed to a recipe that is purported to be "for the Stone, Back, or Stomach, or to make a Woman Conceive."[460] *A Choice Manual* contains no recipes regarding female complaints or childbirth that are attributed to sources. Only one recipe includes a discussion of the success. "For a woman travelling [sic] with child," the author indicates that

[455] Lunger-Knopper, "Opening the Queen's Closet," 481.
[456] Stine, "Opening Closets," 44.
[457] W.M., *the Queen's Closet Opened* (1674) 114.
[458] W.M., *the Queen's Closet Opened* (1674) 154.
[459] W.M., *the Queen's Closet Opened* (1674) 141.
[460] W.M., *the Queen's Closet Opened* (1674) 165.

"Take and give her Titany to drink in the morning, and shee shall be delivered without peril," and "binde the hearb Argentine to her nostrils, and she shall be soon delivered, or else Polipodie and stamp it, and lay that on the womans foot in manner of a Plaister, and she shall be delivered quick or dead, or else give her Savorie with hot water, and shee shall be delivered."[461] The recipe is a composite of treatments, indicating several cures, both to be ingested and applied externally, to provoke labour and childbirth. Specifically female medicine is associated with an anonymity that would lead me to believe that it emerges from an oral tradition, rather than the exchange of recipes between professionals.

Despite the absence of male contributors from female recipes, these texts were surprising in the diversity of their cures. As I have discussed in earlier chapters, women were affiliated with innate knowledge about the female body, particularly reproductive events. Therefore, when I began my research I expected to find the recipe books primarily focused on similar material to that in gynecology and obstetric texts. However, none of the recipe books contain information on the treatment of uterine or vaginal complaints, or explicit detail on the physiological problems associated with childbirth. *The Queen's Closet Opened* contained twenty one recipes specifically pertaining to the female body and reproduction. Eleven related to the production of breastmilk, one to conception, four to avoiding miscarriage, and four to conditions experienced during childbed. The final three related to the female body generally. In total, this is only eight percent of the recipes. *A Choice Manual* contained only five percent, or eighteen recipes, on the female body, of which fourteen related to pregnancy and miscarriage, three to the breast, and one to green sickness. In *The Queen Like Closet,* there are no recipes that relate explicitly to the female body or childbirth. The trend holds true in Hannah Woolley's other publications, there are also no female recipes in *the ladies delight in preserving, physic, beautifuying, and cookery*.[462]

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[461] W.I, *A Choice Cabinet,* 47.

[462] Hannah Woolley, *The ladies delight: or, A rich closet of choice experiments & curiosities, containing the art of preserving & candying both fruits and flowers : together with The great cook; or, The art of dressing all sorts of flesh, fowl, and fish. / By Hannah Wooley. ; To which is added:*

I believe that this absence can be attributed to changing understandings about male access to the female body, and the corresponding shift in expectations of female authority over female physiology. As Katharine Park discussed, throughout the early modern period there was an increasing emphasis on the exploration of female bodies through dissections.[463] As a result, expectations about how women's experience qualified them as medical practitioners changed. They no longer were considered to possess exclusive knowledge of female anatomy and conditions. Additionally, the work of the Royal Society increasingly qualified the terms of empiricism. In the case of women associated with members of the Royal Society like Mary Evelyn, this resulted in an increasing divorce between definitions of practice, with women remaining affiliated with household medicine while men took the same techniques into the realm of science.[464] This move away from implicit, embodied knowledge to women's association with household physic became the primary site of female experience**.** Instead of possessing embodied knowledge, female authority was projected away from "intutitive physiology" to the range of external experiences within the household. Therefore, instead of focusing on female physical complaints, these texts display the range of health concerns that a housewife would be expected to understand and treat.

Recipes in all three texts treated a broad range of diseases including consumption, plague, gout and jaundice, as well as treatments for discomfort or pain in body parts including the stomach and intestines, chest, and eyes. In all three, the most frequently cited treatment was for external injury, including wounds, the bites of mad dogs or stings of scorpions, or beautification treatments like the removal of pimples or the treatment of bad smells. These recipes accounted for twenty six percent of *the Queen Like Closet,* thirty percent of *A Choice Cabinet,* and twenty eight percent of *the Queens Closet Opened.* In *The*

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*The ladies physical closet: or, Excellent receipts, and rare waters for beautifying the face and body (*London, 1677.)

[463] Katharine Park, *Secrets of Women: Gender, Generation and the Origins of Human Dissection* (New York: Zone Books, 2006) 169.

[464] Lynette Hunter, "Sisters of the Royal Society: The Circle of Katherine Jones, Lady Ranelagh" in *Women, Science and Medicine 1500-1700,* ed. Lynette Hunter & Sarah Hutton (Thrupp: Sutton Publishing Ltd. 1997) 188.

*Queen Like Closet,* the second most common treatment related to consumption, with nine recipes. Beyond this emphasis, the next most popular recipe was for the lungs, with every other disease receiving no more than three listed treatments. *A Choice Manual* contained twenty one recipe related to wind and discomfort in the gut, and nineteen recipes for the eye. Restoratives were also prominently emphasized, with fourteen recipes, and the related subject of curing headaches had eleven listed recipes. *The Queen's Closet Opened* had the highest diversity and number of recipes, containing thirty recipes relating to the stomach and digestion, twenty related to the kidneys, sixteen plague recipes and fifteen recipes for the eyes.

Additionally, all three texts make use of cookery to a greater or lesser degree. *A Choice Manual* is the most focused on medical recipes, but the cookery element is evident in the high levels of use of ingredients like sugar and alcohol. Both *The Queen's Closet Opened* and *The Queen-like Closet* incorporate explicit cookery recipes. Hannah Woolley mixes preserves, medicines, and cookery within the body of her text, placing "To make the best bisket-cakes" between "for a Cough of the Lungs, or any Cough coming of cold, approved by many" and "perfumed roses."[465] Later editions of *The Queen's Closet Opened* include "The Compleat Cook," which contains recipes like "To dress a Pig the French manner"[466] and "To make a Devonshire White pot."[467] These books demonstrate the meshing of medicine and female responsibilities. Diet was one of the non-naturals, which allowed women to regulate health through the application of appropriate recipes. Additionally, cookery could be used as a transmission instrument to provide medicine; many recipes called for food prepared as candy lozenges or in spirits or waters. Preparation or management of food was more generally a female duty. It is difficult to say if this mingling in recipe books is due to ideas about non-naturals, or capitalization on multiple themes of female interest. The recipes were intermeshed enough that they became part of the same genre.

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[465] Woolley, *The Queen Like Closet*, 25-27.
[466] W.M., *The Queen's Closet,* Img 163.
[467] W. M., *The Queen's Closet,* Img 167.

Some general statements can be made about the compilation and use of these books from the distribution of recipes. First, the most common recipes in all three books dealt with daily and external injuries or beautification. These would be the most frequent complaints of the household, and also the conditions that would require the most immediate and constant treatment. These conclusions are supported Stine's research into unpublished recipe collections, which demonstrate that the emphasis in recipe books was on treating accidents and chronic illnesses.[468] The three books diverge in their secondary disease listings. In "Making Medicine in the Early Modern Household," Elaine Leong describes the recipe collection of Elizabeth Freke, a Norfolk widow from an elite family who lived in the late seventeenth and early eighteenth centuries. Freke assembled a comprehensive collection of her medical possessions and papers prior to her death that Leong has used to examine household medical preparation and consumption.[469] She demonstrates that the presence of eye medication is likely related to Freke's own suffering in 1710.[470] Using the hypothesis that the presence of medicines or emphasis on particular diseases corresponds to the user's experience with disease, it is possible to theorize that stomach, sight, and consumptive complaints were the most urgent and prevalent in these women's lives. *The Queen's Closet Opened*'s high level of plague recipes is also indicative of a royal concern for preparedness in emergency.[471]

The types of female recipes listed by Henrietta Maria and Elizabeth Grey are also interesting. Elizabeth Grey had no children with her husband. Her recipes on childbirth would be a result of female expectations about participation in childbed rituals, and primarily focused on initiating delivery. Henrietta Maria's relationship with childbirth was more personal and perilous; she lost her first child shortly after its birth in 1629 after a difficult labour, and the birth of Charles II was marked by the same difficulty. The recipes she possessed relating to

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[468] Stine, "Opening Closets," 27.
[469] Elaine Leong, "Making Medicines in the Early Modern Household," *Bulletin of the History of Medicine* 82.1 (Spring 2008) 145
[470] Leong, "Making Medicines in the Early Modern Household," 156.
[471] *The Queen's Closet* contains sixteen recipes relating to the plague, including "A Medicine for the Plague that the Lord Mayor had from the Queen" on page 29.

childbirth specified a desire for "safe deliverance,"[472] and dealt with the aftercare of the mother, including "To ease Womens Child bed throws that are taken with cold a week or two after their Delivery"[473] and "For women swounding fits after delivery of child,"[474] "A very good means to stay a Looseness that happeneth in childbed"[475] and recipes relating to the production of milk and care of the breasts. These recipes imply a heightened concern for restoring the health and safety of the mother. The recipes relating to the female body that remain in these collections do not possess the singular, authoritative knowledge about female wellness implied by earlier texts. However, they do emphasize the link between female knowledge, experience, and responsibility. These recipes remained in the collection because they had practical applications in the lives of women.

Despite the potential to link the preservation of recipes with personal complaints, the format of recipes is minimalistic, often structured in a single paragraph with sparse description of ingredients or procedures. In *the Queens Closet Opened*, "An approved Medicine for a Woman in Labour to make, come, and prove safe Deliverance" instructs the reader to "Take powder of Cinamon, one dram, powder of Amber half a dram finely beaten, mingle it with eight spoonfuls of Claret Wine, and so let her drink it."[476] *A Choice Manual* instructs readers that "For a woman that hath her Flowers too much" they should "Take a Hares foot, and burn it, make pouder of it, and let her drinke it with stale Ale."[477] T*he Queen Like Closet* includes a recipe for "A most excellent Cordial proved by very many" that indicates that the reader "Take three Grains of East Indian Bezoar, as much of Ambergreece, powder them very fine with a little sugar, and mingle it with a spoonful and half of the Syrup of the Juice of Citrons, one Spoonful of Syrup of Clovegilliflowers, and one spoonful of Cinamon Water, so take it warmed."[478] In all these cases, there is a degree of uncertainty in comprehending the recipe. At what point should the medicine "to make, come, and prove safe Deliverance" be

[472] W.M., *the Queen's Closet Opened (1674)* 84.
[473] W.M., *the Queen's Closet Opened (1674)* 113.
[474] Ibid.
[475] W.M., *the Queen's Closet Opened (1674)* 137.
[476] W.M., *the Queen's Closet Opened (1674)* 84.
[477] W.I, *A Choice Cabinet*, 87.
[478] W.M., *the Queen's Closet Opened (1674)* 69.

given to the woman? For what reason must the ale ingested with the powdered hares foot be stale, and what length of time should be expected in the preparation? What is the intended of effect of "To make Oyl of Excester"?[479]

What these sources demonstrate is the absence of context in recipe books. In all three of my published recipe sources, recipes are identified by brief titles like ""Dr. Reads Perfume to smell against the plague,"[480] or "To take away a hoarsnesse."[481] For recipes that do not include the affliction in the title, like "An excellent artificial Balsom,"[482] frequently a concluding sentence will discuss the curative properties. In *the Queen Like Closet,* Woolley includes a series of spirits and waters, including "To make Spirit of Oranges or of Limons" and "to make Limon water."[483] No diagnosis or treatment advice is included in the recipe; instead, the reader would be expected to have the herbal and medical knowledge to accurately utilize the recipes. Woolley frequently relies on minimal descriptions. For example, "To make Rosemary Water," the recipe provides only directions on the distillation process; it is not associated with any disease and no treatment suggestions are offered.[484] Jennifer Stine observes in her analysis in *Opening Closets* that one of the most significant absences in the recipes was the description of ingredients. Recipes identified the plant to be used, but not the part of the plant, indicating an implicit knowledge of the proper use of herbs and distillations..[485] Within the body of the recipe, the emphasis was on the ingredients, with minimal preparative instructions. Not all recipes include instructions on application or treatment techniques. This results in an interesting image of female proficiency in deciphering the situation to use a recipe. In order to successfully utilize a recipe in any one of the published texts, a reader would first have to diagnose the condition through a series of recognizable signs or symptoms that are not included in the recipe. They would then prepare, and would have to possess the confidence to determine the means and length of

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[479] W.M., *the Queen's Closet Opened (1674) 73.*
[480] W.M., *the Queen's Closet Opened (1674)* 37.
[481] W.I, *A Choice Cabinet,* 13.
[482] W.M., *the Queen's Closet Opened (1674)* 91.
[483] Woolley, *The queen Like Closet* 6.
[484] Woolley, *The Queen Like Closet,* 7.
[485] Stine, "Opening Closets," 28.

treatment. Finally, they and the patient would have to determine the success of the recipe. A statement of "proved" or "est probatum" in the recipe book did not indicate a guarantee of success, but instead implied a successful treatment by a previous user. This freedom in selecting and using recipes was indicative of the scope of female authority. The physical recipe was only the minimal indication of the accumulated preparative and diagnostic tool of female practitioners.

The extent of female proficiency is also evident in the range of treatment techniques.

The format of the recipes is not always explicit in the method of application; although some titles contain the type of medicine, like "A water for the biting of a mad Dog"[486] or "A Purging Dyet-Drink, the Proportion for four Gallons,"[487] many simply state the targeted condition. Examples of this style of naming include "For the prick of a Needle or Thorn,"[488] "To make a rare Medicine for the Chine-Cough"[489] and "For to know whether he that hath the Flux shall live or die"[490] Additionally, not all recipes are explicit in the method of treatment. To obtain a full list of the methods of treatment, I reviewed the types of cures indicated in the titles, and additionally analyzed the bodies of the recipes for phrases like "Take three spoonfuls,"[491] "upon a knifes point,"[492] or "as hot as may be suffered apply it."[493] Conclusions about the type of application also demonstrated the spectrum of female skill in treatment. External applications required the highest degree of skill and implied surgical practices. A recipe for "the Powder" instructs the reader to "dip the end of ten tents in this powder," implying a further use and additional equipment in treating wounds.[494] "For the mother" instructs the reader to prepare the recipe, "then put it in a linen cloth, and lay it to her Navel, as hot as she may suffer it, four or five times."[495] The preparation of cordials and waters required

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[486] W.I, *A Choice Cabinet,* 61.
[487] W.M., *the Queen's Closet Opened (1674)* 66.
[488] W.M., *the Queen's Closet Opened (1674)* 99.
[489] W.M., *the Queen's Closet Opened (1674)* 33.
[490] W.I, *A Choice Cabinet,* 46.
[491] W.M., *the Queen's Closet Opened (1674)* 33.
[492] W.I, *A Choice Cabinet,* 4.
[493] W.M., *the Queen's Closet Opened (1674)* 105.
[494] W.M., *the Queen's Closet Opened (1674)* 77.
[495] W.I, *A Choice Cabinet,* 114

more preparative skill, often explicitly requiring distillation. Recipes for Aqua Mirabilis instruct the reader to "mingle all these together over night, the next morning set them a stilling in a glass Limbeck."[496] Hannah Woolley's recipe "To make Aqua Mirabilis a very delicate way" specified that the ingredients should "stand all night in the Still, not an Alembeck, but a Common Still"[497] The process of distillation is not expanded, the reader is expected to have access to and familiarity with the necessary equipment to produce the recipe.

The emphasis on type of treatment is not uniform between the three sources. I determined that *the Queens Closet Opened* contained one hundred and eighty three recipes producing liquids and forty recipes for solids to be orally consumed, for a total percentage of forty six oral recipes in the collection. Twenty six percent of the recipes were for topical applications like face washes and balms, six percent called for rags and bags to be applied externally, and four percent were perfumes. The final one percent, three recipes in total, called for clysters, which would act as enemas. Hannah Woolley has a similar emphasis on liquids and distillation. As a result, sixty four recipes are liquids to be ingested, with only five recipes for oral solids and fourteen recipes for external applications. *A Choice Manual* contained forty nine recipes calling for oral solids and one hundred twenty five for liquids, for a total of half the recipes. Compared to *the Queen's Closet,* a much higher proportion of the recipes were for external applications, one hundred seventy one recipes created balms, water for the eyes, or cloths for an approximate total of fifty percent. The final one percent, five recipes, were for clysters. Hannah Woolley's work had the most singular emphasis on distillation, and Elizabeth Grey's recipes required the highest degree of surgical skill. Henrietta Maria's recipe collection falls between the two sources, containing a spectrum of treatments.

The structure of the recipe books reflects a process of gradual collection in all cases. Stine indicates that because recipe books were rarely written from start to finish, their internal structure was often inconsistent.[498] Even *the Queen Like*

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[496] W.I, *A Choice Cabinet,* 4.
[497] W.M., *the Queen's Closet Opened (1674)* 1-2.
[498] Stine, "Opening Closets," 23.

*Closet*, which was arranged explicitly for publication, does not thematically group recipes. However, all three books contain indexes to aid consultation. *A Choice Manual of rare and select secrets* contained "A Table of Contents" immediately after the letter to the reader. This section was structured alphabetically. The selections under C include "For a Consumption," "To make Cammomill oyle," "To Cure Wounds that be Cankered, and doe burn"" "for the dry Cough and Physick," "The Powder of Crabs Clawes" and "To prevent a consumption."[499] From this sample, it is apparent that the letter "c" does not refer singularly to the disease, but to the primary feature of the recipe. *The Queen Like Closet* contained an index entitled "The Contents of the First Part" immediately after the end of the original text and before "A Supplement to the Queen-Like Closet, or a little of everything." It is arranged alphabetically and focuses on the title of the recipes. Because of the content, many of the entries are food, including "Candy as hard as a Rock," "Caroway Cake," and "Cherries in Jelly." Medical recipes are listed minimally and not consolidated by disease, the list includes two separate entries for "Consumption" as well as "Custard for a Consumption." Other medical recipes include "Cordial most excellent" and "Cough of the lung." (all img 181) The lack of consolidation indicates a low emphasis on reader convenience, which is surprising given Woolley's explicit intention of publishing to share her experience with gentlewomen.

Indexing changed throughout the publication history of *the Queen's Closet Opened.* In the 1655 edition, the first publication of the text, both "A Table to the Pearl of Practice" and "A Queen's Delight" are attached at the end of the text. The table is a list organized by the page number of the recipe, beginning with "Dr. Butler's preservative against the plague" on page 1 and concluding with "A receipt for an extraordinary wasting of the back, and for the floxe and stranguary, used by Justice Hutton" on page 191.[500] The same format is used in "A Table to the Queens Delight; of Conserves, Preserved, Candying, and of most Excellent distilled water." By the second edition in 1656, the format was adapted. Recipes were arranged thematically, including "Canker in the mouth to cure," "Cancer to

[499] W.I., *A Choice Closet*, img. 5.
[500] W.M., *The Queen's Closet Opened (*1655), Img 163.

prevent and remedy – 110, 125" "Consumption to cure, 3, 9, 10, 13, 22, 34, 42, 123, 186, 299, 278, 279, 295", conception to help, "cornes to take away" "Cordials most excellent," "Conserves of all sorts to make, and their virtues."[501] This grouped multiple types of recipe under the same heading for the reader's comparison. Some recipes remained outside the umbrella of disease, like the listing for cordials.

The organization of the index was important in encouraging use of the text. Both *A Choice Manual* and *the Queen's Closet Opened* had long publishing runs, indicative of their popularity. Their indexes made them useable, allowing readers to search by disease or intent and easily track comparable recipes in the same collection. The restructuring of *the Queen's Closet Opened* in particular is evidence of the attempt to make the text more accessible. Both *A Queen Like Closet* and the 1655 *Queens Closet Opened*'s table appear to be a case in which the compiler or publisher compiled a list for convenience, consulting the index rather than flipping through the book. To use an index of this type would require a high level of familiarity with the layout of the text and a knowledge of the particular recipe required. For a casual user, these texts would be an inconvenience in comparison with personal collections, which would be familiar through the process of construction. Thus, the indexes were both reflective of the increased attention to indexes in scholarly and scientific texts, and a concession to the mass medium, designed to allow for casual use of the text.

Recipe books also applied to common expectations of skill in the structure of the recipes. Recipes were structured minimally with references to cookery techniques and appliances, allowing women to translate their cookery skills to the medical field. This connection was emphasized by the development by *the Queen's Closet Opened, which* by 1674 had inserted a third text to the "Pearl of Practice" and "The Queen's Delight." "The Compleat Cook: expertly prescribing The Most Ready Wayes, whether Italian, Spanish, or French, for Dressing of Flesh, & Fish &c" contained only cookery recipes. Hannah Woolley makes no distinction between medical, distilled, and cookery recipes in *the Queen Like*

[501] W.M., *The Queen's Closet Opened (*1655), Img 156.

*Closet*. The text was composed of one hundred eighty nine recipes, of which fifty six percent were food preparation. Recipes ranging from "To Candy Flowers the best way"[502] to "to make Cakes without Fruit"[503] to "A most excellent Cordial proved by many."[504] *A Choice Manual* is the only text that focused exclusively on medical recipes. Cookery skills are implicit in the preparation of treatments. "The Lady Nevil for a sore Breast, by cold festering milk" instructed the reader to "Take of beans and linseed, of each one little handful, dry them and beat them to powder, then take a quantity of Milk, and the yolk of two new laid Eggs, and boyl them together, and put in the powder of beans and linseed, and boyl it to a Poultess, and lay it to the breast as hot as may be endured."[505] To complete this recipe, the reader would have to have access to the necessary grinding equipment, and the majority of the recipe called for household ingredients like milk and eggs. A familiarity with the texture of a Poultess was complimented by common household preparations like boiling liquids. A recipe in *A Choice Cabinet* instructs the reader "To cause a woman to have her Sickness. Take Egrimonie, Motherwort, Avens, and Parsley, shred them small with Oatmeal, make Pottage of them with Pork, let her eat the Pottage, but not the Pork."[506] In this case, the medicine was the food, and the reader was instructed to control consumption in order to guarantee success. The popularity of these texts was partially in their acknowledgment of the skillset of their female readers. Recipes demonstrated the scope of skills, but catered to the access provided by household duties.

The publication of these texts emphasized the degree of implied knowledge in the field of household medicine. Recipes in all three texts were minimal, necessitating a high degree of awareness of preparation and diagnostic techniques before the recipes themselves could be used. However, this knowledge was not limited to the women composing the original texts that were appropriated and published by men; the popularity of these sources indicates that their readers also found them to be a valuable medical resource, which demonstrates common

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[502] Woolley, *The Queen Like Closet*, 29.
[503] Woolley, *The Queen Like Closet*, 44.
[504] Woolley, *The Queen Like Closet*, 69.
[505] W.M., *The Queen's Closet Opened* (1574) 141-142.
[506] W.I., *A Choice Cabinet*, 90.

expectations about female skill. The type of experience emphasized in recipe books was not inherent or easy to obtain. The emphasis on attribution and the spectrum of recipes is indicative of the necessity of experience through time and effort in the collection of these recipes. To be trusted, they had to be tested, and the texts informed readers through statements of efficacy that even if they had not personally tested the recipes, they came from authoritative sources or had been used and demonstrated effective in healing. This kind of experience in the home was promoted by the publishers of recipe texts, who appropriated the authority of female practitioners in order to profit. The texts can be deceptive, emphasizing charity and promoting the names of the original compilers when in actuality, only Hannah Woolley published her own collection of works. Although this is an important shift in the way that female authority was received publically, it still demonstrates the division between acceptable female practice and the pursuit of profit. It was acceptable for upper class women to maintain private recipe collections, but not to publish them. It was only in the absence of the original compilers that these texts were published and gained popularity. Although recipe books demonstrate the dynamics and extent of female medical authority, they do not equate to an exclusively female genre.

## Conclusions

I have presented cases where female authority was compromised, mediated, disregarded, or appropriated by professional men, and yet retained or relocated through social and cultural forces outside the control of the profession, notably religious expectations and printing**.** At various points during these periods, female claims to knowledge were discounted as too closely associated with bodies; women were heralded as authorities of childbirth and care but at the same time stripped of understanding of what was "really" happening in their bodies. They were accused of keeping secret some implicit female knowledge, and yet established as authorities in healing, particularly in the case of recipes, through two convergent routes: domestic and religious norms, and the market for books. I utilize multiple cases to demonstrate this uncertainty in the definition and appreciation of experience and gender. There were women who participated in experiments, like Mary Evelyn, and yet were excluded from newly formed institutions of experience. There were demonstrations of female authority due to the possession of a female body, like the invisible intermediaries in gynecological and obstetric texts. In recipe books, women were presented as authority on the title pages of books that listed their authors as men. Monica Green argues that one of the issues of medieval medicine is how knowledge was produced and who "owned" it.[507] My research went further in demonstrating the uncertain coexistence of different types of authority, and the fluctuating power attributed to women as sources of knowledge and owners of experience.

The four chapters share common themes of female agency, authority, and experience. This can be seen in their roles as mediators between the patient body and physicians, as noble healers working under charitable and social responsibilities, as women performing science experiments and distilling alcohols in the home, and when the role of the female household healer became crystallized in the publication of recipe books. Experience was a problematic concept in this period. Physicians primarily associated it with the competition of unlicensed

[507] Green, *Making Woman's Medicine Masculine Masculine: the Rise of Male Authority in Pre-Modern Gynaecology* (New York: Oxford University Press, 2008) viii.

practitioners, and thus spoke against empiricism by explaining that it did not afford insight into the interior causes of disease and health. At the same time, physicians were participating in the new high scientific culture of experience and experiment and distinguishing their methods from traditions of experience. Experience was a capable tool for most women, serving as the primary qualification for unlicensed midwives and providing women more generally experience in understanding the diseases they saw and how to treat them. Women were associated with the body and tactility, and used this skill in their private practices. When experience was claimed by upper class men and scientists like Robert Boyle, the parameters of valid experience were formalized. Instead of the assumption of information through interactions with nature, experience was recast as something that had to be structured, measured, and replicable to create validity. Recipe books reflect this new idea of experience, creating collections that used the authority of the first author or attributions to indicate that the recipes had already been proven and severing the link between personal experience and skill. Following the recipe allowed proficiency, and experience moved away from the localized bodies of women to a literary format that could be reproduced, exchanged, and altered.

A great deal of research has been done on female empirics, nurses, and midwives. These formal professional categories are problematic because they emphasize the point of contention that formal medical authorities like universities and guilds had with women. In order to be classified under these medical roles, women had to accept payment. This same financial transaction raised the negative attention of regulatory medical bodies and castigated women as empirics without skill and authority. Each of my chapters has developed a case in which women interacted informally with medical and scientific bodies, and thus escaped full, formal reprisals. When women acted as intermediaries between physicians and their peers who experienced personal medical problems with their genitals, I argue that they proceed in the position of an aid to the patient, not an assistant to the doctor. Noble women like Grace Mildmay and Anne Halkett saw it as a duty to provide care for their family and servants, integrating unpaid medicine into their

daily routines as hobbies. Even women like Mary Evelyn, who existed at the margin of the Royal Society as the wife of a member, were active in the private distillation and scientific work of their home. The case of recipe book publication is interesting because it can be seen to mark the decline of this trend with the publications of Hannah Woolley, but dominant texts in the field, originating in the closets of Queen Henrietta Maria and Elizabeth Grey, diverted profits from the female compilers to the male authors and publishers. Woolley's publication, too, emphasized the degree of assistance she provided through the publication, rather than her own ideal of profit. The ideal female practitioner had skill, but used it only to selflessly benefit those around her. She did not impinge on male profits and did not harm her patients, and therefore she was allowed to exist, filling in the spaces where male authority was absent.

My work is only an entrance into points of conflict and collusion between informal female practitioners and male power structures. Further research into manuscript sources of recipes, memoirs, and letters will expand the work I began in chapters three and four. The existence of medicine as a household responsibility of women under the general category of "huswifery" needs to be refined and understood. I have only begun to understand the tense relationship between male publications of purportedly female sources like recipe books. Further investigation and explicit comparison of published and manuscript sources may help evaluate the significance of male appropriation and the features of a female versus a male medical text. Focusing on cases of rural practice will help me to isolate female and informal practice that lacked the reliance on formal care. Geographically speaking, physicians were concentrated around urban populations, particularly London. Cases like York, Leeds, and Durham demonstrate female landowners who had to rely on their own skill due to the lack of alternatives. The more we understand about the extent of female confidence in their skills, the stronger analyses of general female practice, or female temporary medical practices, will be.

In demonstrating the extent that medicine penetrated into social relationships and home life, I refine the image of the medical marketplace

proposed by Lucinda McCrae Beier.[508] Care began in the home, but is difficult to reconstruct due to the very private nature of the subject. With attention to detail, it will be possible to understand how and why these women performed medicine, and the extents of their personal and private authority. Understanding medicine in the home will in turn clarify the factors which necessitated external care and the use of professionals. Recent history has begun to rewrite women into the story of medieval and early modern medicine, but there is a great deal of work to be done on the importance of experience, touch, and body knowledge in constructing the pre-modern view of the Galenic body. Women, who were formally excluded from being physicians and implicitly deterred from other medical professions, serve as cases that show the penetration of ideas about body structure and authority in healing. The turbulent female experience of experience is demonstrative of the changing landscape in pre-modern Europe.

The existence of women as integral informal features in the medical landscape led me to reconsider my assumptions about the structure of receiving medicine and care in the medieval and early modern periods. Physicians would like to believe that they were the elite and primary source of medical care during this period, with women acting as stop-gaps when physicians were unavailable, or subordinate to the authority of physicians. In reality female medical treatment was the unacknowledged norm for the majority of people, even in elite households with the finances to procure paid medical assistance. Women monitored the health of their families, a category which also implicitly included friends and tenants, during both health and sickness. In the case of Ann Fanshaw, women would even decide against attempting to acquire formal medical services and instead cared for each other. Women were performing undesirable tasks like caring for the sick, or tasks that are deemed "nonmedical" like midwifery. Nevertheless, women prepared cures and dictated when and how physicians would be used. Care began in the home, under the umbrella of charity and excluded from criticism because of its non-fiscal nature, and as a result women controlled most medical treatment.

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[508] Lucinda McCray Beier, *Sufferers & Healers The experience of illness in Seventeenth-Century England* (London & New York: Routledge & Keegan Paul, 1987)*:* 4.

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