Introduction

The Anthropology of Medicine and Gender in Spanish Culture

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This special number for *eHumanista* probes the relationship between medicine and gender/sex as represented in aesthetic works, paying close attention to how the sexes negotiate their space within medicine as a field of epistemological inquiry and as a for-profit business. It also investigates the limited access that women had to medical knowledge even while relegated to the margins of society. As will be clear from reading this introduction and from the works included, premodern women had extremely limited access to health care. Women were not permitted to study or legally practice medicine. Moreover, the patriarchy of premodern Spain exhibited a deep anxiety regarding women being *seen* or touched by male doctors on account of the deep-rooted fear of undermining women's chastity, a notion inherently linked to men's sense of honor/*honra*. It could be said that for medieval and Renaissance cultures the value of male honor was so high that it outweighed a woman's life, to the point where paterfamilias would jeopardize women's lives to prevent damage to the family's reputation by avoiding doctors.

As can be gleaned from the previous lines, this monographic project places women at its epistemic center, allowing us to continue uncovering the structural gender inequalities that plagued premodern societies, paying close attention to the effects of these inequities on women's health. The special number was intentionally devised to be expansive in breadth and depth, spanning the periods from the Middle Ages and the Golden Age period through the present and covering a wide array of literary genres that range from chivalry to drama and Santería, or spiritism. This multifaceted approach will allow readers to understand the evolution of medicine and therapeutics across time and the role of female caregivers within communities and households.

Today, health care has turned into such an integral part of our daily lives that we visit doctors' practices even when we are well. Preventive or proactive care has become just as essential as reactive care, as screenings and tests can help detect fatal diseases early enough to change outcomes, as is the case with cancer, diabetes, and Human immunodeficiency virus (HIV), among others. These breakthroughs in medical science and technology have improved both our life expectancy and our quality of life. But there are other elements of health care that are equally crucial, namely the proliferation of iatric resources. In modern industrialized countries, we often take for granted the plethora of clinics, hospitals, and specialized physicians. Particularly in large metropolitan areas, we can make same-day appointments to see a doctor, and appointments with specialists are relatively easy to attain. Ambulances and even helicopters can readily be deployed to transport patients to urgent care facilities or to out-of-state hospitals in life-or-death situations. This plethora of options for medical care, however, is a relatively recent phenomenon. Premodern people lacked even the most basic care. Firstly, university-trained physicians were scarce and practiced mainly in large urban places, and most of the European population lived in rural areas during a time when transportation was challenging. Medical attention was expensive for manual laborers who resided outside of the central areas of cities, which were the centers of politics, culture, and economic power in medieval feudal societies. But even those who could pay for these highly specialized services had to contend with the fact that

the science and technology were underdeveloped even at the turn of the twentieth century. It is not a coincidence that motherhood was the leading cause of death for adult women up until the early twentieth century, and simple viral or bacterial infections could be deadly conditions for the general population before vaccines and the discovery of penicillin in 1928 as well as other advances in medical care. These existential threats have been by and large eradicated. Nowadays, infections can either be prevented or safely treated. Similarly, pregnancy can be far safer now thanks to clinical advances in diagnosing and managing complications with the help of pharmaceutics and state-of-the-art facilities and equipment for surgical procedures.

The disciplines of medicine, anthropology, gender studies, and culture generally interface in multiple complex ways with regards to what Marcel Mauss called "les techniques du corps" (1934) and Monica H. Green "the technologies of the body" (2005). The study of the evolution of medicine across time can best be undertaken through inter- and multidisciplinary approaches. The dichotomy between disease and good health can be thought of as transhistorical and immutable and as periodized and changing without contradictions. Sickness and health are transhistorical and immutable insofar as a good health has been and still remains desirable and illness undesirable. Aside from notable cases of individuals who willed a particular illness to better serve God,[1] peoples of all cultures have strived to either avoid disease or restore good health. But the perceptions of what constitutes diseases and how to combat them have been—and are still—shifting from pre-Socratic milieus to the present. In Ancient Greece, as can be gleaned from the Hippocratic *On the Sacred Disease*, laypeople believed that epilepsy had a divine provenance. The author of *On the Sacred Disease*, putatively Hippocrates, attempts to *detheologize* epilepsy, situating the condition squarely within the biological makeup of the human body. The medieval laity attributed a similar biogenesis to leprosy, while Renaissance moralists and some people thought that syphilis was God's way of exacting punishment for unbridled lust. This type of superstitious or faith-based perception of medicine exists even today in some cultures. For example, some parts of Africa take cancer to come from God. The professed etiology of disease is significant because ideological beliefs about illnesses often determine whether patients seek medical help or simply endure the pain, awaiting divine redemption. The predominant attitude regarding "divine-willed" diseases is that if God caused the conditions, either directly or via demonic intermediaries, only God can heal them, hence the popularity of religious pilgrimages and apotropaic artifacts such as amulets, rosaries, crucifixes, and so on. Similarly, prayer is viewed both as prophylactic and as restorative. Largely because of these theocentric convictions, most cancer patients in Northern Nigeria languish and die without seeking medical help, as Ahmed M. Sarki and Babangida L. Roni observe in their aptly titled essay "This Disease is 'Not for Hospital'" (2019). Similar attitudes toward sickness and pain had been recorded about medieval women who were more inclined than men to see illness as something to be endured rather than cured (Walker Bynum, "The Female Body," 189).

History of medicine has taught us how the taxonomy of diseases has evolved over time as well as how the approaches to healing and maintaining a good health have fluctuated. Medical historians have diligently uncovered the intricate ways in which clinical knowledge has been transmitted across time, cultures, and geography, tracing its theoretical seedbed back to the Hippocratic medical corpus. Broadly speaking, Greek knowledge penetrated Ancient Rome in a

[1] In medieval spirituality, of course, we have the examples of ascetics who wanted to be fools for God, while mystics had a similar inclination. Caroline Walker Bynum tells us of Beatrice of Nazareth who asked her confessor if God would accept her sacrifice of going mad for Him as a means of following him ("Women Mystics" 192). Some mystics also desired death in order to unite with their Lord.

piecemeal manner. Howard W. Haggard attributes Romans' skepticism toward Hellenic medicine to two overarching factors. First, the first Greek physicians who relocated to Rome were both unskilled (quacks) and corrupt, which is, incidentally, how Francisco Delicado represents male doctors in *La Lozana andaluza* (1528), as I discuss in my contribution. Second, Hellenic medicine was heuristic and science-based, and the Roman culture was predominantly faith-based (Haggard 3–25). With humor and slyness, Juan Ruiz satires these dynamics in the episode of the Greek philosopher and the Roman ribald in *Libro de buen amor* (ca. 1342) where the Romans seek to convince Greek officials that Rome is ready and worthy of Greece's "ciencia," by which the poet means all branches of knowledge, including medicine. In life, like in Juan Ruiz's *Libro*, Greek *scientia* (science) makes its way into a Roman society that is unprepared for it, if not contemptuous of it, but eventually medicine was adopted as an art aimed at assuaging patients' pain with empathy and integrity, as the Hippocratic Oath dictates. The Greco-Roman tradition, which was based on the humoral theory that dominated clinical thought well into the early modern period, passed through the academic sieve of Byzantium and Alexandria. The Byzantine iatric tradition entered the Arab world, which in turn went full circle back to European academic institutions via the translations of Arabic texts into Latin in centers of higher learning, such as Salerno, Montpellier, Paris, and the Toledo School of Translators. From the eleventh century onward, academic institutions placed the art of healing at the front and center of their curricula, solidifying the Neo-Galenic school of thought as the bedrock of a medical education. The newly minted works written by Hippocrates, Galen, Rufus of Ephesus, Soranus of Ephesus, Avicenna, Rhazes, Serapion (Ibn Sarabiyun), Albucasis, among others, became the reference books in university libraries and in some doctors' offices.

The subfield of medical anthropology is equally relevant to the development of the medical humanities because anthropological applications to the study of medicine widen our understanding of the intricate ways culture, politics, religion, race, gender, sexual orientation, and social class interact and determine how we conceptualize, diagnose, and treat diseases. From this protracted list of variables, I want to underscore the effect of gender/sex because some illnesses are inherently gendered, meaning that they are specific to man or women. Hippocrates's *Diseases of Women* and Soranus of Ephesus's *Gynecology* already suggest that certain diseases pertain only to women. More explicitly, the condition of hysteria, a word stemming from the Greek *hystera* (uterus), was thought to affect women alone even before Freud theorized it as a female neurosis in "The Aetiology of Hysteria" (1896). The condition of hysteria was also linked to what the Middle Ages recognized as the wandering womb, or "el mal de la madre" in Spanish, which was a belief that the uterus moved through the body, causing multiple pathologies in women. The wandering womb was a prominent literary motif in premodern Iberia, as can be seen by its dramatization in masterpieces such as *La Celestina*, *La Lozana andaluza*, and others. Women, though, were believed to be immune to certain other illness. *Amor Hereos*, commonly known as either lovesickness or love melancholia, is a fitting example. Lovesickness was first conceived of as a condition that affected men exclusively. The etymology of "hereos" allegedly stemmed from "heroes," namely noblemen who performed feats of arms. This purported etymon gave rise to the conviction that *amor hereos* was not only a male illness, but also that occurred to members of the noble class solely, as Duchess Coleria hints in Diego de San Pedro's *Cárcel de amor* (1492) after her son Leriano dies from the condition (173). As I have written elsewhere, Gerard de Solo in his commentary to ar-Rāzī's *Liber ad Almansorem*, translated by Gerard Sabloneta into Latin in the thirteenth century, wrote that *amor hereos* infected only strong and noble men "because knights were more suited to have this passion than others" (López González

129). This hypothesis survived well into the Renaissance, as Elizabethan culture dubbed lovesickness "knight melancholy" on account of its prevalence among the chivalric class. Mary F. Wack, nevertheless, has recently proved that *amor hereos* sickened men and women equally (1986).

Medicine and Gender to the Present

In industrialized societies, gender no longer determines who can practice medicine or who can treat female patients. Our universities educate and train men and women evenly to care for people's health regardless of their sex. In medicine today, gender, sex, and sexual orientation are inconsequential; male physicians of any specialty can *see* female patients and female physicians can treat men. The erasure of gender boundaries in medical practice has had a double consequence that most of us rarely consider. Medicine, firstly, can be perceived as a democratized field in which people of any race, age, faith, and gender can partake. In the United States, as well as in most civilized countries, women have an equal opportunity to study and practice medicine, or any other academic discipline for that matter. Secondly, women can be treated by male physicians without the societal stigma attached to female sexuality or the masculine notion of honor, one directly related to the female body. Male gynecologists and obstetricians tend to mothers' deliveries with the same normalcy that a female doctor can perform vasectomies upon men. This egalitarian system and gender fluidity in medicine, it bears reiterating, is relatively novel. On the one hand, women were not permitted to attend universities until Oberlin College in Ohio first admitted female students in 1837. Sixteen years had to pass before Elizabeth Blackwell became the first woman to obtain a medical degree in 1853 in the United States. Before that, women had a relatively minor official role in the field of medicine, limited to working as nurses in hospital and monasteries and also as lay midwives and as healers within their households and in marginal communities.

On the other hand, gender/sex historically determined who treated female patients and for what diseases. As Katharine Park reminds us, the medical understanding of the human body differs "dramatically from culture to culture and period to period" (322). Pre-Enlightenment societies were apprehensive about male doctors treating female patients, particularly in relation to obstetric care or other conditions related to reproduction and sexuality, owing to cultural attitudes toward honor. Since we still live by and large in patriarchal societies, I want to distinguish premodern from modern patriarchies by modifying premodern ones with the adjective "oppressive" by reason of their denying women basic freedoms and rights that men fully enjoyed. Although it should be noted that some modern patriarchal societies still exist today, similar concerns may exist, but they are beyond the scope of this introductory note. In oppressive patriarchal societies, honor was inextricably attached to female sexuality so that women's bodies were essentialized as the repositories of the masculine honor/*honra* as well as of male anxieties regarding femininity and female sexuality. Because women's sexuality was intricately intertwined with male honor, men employed all possible means at their disposal to suppress women's freedoms, rights, and even desires. Men mostly arrogated for themselves the right of determining who women could love and see. Hiding young women from the male gaze was a *sine qua non* to safeguard both their chastity and their good name, while also removing temptation from men and from women. The unintended, or intended, consequences of curtailing women's rights and freedoms were that they could not always be seen by male doctors who possessed, by virtue of their sex, a monopoly of university-acquired medical knowledge. In

medieval and Renaissance Iberia, as Jean Dangler points out in her study on medical phenomena in Jaime Roig's *Espill*, Rojas's *La Celestina*, and Delicado's *La Lozana andaluza*, the typology of the prostitute-curandera bourgeoned in aesthetic works (2001).

Howard W. Haggard's research on medieval and pre-medieval medicine has shed light on the consequences of the gender disequilibrium in women's mental health. After analyzing the medical culture of primitive peoples as well as of Ancient Greece and Ancient Rome in *Devils, Drugs, and Doctors* (1913), Haggard zeroes in on the role Christianity played in the deterioration of medical care for women. Christianity of course was instrumental in establishing female virtue and chastity as the cardinal points of women's social and self-worth. The significance of womanly chastity was so immense in Christian thought that Saint Augustine extolled Lucretia's suicide— despite her paganism and despite suicide being a deadly sin in theological discourses—because she took her own life to defend her wifely chastity. In medieval Iberia, Lucretia was widely eulogized for her sacrifice, the message being that her chastity had a higher value that her own life and that the sin and crime attendant to suicide are forgivable if committed in defense of men's honor. This axiological worldview gave way to the proliferation of Christian virgins who either killed themselves or met death at the altar of protecting their virginity. Let us recall that Juan de Mena in *Laberinto de Fortuna* (1444) and San Pedro in *Cárcel de amor* wholeheartedly praise Doña María Coronel for ending her life by means of burning her own genitalia with coals in order to extinguish her sexual desire. María Coronel's act, which was equated to that of the Roman Lucretia, was construed as a heroic feat for protecting her chastity at the expense of her life. Hernán Núñez de Toledo in his influential *Glosa sobre las* Trezientas *del famoso poeta Juan de Mena* (ca. 1499) lauds her sacrifice as follows:

> Estando su marido absente vínole tan grande tentación de la carne, que por no quebrantar la castidad y fe devida al matrimonio elijó [sic] antes de morir, y metióse un tizón ardiendo por su miembro natural, de lo qual murió […]. La opinión de otros es que la dicha doña María Coronel, su muger, estava en Sevilla; y como le viniesse la dicha tentación, por no hazer cosa que no deviesse se mató de la manera que conté. (402)

Mena's gorgeous wordplay with María's last name "digna *corona* de los *Coroneles*,/ que quiso con fuego vencer sus fogueras" (79cd, emphasis added) is meant to equate her sacrifice to that of a martyr who is crowned with divine laurels (*corona*). The evocative imagery of vanquishing her fires (*sus fogueras*) with fire (*fuego*) is also fraught with religious overtones, for her spirit triumphs over the temptations of the flesh, sending a powerful message to other women that it is preferable to end their lives than to relent to desire. When women's bodily integrity is more important than their own lives, men and women would do anything to protect it, including refusing to consult male doctors during illnesses. It is unsurprising that Haggard dubs the Middle Ages the most precarious period in history for women largely because the new faith-based social system deprived them of the aid that male doctors had provided to women in Ancient Greece and Rome. Haggard concludes that these cultural circumstances "were making childbirth more and more hazardous" (25).

The notion of gendered medicine comprises many aspects of human life. Haggard and other scholars after him have studied how the oppressive patriarchy sought to police and control female sexuality, reproduction, and women's bodies. In my second scholarly book entitled *Motherhood and Mental Health in Medieval Spanish Culture*, I argue that the patriarchal society of medieval Iberia was instrumental in triggering mental disorders in young women and in

mothers. The male apprehensions regarding female sexuality and sexual desire moved the patriarchate to establish guardrails to police women's bodies. Reputable families erected tall walls to protect women from the outside world, preventing them from seeing and from been seen by men. The tall walls erected by Pleberio in Rojas's *La Celestina*, by Lorenzo Bentibolli in Cervantes's "La Señora Cornelia," and by Bernarda in Lorca's *La casa de Bernarda Alba* become symbols of the separation of the sexes in Iberian cultures across time. Spaces were gender coded. Internal places were occupied by women (and male family members), while external spaces belonged to men. Women venturing outside the confines of their homes exposed themselves to harmful gossip and to male desire, which helps explain why even Lorca's Bernarda Alba simultaneously forbids her daughters from exiting the confines of her home and bars all men from going inside, a panoptic-like form of control that brings the tragic irony of Pepe el Romano impregnating Adela into sharp focus. There were other mechanisms of control put in place by men, such as strict sartorial codes. Women typically used multiple layers of clothes that covered their bodies from head to toes. Men also employed female chaperons as the eyes and consciousness of the patriarchate, so that noblewomen were rarely alone. Sex out of wedlock was a crime punishable with social ostracism and even death. When women lost their chastity before marriage, voluntarily or involuntarily, they exposed themselves to excessive danger. If intercourse resulted in pregnancy, acute melancholia, paranoia, and puerperal psychosis were a likely outcome. As I show in *Motherhood and Mental Health*, literature has many examples of unwed women who are impregnated, and they go through unspeakable pain as a result. Some of them kill their newborns, others seek abortions, and some become acutely depressed and attempt suicide. Oppressive patriarchies had a damaging effect on women's mental health, which is an area of inquiry that merits far more academic attention. This special number, in sum, hopes to pave the way to continue paying attention to the complex ways in which gender and sex have shaped health care and medical knowledge across time and across cultures.

Works Cited

Dangler, Jean. *Mediating Fictions: Literature, Women Healers, and the Go-Between in Medieval and Early Modern Iberia*. Lewisburg, PA: Bucknell University Press, 2001.

Haggard, Howard W., *Devils, Drugs, and Doctors: The Story of the Science of Healing from Medicine-Man to Doctor*. London: William Heinemann, 1913.

López González, Luis F. *The Aesthetics of Melancholia: Physical and Spiritual Diseases in Medieval Iberia*. Oxford: Oxford University Press, 2022.

—. *Motherhood and Mental Health in Medieval Spanish Culture*. (Under review)

Mauss, Marcel. "Les Techniques du corps." *Journal de Psycologie Normal et Pathologique* 32 (1934): 271–93.

Mena, Juan de. *Laberinto de Fortuna*, edited by John G. Cummins. Madrid: Castalia, 1990.

Núñez de Toledo, Hernán. *Glosa sobre las* Trezientas *del famoso poeta Juan de Mena*, Edited by Julian Weiss and Antonio Cortijo Ocaña. Madrid: Ediciones Polifemo, 2015.

Park, Katharine. "Was There a Renaissance Body?" *The Italian Renaissance in the Twentieth Century*, edited by Walter Kaiser and Michael Rocke. Florence: Olschki, 2002, pp. 321–35.

San Pedro, Diego de. *Cárcel de amor. Obras completas*, edited by Keith Whinnom. Madrid: Castalia, 1971.

Sarki, Ahmed M. and Babangida L. Roni, "This Disease is 'Not for Hospital': Myths and Misconceptions About Cancers in Northern Nigeria." *Journal of Global Health Reports* 3 (2019): 1–5.

Wack, Mary F. "The Measure of Pleasure: Peter of Spain on Men, Women, and Lovesickness." *Viator* 17 (1986): 173–96.

Walker Bynum, Caroline, "Women Mystics and Eucharistic Devotion in the Thirteenth Century." *Women's Studies* 11 (1984): 179–214.

— "The Female Body and Religious Practice in the Later Middle Ages." *Fragmentation and Redemption: Essays on Gender and the Human Body in Medieval Religion*. New York: Zone Books, 1991.