

# WISE WOMEN AND MEDICAL MEN: OBSTETRICS AND GYNECOLOGY IN THE MIDDLE AGES

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## Abstract

**During the middle ages, simply being female was a very hazardous proposition. Propriety prevented most male doctors from treating women for any conditions related to sexuality or reproduction. This may have been just as well, since the treatments offered by the medieval physician were marginally effective at best, and were often spectacularly harmful. Instead, medical care of women was largely provided by midwives and 'wise women' (lay healers). Many of their methods were no better than those of the doctors, and some are quite shocking by today's standards. Others are merely odd or amusing. However, a few have stood the test of time and are still in use, in various forms, by modern midwives and physicians.**

**At various times, the wise women and midwives of the middle ages were persecuted for their methods, ostracized for performing abortions, and hung or burned as witches. Ultimately, they were marginalized by the medical establishment when physicians realized that obstetrics and gynecology could increase their own profits. Through it all, however, these wise women and midwives provided an essential service to their communities, and left behind a legacy that endures to this day: that of women responding to a need and providing care for one another.**

The Medieval period, or Middle Ages (approximately 476-1440 AD), began with the demise of classical civilization and ended around the time the printing press was invented. This period was characterized by the domination of all aspects of life by the Church, and among scholars, by a great respect for the teachings of the ancient Greek and Roman philosophers. In medicine, the study of the writings of great physicians, such as Hippocrates, took precedence over the study of diseases and living patients (Major 1954, 223-224).

Most medieval doctors still followed the methods outlined by Hippocrates a thousand years earlier. Hippocrates wrote on a number of women's health topics, and it is clear that he did not share our modern concepts of evidence-based medicine and patient-centered care. In one book, he made the following recommendation for inducing an abortion: "on the 6<sup>th</sup> day of her pregnancy, the woman should perform a number of mighty leaps, making her heels touch her buttocks. After the 7<sup>th</sup> leap, the seed will fall out of her with a clatter." (Rowland 1981, xv). (Hippocrates made no mention of how a woman might know that she was exactly 6 days pregnant.) His recommendations for expediting labour

were equally strenuous. The woman was advised to run up and down steps, to fasten herself to a ladder and have someone else shake it violently, or to lie in bed and have someone repeatedly raise and drop the foot of the bed (Rowland 1981, xv). It is little wonder that women of the time may have preferred the care of midwives over doctors!

In medieval times, both European and Arabic doctors were expected to have a theoretical knowledge of obstetrical and gynecological matters. However, their sense of propriety prevented them from actually inspecting a woman's "vital parts" or delivering an infant. They might be present at a delivery if the woman was noble or wealthy, but usually waited outside the chamber while the midwife attended to the patient. The few who did do deliveries handled only the most standard presentations; anything more complicated than a footling breech was deferred to a midwife (Rowland 1981, xv). (This is an interesting contrast to the modern situation, in which midwives usually handle only uncomplicated deliveries, and breech presentations not responsive to version are generally referred to an obstetrician.)

Like today, however, many rural areas and smaller towns didn't have a doctor at all. As a result, midwives and wise women (lay healers) provided not just obstetrical care, but nearly all primary care in these areas (Achterberg 1990, 42).

Medical and surgical textbooks of the period are reflective of this approach: if instructions for childbirth are given at all, they are in terms of what "the midwife should do" in a given situation. A Latin treatise by Guy de Chauliac illustrates this attitude, in a passage on multiple births: "Childbirth is also made difficult because of many children; sometimes there are two, and according to Avicenna five or more, and according to Albucasis more than seven, even ten, so he says. And because the matter requires the attention of women, there is no point in giving much consideration to it." (Rowland 1981, xv). Thus the avid student of medical history, who yearns to discover how de Chauliac's contemporaries would have handled a birth of decuplets, is left unsatisfied in the end.

Fortunately, during the middle ages, literacy became more common among ordinary people. As a result, there were a number of practical handbooks published in English on the subject of women's health, aimed at midwives and nuns (who between them did most obstetric and gynecological care) and at women patients themselves (Rowland 1981, 18). Such books often contained a very odd assortment of information: the best-known, believed to be written by a woman nicknamed Trotula, was a comprehensive gynecological text that included such tidbits as "the manner of tightening the vulva so that even a woman who has been seduced may appear a virgin" and, at the end, a section on cosmetics, including make-up tips and instructions on how to reduce wrinkles (Rowland 1981, 4-6). However, this was no stranger than similar books written for the male physician of the day: one of these, amid a section on recipes for various tonics, included instructions for making gunpowder (Rowland 1981, 14). The introduction of the third volume of another medieval medical text was as follows: "In this book I intend, God being my helper, to treat of those sicknesses which particularly concern women, and as women are in general venomous [sic] animals I shall follow it up with a treatise on the bite of venomous animals" (Rowland 1981, 13-14).

Works written during the medieval period betrayed an assumption that all women, and particularly wealthy ladies and nuns, were delicate creatures who required special medical care. One author wrote that women who “are nourished with hot food and drink and live in much ease” (i.e., the privileged upper class) would menstruate more often and for a longer time than other women, and would be weakened by the resulting loss of blood (Rowland 1981, xiii).

A fetus was considered to be in an especially vulnerable state, which is not surprising considering the Middle Ages’ high incidence of miscarriage, stillbirth, and neonatal death. However, while modern prenatal care is concerned with matters such as nutrition and avoidance of teratogenic chemicals, these were of little concern to medieval women. Their lack of knowledge about what caused miscarriages and birth defects meant that their fears were focused on much less tangible dangers. For instance, it was thought that if a pregnant woman “curses, blasphemes, or swears at someone”, her child would be deformed. People also believed that anything that startled the mother during pregnancy would affect the unborn child. So, for example, seeing a deformed person would cause a similar birth defect, and if a dog jumped up and startled a pregnant woman, her child would be born with “dog feet”. For this reason, pregnant women were advised to stay indoors as much as possible. This was especially true after dark, for there were other dangers then: if a woman looked at the moon, her baby would become a lunatic or a sleepwalker. Other beliefs concerned miscarriage and neonatal death: for example, expectant mothers were warned never to agree to be the godmother of a newborn, because then one of the children- the born or the unborn- would die (Shorter 1982, 49). In Norway and Germany, it was also a common belief that every child cost the mother a tooth (Shorter 1982, 51).

Medieval childbirth was, of course, a low-tech affair by modern standards. However, there were a few simple devices used by midwives to facilitate a birth. One such tool is the birthing stool: a chair or stool with a large hole cut out of the centre of the seat. Birthing stools have been part of midwifery for millennia; their first recorded use was in ancient Egypt. They had remained popular in Italy since that time, and midwives in many European countries adopted their use in the early 15<sup>th</sup> century (Shorter 1982, 56). The birthing stool allowed a woman to give birth in an upright position, with the aid of gravity. The baby pressed down directly on the cervix, which sped up the delivery process, and the mother was more comfortable than she would have been laying in a bed (Wertz and Wertz 1977, 13-14). Often, one of the midwife’s assistants would wrap her arms around the mother from behind, and would press down on the abdomen in the area of the uterine fundus during contractions, thereby helping to expel the baby (Shorter 1982, 56).

Interestingly, use of the birthing stool has experienced a revival in popularity among modern-day midwives, and in today’s hospitals, an upright birthing chair is usually available.

Throughout history and until quite recently, midwifery was closely associated with magic and sorcery. Both midwifery and the allopathic medicine of the middle ages made

extensive use of astrology to determine whether, how, and when to treat ailments. The use of amulets, incantations, and snakeskin girdles considered to have supernatural powers had been part of standard birthing practice for many centuries, and was not considered at all sacrilegious. It is said that even the Virgin Mary wore an enchanted girdle during her confinement, and that this girdle was then kept at the Cathedral of St Peter in Westminster until at least the 13<sup>th</sup> century (Rowland 1981, 31-32).

Precious stones, particularly eaglestone (any small rock found inside the nest of an eagle), were widely recommended for use during childbirth, by sources as diverse as Plutarch, Trotula, and the Talmud. Placed near the vaginal opening during labour, the eaglestone was believed to draw out the baby and placenta, thus shortening the duration of the birth process. (Most texts warned that the stone must then be immediately removed, or it would also draw out the womb: fatal uterine inversions were often ascribed to a stone left in place too long.) The eaglestone could also be used earlier in the pregnancy, to prevent abortion. Worn around the neck, it exerted its magnetic properties upwards, and therefore served to hold the fetus up inside the body (Rowland 1981, 33).

Jasper was another stone considered to be helpful in pregnancy, childbirth, and lactation, and one 11<sup>th</sup>-century author advised that the woman should hold a piece of jasper in her hand for the full nine months of her pregnancy. This advice was clearly intended for the high-class lady with household servants, for it would certainly have interfered with the daily chores of most other women! More reasonable authors simply suggested that a jasper amulet be worn during pregnancy (Rowland 1981, 34).

Reformation-era proscriptions against sorcery turned all of these practices- amulets, astrology, incantations and magic girdles- into religious issues. Laws were passed that specifically condemned their use during childbirth, and a great many midwives were among those tried and executed as witches. The earliest known midwives' oath, from 1567, includes a promise to refrain from using enchantments or sorcery during a woman's labour. Only one ritual was permitted: that of baptizing the child (often the moment it began to crown) if for any reason its death seemed imminent (Rowland 1981, 12, 30-32).

There are a number of remedies that are common to most medieval obstetrical texts. Making the woman sneeze is recommended by many authors to induce labour, while making her sneeze and then causing her to become angry, is suggested before inserting any sort of vaginal suppository, in order to increase its effectiveness (Rowland 1981, 28-29).

Most of the problems encountered by medieval healers were similar to those that concern doctors and midwives today although their interpretation and management were often quite different. For instance, there were numerous reasons given in medieval texts to explain why menstruation might stop, aside from pregnancy and menopause. These included hard work, "because of the heat or the cold of the wombe or the heat or cold of the humours that be enclosed in the wombe, or excessive dryness of their complexion, or being awake too much, thinking too much, being too angry or too sad, or eating too little." This retention of the blood was considered to be unhealthy; women who became pregnant

during such a time were thought likely to have a child with leprosy or some other 'evil' disease, and even those that did not become pregnant were considered to be at high risk of developing problems such as heart disease or hemorrhoids. Fortunately, there were remedies: bathing in boiled herbs, cupping (affixing a small earthenware cup to the skin using suction produced by a burning candle: a practice still common among practitioners of traditional Chinese medicine) under the nipples and kidneys, eating spicy foods, and bloodletting from the big toe were standard treatments. Failing these, those treating the woman were advised to give her herbal medicines and try to make her by turns "very angry, very sad, and very merry" (Rowland 1981, 59-77), in an effort to stimulate the flow of menses. Curiously, the treatment for a woman who bleeds too *much* was very similar: cupping under the nipples and kidneys, and bloodletting on the legs to draw the blood away from the womb. Only the herbs given were different (Rowland 1981, 59-77).

In the middle ages, it was widely believed by both doctors and lay healers that hysteria stemmed from the uterus being too high up in the body. Since the uterus was believed to be sensitive to smell, it could be enticed back down into its normal position by either placing a pleasant-smelling substance near the vagina (toward which the uterus would then migrate) or by placing an unpleasant-smelling substance, such as burnt hair, near the nostrils (thereby causing the uterus to withdraw downward). This belief appears to be the basis of smelling salts used for fainting or hysterical ladies, a practice which persisted until quite recently (Rowland 1981, 28-29).

The cure for some conditions was sexual intercourse, a remedy which posed a particular problem for unmarried women and nuns. Most texts advised that for these women, it was better to live with an unpleasant condition during the present, in order to avoid eternal damnation by seeking a sexual cure (Rowland 1981, xiii). However, this was only the 'official line', and it is unknown what advice was actually given to unmarried women behind closed doors.

For couples unable to conceive, midwives suggested a number of fertility tests. One involved planting bran seeds in two pots, and then having the woman urinate in one pot, and the man in the other. If the seeds in both pots sprouted, then both were fertile, and could be helped to conceive by potions from the midwife. If the seeds in one of the pots failed to grow, that person was infertile and even the strongest medicine could offer no help. In that case, only a miracle could give them a child (Rowland 1981, 34-35).

Compared with modern parents, medieval couples also had much more control over the gender of their children. If a couple desired a son, they had only to dry the vulva and uterus of a female hare or pig, grind the dried organs into a powder, and drink the powder mixed in wine prior to intercourse. Couples hoping for a daughter were advised to do the same with the testicles of the male animal (Rowland 1981, 35).

Medieval texts cited many possible causes for a uterine prolapse. These included retention of blood (i.e., failure to menstruate), evil humours, paralysis caused by cold, (from sitting too long on cold stones, taking cold baths, or drinking too much cold water), and of course, forgetting to remove the eaglestone after a delivery. Fortunately, the uterus

could usually be put back in place manually, and could be coaxed to stay there by a similar principle to that used in hysteria. To coax the womb to stay up where it belonged, evil-smelling things (ox feces thrown on hot coals was recommended) were placed near the genitals, and sweet-smelling things near the nose. The uterus would tend to migrate away from the nasty smell and toward the pleasant one, and so stay up in its natural position (Rowland 1981, 100-101).

Thanks to the midwives' handbooks, we have a great deal of information about medieval childbirth. One author described a normal birth as a child who presents with the head down, and who arrives in "twenty pangs or less" (Rowland 1981, 41-42). Presentations other than headling or footling required that the child be pushed back into the womb and manually rearranged into the correct position. This was apparently effective often, but certainly not always. Sometimes, if the baby was badly stuck, the midwife would have to dislocate or amputate one of his limbs to get him out. It was not uncommon for people to go through life with major disabilities because such a procedure had been necessary during their birth (Achterberg 1990, 46). That was preferable to the alternative, however: when dislocation or amputation was unsuccessful, the baby would be forcibly extracted using hooks, either whole if possible, or in pieces if necessary. The exception was a situation in which the mother was already dead, in which case a Caesarean section would be performed in a final attempt to save the infant (Rowland 1981, 44-45). Caesareans were never performed on living women, because they were almost invariably fatal for the mother (Shorter 1982, 160-164; Wertz and Wertz 1977, 139).

Failure to expel the placenta following the birth of a child was considered to be the result of a weak womb, caused by fasting, great anger, wrath, or being beaten. In such cases a midwife could often pry the placenta free using her fingernails. Failing that, fumigation might be effective. The woman was to sit on a birthing stool, above a small pot. In the pot, the midwife would place powdered goats' horns and goats' feet, and these were set alight so that they created a great deal of smoke. The smoke was directed upward toward the woman's vagina, and this would help the placenta to come free (Rowland 1981, 146-147).

Both in childbirth and in the treatment of everyday maladies, herbs were used a great deal by midwives and lay healers. Herbs were available for nearly every malady, from fibroids to erectile dysfunction. Midwives and wise women were often sought out for these remedies, which were probably as effective as those offered by the medical doctors of the time.

As a result of their knowledge of herbs, wise women also knew what plants could be used to cause an abortion, or to poison someone. Of course not all of them did these things, but probably some did. A lot of people visited wise women late at night, in secret, either because of their sinister reputation or because they were seeking these services (Achterberg 1990, 42). It is likely that the women of a community advised each other about which midwives were willing to provide abortions or other illegal services.

So it was that, while medical doctors treated many men and a few of the wealthier women, nearly all obstetric and gynecological care in the middle ages was done by lay healers and midwives. This tradition of women caring for women was the norm not only during this period, but throughout recorded history. All of this changed in the 1600s, thanks to a British physician with the unfortunate name of William Smellie.

Unlike other doctors of the time, Smellie was interested in obstetrics. He attended many deliveries using the recently invented obstetrical forceps. Compared with midwives' hooks, the forceps had the notable advantage of freeing an infant from its mother without killing it in the process (Wertz and Wertz 1977, 34). Smellie had great success with this new instrument, and he saw in obstetrics the potential to ease women's suffering, while also making himself a considerable amount of money. He soon put out an advertisement to other doctors: "Midwifery Taught for Five Shillings".

Prudery was still a problem, and obstetrics was practiced under the bedclothes. But students came, and so did patients, attracted by Smellie's offer of free care for poor women. Physicians were looking for ways to increase their knowledge and earn more money, and Smellie's timing couldn't have been better. The school flourished. The first obstetric wards in Britain opened in 1739, and in 1752 Smellie's school became the General Lying In Hospital (Carr).

Midwives continued to practice, and of course they are practicing still. But over the years, male doctors increasingly became the main providers of obstetric and gynecological care. Today, of course, we are seeing increasing numbers of women in medicine, and many of those are choosing to work in areas of women's health. All of this may seem like a new trend, but in fact it is a shift back to what may be the most ancient tradition in the history of health care: that of women caring for women.

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