EMBODIED KNOWLEDGE: MIDWIVES AND THE MEDICALIZATION OF CHILDBIRTH IN EARLY MODERN ITALY

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ABSTRACT

JENNIFER F. KOSMIN: Embodied Knowledge: Midwives and the Medicalization of Childbirth in Early Modern Italy
(Under the direction of Melissa M. Bullard)

In addition to being highly visible figures in the ritual life of Italian society, midwives were bearers of a unique expertise of the body and sexuality which granted them entrance into the legal and political worlds of early modern Italy. This dissertation examines the development of midwifery in three northern Italian states (Savoy, Lombardy, the Venetian Republic) from roughly 1600-1800, a period which spans both the earliest efforts by Church and State to regulate practice and the eventual institutionalization of midwifery education. This study aims to understand how both cultural meanings and the management of sexuality, gender, and reproduction were changing over the course of the early modern period. Because male birth attendants remained rare in Italy during this period, the development of Italian midwifery presents a unique perspective on the medicalization of childbirth in Europe. Although historians of medicine have tended to consider early maternity institutions as starting points in studies of the medicalization of childbirth, this project emphasizes the continuities between eighteenth-century institutions and earlier asylums for women which emerged, especially in Italy, in the era of the Counter Reformation. Throughout the eighteenth century, maternity hospitals and schools for midwives were therefore informed by impulses which were simultaneously scientific, religious, charitable, and disciplinary, defying any singular categorization. Furthermore, despite the fact that medical thought in the well-connected northern Italian cities of Turin, Milan, and Venice was significantly influenced by continental medical culture, I argue that these cities
developed distinct, “Italian”, modes of thought with respect to the science and management of childbirth.
ACKNOWLEDGEMENTS

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<tr>
<td>ACT</td>
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<td>ASDt</td>
<td>Archivio Storico Diocesano di Torino</td>
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<td>AOSG</td>
<td>Archivio Ospedale S.Giovanni, Turin</td>
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<td>AST, p.s.</td>
<td>Archivio di Stato di Torino, prima sezione</td>
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<td>AST, s.r.</td>
<td>Archivio di Stato, di Torino, sezioni reunite</td>
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<td>ASM</td>
<td>Archivio di Stato di Milano</td>
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<td>ASDm</td>
<td>Archivio Storico Diocesano di Milano</td>
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<td>IPPAI</td>
<td>Archivio Storico dell'Istituto provinciale di protezione ed assistenza all'infanzia, Milan</td>
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<td>ASV</td>
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<td>ASTv</td>
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INTRODUCTION

Over the course of the seventeenth and eighteenth centuries, the professionalization of medical practice and the extension of that practice into traditional spaces profoundly altered the ways in which childbirth was understood and embodied. Fundamental to these developments was the emergence of new childbirth spaces, techniques, and technologies. Scholars have often characterized the medicalization of childbirth in Europe and North America as a protracted struggle between men and women in which the knowledge and practice of traditional midwifery was rapidly eclipsed by masculine science. In Italy, however, this paradigm of exclusion is more complicated. Rather than maneuvering to usurp women’s place in the birthing room as in France or England, physicians and state officials in Italy aimed their efforts at professionalizing female midwives through new, formal courses of instruction. By the mid-eighteenth century a handful of hospitals incorporated small maternity wards staffed by midwives in conjunction with such training programs, thereby merging Enlightenment-era reform efforts with the new medical emphasis on clinical education. Childbirth in Italy thus remained a female guided event throughout the early modern period, though one which was increasingly subject to male supervision and a masculine scientific episteme.

This dissertation explores the institutional development of the maternity hospital and midwifery school in eighteenth-century northern Italy. What was the impact of the gradual shift from traditional to medicalized midwifery on cultural understandings of and attitudes toward childbirth, sexuality, and the female body? Where possible I aim to reconstruct the social profile and individual responses of the midwives, pregnant women, and medical men involved. Both the
chronology and geography of this project are aimed at complicating scholars’ assumptions about the medicalization of childbirth in Europe and the ideology of care during the early modern period. Although historians of medicine have tended to view the institutionalization of midwifery education in Italy as a major break in the attitudes of state and medical officials toward the management of pregnancy and sexuality, this project seeks to emphasize the continuities between the medicalization of care in the eighteenth century and changes which were in motion well before. Already by the early seventeenth century, for instance, an initial wave of midwifery legislation had begun to alter the practices and body of knowledge surrounding childbirth (chapter 1). Such early interventions, including those by a reinvigorated Counter-Reformation Church, had the effect of transforming midwives’ traditional role within the community by positioning them as intermediaries between local interests and the new privilege with which Church and State sought to intervene in those affairs. At the same time, the earliest maternity wards and midwifery schools, far from being strictly scientific spaces, tended to share much in terms of ideology and organization with convents and earlier asylums for ‘fallen’ women. This project places the emergence of hospital maternity wards and schools for midwives within a broader chronological frame in order to highlight precisely these kinds of historical continuities.

A Comparative Approach

Unlike the majority of studies of early modern midwifery, particularly in Italy, my research distinguishes itself by favoring a comparative approach. Through an investigation of midwifery in three early modern Italian states - the Duchy of Savoy, Austrian Lombardy, and the Venetian Republic - this dissertation explores the changing means by which communities and then governments sought to influence gender, sexuality, and reproduction. By addressing the changing social and professional status of midwifery in these states, my research will shed light
on the regional variances effected by three vastly different ruling regimes and medical cultures, while keeping in mind the ways in which “Italian” birth practices as a whole developed in contrast to those elsewhere in Europe. Indeed, medical thought in Turin and Milan was significantly influenced by the continental medical cultures of Paris and Vienna, respectively, and yet each city developed distinct modes of thought with respect to the management of pregnancy and childbirth. Venice, on the other hand, was an important center for medical publishing in Italy, with a long history of medical discovery at its University in Padua. Turin saw the first ever maternity ward in Italy, at San Giovanni hospital in 1728. And Milan launched one of the first attempts in Italy to extend midwifery education throughout its vast provinces. These three cities thus offer a particularly rich documentary sourcebase from which to work.

English-language studies of Renaissance and Early Modern Italy have long concentrated on the city-states of the Central-North, above all Florence and Venice, as well as Rome and the Papacy. By addressing states like the Duchy of Savoy and Austrian Lombardy, we may gain a new perspective on Italian medicine and charity in the period between the Counter Reformation and the Enlightenment. The foreign influences in each of these regions – France in Savoy, and Austria in Lombardy – makes these interesting case studies to understand whether there were particularly ‘Italian’ responses to concerns over reproduction, maternal safety, and infant welfare. A chapter on Venice and its mainland territories provides for further comparison, as the Venetian Republic was notoriously able to stave off foreign influence before 1797.

These three case studies have also allowed me to connect center and periphery in a way that local studies have not. In Turin, Milan, and Venice, initiatives to expand midwifery education by establishing schools in these capital cities were aimed above all at provincial women, who would eventually return to their home communities to spread the new, scientific
knowledge of birth they had gained in the city. Resistance by local women to hiring such newly trained midwives, however, meant that such knowledge was only unevenly introduced into the provinces. Instead, expectant mothers tended to prefer older, more experienced midwives, regardless of their lack of formal education. Later initiatives to expand the midwifery school system to provincial centers also experienced various setbacks and delays, suggesting that there was far from widespread acceptance of such endeavors.

While this study is necessarily broad – focusing on developments occurring in three different states over the course of nearly two centuries - I have attempted to present these developments in as specific and ‘local’ a way as possible. I have included, where the evidence has permitted, the voices of the midwives themselves –both those who attended formal courses of instruction and those who were resistant to such programs - as well as those of the directors of the midwifery schools tasked with these women’s instruction. I have also endeavored to recreate as fully as the sources allow the daily interactions and activities which would have taken place in an eighteenth-century maternity ward and midwifery school. This work is therefore intended as a social history of midwifery which nevertheless takes into account the institutional, medico-intellectual, cultural, and political contexts in which midwifery was transformed over the course of the seventeenth and eighteenth centuries.

**Historiography**

In the development of women’s and gender history, feminist critiques of science have occupied a central space.¹ During the 1970s and ‘80s, feminist historians first began to challenge

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the heroic narratives of western medicine in which the medicalization of childbirth drastically improved the safety and comfort of pregnant women and newborn babies. This initial wave of scholarship argued that the shift from traditional to medicalized childbirth entailed both the loss of women’s age-old and ‘natural’ profession, and the subjection of the female body to a penetrating male, medical gaze. Since then, scholars like Monica Green have receded from such politicization and turned fully to the historical record for their arguments. Green, for instance, challenges any notion of midwifery as a timeless profession, meticulously charting the solidification of traditional customs and practices into what might soundly be called an occupation only in the thirteenth or fourteenth centuries. The rise of cultural studies and the linguistic turn further led scholars to view early modern childbirth and midwifery from a variety of novel perspectives: they have explored the social construction and performance of maternity; childbirth rituals; and the cultural and political meanings attached to pregnancy and pregnant

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bodies in particular historical moments. Although recent historical work has been much less polemical in tone than in the 1970s and 1980s, the fact that ‘reproductive rights’ continues to permeate current media and political discussions means that the history of childbirth remains a particularly relevant field of inquiry. The present study moves away from judgments about the shift to medicalized childbirth and from the question of how men came to dominate the birthing room; instead, I am interested in understanding the kinds of negotiation and accommodation which were necessary when traditional and scientific midwifery came into contact in eighteenth-century Italian midwifery schools and hospital maternity wards. What were the responses of midwives to formal courses of instruction? Of the women who suddenly had to choose between traditionally trained and ‘scientifically’ trained midwives? Of the male practitioners who were attempting to establish themselves in a field long dominated by women?

Although the primary focus of this dissertation is on the emergence and development of childbirth institutions, I have aimed where possible to consider the cultural dimensions of changing thoughts about sexuality, reproduction, and the body in Italy over the two centuries from 1600 to 1800. In this, I have drawn from a rich body of interdisciplinary studies weaving theories and methodologies from history, art history, and literary analysis to explore early modern Italian medical treatises and midwifery manuals (chapter 2). Previous scholars have demonstrated the ways in which masculine science invested itself in women’s health and reproduction through the emergent fields of gynecology and obstetrics over the course of the long eighteenth century. By employing gendered discursive strategies, men attempted to

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organize and control female anatomy and reproduction in such texts.\(^5\) Ludmilla Jordanova and Lianne McTavish have taken a similar approach to the anatomical drawings found in medical texts, arguing that the visual construction of bodies underpinned broader epistemological shifts and was essential to the production of a particularly masculine knowledge of reproduction and the female body.\(^6\) Building upon this rich scholarship, this work is the first to focus entirely on Italian midwifery and obstetrical manuals, particularly the proliferation of these texts after the second decade of the eighteenth century.

In the context of early modern Europe, the vast majority of scholarship on midwifery has focused on France and England. Nevertheless, because the development of midwifery and obstetrics in early modern Italy defies the continental model in which male practitioners increasingly established themselves as rightful birth attendants, the Italian case presents a unique window onto the medicalization of childbirth. Studies of early modern Italian midwifery have been carried out almost exclusively by Italian scholars; however, since much of this work has not been translated into English, it has only been sparsely integrated into the broader historiography. The Italian scholarship also tends to concentrate on developments in local contexts and to focus on the period after the formal institutionalization of midwifery education in the mid-eighteenth century.\(^7\) Although many of these authors have hinted at the role of the Catholic Church in


shaping the development of midwifery in Italy, as yet Nadia Maria Filippini’s *La Nascita Straordinaria* (1995), a study of the changing attitudes toward cesarean section and the fetus in the eighteenth century, has been the only extended examination of this relationship. This dissertation builds upon Filippini’s intellectual history by attending carefully to the interactions between the Church and communities on a local level. I argue that parish priests were often important advocates of traditional midwives in their communities, even vis-à-vis newly trained midwives returning from formal instruction in the city. Parish priests also shared important functions with midwives in protecting and regulating female honor, sexuality, and illegitimacy – by choosing, for instance, to aid in the anonymous abandonment of an illegitimate newborn. By rejecting male involvement in childbirth, the Catholic Church, at both a local and institutional level, played a fundamental role in shaping the management of childbirth in Italy.

In neither the Anglo-French nor the Italian context has the medicalization of early modern childbirth been subjected to a sustained spatial or architectural analysis, despite the fact that both space and place were important elements of the changes to childbirth associated with medicalization. Although architectural historians such as Annmarie Adams have noted the significance of removing childbirth from its domestic environment to the hospital or clinic as a means of shifting authority from midwives and neighbors to professionally trained physicians, few historians have shown interest in developing this argument or in approaching midwifery from the perspective of material culture, architecture, or space.8 By taking seriously the architectural and material elements of the new spaces for childbirth and midwifery instruction which developed in eighteenth-century Italy, my research will begin to address these themes and

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 hopefully open the door to additional research.\textsuperscript{9}

The present study draws on recent scholarship which has greatly expanded our knowledge of the ‘medical marketplace’ in early modern Italy. In the context of the Kingdom of Naples, David Gentilcore’s investigation of medical pluralism and the Protomedicato has helped to develop the most accurate picture yet of the early modern Italian medical marketplace. Gentilcore’s conception of a tripartite and overlapping influence on early modern medical practice from religious, learned, and popular spheres has greatly informed my own thinking about midwives. Additionally, Gianna Pomata’s study of cure agreements and the agency of patients in Bologna has shown the ways in which practitioners and patients were on much more equal footing in a period when the medical arena overflowed with treatment options. Sandra Cavallo, working in Piedmont, has argued that barbers and (most) surgeons occupied an artisanal social milieu rather than the elitist circles of university trained medical professionals in which historians of medicine once placed them. Collectively, this scholarship has allowed historians to construct a picture of medicine in the early modern period that breaks down outmoded assumptions about professionalization and authority.\textsuperscript{10} Not only did trained practitioners compete with itinerant charlatans in the early modern medical marketplace, but medicine was still very much a site in which science, religion, and popular knowledge were conflated and disputed. Building off of these innovative studies, the present work contributes to our understanding of practitioner legitimation, patient involvement, and medical authority in the pre-


modern medical marketplace. Indeed, midwives represented a type of medical practitioner whose authority still derived from community sanction long after other formal requirements were technically in place. Likewise, the efficacy and application of ‘scientific’ midwifery extended only so far as women could be expected to internalize and accept such methods – a conclusion that, despite modern expectations about medical progress, was far from given.

Sexuality, Medicine, and the Body in an Early Modern Context

One of the primary goals of this dissertation is to identify the strategies by which various political and social bodies attempted to regulate or influence sexuality and reproduction over the course of the early modern period. My understanding of the management of early modern sexuality has been deeply influenced by Isabel Hull’s concept of the “sexual system” whereby the emergence of a new social discourse surrounding sexuality in turn functions to establish a new set of sexual behaviors attached with new meanings. In her study of Germany, Hull argued that “because sexual behavior is at the heart of social reproduction and is symbolically central to social classification and the interpretation of order,” the sexual system was deeply imbricated in the emergent state and social institutions of eighteenth-century Germany.11 My project is informed by Hull’s formulation of the sexual system and the dialectical nature of the process by which sexual behaviors are inscribed with social and political meanings. I approach the nascent legislative efforts directed toward midwifery in Italy from the early seventeenth century as indications of a shift in political and religious authorities’ attitudes toward reproduction and the ordering of sexual behavior. My research, following Hull, thus highlights the role of gender and sexuality in state formation. Amidst widespread fears of depopulation, for instance, a state

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experiencing a quick growth in its international profile, such as Savoy in the eighteenth century, quickly launched pro-natalist policies which had profound effects on the practice of midwifery and the social experience of childbirth.

My dissertation also seeks to illuminate the process by which particular understandings of bodies and bodily processes become, in specific historical contexts, dominant models which in turn function to naturalize culturally encoded ideas about gender and sexual difference. Following Mary Fissell and Lisa Forman Cody, I posit childbirth and the pregnant body as important symbolic sites through which larger social, cultural and political developments were understood and negotiated during the early modern period. To understand such processes, my analysis is theoretically informed by the growing body of historical scholarship which emphasizes discourse in effecting social and cultural change. Like other scholars influenced by the linguistic turn, I suggest that language and textuality occupy important and constitutive elements in the construction of social realities. However, my approach to discourse analysis is a multimodal one which understands language use in relation to a range of semiotic fields. In this light, I attach particular significance not only to transitions in language related to midwifery, sexuality, and childbirth, but also to shifts in visual representations of fetuses, reproductive organs, and the pregnant body.

The knowledge of the body that women gained through apprenticeship and traditional networks was profoundly different from the theoretical understanding of the body taught by men at universities, differences that were encoded in both language and image. What were the broader implications when empirically trained midwives brought their knowledge and expertise to the hospital and formal programs of midwifery education administered by men in the eighteenth

century? Instructors at the new midwifery schools, such as Giovanni Menini in Venice, were indeed sometimes compelled to use ‘common’ and dialectic anatomical terms in their lectures so that their students could better understand them. At the same time, these women were exposed to anatomical drawings and obstetrical models which were inscribed with the masculine scientific epistemology of their creators.

Historians such as Barbara Duden and Roy Porter have identified the body as a “historically contingent site of subjectivity,” and therefore a potential medium through which to explore this interplay of material realities and discourses. Duden, in particular, though her formative work on one German physician’s case studies, has illustrated the necessity of historicizing the body and being attentive to the historicity of matter more generally. Following Michel Foucault, Duden writes that the discovery of the “modern body” was “a unique creation arising from the interplay between the ‘medical gaze’ and the material it both examined and fabricated.” The seventeenth and eighteenth centuries were in fact critical to this process, according to Duden, as a time when “a new and unparalleled regulating and ceremonial demarcating of the corporeality of the European upper class” attached significant strategic and symbolic importance to the body. Through new practices of dissection and anatomy, “connections, deeply rooted in popular culture, between this (invisible) interior and the macrocosm were eradicated,” a rupture which allowed the “state” to gain power because “the ‘biological’ body and the ‘social’ body were interconnected…in the culture’s conscious.” My project engages with this genealogy of the modern body laid out by scholars like Duden and

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15 Duden, 10.
remains attentive to the vastly different encounter with the pregnant body experienced by the mothers, midwives, and medical men in my project. For the modern reader, who understands and experiences pregnancy in a fundamentally different way – through accurate blood tests, ultrasounds, detailed development charts – the eighteenth-century women who had to interpret and negotiate movements and flows, the possibility of a number of different kinds of false pregnancies, and the potential of bodily fluids to change form and position may seem quite foreign. Yet, it is one goal of this project is to address my subjects on their own terms and remain attentive to the implications of their quite different experiences of the body and its functions.

**Organization**

Chapter 1 provides an introduction to the social and cultural world of early modern Italian midwives. In addition to their birthroom activities, midwives acted as expert witnesses in court (in cases of rape, marriage annulment, infanticide, abortion), counseled women on a variety of female diseases, and often acted as intermediaries when illegitimacy or rape threatened social harmony. The chapter also traces the earliest regulation of midwives, first by the Church and then by state health boards and *protomedicati*. Midwives, I argue, particularly after the Counter Reformation were increasingly positioned as intermediaries between their communities and both Church and State.

Chapter 2 turns to the medical thought surrounding childbirth in the early modern period, and its development in Italy from roughly 1600 to 1800. Focusing primarily on midwifery manuals, I examine the visual and discursive strategies by which men attempted to exert their authority over childbirth, particularly in the context of the professionalization of medicine in the eighteenth century. This chapter leaves us with the question of how a new conceptualization of reproduction and the female body in the seventeenth and eighteenth centuries may have impacted
the interactions and experiences of midwives, pregnant women, and the (relatively few) male practitioners who actually intervened in these processes.

Chapters 3, 4, and 5, which constitute the bulk of this dissertation, are case studies of the emergence of public institutions for midwifery education and maternal welfare in three Italian states – Savoy, Lombardy, and Venice, respectively. In these chapters, I ask how the developments discussed in chapter 2 may actually have played out “on the ground.” Turin, the capital of Savoy, has received little attention from scholars for a variety of reasons. First, it was a distinctly early modern city which came of age only in the late sixteenth and early seventeenth centuries, a period typically seen as in decline and so long overlooked by researchers, rather than during the Middle Ages or the Renaissance. Second, the strong French influence on Savoy has invited scholars to question the ‘Italianess’ of the state in the first place. However, Turin was also the site of the first Italian maternity ward, established at the Ospedale di San Giovanni Battista in 1728, a model for similar endeavors on the peninsula. I argue, nevertheless, that the Turin maternity ward was also distinct from the midwifery programs established in Milan and Venice (and elsewhere) in the second half of the eighteenth century. Though generally grouped together, the Turinese project, which aimed at maternal welfare, shared much with the various asylums for women founded during the Counter-Reformation. Like those institutions, the maternity ward at San Giovanni was interested in moral education and improvement for the pregnant women who were most likely there to deliver an illegitimate pregnancy. Midwifery education only came second as a founding principle of the Turinese project.

By the second half of the eighteenth century, however, an interest in obstetrics had burgeoned within the medical profession, at the same time that the Enlightenment conviction in the ability of science and reason to protect the health of a state’s subjects and to grow the
population began to take hold. In both Milan and, later, Venice, initiatives to formally train midwives aimed primarily at the expansion of scientific midwifery and rationalized medical thought, particularly in the provinces. While maternal welfare and the preservation of maternal and infant life were considered desirable by-products of this process, the reform of fallen women was much less at the forefront of the new maternity hospitals and wards introduced after midcentury than they had been in Turin. Instead, practitioners increasingly viewed such sites more in terms of their value for clinical education. Reformers and medical men in all three states, however, had to deal with resistance on multiple fronts. While the introduction of pregnant women of questionable moral status into the public space of the hospital (near impressionable female foundlings) was debated by the hospital board in Turin, by contrast midwives, mothers and (at times) parish priests remained suspicious of attempts to educate women in formal midwifery schools in Milan and Venice.

The historian David Kertzer has written that “outside institutional forces – such as church and state – have long sought to influence reproductive behavior, not only through coercive measures (such as criminal laws), but [also] through social policy programs (such as poor relief for mothers and children).”16 This project explores the latter type of control as it was manifested in eighteenth-century Italy in the guise of the maternity ward and midwifery school. It is interested in how and why church, state, and the medical profession attempted to exert influence on women’s bodies at the end of the early modern period. However, this dissertation aims above all to highlight the moments in which such efforts were resisted or negotiated by the women and men who came into contact with them.

In 1719, an official of the Venetian health board, the *Provveditori alla Sanità*, expressed with some frustration the lack of success attempts to regulate midwifery in Venetian territories had met. Despite repeated proclamations (issued in 1624, 1632, 1682, 1684, 1689, 1690, 1695, 1704), there were still “grave disorders that exist[ed] in regards to the midwives;” namely, that of the 132 midwives active in the city, only 63 possessed any kind of formal license.¹ Not only were these many unauthorized midwives “poorly or not at all learned,” but since they were often ignorant of the baptismal rite which they might be called upon to perform in an emergency situation, they were also responsible for depriving “many innocent souls of the vision of God.”²

The situation apparently changed little over the next half century: a 1778 survey found that in Padua, one of the largest mainland cities in the Veneto and home to Venice’s distinguished university, only six of the twenty-one practicing midwives were appropriately licensed, despite the introduction of midwifery schools in both Venice and Padua since the beginning of the decade.

As David Gentilcore has compellingly demonstrated, the attempts by weak government bureaucracies to regulate the diffuse and multifaceted early modern medical marketplace were


never more than partially successful. In the Kingdom of Naples, for instance, an official of the Royal Protomedicato lamented in 1675 that even more than a century after the office was created to regulate medical practice, “many in the city…not being Doctors were treating without…privilege or approval.” The Neapolitan Protomedicato, like the Venetian health board, functioned as a medical tribunal, enjoying both civil and criminal jurisdiction, and was empowered to examine, license, and inspect the various medical practitioners within the Kingdom. As in the Venetian Republic, midwives in the Kingdom of Naples represented one segment of the healing population that proved particularly hard to control. Despite the fact that Midwives in Naples had officially been subject to examination and licensing by the Protomedicato since 1580, many were still acting without official recognition decades later. In 1648, one vice-Protomedico described the situation he confronted regularly in the countryside with exasperation: “the pregnant women and the people create midwives at their own whim, who then openly pass themselves off as such, without any recognition or experience at all, to the great harm of mothers and infants.”

The similarities between this statement by an official in Naples and that of the health board in Venice sheds lights on the continuities between the linked processes of bureaucratization and professionalization which occurred in various Italian states during the seventeenth and eighteenth centuries. The desire by both states and medical authorities to regulate the practice of medicine, including midwifery, met with resistance from local communities hostile to the implied erosion of traditional forms of interaction and authorization.

3 David Gentilcore, Healers and Healing in Early Modern Italy (Manchester: Manchester University Press, 1998); “‘All that Pertains to Medicine’: Protomedi and Protomedicati in Early Modern Italy,” Medical History 38 (1994): 121-42.

4 Quoted in David Gentilcore, “‘All that Pertains to Medicine’: Protomedi and Protomedicati in Early Modern Italy,” 132.
Midwives, who relied both on the community to legitimize their work and, increasingly, on the medical authorities to grant them legal privilege to practice, found themselves in a difficult position. Midwives negotiated these tensions just as they mediated the relationship between individual clients and the larger community, and between local Italians and the wider interests of Church and State. I argue that it was this role as mediator that made early modern midwives unique figures in the Italian landscape, and a particularly useful group through which to understand broader changes to management of sexuality, gender, and reproduction taking place in the seventeenth and eighteenth centuries.

In his treatment of Italian medical practice, Gentilecore observed that midwives were unique among medical practitioners in that their work and expertise were at once part of learned, popular, and religious traditions. Midwives controlled and directed the majority of early modern births with a mixture of traditional healing knowledge passed down through apprenticeship, prayer, and a host of popular reproductive rituals. Midwives’ social identity, however, comprised more than their ability to deliver babies. For one, midwives were expected to guide the religious activities of soon-to-be mothers throughout their pregnancies, preparing them spiritually for what was, in the early modern period, potentially a life-threatening event. In the case of emergency, it fell to the midwife to assume temporarily the religious authority of the priest and baptize the child in order to protect its soul. Finally, the midwife maintained a highly visible presence in the ritual life of Italian society, carrying the newborn whom she had delivered to the baptismal font for its spiritual birth and symbolic entrance into the community, and often being named godmother (“comare”) in honor of her services.

Midwives were also experts on a number of ‘female’ diseases, particularly those that

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5 David Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester: Manchester University Press, 1998), 82.
affected menstruation and sexual functioning. As a result, those who lifted new life into the world might also deal with more troubling concerns such as abortion, contraception, impotence, and infanticide. The still rudimentary understanding of the processes of reproduction at the opening of the early modern period added an additional mysteriousness to midwives’ work. Even as such associations occasionally sprouted suspicions as to midwives’ potentially illicit activities, this same knowledge proved instrumental to the workings of the early modern legal system. Midwives frequently gave testimony in cases of rape, marital discord, and infanticide. Therefore, the importance of midwives’ duties both in the birthing room and the courtroom made them respected and sanctioned figures, even at the same time that their involvement with the secrets of generation and semi-magical healing practices could elicit doubt. It was this position at the intersections of multiple traditions that found midwives targeted by new modes of ecclesiastical, municipal, and medical regulation between the sixteenth and eighteenth centuries.

The Counter-Reformation, the professionalization of medicine, and the growth of the early modern Italian state all held implications for the work and recognition of Italian midwives between the late-sixteenth and late-eighteenth centuries. The Tridentine Church sought out the assistance of midwives in order to extend ecclesiastical influence into the private lives of the community. At the same time, physicians and surgeons, interested in protecting and advancing their own privileges within a competitive system of medical pluralism, took an increasing interest in the practice of midwifery. State governments, particularly in the wake of repeated

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6 Statutes from the Venetian health board, for instance, specifically prohibit midwives from engaging in any activities which might produce an abortion, while suggesting (with likely exaggeration) that midwives are often persuaded by money to do so: “L’esperienza ha spesso confermato che qualche d’una delle Levatrici scordata di Dio, e dell’Obbligo suo, abbogliata dal denaro e speranza di gran lucro si è indotta ad adoperare rimedi per far disperdere la creatura, vengono pericò rigorosamente incaricate le medesime a scarso del loro impiego, onore, ed altre pene temporali prescritte dalle leggi criminali, anche dalla vita stessa secondo la grandezza del delitto, di non preparare, ne far preparare, meno di porgere a persona nessuna sia maritata o libera, delle medicine, bevande, polveri, ad altre cose per far sperdere la creatura sia vivo, o morta.” ASV, Sanità, b. 591, “Istruzione per le Levatrici,” n.d., likely 1794.
outbreaks of plague and later under the auspices of Enlightenment ideology, appropriated an ever larger role in ministering to the public health of the subjects within their territories and sought to regulate midwifery in the interest of the public good. For varying reasons, then, early modern ecclesiastical, state, and medical authorities wished to establish tighter control over the practice of midwifery. Yet, such efforts ultimately proved difficult precisely because midwives’ work existed at the juncture of each of these corporate bodies’ interests.

Through an analysis of the various forms of legislation directed at midwives from the sixteenth to the eighteenth centuries - including Canon and Synodal decrees, municipal ordinances, and statutes of the various medical colleges and Protomedicati – this chapter aims to give a broad introduction to the practice and regulation of midwifery in early modern Italy. I reference and build upon the scholarship of medical historians such as David Gentilcore (on Naples and Parma) and Gianna Pomata (on Bologna), and historians of midwifery and childbirth, such as Nadia Maria Filippini and Claudia Pancino, to provide a wide regional comparison of Italian midwifery, before focusing more exclusively on Northern Italian practices in the chapters that follow. In addition to statutes and decrees, I have considered prescriptive literature, such as confessional handbooks and midwifery manuals, as well as trial records from the various early modern courts - secular, ecclesiastical, and inquisitorial. The latter provide a unique opportunity to access the words of midwives themselves in their public function as expert witnesses. Though mediated, of course, by men (and by the broader epistemological frameworks of Church or State), these records reveal both instances in which midwives’ actions became transgressive and those in which midwives’ knowledge and professional status were legitimated before the law. Ultimately, the two centuries between the Counter Reformation and the Enlightenment saw both gains and losses for midwives. Though midwives’ important social and spiritual roles were
enhanced in the era of Catholic Reform, midwives were also brought under increased supervision by the Catholic Church and pressured to conform to rigorous standards of orthodoxy. Similarly, movements by state and medical authorities to license and regulate midwifery provided midwives with greater official recognition and sense of professional identity, while at the same time circumscribing the midwife’s professional range of duties and often subjecting midwives to a harsh and misogynistic invective.

I: Ecclesiastical Regulation

Baptism and Abortion

In early modern European society, childbirth was an event at once mediated by and understood through religious practice. For pregnant women in a period when childbirth was wrought with danger and the looming potentiality of death, religious ceremony and ritual provided both comfort and the possibility of active intervention. The Virgin Mary, who conceived without sin and delivered her son without pain, served as a powerful example to whom pregnant women could look for guidance. A host of saints represented additional intercessors, and many became particularly linked to pregnancy and childbirth. The birth itself was followed often by elaborately celebrated baptismal ceremonies that marked the symbolic entrance of the newborn into the Christian community. In sixteenth- and seventeenth-century Italy, the midwife had the duty of supervising the religious regimen of birth, not only to facilitate the entrance of new life, but also to guide the pregnant woman in a spiritual program prior to her delivery, and, perhaps most important, to ensure the salvation of the infant soul in an emergency.

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7 For a thorough discussion of the role of the Virgin Mary in early modern childbirth traditions, see Fissell, *Vernacular Bodies*, 14-24.

8 For evidence of lavishly celebrated lying-in and baptismal ceremonies, and the sumptuary legislation that regulated them in some areas, see Patricia Allerston, “‘Contrary to the Truth and also to the Semblance of Reality?’ Entering a Venetian ‘Lying-In’ Chamber (1605),” *Renaissance Studies* 20/5 (2006): 629-639.
It comes as no surprise, then, that the Catholic Church was the first to assert a regulatory authority over the practices of midwives. From as early as the twelfth and thirteenth centuries, Church decrees repeatedly mentioned the obligation of the laity, and particularly of midwives, to perform the sacrament of baptism in urgent situations. In fact, the medieval Church had already given considerable attention to the matter and all its possible contingencies. If the mother died during childbirth or even very late into her pregnancy, extreme measures were to be taken to ensure at least the salvation of the newborn’s soul, if not the preservation of life. The Councils of Canterbury (1236) and Trèves (1310) recommended in such cases the surgical post-mortem extraction of the fetus for the explicit purpose of performing baptism.\(^9\) Church decrees even counseled that the mother’s mouth be propped open during the procedure to ensure that the baby did not suffocate.\(^10\) Artwork from this early period suggests, furthermore, that the midwife herself undertook this kind of surgical intervention, which indicates just how wide ranging the practices of the medieval midwife might be.\(^11\)

By the sixteenth century, the reform of Catholic practices brought renewed interest from the Church in the practice of midwifery. That interest was at least threefold. First, in the midst of the heated theological debates of the Protestant Reformation, baptism emerged as a fundamental point of disagreement. As Protestant theologians increasingly attacked infant baptism as practiced by the Roman Church, Catholic reformers placed even more emphasis on the essentialness of baptism to Roman Catholic doctrine and Christian salvation. Second, through the

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process of Catholic reform, the contours of the Church began to stretch further into the daily lives of early modern Catholics. Marriage, sexuality, and morality all came under increasing scrutiny by members of the secular clergy – generally through the supervision of the parish priest. Through her direct involvement in births, healing and folk rituals, and the intimate concerns of neighbors, the midwife represented a potential point of access into the community for the Counter Reformation church. By increasing control of the midwife’s practice and instruction, the clergy envisioned a medium through which the tenets of Catholic reform and stricter moral standards might be relayed to its flock.

Finally, the varied and often syncretistic forms of popular piety, healing, and sympathetic magic practiced by early modern Italians were looked upon with increasing suspicion by a reforming Catholic Church intent on rooting out all such heterodoxy and ignorant superstition. The peasant population, with its strong traditions of popular healing and folk magic, both of which were frequently tied to women and the female body, received especial attention. The host of folk traditions related to pregnancy and childbirth, coupled with the fact that birth itself was still a mysterious, female-controlled event, made this an area of particular concern for the Counter-Reformation church. Through proper instruction of midwives, the Church therefore sought to eliminate one zone of superstitious folk belief and ensure that childbirth was accompanied by orthodox rituals and prayers.

As mentioned previously, the Church’s concern with baptism had brought midwives into the orbit of ecclesiastical regulation from an early date. Under attack from Protestant reformers who challenged the necessity of baptism for salvation, the Church in Rome responded by making baptism central to the tenets of Catholic Reform. The canons and decrees of the Council of

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Trent firmly reminded the faithful that “if any one denies, that infants, newly born from their mothers’ wombs, even though they be sprung from baptized parents, are to be baptized” then he “be anathema.” Renunciation of the duty to baptize one’s newborn infant was, therefore, a serious enough offense to warrant excommunication.

Midwives’ role in delivering infants subsequently took on increased significance in the eyes of the Church as guarantors of the salvation of newborn souls. The official catechism for parish priests that emerged from the Council of Trent paid direct attention to the role of midwives in baptism. Considering the possible necessity of lay involvement in the sacraments, for instance, the catechism outlined the desired hierarchy of those who might perform baptism – if a man is present, he shall be preferred over a woman, a cleric over a simple laymen. However, it is further specified that “midwives…when accustomed to its [baptism] administration, are not to be found fault with, if sometimes, when a man is present, who is unacquainted with the manner of its administration, they perform what may otherwise appear to belong more properly to men.” Such a concession should not be taken lightly. Midwives were being granted access to rites that had long been firmly gendered masculine. No comparable acknowledgement of women’s religious authority superseding men’s appears elsewhere in the catechism.

In addition to the standardization of theology, the Catholic Reformation was interested in a concurrent reinvigoration of piety on the part of both clergy and laymen. The 1614 *Rituale Romanum* issued by Pope V, the first attempt to publish a standard version of the Roman rites,

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15 *The Catechism of the Council of Trent; published by the Command of Pope Pius the Fifth.* (New York: F. Lucas Jr., 1850), 121.
reflects just such movement toward greater uniformity in religious ritual and renewed impetus to properly educate the secular clergy. As Wietse de Boer notes, however, the Counter-Reformation agenda went beyond the reform of clergy; indeed, “concerns about the social order came to dominate spiritual agendas, and…the public and private spheres became intertwined as never before.”\textsuperscript{16} This newly imagined role in social discipline is apparent in the Church’s dealings with midwives. By advocating a close relationship between parish priest and midwives, the Church sought to inculcate orthodox prayers and rituals among the female peasant population, to make clear the Church’s position on the sinfulness of abortion, and to ensure that newborn souls were not lost without baptism.

Under the 1614 \textit{Rituale}, midwives came officially under the direct control of the parish priest, a relationship that would have important implications for the trajectory of midwifery practice in Italy over the course of the early modern period. In addition to the injunction that “pastors are strictly bound to take care that the faithful, and especially midwives, be well instructed in the manner of administering the sacrament,” the Ritual noted that “no one should be permitted to perform the office of midwife, who does not hold the Catholic doctrine on the necessity of Baptism.”\textsuperscript{17} Church authorities continually emphasized that the sometimes chaotic atmosphere during birth often resulted in the midwife forgetting to baptize the infant or perhaps


\textsuperscript{17} “De Sacramento Baptismi,” \textit{Rituale Romanum Pauli V, Pontificis Maximi, jussu editum et a Benedicto XIV} (Tornaci Nerviorum: Descelee, Lefebvre, 1896) , 6.
muddling the rite, and thus proper (and repeated) instruction was necessary.¹⁸

Various provincial and diocesan synods subsequently codified localized versions of the general decree outlined in the Ritual.¹⁹ Italian midwives might be required to present themselves to their parish priest periodically in order to be instructed in the proper form of the baptismal rites. The *Rituale* required, further, that Episcopal officials undertake regular visitations, during which they would, among other duties, examine practicing midwives on their knowledge of the sacraments. ²⁰ In Rome, where the parishes of S. Maria in Campo Carleo, San Lorenzo in Lucina, and S. Maria in Monticello were three of the earliest to hold regular examinations of midwives, the Cardinal Vicario required at just such an Episcopal visitation that *ostetricanti* be “god fearing and of good morals.”²¹ Significantly, the administration of emergency baptism by a midwife was not just an extreme possibility in a time when high numbers of newborns died.²² The emergency baptism of one Roman child by a midwife was recorded in the parish register of Santa Maria in Trastevere as early as 1568: “Livia of Messer Lelio Parmegiano and the Roman woman Ginerva, was baptized. She [Livia] was born between the 12th and 13th hour. This I, donna Pacifica,

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¹⁹ James O’Kane, *Notes on the Rubric of the Roman Ritual regarding the Sacraments in General, Baptism, the Eucharist, and Extreme Unction* (New York: P. O’Shea, 1883), 86.


midwife, affirm.”23 In the small village of Pentidattilo in Calabria, where the midwife Virginia Squillaci seems to have been responsible for nearly all of the community’s births in the first years of the seventeenth century, twenty-seven out of 611 baptisms are recorded as being administered by the midwife in times of “imminent danger of death.”24

The argument for increased supervision of midwives could be driven home when episcopal or local inspections turned up evidence of abuses. In the Bassa Friulana, for instance, the midwife Pasqua Guarini attracted the attention of the Inquisition after her parish priest reported her for “abuse of the sacraments.” Pasqua testified to the Holy Office after delivering a local woman called Maria da Palazola that, believing the newborn “was dying soon, I baptized her, with the name Maria,” but “then the newborn revived, and I took her to the Church as her father and mother desired.” When the priest asked Pasqua whether the child had yet been baptized, however, the midwife replied in the negative, as she did not “believe that it was a great sin to baptize an infant twice” because she had “many times seen that priests, told that an infant was baptized at home;…had poured water on the body another time in church.”25

This episode stands out for at least two reasons. First, it should be noted that the punishment given Pasqua was little more than a verbal reprimand. The Inquisition was not interested in persecuting an uninformed midwife, only in ensuring that her ability to administer the sacrament of baptism was sound for future situations.26 In this case, the ecclesiastical

23 Schiavoni, 48.
24 Tommaso Astarita, Village Justice, 192.


authorities emphasized the role of the parish priest in the matter, calling for the local clergy to step up its instruction of midwives. Second, the case reveals that not only were priests concerned about what went on in the birthing room, but that they had access to networks which could provide that information. In the century after Trent, the parish priest’s relationship with the local community had become closer, their increased contact with midwives being a potentially important part of that connection.

On the other hand, some midwives were more rigorous administrators of religious rites than the parish priests from whom they were supposed to receive instruction on such matters. A case heard before the ecclesiastical courts in Turin, for instance, included the testimony of a sixty-year-old midwife named Maria Toretta. Amidst claims that the local parish priest was neglectful of his duties, ignorant of religious rites, and often absent from his parish, Maria Toretta testified that on several occasions she had been forced to baptize newly-born infants herself because the priest was nowhere to be found. On one occasion when the priest, don Ronco, was present, Toretta even had to step in when the ill-trained cleric stated “Ego te absolvo a peccatis tuis” instead of the correct “Ego te baptizo.” “When I realized [the error],” stated Toretta, “I signaled with my head to make [the priest] understand that he had misspoken.” Although don Ronco eventually repeated the rite with the correct form, Toretta recalled that from then on, she always made herself especially alert at all baptisms, and in fact did have to intervene on other occasions.

In both cases, a close relationship between parish priest and midwife presented a point of

27 “Processo per abuso,” 291-292.

28 Archivio Storico Diocesano di Torino (ASDt), 9.6.21 #11, Case against the Curate of Santena, 1731.

29 ASDt, 9.6.21 #11, Case against the Curate of Santena, testimony of Maria Toretta, 1731.
access into the community for ecclesiastical authorities. In addition to teaching the midwife the
proper form of the sacrament of baptism, the parish priest was also commonly tasked with
guiding her in her dealings with community members and encouraging her to promote more
orthodox practice in relation to childbirth and healthcare. This practice finds clear illustration in
the case of abortion. Decrees from local synods coupled directions for the priest to teach local
midwives the proper form of baptism with an admonition to make sure that these midwives also
knew the church’s position on abortion.\(^\text{30}\) This stance appears to be an obvious addendum
considering that midwives were the community members most likely to know the proper
medicines and herbs to bring about menstruation.\(^\text{31}\) Beliefs about the moment at which the soul
entered the fetus (and thus at what point it became illegal to procure an abortion) were hotly
contested in the early modern period, but the severity and sinfulness of the abortion of a
‘quickened’ child was clear.\(^\text{32}\) In early modern Italy, “both the woman willfully obtaining an

\(^{30}\) Common opinion at this time held that the soul entered the fetus at the time of quickening, which was held to be
different for males and females. Thus, the Church stated that abortion was only illegal after forty days in the case of
boys and eighty days in the case of girls. This ruling, of course, rests on the notion that the sex of the fetus could be
determined prior to birth, when in fact such determinations were as yet impossible.

\(^{31}\) On midwives’ role in regulating menstruation in various parts of Europe see Merry E. Wiesner, *Women and
Gender in Early Modern Europe* (Cambridge: Cambridge University Press, 2000), 54-56; Sara Read, *Menstruation

\(^{32}\) There was much debate over the processes of fetal development in the seventeenth and eighteenth centuries. Some
physicians and scientists held to an explanation based on preformationism, in which the form of the living thing
exists prior to its development. Some preformationists suggested that all organisms were created at one time and
thus were already in existence at the time of conception. Epigenesis, on the other hand, which was spurred on by the
important seventeenth-century discoveries by scientists like Regnier de Graaf and William Harvey regarding the
female ovum, held that living things come into existence through a number of stages of gradual development. For
the relationship of these debates to concerns over ensoulment, the practice of cesarean section, and the crime of
of Fertility in England from the Sixteenth to the Nineteenth Centuries* (London: Methuen, 1984), 121; Nadia Maria
Filippini, *La Nascita Straordinaria: Tra Madre e Figlio: La Rivoluzione del Taglio Cesareo (Sec. XVIII-XIX)*
abortion and whoever aided her were guilty of a capital crime.”³³

Apparently, most midwives complied with the directives of the Church on the issue of abortion. In criminal cases, midwives seem to have been infrequently accused of inducing abortions; in some communities, that role became associated instead with the figure of the procuress. In Pentidattilo, for example, it was common knowledge that one Anna de Amico, a foreigner to the village, worked as a procuress and knew “the roots” used to induce an abortion. During a criminal investigation in 1710, Anna’s reputation for arranging abortions (including her own) in the community became central to the case’s proceedings, and the courts turned to the expertise of the village midwife.³⁴ Maria Romeo, the thirty-six-year-old midwife, testified that she had found Anna in the midst of a pool of blood in which “there were two small pieces of flesh, and attached to them two small bits of roots, so that, as a midwife and an expert [she] soon judged that the said Anna was pregnant, and had had an abortion because of the said roots.”³⁵ Although Maria was clearly familiar with the methods for inducing abortion, she was not the person women in her community sought out for such procedures.

In addition to instructing the midwife about baptism and abortion, the parish priest also requested that information about births be reported to the local parish in a timely fashion. Midwives were required to record their names and those of the infants they delivered in the newly standard birth registers of the local parish, or were in any case told to remind new parents to do so promptly. This service facilitated the superior record keeping that was an aim of

³³ Astarita, *Village Justice*, 156.

³⁴ Astarita, *Village Justice*, 70-73.

³⁵ Quoted in Astarita, *Village Justice*, 73.
Catholic reform in the era of the Counter-Reformation. Claudio Schiavoni has studied the increasingly systematic and comprehensive record keeping in Rome in the century after Trent. In large parishes, baptisms were recorded along with “the first and family name of the midwife; her address and the vicinity in which she had performed her office; the nature of that intervention (natural birth without any difficulty; difficult birth for which was necessary the preventive presence of the parish priest; difficult birth for which the midwife had needed to impart a baptism of necessity, etc.); if she was a godmother in successive baptisms; if the midwife had or had not received canonical approval from her parish priest…comments on the professional quality and morality of the midwife.” In Venice, likewise, by 1560 the Venetian Patriarch decreed that midwives had to report all births within one day of their delivery, an injunction found commonly throughout the peninsula. Midwives might also be required to record the name of the newborn’s father. In England, similarly motivated priests advised midwives that the best time to enquire about such information was during the labor itself, since in a moment of pain and travail it would be nearly impossible for the mother to lie. Such information gathering reflected the community’s traditional imposition that the father care or provide financial support for his offspring – legitimate or not.

In Venice, the Patriarch’s punishment for a midwife who did not report a birth within one day was surprisingly harsh – public shaming in the Piazza San Marco and the potential for a one-

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36 On record keeping and the Counter-Reformation Church’s movement toward increased social control and community involvement see Kasper von Greyerz, Religion and Culture in Early Modern Europe (Oxford: Oxford University Press, 2007), esp. 54-55.

37 Schiavoni, 48. This emphasis on written records of births (and deaths) may have served inadvertently to help codify the work midwives did as a professional occupation.

38 Daniela Hacke, Women, Sex, and Marriage in Early Modern Venice (Burlington, Vt: Ashgate, 2004), 156-57.

year exile.\textsuperscript{40} Legitimacy and sexual deviance were obvious targets of such legislation, especially in light of the significant reorganization of marital practices undertaken after Trent. Clearly, the midwife’s duty had become even more closely tied to the moral strength and proper functioning of her Christian community. By implication, however, midwives could be placed in a particularly difficult situation in the event of an illegitimate or undesired birth that the parents did not want to disclose. If, as one historian has argued, “parish priests and confessors became the focal point of a complex power game in which the forces of local community life met with the reinforced structures of the church hierarchy,”\textsuperscript{41} it can be added that midwives came to represent a secondary intersection in this ‘game’ between community interests and those of the local clergy.

In fact, evidence shows that midwives were not always so ready to facilitate the Church’s newfound interest in policing the sexual morality of the community. In Venice, for instance, the records of the health magistracy reveal several cases where midwives were sworn by their clients to the utmost secrecy – likely in cases of illicit affairs. In 1795, Andrea Molin placed a young woman named Maria in the home of a local midwife and requested that she feed, cloth, and house the parturient woman with great discretion – this despite prohibitions against exactly this kind of behavior on the part of midwives. Only when the midwife did not receive compensation for all of these expenses did she take the case to the Venetian authorities.\textsuperscript{42} Nevertheless, this case suggests that a midwife might choose to respect the wishes for the privacy of those who came to her for her services and aid, privileging community bonds – or perhaps her own financial interest - over the interests of the parish clergy.

\textsuperscript{40} Hacke, 157. Whether this form of punishment was ever actually applied is unknown, though there is good reason to be skeptical – expert midwives were always in need, particularly in Venice’s densely populated confines.

\textsuperscript{41} De Boer, 206.

\textsuperscript{42} ASV, Sanità, b. 181, Petition of Andrea Molin, 26 August 1795 and Petition of Antonia Basquesti, 21 August 1795.
Far from eager to reveal clients’ secrets to ecclesiastical or secular authorities, it is clear that many midwives, whether through a sense of professional obligation, loyalty to the community, or financial incentive, chose to protect such information. A desire for secrecy, particularly in cases of illegitimacy, led to the problematic situation of newborns being deposited in already burdened foundling institutions outside of their home communities. The 1609 statutes of Santo Spirito, a foundling home in Casale, near Turin, declared that if orphans “have been brought by others from outside the city, the rector must…use diligence…in order to know from whence they have been brought and immediately send them back to the community of that place which will have the responsibility of nourishing them.”

A further ordinance issued by the civic authorities in Turin in 1675 declared significant penalties be meted out to midwives or others who abandoned foundlings from outside the city and didn’t notify the authorities. Although care of illegitimate children had traditionally fallen upon the community, and through local pressure on the father, historians have demonstrated that at least by the eighteenth century, these bonds had begun to weaken. Community “control over heterosexual relationships…diminished sufficiently that the vision of the illegitimate child of unknown parentage, deprived of any


44 Cavallo and Cerutti, 102. Studies have demonstrated that many of the babies deposited at foundling homes were actually legitimate; however, most of these children were not dropped off anonymously but rather sent with some form of identifying object, such as a note or prayer card, in the hopes that the parents might eventually be able to care for the child and return to retrieve him. On the abbandonment of legitimate children and the notes which often accompanied them see L. Tittarelli, “Gli esposti all’ospedale di S. Maria della Misericordia in Perugia nei secoli XVIII – XIX,” Bollettino della Deputazione di Storia Patria per l’Umbria (1985): 23-130; Franca Doriguzzi, “I messaggi del’abbandono: bambini esposti a Torino nel’ 700,” Quaderni Storici 53/2 (1983): 445-468; Flores Reggiani, “‘Si consegna questo figlio’: Segnali, messaggi, scritture,” in ‘Si consegna questo figlio’: L’assistenza all’infanzia e alla maternità dalla Ca’ Granda alla provincia di Milano, 1456-1920, eds. Maria Cannella, Luisa Dodi, and Flores Reggiani (Milano: Università degli Studi di Milano, Skira, 2008), 135-158.
identity tended to prevail over that of the natural child whose origin was known to all. In order to protect her honor and livelihood, the mother of an illegitimate child increasingly sought out large, anonymous urban welfare institutions to assume care of the child.

Midwives, Morality, and the Ecclesiastical Courts

Midwives’ dealings with the ecclesiastical courts clearly illustrate their intermediary position between community and clerical authority. Although early church regulations did not generally specify the medical knowledge a midwife must have – instead emphasizing her desired moral characteristics – ecclesiastical authorities frequently deferred to midwives’ anatomical expertise when it came to legal matters. The *Corpus juris canonici*, issued in 1580, stated that the testimony of midwives was admissible in ecclesiastical court, though it advised the rather excessive consultation of seven midwives (a standard that was rarely if ever met in practice). In the wake of the Council of Trent, the Church took an aggressive role in regulating the sexual and moral behavior of its flock. Licit and illicit sexual behavior were more clearly defined and the latter actively sought out for examination by clergymen, and, if necessary, the church courts. These strictures shifted the burden of managing heterosexual relations from the community to the Church, which in turn provided some women with legal safeguards to their honor. Particularly in cases concerning rape, false promise of marriage, or the desired dissolution of a


47 *Corpus juris canonici*, vol. 2, Titulus XIX, de Probationibus, Cap. IV (Lipsiae: sumptibus Bernh. Tauchnitz Jun., 1839), 296.
marriage, cases in which a physical examination might be necessary, the courts valued midwives’ expertise and ability to make legible the female body. Midwives also testified in cases of sexual assault, abortion, and infanticide, thus placing them within the orbit of the new forensic and medico-legal thought developing at the time. Local decrees suggest, however, that there was a fair amount of concern about midwives being moved by loyalty to protect women in their community. Thus, in cases where examination was required to corroborate a woman’s virginity or pregnancy, the courts might summon “midwives from different parishes…to carry out inspections” in order to achieve a greater level of objectivity.48

In the wake of the Tridentine reform of marriage the flow of cases to ecclesiastical courts increased steadily. The Decree Tametsi reconfirmed marriage as a sacrament and formalized the proper manner in which a marriage could be formed and the (limited) reasons for which it could be annulled.49 Sexual dysfunction that resulted in infertility (the production of offspring seen as the goal of marriage and the only legitimate reason to engage in sexual activity) and an unconsummated marriage were among the most cited reasons for the dissolution of a union, and, in each case, required a physical exam. As marriage and sexual behavior became normalized and more strictly regulated, it seems that women in some situations actually had better recourse to protest abuse or an unfavorable union. In Venice, for instance, Daniela Hacke has noted a

48 Hacke, 158.

49 The Decree Tametsi issued at Trent reconfirmed marriage as a sacrament, attempted to heavily suppress extramarital sexual relationships such as concubinage (clerical and lay), and formalized the proper manner in which a legitimate marriage could be formed. Afterwards, proper marriage required a public ceremony performed before a priest and several witnesses preceded by marriage banns. In contrast to traditional practice, the consummation of the marriage could take place only after the marriage ceremony itself, rendering sexual relations entered into after just the promise to be sinful behavior in the eyes of the Church. See John Bossy, Christianity in the West, 1400-1700. (Oxford: Oxford University Press, 1985), 25; Merry E. Wiesner, Christianity and Sexuality in the Early Modern World: Regulating Desire, Reforming Practice (London: Routledge, 2000), 106-108.
significant rise in such marriage-related cases initiated by women during this period. In any case, the Church looked upon the sacred bond of marriage with increased gravity, and the midwife’s knowledge and skill were frequently called upon to determine the efficacy of that bond.

The case of a purported rape recorded in the ecclesiastical archive in Milan demonstrates both the reliance of early modern courts on the expert testimony of midwives and the significant cultural and legal repercussions wrought by the changes to marital practices after the Council of Trent. The case surrounded the apparent deflowering of a fourteen-year-old girl named Marta in her home in the Porta Ticinese neighborhood of Milan by Giovanni Battista Ferrari in 1592, apparently under the guise that Ferrari wanted to take her as his wife. The promise of marriage (verba de futuro) had traditionally been sufficient to solidify a couple’s bond enough to have sexual relations, though cases of broken marriage promises were common both before and after the Council of Trent. When Marta’s father brought charges against Ferrari for the deceit and deflowering of his daughter, the latter began a smear campaign against the young woman. He contended that she was a loose woman who had already had sexual relations with men many times before he came along, accusations which Marta’s father and sister vehemently denied. To determine whether or not Marta had been deflowered by the accused, a midwife named Ippolita de Santo Nazaro was called to examine the girl. Ippolita testified that:

Having used the due diligence and procedures necessary in such things, and having diligently considered the [girl], I say it to be the truth that the girl by her husband was deflowered, but that she doesn’t have the [physical] qualities to indicate that she has

50 Hacke, 40-52.

51 Hacke notes in her review of Venetian cases that midwives were the only female witnesses to be recorded in conjunction with a profession. Thus in a similar sense as the parish records described above, court records worked to legitimize midwives’ work and solidify a professional identity through official documentary procedures. Hacke, 40-52.
given birth, having found in her a narrowness such that makes me think and judge this way.  

In her testimony, the midwife alludes only vaguely to the examination she has performed, though there is clearly an implied standard of procedure in such cases. In the late sixteenth century, the midwife’s authority remained tied to her traditional and experiential knowledge rather than any formal educational or anatomical program. In this case, Ippolita made an unequivocal pronouncement based upon her observational expertise, and the court trusted the midwife’s knowledge and praxis. For the ecclesiastical authorities, the sexual encounter between Marta and Giovanni had been rendered illicit in any case due to the new, formalized procedures for forming a marriage and the expectation that sexual relations would come only after the marital bond had been consecrated by a religious official.

Reproductive Rituals: Childbirth, the Sacred, and the Inquisition

The Church’s final point of interest in midwives’ work centered on the host of peasant rituals associated with childbirth, which were viewed as troublesome expressions of the rampant superstition and ignorance prevailing among the early modern populace. As already evidenced in the Church’s restructuring of marriage ritual, Catholic Reform was characterized by a more active clerical presence intent on normalizing the moral and spiritual behavior of the Catholic community. Policing the most intimate and personal behaviors of its community members must

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52 Archivio Storico Diocesano di Milano (ASDMi), Y6250, Trial of Tommaso Monasteri against Giovanni Battista Ferrari, 1593. “Avendo usate le debite diligentie et circostanze in simili cose necessarie et diligentemente il tratto considerato dico essere la verità che detta putta da marito è stata sverginata ma però non ha le qualità che si ricercano di haver fatto figlioli havendo trovato in lei strettzza tale la quale mi fa pensare et giudicare cosi.”

often have proved difficult, however. Childbirth, as the female-controlled ritual \textit{par excellence},
was an obvious target, precisely because of the traditional lack of a male presence.

At the most essential level, folk practices surrounding pregnancy and childbirth were intended to assert some control over the apparent vagaries of life and death in an age of pre-modern medicine. The rituals associated with childbirth were numerous and widely employed. Taking stock of the various birth rituals encountered in his ministrations as a physician and Dominican friar, Girolamo Mercurio was particularly struck by the practice of girdling a woman with a belt of verbena gathered on a specific feast day. He also mentions the lighting of a pilfered paschal candle at a mass said by a priest named Giovanni, and the common rural custom of the husband placing his hat over the women’s pregnant belly.\footnote{Girolamo Mercurio, \textit{Degli errori popolari d’Italia. Libri sette} (Venice: Giovanni Battista Ciotti, 1603), 382; Rudolph Bell, \textit{How to Do It: Guides to Good Living for Renaissance Italians} (Chicago: University of Chicago Press, 1999), 108, 110.} Other contemporaries pointed to the use of various herbal remedies when labor proved difficult. Many women and midwives tried tying a magnet around one or both of the woman’s thighs or placing seeds of coriander underneath the woman’s skirts in order to hasten delivery.\footnote{Laurent Joubert, \textit{The Second Part of the Popular Errors}, trans. Gregorgy David de Rocher (Tuscaloosa: University of Alabama Press, 1995), 189.} An additional host of reproductive rituals worked to unblock fluids, increase fertility, and prevent miscarriage. Women used mandrake in remedies to facilitate conception, for instance, and, once pregnant, sometimes carried an eagle stone to protect the child in the womb.\footnote{Jacqueline Marie Musacchio, \textit{The Art and Ritual of Childbirth in Renaissance Italy} (New Haven: Yale University Press, 1999), 140.}

Often, these domestic superstitions and popular healing practices were used in conjunction with religious and sacred rituals. Orthodox practices – such as prayer to the Virgin Mary, use of relics, and display of representations of biblical births or confinement scenes - were
also important sources of mediation during childbirth.\textsuperscript{57} Supplication to saints and relics linked to one’s city or village gave these rituals a local character. What became a concern for the Church was the intermixing of sacred and profane. Most troubling to the Church were undoubtedly cases in which midwives or other healers actually presumed to assert power over the sacred in a manner rivaling the priests. The Dominican Mercurio, who had particular access to these reproductive rituals through his position as travelling physician, was therefore especially interested in defining and separating acceptable religious praxis from folk superstition. Thus while most non-orthodox childbirth rituals did little more than exasperate reform-minded clergy, those practices which seemed to challenge the spiritual authority of priests garnered more intense efforts at re-Catholicization. From Venice to Southern Italy, for instance, wise women’s healing abilities were closely tied to their perceived access to the divine through the practice of “signing.”\textsuperscript{58} In the late sixteenth century, a healer from the Veneto, Elena Crusichi, related to the Inquisition the normal procedure for healing someone who had been bewitched: “I make the sign of the Cross three times and I say: I sign you…by the servant of the world…by the beard of Jesus, by the milk of the Virgin Mary, that every ill shall be undone from here and shall go away.”\textsuperscript{59} Clearly, Elena’s healing infringed on the priests’ monopoly to invoke the divine through exorcism and prayer. In the Friuli, the Holy Office was likewise confounded and concerned over a local practice – one more directly related to childbirth – in which “babies who came out of their mother’s wombs dead” were taken to certain women who attempted to resuscitate them by “displaying them before the altar of the Madonna and [having] the Holy

\textsuperscript{57} Musacchio, 125-126.


\textsuperscript{59} Quoted in Martin, \textit{Witchcraft and the Inquisition in Venice}, 145.
Mass celebrated” and “saying particular prayers.”

The power of such rituals was explicitly tied to strong peasant beliefs about the female body and a spiritual-religious understanding of sickness and malady. Through their healing abilities, wise women and midwives thus effectively made claims to access the healing power of the sacred in a way parallel to priests. As the Church attempted to evangelize the popular masses by consolidating its authority over the afterlife and fortifying priests’ ability to intervene in the sacred, it ran up against one of its strongest challenges in women’s natural power derived from their ability to give birth. According to Luisa Accati, if the womb gives life, then it also has “the strength, by analogy, to confront and destroy that which was opposed to life and fertility” and thus “women were the most dangerous adversaries of the priests [as] they literally made problematic the priest’s hegemony of the sacred.” Since men could not claim such bodily powers for themselves, they attempted to control its expression by women, as seen in Inquisitorial records throughout the sixteenth and seventeenth centuries.

Midwives not only had access to the womb, but also power over it, an authority rooted in their knowledge of the secretive and mysterious processes of birth. The significance of this knowledge is clearly demonstrated in the ubiquitous presence of the womb in Italian folk beliefs. In the territory of the Friuli, for instance, witchcraft practiced by women in peasant communities

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was explicitly predicated on “the magical power of the female womb.” An intact caul, or afterbirth, was “a much sought after and highly treasured charm” which was believed “to bring special fortune and was preserved with great care.” In Venice, the caul was used in a variety of protective charms; for instance, worn around one’s neck it prevented drowning. Midwives, with their obvious proximity and ease of access to the remnants of the amniotic sac, were often sought out for advice on caul beliefs and uses, or as in the case of one Olivia in 1591 to perform the baptismal rite over it.

Although generally caul beliefs were viewed less as heresy than as peasant superstition by the Church, the practice of some midwives of taking the caul secretly with them to be baptized along with the newly delivered child could easily incite the Inquisition for the obvious abuse of the sacraments. In the case of Olivia, the repercussions were not particularly harsh: the midwife received only the warning “not to do such things, and [was] shown the great sin that it is, and the offence towards God, and the prejudice to her own soul and body that it could bring.” Still, the infringement on the priests’ monopoly of access to the sacred clearly remained troublesome to the ecclesiastical authorities. This concern about midwives’ involvement in such rituals was apparently widespread. A decree from the 1679 synod of the diocese of Otranto, on the southeast tip of Italy, speaks to very similar concerns about midwives involvement with the sacred:

65 R. Martin, 128.
66 R. Martin, 128-129.
67 R. Martin, 175-176.
68 As cited in R. Martin, 177. Original: ASV, Sant’ Uffizio, b. 67, 16 May 1591.
We warn midwives, and command them under pain of excommunication, that whilst bringing infants to baptism or carrying them back home from baptism they abstain from all superstitious observances, nor place anything above [the infants] while they are being baptized, which could be used afterwards in sorcery, or (as they say) for remedies.\textsuperscript{69}

This last phrase is particularly telling; the religious authorities were articulating a disjunction between what midwives perceived themselves to be doing – healing - and how the Church wished to define such acts – as illicit magic.

As evidenced above, midwives certainly could be implicated by the Catholic Reform impulse to root out all manner of heresy and superstition. Contrary to a persistent strain of early Inquisition historiography, however, midwives were not frequently targets of the Inquisition.\textsuperscript{70}

Notwithstanding sporadic occurrences like the case of Olivia above, the Roman Inquisition seems to have only rarely implicated midwives in illicit activities. When midwives do appear before the authorities, as in the cases of Olivia or Pasqua Guarini, it is generally out of a concern for the proper administration of the sacrament of baptism and the use of orthodox prayers, rather than suspicion of maleficent witchcraft. As such, any punishment meted out to such women was typically very light. More frequent was the presence of midwives in trial records as witnesses, valued for their first-hand knowledge of events in the birthing room and, presumably, for their expertise regarding popular healing practices. Thus, while midwives themselves weren’t commonly accused of causing impotence through sorcery or procuring abortions, they could

\textsuperscript{69} Quoted in David Gentilcore, \textit{From Bishop to Witch: The System of the Sacred in Early Modern Terra d’Otranto} (Manchester: Manchester University Press, 1992), 146.

provide valuable information as to the necessary ingredients required to perform such magic and could perhaps also point to those in the community with the skill to do so. As in the testimony of the Pentidatillo midwife Maria Romeo about her neighbor’s involvement with local abortions, midwives often provided just the kind of privileged information that the clergy desired to have.71

A childbirth scene documented in the records of the Holy Office in Venice provides one remarkable illustration of several of the themes addressed above. The episode demonstrates in the first place that female knowledge and tradition governed reproductive practice and, secondly, that midwives could be viewed as important enforcers of religious orthodoxy during pregnancy and parturition. In 1578, a midwife named Catherina, “comare zentil,” was delivering the wife of an artisan named Guglielmo Cromeri in the presence of Guglielmo’s mother-in-law, Vienna Bertapaia. Some days after the happy birth of a baby girl, Vienna, at the forceful urging of her confessor, denounced her son-in-law to the Sant’Uffizio for heretical practices; specifically, the husband had mocked the invocation of the saints and displayed generally irreligious behavior in the home. Particularly troubling to Vienna was the fact that Guglielmo had infringed upon an entrenched tradition of calling on the Virgin Mary for protection and assistance during childbirth. According to Vienna, her son-in-law opposed such religious practices, doubting their efficacy, and saying that it was certainly enough “to pray to Christ” and “say the Lord’s Prayer” rather than invoking the Virgin and saying the rosary.72

During the ensuing trial, Guglielmo’s behavior at his wife’s delivery was an important part of the proceedings. Catherina, the midwife, testified to the events of the birth: with Vienna kneeling before the parturient woman, “exhorting her to invoke the Virgin Mary,” the women

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71 See n.29 above.

said prayers “as is always done” in order “for the baby to be alright” because “she [the newborn] was [in danger] for a bit.” At the inquisitor’s query about whether “one should invoke Christ and not the Madonna,” at such times Catherina’s reaction was vehement: “My Lord, no! O, Christ be blessed!”

Although Catherina ultimately testified that she was too intent on her work to take notice of the troublesome Guglielmo, she was nonetheless describing a scene in which women’s knowledge and experience directed both spiritual and physical events. Moreover, as documented by the Inquisition, it was the midwife, Catherina, and the mother-in-law, Vienna, who stand as representatives and enforcers of religious orthodoxy against the irreverent Guglielmo. The moment of birth might therefore become a time when traditional patriarchy was destabilized and women’s authority paramount.

In sum, the Catholic Church’s interest in midwives over the course of the long century after Trent was multifaceted. On the one hand, midwives were seen as a possible medium through which ecclesiastical authorities might “re-Catholicize” their flock, particularly in the countryside. Furthermore, the religious identity of midwives was heightened by their ability to perform emergency baptism at a time when the rite took on even greater significance in the Catholic world. On the other hand, midwives were also part of a somewhat subversive tradition of popular healing dealing with and predicated on the generative power of the female body. In this way, midwives were always potentially transgressive figures, capable of healing and giving life, but also theoretically of the opposite through their knowledge of healing rituals and proximity to the female body and the womb. Ecclesiastical regulation was thus aimed both at controlling and utilizing midwives and their authority within the community.

The relationship between local midwives and parish priests was strengthened during this

period. Priests were tasked with overseeing midwives and ensuring their knowledge of baptism, good morals, and demonstrated orthodoxy. The Church’s stricter policies regarding record keeping and baptismal registration further facilitated the local surveillance of midwives and childbirth. For the most part, however, this relationship provided midwives with a respected and valued position within the community. Sanctioned midwives had their names posted within their local churches, demonstrating the priest’s approval and their place of significance within the local community. Furthermore, midwives’ medical and healing expertise generally went unquestioned in this period; only in the second half of the seventeenth century did secular powers begin to interest themselves in midwives’ work, and only much later than this, in the late eighteenth century, did states or medical authorities really influence the medical activity or social profile of early modern midwives.

II: Secular Regulation

Ordering the Early Modern Medical Marketplace

In 1717 a Bolognese midwife named Angela Nannini was brought to the attention of the city’s Protomedicato, or medical tribunal, after the pregnant woman she was treating died. In danger of miscarrying early in her pregnancy, Virginia Calegari, at the behest of her mother, had called the midwife Angela who “took her [mother] to the apothecary, and there ordered some [drug] to eat… and… gave this to the patient.”74 Unfortunately, Virginia died several days later at Bologna’s Hospital of Santa Maria Maddalena at which time her husband, Lazzaro, brought charges against the midwife. Although Angela was eventually reprimanded by the Protomedicato, the tribunal’s condemnation lay not in the fact that her patient ultimately died,

74 Quoted in Pomata, Contracting a Cure, 77.
but that Angela had administered an oral prescription, something firmly prohibited, not only for midwives, but all medical practitioners other than physicians.

This episode, preserved in the records of the Bolognese Protomedicato, presents a rare window into the practice of early modern medicine, illuminating at once concerns about professionalization, hierarchy, and gender. Of primary interest is the fact that midwives were firmly understood to be medical practitioners whose work fell under the jurisdiction of the medical authorities within the city of Bologna, a situation not nearly so clear in the sixteenth century as it was in the eighteenth. Secondly, there is the persistent question of female hegemony over women’s medical and reproductive matters. For the Protomedicato considering the case of Angela Nannini, the issue was one of professional bounds, not of expertise. By administering an oral remedy Angela had violated the limits of midwives’ sanctioned duties as determined by the Protomedicato. Yet, as Gianna Pomata has pointed out, the authorities never questioned the nature of the concoction Angela prescribed nor its efficacy in treating a complicated pregnancy. Finally, Virginia’s course of treatment sheds light on a moment of transition in the understanding and management of disease in early modern society. Virginia’s mother, perhaps representative of a more traditional position, immediately sought the aid of the local midwife, even for complications arising very early in her daughter’s pregnancy. When the midwife’s treatment proved ineffective, however, Virginia’s husband Lazzaro considered the best recourse to be the hospital, where Virginia would most likely have been treated by a male physician or surgeon.

Was Midwifery a Profession?

For most of the medieval period there is little evidence to suggest that midwives shared any sense of professional identity, or that women necessarily even specialized in the work of delivering babies. Monica Green has concluded that, rather than being a timeless profession, “the
occupation of midwife, in the sense of someone with specialized skills recognized by the community emerged only gradually out of the services previously performed by kinswomen and female neighbors,” sometime between the thirteenth and fifteenth centuries. The variety of and flexibility in the use of terminology for midwives in Italy during the early modern period reflect this past. In Florence, for instance, the term “comare” (literally “with the mother”) could be employed interchangeably to mean either godmother or midwife. This fusion of meanings reflected the fact that often those who delivered a child into the world were also the ones to present the child for its spiritual birth into the Church.

Elsewhere in Italy, midwives could be called mammame, comari, levatrici (from the Italian for “to pull”), raccoglitrici (from the Italian for “to catch”), and, later, ostetricanti, evidence of regional distinctions and the changing social and cultural identity of midwives over the early modern period.

If Italian midwives lacked a defined professional identity in the medieval period, the situation had obviously changed by the sixteenth and seventeenth centuries, a transition effected in part by the regulatory measures discussed in this chapter. Gianna Pomata’s investigation of the medical landscape of early modern Bologna has revealed that some urban midwives adopted commercial practices to advertise their services. Thus some Bolognese midwives had their own shops, authorized by the city’s medical authorities, with easily identifiable sign posts displaying their services to the community, such as one in 1606 marked by three crosses. More

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76 Musacchio, 47-48.

77 Green, 135.

78 Pomata, *Contracting a Cure*, 56.
commonly, upon examination and approval by a licensing body (or the parish priest), a midwife would have her name recorded in a catalog of approved midwives and posted visibly at her parish church. Clearly, midwives were established as a visible and recognized part of the early modern medical marketplace. By the mid-seventeenth to early eighteenth centuries, secular authorities across Italy began to examine and license midwives, either apart from or in addition to the regulations imposed by Church and clergy discussed above. While the scope of such examination and licensing tended to circumscribe midwives’ duties from what they had been previously, the duties of the midwife were nonetheless becoming more clearly defined and standardized, as was the knowledge surrounding giving birth.

With respect to the established early modern Italian medical hierarchy, midwives were always somewhat liminal figures, positioned on the fringes of legal medicine. As historians of medicine have demonstrated, however, so too were the majority of early modern practitioners. If the accepted medical hierarchy included physicians, apothecaries, and barber-surgeons, early modern patients had a range of additional resources to turn to, including charlatans and other itinerant healers, wise women, midwives, exorcists, and various holy men and women. In fact, the saturation of the market with medical services compelled many popular healers to specialize,

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79 For instance ASV, Sanità, b. 748, “Regolazione delle Comari Levatrici,” 5 May 1719.

such as the *norcini* who were known to perform lichotomy and cure hernias. The fact that patients crossed between regular and irregular, learned and popular forms of medical service with ease and frequency suggests, further, that such imposed dichotomies carry more meaning for modern audiences conditioned to clear distinctions. For early modern Europeans, on the other hand, both sickness and healing existed within the confluence of popular, scientific, and religious contexts. Ultimately, changes in the perception of midwives and midwifery from the medieval to the early modern period reflected broader shifts in how disease and its management were understood and regulated.

**Regulatory Bodies: Health Boards and *Protomedicati***

Apart from the religious influences described above, the course of Italian midwifery in the early modern period was affected by two broadly contemporaneous developments: the growth of the early modern state and the professionalization of medicine. Over the course of the sixteenth century, early modern states increasingly established their authority in regulating matters of health within their territories. The permanent health boards which sprang up during this period had their *raison d'être* in the prevention and amelioration of the plague. However, the duties and jurisdiction of the health boards quickly expanded, coming to regulate not only the

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81 Pomata, *Contracting a Cure*, 75.

movement of people and goods during times of epidemic, but also the marketing of foods, sewage, beggars and prostitutes, burials, cemeteries, and the activity of hostleries, even during times free of disease. Initially, the health boards were not strictly concerned with the regulation of medicine, though, over time some did get involved in this area. For many years, however, most of the early modern health boards did not even have permanent physicians on their committees, though they might make recommendations for these in time of plague. The regulation of medical activities in early modern Italy was thus more commonly undertaken by medical colleges and corporations, or through the establishment of official medical tribunals, called protomedicati.

Increasingly, the most important institutions with regards to the regulation of medical care in early modern Italy were the protomedicati. Essentially a medical tribunal, the protomedicato heard cases of malpractice and controlled the city’s medical practitioners through examinations, licensing, and periodic inspections. David Gentilcore distinguishes three forms which the protomedicato could assume: royal, collegial, and municipal. In Naples and Turin, examples of the first, the authority of the protomedicato to grant licenses, inspect apothecaries’ shops, and arbitrate medical suits derived directly from Royal authority, meaning that the relative power of the local medical colleges was always kept in check. Here, the protomedicato developed in a bureaucratic fashion and might come to assume control of functions not traditionally associated with the medical college, such as the publishing of medical books and the


management of plague and contagion. Milan, like Naples under Spanish administration during this period, had a similar system. In Bologna, Siena, and Rome, by contrast, the protomedicato grew much more directly out of the collegial system. In these cases, the duties of the protomedico had their origins in the medical colleges’ late medieval statutes granting “jurisdiction over disputes between doctors and patients, over the inspections of apothecary shops and the charging of fines, as well as the licensing of itinerant practitioners.” Collegial protomedicati would elect a protophysician from within the college’s ranks, thus ensuring that the interests of the medical college continued to be privileged. In cases such as Siena’s, the medical colleges could be quite strong, jealously guarding their right to grant degrees and strictly regulating the numbers of physicians who could rise to the ranks of college member.

Finally, in smaller municipalities such as Gubbio and Benevento, near Naples, the city government itself might direct the activity of its medical practitioners by establishing a more localized municipal protomedicato. Venice and Florence remained unique in this respect, never establishing protomedicati in the strict sense. In Venice, the authorities utilized the city’s highly developed health board, the Provveditori alla Sanità, to perform the functions that the protomedicato undertook in other cities. In Florence, an entrenched and powerful medical guild found its authority gradually eroded by the city’s medical college only in the sixteenth century. Increasingly, the college assumed responsibility for licensing practitioners and settling medical disputes, without, however, the city ever establishing a protomedicato. Despite the differences

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86 Gentilcore, Healers and Healing, 32.
87 Ibid., 33.
88 Gentilcore, “‘All that Pertains to Medicine,’” 33.
89 On the origins of the Venetian Health Board see Cipolla, Public Health and the Medical Profession, 11-12.
90 Cipolla, 71-75.
in form of the Italian *protomedicati*, Gentilcore argues that the overall roles and responsibilities of these regulatory bodies were remarkably similar across Italy.\(^{91}\)

Perhaps the most important privilege reserved to the *protomedicati* was their ability to grant licenses. During this period, the medical license came to represent a mark of legitimacy and recognition that held increasing weight within the community. For one, unlicensed healers might be fined and punished or banned. In addition, the more aggressive policing of the medical community by the *protomedicati* from the mid-sixteenth century on meant that both the professional identity and range of duties allowed to certain practitioners became more narrowly defined. Only after this kind of regulation was enforced did distinctions between physicians, apothecaries, surgeons, and barbers solidify. A wide variety of healers who offered their services outside of this professional hierarchy might be granted temporary licenses to practice, but their position on the fringes of the professional medical system was, over the course of the early modern period, more strictly reinforced. Midwives, as previously noted, always represented a marginal space at once in and out of the professional medical system, simultaneously excluded because of their gender and valued for the essential societal function they performed. However, by their formal inclusion in statutes of the *protomedicati* and medical colleges in many locations by the seventeenth century, midwives gradually secured a position more closely associated with the established medical system.

In what ways did the *protomedicati* interact with local midwives? Upon arriving in a city or village to carry out a visitation, the *protomedicato* appointed representatives, usually one physician and one apothecary, “to announce to the governor or other person in charge” that they have arrived, “and wish to conduct the visitation” and then to proceed to examine all categories

\(^{91}\) Gentilcore, *Healers and Healing*, 33.
of medical practitioners. Non-graduate\(^{92}\) physicians were questioned about “fevers and other specific diseases” while non-graduate surgeons were asked about “head wounds, nerve pains, and other things necessary for bone-setting” and barbers about “how they recognize the veins, what they call them, where they are located, how they let blood, how they use a lancet or other instruments.”\(^{93}\)

As early as 1580, rather earlier than elsewhere in Italy, the Neapolitan *protomedicato* included midwives in its list of practitioners to be examined. Modeled on the highly centralized Spanish *protomedicato*, Spanish Naples developed one of the largest and most bureaucratic of the Italian *protomedicati*, likely explaining how midwives came so early under the authorities’ regulatory orbit there. The visitation instructions of the *protomedicato* in Naples specified that midwives be examined “on how they help women who cannot give birth when the infant is coming out head first, which is a natural birth, or when an arm or a leg [comes first], and when the [mothers] are unable to discharge the afterbirth, or other obvious danger.” Although in practice midwives often dealt with a wide range of diseases of women and children, the interest here was obviously limited to practices during childbirth only. To conclude the examination and licensing procedure, the representative would “issue…the midwife a license or confirmation to practice the office of midwife.” Such licensing procedures also included fees of not an inconsiderate sum, something that could be a substantial deterrent to applying for a license for practitioners with modest means, as midwives and charlatans often were. The license charge for midwives and barbers tended to be comparable, suggesting a similar status within the medical

\(^{92}\) Non-graduate practitioners were those who had not been granted degrees by the medical colleges. Generally non-graduates encompassed empirics, charlatans, and women.

\(^{93}\) Archivio di Stato di Napoli (ASN), *Protomedicato*, “Instructions to the physician and apothecary…who will carry out the visitation… (1580),” David Gentilcore (trans.), [http://www.le.ac.uk/history/dcg2/medicine/sources.htm](http://www.le.ac.uk/history/dcg2/medicine/sources.htm)
hierarchy. In Naples, the *protomedicato* authorities charged both “barber [and] midwife twelve carlini, regardless of whether they have been examined before.” By comparison the license for non-graduate physicians and surgeons cost considerably more at three ducats. Such licensing activities were thus always partly concerned about financial revenue, though they equally represented an aggressive stance by graduate physicians to establish a well-defined medical hierarchy with themselves as unquestioned leaders. Thus barbers were directed “to swear not to let blood” and midwives not to prescribe oral medications “without the order of a physician.” Indeed, “if a non-graduate physician or surgeon, mountebank, bone-setter, distiller, or other [practitioner]…impedes on the realm of physic” the *protomedicato* could “impose a fine of 150 ducats.”

In Naples, then, the midwife was clearly ascribed a semi-professional status in line with the recognition given to barbers. The duties of barbers and midwives also shared important similarities – both were characterized by the manual aspect of their work and their association with the body and its fluids. This proximity to the impure excretions of the body distinguished such practitioners from the physicians, who touted their theoretical knowledge and the observational, hands-off kind of medicine they practiced. In a medical system still dominated by Galenic and humoral theory, the blood and fluids that barbers and midwives purged from the bodies of their patients were viewed as polluted, the cause of unhealth in the patient’s body. Thus both barbers and midwives shared a marginal position within the medical hierarchy because of their need to touch and examine the foul, unclean body.

Over the course of the next century, *protomedicati* across Italy would follow Naples in

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94Ibid.

95 On barbers and their association to the body see Sandra Cavallo, *Artisans of the Body in Early Modern Italy: Identities, Families, and Masculinities* (Manchester: Manchester University Press, 2007); Pomata, 64-66.
establishing stricter guidelines for the practice of medicine and addressing midwives for the first time in their statutes. In Rome, for instance, a 1620 decree from the protomedicato of the Papal States instructed that women healers could only receive licenses for the practice of midwifery. Women who attempted to heal in any other context were subject to fines of 25 scudi. In 1627, the Roman protomédico added that “midwives in order to practice must first be examined and approved by the protomédico or one of his deputies.” Bologna and Siena followed this lead somewhat later; the protomedicati in these cities first began examining and licensing midwives in 1674 and 1686, respectively. In Milan and Turin, on the other hand, the regulation of midwifery came about only in conjunction with the institution of formal schools for midwifery instruction – well into the eighteenth century.

In Milan, the lack of regularized statutes governing midwifery practice before the second half of the eighteenth century may stem from the fact that there were jurisdictional conflicts between the protomedicato and the College of Barbers, both of which made some weak attempts to control midwifery licensing in the seventeenth century. The result of this confusion was that most midwives eschewed any kind of licensing at all and continued to practice indifferently. In fact, one representative of the Milanese protomedicato wrote after his visitation to a number of rural communities in 1767 that,

for the most part, the priest of the village chooses either the oldest woman or the one least encumbered by husband and children, and instructs her on the baptismal formula and

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96 Schiavoni, 45.


98 Gentilcore, “’All that Pertains to Medicine,’” 131; Pomata, 64.

posts upon the altar [of the church] her name, for the common notice of the people. Some priests instruct these women, to the extent they may know of it, in the art of obstetrics.  

In the absence of any coherent licensing system by either the medical college, the college of barbers, or the protomedicato, midwives in Milanese territory retained traditional modes of ecclesiastical authorization well into the eighteenth century.

In Venice, the first half of the seventeenth century also witnessed the emergence of new midwifery legislation. The city’s health magistrates, the Provveditori alla Sanità, began examining and registering midwives in 1624 in order for them to appear on the city’s official midwives’ roll. These licensing instructions shed valuable light on the training of midwives. In order to receive the license, Venetian midwives had to present a testimony from a midwife with whom they had apprenticed for a period of two years. Particularly before the introduction of public schools for midwives, informal local apprenticeships, at times within the same family, constituted the most common and important entryway into the practice of midwifery. In addition, according to the Venetian statutes, the midwife was to be examined by one doctor and “two women expert in the profession” who had already been approved by the Provveditori.  

In addition, the Venetian statutes acknowledged the religious component of the midwife’s activities, requiring that aspiring midwives present written support from their parish priest certifying their knowledge of the proper form by which to administer the sacrament of baptism in cases of necessity. In fact, the Venetian Provveditori justified their intervention into the regulation of midwifery in the first place because of “the confusion that follows a large number

100 ASM, Sanità, b. 186, “Relazione della visita fin’ora eseguito nello Stato di Milano della Commissione della Facoltà medica,” 2 May 1767. “Per lo più il parroco del villaggio prescieglie o la più vecchia donna, o la quella che è più disimbarazzata del marito e della figliolanza, la istruisce sopra la formula del battesimo, e poi pubblica all’altare il nome, per commune notizia del suo popolo. Qualche curato istruisce queste donne, per quanto può egli sapere nell’arte stessa ostetricia.”

of women in time of birth and the loss of life and soul of infinite newborns because of the
inexperience of many women who take on the office of midwife without having the required
practice or experience.”102 Clearly, the Venetian medical authorities’ interest in controlling
midwives reflected both spiritual and medical concerns.

These early examples of the secular regulation of midwifery are largely similar in that
they describe almost exclusively what midwives should not do rather than establishing standard
childbirth procedures. The most important injunctions, repeated frequently, were against
midwives letting blood, prescribing oral medications, or using surgical tools. In many cases,
midwives were directed to call in a surgeon as soon as the birth turned difficult. Such
prohibitions also reinforced the judgment that women were not allowed to practice any kind of
medicine apart from midwifery. Thus at the same time that the practice of midwifery was granted
official recognition by the medical authorities, a long line of women’s healing practices were
rendered illicit and illegitimate. It is important to note, however, that in practice there were
significant divergences from the ideals prescribed in the legislation described above. Despite the
precocious attempts to regulate midwifery in Naples and Venice, for instance, the reality which
emerged in these cities mirrored that of cities, like Milan, which did not attempt to enforce
comprehensive midwifery regulation until the eighteenth century. Prohibitive licensing fees, a
mistrust of outside intrusion, and the lack of authorities’ real capacity for enforcement prompted
many midwives to simply continue to practice unlicensed. As community authorization and trust
remained, throughout the seventeenth century, the most important factor in a midwife’s success,

102 Quoted in Daniela Pillon, “La comare istruita nel suo ufficio. Alcune notizie sulle levatrici fra il ‘600 e il ‘700,”
tempo del parto et perdita del corpo e dell’anima d’infinite creature per la inesperienza di molte donne che si
pongono all’esercito d’allevaressa o Comare senza havere la dovuta pratica o esperientia.”
particularly in rural areas, the appeal of a license from a medical college or protomedicato was limited.

**A Masculine Birth: The Emergence of a Medical Discourse on Childbirth**

The seventeenth century marked not only the first attempts by many cities to legislate the practice of midwifery, but also efforts by many medical practitioners to better define, theorize, and standardize the knowledge of childbirth. The publication in 1595 of Girolamo (Scipione) Mercurio’s *La Commare o Raccoglitrice (The Midwife)*, the first vernacular midwifery manual in Italian, represented the masculine infiltration of a field in which women’s knowledge had long been sovereign. This coup was not exceptional, but rather part of a larger, pan-European process which Monica Green has labeled “the masculine birth of gynecology.” The rediscovery of ancient texts by Galen and Soranus during the Renaissance provided medical men access to the realm of gynecology and women’s secrets for the first time in centuries, ultimately culminating in the emergence of obstetrics as an exclusive, masculine field by the eighteenth century.

Although the twin processes of the masculinization and medicalization of childbirth will be treated more extensively in subsequent chapters, suffice it here to say that as the medical legislation of early modern Italy publically legitimized and granted a cohesive identity to midwives, it ultimately came to define the practice of midwifery in more limited terms. If the apprenticeship training advocated by the Provveditori in Venice protected traditional networks of knowledge about childbirth, the examination procedures implemented by the protomedicati in

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cities like Naples, Bologna, and Rome began a gradual process by which women’s authority in the birthing room was eroded and replaced by the learned opinions of male physicians and surgeons. Indeed, even the simple distinction between “natural,” or head first, deliveries, and all others in the instructions given by the Neapolitan protomedicato codified a distinction that was absent in traditional accounts of childbirth. Other changes advocated by male medical professionals – such as the transition to the lithotomy (supine) position – transformed the cultural iconography of birth as well.105

Writers like Mercurio described midwives’ duties in progressively limited terms. In ancient Rome, Mercurio wrote, the midwife had had three distinct functions: to determine if a woman was pregnant, to examine a potential bride to ensure she was capable of carrying male children and to offer advice on the best husband (humorally speaking), and, of course, to deliver the baby. By the time he was writing, according to Mercurio, midwives were only responsible for the last of these.106 The clearest illustrations of this circumscription in responsibility were mandates issued repeatedly in Italy and across the continent to call in a physician or surgeon during difficult births. Mercurio wrote that “when…the Midwife finds herself in a very difficult situation” such as when there are sores or masses on the womb, or after normal remedies and purgations do not prove effective, she should “immediately make recourse to a doctor or surgeon.”107 There was thus the growing perception that midwives’ duties encompassed only the birth itself and preferably only normal births at that. In 1652, for instance, the protomedico of the


106 Mercurio, Bk. I, 81.

107 Mercurio, Bk. 2, 181.
Kingdom of Naples, Antonio Santorelli, determined that midwives need only be examined for what to do during the birth, not before or after. Although Mercurio and the Protomedico Santorelli may have been describing the desired situation more than what occurred in actual practice, they were nevertheless participating in a process of redefinition and circumscription of midwives’ duties characteristic of the early modern period.

Transitions

Mercurio’s text was significant not only for its presentation of “women’s secrets” in the vernacular, but also because it effectively became the standard handbook of midwifery in Italy until the eighteenth century. In 1689, when the medical authorities in Venice established new guidelines for examining and licensing midwives, they directly incorporated Mercurio’s text. As was typical, the new requirements were first issued to the parish priests, and by them then made known to local midwives. The new procedures subsequently required that midwives:

Be examined and approved as follows: they must know how to read, before every exam they are to be given for a text the “Libro della Comare,” they must present a sworn certificate by an anatomist that that they have attended for two years demonstration of the matrice (womb) and the genital parts of woman, also [they must present] a testament certifying two years of practice with an approved midwife. Following, the examination of the Magistrato, is given by the proto medico in the presence of the priors of the College of Physicians and Surgeons and two midwives.

As Daniela Pillon notes, the Venetian statutes represented a moment of transition, both theoretically and technically, in the practice of midwifery. The elevation of midwifery to a

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108 Santorelli was Neapolitan Protomedico from 1651; prior to his appointment he held the chair in theoretical medicine at the University of Naples and authored numerous medical treatises.

109 Gentilcore, Healers and Healing, 82.


111 Pillon, “La comare levatrice,” 69.
science was predicated on the anatomical breakthroughs of the previous century. This, along with the fact that the licensing of midwives was increasingly placed in the hands of (male) medical practitioners, meant that the accepted and medically sanctioned knowledge surrounding childbirth would be lifted from the hands of female midwives. In fact, by the late eighteenth century, many states were beginning to ban midwives’ expert testimony, once unquestioned in court, in favor of male practitioners’ ‘superior’ knowledge. Thus the story of midwifery legislation during the seventeenth and early eighteenth centuries is somewhat paradoxical: on the one hand, some midwives received public sanction and authorization through the acquisition of official licenses in a manner which elevated their art into a professional occupation; on the other hand, the midwife envisioned in new medical legislation was one whose duties had been sharply restricted. This reimagined midwife stood at a considerable distance from her traditional counterpart who had been known as an expert on all areas of women’s and children’s health. In theory, she was now merely a birth attendant.

Such a conclusion would, of course, fail to acknowledge the ways in which midwives and community members may have openly or clandestinely resisted the novel forms of legislation introduced during the early modern period. Just as midwives were intermediaries between local communities and the growing influence of the Counter-Reformation Church, so too were they at the center of a struggle between an entrenched tradition of popular healing practices and an aggressive drive by the medical authorities to define and regulate the bounds of legal medicine. And just as midwives might resist the Church’s intrusion into the community, so, too, might they strive to protect the traditional ways in which midwifery was sanctioned and practiced. Indeed, early modern midwives employed a variety of strategies in order to negotiate the regulation and legal bounds of their profession. Some, like Angela Nannini, clearly offered a range of medical
services that extended well beyond the immediate moment of birth. It is also likely that midwives, whether licensed or not, did not immediately cease prescribing oral remedies or bleeding their patients as such remedies played a central role in women’s traditional healing repertoire. In 1722, a midwife in Otranto, Camilla Rubino, for instance was still known for her “childbirth potion” (*beveraggio del parto*).\(^{112}\) Both officially in their capacity as expert witnesses and informally, midwives also continued to be important sources of information within the community on sexual diseases and dysfunction throughout the seventeenth century. Still other midwives, particularly those in the rural countryside, simply continued to practice unlicensed, supported by communities that were in any case suspicious of outside influences and learned medical practices, particularly with respect to such an intimate and female-centered act as childbirth.

The traditional mode of authorizing a midwife, through community agreement, represented a potent form of resistance to the efforts of the medical authorities. In 1648, as we have seen, such resistance incited the ire of one Roman vice-*Protomedico*,\(^{113}\) who found that “the pregnant women and the people create midwives at their own whim, who then openly pass themselves off as such, without any recognition or experience at all, to the great harm of mothers and infants.”\(^{114}\) The frustrated vice-*Protomedico* had in effect articulated the confrontation between two competing methods of sanctioning medical practice in the early modern period, a traditional one resting on the wishes of the patients, and a professional one predicated on examination and licensing from above.

\(^{112}\) Gentilcore, *From Bishop to Witch*, 145.

\(^{113}\) The vice-Protomedico was the Protomedico’s representative in the countryside.

\(^{114}\) Quoted in Gentilcore, “‘All that Pertains to Medicine,’” 132.
Gianna Pomata has thoroughly discussed this patient-centered system as it existed in early modern Bologna. Pomata found that, in addition to passing an examination, Bolognese healers might successfully secure licenses by presenting testimonials from patients who had been treated successfully. Although testimonials were a strategy used most frequently by folk healers, they nonetheless represented a medical system characterized by “the coexistence of two sources of legitimization…the medical authorities, above, and the patients, below.” The fact that, at least initially, the medical authorities had to accommodate traditional forms of legitimation is evidenced by the virtual lack of fines or punishments meted out to unlicensed midwives in the records of the various protomedicati. In Rome, for instance, the first prosecution of a midwife for venturing beyond the limited scope prescribed by the medical authorities did not come until 1703, more than seventy-five years after the initial statutes were put in place. Likewise, in Venice there is little evidence that midwives’ lack of attendance at anatomical lectures prevented their acquisition of a license. In city after city, statutes exhorting the necessity of midwives to be examined and licensed were repeated frequently throughout the seventeenth and eighteenth centuries, suggesting that such attempts at regulation had only a limited impact. Much more commonly, communities retained a traditional system of validation that involved recognition from a parish priest based upon successful years of practice, good character, and local approval and recommendation. The regulation of midwifery was a process continually negotiated and contested by midwives, their local communities and parishes, and medical and state authorities.

115 Pomata, Contracting a Cure, 51.

116 “1703 – Processo contro alcune levatrici di Viterbro che medicavano in Chirurgia senza alcuna licenza,” in Fausto, Quattro Secoli, 47.

Italian Midwives: A Profile

While substantial demographic and socioeconomic data about Italian midwives remains scarce for the sixteenth and seventeenth centuries, more detailed information increasingly appears in the archival record from the eighteenth century on. Better record keeping generally, as well as the considerable bureaucratic efforts involved in the establishment of the first schools for midwives and maternity wards in has left us with a considerable amount of evidence about eighteenth-century midwives in Turin, Milan, and Venice. In particular, this brief discussion relies especially upon supplications and parish correspondence from communities in and around these cities in relation to the opening of midwifery schools there. The documentation suggests that while midwives were respected within their communities, the remuneration for their services – particularly in rural areas - was generally modest. Most practicing midwives were mature women, whose own children were grown enough to accommodate a midwife’s unpredictable work schedule. Additionally, some women seem to have turned to midwifery after the death or incapacitating injury of a spouse, as a means of self-support in the face of a drastic reduction in family income.

In Milan, government-sponsored surveys conducted in the parishes of the surrounding countryside in anticipation of the opening of formal midwifery training programs provide a valuable data source. For instance, these documents reveal that the generally modest compensation a rural midwife might expect to receive for a birth could vary widely from community to community, and likely birth to birth. In rural Bonsilgio for example, the deputies of the Estimo reported that a midwife was paid on average around thirty soldi per birth, while in Cassino Scanasio (Rozzano) the expected fee was three lire.\textsuperscript{118} In the parish of Bruzzano, about

\textsuperscript{118} There were approximately 20 soldi to 1 lira.
ten kilometers north of Milan, the records indicate that in some cases midwives charged as little as ten soldi but as much as thirty soldi in others. Many other communities reported between twenty and thirty soldi as a typical fee per birth, though more rarely communities, such as Macconago, recorded remuneration amounts as high as five lire. Some communities, like Bovisio, designated different fees for ‘normal’ clients (twenty soldi) and ‘poor’ clients (ten soldi). These amounts could result in widely different annual wages, due in part to midwives’ potentially irregular work, particularly in smaller communities. Reported annually, the differences in wages might run from under ten lire in some communities to more than 120 lire annually in wealthier towns. By comparison, a Milanese mason could make around 1.63 lire per day or roughly 430 lire annually around the middle of the eighteenth century; a mason’s assistant around 0.85 lire (around 17 soldi) per day or 221 lire annually. A laborer in Venice or Genoa in the same period made on average 520 lire annually.

Although rural midwives’ wages were clearly modest, urban midwives might hope for a somewhat more lucrative practice. In Venice, for instance, not only does the per-birth fee seem to have been higher, but the logistics of travel on the water-filled city were sometimes factored into payment as well. In 1795, a Venetian midwife named Anna wrote that she had treated the wife of Francesco Pitor over the course of eight months during her pregnancy, which was

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119 ASM, Sanità, b. 269, “Sommario delle Delegazioni de’ Regi Cancellieri eccitati dalla R.I.P. con lettera 20 Giugno 1790 ad informare di Comune in Comune sopra i seguenti articoli…”

120 Ibid.

121 A wide range of annual salaries was reported: Towns listing wages for midwives as under 10 lire annually included: Monzoro at six lire, Castellazzo at seven lire, Lucernate at eight lire. Vanzago reported an annual salary of 12 lire, 30 lire was recorded for Casorazzo and Canegrate, 50 lire was reported in several communities (Cornaredo, Origgio), 60 lire in Cero, 70 lire in others (Garbattola, Nerviano), 110 lire in Saronno, and 120 in Arluno.

122 Aldo de Maddalena, Prezzi e mercedi a Milano dal 1701 al 1860, Volume 1 (Milano: Banca Commerciale Italiana, 1974).

123 This calculation is based on an estimated 260 working days per year. See Paolo Malanima, L’economia Italiana: Dalla crescita medievale alla crescita contemporanea (Bologna: Il Mulino, 2002), 420.
plagued with ill-health, as well as for three consecutive days, even sleeping in the same room as the pregnant woman, when she went into labor in early January 1794. For the entirety of her services, Anna charged forty-four lire, which included ten lire for boat services.\textsuperscript{124} Not only does Anna’s story suggest that urban midwives likely made considerably more than provincial ones, but also that the services offered by midwives were far from isolated to the birth itself. Visits could take place both before and after labor and delivery and often did, and even the birth itself could extend over the course of several days.

The new maternity wards could also be a place where a midwife could cultivate a profitable career. In Turin, for example, the first head midwife employed at the new maternity ward in the Ospedale di San Giovanni was awarded the considerable salary of 300 \textit{lire} per year, at least as much as a hospital staff surgeon or physician could hope to make in the same period.\textsuperscript{125} In Milan, records from the maternity ward at the Ospedale Maggiore indicate that in the first few decades of the eighteenth century the staff midwife was paid a much more modest 3 lire per month. By 1742, however the sum was apparently insufficient to attract a long term midwife and the hospital increased her wage to 7 \textit{lire} per month.\textsuperscript{126} Given the fact that the maternity ward had trouble retaining midwives during the eighteenth century, as well as the Ospedale Maggiore’s perpetually overburdened budget, these wages may have been somewhat less than what an urban midwife in Milan could expect to make on her own.

Toward the end of the eighteenth century, some cities and local towns in Italy

\textsuperscript{124} ASV, Sanità, b. 181, Supplica of Anna Mioto, 18 Novembre 1795.

\textsuperscript{125} Tirsi Mario Caffaratto, \textit{L’Ospedale Maggiore di San Giovanni Battista e della Città di Torino: Sette Secoli di Assistenza Socio-Sanitaria} (Turin, 1984), 66.

\textsuperscript{126} By comparison, the staff surgeon for the women’s ward at San Giovanni, who was tasked with visiting the foundling/maternity ward once a day, received a salary of 60 lire per year. Carlo Decio, \textit{Notizie storiche sulla ospitalità e didattica ostetrica Milanese raccolte da carlo decio} (Pavia, 1906),113.
experimented with salaried municipal midwives, *levatrici condotti*, in the vein of the municipal physicians and surgeons which had been common for centuries. These midwives would provide free services for the community’s most indigent families, in exchanged for a fixed salary supplied by the local government. As with per-birth fees, fixed salaries could also vary widely depending upon location. When the city of Turin began to supply its population with *levatrici condotte* in 1789, the three midwives received salaries of 72 lire per year, while three substitutes received 24 lire.127 Some small villages outside of Milan also began supplying communal midwives in the last decades of the century. In the small town of Roncello, about twenty-five kilometers northeast of Milan, for instance, the town council in 1780 began selecting a midwife who would receive 25 lire per year to serve those in the community who couldn’t otherwise afford assistance during childbirth.128 In Turbigo, about thirty-five kilometers west of Milan, a 1785 decision by the local government allocated fifty lire annually for a communal midwife.129

It is clear from the documentary evidence that midwives were not always compensated adequately or in a timely manner for their services. In such cases, the midwife might make a complaint to the local health board or *protomedicato* for redress. In 1782, for instance, the Venetian midwife Angela Rizzardini wrote that after delivering the wife of Sgualdo Campolin Murer her payment was repeatedly delayed, until which time she felt compelled to solicit outside assistance.130 Similarly, Anna Miotta, originally from Padua but living at the time in the S.

127 By the middle of the nineteenth century, the number of municipal midwives in Turin had risen to 15, one for each of the city’s parochial districts. *Condotte* were expected to have studied at the city’s midwifery school; the city government also made a pact with women to pay their expenses at the school in exchange for service as a *levatrice condotta*. Tirsi Mario Caffaratto, *L’ostetricia, la ginecologia e la chirurgia in Piemonte, dalle origini ai nostri giorni* (Saluzzo: Edizioni Vitalità, 1973), 37.

128 ASM, Sanità, parte antica, b. 272, “Comuni,” “Roncello”, 1 March 1780.

129 ASM, Sanità, parte antica, b. 272, “Comuni,” “Turbigo”, 13 March 1785.

130 ASV, Sanità, b. 174, Supplica of Angela Rizzardini, 24 January 1782.
Angelo neighborhood in Venice, made a supplication to the health board after she helped treat and eventually deliver the wife (consorte) of Marco Correr over the course of several weeks. During late June and July of 1791, Miotta reported that she was called “more and more times…to appear at the bed [of the pregnant woman] in the late hours of the night to assist her while [she was] bothered by excessive pains,” ultimately resulting in an abortion.\textsuperscript{131} Miotta claimed that during her long hours she had been compensated with only chocolate and coffee, even though she seems to have, at her own expense, paid for and retrieved medicines prescribed by a doctor for the ailing parturient. In consideration of the extended time spent at the pregnant woman’s side and the expenses she supplied for the medicine, the midwife requested that she be reimbursed 30 lire.\textsuperscript{132}

In some cases, a midwife might even go beyond the normal bounds of her profession to help a client who was pregnant out of wedlock – only to be rebuffed in the end by the woman’s suitor. Regina Servasoni, for example, was called by a certain Paolo in Calle de’ Fabri, whose last name she never discovered, to treat in utmost secrecy and at the most ‘inconvenient’ times the man’s pregnant consort.\textsuperscript{133} Despite numerous entreaties, Regina never received compensation and was forced to take her case before the Venetian health board. The frequency of cases brought by midwives like Angela Rizzardini, Anna Miotta, and Regina Servasoni suggest that fair and timely compensation for a midwife’s services could be difficult to obtain, particularly for a group with no guild or professional organization to provide support. Moreover, the strained emotions involved when a birth resulted in the infant’s or mother’s death likely resulted in some family’s

\textsuperscript{131} This term was used to refer to a number of situations that today we would distinguish, including a miscarriage early in pregnancy and a full-term still birth. ASV, Sanità, b. 178, Supplica of Anna Miotta, 7 September 1791.

\textsuperscript{132} ASV, Sanità, b. 178, Supplica of Anna Miotta, 7 September 1791.

\textsuperscript{133} ASV, Sanità, b. 181, Supplica of Regina Servasoni, 9 December 1795.
greater reluctance to pay their midwife.

There is also a great deal of evidence to suggest that midwifery was a trade passed down in families, from mothers to daughters, aunts to nieces, and even from mothers-in-law to daughters-in-law. In Venice, for instance, a long-practicing midwife recalled the excellent reputation of and community respect for her mother-in-law, Elena, from whom she had learned the art.134 Francesca Bressanin, a 50-year-old Venetian midwife, also noted that she learned the art from her mother-in-law, Giroloma Settelico, as well as from her aunt, Tommasina Nani. Additionally, the 1790 Venetian midwives’ register, which listed approved midwives and the students who were apprenticing under them, saw several mother-daughter and mother-daughter-in-law pairs among them. Maddalena Antoni, Catterina Costantini, Franca Maddalena Decrichi, Maddalena Lucchini, Orsola Rossi, and Rosa Santi, for example, all had apprentices who were daughters or other family relations.135 In the Milanese countryside as well, familial ties linked midwives in rural communities. In Bosisio, a Lombard community on the shores of Lake Pusiano, two midwives had served the pregnant women there for as long as anyone could remember: Cristina Appiana and her elderly mother-in-law, from whom she had learned the trade initially.136 These records suggest that there were strong familial and matrilineal ties which governed early modern midwifery practice.137 The 1790 midwives’ roll from Venice further indicates that the introduction of midwifery schools did not immediately disrupt these familial patterns, particularly where the formal schools continued to use apprenticeships as a means of training.

134 ASV, Sanità, b. 172, Supplica, 5 February 1778.
135 ASV, Sanità, b. 584, Register of Midwives, 1790.
137 ASV, Sanità, b. 177, Supplica of Francesca Bressanin, 16 February 1790.
Registration records from the first years of the Venetian midwifery school make clear that most of these aspiring midwives came from the middling or poorer classes. Unlike the numerous examples of well-to-do London midwives documented by Doreen Evenden for the seventeenth and early eighteenth centuries, late eighteenth-century Venetian midwives do not seem to have been drawn from the more prosperous strata of Venetian society. For women whose husband’s occupations are listed, we can see that many were laborers or small merchants. Some of the professions listed include: cook, helmsman (*nocchiero di nave*), tailor, servant, coffee maker (*caffattier*), bricklayer, lieutenant, printer, barber, and shopkeeper. In the provinces of the Venetian Republic and the Duchy of Milan, the humble background of most midwives is even more obvious. Supplications to the health boards in these cities often cite the exceedingly modest economic conditions of many rural midwives. In the village of Carate outside of Milan for instance, the licensed midwife Clara Madalena Galimberti, a widow, wrote that she was barely able to provide for her “poor, numerous family,” particularly in the face of two unlicensed midwives with whom she was forced to compete.  

In Venice in 1787, a midwife named Alessandra Longo Spinarol petitioned the health board to be approved and licensed despite the fact she had not attended the anatomical demonstrations and two years of schooling required for official recognition. Spinarol argued that she had practiced successfully for eleven years, two of which were in the company of her aunt, also Alessandra, and nine of which were under the guidance of her mother, Cristina Longo. Now, finding herself in a “miserable state because of having to tend to a numerous family, comprised of seven children in tender age, with one male and six females, and a husband without work, bereft of every human aid, such that with that profession [of midwife] I offer the only miserable sustenance to this so unhappy family,”

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138 ASM, Sanità, c. 270, Supplica of Clara Madalena Galimberti, n.d.
Alessandra was desperately seeking approval from the health board so that she could continue to practice as a midwife legally.\footnote{ASV, Sanità, b. 589, Supplica of Alessandra Longo Spinarol, 26 April 1787. “Ritrovandomi in stato miserabilissimo perchè ritrovandomi carica di una numerosa famiglia, composta di sette figli in tenera età con un maschio e sei femmine, et il marito senza impiego priva di ogni umano soccorso che con tal professione porgo l’unico miserabile sottentamento a si infelice famiglia.”}

Demographic data from the Milan, Venice, and Padua all indicate that midwifery was often a profession for mature women. Many of the parishes in and around these cities reported that their midwives were women in their fifties or sixties who had been long-practicing, often for ten or twenty years, initially as apprentices. Very likely, these women did not take up the profession until after their own childbearing and childrearing years had passed, given the demanding schedule required of a midwife. Because of the similarity of the data in all three cities, a summary of the findings from Padua will suffice here to illustrate the point. In 1774 in the Paduan parish of Altichieri, for instance, there were three midwives listed as active. Their ages were 67, 60, and 62, and they had been serving as midwives for 19, 12, and 14 years, respectively. In Cadoneghe the pattern was much the same: two midwives aged 67 and 66 had an average of 22 years’ experience each between them. Data from other parishes confirm that midwives were women of mature age. In the parish of Anguillara the average age of the four midwives was 66; in Santa Maria delle Carceri the midwives’ average age was 52; in Castelbaldo, 53; in Cartura, 57; in Monselice, 60; and in Pozzonuovo, 44 years of age.\footnote{ASP, Sanità, b. 154, b. 155, “Sopra le comari, ove si vede dalle note, ed attestati dei RR Parrochi mandate all’Ufficio quelle che esercitavano tal mestiere nell’anno 1774, e quelle che in seguito si portavano in Padova alla Scuola d’ostetricia.”} This pattern was also much the same for the 21 midwives practicing in the city of Padua itself: their average age was 50.\footnote{ASP, Sanità, b. 153. One of these midwives was listed as an assistant to her mother, and another as an assistant to her mother-in-law.}
In sum, Italian midwives in Lombardy, Savoy, and the Veneto were generally mature women who had learned their trade through apprenticeship, often under the guidance of a mother or another female relative. While their compensation was by no means extravagant, experienced midwives nonetheless commanded respect from their communities born out of familiarity and trust earned over years of practice. This brief survey will serve to highlight the changes which the three states under consideration sought to produce within the practice of midwifery through the introduction of formal midwifery schools and maternity wards, including significant alterations to the demographic profile of acting midwives.
TEXTUAL DELIVERIES: READING EARLY MODERN MIDWIFERY MANUALS AND OBSTETRICAL TREATISES

In his 1596 manual for midwives, the Roman physician and Dominican friar Girolamo (Scipione) Mercurio related an account, originally told by Aristotle, in which a woman of the Morea, who was having an adulterous affair with a dark-skinned Ethiopian and became pregnant by him, nevertheless gave birth to a white daughter. Mercurio is hardly bewildered by the story; it can be explained fully by “that which all of the world knows is true [and]…most certain,” namely that “the strong imagination of the pregnant woman has the force to mark the body of the infant with the appearance of the thing considered in the woman’s mind.”¹ In a treatise on women’s diseases, Mercurio’s contemporary, the Venetian doctor Giovanni Marinello explained the situation in greater detail: a woman engaged in an adulterous affair will in fact be more likely to have a child resembling his legal, though not actual, father precisely because an “adulterous wife is so afraid of her husband finding out, that she continues to have him in her mind during the [sexual] act.”²

¹ Girolamo Mercurio, La commare o ricoglitrice (Venice: Giovanni Battista Ciotti, 1601), Bk. 1, Ch. 12, 94. “Ma per verità più aperta, e manifesto piglio quello, che da tutto il mondo è conosciuto vero, anzi certissimo, ed è, che la forte imaginazione, e il fisso pensiero della donna ha forza di segnare nel corpo della creatura la somiglianza, e l’imagine della cosa desiderata.” Notes for La Commare will be referring to the 1601 edition.

² Maria Luisa Altieri Biagi et al., eds., Medicina per le donne nel Cinquecento: Testi di Giovanni Marinello e Girolamo Mercurio (Turin: UTET, 1992), 57. “…perciòché le moglie essendo in adulterio e temendo de’ lor mariti, di continuo mentre dura quello atto gli hanno nella mente.”
This wisdom regarding the imagination of pregnant women\(^3\) was not unique to Italy; similar notions are to be found in a multitude of sixteenth-, seventeenth-, and even eighteenth-century European midwives’ manuals.\(^4\) Before investigating these manuals for their cultural significance and evolution over time, it is necessary to consider briefly the wondrous power ascribed to pregnant bodies in the early modern period. At a time when paternity was essential to determine inheritance, when adultery was punishable by death, and when the notion of _onore_ was highly valued, a woman’s ability to control the outward appearance of her newborn child should not be underestimated. Regardless of the male contribution to human generation – a topic on which early modern medical men devoted countless pages – it was, ultimately, the maternal imagination which held the power to engender the form of her offspring. Midwives, conduits between the intimate space of the birthing chamber and the public world of the community, had similar command. They could pronounce sex, paternity, virginity, shape the body of the fetus with their touch, and they could control the spiritual fate of a dead or sickly newborn through baptism.

In writing treatises on women’s disease and manuals for midwives, medical men confronted such uniquely feminine powers with their own, strictly masculine authority obtained through participation in the exclusive environment of the university and in the new anatomical science of the sixteenth century. Although most of these men had never been present at an actual birth, they had gained an alternative, invasive understanding of female anatomy through the

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\(^4\) A 1745 French treatise by Isaac Bellet (translated into Italian in 1751) arguing against maternal impression criticized women (and men) for perpetuating the long-held belief to their own physical detriment, suggesting nevertheless that the belief was still widespread into the eighteenth century. Isaac Bellet, _Lettere sopra la Forza dell’Immaginazione delle Donne Incinte_ (Venezia: Giambatista Pasquali, 1751).
practices of dissection. By breaching the veils of clothing and skin, physicians mapped the inner-workings of the female body, ascribing their own names to their discoveries, and authorizing their own patriarchal notions of how bodies looked and functioned. In places like Paris and London, midwifery manuals served as a vehicle by which men sought to enter and secure their place in the birthing room. In response, by the end of the seventeenth century, prominent female midwives in France, England and Germany – Louise Bourgeois, Jane Sharp, and Justine Siegemund – had all published midwives’ manuals which praised midwives for their skills and argued that women’s personal experience of birth provided them with knowledge men would never be able to obtain.⁵

By contrast, in seventeenth- and eighteenth-century Italy, women did not write about pregnancy and childbirth. There was no desperate need to defend the midwife’s role in childbirth because she was still the relatively unchallenged guardian of the knowledge and rituals surrounding pregnancy and parturition. Girolamo Mercurio’s 1596 La commare o riccoglitrice was, in fact, the only native vernacular treatise printed in Italy until the publication in 1721 of Sebastiano Melli’s work on the subject.⁶ Even taken more broadly, writings addressed to women on the care and handling of female diseases were slim: Michele Savonarola produced a work for the women of Ferrara in manuscript form in the fifteenth century, and Giovanni Marinello published Le medicine partenenti alle infermità delle donne in Venice in 1563. By the second half of the eighteenth century, though, the publication of Italian obstetrical manuals began to accelerate. Although most of the Italian states emphasized the training of female midwives in


⁶ Sebastiano Melli, La comare levatrice; istuita nel suo ufizio; secondo le regole più certe, e gli ammaestramenti più moderni (Venice: Gio. Battista Recurti, 1721).
new schools, meaning that female midwives were not significantly challenged as attendants for most births, obstetrics had emerged in the universities and academies as a fundamental branch of surgery. As increasing numbers of surgeons were instructed in obstetrics, a number of them did try to carve a place for men in the birthing room, at least in difficult cases.

In this chapter, I examine the evolution of the early modern popular midwifery manual into the much more specialized and scientific eighteenth-century obstetrical treatise. The first half of this chapter discusses midwifery manuals published in the late sixteenth and seventeenth centuries: first, as they appeared on the Continent and in England; second, the single manual published in Italy during that period. The remainder of the chapter turns to the second half of the eighteenth century and focuses on Italian scientific midwifery manuals (or obstetrical treatises) directed at a more limited professional (and largely male) audience to consider how male writers employed the medium of print to develop their own professional discourse and identity as they sought to enter a traditionally female field for the first time.

I. The Male Development of Midwifery Manuals: Sixteenth to Seventeenth Centuries

Early modern midwifery manuals were indisputably ‘popular’ texts. Not only did their subtly transgressive subject material attract readers with mainly lascivious interests, but midwifery manuals also presented a great deal of practical information on sex, conception, pregnancy, and common female diseases. Indeed, these manuals share much with the wider genre of “how to” books popular during and after the Renaissance. As Rudolph Bell notes, an eager sixteenth-century reader might easily have found advice manuals “telling farmers how to govern their wives, books telling priests how to use the confessional to guide their parishioners
toward proper behavior, vernacular medical advice, herbals, books of secrets” and cookbooks.  

Given the still mysterious nature of conception and generation, midwifery manuals’ information on, for instance, how to conceive a boy; how to know if a woman is really pregnant; how to have a smooth delivery; and how to choose a good midwife and wetnurse was all highly sought after. The fact that these manuals often contained practical recipes and cures indicates that they could serve an important household function as well. Long digressions into biblical authority and examples from antiquity further added story-like elements to these texts. Finally, the important visual component of early modern midwifery manuals meant that they were potentially accessible to even an illiterate audience. In any case, “readership” and “audience” were always more flexible terms in the early modern period, when the information and advice gleaned from one text might be passed on orally from individual to individual and household to household.

At the same time, midwifery manuals were emblematic of a new scientific tradition taking hold in the early modern period. In the sixteenth and seventeenth centuries, medical men across the European continent began to translate the discoveries of the new anatomical and observational science into vernacular treatises. Female anatomy and childbirth, topics traditionally couched in the language of “secrets” were broached in such texts, reproducing in print the more literal penetration of the body enacted by the practices of anatomy and dissection.  

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The proliferation of anatomical treatises in this period was thus a pan-European phenomenon reflecting the transformed epistemological parameters of the scientific world. As anatomists’ understanding of the body became progressively more complex and scientific, the role of the Divine was consequently minimized and that of Nature or Mechanism emphasized.\(^\text{10}\) The Paduan anatomist, Hieronymus Fabricius (1537-1619), for instance, helped revive Aristotelianism and focused increasingly on the interrelated function of bodily systems and the establishment of normative and unified physiological models.\(^\text{11}\) Despite the trans-national character of scientific writing in the early modern period, this chapter argues that midwifery manuals were also cultural artifacts of the specific local and historical contexts in which they were produced. Thus it is my aim in this chapter to discern to what extent Italian midwifery manuals and obstetrical treatises can be distinguished from those produced elsewhere during this period.

As a genre, midwifery manuals shared a common structure, employed many of the same rhetorical devices, and were generally published in the vernacular to be made available to a wider audience.\(^\text{12}\) They discuss comparable material, offer similar advice, incorporate the same

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\(^{12}\) Lianne McTavish, *Childbirth and the Display of Authority in Early Modern France* (Ashgate, 2005), 25-27. McTavish points out the generic nature and common conventions employed in French obstetrical texts of the period.
biblical and classical anecdotes, and feature common visual conventions. In fact, due to the nonexistent practices of copyright and intellectual ownership, the manuals often borrowed outright from each other.\textsuperscript{13} Typically divided into several parts or books, the manuals tended to discuss (in roughly the following order) female (and sometimes male) anatomy relevant to generation; sexual problems like sterility; the processes of conception and generation; childbirth and the many difficulties that can arise due to the fetus’ position or sickness of the mother; and often some treatment of the diseases of women and children more generally. As a result of the still wide dependence on ancient authority and textual learning in medicine and natural philosophy in the early modern period, little new information was actually produced in these manuals until the late seventeenth century, despite authors’ frequent claims to originality and innovation.\textsuperscript{14}

In line with the new observational science’s investment in visuality, tropes of sight and illumination frequently figure into early modern midwifery texts.\textsuperscript{15} By emphasizing the visual nature of their work, these authors were affirming the new scientific value placed on direct observation.\textsuperscript{16} Even beyond asserting the superiority of visual and observational over tactile knowledge, however, male manual authors were manipulating the way in which aspects of women’s health and gynecology had historically been couched in a language of “secrets” or “mysteries.” Thus Hugh Chamberlen (1632-1720), the London man-midwife traditionally associated with the invention of the forceps, described his midwifery treatise as a collection of

\textsuperscript{13} Bell, \textit{How to Do it}, 8.


\textsuperscript{15} Bicks, “Stones,” 4.

\textsuperscript{16} McTavish, 63-68.
“rare secrets brought to LIGHT which for many years were locked up.”¹⁷ His brother Peter (1630-c.1720), also a well-known physician and obstetrician, suggested that a midwife ignorant of the practice of anatomy “is no more fitting for that Faculty, than a blind man to judge of Colours.”¹⁸ The French physician Francois Mauriceau (1637-1709) turned his ire to other male practitioners, suggesting that many authors of midwifery texts were like “those Geographers who give us a description of those Countries they never saw,” having never actually seen a female body dissected or attended a pregnant woman in person.¹⁹ These analogies emphasize the visual component of midwifery and stress the importance of men’s visual mastery of the female body – through anatomy – as that which traditional midwifery lacks and of which it is most in need.

The cartographic metaphor employed by Mauriceau is particularly apt as sixteenth-century anatomists were quite literally in the process of mapping the female body, discovering and naming new structures under a masculine paradigm, and, ultimately, shaping future understandings of those structures by controlling their representation and description in printed texts. The importance of scopic revelation to this project is explicit: for the authors of early modern midwifery texts, the direct observation of even one female body through anatomical dissection was privileged rhetorically in these texts over the tactile knowledge gained over years of experience by the traditional midwife. Indeed, apart from the more commonly cited forceps, some of the most important new tools developed for obstetrics were intended to enhance male practitioners’ sight of women’s bodies. The speculum matricis, for instance, was used to dilate


¹⁸ Peter Chamberlen, *Dr. Chamberlain’s Midwifes Practice: or, A Guide for Women in That High Concern of Conception, Breeding, and Nursing Children* (London: Thomas Rooks, 1665), author’s preface to the reader.

and visualize the interior of the vagina. The Irish physician James Wolveridge even saw fit to use the term as the title of his 1670 midwives’ manual, underlining his interest in peering into the secrets of female bodies and the processes of generation.

In revealing a mixture of long-guarded and newly discovered anatomical ‘secrets,’ vernacular midwifery manuals participated in both the transmission of elite scientific culture and the formation of uniquely early modern understandings and meanings of the body. Many of the manuals expose a tension between the author’s desire to praise anatomy as the manifest expression of Nature’s perfection, and a masculine anxiety over the threat to the patriarchal ordering of their world which was implicit in many of the anatomical discoveries of the sixteenth century. Thus on the one hand Helkiah Crooke describes the project of anatomy as the study of the perfection of man as a physical being, ultimately as a means to approach a greater understanding of God:

Seeing then that Man is a Little world, and containes in himselfe the seeds of all those things which are contained in the most spacious and ample bosom of this whole Vniuerse… whosoeuer dooth well know himselfe, knoweth allthings, seeing in himselfe he hath the resemblances and representations of all things. First, he shall know God, because hee is fashioned and framed according to his Image, by reason whereof, hee is called among the Diuines, The Royall and Imperiall Temple of God…And…by the dissection of the body, and by Anatomy, wee shall easily attaine vnto this knowledge. For seeing the soule of man being cast into this prison of the body; whosoeuer will attaine vnto the knowledge of the soule, it is necessarie that hee know the frame and composition of the body.

On the other hand, Crooke’s discussion of female anatomy exhibits a characteristic need to establish a firm hierarchical relation between the sexes: Soon after conception, he writes, “the fruitle [embryo] proueth male or female because of the temper of the seede and the parts of

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21 James Wolveridge, *Speculum Matricis Hybernicum; or, The Irish Midwives Handmaid* (Edward Okes, 1671).
generation…wherefore a woman is so much less perfect than a man by how much her heate is lesse and weaker then his.”

Crooke’s generative anxieties reflect the fact that, in startling and profound ways, new anatomical discoveries had transformed the ways in which bodies and the process of generation were understood. The prevalent model of sexual differentiation until the mid-sixteenth century held that male and female reproductive organs were homologous structures, though in the female case, the organs, because of a lack of heat had failed to turn outward. In English, the term ‘yard’ was often used to describe both the male penis and female vagina, and ‘stones’ referred both to the male testicles and the female ovaries. In this way, the most important human and bodily functions reinforced the patriarchal and hierarchical visions which governed men’s worldview. The new anatomical knowledge obtained through bodily dissection, however, presented a challenge to this one-sex model of sexual differentiation. Among the scientific community it had become quite apparent that the male and female reproductive organs were not homologous inversions of one another, but were in fact quite distinct.

Perhaps even more anxiety-provoking was the contemporary reevaluation of the female contribution to the act of conception. Aristotelian theory held that in the process of generation the male seed contributed form and essence whereas the female only matter; however, this view

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23 Crooke, 217.

24 According to Galen: “the difference betwixt her and the male, that in males the parts of generation are without the body, in females they lie within because of the weakness of the heat which is not able to thrust them forth”; as cited by Helkiah Crooke, Microcomographia (1618), 271-72. See also Thomas Lacquer, Making Sex: The Body and Gender from the Greeks to Freud (Cambridge: Harvard University Press, 1990), 59. On the “one-sex” model of sexual differentiation in the early modern period and discussion of its pervasiveness see Valerie Traub, The Renaissance of Lesbianism in Early Modern England (Cambridge: Cambridge University Press, 2002), 191-195; Elizabeth Spiller, Science, Reading, and Renaissance Literature (Cambridge: Cambridge University Press, 2004), 67-69; Winfried Schleiner, “Modern Controversies about the One-Sex Model” Renaissance Quarterly 53/1 (2000): 180-191.

25 Traub, Renaissance, 90.
had come under attack during the course of the sixteenth and seventeenth centuries. Increasingly, physicians subscribed to a Galenic two-seed model which afforded women a more active role in conception.\textsuperscript{26} By the mid-seventeenth century, William Harvey and Regnier de Graaf had each independently visualized the ovaries and had begun to incorporate the term ‘ovum’ in reproductive discourse.\textsuperscript{27} The occasional descriptive contradictions found in early modern midwifery manuals were therefore likely a result of medical men’s personal struggles wrought by new understandings of the most fundamental aspects of the self. For men, especially, knowledge of the female body as neither homologous nor entirely subservient to the male may have caused considerable uncertainty as to the extent of their role in reproduction.

Many historians have argued that male reproductive anxieties are distinctly apparent in much of the anatomical literature produced after Vesalius. As Caroline Bicks and Jonathan Sawday have shown, the metaphorical language used to describe the reproductive organs in such texts functioned “to constrain the body within the overarching organization of patriarchal authority.”\textsuperscript{28} Thus female reproductive organs were described and defined dismissively as less-perfect versions of male counterparts, replacing homology with hierarchy. It may have been particularly necessary at a time when women's bodies were shown to be both alien and more independent than previously thought to create a metaphorical language that worked to denigrate and master female anatomy. Indeed, male authors generated for themselves a language that reestablished the essentialness and dominance of the male seed in the process of conception.

As models structured around male and female generative homology were replaced,

\textsuperscript{26} McTavish, \textit{Childbirth and the Display of Authority}, 183.

\textsuperscript{27} Angus McLaren, \textit{Impotence: A Cultural History} (Chicago: Chicago University Press, 1997), 87.

\textsuperscript{28} Sawday, \textit{The Body Emblazoned}, 226; Bicks, “Stones,” 2.
discussions of reproductive anatomy began to take on a harsh and divisive binarism. Crooke, for instance, described men's 'stones' (testicles) in exalting words as “houshold Goddes which doe blesse and warme the whole bodye.”\textsuperscript{29} The womb, by contrast, is passive and cold, simply “a field or seed-plot to receive and cherish the seed”.\textsuperscript{30} Interestingly, Crooke usurps for men women's traditional position in the home, the position so often tied to their reproductive capacity, and banishes them to the outside. Another well-known English text, the Bartholinus Anatomy, is even more creative in its images, suggesting that the neck of the womb “gapes to receive the Yard, as a beast gapes for its food.”\textsuperscript{31} Vesalius also employed animal imagery to describe female reproductive organs, suggesting that the membranes surrounding “the seminal vessels [ovaries]...strongly resemble bat's wings.”\textsuperscript{32} More subtle but just as significant was these authors’ normalization of masculine identity against a weak and monstrous female other through explicit illustrations and the convention of describing female anatomy only with respect to the ways it differentiated from male physiology. For Valerie Traub, “the scatological disgust about the female genital interior” reflects “the danger and ambivalence involved in unveiling Nature’s secrets.” Midwifery manuals and anatomical atlases were therefore “born…of an investment in patriarchal reproduction…dread of the female genital interior” and the more “historically specific anxieties about male impotence and exposure.”\textsuperscript{33} A more thorough understanding of female anatomy and the ‘discovery’ of structures like the clitoris indeed forced men to reconsider

\textsuperscript{29} Crooke, 241.

\textsuperscript{30} Crooke, 55.

\textsuperscript{31} Thomas Bartholin, \textit{Bartholinus Anatomy} (London: 1668), 70.

\textsuperscript{32} Bartholin, 181.

\textsuperscript{33} Traub, \textit{Renaissance}, 122.
engrained notions about female desire and sexual pleasure. Fears about the implications of anatomical dissection, and of newly revealed sexual structures emerged in a wider cultural context in stories about uncontrollable tribades, cuckoldry, and castration.

The vast majority of midwifery manuals produced in the sixteenth and seventeenth centuries extended this marginalization of female anatomy to midwives themselves. In fact, the justification for many authors’ decision to divulge women’s secrets in the vernacular is the alleged ignorance of the majority of midwives. For instance, in his 1665 manual, Dr. Chamberlain’s midwifes practice, Peter Chamberlen railed against the “great many Women [who] presume to take upon them this Mysterious Office [midwifery], [and so] do bring great danger, and oftentimes death upon such as they rashly undertake, being unskilled in the Anatomical parts.” In the collected works of the well-known French physician and royal surgeon Ambroise Paré (1510-1590), midwives are mentioned only as attendants to surgeons in complicated births or as the cause for which a birth goes horribly wrong. Paré described in detail the case of a birth in which he was called too late:

Once I was called unto the birth of an infant, who the midwives had assayed to draw out by the arme, so that the arme had been so long forth that it was gangrenate, whereby the childe dyed; I told them presently that his arme must bee put in againe, and hee must bee turned otherwise. But when it could not bee put backe by reason of the great swelling thereof, and also of the mothers genitals, I determined to cut it off with an incision knife, cutting the muscles as neare as I could to the shoulder, yet drawing the flesh upwards, that when I had taken off the bone with a paire of cutting pincers, it might come downe

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34 As Katherine Park notes, the sixteenth-century ‘discovery’ of the clitoris (both Gabriele Falloppio and Realdo Colombo vied over recognition for the discovery of the structure) was really a rediscovery; Greek medical writers had been well aware of the clitoris as an anatomical organ. However, this information was largely lost to medieval and Renaissance experts. Colombo’s acknowledgement of the clitoris as the site of female sexual pleasure was quite new in the 1500s and had a significant cultural impact. For more on the rediscovery of the clitoris, as well as an alternative understanding of sex difference in the medieval and early modern period, see Katherine Park, “The Rediscovery of the Clitoris,” in The Body in Parts: Fantasies of Corporeality in Early Modern Europe, eds. David Hillman and Carla Mazzio (New York: Routledge, 1997), 171-93.

35 See Finucci, The Manly Masquerade, chapters 2 and 6.

36 Peter Chamberlen, Dr. Chamberlain’s Midwife’s Practice, author’s preface to the reader.
againe to cover the shivered end of the bone, lest otherwise when it were thrust in againe into the wombe, it might hurt the mother. Which being done, I turned him with his feete forwards, and drew him out as is before sayd.37

Here, the horrific outcome of the birth was tied to the ignorance of the midwife. Whereas supporters of traditional midwives praised their healing and skilful touch, for Parè and other manual writers the tactile abilities of the midwife are inverted into a destructive force which maims the physical body of the infant, ensuring its death and the likely death of the mother. The only possible solution then involves the acutely masculine intervention of the surgeon’s tools.

The 1682 volume *The English midwife enlarged* presents a view of midwives suggestive of an already declining trade in the urban centers of England.38 In order to describe the proper midwife, the anonymous author creates a fictitious dialogue between a midwife and a physician, appropriating the midwife’s voice and actions. The midwife begins: “Dr. Sir I am come according to my promise, to give you an account of the event of the directions you was pleased to give me last Night concerning Mrs. Styles, the which indeed Sir have succeeded marveilous prosperously, and she now thinks herself in Paradise to what she was before, and hath sent you Sir a small gratuity according to her ability…”39 The hierarchical relationship between the doctor and midwife is firmly established, as is the duty of the midwife to report on her actions to a male physician even in the event of a normal birth.

II: An Italian Midwifery Manual: Scipione Mercurio’s *La Comare o Raccoglitrice* (1596)


38 Anon., *The English Midwife Enlarged* (London: Thomas Sawbridge, 1682); The anonymous author (or more likely compiler, since much of the information is to be found in previous manuals), cites the need for the current volume as the fact that previous authors (Sir Theodore de Mayern, Dr. Chamberlen, and the publishers of the *Compleat Midwives Practice* are mentioned by name) had never “practiz’d the Art [never been present at a delivery]” themselves, the implication being that the anonymous author had (it was certainly possible for physicians in London to specialize in obstetrics by 1682).

39 Anon., *English Midwife*, 33-34.
Girolamo Mercurio’s (c.1550-1615) late sixteenth-century manual for midwives is, on one hand, clearly a part of the pan-European dialogue confronting and reframing female anatomy and presenting to a vernacular audience some of the secrets of conception and generation. On the other hand, *La Commare* is a product of the cultural and social practices and beliefs surrounding pregnancy and childbirth from a particularly Italian viewpoint. In structure, *La Commare* mirrors many Continental and British midwifery texts, beginning with a lengthy anatomical section and continuing on to tackle a wide variety of topics related to pregnancy and parturition, including the best practices for conception, care of women during their pregnancy, sterility, monstrous births, how to tell if the child is male or female, and the maternal imagination. The text then turns to delivery and the many possible difficulties and malpresentations which may arise during childbirth. It is difficult to establish the exact readership for Mercurio’s text or the literacy of midwives in general; however, it has been suggested that similar advice manuals could have been read not only by “the well-to-do, joined as often as not by their wives, in towns and the countryside – lawyers, doctors, merchants, master craftsmen, substantial landowners, and rich peasants, along with eager and talented artisans” - but also that accessible vernacular works like Mercurio’s “may have been purchased…by people who owned few other books.” Even those who were not literate or semi-literate might have understood Mercurio’s manual through its strong visual component, imparting visually ideas both about female anatomy and the competence of the midwife. Finally, as with much of early modern print, transmission was likely not restricted to primary owners; where communal and oral traditions remained strong, the

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40 Bell, *How to Do It*, 15.
wisdom in manuals such as Mercurio’s could easily have been related by mouth from midwives to apprentices or mothers, or in the reverse.⁴¹

Like his European counterparts, Mercurio emphasizes anatomical and observational knowledge as virtues of the new science and of the ideal medical practitioner. He continually justifies his own authority in the matters of which he writes by referring to his experience under the tutelage of Giulio Cesare Aranzi in Bologna,⁴² in which he personally “saw” the extraction of a live child from the womb of an “unfortunate woman pregnant in her ninth month who was killed” and “it was of great advantage to me to see…the natural site of the human creature in the maternal womb.”⁴³ Mercurio also witnessed the caesarean operations of two women in Toulouse. Thus, while neither of these experiences would have given Mercurio direct knowledge of a normal birth, he could claim superiority over the majority of manual writers, such as the well-known Swiss physician Jacob Rueff (1500-1558), because such men “had neither seen nor [are] certified to practice an anatomy dissection of this natural site.”⁴⁴ Tropes of sight and illumination are also threaded throughout Mercurio’s text. Like Hugh Chamberlain’s stated intention of bringing long-hidden secrets into the light, Mercurio hoped his text would “give light to the instructions for the midwife.”⁴⁵

⁴¹ Ibid.

⁴² Giulio Cesare Aranzi (1529/30-1589) was a professor of anatomy and surgery at the University of Bologna where he received his degree in 1556. He made important anatomical discoveries related to the fetus and was fundamental to elevating anatomy to a major branch of medicine. For more on Arazni see Vivian Nutton, “Humanist Surgery” in The Medical Renaissance of the Sixteenth Century, eds. Andrew Wear, Roger Kenneth French, Iain M. Lonie (Cambridge: University of Cambridge Press, 1985), 75-99.

⁴³ Mercurio, Bk. 1, Chap. 3, 14. “…io vidi in Bologna l’anno Mille cinquecento, e settantotto in una sfortunata donna gravida, che nel nono mese fu ucciso; perche essendo chiamato l’Eccellentissimo Signor Giulio Cesare Arancio…per cavare la creatura vivo del corpo della madre…hebbi grande agio di vedere con mio commando il sito naturale della creatura humana nel ventre materno…”

⁴⁴ Mercurio, Bk. 1, Chap. 3, 14-15.

⁴⁵ Mercurio, author’s preface.
Thus not only had Mercurio clearly read many of the midwifery texts proliferating on the Continent – he mentions (often to correct them) works by Eucharius Rösslin (c.1470-1526), Rueff, and Laurent Joubert (1529-1582) specifically – but he was also engaging in their project of constructing knowledge about female bodies and masculinizing the practices of women’s medicine. The anatomical treatment in La Commare subtly normalizes masculine reproductive anatomy against a weaker female form through both metaphorical language and striking visual representation. Mercurio includes the widely circulated drawing of the female matrix initially printed in Vesalius’ De Humani Corporis Fabrica (1543) which is nearly identical to male anatomy, implying a homology between male and female structures despite the fact that Galenic notions of isomorphism had already largely begun to break down. The appropriation of classical poses to display dissected female abdomens, and the comparison of the cervix to a “large bag” and the vaginal opening to the mouth of a fish all suggest that Mercurio was involved in the same fetishization and objectification of the female body that captivated medical men across Europe.

By contrast to other contemporary writers, however, Mecurio’s unusual acknowledgement and praise of the midwife’s skill stands out. In his manual, Mercurio gives a detailed description of the good midwife, which it will be useful to quote at length:

The wise and prudent midwife is as necessary to pregnant women as the good physician, in fact more so, because, if he helps with advice, she helps both with advice and her hands…The good midwife must be very skilled and experienced, and have safely helped at many births. She should not, however, be so old as to have problems with her eyesight or with weak and trembling hands. If she is, great problems may ensue, since in difficult deliveries she will need great strength to extract the baby…She must also be aware and

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46 Arazni was Vesalius’ student in addition to being Mercurio’s teacher.

very careful to know when the birth is close, distinguishing the real labour pains from other pains, and be ready to place the pregnant woman on the bed or on the birthing chair. The good midwife should always have an assistant, not only as an apprentice, to be well-instructed in this most important practice, but also because in all circumstances the assistance should be ready to help as necessary, for example handing over oils, warm grease, towels, scissors and thread to cut the umbilical cord, or skillfully extracting the placenta, and other such things. Not all women are capable of doing this... The midwife should be affable, cheerful, gracious, humorous and brave, and she should always encourage the women, promising them that they will certainly give birth to a boy, that they will not have too much pain, and that she knows this because of many signs she has observed in other women. I think that even if this is a lie it can be said without fear of committing a sin... since in Plato, in the sixth book of the Republic, allows the physician to tell lies to comfort the sick... Besides all this, the midwife must be pious and devout, and must remind pregnant women, before the delivery, that they should not reach the moment of giving birth without having been to confession and to communion, because childbirth is accompanied by obvious danger of death. She must also persuade them of how commendable and beneficial it is amidst danger to resort to prayers for the intercession of saints, especially to the glorious Virgin Mother of God, who, having given birth to her son without sin and without pain, will be well disposed to help those who conceive their children in sin and give birth to them with much pain.\footnote{Mercurio, Bk.1, Chap. 18, 87-89. This translation is Paola Tinagli’s and can be found in Mary Rogers and Paola Tinagli, eds. Women in Italy, 1350-1550: Ideals and Realities (Manchester: Manchester University Press, 2005), 176. “Altrettanto è più necessaria alle donne gravide la saggia e prudente Commare di quello sia il buono Medico: e imperocchè se questo col consiglio, e con la mano... Deve dunque la buona Commare essere molto pratica, e esprimentata, e deve haver raccolto molte creature felicemente, ma non sia vecchia molto, acciò non habbia difetto nel vedere, debolezza, o tremor nelle mani, poiche così per l’uno mancamento: come per l’altro possono occorrere pericoli notabilissimi, essendo di bisogni ne’ parti preternaturali havere forza grandissima per ridurre le creature nel sito naturale... Deve inoltre essere accorta, e diligentissima nel conoscere il vero tempo del parto, e nel discernere le vere doglie di quello dell’altre: accio possa essere pronta in tale occasione a collocare le donne gravide sul’letto, o seggiola, il che è di grande importanze: perchè comParéndo le humità solita si perda tempo in aiutare la creatura; e suggendo tale occasione, le parti della Natura non restino ascritte, e perciò il parto poi si rende dificilissimo. Non abbandoni mai giorno ne notte la gravida, perché nella sua assenza possono sopra giongere i dolori, e l’ora, e la humidità del parto, e in quell tempo, che si manda chiamare la Commare, si può perdere la predetta opportunità... Habbia sempre la buona Commare una aiutante non solo, come sua allieva per instruirla bene in questo importantissimo esercizio, ma anco acciocchè in ogni occorrenza sia prontissima ad aiutarla ed conforme al bisogno come in porgere ogli grassi caldi, sciugatoi, forbici, e filo nel tagliare l’ombilico: ovvero in tirare fuori drettamente la seconde, e in atre cose simili; il che fare non sono buone tutte le donne... Sia la Commare affabile, allegra, gratiosa, burliera, coraggiosa, e faccia sempre buono animo alle gravide col promettermel, che partoriranno un figlio maschio al sicuro, e che non sentiranno molto dolore, e ch’ella ben lo sà per molti segni, che ha osservato in altre, il che quantunque sia bugia, non essendo detta per danneggiare altrui, ma solo per aiutare e inanimare le partorienti, credo si possa dire senza scrupolo di peccato tanto maggiolmente: quanto Platone nella sua Republica vuole il medico, al quale concede a dire bugie per consolare l’ammalato. Deve oltre le predette cose essere la valente Commare pia e devota prima avanti il parto in ricordare alle donne gravide, che mai si conducano a tale passo senza confessarsi e comunicarsi per il manifesto pericolo di morte che accompagna il parto, e poi in persuaderle quanto sia lodevole, e giovevole insieme ne’ nostre pericoli ricorrere alle orazione e intercessione de’ Santi, ma sopratutto a quelle della Gloriosa Madre d’Iddio Vergine sempre la quale havendo pertorito il suo figlio senza peccato, e dolore sarà facile in aiutare quelle, che i loro in peccato concepiscono, e con molte pene gli partoriscono.”}
The emphasis on the physicality of midwifery reflects the traditional hierarchical divisions between what midwives (or surgeons) do and what physicians do. Contemporary descriptions of barber-surgeons, for instance, share a similar preoccupation with physical description, delimiting the work of the surgeon to a manual trade in which one dirties one’s hands – distinct from the physician’s intellectual and theoretical knowledge and practice. Many midwives’ manuals point out midwives’ tactile knowledge to demonstrate its insufficiencies and frequent abuses. Ambroise Parè, for example, depicts the midwife’s touch as threatening and harmful, repeatedly the cause of injury as when “in foolish rashnesse…shee draweth away the wombe with the infant” or when dislocations are caused when the infant is “too carelessly and violently drawne forth by the midwife” or when a watery tumor is caused “by the violent compression of the head by the hand of the Midwife.” In these cases, the midwife’s touch lacks the rational application and objectivity of the male practioner. Female attributes like rashness and emotionality impede a successful delivery.

For Mercurio, however, the midwife’s intuitive, tactile knowledge is presented in a more positive light, as the quality which makes her even more valuable to a pregnant woman than the physician. Whereas for Ambroise Parè the midwife’s touch is destructive, Mercurio’s sees the midwife’s touch as protective and secure: during delivery “the midwife takes with her hand the head of the infant and moves it here and there, two or three times, with great skill in order to better dilate the opening [of the womb]” The power of the midwife’s touch is reinforced

49 Sandra Cavallo, Artisans of the Body in Early Modern Italy (Manchester: Manchester University Press, 2007), 17-19.

50 Parè, 934, 594, 289.

51 Mercurio, Bk. 1, Ch. 23, 85. “Rotte che sarano le seconde, usciranno l’humidità in abbondanza, e all’hora deve la Commare d’estranemente con ambe le mani prendere la testa del figliuolino, e moverla quà, e là, due o tre volte con molta agilità per dilatare meglio l’uscita in quei luoghi angusti...”
further through the inclusion of a rare woodcut depicting the moment of birth. With sleeves rolled-up, the midwife’s strong arms guide the child from its mother’s womb. The scene is calm; only the midwife and her patient take part in this private and female event. Implicitly, this image affirms that the midwife’s knowledge is steeped in her own personal experience of childbirth and thus that her gender makes her particularly able to confront the situation arising in front of her.

As rendered in word and image, Mercurio’s midwife presents a confident figure, highly skilled and experienced. She recognizes the signs of impending birth or potential difficulty and controls these circumstances through touch. She is even presented as presiding over a hierarchy of the birthing room as Mercurio makes clear that she requires her own assistant to undertake more menial tasks and even the important removal of the placenta, leaving the midwife to focus her attention on the delivery of the child. The capable and proactive midwife of _La Commare_ is thus a far cry from the image we are left with in Jacques Guillemeau’s (1550-1613) 1609 treatise, _Childbirth: Or, The Happy Delivery of Women_, in which the midwife is in a clearly auxiliary role to Nature, admonished not “to doe any thing rashly, but suffer nature to worke, notwithstanding in that which shall bee needful.”

Mercurio indeed has considerable faith in the ability of Italian midwives. Noting with some frustration that a strong sense of onestà on the part of both doctors and pregnant women generally keeps physicians from examining them directly, Mercurio nonetheless acknowledges that since this is the case, midwives must be well informed about the potential difficulties arising both during the birth itself and throughout the course of a woman’s pregnancy. Here and in the context of Book Three (which focuses entirely on women’s gynecological diseases), Mercurio

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52 Guillemeau, 86. A similar admonition to the midwife not to interfere with nature’s due course can be found in Pechey, 108: “Therefore the said Midwife, nor any of her assistants, must not do any thing rashly, for to precipitate or hasten Nature.”
reveals the broad range of duties that fell under the purview of the midwife. He advises the midwife to be constantly vigilant for signs of abnormal growths or marks on the body of the pregnant woman, therefore implying that in addition to verifying pregnancy and presiding over the eventual delivery, the midwife was actively involved in the care of the pregnant woman throughout the interceding months.

When delivery finally arrives, the Italian midwife’s expert control over the scene depicted in Mercurio’s text stands in marked contrast to the midwife presented in the work of Parè, Guillemeau, and the collected authors of *The Compleat Midwife’s Practice*. Mercurio’s midwife is able to make the decision as to whether to break the laboring woman’s water, an action prohibited by Guillemeau, and to recognize when a situation is so severe that surgical intervention is necessary. At the same time, Mercurio informs his midwife how to deal with a child who has died in the womb:

First, cover the patient’s face to keep her from seeing so frightening a procedure. Then, with the nail of her middle finger…dig into the dead baby’s abdominal skin…[to] ease the passage of the rest. Next…try to get the creature into a headfirst position and use a hook…to pull it out. If the fetus is feet first…just hook as best you can, being very careful not to wound the mother…

Mercurio continues in horrifying fashion: if the fetus is too large to be removed in one piece, the midwife should proceed to cut the body into pieces in order to evacuate it from the womb.

Significantly, in most other manuals the removal of a dead fetus is clearly within the realm of

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53 Mercurio, Bk. 2, Chap. 26, 158-160.
54 Mercurio, Bk. 2, Chap. 16, 136.
55 Mercurio, Bk. 2, Chap. 27, 161-164. “Avvertisca dunque la Commare, o Cirugico, che avanti si metta a tal impresa, veli la faccia alla patiente, acciò non vegga cosa tanto horribile, e poi aiutandosi con l’unghia del dito grosso, o con altro, cerchi difendere le pelle della pancia, acciò possa tirar fuori le budele, che questo solo basterà a fare uscire la creatura facilmente; ma prima cavi fuori gli intestini. Dopo questo se la creatura morta si ritrova posta con la testa avanti, si debbono fare alcuni uncini fatti a posta, che si porranno in disegno un poco più a basso, e si scciono nella cavità de gli occhi, o dell’orecchia, o sotto il mento, che così commodamente si potrà tirare fuori. Ma se sarà co’ piedi avanti, gli uncini si attachino al meglio, che si può, avvertendo solo di non ferire la madre.”
operations conducted by the surgeon or other male practitioners.\footnote{56} In fact, Mercurio even takes the highly unusual position of advocating his midwives be trained in the use of surgical instruments so that they might handle difficult cases when a surgeon or physician is unable to attend.\footnote{57} Thus, the midwife’s capabilities extend well beyond the management of normal births to include a multitude of serious and risky procedures as well. Nevertheless, even as she wields the surgeon’s tools, treading between the boundaries of popular and professional medicine, she remains for Mercurio an intimate figure.

The midwife must be perpetually aware of the emotional needs of the mother, encouraging her or shielding her when necessary from the unnatural sights before her or comforting her by ensuring that she will deliver a healthy baby boy. Not unrelated, it is up to the midwife to direct the spiritual regimen of the soon-to-be mother in the period preceding her delivery, from confession to the baby’s eventual baptism. She should direct the pregnant woman toward identification with Mary through prayer and use of religious relics, amulets, and images. Just as important, the midwife was responsible for performing an emergency baptism in order to protect the infant’s spiritual fate, if not its life, in an emergency situation.

\textbf{III: Eighteenth-Century Obstetrical Texts and the Emergence of a Professional Discourse}

Throughout the course of the seventeenth century, Mercurio’s text remained the standard reference work for those interested in childbirth and midwifery in Italy, running through at least seventeen editions.\footnote{58} A Venetian statute of 1689 even required midwives to read Mercurio’s text.
in order to obtain an official license. Though translations of Continental works were available in Italy, no new works by Italian authors were published during the seventeenth century. It was not until 1721 when the Venetian surgeon Sebastiano Melli published his *La comare levatrice istruita nel suo ufizio* (The Midwife Instructed in her Duties) that Italian writers reemerged in print on the subject. Although Melli was the first to popularize the term ‘*levatrice,*’ seeming to indicate a more scientifically trained midwife over the traditional ‘*comare*’ or ‘*mammana,*’ his work presented little that was new in terms of either knowledge or praxis. Melli’s text followed Mercurio’s in form, beginning with a section on anatomy, followed by a discussion of normal and difficult births, and concluding with a consideration of the diseases to which parturient women and young infants might be prone.

Like many of the midwifery manuals of the sixteenth and seventeenth centuries, Melli relied on the authority of ancient sources, particularly the Bible, Aristotle, Hippocrates, Soranus and Galen. Early modern midwifery manual writers, almost exclusively men, appealed to the textual authority of ancient wisdom to mask the fact that they had themselves very little in the way of practical knowledge of childbirth. Occasionally these men were called to assist at difficult births or were able to gain access to the body of a deceased pregnant woman; any systematic involvement with childbirth was, however, entirely absent until the eighteenth century. Melli, like Mercurio, also engaged in lively debates with the most prominent midwifery writers of the time, such as Gillemaeu, Mauriceau, and Paré, highlighting the highly inter-textual and self-referential nature of these works. Finally, Melli’s text shares much of the philosophical qualities of earlier manuals, locating the origins of women’s pain during childbirth in Eve’s sin.

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and pondering the wonders of human conception and generation, all the while discussing female reproductive anatomy in imaginative metaphor (often borrowed from other writers).  

Melli, like Mercurio, spends a lot of space describing the ideal midwife. Both agree that the midwife has three main duties: first, to determine virginity and to discern, ahead of marriage, whether a woman and a man are both able to produce children; second, to know if a woman is pregnant or not; and third, to help women before, during, and after childbirth. These first two responsibilities in particular demand a midwife who is discreet, but also well-trained, given the severe consequences potentially involved. She must be punctual, attentive, knowledgeable and experienced, agreeable and comforting in temperament, sober, charitable and, especially, god-fearing. Indeed, Melli then spends an entire page on the sin of abortion. The midwife will also likely find herself in some occasion dealing with a young woman dishonored by an illegitimate pregnancy, a situation once again requiring the utmost discretion and prudence. Melli’s meandering presentation of the midwife’s moral and spiritual obligations includes a page-long digression on virginity and the inclusion of a passage from Ariosto discussing virtue in women. Only then does Melli write that the midwife should also know how to read and write, and to have a complete knowledge of female reproductive anatomy.

61 È la Vulva di figura di un mezzo ovo tagliato per lungo, e nel’ mezzo ha una rimo; perciò il Sig. Scipione Mercurio l’assomiglia al capo del pesce barbo. L’elevatezze che si osservano da una parte, e dall’altra si chiamano Monticoli di Venere, per assomigliarsi a due piccoli monticelli; dilatati un poco i quali, si vedono altre due parti un poco elevate, che per esse risulta la rima-magna, e si chiamano Labbra della Vulva; perché dilatare queste si apre come una buca: Dal Signor Mauriceau vengono chiamate Portiere, da Greci, Pterygometà, da altri impropriamente Ale, e tanto li monticoli, quanto le labra si dividono in destra, e sinistro.

62 Melli, Bk. 2, Ch. 2, 145.

63 Se capitassero di queste tali vi persuade a compartire la fragilità del vostro sesso donnesco, e dopo averle con amorosa correzione notificato lo scapito che incontrano le figlie in commettere tali errore (mentre perdono la loro verginità, vengono colla colpa a restare destitute di onore, e della stime di essere gradite, sapendosi che qualunque pianta senza fiore, è senza prezzo) vi persuade a procedure con tutta la cuatela nell’aiutarle, perché riuscendo bene, abbino stima della vostro abilità. Bk. 2, Ch. 2, 149.

64 Melli, Bk. 2, Ch. 2, 152.
Despite the growing importance attached to a midwife’s formal training and intellectual abilities, this attention to her moral and spiritual qualities remained a staple of Italian midwifery texts in the eighteenth century. In Giacomo Tranquillini’s 1770 instructional guide for midwives, for instance, he writes that the ideal midwife should have a firmness of body and mind, indeed a virile soul not generally found in women, as she must comfort and enliven pregnant women whose pain may cause their spirits to flounder. Next, the midwife need demonstrate the utmost discretion and secrecy (“secrecy comparable to a confessor”). Honor, cleanliness of body and dress, good health, small hands, and agility are also mentioned, all apart from any reference to the woman’s intellectual capacities.\(^{65}\) The midwife was therefore a complex figure, mediating

\(^{65}\) These descriptions can be compared to Pietro Paolo Tanaron’s discussion of the (quite similar) qualities required of a good surgeon-obstetrician: “Un Raccoglitore di Parti deve essere intelligente, sobrio, cioè a dire, non soggetto a vino, e di un animo quieto. Deve essere modesto, e discrete, d’un aspetto grazioso, ben fatto della sua persona, che non abbia nessun difetto corporale, e che abbia molta dolcezza verso le sue ammalate, sopratutto quando egli opera. Deve essere sagace, caritatevole verso le povere Donne, che hanno bisogno del suo soccorso. Non deve essere nè troppo giovine, nè troppo vecchio, ma che sia nel vigore dell’età sua, e che abbia la forza per operare ne’ Parti laboriosi; che abbia una Mano piccolo per poter’introdurla facilmente quando bisogna nell’Utero di una Partoriente, per rivoltare un Bambino mal situate, o per distaccare la Placenta aderente a questo viscere. Finalmente deve avere una perfetta cognizione della struttura, e degli usi degli Ossi della Pelvi della Donna, e degli Organi della Generazione de’ due Sessi, e soprattutto di quelli della Donna tanto esterni, che interni…Un Raccoglitore deve essere discrete nel custodire religiosamente il segreto; imperciocchè s’incontrano spessissimo delle occasioni, ove l’onore e la reputazione delle famiglie gli sono confidate; così s’egli mancasse in questa bella qualità, sarebbe sovente la cagione del disordine delle famiglie, e lo scompiglio di ciò, che fa la buona armonia, e la concordia dell’Umana società. Un Raccoglitore deve avere un aspetto grazioso, e molta dolcezza; imperciocchè egli non deve presentarsi davanti alle Donne, per le quali egli è chiamato, che con una positiva lindura, e affabilità, e non con affettazione e rozzezza, né con un apParécchio d’strumenti capaci di dar loro (come anche agli assistenti) del terrore”/ “A surgeon-obstetrician must be intelligent, sober, that is not subject to wine, and of a calm spirit. He must be modest, and discrete, and of a delicate character, well-constructed physically, without any physical deformity, and with much care toward his patients, above all when he operates. He must be wise, charitable toward poor women, who have need of his care. He should be neither too young, nor too old, but rather in the rigor of his age, and must have the force to operate during laborious births; he should have a small hand in order to be able to insert it easily in the uterus of a pregnant woman when there is the need, to turn a poorly positioned baby, or to be able to detach the placenta from the uterine wall. Finally, he must have a perfect understanding of the structure and use of the bones of the pelvis of a woman e of the organs of generation of both sexes, but above all of those of the woman, both external and internal…A surgeon-obstetrician must be discrete in his religious safeguarding of secrets; since he will frequently encounter occasions where the honor and reputation of families are entrusted to him; such that if the surgeon-obstetrician is lacking in this quality, it will cause disorder for the families, and the confusion of that, which makes the good harmony and concord of human society. The surgeon-obstetrician should have a delicate and very sweet character; for the reason that he must not present himself in front of the women, for whom he is called, unless with a positive delight and affability, and not with stiffness and clumsiness nor with a set of instruments capable of giving the women (and also the assistants) terror.” Pietro Paolo Tanaron, Il Chirurgo-Raccoglitore Moderno (Bassano: 1774), 7-8.
between her patients and both the spiritual and medical worlds which circumscribed her activity.

Despite being written for the improvement of midwives, Melli’s text is curiously short on details relating to normal births. This preponderance on malpresentations and other birth pathologies reflected medical men’s exclusion before the eighteenth century from almost all natural births. Instead, La Comare Levatrice details chapter by chapter different causes of difficult births, followed by a series of plates detailing the various positions a fetus may take in the womb. These artistic renderings share much with their seventeenth-century French counterparts, which have been extensively studied by Lianne McTavish. According to McTavish, the depictions of fetuses in many early modern midwifery manuals participated in a self-conscious misrepresentation of the actual situation in the womb. Full-term fetuses are shown floating, often completely extended, in wombs with ample space, quite unlike the actual cramped confines of the womb at the end of pregnancy – a fact fully known by the men writing these texts. While the mother has been reduced to the womb, or perhaps a torso, the fetus, always male, is presented as the focus of an implied male expert. Though the text accompanying such images contrasted with the visual message they imparted – both the mother’s labor and physicality, and the fetus’ cramped positioning in the womb were highlighted in the written material – these images nonetheless served as “ideas in visual form that could guide the cerebral activity of practitioners asked to intervene in difficult deliveries.”66 By reducing an infinite number of possible malpresentations to a dozen or so “ideal” types, early modern representations of fetuses functioned as “diagrams meant to provide support for surgeon men-midwives’ haptic acquisition of knowledge of the womb without offering a visual likeness of the womb.”67

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66 McTavish, Childbirth and the Display of Authority, 188.
67 McTavish, Childbirth and the Display of Authority, 190.
Furthermore, the visual depictions of fetal presentations in Melli’s text highlight the surgical intervention required to ‘see’ inside the womb. The flesh is cut and pulled back to offer a view of the fetus inside the womb, evoking men-midwives’ frequent argument that their anatomical knowledge provided them a more thorough and scientific understanding of childbirth than midwives’ solely tactile experience.

Melli’s manual, published in 1721, marks a transitional moment in scientific writings about childbirth. For the first time, in France, Holland, and Britain, if not yet in Italy, medical men were beginning to establish childbirth as a field of knowledge rightly belonging to medicine. Generally within the context of surgical education, courses in obstetrics emerged in universities, academies, and in private homes for the edification and practical training of male practitioners. Indeed, by the time the next spate of Italian midwifery texts were published, in the 1760’s, both the institutionalization of formal instruction for midwives and the establishment of university posts in obstetrics were common features of Italian medical practice, particularly in larger cities and university towns. The contrast between the later midwifery texts, which proliferated in Italy after midcentury, and their predecessors is marked; although structurally reminiscent, the content in later manuals has been much altered.

In Italy, the midwifery texts published in the second half of the eighteenth century were predominantly authored by elite, university-trained surgeons (medici-chirughi) who were typically involved in the teaching of obstetrics, either at the universities, in local medical colleges, or even through private lectures in their own homes. Several of these writers also instructed female midwives at the first Italian midwifery schools: Guiseppe Vespa in Florence.

68 Courses of instruction in obstetrics were offered to surgeons and physicians in Turin (1732), Ferrara (1750), Bologna (1757), Florence (1758), Siena (1762), Pavia (1764), Milan (1768), Padua (1769), Venice (1773), Rome (1786), and Genoa (1799). Pancino, “La Comare Levatrice,” 630.
Pietro Sografi in Padua, and Vincenzo Malacarne in Venice all wrote treatises on childbirth. For the most part, however, these texts were directed at other surgeons interested in learning obstetrics. Although the author might casually note that their text might be used for the instruction of midwives as well as surgeons and other male practitioners, their lengthy anatomical discussions and emphasis on difficult and non-natural births suggest that the main audience was other learned surgeons. Most significantly, the later eighteenth-century texts were engaged in a self-conscious effort to define through print a new field of surgical practice in an area that had not traditionally even been considered medical. Unlike the sixteenth- and seventeenth-century midwifery manual writers, eighteenth-century authors were writing about a set of practices and beliefs for which they had begun to accumulate significant first-hand evidence and experience. Also apart from the early texts, which were, in Helen King’s words, “a combination of antiquarianism, irrelevance, salaciousness and the blindingly obvious,” the obstetrical texts of the later eighteenth century actually offered new knowledge, forged through the application of theory to practice.69 Indeed, it was this combination of theoretical and anatomical learning applied to practice upon which the new class of surgeon-obstetricians would base their claims to medical authority in childbirth.

It is therefore not surprising that the Pavian medico-chirurgo and professor of Obstetrics Giuseppe Nessi opens his treatise Arte Ostetricia Teorico Pratica (1779) with claims to both textual mastery and practical experience: “The obstetrical treatise that I present to you…is the result of how much I have excavated from the writing of numerous Authors, and from many favorable and sinister observations made in various places, and at various times at the beds of

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69 Helen King, “As if none understood the art that cannot understand Greek': the education of midwives in seventeenth century England,” 184-198 in The History of Medical Education in Britain, eds. Vivian Nutton and Porter, Roy (Amsterdam: Rodopi, 1995), 189.
Pregnant and Post-partum women, and recorded with diligence and precision.”70 Nessi thus holds the value of his treatise as much in his own experiences and observations as those of either the ancients or contemporary obstetrical writers. In fact, Nessi boasts that he has excised from his treatise much that bogs down other similar texts; he has abandoned “superfluous digressions, however erudite they might be, and useless reflections, however connected, touching instead on only those circumstances, which can instruct” and improve one’s practice.71 Decades before Nessi, the Florentine surgeon Giuseppe Vespa, who had been trained by the famed French obstetrician Leveret in Paris, made a similar pronouncement when he was named chair of obstetrics at the medical school of Santa Maria Nuova hospital. After disparaging the wandering, often senseless practice of studying only other authors, Vespa praises the practices of observation and experimentation in science and medicine. Was it not more fruitful, he questioned “to interrogate [nature] with repeated experiments, penetrating into her secret recesses with the force of assiduous and well-thought-out observations?”72 Likewise, Pietro Paolo Tanaron, professor of obstetrics and surgery at the University of Pisa, in his 1774 treatise, *Il Chirurgo- Raccoglitore Moderno*, wrote of obstetrics as a field that was constantly in the process of perfecting itself, rather than a discrete body of knowledge that could simply be transmitted from generation to


71 Nessi, iii. “A tal effetto, ho procurator di esprimermi con istile semplice e facile, e non distrarre lo spirito di chi leggerà con digressioni superflue, quantunque erudite, e riflessioni inutil, quantunque connesse, toccando ne’fatti soltanto le circostanze, le quali possono istruire…”

72 Giuseppe Vespa, *Dell’Arte Ostetricia Trattato di Giuseppe Vespa Professore di Chirurgia, diviso in tre parti procedute da vari ragioanmenti* (Firenze: Appresso Andrea Bonducci, 1761), 2. “Di quanto mai sono gli uomini debitori a quei sommi Spiriti, che sdegnando il basso invecchiato metodo di pensare per via di vane ipotesi, o sistemi fondati sull’altrui immaginazione, e di prendere per ispiegazioni certi termini voci di senso, resi venerabili sotto l’ombra di illustri nomi; ebbene i primi il bel coraggio di far uso della propria ragione, ed invece d’innovin la Natura, ed interrogarla con replicati esperimenti, penetrandone ne’ di lei segreti recessi a forza di osservazioni assidue e ben meditate?”
generation. Even though many authors had written on the subject, Tanaron pointed out, observations and experiments made since “have illuminated many facts that were unknown in [those authors’] days.”

Although the obstetrical manuals published in Italy in the second half of the eighteenth century resembled their predecessors in structure, the content of these texts had undergone significant changes, reflecting new advancements in the field. Generally divided into three parts, the manuals move from a discussion of anatomy and the organs involved in generation, to labor, with a concentration on difficult and non-natural presentations, and are often concluded with a discussion of diseases related to childbirth, care for the newborn baby, false conceptions, abortion, and sterility. In addition to the excising of many narrative departures and classical anecdotes, however, the later texts highlight the importance of pelvic anatomy in their first sections. Originating with the reflections of Hendrik van Deventer on the size, shape, and significance of the pelvis in labor, and the careful examination of normal births undertaken by William Smellie, the eighteenth century saw revolution in obstetrical thinking. For the first time, practitioners could systematically determine if a woman would have difficulty giving birth ahead of time. By carefully examining the relation between pelvic size and shape, the orientation of the uterus, and the position of the fetus in the womb, as well as the delivering woman’s posture,

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Deventer believed that nearly all births could be completed without the introduction of instruments.\footnote{Wilson, \textit{The Making of Man-Midwifery}, 181-182.}

Thus while Melli and his predecessors had barely mentioned the pelvis, beginning his section on reproductive anatomy with the “soft” generative parts, writers after midcentury dedicated entire chapters to minutely detailing all the bones which comprised the pelvic basin and how its size and the positioning of the womb within it determined how smoothly or difficultly a birth would proceed. Francesco Valle, for instance, in his 1767 treatise, \textit{Trattato del Parto Naturale e dei Parti Divenuti Dificli per la Cattiva Situazione del Feto} (Treatise of Natural Birth and of Births become Difficult because of the Poor Situation of the Fetus), dedicates some twenty pages to his discussion of the pelvis, before even addressing any other aspect of reproductive anatomy. Likewise, the title of the first lesson in Pietro Sografi’s manual, on which he based his instruction of both male and female students in Padua, reflected the centrality of understanding pelvic structure to the modern conception of obstetrics: “The Definition of Obstetrics and the Description of the Pelvis.”\footnote{Pietro Sografi, \textit{Corso Elementare dell’Arte di Raccogliere i Parti, Diviso in Lezioni} (Padova: 1788), 27.}

In order to determine the good or bad proportions of the pelvis, midwifery-manual authors also championed a new kind of internal examination to be performed on the pregnant woman prior to labor. Called “\textit{il toccamento}” (the touching) or “\textit{l’esplorazione}” (the exploration) in Italian manuals,\footnote{Vincenzo Malacarne, \textit{L’Esplorazione Proposta come Fondamento dell’Arte Ostetricia} (Milano: Giacomo Barelle, 1791); Tanaron, 145-158; Nessi, 43-46.} this exam would enable the midwife or surgeon to correctly determine virginity, sterility, whether a woman was pregnant, how close she was to delivery, whether she was experiencing false or real labor pain, and, perhaps most importantly, whether delivery would
be impeded at all by a malformed pelvis. Tanaron describes the procedure thusly: “By “Touching” is meant the introduction of one, or two Fingers into the Vagina of the Woman, after greasing them with oil, or butter (butirro), in order to touch the mouth of the Womb (Matrice), and to identify the figure of this, and to discover by this method that which certainly could not be identified otherwise.” As they advocated for touching as an essential practice in obstetrics, however, male practitioners had to work hard “to counter the cultural norms that aligned touch with at best manual labor and at worst –given what they were touching – with out-right lechery.” The manual exploration of a woman’s genitals had to be re-contextualized as an expression of scientific rationality and medical authority, all while maintaining decorum.

At the same time, the touch was essential for extricating the management of childbirth from the whims of the pregnant woman herself. Instead of relying on the patient’s word and interpretation of her own symptoms – for instance her account of stopped menses to indicate pregnancy – the male practitioner could now make determinations based on his own rational understanding and exploration of the female body. As Pietro Paolo Tanaron writes, “all the ways women have thought to know if they are pregnant in the past are notoriously uncertain,” the only “true means [to know] is Touching.” Thus while sixteenth- and seventeenth-century midwifery manuals writers had emphasized their visual mastery of the female body, particularly through

78 Several manual authors note that bone malformations may be caused by childhood or adult cases of rickets. See for instance: Tanaron, Il Chirurgo-Raccoglitore Moderno, 18; Vespa, Dell’Arte Ostetricia, 61; Nannoni, Trattato di Ostetricia, 37.

79 Tanaron, 145-146. “S’Intende per Toccamento l’introduzione d’uno, o due Dita nella Vagina della Donna, dopo averle unte d’olio, o di butirro, per toccare l’orifizio della Matrice, affine di riconoscerne la figura, e scuoprire per questo mezzo ciò che certamente non si potrebbe riconoscere altrimenti.”


81 Tanaron, 148. “Così una donna che non è sicura d’esser gravida, e che vuole assicurarsene, sia che alcune de’ segni sopracennati appariscano o no: il vero mezzo è il Toccamento.”
practices such as dissection and anatomy, eighteenth-century obstetrical authors worked to reappropriate touch from traditional midwives. Long considered the less-worthy counterpart to seeing, touching became, for male obstetrical writers in the eighteenth century, the most important expression of masculine and scientific rationality in the birthing room.82

A much smaller subset of the texts were authored by physicians (medici-fisici), who demonstrated little interest in involving themselves in obstetrics in Italy, at least during the eighteenth century. Traditionally, physicians might be called in by a pregnant woman to advise on matters of diet and regiment, or to prescribe a medication; the practice of obstetrics, however, with its obvious manual component, was considered much too physically involved for the likes of university-trained physicians. In some cases, physicians wrote treatises on obstetrics –usually heavily reliant on classical sources and filled with un-translated Latin - the textual nature of which was well within the appropriate professional parameters of a university-trained practitioner. In at least two cases in Italy, physicians also wrote treatises directed specifically at female midwives. Pared of the lengthy digressions and philosophical discussions of conception and other physiological processes found in earlier midwifery manuals, these physician-authored guides were often composed in dialogue form so as to be most easily understood by and useful to a female audience. As male instructors like Sebastiano Rizzo and Luigi Calza would do in their lectures to female midwifery students, physicians Natale Bernati and Giacomo Tranquillini employed the dialogue form in their texts so that ‘coarse’ female readers could conceive of the practice of midwifery as a series of more easily remembered questions and explanations.83

82 Mark M. Smith, Sensing the Past: Seeing, Hearing, Smelling, Tasting, and Touching in History (Berkeley: University of California Press, 2007), 100-101. Smith notes that obstetrical writers also gendered touch, making their touch represent rationality and restraint, while the midwife’s touch was depicted as irrational, reckless, and harmful.

83 Giacomo Tranquillini, Dottrina della Comare, o sia Breve Compendio d’Arte Ostetricia (Verona: 1770); Natale Bernati, Breve Istruzioni dell’Arte Ostetricia ad uso delle Comare Levatrici (Treviso: Giannantonio Pianta, 1778).
Unlike the treatises discussed above, however, neither of these physician-authored manuals purports to reveal new information; rather, their stated aim is to distill the best of the knowledge presently available into a more approachable form.

At the same time, the manuals directed at midwives made implicit and explicit judgments about the intellectual abilities of women, the current state of midwifery, and the appropriate professional boundaries between various kinds of medical practitioners. For instance, the Trevisan physician Natale Bernati’s use of the dialogue instills immediately a strict hierarchical relationship between doctor and midwife. The midwife’s traditional mode of learning through long practice is quickly revealed as inadequate in the eyes of the physician:

Medico: But with what foundation do you practice your Trade?

Comare: I practice in the manner, that I have learned watching those other women older than me perform [the office of Midwife].

This is all well and good, responds the doctor, when the birth is normal (which, he says, requires little study, and little effort), but what about when the fetus is poorly positioned and the woman finds herself in difficulty? The midwife responds that traditionally she has used cordials, powders, and waters to move along the birth (an obvious simplification of the activities of most midwives), or else called in assistance from another midwife, a surgeon, or a physician. The doctor’s response is patronizing: “My dear woman, if this is all you know, you are little expert in your Art, and it is necessary that you learn many things, if you want to exercise your Profession with honor and utility for your Clients.” Nevertheless, the midwife answers obsequiously that she will gladly be instructed by the doctor, whose knowledge vastly exceeds her own, as she

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84 Bernati, 9. “Medico: Ma con quai fondamenti practicate il vostro Mestiere? Comare: Io lo faccio nella maniera, che ho imparato vedendo operare altre più vecchie di me.”

85 Bernati, 10. “Donna mia cara, se altro non sapete, voi siete poco perita nella vostr’Arte, e vi è necessario imparare molte cose, se volete esercitare la vostra Professione con onor vostro ed utile delle vostri Clienti.”
often agrees elsewhere when the doctor notes her lack of understanding of various topics (“M: I see first of all, that you are little informed about the internal organs, and [anatomical] parts that everyday you are required to treat. Is that not true? C: Very true”). Thus the physician can erase in print the widespread resistance to male, scientific intervention in childbirth which emerged so clearly when states began to experiment with institutionalized, formal instruction of midwives.

Tranquillini, a medico-fisico from Rovereto, wrote in the preface to his 1770 treatise that he was compelled to such an undertaking because of the great lack of initiative in Italy toward instructing its midwives, despite their unquestionably important service to the public good. At present, he wrote, doctors were loathe to involve themselves in the training of women, and manuals on the subject were either too cumbersome and “poorly ordered, or too limited, and therefore obscure…or written in languages that our women do not possess,” resulting in the fact that “this art is practiced by unlearned persons,” causing many “pitiful disorders.” Tranquillini’s manual is divided into ‘dialogues’ and is organized somewhat differently from the texts discussed above. In the first dialogue, Tranquillini engages his ‘disciple’ (discepola) in a conversation about the necessary qualities a midwife must have; the anatomical parts relative to generation; fecundity, conception, and sterility; and the growth of the fetus in the womb. The second dialogue covers the possible range of birth situations, including difficult births and false conceptions. The third dialogue diverges from other texts, however, by addressing a veritable compendium of ‘diseases’ and difficulties a pregnant or post-partum woman, or a newborn child might face – such as coughs, hemorrhages, swelling, venereal diseases, fevers, and so forth.

Although beginning with the standard criticism of the great disorders caused by ignorant

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87 Tranquillini, Dottrina della Comare, v-vi.
midwives, Tranquillini nevertheless takes a considerable less condescending tone toward his female readers than does Bernati, as demonstrated partly by his more complex treatise.

Hardly a brief treatise at some 270 pages, Tranquillini’s manual indeed suggests a great deal of confidence in the abilities of a well-informed midwife. His lessons cover manually turning a mal-presenting fetus, how to perform a manual exam prior to labor to predict if there will be difficulties during the birth, how to check manually to see if the fetus is dead, how to extract a dead fetus, and the use of instruments in certain situations – all operations other authors suggested be in the hands only of male practitioners. As evidenced by Tranquillini’s extensive information on the diseases of women and children, the physician implicitly acknowledged the reality most Italian midwives experienced on a day-to-day basis in the eighteenth century. While urban midwives might reasonably have timely access to a trained surgeon or physician, those in rural settings were largely on their own, regardless of whether a situation required “the aid of art” (surgery or instruments). Thus while surgeons with a personal interest in obstetrics emphasized in their writings the deference of female midwives to male practitioners and the necessity of calling in a surgeon immediately when labors became difficult, Tranquillini, as a physician less concerned with professional rivalry, may have felt freer to instruct midwives more comprehensively.

By contrast, when surgeons wrote to instruct midwives, their advice to female practitioners was quite different. The Bergamese surgeon, Orazio Valota, for instance, was much more conservative than Tranquillini in the instruction he gave to his female audience in his 1791 manual, La Levatrice Moderna (The Modern Midwife). 88 It may be useful here to compare several passages from the texts of Tranquillini, Bernati, and Valota to better understand the

88 Orazio Valota, La Levatrice Moderna, Opera Necessaria all Comari, ed Utile ai Principanti d’Ostetricia, ed ai Reverandi Parrochi (Bergamo: Locatelli, 1791).
broader epistemological differences between the works. For example, the following passages describe a midwife’s responsibilities in a delivery made difficult by some odd presentation of the fetus (ie hands, neck, thighs, etc. are presenting). Bernati, explaining how a midwife should handle a fetus presenting with his hands above or close to the head, says that if the woman had already delivered many children and has a “soft orifice” then the situation may not need much special handling at all, just that the midwife ensure that the head and hands are not set at angles from each other. If, instead, the midwife believes the positioning will render the birth difficult, she must:

I. Transport the pregnant woman to bed, situated such that she is horizontal, or with her posterior slightly raised.

II. Push the fetus back lightly toward the back of the uterus, resting the end of your fingers above one of the shoulders.

III. Put the hands and the arms of the fetus back to their sides, and hold back the head close to the vaginal opening until a contraction occurs.

IV. Obtaining with this contraction, that the head penetrates the vaginal opening, meanwhile make sure that the hands and arm do not move.

V. If it is difficult to direct the arms, and you fear a laborious birth, pull the fetus out by its feet. 89

Tranquilli, after considering the reasons for such a presentation (hands first), instructs the midwife that:

This position cannot be certified for sure, except after the waters have broken; before, therefore, that this part advances in the vagina, and that the waters have stopped flowing, position the mother in bed, with her buttocks raised, as I have told you other times; you will reintroduce into the uterus the hands which have come out, and immediately after, climbing with the hand up the body of the fetus, you will aim to find the thighs of the same, which you will turn little by little toward the belly of the fetus, taking the legs, and

89 Bernati, 34-35.
I. Portando in letto la partoriente situate in modo che se ne stia orizzontalmente, o un poco sollevata con le natiche.
II. Respingendo leggermente il fanciullo verso il fondo dell’utero appoggiando le punta delle dita sopra una delle di lui spalle.
III. Rimettendo le mani, e le braccia del fanciullo a lati, e trattenendo il capo vicino all’orificio fino arrivi un qualche premito.
IV. Procurando con questo premito, che il capo penetri l’orificio, e frattanto impedire il movimento delle mani, e del braccio.
V. Se con difficoltà si possa dirigere le braccia, e si tema il parto laborioso, si tragga per i piedi.
next the heels, forcing them skillfully toward the mouth of the uterus; and if you can’t
grasp but only one thigh, force first this one, that in following you can easily find the
other; in that manner, push the feet in the mouth of the uterus, and pull little by little,
making sure that in the pulling, as in the turning of the fetus, if it comes with the face
toward the front, you observe all the cautions, that.. I have taught you.90

Finally, in this situation,91 the surgeon Valota instructs the midwife to do the following:

Since the fetus in the above-mentioned presentations always finds itself obliquely
situated, thus the only remedy is the extraction of the fetus by its feet, an operation which
belongs to the Surgeon; therefore the Midwife will have the diligence to know the part
presented, and so will call the Surgeon.92

The difference between Vaolta’s recommendations and those of Tranquillini and Bernati are
quite striking. While the latter clearly see the manual turning of the fetus in utero as well within
the midwife’s capabilities, for Valota the midwife’s sphere of intervention has been
circumscribed dramatically. Not only are those situations which might require a surgeon’s tool
out of the female practitioner’s reach, but so, too, are a number of difficult natural situations
traditionally handled by women.

In fact, Valota’s text is clear evidence that even a midwifery manual written explicitly to
instruct female midwives might not necessarily be destined to be owned or read by women
independently. Valota’s manual, for instance, includes a preface directed specifically to the

“doctors and surgeons of Brescia,” whom he implores to learn the art of obstetrics, particularly

90 Tranquillini, 104. “Non si può ben certerificarsi di questa positura, che dopo rotte le acque; innanzi adunque, che
s’avanzì questa parte nella vagina, e che terminino d’uscire le acque, posta la madre in letto, ed alzate le sue
natiche, come vi dissi altre volte, farete che ritrocedano nell’utero le uscite mani, e subito dopo rampicando colla
mano per il corpo della creatura, procurerete di ritrovar le coscie della medesima, le quali tirate a poco a poco
verso il ventre della stessa, prenderete le gambe, e in seguito le calcagna, riducendola destramente alla bocca
dell’utero; e se non poteste ghermire, che una sol coscia, ridurrete prima questa, che in seguito poi più facilmente
ritrovare l’altre; in tal maniera ridotti i piedi nell’orifizio dell’utero, tirarete a poco a poco, osservando si nel
tirare, come nel voltar la creatura, se venisse con la faccia verso il davanti, tutte quelle cautele, che a suo luogo vi
ho fatte imparare.”

91 In fact, when the fetus’ neck, shoulder, back, chest, abdomen, arm, hand, or hip presents, Valota’s instructions are
all the same.

92 Valota, 124. “Siccome il feto nelle suddette presentazioni si trova sempre trasversalmente situate, così il remedio
unico è l’estrazione del feto pe’ piedi, operazione che al Chirurgo appartiene; sicchè la Comare farà la diligenza di
conoscere la parte presentata, indi chiamerà il Chirurgo.”
given the current situation in which “the midwives of my Province do not take care to train themselves in their art and continue in such a delicate moment to act with ignorance and presumption, discunt periculis nostris, et experimenta per mortes agunt (they acquire knowledge from our dangers and they experiment by way of our deaths).”

Valota’s invective against the ignorance of midwives was common in both texts directed at male practitioners and those intended to train midwives themselves. The Brescian surgeon writes that it was his compassion enlivened by the disastrous consequences of midwives’ rash acts which most compelled him to write his treatise: “I have seen many miserable victims of their carelessness. How many mothers killed in the flower of their years because of inexpert Midwives! How many children torn apart, mutilated, killed because of the reckless attempts of the same!” This oft-repeated, if dramatic, reproach against female practitioners functions to justify the distinctly limited role Valota envisions for them while simultaneously reinforcing the need for the still controversial field of obstetrics, which was by then conceivably taught and practiced by men.

Side by side with such polemic against female midwives in many midwifery manuals stood also the disparagement of other male obstetrical writers and practitioners. In Lorenzo Nannoni’s case studies, the obstetrician often finds himself summoned to situations that have been mishandled, not by midwives, but by male surgeons or physicians before him who are little trained in the art of obstetrics. In the preface to the Neapolitan surgeon-obstetrician Pio

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93 Valota, viii. *Le Levatrici della mia Provincia, non si curano di abilitarsi nell’Arte loro e continuano in un punto così delicato ad operare con ignoranza e presunzione, discunt periculis nostris, et experimenta per mortes agunt.* The Latin quote comes from Pliny, *Naturalis Historia,* 29.18, describing greedy Greek doctors out only to make money for themselves.

94 Valota, viii. “Io ho vedute molte vittime miserabili della loro temerità. Quante madri uccise sul fior degli anni dalle inesperte Levatrici! Quante figli straziati, mutilati, uccisi dal termerari tentativi delle medesime!”

95 Nannoni, eg. 102 (osservazione xvii), 106 (osservazione xix), 203 (osservazione xxii).
Urbano Galeotti’s 1787 treatise, *Ostetricia Practica*, likewise, the author spends as much time lamenting the current situation in which ignorant midwives botch births as he does describing how many inexperienced surgeons recklessly wield their instruments to the detriment and physical harm of women and infants.\(^96\) In one case related by the Neapolitan surgeon, both mother and baby became “victims” of the unskilled hands of an ignorant surgeon who did not know to rotate the infant during a feet-first delivery, resulting in the head catching on the pubic bone and leading to a severe infection.\(^97\) Galeotti links these kinds of disastrous results to lack of hands-on training. Galeotti’s own knowledge, by contrast, gained through personal experience as demonstrated by his case studies, is presented as clearly superior to that of manual writers whose information is based predominantly on other texts. In discussing feet-first deliveries, for instance, Galeotti finds incredulous that many authors describe “as natural” that kind of birth, though he admits he would not be so dubious except that he has “seen in practice those problems the passage of the head of the fetus is subject to” when delivered this way.\(^98\) Even the use of machines and models cannot recreate the same kinds of difficulties that may arise during an actual birth and befuddle the male practitioner with such limited experience.

Print was a particularly male medium, and one which became critical to the professionalization of medicine in the late eighteenth century. For instance, the establishment of new print forms, such as the scientific journal, highlighted clinical findings, and fostered

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\(^97\) Galeotti, *Osservazione Terza*, 75-76.

\(^98\) Galeotti, 71-72. “Ho più volte intense dire, che può chiamarsi naturale quell parto, in cui il feto si presenta coi piedi. Io ho tutta la mia difficoltà a crederlo, e questa difficoltà non l’averei, se non sapessi, e se non avessi veduto in pratica a’ quali inconvenienti è soggetto il passaggio della testa del feto dall’orifizio dell’utero, e dall’arco della pube.”
competition between male obstetrical practitioners. Their writings became a fundamental component of the development of obstetrics as a distinct medical and professional field. As Jeanette Herrle-Fanning has argued in her study of eighteenth-century British midwifery texts, “scientific midwifery” (later obstetrics) was a profession which in many ways wrote itself into existence by evolving a system of publication and lecturing that disseminated a new kind of knowledge about reproduction.” By comparing his knowledge to other (male) practitioners’ in print, a surgeon-obstetrician could help solidify for himself a position among the elite in a burgeoning field.

Whereas in the seventeenth century a childbirth writer could assert his authority through the mastery of classical authors, during the eighteenth century this reliance on acquired wisdom became insufficient. As a growing number of male practitioners gained access to women’s bodies before, during, and after delivery, first-hand accounts of their interventions appeared more commonly in midwifery and obstetrical manuals. Increasingly the case study, in which the male surgeon or practitioner could become the subject of the birthing event, became critical for an obstetrical writer to establish his experience and expertise. Moreover, case studies, which often highlighted and praised the manual skill of the male practitioner, were reflective of the distinctly surgical nature of obstetrics and linked eighteenth century midwifery manuals with earlier surgical treatises, which also commonly included them. As Eve Keller notes, the case history also became a valuable medium through which early modern male medical practitioners could engage in the “consolidation of a subject gendered as masculine, a subject that is

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100 Nancy G. Siraisi, Medieval and Early Renaissance Medicine: An Introduction to Knowledge and Practice (Chicago: University of Chicago Press, 1990), 170-172; McTavish, Childbirth and the Display of Authority in Early Modern France, 40; Joseph P. Byrne, Health and Wellness in the Renaissance and Enlightenment (Santa Barbara: ABC-CLIO, 2013), 130.
autonomous, authoritative, self-directing, and, above all, distinct from the body.” Thus in their case studies, male authors evoked female bodies that could be subjugated and mastered by rationality and “the modern transcendence of the masculine mind.” According to Lianne McTavish in her study of French treatises, despite their claims to first-hand, unique experience, these case studies often followed closely to known narrative scripts:

They typically begin by stating the date of the incident and providing information about the client, such as her husband’s occupation. The tales then give an overview of the women’s physical condition, stressing its dire nature while referring to the one or more previous practitioners who had only made it worse through mismanagement. The surgeon man-midwife’s heroic entrance into the lying-in chamber is thereby positioned as a turning point; his intelligent interventions bring the woman, and sometimes even her child, back from the brink of death.

Although Italian authors were less likely to include numerous case studies in their manuals than some of their Continental and British contemporaries, likely owing to their generally more limited intervention in actual births, there are a few examples which should be noted. For instance, the Tuscan surgeon Lorenzo Nannoni and the Neapolitan surgeon Pio Urbano Galeotti (who was in fact trained in Florence under both Lorenzo’s father Angiolo and Giuseppe Vespa) for instance, both included a series of case studies (osservazioni) in their midwifery treatises. Nannoni’s twenty-four case studies, studded throughout the text, do in fact generally conform quite closely to the model identified above by Lianne McTavish. In one osservazione concerning an obstructed birth, for instance, Nannoni writes that:

A vigorous woman, wife of a farmer for the Monastery of San Ambrogio, had become pregnant for the first time around the age of forty. She reached the end of her pregnancy at the beginning of November 1784. The vaginal opening dilated sufficiently, the waters

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102 McTavish, 40.

103 Lorenzo Nannoni, Trattato di Ostetricia e di lei Respettive Operazioni (Siena: Luigi e Benedetto Bindi, 1788). Francesco Valle also occasionally makes references to his personal experiences treating women in his manual.
poured slowly, and the head presented, but the back of the head was turned facing upward, in the manner such that the head was presenting with its greatest width at the smallest part of the pelvic inlet (stretto superiore) and was immediately an obstacle to the good outcome of the birth. The pains kept up for some time, with any good result, when I was called in. I managed with some fingers to put the head in a better position, pushing back the frontal protuberances, and recalling the back of the head laterally, and I made an emission of blood to reduce the resistance of the external parts. The head was maintained in the same situation, and, so, having waited unfruitfully for some hours, I resolved to operate, which I did with the pincers (tenaglia), which I put rather far internally, and grasping the head of the fetus, I noted, that still pulling in that manner, in which the head presented, it would give way, and so in that direction I pulled, and I extracted [the fetus] alive…The woman has in succession become pregnant again, and gave birth successfully.\textsuperscript{104}

Although there is no fumbling midwife or inexperienced surgeon to blame in this case history, Nannoni does present a situation that has become irresolvable except by his own skillful application of the surgeon’s tools, which done, produces rather easily a happy outcome.

Nannoni’s case studies also highlight the wide extent of his knowledge, which includes not only obstetrics but also gynecology. Nannoni recalls, for instance, his treatment in 1782 of a young woman afflicted with a venereal disease which she had caught from her bookseller husband.\textsuperscript{105}

Galeotti’s twenty-six case studies form the entire second part of the author’s manual, following a very concise first part which includes only brief discussions of generation, conception, the development of the fetus, and natural births (as well as three additional case

\textsuperscript{104} Nannoni, 214-215. “Una vigorosa donna moglie d’un Fattore del Monastero di S. Ambrogio, ingravidò per la prima volta nell’età di circa quaranta anni. Giunse al termine della gravidanza al principio di Novembre 1784. L’orifizio si dilatò alquanto, le acque colarono, ed il capo si presentò, ma l’occipite riguardava alquanto anteriormente, di maniera che presentandosi il capo col maggiore diametro al più piccolo dello stretto superiore, era subito un ostacolo per la felicità del parto. Si mantenevano da qualche tempo i dolori, senza alcun buon risultato, quando io fui cercato. Procurai con alcuni diti di mettere nella migliore situazione il capo, respingendone le protruberanze frontali, e richiamando l’occipite lateralmente, come feci un’emissione di sangue per allontanare la resistenza delle parti esterne. Si mantenne il capo nella medesima situazione, e perciò, avendo aspettato infruttuosamente alcune altre ore, mi risolsi d’operare il che feci con la tanaglia, che portai assai internamente, ed abbrancato il capo del feto, rilevai, che ancora tirandolo in quell senso, nel quale si presentava, avrebbe ceduto, e perciò in quella direzione lo tirai, e l’estrassi vivo. Per regolata forza, che procurassi di fare, rimasero sempre danneggiate alquanto le parti molli, e sopra tutto il claustro-vagitale, nel cui tratto nacque un’esulcerazione cancrenosa, quale terminò felicemente, avendo avuta solamente allora la precauzione di allontanare le Parèti della vagina, per impedirne la coalescenza. La donna ha in seguito ringravidato, e partorito felicemente.”

\textsuperscript{105} Nannoni, 98-99.
Clearly, Galeotti’s text represents a shift away from the lengthy theoretical treatise to obstetrical manuals structured entirely around cases and a practitioner’s personal experiences and observations. Galeotti’s cases also conform closely to McTavish’s script, frequently featuring erring midwives; at least three times, the author is called in to assist when a midwife has misidentified the part of the fetus presenting, mistaking a shoulder or thigh for the fetus’ head.

Yet, Galeotti’s case studies at times differ from those described by Eve Keller in treatises by mid-eighteenth century British practitioners like Edmund Chapman and Percival Willughby. Keller writes that the case studies in British texts reflect the broader “shifts in the self-presentation of the practitioners and in their constructed connection to others in the birthing process” occurring in the late seventeenth and early eighteenth century. In particular, these accounts reveal a “childbearing woman” who is “decreasingly present as a subject in these texts. Her verbal participation becomes either irrelevant or obviated altogether,” as are the voices of others present at the scene.106

While it is true that Galeotti, like Nannoni, presents himself as the central figure of the birthing events he describes, he is at times also intensely aware of the pregnant woman under his care. In a case which the surgeon describes as one of his most difficult, when a baby presented with its shoulder forward and the pregnant woman’s water had been broken already for three days before he was called in, Galeotti recalls that he was almost unsuccessful in completing the necessary maneuvers because “the screams of the pregnant woman and the difficulty that I encountered in turning the fetus filled me with confusion.”107 Galeotti also emphasizes the youth of the woman, who, illegitimately pregnant, was attempting to keep her condition secret from her

106 Keller, Generating Bodies and Gendered Selves, 170.

107 Galeotti, Osservazione Ottava, 92. “Le strida della Partoriente, e la difficoltà che incontrai nel rivoltare il feto mi empirono di confusione…”
parents and had been attended during her labor only by a young servant. Galeotti relates that the
friend, a maid, had been so troubled by seeing the girl in such great torment and “brought so low,
and fearing death, she put aside every regard, and confided to the mother her [daughter’s]
wretched situation.”108 In another case, Galeotti is not so much overwhelmed but aided by the
woman under his care: “I found this woman lying on her back in bed, all afflicted…and when
she saw me she began to recommend herself to me, giving me signs of courage, and [she was]
very disposed to doing all that I instructed her to do.”109

Thus, while in some instances Galeotti could perform the kind of maternal erasure
described by Keller – he describes one case in which he extracted a dead fetus from a mother
without relating any aspect of the woman’s reaction or mental state.110 He also at times showed
himself intimately aware of the living woman he was treating and allowed the colaborative work
of practitioner and patient to be expressed in his writings. The case study as employed in Italian
obstetrical manuals was therefore a rhetorical device with several, overlapping, and even
potentially conflicting, meanings. On the one hand, the case study was employed ostensibly to
instruct. On the other hand, the case study was clearly a tool employed by male practitioners to
re-center themselves as subjects in the birthing event; to emphasize the individual writer’s skills
and practical experience (often at the expense of both midwives and other less-accomplished
surgeons); and textually to refashion childbirth as an event which could be rationally ordered,

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108 Galeotti, Osservazione Ottava, 90. “Questa era gravida di sette mesi, nel corso dei quali era stata cautelata in
maniera di nascondere alla madre ed ai domestici la sua gravidanza, quale soltanto aveva confidata ad una
Giovane cameriera. Nel corso di questi tre giorni essa spassionava gl’atrocì suoi tormenti colla medesima, talché
vedendosi malamente ridurre, e temendo alla morte, mandò da parte ogni riguardo, e confide alla madre la
disgraziata situazio.”

mi vide cominciò a raccomandarmisi, dandomi segni di coraggio, e dispostissima ad eseguire quanto da me le
veniva ordinate.”

110 Galeotti, Osservazione Duodecima, 109-111.
understood, and managed. The fact that some writers included those cases with tragic outcomes, where mother and/or baby died; or mentioned the screams and miserable circumstances of their patients meant that even highly-trained male practitioners were not always successful at conforming to the infallible and stoic image they wished to present of themselves.

IV. Theological Embryology and the Cesarean Operation

A final aspect common to all the eighteenth-century Italian midwifery texts, which bears considering, is their emphasis on baptism.111 While most authors dedicated a chapter to the necessity of instructing midwives and other practitioners in the baptismal rite, so that they could perform it in the case of emergency, there were even entire texts published in this period on the subject. The priest Girolamo Baruffaldi’s 1746 treatise, La Mammana Istruita per Validamente Amministrare il Santo Sacramento del Battesimo (The Midwife Instructed in how to Validly Administer the Holy Sacrament of Baptism), runs nearly seventy pages and includes twenty chapters detailing the situations in which a midwife might be called on to perform a baptism, the correct procedure, what to do if the child then survives, and whether or not a Christian midwife can deliver a Jewish mother.112 As Claudia Pancino notes, an emphasis on the midwife’s religiosity and good Christian character made particular sense in the sixteenth and seventeenth centuries, when midwifery was overseen and regulated almost exclusively by the Church and the only sanction a midwife required to practice was the approval of her parish priest. What requires further examination, however, is the fact that the eighteenth century saw only an increase in the

112 I refer to the 1774 reprint. Girolamo Baruffaldi, La Mammana Istruita per Validamente Amministrare il Santo Sacramento del Battesimo in caso di Necessità alle Creature Nascenti (Venezia: Pietro Savioni, 1774). The treatise was first published in 1746.
Church’s preoccupation with the salvation of newborn souls, a concern echoed in the midwifery texts of the period.113

Part of the impetus for this preoccupation with baptism in the eighteenth century came from new scientific discoveries relating to embryology and the heated debates about ensoulment and animation which resulted. While some argued that the advanced organization of the animal embryo attained during development existed complete in some form from the time of conception (preformationists), others held that the embryo developed gradually from unorganized matter (epigeneticists). The notion behind preformationism that essentially an entire human being was present at conception, only waiting to be revealed over time during development, appealed to Christian theologians who seized on the opportunity to harness science to support a religious worldview. To such thinkers, the preformation thesis allowed for the argument that human ensoulment began at conception, something that aligned well with the idea of Mary’s Immaculate Conception. This represented a quite drastic revision of traditional Aristotelian and Thomistic doctrine on ensoulment which held that animation began at between thirty and forty days for males, and seventy to eighty for females. These figures provided the basis for both Church and legal codes; that is to say, abortion was only considered a crime if carried out after these supposed points of animation. They also shaped women’s own perceptions and understandings of pregnancy, as, in the early stages after conception, there was seen not to exist a child, but rather an unformed mass that could still be false pregnancy (mole), retained menses signaling some kind of ill-health, or even something more malicious or monstrous.114

113 Pancino, “La Comare Levatrice,” 615.

One of the works inspired by these new discoveries and debates was the extraordinarily influential treatise of Francesco Emmanuele Cangiamila, *Embriologia sacra: Ovvero dell'uffizio de' sacerdoti, medici e superiori circa l'eterna salute de' bambini racchiusi nell'utero* (“Sacred embryology: That is, on the duty of parish priests, physicians, and officials with respect to the eternal well-being of infants still in the womb”). Cangiamila, who was a Palerman priest at the time he wrote his influential treatise, eventually became bishop of the dioceses of Palermo as well as head inquisitor of Sicily. Deeply influenced by the thought of preformationists who argued that the soul entered the embryo at or directly after conception, Cangiamila was also especially concerned about what he perceived as rising rates of abortions.\(^{115}\) Even worse than the loss of life entailed in abortion, however, was the fact that, in many cases, no efforts had been made to baptize these countless unborn fetuses. The *Embriologia Sacra* thus included chapters on the causes of voluntary and involuntary abortion, how priests can help to prevent them, whether animation begins at conception, and the procedures for baptism in a variety of cases. A bestseller, *Embriologia Sacra* was translated into numerous languages and remained a relevant and much-cited work well into the nineteenth century. In fact, the *Embriologia Sacra* even had a direct influence on legislation in Cangiamila’s native Sicily. The work received both Papal support and the endorsement of the Spanish King of Sicily, Charles III (later to assume the Spanish crown), who went so far as to issue a decree in 1749 making the cesarean operation mandatory for women who died while pregnant (even if there was only the suspicion of pregnancy).\(^{116}\)

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\(^{115}\) He spoke in terms of both voluntary and involuntary (what today would be called miscarriages) abortions.

Overall, Cangiamila’s position on baptism and the cesarean section was an extreme one. Owing to his belief that ensoulment followed closely if not immediately after conception, the priest argued that baptisms should be performed on all abortions, even those which occurred in the early days of a pregnancy. He also advocated that the cesarean operation be performed not only on all dead women that were suspected or known to be pregnant, but in certain cases on live women as well, even though surgical conditions at the time effectively ensured the mother would die in the latter situation. The text explains in detail how the fetus can survive for short periods in the womb even after the mother’s death, cause, according to Cangiamila, to intervene with a post-mortem cesarean at such times. Furthermore, parish priests would have to be ready and willing to perform the procedure themselves, as the reluctance of relatives to the dissection of the pregnant woman or the non-payment of a surgeon might prevent others from acting.\textsuperscript{117}

With the introduction of theories which potentially moved animation all the way back to conception, however, writers like Cangiamila began to think of the fetus as, if not an individual, then at least a creature independent of the mother who was deserving of the tutelage of the state. Thus according to Cangiamila, the fetus “becomes animated” in the first few days, if not immediately after conception, and therefore, “however small…it nonetheless is living…and is therefore never licit to murder it.”\textsuperscript{118}

Of course, it was not only priests who discussed the cesarean section in print. A number of learned physicians and surgeons, as well as some state officials and lawmakers considered the procedure in their writings. As early as the late sixteenth century, in fact, the first Italian

\textsuperscript{117} Cangiamila, \textit{Embriologia Sacra}, Bk. II, Ch. VIII, 138-142.

\textsuperscript{118} Cangiamila, \textit{Embriologia Sacra}, 16. “Il feto venga animato ne’ primi giorni, e forse subito dopo il concetto, e che in circostanze di aborti la prima cura, che debbe aversi’, è di osservare, se il detto Feto, quantunque piccolissimo, si muove, e in conseguenza ha vita, per subito battezzarlo, e non è lecito ucciderlo.”
midwifery manual printed on the peninsula, Scipione Mercurio’s *La Commare o Raccoglitrice*, had described the cesarean operation in glowing terms, having seen the operation performed on a woman in France during his training. A Dominican friar as well as a physician, Mercurio even claimed that the cesarean could be safely executed on a living woman, though he recommended that only surgeons and physicians attempt the operation. By the second half of the eighteenth century, few Italian midwifery manuals failed to engage the topic. There were even occasional texts devoted entirely to the operation, such as the Venetian Girolamo Persone’s *Dissertazione sopra l’Operazione Cesarea* published in 1778. An advocate of the operation, Persone, who was a member of the Venetian college of physician-surgeons, attempted in his dissertation to extensively detail the reasons why the cesarean operation was non-lethal and could be performed on a living subject. Making comparisons to other surgical procedures commonly practice at the time, such as the removal of kidney stones, Persone argued for the safety of cesarean section and claimed to have performed it himself several times on women in Venice.

Although there were certainly some practitioners who argued against the cesarean entirely, there was also a range of opinions among the operation’s proponents as to when, how, and by whom the cesarean operation should be undertaken. The learned Tuscan surgeon, Pietro Paolo Tanaron, for instance, was a strong exponent of performing the procedure, even potentially when the mother was still alive. If the child’s passage was undeniably blocked yet the infant suspected still to be alive, were there men, he queried, “so barbarous, and so deprived of humanity, that they could plunge a knife into the breast of a poor, little infant (*creatura*) and cut

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119 References in this article are to Girolamo Scipione Mercuro, *La commare o riccoglitrice* (Venice: Giovanni Battista Ciotti, 1601), the text was originally published in 1596.

120 The Dutch obstetrician Hendrik van Deventer, who opposed surgical intervention during childbirth in general, was probably the most well-known and respected critic of the cesarean operation. William Osborn and many other English practitioners also opposed the operation. Cesareans on live women, though written about in many medical texts, were in practice extremely rare in eighteenth-century Europe.
it to pieces...so that it could be pulled out?"\textsuperscript{121} The cesarean section was therefore not only the more humane option when compared to horrors of an embryotomy, but, according to Tanaron, it could effectively and safely be practiced on a living mother. Tanaron supported this latter position with persuasive case studies, though, given the lack of aseptic practices at the time, it is unclear whether or to what extent any of these may have been partially embellished.\textsuperscript{122} Nevertheless, Tanaron went so far as to argue that the learned practitioner who failed to perform a cesarean in a situation where it could be of aid should be judged in line with any other murderer:

Princes, and Magistrates judge to be the offenders those prostitutes, and other women, known to have caused the deaths of their children, either through a procured Abortion, or an Infanticide; so why not punish similarly those, who because of fault, or negligence, cause to perish within the womb those unfortunate infants... even though they could have saved them with the application of their profession? Since this question concerns [the loss of] the physical life, no less than the spiritual one, and as there should be equal consideration for the one as for the other crime, then any Practitioner (Professore) who out of negligence, or, even more if out of politics, or maliciousness omits [to perform] the Cesarean Operation he should receive a severe penalty, as grave as that for the perpetrator of Homicide.\textsuperscript{123}

If Tanaron, a practicing surgeon, never advocated for a midwife, priest, or other layperson to undertake the cesarean operation, there were some medical authors who did.

\textsuperscript{121} Pietro Paolo Tanaron, \textit{Il Chirurgo-Raccoglitore Moderno, che assiste le Donne nei parti} (Bassano: 1774), Bk. III, 26. "Ma quando di crede che il Bambino sia vivo, e che sia impossibile farlo uscire per la via naturale, possono mai darsi Uomini così barbari, e così privy di umanità, da imergere il coletello nel seno di una povera piccolo creatura e tagliarla a pezzi, e a brani per poter tirarla fuori?" At the time, apart from the cesarean section, the only sure method for delivering an obstructed fetus was to perform a craniotomy or embryotomy and pull the baby out in pieces, a procedure typically performed by a surgeon. This was seen as the safest procedure for the mother.

\textsuperscript{122} Tanaron, \textit{Il Chirurgo-Raccoglitore Moderno} Bk. III, Ch. III, 25-95.

\textsuperscript{123} Tanaron, \textit{Il Chirurgo-Raccoglitore Moderno}, Bk. III, Ch. III, 95. "I Principi, e i Magistrati guidicano ree di morte quelle Meretrici, o altre convinte di aver fatto morire le loro prole, per mezzo di un procurator Aborto, o Infanticidio; e perchè non si puniscono similmente coloro, che per colpa, o negligenza fan perire nell’Utero quegl’Infelici Bambini colle loro Madri, i quali possono coll’uso della loro professione salvare? Mentre in questo caso si tratta della lor vita corporale, non meno che della spirituale; e perciò si dovrebbe avere un’eguale considerazione si per l’uno che per l’altro delitto, imponendo a tal effetto pena afflittiva, e grave, come reo di Omicidio."

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Considering the situation practically, some writers conceded that there might be situations, particularly in the rural countryside, where a midwife was the only qualified person present and so argued that midwives, too, should be instructed in the procedure. The Bergamese surgeon, Orazio Valota, another proponent of the cesarean operation, accepted the possibility that either a midwife or a parish priest could be called upon to perform the operation and was confident in their abilities if well-instructed. In his *La Levatrice Moderna, opera necessaria alle comari ed utile al principanti d’ostetricia, ed ai reverandi parrochi* (“The Modern Midwife, a work necessary for midwives, and useful to practitioners of obstetrics, and to parish priests”), the surgeon is less philosophical than Tanaron, limiting his discussion to a careful description of the operation, as befitted a manual directed much more toward practical use by midwives (rather than the dense, theoretical exploration of obstetrics for male students present in Tanaron’s text). Valota did limit the midwife or the priest to performing the cesarean in cases where the mother was already dead. A cesarean section on a living woman should never be attempted unless by a trained physician or surgeon, he reasoned, though of course this procedure was rare anyway.

**Conclusion**

This chapter began with a wide focus and gradually narrowed to consider those midwifery texts published in Italy in the second half of the eighteenth century. The broad discussion of early modern men’s writings about childbirth and women’s diseases with which the chapter opened will hopefully have provided a basis for understanding the historical and literary contexts out of which the latter Italian texts developed. Early modern midwifery manuals were indeed evidence of a rich pan-European dialogue in the sixteenth and seventeenth centuries.

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regarding aspects of women’s health, childbirth, and the still-mysterious processes of conception and generation. Men’s entrance into childbirth at this point, however, was largely confined to the rhetorical and literary realms. Men might hope to restore patriarchal equilibrium and confront their generative anxieties in print, through imaginative metaphor and visual construction. But few male practitioners at this time had any practical experience of childbirth and based their claims on a combination of ancient wisdom and anatomical knowledge and observation.

Only in the eighteenth century did male involvement in normal births allow surgeon-obstetricians like Wiliam Smellie and Henrik von Deventer to conceptualize a theoretical understanding “of the relationship between pelvic anatomy, the position of the uterus, and that of the fetus, in order to prescribe various maneuvers designed to re-align all three elements and establish the conditions for a natural delivery.” With this much firmer foundation on which to intervene in births, both normal and difficult, male practitioners’ print projects became increasingly about establishing a good professional reputation. Eighteenth-century midwifery texts played a critical role in the establishment and general recognition of ‘obstetrics’ as a distinct branch of surgery and field of inquiry in its own right. As medical specialism was still looked upon with some suspicion in the eighteenth century, the emergence of obstetrics as a generally accepted field was in fact somewhat of a novelty in the practice of medicine at the time. Yet, through print, obstetrics practitioners could tout the vital importance of their field for saving the lives of mothers and future citizens, define their own distinguished position in a centuries-old lineage of childbirth writers, and demonstrate their esteemed practical experience.

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through, generally felicitous, case studies. By imagining themselves as heroic subjects of the birthing room, male obstetrical writers of the second half of the eighteenth century literally helped create – through print - the profession which they hoped ultimately to control.
In 1728, the village of Filetto, some thirty kilometers north of Turin, was the site of “great scandal” and “public murmurings.”¹ For months, the local priest, Giovanni Caomino, had been frequenting the house of a surgeon named Giovanni Mioli, purportedly to facilitate his “friendship” with Mioli’s daughter, Appolonia. In what was clearly a well-known secret in the town, Caomino and Appolonia were engaged in a protracted, sexual relationship, begun around Carnival time two years prior.² The scandal came to a head when Appolonia became pregnant by “the seed of the priest, Caomino,” according to what was “said publically.” When Appolonia began to appear visibly “pregnant in the stomach,” she “absented herself” from the town, presumably with Caomino’s financial support.³ Conveyed to the Crocetta neighborhood on the perimeter of Turin, Appolonia give birth to the child in secret and abandoned the infant, though witnesses noted that when she returned home less than a month later her health seemed to have recovered poorly from the ordeal.⁴

¹ Archivio Storico Diocesano di Torino (from now on ASDt), Tribunale Archivescovile, 9.6.20, Fasc. 21, Trial of Giovanni Caomino, 1728.

² ASDt, Tribunale Archivescovile, 9.6.20, Fasc. 21, Trial of Giovanni Caomino 1728, Testimony of Lorenzo Michele Leona.

³ Ibid.

⁴ ASDt, Tribunale Archivescovile, 9.6.20, Fasc. 21, Trial of Giovanni Caomino, 1728, Testimony of Antonio Sbodio.
Although Appolonia’s relationship was widely known, and clearly provided the village with an enticing scandal for gossip, the affair between a priest and a young, unmarried woman was apparently not offensive enough to spur drastic action against either party. The prospect of an offspring, for whom the burden of care would fall upon the broader community, was, on the other hand, insupportable. Only when Appolonia became pregnant and the evidence of her shame tangible was the young woman compelled to leave home. While an illegitimate pregnancy might have been absorbed by the community in the seventeenth century, significant changes to the social, demographic, and moral landscape of early modern Italy had weakened such communal ties by the eighteenth century. Appolonia, faced with an unwelcome pregnancy, was taken to Turin to give birth far from the community’s scrutiny, perhaps at the home of a distant relative or an urban midwife contracted by Caomino himself. No institution yet existed to which women like Appolonia could turn to give birth safely and secretly and leave with their honor intact.

In the exact year of Appolonia’s plight however, Duke Victor Amadeus II of Savoy announced plans for a novel project in the ambit of public welfare and maternal assistance. Victor Amadeus’s proposal to build a maternity ward in the capital was the first of its kind in Italy. Directed at precisely those women who, like Appolonia, were of otherwise of good background, but had shamefully compromised their honor with an unwanted pregnancy, the maternity ward would offer a secure and secret place to give birth and deposit the child. For the first time, a state institution was attempting to act as custodian of female honor and sexual morality, a role traditionally supplied by community and religious networks. In this chapter, I will examine the development of the first Italian maternity ward, as well as its closely related contemporary, a school for midwives, in Turin in the first half of the eighteenth century. Yet,
instead of focusing on the ‘medicalization’ of childbirth represented by these developments, I choose to emphasize the numerous non-medical forces which informed the creation of this novel childbirth space in Italy.

**From Care to Cure: Some Notes on the Early Modern Hospital**

Until the eighteenth century, the hospital remained predominantly an institution of charity and welfare, still bearing much of the form and ideology of its medieval forebears. Although by the second half of the eighteenth century the hospital was beginning to solidify an identity as a clinical site, associated with medical training and scientific discovery, older charitable associations were hard to dissolve. In fact, throughout the century in many parts of Italy the ospedale’s main functions were still to succor and provide for the impoverished, abandoned, aged, disabled, and incurable sick of the population. Yet, the changes to the social position and wider epistemology of medicine described by Michele Foucault in his study of the “birth of the clinic” were real, if not as sudden as Foucault would have it.

Foucault located critical changes in medicine – including a new emphasis on statistical enumeration, pathological anatomy (autopsy), and the emergence of the modern medical patient, one separated by the ‘medical gaze’ from his ‘person’ and reduced to his ‘disease’ - in the post-Revolutionary world of late eighteenth-century France. Together, these changes can be classified under the rise of clinical medicine, which transformed the role of the hospital in medical thought and praxis. The ability to amass statistical information and the availability of bodies for post-mortem dissection rendered the hospital a central locus of medical advancement and professional development from the late-eighteenth century on, and began to strip the hospital of its traditional charitable and religious identity. Although relevant, Foucault’s observations on

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the significant epistemological changes which medicine underwent at this time lack a certain historical rootedness. It is thus important to remember, as noted historians of the hospital such as Guenter Risse and Colin Jones do, that that “the birth of the clinic” was ultimately a product of earlier medical developments and of the complex interplay between “society and the production of medical knowledge.” Indeed, the medicalization and secularization of the hospital was a long, often stilted process spanning at least two centuries.

The discussion of the emergence of the hospital maternity ward in Italy which follows illustrates several key points in the transformation of the hospital and of medical practice at the end of the ancien régime. At this point, it serves well to bear in mind that a specialized medical institution for pregnancy is, by its nature, somewhat paradoxical: pregnancy is not in itself a pathological event (though it can be pathological in its development). Nor did early maternity hospitals cater to sick or at risk women; in fact, regulations for these new institutions often explicitly denied entrance to such categories of patient. Thus, even as eighteenth-century male medical writers increasingly pathologized birth in their treatises to justify their increased involvement in the field, the initiatives spawning the first maternity institutions shared little of these writers’ understanding of childbirth as a medical event. Instead, the main thrusts behind early proposals for public maternity wards in Italy, as elsewhere, were charitable and religious. These two not always complementary impulses, the charitable on the one hand and the medical on the other, make the hospital maternity ward a fascinating starting point for considering broader changes in the management of gender, sexuality, and public health taking place in the eighteenth century.

Despite their strong charitable component, early lying-in wards and maternity hospitals have typically been considered by historians of medicine within a narrative framework of medical progress. Historians of medicine since the nineteenth century have thus tended to locate the impetus for the creation of European maternity hospitals in seventeenth- and eighteenth-century developments in medical practice and scientific knowledge, especially the professionalization and masculinization of the medical field. According to Margaret Connor Versluysen, the maternity, or lying-in, hospital was a defining element in both the medicalization and masculinization of childbirth: “lying-in hospitals brought immediate professional rewards to doctors,” provided men-midwives with “invaluable…clinical experience,” and served to position the “midwife as subordinate to the doctor.” Whether viewed positively, as medical advancement, or negatively, as a male appropriation of a formerly female sphere of knowledge and influence, the development of specialized maternity hospitals in the eighteenth century has been seen to lead progressively to the near-universal hospitalization of birth in the twentieth century.

This predominantly Whiggish view, however, masks the fact that institutional maternity care initially focused more on charity than medicine. A strict focus on the institution’s medical character has thus resulted in the lying-in hospital being the - perhaps not wholly deserving - recipient of much condemnation. Citing poor hygiene, high mortality rates, and frequent outbreaks of infection, especially puerperal fever, historians of medicine such as Thomas McKeown have argued that “when first introduced, and for many years after…institutional

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confinement [of pregnancy] had an adverse effect on mortality.”

Another historian has bluntly called the hospitals “a disaster,” suggesting that “it would have been better if they had never been established before the introduction of antisepsis in the 1880s.” The debate over the implementation of a maternity ward in Turin with which this chapter begins, however, suggests that the “medicalization of childbirth” was as much a social and political development as it was a medical one. In Turin, medical professionals never held a monopoly on decisions regarding the maternity ward or the practice of medicine that went on inside.

In Turin, as in Italy more generally, the medicalization of childbirth was not characterized by a sustained attack on the practice of midwifery or by the forced exclusion of women from that practice, as was the case in France or England. Rather than maneuvering to usurp women’s place in the birthing room, male physicians and officials in Italy aimed their efforts at professionalizing female midwives through new courses of instruction and clinical training. Childbirth in Italy thus remained a female guided event throughout the early modern period, though one which was increasingly subject to male supervision and a masculine scientific episteme. Why was this so?

My intention in this chapter is to explore the complicated process of medicalization in Italy by emphasizing the social rather than explicitly medical motivations for the novel creation

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8 This negative view remains persistent, though it has been challenged recently by historians such as Lisa Forman Cody who makes a thorough comparison between mortality rates and conditions within London maternity wards and those which existed at large, arguing that they were comparable. See Lisa Forman Cody, “Living and Dying in Georgian London’s Lying-In Hospitals,” Bulletin of the History of Medicine 78/2(2004):309-348.


of one particular childbirth space – the hospital maternity ward. As the first institution of its kind in the entire Italian peninsula, the public maternity ward in Turin deserves especial attention. In addition to teasing out the concerns of both Royal reformers and hospital administrators in the creation of a new institutional space for pregnant women at San Giovanni Hospital, I will consider the practical impact of Savoyard reforms on the women, foundlings, and midwives who negotiated the novel public space and intellectual regime of the hospital maternity ward. In addition, I will consider alternate forms of maternal assistance available to poor women in eighteenth-century Turin, namely the Compagnia delle Puerpere. A charitable association directed by elite women, the Compagnia provided domiciliary aid to indigent women in order that they could nurse their own infants, or, at the very least, not be constrained to resort to abandonment. Despite their differing aims and organizing principles, both the maternity ward at San Giovanni and the Compagnia delle Puerpere benefited from a mixture of private and public charity. The pre-welfare state of the eighteenth and early nineteenth centuries was still compelled to draw on multiple sources, religious and secular, public and private, to provide assistance to needy populations.

I. Italy’s First Maternity Ward

In Italy, Turin was hardly the first state that attempted to regulate and license midwives. As late as 1709, for instance, an edict issued by the Protomedicato of Savoy restating the prohibition against medical practitioners exercising their art without official license failed even to mention midwives. Venice, Naples, and Bologna, by contrast, had all had official statutes

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11 A partial list of the practitioners mentioned includes: doctors, surgeons, apothecaries, barbers, druggists, sellers of live things, chemists, distillers, mountebanks, sellers of aquavita, and vagabonds. F.A. Duboin, Raccolta per ordine di materia delle leggi, editti, manifesti, emanate dai sovrani della real Casa di Savoia sino all’8-12-1798, 23 Toms (Turin, 1818-69), Book VII, Tit. XII, Ch. III, 99.
regulating the practice of midwifery from much earlier dates.\textsuperscript{12} Savoy was unique, however, in that it was Italy’s closest approximation to an absolutist state with international influence. Particularly after the Treaty of Utrecht concluded the War of Spanish Succession in 1713, Savoy emerged on the international stage effectively for the first time, a territorial power with all the monarchial trappings of its European neighbors, including a new royal title of King (of Sardinia) for its leaders.\textsuperscript{13} Between 1717 and 1730, Victor Amadeus II oversaw a period of ambitious reform in his Savoyard territories, inspired in part by those of the French state under Louis XIV.\textsuperscript{14} Despite the positive outcome of the Treaty of Utrecht, two disruptive wars and near-constant tension with France since the last quarter of the seventeenth century had left Savoy’s lands ravished, it’s subjects reduced to widespread poverty, and its treasury with immense debt. Savoy was therefore in desperate need of broad economic reform in order to maintain its military readiness. Sweeping tax reform, a crackdown on feudal and ecclesiastical privilege, and attempts at the rationalization of the state bureaucracy were hallmarks of Victor Amadeus II’s initiatives in the second and third decades of the eighteenth century.\textsuperscript{15}


\textsuperscript{15} Victor Amadeus II’s reign is best remembered for his tireless efforts to compile an accurate land register, or \textit{catasto}, on which to base tax assessments. The resulting cadastral register (which was put into effect only after Victor Amadeus’ abdication, in 1731) was purged of much of the privileged and ecclesiastical exemptions which had encumbered and severely limited tax collection in the past. Symcox, 125-127; Storrs, 92. On reform in Turin more generally see: Guido Quazza, \textit{Le riforme in Piemonte nella prima meta` del’700} (Modena, 1957); Guido Astuti, “Legisla\'zione e riforme in Piemonte nei secoli XVI-XVII’ in \textit{La monarchia Piemontese nei secoli XVI e XVII} (Rome: 1960); Stuart J. Woolf, “Sviluppo economico e struttura sociale in Piemonte da Emanuele Filiberto a Carlo Emanuele III,” \textit{Nuova Rivista Storica} 46/1 (1962): 1-57.
If the primary aim of these reforms was to ready and strengthen the state for the purposes of war, Victor Amadeus II was also interested in fashioning himself an absolutist ruler and in centralizing institutions throughout the Duchy. To facilitate this process, Victor Amadeus II’s new corps of French-inspired intendants served as agents of the central government on the ground and reported back to the Duke on conditions in the provinces. In this vein, Victor Amadeus II counted among his reform projects efforts to reorganize and centralize the Duchy’s public health and welfare services, stripping some of the control in these areas from local religious and municipal control. In 1716-1717, for instance, the first large-scale measures to centralize poor relief, beginning with Piedmont, were announced. In a program devised by the Jesuit Andrè Guevarre, who had been responsible for a similar reorganization of welfare and charity in Southern France, begging and almsgiving were strictly prohibited in the capital, in favor of charity dispensed through centralized institutions. The introduction of a territorial network of almshouses directed through a large central institution based in Turin followed. In other words, Guevarre had formulated a vision of poor relief for the Duchy which “appealed to Victor Amadeus because it meant that private, spontaneous Christian charity would be institutionalized under state control, and the secular power would replace the clergy as the dispensers of relief.” Although Sandra Cavallo has questioned whether the novelty and success of such public welfare initiatives have been overestimated by historians, the fact that together

16 Symcox, 120-121.

17 Symcox, 199. This system would displace traditional, decentralized modes of charity, based on individual almsgiving and begging. Now the poor were directed toward the hospital where they could be contained; foreigners, further, were harshly forced out of the city. Devoted laypersons were requested to make donations to the main poor hospital, the Ospizio di Carità, rather than to private individuals.

18 Symcox, 199. For a contemporary and highly celebratory account, see A. Guevarre, La mendicita sbandita col sovvenimento dei poveri (Turin, 1717).
they represented the first territory-wide (and the most comprehensive in Italy up to that time) attempt to deal with poverty remains a significant achievement.19

In addition to the above reforms in the area of public welfare, in 1728 Victor Amadeus II presented plans for maternity ward to be installed at San Giovanni hospital, the central hospital in the Savoyard capital of Turin. Initially a refuge for the poor, the Ospedale Maggiore di San Giovanni Battista had, by the eighteenth century, begun to emphasize the cure as well as the care of the city’s indigent sick. During the reigns of Victor Amadeus II and his successor, Charles Emmanuel III, San Giovanni would see its status elevated in the eyes of the medical profession as the University of Turin was overhauled and medical education began to embrace bedside training and the experience gained through work at the hospital. At the same time, San Giovanni still retained its charitable identity - maintaining a ward for long-term incurabili and taking in the majority of the city’s foundlings. Following other Italian hospitals, San Giovanni had not traditionally extended its services to pregnant women. That role was assumed, if at all, by convents or women’s asylums, generally on an informal basis. The proposal of a maternity ward attached to the city’s central hospital was thus a novelty, the first of its kind in the entire Italian peninsula.

The justification for the maternity ward project was twofold. First, a maternity ward would offer unmarried pregnant women and poor married women in need of a secure and private location to give birth and, if necessary, abandon the child. Anonymity and “compassionate support” would be granted “to those young women who imprudently lose their honor.” Simultaneously, the ward would offer tender “Christian uplift” to poor married women with

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nowhere else to give birth in the dangerous time of labor. The intended recipients of the ward’s services were thus all those pregnant women who, either “devoid of permanent residence, [or] because of their poverty, have neither space nor assistance sufficient to give birth in their homes.”

Second, the maternity ward would facilitate the formal and most up-to-date instruction of midwives, something that the royal reformers thought was desperately needed. Victor Amadeus II’s proposal mentioned in particular the duchy’s lack of a sufficient number of qualified midwives to serve the general population and of the kind of institution necessary to train them in the first place. What was urgently required, according to the royal note, was a program of formal midwifery education on the lines of Paris’s Hôtel Dieu, where young women would receive both practical and theoretical instruction in midwifery in a hospital setting. In fact, Victor Amadeus lost no time in enlisting the Parisian surgeon Pietro Simone Rouhault as a primary consultant for the project. According to the plans which emerged from this collaboration, the pregnant women who applied to the maternity ward would be cared for by an expert midwife “perfectly trained” in the art of midwifery during a long period of apprenticeship at the “hospital of Paris,” ie the Hôtel Dieu. This head midwife (maestro levatrice) would also have the responsibility of “instructing others not least for the service of the hospital [San Giovanni] as for the public.”

During a period of six months, novices and those practicing midwives “not sufficiently capable”

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20 Archivio Ospedale di San Giovanni Battista (from here on AOSG), Cat. 1, Cl. 3, fasc. 1, 1732. “Quest’opera avendo perfi ne così l’onesto per dar un sicuro ricovero a quelle fanciulle, che incautamente perdono il loro pregio, ed un pietoso sostegno ai miseri, ed incerti loro parti, come la carità, per apportare a quelle maritate, che sono povere un Cristiano sollevamento nella perigliosa congiuntura di parto, e perfine il pubblico bene, per ammaestrare sotto la disciplina d’una sperimentata alevatrice altre donne, esige un discreto, non meno che cauto provvedimento per l’ottenimento di cui si sono addattati li seguenti mezzi.”

21 AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide,” 6 May 1728, Cat. 10, Cl. 1, Fasc. 3.

22 Rouhault was also the main author of the maternity ward’s first official “Regolamento” published in 1732.

23 F.A. Duboin, Book XII, Tit. XIX, Chap. II, 644; “La maestra levatrice…ammaestrerà poi queste [donne] non meno per servizio dello spedale che del pubblico…”
would profit from both semi-formal courses led by the head midwife and a program of practical training at the side of the ward’s patients.\textsuperscript{24} The Turin maternity ward would therefore serve the public good by providing a gravely needed public service to the greatest number of potential recipients.\textsuperscript{25} In addition, the midwifery school would facilitate the most advanced training to prospective midwives, who, it was hoped, would then bring their new knowledge and expertise back to local communities throughout the Savoyard territories.

Almost immediately upon receipt of these plans, the hospital board of governors in Turin voiced opposition to the maternity ward project. Such resistance reflected in large part the novelty of the venture. As noted, Italian hospitals, while historically important centers of public charity, rarely extended services to pregnant women. The hospital board, which consisted of both lay and ecclesiastical city elites, centered their opposition to the maternity ward project around two areas of concern. The first focused on financial concerns and spatial restrictions. A royal envoy on a recent scouting trip had designated a few small, freshly built rooms suitable to house the modest eight beds requested by the Duke for the maternity ward. However, the new rooms had been intended, not for the reception of new patients, but rather to provide more space for the hospital’s already overflowing population of orphans. According to the board, “the greater part” of the hospital’s “poor foundlings” were “sick, and…dying as a result of being too constricted.”\textsuperscript{26} In this respect the board was not exaggerating: supporting an annually-increasing number of foundlings remained a pressing concern for the hospital throughout the eighteenth and nineteenth centuries. Unsurprisingly, the hospital governors were also irked by the fact that the

\textsuperscript{24} F.A. Duboin, Book XII, Tit. XIX, Chap. II, 646.

\textsuperscript{25} This does not mean that all women were eligible to give birth at the maternity ward. See below, p. 146.

\textsuperscript{26} AOSG, Cat. 2, Cl. 5, fasc. 1.3, 20 January 1728; the new rooms were intended to provide more space “alli Poveri esposti buona parte de quali si amalavano, e molti ne morivano per esser troppo ristretti, e la privazione delle camera si farebbe cadere in angustie...”
royal instructions had placed the financial burden of the new ward, including salaries for the director and head midwife, solely upon the hospital itself. In general, then, the maternity ward project appeared to the hospital board as a major infringement on its prerogatives and authority over the governance of the hospital by the Royal government. On the matter of finances, however, Victor Amadeus and his royal advisers were firm: the Royal government was happy to take the credit for promoting the maternity ward to fulfill a much needed public service, but it would be the hospital’s problem to maintain it on a daily basis.

The second point of opposition leveled by the hospital board underlined a more general moral aversion to the nature of the project. Specifically, administrators worried that the proximity of the proposed ward to the great number of young female foundlings might have the effect of inciting the girls to “great scandal” when they themselves reached maturity. The board, already alive to the inherent financial and social challenges facing female orphans, was here articulating their fears that this impressionable group would fall into similar patterns of promiscuity as they believed the majority of the ward’s pregnant population had. At the same time, the members’ concerns when confronted with the unavoidable physical closeness between the two groups in the cramped quarters of the hospital may have been conditioned by the medical logic of the day. Theories of ‘moral contagion’, developed in the first half of the eighteenth century, held that the corpuscles emitted by each individual body “were imprinted with the mark of that person’s temperament and physical condition” and that persons in close proximity could very literally transmit “psychological states through the skin.”

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27 AOSG, Cat. 2, Cl. 5, fasc. 1.3, 20 January 1728; the fact that the hospital was, “pieno di figlie ivi rittirate dalla loro infanzia vi era da temere che la vicinanza di tal Opera possa talvolta esserli incentive di qualche scandalo massime alle maggiori d’età.”

understanding of the body and its relation to the environment, medical officials in Turin and elsewhere warned, for instance, that wet nurses had to be carefully selected for both their physical health *and* moral respectability, as breast milk was believed to transmit moral qualities, such as temperance or charity or, less favorably, licentiousness and depravity.\(^{29}\) Thus the morally suspect women who came to the ward to give birth represented a very real threat to the young foundlings in whom the hospital had always aimed to instill correct propriety and religious values. In short, the erection of a hospital maternity ward which would serve predominantly poor, unmarried women in a public space excited a host of moral concerns among the city elite who governed the hospital.

Ultimately, the hospital administrators’ grievances rang hollowly on Royal ears. According to Sandra Cavallo, the hospital board’s reservations about the maternity ward and the Royal government’s unwillingness to compromise were expressions of a broader struggle for control over the institution in a period when Victor Amadeus was attempting to limit precisely the kind of local autonomy represented by the hospital and its non-Royal governors. The installation, dating from this period, of a *Regio Protettore*, essentially a Royal representative, onto the hospital board was an instance – met with considerable indignation by the traditional hospital elites – of tangible Royal interference in the daily governance of the hospital.\(^{30}\) In this view, the hospital board should not be seen as a conservative force putting up “strenuous resistance to the medical reform of hospitals, advocated for by the more progressive medical profession and more enlightened representatives of the state” but rather as an entity struggling


with encroachment by a new class of state functionaries on its traditional prerogatives. As Cavallo’s point makes clear, viewing the installation of a maternity ward in Turin through a purely medical filter leads to a distortion of the actual motivations and pressures on the actors involved.

It is clear that the main intention of the maternity ward project was to provide certain groups of women with charitable assistance, rather than to improve medical care. The latter was stressed only in the documents pertaining to the school for midwives, discussed below, which was, in any case, of secondary importance at this point in time. However, neither was the nature of the struggle over the ward strictly a power conflict between the hospital’s traditional elites and the ascendant royal authority. The hospital’s concerns over the moral implications of the ward were hardly hollow protest. When the official regulations governing activity within the ward were drawn up they bristled with preoccupation for the protection of female honor and the maintenance of propriety. The ward’s statutes, for instance, emphasize the importance of keeping secret at all costs the identities of the women giving birth in shame. Repeated verbal gestures toward the preservation of “secrecy and honor,” “precise secrecy,” and the constant maintenance of “good order” suggest that both Royal reformers and the hospital governors were sensitive to potential concerns about the presence of pregnant women within the wider context of the hospital. At the same time, it is clear that the hospital, at the needling of the Savoyard state, had accepted a new role as custodian of female honor for women whose communities and kin could or would no longer fulfill that role.

In practice, the concern for secrecy translated into highly regulated movement into, out of, and within the small maternity ward. Located in a newly constructed section of the female wing of Turin’s large Ospedale Maggiore di San Giovanni Battista, the maternity ward

31 Cavallo, Charity and Power, 191.
comprised three rooms: a modest main room (initially with eight beds, though shortly increased to twenty) with “curtained beds” was accompanied by a small delivery chamber “with a fireplace, in front of which there will be one or two beds to receive those women, who are in the pains of labor; the fireplace will serve moreover to warm the linens for use of the pregnant and laboring women.” Finally, a third room nearby would house the personal living quarters of the head midwife “so that both day and night she can with promptness care for the women in labor.”32 Officially, the ward was under the control of a director (direttore), elected every three years from the among the hospital rectors (rettori), whose job it was to observe “vigilantly” the implementation of the ward’s rules. Making once weekly visits to the hospital, the director was to “carefully observe what happened there and remedy any abuses he might find, having always the aim of singularly maintaining charity and good order.”33

It was the head midwife, however, who was largely responsible for overseeing the day-to-day activity in the ward. It was she who maintained the ward’s provisions, including firewood and the pregnant women’s daily allotment of food, and she who directed the small number of servant women who assisted her. It was the midwife who received new patients and registered them (though it was technically the director who had final say on the acceptance of each individual woman), and she who managed the actual births when patients went into labor. Significantly, it was the midwife’s duty to instruct other women in her art, encouraging their

32 AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide,” 6 May 1728. “Una sale, nella quale vi saranno dei letti con cortine, ed un’altra per dir la Messa; all’estremità od a fianco di questa e nel medesimo piano una piccola camera con suo focolare, avanti cui sarà uno o due letti per ricevere le donne, che sono nelle doglie del parto; servirà di più il suddetto focolare per scaldare le biancherie per uso delle donne gravide e di parto. Nel medesimo piano vi sarà una stanza per la Levatrice, accioché di e notte possa con prontezza soccorrere le donne nel parto.”

33 AOSG, Cat. 1, Cl. 3, fasc. 1, 1732; “Il direttore che a quest’opera sarà destinato e scelto di tre in tre anni del consiglio della presente città, dovrà specialmente vegliare all’osservanza di questo regolamento, portandosi almeno una volta per settimana alla sala delle partorienti per informarsi attentamente di ciò che vi occorre e rimediare agli abusi che vi scoprissi, avendo sempre di mira di mantenervi singularmente la carità ed il buon ordine.”
“careful attention toward the pregnant inmates, making them minutely observe any pathologies both before and after birth, to which they must always be attentive, teaching them all the procedures which are necessary for a perfect training, and guiding them also in trying their hand at operations under her gaze and direction.”

Thus it was overwhelmingly the head midwife who was responsible for providing poor women with a safe and secure environment to give birth, and for transmitting the knowledge and praxis of midwifery to student midwives.

Security in the maternity ward meant privacy and anonymity. “In order to conserve in the ward privacy and honesty,” the regulations state, only those with “written license from the director” and head midwife could enter. For her part, the head midwife was to “practice an exact propriety, and observe that the same was conserved in” all those around her. Two “robust” female assistants, in addition to “making the beds of the pregnant women…sweeping the floors and fireplace…[and] transporting back to their beds women just delivered,” were tasked with guarding the doors to the ward, allowing entrance and exit only to those with the proper approvals. Even sanctioned visitors were to be accompanied by one of the assistants to

34 AOSG, Cat. 1, Cl. 3, fasc. 1, 1732. The head midwife would instruct students “adoperandosi in modo che nel corso del sei mesi usino una sollecita attenzione verso le partorienti facendo loro minutamente osservare la qualità de’ morbi si avanti che dopo il parto, al quale dovranno sempre essere presenti, isegnando loro tutte quelle pratiche, le quali sono necessarie ad un perfetto ammaestramento, ed istradando eziandio le medesime a porre la mano alla operazioni sotto li suoi occhi e la sua direzione.”

35 AOSG, Cat. 1, Cl. 3, fasc. 1, 1732. “Siccome per conservare nell’opera il secreto e l’onestà è necessario che sia chiuso a chi non si aspetta l’accesso alla sala, così non potra nessuno esservi introdotto, salvo con licenza in iscritti del direttore, cui egli non condiscenderà senza qualche giusta premura, ed a riguardo di persone che sieno conosciute.”

36 AOSG, Cat. 1, Cl. 3, fasc. 1, 1732. “Professerà ella un’esatta segretezza, e dovrà altresì’ vegliare per conservare in altri la medesima.”

37 AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide,” 6 May 1728; “Si sceglieranno due serve forti e robuste, non solo per fare i letti delle donne gravide e di parto e scopare la sala e stanza del focolare, ma per riportare ancora nel loro letto le donne dopo il parto. Serviranno inoltre a vicenda le suddette serve per aprire e chiudere la porta della sala senza permettere l’ingresso a chississia, se prima non avranno avuto il consenso della levatrice, ed allora accompagneranno le persone al letto della donna a cui vogliono parlare, e che non permetteranno che vadano le medesime ad altro letto per non molestare le donne che non vogliono essere vedute.”

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the bed of the woman being visited, and not allowed to wander elsewhere so as “to not bother women that did not want to be seen.”

Most stringent were the restrictions on male visitors. Unlike the lying-in hospitals being erected roughly contemporaneously in London, the maternity ward at San Giovanni strictly prohibited young male surgeons from using the ward for clinical instruction. Although the regulations require the head midwife to alert a doctor or surgeon in “cases of necessity,” under no circumstances were male trainees allowed to accompany their instructor into the ward. When a surgeon was called to the ward to draw blood, he was directed to “return immediately after” completing “his operation” and not “to go to any other bed” except that of the woman being attended. If needed to draw the blood of a woman in labor, the surgeon, having performed the operation, was to leave promptly and not to “stay to observe the delivery.” In fact, initiatives to strengthen male oversight, by providing for a surgeon to be present at the ward continuously to assist with any possible emergencies, were firmly rejected by the hospital board. Later in the century, a number of vocal surgeon-obstetricians would bemoan the fact that, in Italy, women’s “irrational” sense of modesty made them entirely resistant to male intervention during childbirth, leaving Italian obstetrics well behind in practice compared to those countries Oltramontani. The opposition to male involvement in childbirth in Turin suggests, however,

38 Ibid.
39 AOSG, Cat. 1, Cl. 3, fasc. 1, 1732; “Il medico e il ceruscio, avvisati che saranno per mezzo della levatrice ne’ casi di necessita’, si porteranno a dare i loro ordini ed a fare le rispettive operazioni al letto delle inferme, senza poter condurre con essi loro nesun praticante od altra persona. Adempiuto il loro uffizio si ritireranno, ne’ sarà loro lecto visitare alcun altro letto.”
40 AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide,” 6.5.1728; “Il chirurgo destinato per far le cavate di sangue si ritirerà subito fatto la sua operazione e non andrà ad altro letto che a quello ove giace la donna a cui deve cavar sangue; se fosse il medesimo chiamato per salassare una donna nel temp del parto, fatta la cavata di sangue, se ne andrà via e non potrà fermarsi per vedere levare il parto.”
41 See for instance Sebastiano Rizzo Della Origine e dei Progressi dell’Arte Ostetricia, Prolusione Recitata il giorno 17 Settembre 1776 (Venezia: Carlo Palese, 1776).
that it was more than just women’s modesty keeping men out of the birthing room. Men, too,
particularly representatives of the Church, were wary about relinquishing the control they did
have over midwives to male practitioners, especially in matters of such spiritual importance.42 A
wariness that was manifest in the lack of male involvement, in either the care of patients or the
instruction of trainee midwives, at the maternity ward.

Even before entering the maternity hospital, patients were subjected to a careful
screening process. While unmarried pregnant women could be admitted from the seventh
month43 of pregnancy on, except if some emergency required earlier intervention, poor married
women were only to be admitted in their ninth month, and then only after having presented to the
director of the ward a certificate from their parish priest attesting to their poverty and the
permission of their husbands. In general, all women wishing to be admitted to the ward were to
register their first and last names and birthplace with the head midwife. However, a clause did
allow for unmarried women who wished to keep their identities secret to do so; married women,
at least in theory, received no such special allowances and their personal information was
expected always to be carefully documented.44 In this respect, the hospital board was concerned
with married women burdening the already over-crowded hospital by abandoning legitimate
children, an action that both the board and the royal government frowned upon. In fact, “any
married woman who, with the intent of unburdening herself of her birth, hides that the child is

42 The parish priest tended to play a protective role vis-à-vis the midwife in this period, often petitioning on the
behalf of long-time practitioners who were, for one reason or another unable to attend the midwifery school,
requesting that they be licensed regardless. The priest kept a close relationship with the midwives in his parish above
all to ensure that they were well versed in the baptismal rite, but also as a means of accessing information about and
asserting control over the sexual behavior of the parish.

43 AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide,” 6 May 1728; while the 1728 document
states that at seven months unmarried women should be permitted to enter the hospital, the regulations issued in
1732 amended this to eight months. Both allow for earlier admittance in the case of emergency.

44 Ibid.
legitimate...will incur, no less than her husband, the penalty carried by the Royal Constitution.”

Nevertheless, discretion was clearly the hospital’s driving concern. The original 1728 regulations state that “all those who shall serve in the…ward, in whatever capacity, shall be required and obliged to keep silent on and conceal the things which cannot be divulged without offending other people’s honor… if a woman in the pains of labor should present herself masked in order not to be known, she shall be served by the midwife without the latter ascertaining who she is.” Thus even the possibility that a married woman might leave her child to the care – and cost - of the hospital did not override the more acute concern to protect the anonymity of those women whose presence in the ward was conditioned by fear of a loss of honor. Although the hospital’s financial solvency was a perpetual concern, the protection of female honor in theory took precedence.

What, then, were the motivations for the creation of a maternity ward which represented both a financial and moral challenge for the hospital? As noted, the maternity ward project was part of a larger program of Royal reforms aimed at strengthening the Savoyard state’s administrative, fiscal, and institutional structures, as well as at drawing under much stricter, central control matters, such as public health, which had long been directed at a local level. At the same time, the novel proposal of a hospital maternity ward had long roots in the gradual changes to the management of sexuality, honor, and reproduction in Italy which had emerged out of the reforming and disciplining impulses of the Counter-Reformation.

45 AOSG, Cat. 1, Cl. 3, fasc. 1, 1732. “Se qualche maritata, a motivo di scaricarsi del parto, occultasse ch’egli fosse legittimo, ove a scoprrire si venisse l’inganno, inorrerà non tanto la medesima, quanto il marito, nella pena portata dalle Regie Costituzioni.”

46 AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide” 6.5.1728. “Tutti quelli che serviranno nella suddetta sala di qualsiasi condizione, saranno astretti ed obbligati a tacere ed a tener nascoste le cose senza offendere l’altrui onore non possono essere divulgate…Se…una donna nelle doglie del parto si presentasse mascherata per non essere conosciuta, sarà ella servita dalla Levatrice senza informarsi qual’ella si fosse.”
At the Council of Trent, the Catholic Church had quite radically altered the customary relationship between sexual activity and marriage. The Decree *Tametsi* issued at Trent reconfirmed marriage as a sacrament, attempted to suppress extra-marital sexual relationships such as concubinage (clerical and lay), and formalized the proper manner in which a legitimate marriage could be formed. Afterwards, marriage required a public ceremony performed before a priest and several witnesses preceded by marriage banns. Whereas traditional practice had legitimated pre-marital sexual relations contracted under the promise of marriage, the post-Tridentine Church redefined such sexual relations as sinful behavior.

The Church’s adherence to strict sexual guidelines in the era of the Counter-Reformation mirrored the state’s and the community’s interest in protecting familial status and inheritance. As central to the proper functioning of the early modern social economy, the female reproductive body had to be regulated and controlled. Illicit sexual relations which jeopardized patriarchal equilibrium threatened social discord and shamed the woman’s family as much as herself. A woman whose honor was tarnished faced diminished marital prospects, and thus represented a real financial burden for her family. At the same time, premarital sexual relations or an illegitimate pregnancy that could be funneled into marriage between the partners

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or the proffer of a dowry by the male subject were seen to sufficiently restore a woman’s compromised honor.  

Shifts in the social, demographic, and moral landscape of early modern Italian village life contributed to changed attitudes toward illegitimacy by the late seventeenth century however. While an illegitimate pregnancy might have been absorbed by the community in the sixteenth century, by the eighteenth early modern legal structures – both ecclesiastical and secular - tended to exculpate men and blame women for sexual transgression, leaving unwed mothers with the burden of caring for or abandoning unwanted children.  

Whereas the community’s management of marriage had once protected female honor by pressing men who broke marriage promises to marry or dower the woman, over time increased social mobility and urban migration disrupted these kinds of local safeguards.

Women without strong kin or community networks increasingly turned to secondary outlets, such as urban foundling homes and, later, maternity wards like the one first established in Turin, to hide the evidence of sexual sin. As Jeffrey Watt notes, in Italy in the era of the Counter Reformation, “preserving the mother’s honor by keeping the birth secret eventually displaced saving the life of the baby” as the reason d’être of most foundling homes. Simona Cerutti and Sandra Cavallo, who have most closely studied this phenomenon for Piedmont, explain that premarital “sexual intercourse [by the eighteenth century] had lost its character as a prelude to the state of marriage…For the first time, sexual practice came to be associated

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51 Ferraro, 4, 158-159

52 Alessi, 806.

explicitly with a moral concept of guilt which impacted the sphere of conscience.”\textsuperscript{54} The basic result of this gradual transformation in the community’s sense of morality and shame was that a “responsibility which once had been widely” shared, that is, the responsibility for supporting illegitimate offspring, was now “concentrated on the woman” alone.\textsuperscript{55} If more rigorous attitudes toward women who had become pregnant out of wedlock meant that, by the eighteenth century “illegitimate pregnancy found increasingly fewer spaces of social acceptance,” then it became an imperative of the expanding Royal state to provide social assistance to a particularly vulnerable population.\textsuperscript{56}

Illustrative of the developments outlined above was the Savoyard state’s approach to infanticide. During the 1720s, the Savoyard criminal code underwent major revisions following Victor Amadeus’ initiative to rationalize and render uniform the legal system.\textsuperscript{57} These revised statutes, issued in 1729, reveal considerable preoccupation with the crime of infanticide, as well as the closely related offenses of abortion and abandonment. On paper, the punishments leveled at transgressors – who were assumed by the law to be women – were severe: death for women convicted of infanticide and abortion, as well as for those who had acted as accomplices, and public flogging or exile for mothers who had abandoned their children illegally.\textsuperscript{58} If the state was going to assume the responsibility of protecting female honor, through institutions like the

\begin{itemize}
\item \textsuperscript{54} Cerutti and Cavallo, 373.
\item \textsuperscript{55} Cerutti and Cavallo, 373.
\item \textsuperscript{56} Nadia Maria Filippini, “Ospizi per partorienti e cliniche ostetriche tra Sette e Ottocento,” in Gli ospedali in area Padana fra Settecento e Novecento, eds. Maria Luisa Betri and Edoardo Bressan (Milano: Franco Angeli, 1992) 399.
\item \textsuperscript{57} Symcox, 193-194; Mario Viora, Le Costituzioni Piemontesi, 1723, 1729, 1772. Storia Esterna della Compilazione. (Turin: 1928), ch. 20.
\item \textsuperscript{58} F.A. Duboin, Book VI, Ch. VIII, 82.
\end{itemize}
maternity ward at San Giovanni, then it would give no leeway to women who were seen to take matters into their own hands.

If the abhorrence of infanticide in a religious sense was nothing new, the severity with which it was addressed in the revised Turin criminal code did reflect a new secular imperative against such kinds of behavior. The widespread eighteenth-century belief that the strength of a nation lay in the vitality and numbers of its labor force added a new valorization to motherhood and disapproval toward those who would renounce this duty.\textsuperscript{59} Contemporaries influenced by such populationist thinking therefore viewed infanticide as more than just a moral crime; the loss of a new life was also the loss of a “future citizen.”\textsuperscript{60} Even if, in reality, the punishments meted out to women accused of these crimes were often less severe than the criminal code prescribed (relatively short periods of exile and imprisonment were much more common than capital punishment), the attention to the crime and the severity of the language with which it was addressed indicate the chord which infanticide struck in the public discourse. For instance, in a particularly gruesome case of infanticide heard before the Senato di Piemonte, in which a young mother buried her newly-born son when, according to an expert, he might still have been breathing, the judge (in addition to issuing a capital sentence) declared the woman “an enemy of the state.”\textsuperscript{61} Both the harsh penalties and the civic rhetoric associated with crimes like infanticide indicate that reproductive matters, far from being shielded by modern concepts such as privacy and personal morality, were very much of public and political interest.


\textsuperscript{61} AST, \textit{Sezione Reunite, Senato di Piemonte, Sentenze Criminali 1724-1802}, March 1772, also cited in Baldi, 134.
Furthermore, the increased criminalization of acts such as infanticide came about only when the Savoyard state began to provide havens for women with illegitimate pregnancies to hide. In Turin, the maternity ward was a precocious expression of enlightened trends toward viewing an illegitimately pregnant woman as the victim of seduction rather than as a seductress or sinner, as had been typical in the past. The procedural push in this regard was thus to “offer [such women] a…voluntary, free, and secret refuge, beyond any jurisdictional and penal ambit.” While it was clear that such women had committed shameful acts and were in need of moral and spiritual recuperation – which early maternity wards in Italy offered – there would be no criminal action taken against women with illegitimate pregnancies. In effect, the state sought to intervene in a preexisting system of familial and sexual honor by offering certain women a secure means to remedy the consequences of illicit behavior. As the statutes of a later maternity hospital state, no longer should “a lack of asylum and fear of shame…serve as an excuse for mothers to kill their child[ren].” While social and demographic changes in the eighteenth century had weakened the traditional protections a single mother might be afforded by a watchful community, the state, through new institutions like the maternity hospital, was ready to assume a role in the management of sexuality and public morality.

Considering the legal and moral trajectory of eighteenth-century attitudes towards illegitimacy, the maternity ward project in Turin emerges as a safeguard against crimes like infanticide and abandonment, which were supposed by contemporaries to be on the rise. By

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63 Ibid.
65 On contemporaries’ understanding of the relationship between infanticide, illegitimacy, and poverty see: Silvana Baldi, “L’assistenza alla maternità a Torino nel XVIII secolo,” Sanità, Scienza, e Storia 1/2(1992): 136-140; Maria
offering unmarried women whose honor had been compromised a secure and private location to
give birth and abandon the child, reformers aimed to eliminate the need for such desperate
measures as abortion or child-murder. In fact, a 1739 report by the administrators of the hospital
praised the maternity ward for being “very useful for avoiding frequent infanticides.” 67 There is
little discussion, however, of safety in childbirth or improved methods of delivery in the new
setting of the hospital. At least in its first decade of existence, the maternity ward’s function of
providing a discrete recovery to unmarried women finding themselves pregnant and alone was
more central than its secondary objective of instructing midwives and introducing more rigorous
standards of practice.

The assiduous concern for privacy in the maternity ward was a means of protecting
female honor and an articulation of the movement of such protection away from its traditional
place in the community to institutions controlled by the state. Whether this can be seen as a
progressive or female-centered system is less clear. The protection of female honor can just as
easily be understood as the protection of male or family honor. In a social economy which
elevated honor and purity, the loss of honor associated with a woman’s illegitimate pregnancy
was as much a reflection on that woman’s family as herself, and the potential disruptions to her
ability to marry implied a financial loss for her father. By absorbing the evidence of such illicit


66 AST, Sezione Reunite, Senato di Piemonte, Sentenze Criminali, 1724-1802. An examination of the sentences meted out by the criminal court in Turin between 1724-1801 reveals, rather than an increasing number of infanticides, a rather steady (and rather minimal) 3-4 related cases per year. Silvana Baldi has already noted, furthermore, how the severity of punishments for these crimes diminished markedly in the last quarter of the century. See Baldi, 135.

sexual behavior, the maternity ward therefore served to restore social – and patriarchal – order. The social space open to women whose honor had been compromised by illegitimacy had therefore narrowed over the course of the eighteenth century. Illustrative of this shift was the fact that the maternity ward statutes in Turin made no recourse to seek out the fathers of the illegitimate children birthed there and then left to the care of the hospital. Traditionally, the community, through the surveillance and mediation of numerous groups – including parents, kin, peers, and the church – had been sufficient to pressure the father of an illegitimate child to marry the mother or dower her, thus providing the means to support the child.68 Foundling homes in the Renaissance tended to seek out fathers of abandoned children to pay for their upkeep.69 By the eighteenth century, however, both community and institutional pressures on fathers had diminished.

Ultimately, then, the establishment of a maternity ward represented a shift in the locus of reproductive care from the community to the state. In addition to reflecting changes in conceptions of honor and illegitimacy, the introduction of an institutional space for childbirth was indicative of the heightened suspicion with which the profession of midwifery was viewed in the eighteenth century. Although directed above all by the medical profession, attacks against midwives also played upon old fears regarding the collusion of women in the still mysterious realm of reproduction. The expertise of traditional midwives and wise-women, though always locally valued, had long been viewed by authorities as a potential source of illicit behavior – whether it be the procurement of an abortion, baptismal abuses, the application of sympathetic

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68 Cerutti and Cavallo, 357-360
magic, or some other manipulation of the female body. By removing the care of pregnancy and childbirth from this relatively unregulated state to the confines of the hospital, state authorities aimed to stamp out a host of proscribed birth practices, in particular those that culminated in abortion or infanticide. The first objective of the Royal government in the establishment of a maternity ward – the provision of a safe and secure location for poor women to give birth – was therefore tied closely to the second – the formal education of midwives.

II. A School for Midwives

In theory, the midwifery school in Turin would function as a corrective to the preexisting and highly ineffective system of licensing of midwives. Early licensing practices, which were often shared by both medical and ecclesiastical authorities, were aimed more at certifying the moral rectitude of a midwife than her skill or knowledge. Shortly after the opening of the ward, however, royal authorities sent out notices to the parishes of the city and local boroughs requesting that all those women who practiced the art of midwifery present themselves before a professor of surgery from the university to be examined, and, should they be deemed sufficiently capable, would be “admitted and approved to continue their practice, with permission to display a public sign.” This initial drive toward a comprehensive register of the city’s midwives represented a first step in an even more ambitious program of licensing and control envisioned by Victor Amadeus and his successor, Charles Emmanuel III. The ultimate goal was that all midwives within the city and even (or perhaps especially) the surrounding territories would come

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71 F.A. Duboin, Book VII, Tit. XIX, Chap. II, “Manifesto del Vicario di Torino, del quale notifica essersi stabilito nell’Ospedale di San Giovanni Battista un ricovero gratuito per le povere partorienti, ed una scuola practica per le ostetrici,” 19 June 1728, 646. “Si ingiungono perciò tutte le ostetrici esercenti nella presente città e borghi, nessuna esclusa, a doversi personalmente presentare avanti l’ufficio nostro...per venir quelle che daramo saggio della loro sufficiente esperienza ammesse ed approvate a continuare tal esercizio, con facolta’ d’espone pubblica insegna.”
to be educated at the hospital, rendering traditional and informal modes of training, such as apprenticeship, invalid. At least in its first decades, however, the midwifery school in Turin remained entirely female-controlled, headed by a midwife trained in Paris. It was not until 1759 that Charles Emmanuel overhauled this practice by nominating the respected surgeon Ambrogio Bertrandì to assume control of midwifery education in Turin.\textsuperscript{72}

From the outset, the Savoyard government was intent on stipulating which women were best suited to become midwives, regardless of how closely this image corresponded to the profile most traditional midwives. Although information on the background of midwives in Piedmont is hard to come by, we do know that at that time many practicing midwives elsewhere in northern Italy were mature women and widows.\textsuperscript{73} In contrast, the statutes of the Turin midwifery program insisted that prospective students in the course be young, married women.\textsuperscript{74} Yet the length of the course – six months – would have represented an impractical hardship for most young families, particularly rural ones, which relied heavily on the parental, domestic and agricultural labor performed by women. Those women who were able to enroll in the program were required to submit a certificate from their local parish priest attesting to their good morals and a statement of permission from their husbands. Additionally, applicants were required to know “at least how to

\textsuperscript{72} Alfonso Corradi, \textit{Dell’ostetricia in Italia: dalla metà dello scorso secolo fino al presente} (Bologna, 1874), 4-5.

\textsuperscript{73} See for Milan: Archivio di Stato di Milano (ASM), \textit{Sanità, Parte Antica}, c. 269, 270. For Venice see, for instance, Archivo di Stato di Venezia (ASV), \textit{Provveditori alla Sanità}, b. 589. These documents reveal the diverse social conditions from which midwives in early modern Italy came. It is clear that age was not a deterrent to professional success; rather, a long career earned the respect of others in the community, including the parish priest. Many of these were of very modest social background; at times it was the loss of a husband or son which compelled the woman to begin practicing the art in order to sustain herself and other family members. There is much evidence to suggest that midwifery was a ‘family business.’ Women often trained first under the tutelage of a mother, or other female relative, such as an aunt or mother-in-law.

\textsuperscript{74} AOSG, Cat. 1, Cl. 3, fasc. 1, 1732.
read, so that they could profit from those lessons that will be given in writing and explained, and so also make them qualified for all extraordinary cases” that might arise.\textsuperscript{75}

In practice, the head midwife was responsible for instructing the students in the procedures necessary to recognize the nature of and handle any “disturbances both before and after the delivery.”\textsuperscript{76} The hospital surgeon would supplement this instruction with bi-annual lectures on anatomy. In this manner, the midwifery course represented the efforts of the state to create anew the figure of the midwife. No longer would her expertise and reputation be determined by her own personal experience of childbirth, her long activity within the community, or her access to networks of popular medical knowledge; instead, the new midwife was young, educated in the urban, institutional setting of the hospital, and her knowledge and status were based in part on her literacy and ability to understand scientifically and anatomically the workings of the body.

On paper, such measures would seem to indicate a rapid and total usurpation of female autonomy over the practice and knowledge of midwifery. In reality, however, the changes to midwifery practice and training in Savoy were significantly less extreme. As mentioned, women were entrusted with a considerable sphere of influence with respect to the administration of the maternity ward. It was the head midwife’s responsibility, for instance, to record the personal information of all the unmarried women who came to the ward for care, as well as of the applicants to the midwifery course.\textsuperscript{77} Nominally in charge at all times, the hospital director was only required to visit the ward once weekly; the hospital’s head surgeon was even less visible,

\textsuperscript{75} AOSG, Cat. 1, Cl. 3, fasc. 1, 1732; “Non s’ammetterà donna alcuna a tal imprendimento se non saprà almeno leggere, affinchè possa approfittarsi di quelle lezioni che le saranno date in iscritto e spiegate, per poterle così abilitare eziandio per tutti quei casi straordinari, che nel tempo del suo soggiorno nell’opera accader potessero.”

\textsuperscript{76} AOSG, Cat. 1, Cl. 3, fasc. 1, 1732; “...de’ morbi sì avanti che dopo il parto.”

\textsuperscript{77} AOSG, Cat. 1, Cl. 3, fasc. 1, 1732.
tasked with performing two annual inspections. Midwives’ medical capabilities, then, were little circumscribed. Although she was prohibited from prescribing internal medicines (a normal stricture tallied at non-physician medical practitioners), the head midwife was even initially sanctioned to draw blood and perform enemas when warranted, without the presence of a physician.\footnote{AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide,” 6.5.1728. This was amended in the official regulations released four years later, in 1732, when midwives were prohibited from drawing blood, especially without a surgeon or physician present. See: AOSG, Cat. 1, Cl. 3, fasc. 1, 1732.} When faced with a difficult birth, the midwife was directed to call for the assistance of a male surgeon only in the direst circumstances “when it [was] impossible for her with her hands to extract” the fetus. In all other cases, male surgeons and physicians were strictly forbidden from entering the ward, especially during deliveries.\footnote{AOSG, “Memoriale per lo stabilimento di una sala per le donne gravide,” 6 May 1728. “Ancorchè fosse a lei impossibile colle mani di estrarlo come fara’ chiamare il Chirurgo.”}

**Medicalization?**

It is questionable then to what degree the maternity ward represented – especially in this initial phase – any real ‘medicalization’ or ‘masculinization’ of childbirth. Even the touted clinical nature of the midwifery school was in practice quite limited. Despite Victor Amadeus’ initial proposals, it seems that neither trainee surgeons nor novice midwives were generally allowed to visit the pregnant or laboring patients.\footnote{AOSG, Cat. 1, Cl. 3, fasc. 1, 1732.} Quite unlike the lying-in hospitals described by Margaret Connor Versluysen, which provided the critical clinical experienced needed by male practitioners to enter the field of obstetrics, the maternity ward and midwifery school in Turin functioned in some ways to place the management of childbirth even more firmly in the hands of women, who enjoyed the benefits of official recognition and a wider professional profile.\footnote{Margaret Connor Versluysen, “Midwives, Medical Men, and ‘Poor Women Labouring of Child’: Lying-In Hospitals in Eighteenth-Century London,” 42.}
Young male practitioners, on the other hand, were hardly encouraged to take up the art in anything other than a limited and strictly theoretical fashion. In fact, in contrast to developments elsewhere in Europe, male surgeons in Turin were expressly prohibited from practicing midwifery as a profession until late in the eighteenth century, and even then only six surgeons were authorized to provide an auxiliary role in cases of emergency.82 Although the maternity ward was, in theory, subject to constant male oversight by the director and head surgeon, the daily governance of the ward was functionally in the hands of the head midwife and her female assistants. The degree to which female midwives (or the women who entered the ward as patients) were exposed to the new, masculine field of obstetrics beginning to take root in the universities was thus minimal in Turin until after midcentury, when more aggressive attempts to tie the hospital to the University were made and a male professor was placed in charge of the midwifery school.

For its first several decades of existence, the maternity ward was as much a space dedicated to moral recuperation as it was to a physical recovery. In fact, the ward was in many a ways a direct descendent of those refuges for women which had sprung up in post-Tridentine Italy and which were “designed to provide material comfort and spiritual guidance to poor women,” especially those poor women who had “either fallen or were in danger of falling into sinful practices.”83 At San Giovanni, the maternity ward’s patients were thus expected to

82 F.A. Duboin, Book VIII, Tit. XI, Chap. VII, “Regio Biglietto col quale S. M. nomina i sei chirurghi ai quali permette l’esercizio dell’Ostetricia a Torino,” 2 November 1772. “Nelle Costituzioni per l’Università di Torino abbiamo al tit. 9, cap. 1, paragraph 27 prescritto che non sarà lecito a’ Cerusici di professare l’Arte Ostetricia senza l’espressa Nostra Licenza.” This prohibition against surgeons practicing midwifery remained in effect until the end of the century, with only very limited numbers of official licenses being issued to male practitioners.

83 Monica Chojnacka, “Women, Charity and Community in Early Modern Venice: The Casa delle Zitelle,” Renaissance Quarterly 51/1(1998): 70. See also Sherrill Cohen’s comprehensive treatment of women’s institutions in her The Evolution of Women’s Asylums since 1500: From Refuges for Ex-Prostitutes to Shelters for Battered Women (Oxford: Oxford University Press, 1992). Cohen argues that the emergence of refuges for prostitutes in sixteenth-century Tuscany was part of a trend toward increasing containment and internment of marginalized
undergo a moral transformation as well as a physical one during their recovery. Religious (re)education was stressed for the pregnant inmates, who were assumed above all to have fallen in sin, as soon as they arrived at the hospital. The ward regulations ordered that a chaplain visit the women twice a week, and in times of emergency, “urging them to make their devotions, and always encouraging in them sentiments of piety.” It was believed, moreover, that such moral ‘recovery’ was best “pursued through a rigid separation from the outside,” again, much like that practiced in the above-mentioned women’s refuges and the convents with which they were associated.85

Like the maternity ward, these establishments were interested in providing an institutional solution to the problem of the conservation of female honor, particularly among the poor or those once-wealthy families who had fallen on hard times. In both cases, limited financial means meant that the only honorable and respected outlet for female sexuality – marriage – was off limits. Women of marital age who were not married, particularly those without familial support (and therefore a male guardian) were looked upon with suspicion and assumed to partake in dishonest behavior; the resulting social marginalization effected by such attitudes often resulted in a kind of self-fulfilling prophecy for the women concerned.86

84 AOSG, Cat. 1, Cl. 3, fasc. 1, 1732. “Sarà uffizio del cappellano di visitare due volte per settimana la sala delle partorienti, ed in tutti gli altri casi urgenti, invitandole a fare le loro divozioni, ed insinuando sempre loro que’ sentimenti di pietà che dal suo zelo gli saranno dettati.”

85 Chojnacka notes the important distinction that, while the women’s refuges sought as did convents to create “a secluded environment of prayer, discipline, and contemplation,” they differed from the latter in that the refuges’ ultimate aim was to prepare the female inmates to reenter society. “Women, Charity and Community,” 85.

86 Sandra Cavallo, “Assistenza femminile e tutela dell’onore nella Torino del XVIII secolo,” Annali della Fondazione L.Einaudi 14(1980): 128-129. The Deposito was intended for repentant prostitutes and those in danger of falling into sin, the Opera della Provvidenza targeted young girls of a certain social standing, the Forzate accepted women interned against their will, usually at the bequest of their family, and the Opera di San Giovanni di
eighteenth-century Turin, the maternity ward at San Giovanni was part of expanding network of such female asylums, increasingly under governmental tutelage, of which we can include *l’Opera del Deposito* (founded by private charity in 1684, but put under Royal control in 1742), *l’Opera della Provvidenza* (1735), *le Forzate* (1750), and *l’Opera di San Giovanni di Dio* (1755). The maternity ward, by removing from sight the tangible evidence of a woman’s pre-marital sexuality, was attempting to restore to a particular population of women their compromised honor and make possible their entrance into a respectable social situation—namely, marriage.

The continued ties between the maternity ward and the hospital’s founding population in the second half of the eighteenth century further reflects the mixed character of maternal assistance in this period as both medical/secular and charitable/religious. As the foundling population at San Giovanni continued to grow during the eighteenth century, hospital reformers increasingly called for the orphans’ removal to a new site distinct from the hospital. The funds frequently being reallocated to support the foundlings’ care and upkeep, they argued, should really be directed toward the hospital’s population of sick and “curable” patients. Foundlings, as well as other groups historically served by large, central hospitals like San Giovanni, such as the indigent and “incurable” sick, were increasingly in the eighteenth century seen as burdensome. Instead, as hospitals became more strictly associated with medical care and treatment rather than charity, such populations were moved to separate, specialized institutions. As Aurora Scotti explains, the period between 1750-1850 saw in Italy (however unevenly across

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*Dio* was patterned on the *Provvidenza* but intentioned particularly for young girls of the popular classes and had as its aim to be entirely self-sufficient through the labor of the girls recovered there.

87 Cavallo, “Assistenza femminile”, 142.

the peninsula), “the transformation of the hospital from a place of undifferentiated recovery, intended to provide aid to ‘ailments’ at once social, physical, and psychological, to a place designated to the treatment of health.” Confinement for those groups outside this latter designation could be provided by other institutional solutions, such as work houses or insane asylums, while the hospital developed its reputation as a center for clinical training and pathological study. The transformation of the hospital was “strictly connected to the transformation of medicine from theoretical science, learned dogmatically through texts and expert verbal discourses, to a science taught and elaborated on at the bedside of the sick person himself.” When the foundling population was finally moved from San Giovanni, it is thus telling that the maternity ward was transplanted along with it, creating the specialized maternity house known as the *Ospizio della Maternità* in 1801. Not only were dishonored pregnant women a difficult population to house within the context of a large general hospital, but their care was, like that of foundlings, seen as much in charitable terms as medical.

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91 Scotti, “Malati e strutture ospedaliere,” 236.

92 The reasons cited for the move included the “overly confined and unhealthy site where the *Opera delle Puerpere* was housed [in San Giovanni hospital]; the lack of means of enlarging that space within the borders of the hospital; the influx of pregnant women in great numbers; the great need to increase the number of ‘in-house’ wetnurses, who at present frequently are required to nurse four, or five infants each; the prodigious mortality of infants, that result from these problems; and finally the ever growing number of boys, and girls, who return from [wetnursing in] the countryside after ten years, for whom must be acquired housing and an occupation…” AST, *Materie Ecclesiastiche, Luoghi Pii e Opere Pie, Per Paese*, Mazzo 234 addizione, *Informativa sull’Ospizio della Maternità di Torino*, 18 October 1814. “Il locale troppo angusto, e mal sano ove era collocata l’Opera delle Puerpere; il nissun mezzo di ampliare lo stesso locale nel recinto dello Spedale di San Giovanni; l’affluenza delle Puerpere in grande numero; il bisogno sommo di aumentare le nutrici sedentarie, le quali ben soventi dovevano allattare quatro, o cinque infant per caduna; la mortalità prodigiosa degli infanti, che risultava da questi inconvenienti; infine il numero sempre crescent de figliuoli, e figlie che si restituivano delle campagna dopo li dieci anni, ai quali si doveva procurare locale adattato, ed occupazioni, sono altrettanti motivi…”
III. Alternate Forms of Maternal Assistance: The *Compagnia delle Puerpere*

Although we have discussed to this point the institutionalization and medicalization of childbirth, it would be remiss to ignore other forms of maternal assistance existing in the same period. One of the most important of these was the *Compagnia delle Puerpere*, a voluntary charitable association dedicated to domiciliary maternal and infant care. Originally founded in 1732, at nearly the same time as the maternity ward in San Giovanni was opened, the *Compagnia delle Puerpere* suffered initially from limited and inconsistent funding and disappears from the archival record soon after its formation. Only in the later 1770s was the *Compagnia* reorganized, again with royal support. Sustained by a mixture of public, private, and religious charity that was not uncommon for such organizations prior to the rise of the modern welfare state, the re-founded *Compagnia* proved popular and continued to exist during and after the Napoleonic period.

While the Turin maternal society shared the maternity ward’s goals of supporting poor mothers and preserving a fragile infant population, it did so under rather different ideological parameters and organizing principles. Unique among other charitable organizations of the same period in that it was administered solely by women, the *Compagnia delle Puerpere* had as its stated mission to “succor with charity those unhappy women, for whom pregnancy and postpartum, are for the most part plagued with infinite disadvantages and discomforts.”93 It was because of their natural “weakness, their sex, and their infirmity” that these women deserved

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93 AST, Sezione Corte, Materie Ecclesiastiche, Luoghi Pii di qua dai Monti, Mazzo 16 d’Addizioni, Compagnia delle Puerpere. “Il principale, anzi unico oggetto di tale ordine si è quello di soccorrere con limosine quelle infelici, a quali il puerperio accompagnato per lo più da infiniti disagi, e malori toglie ogni umano mezzo di riparare alla miseria, che già le opprime.”
special consideration among the wider pool of potential charity recipients. The initiative and initial financial backing for the association came from Polyxena Christina Johanna, wife of Charles Emmanuel and mother to Victor Amadeus III. The Princess Christina served as the organization’s first prioress and enriched the Compagnia’s coffers with royal funds. Additional resources were attained from religious organizations and confraternities, wealthy benefactors (who often served in some capacity on the charity’s board or as members), and other private donations. According to the society’s original bylaws, the recipients of aid were to be those women and families that were completely destitute, and particularly to those families whose poverty was exacerbated by numerous children, the desertion or death of a husband, or by a husband who for reason of infirmity could no longer support the family.

At the same time, the society, with full support from the state, aimed at promoting and inculcating the values of responsible motherhood and familial duty among the poor, and at dissuading the abandonment of (legitimate) children at the already overburdened foundling facilities in the city. In this way, the Compagnia delle Puerpere reflected a mixture of public and private charity, religious and secular ideology. In one petition for increased royal support, for instance, the Compagnia reminded its potential benefactors that the association performed a necessary service of “Christian and moral piety” in which its members “all observe the precepts,
that from the fathers of the Church are prescribed to charitable persons, and they make their
virtue serve the common good, toward the true wellbeing of human society.” In this way,
individuals, especially women, of a certain social standing could be seen to demonstrate that
Christian piety expected of them.

On the other hand, the maternal charity was supported by the Turin government for more
secular reasons. As numerous critics reminded the government over the century, the city’s
foundling homes were completely inadequate for the extreme and ever growing burden of
abandoned children they were expected to support. As many as one half of all abandoned
children, regardless of whether they were legitimate or illegitimate, died either at the foundling
home itself or in the care of a never sufficient number of rural wetnurses.98 For government
officials steeped in mercantilist and populationist notions, this regrettable figure represented the
loss of future citizens to enhance the strength and workforce of the state.

Although the regulating board was comprised of women, members of the association
could be of either sex, any rank and age, given that they were able to make yearly donations of at
least three lire in addition to an initial contribution. The association’s organizational structure
included an all-female administration (including a prioress, who by tradition was assigned to a
royal provider, an under-prioress, a secretary, and a treasurer) and sixteen inspettrici who would
be responsible for overseeing operations in specific quarters of the city (later reports lamented
the fact that resources limited the society from reaching out to families outside of the city). The
latter, chosen from among the city’s dames, would be tasked with identifying all the poor
pregnant women in their assigned quarters. In this, the local parishes would serve as a critical,
initial information source. Once identified, the lady inspectors would visit the women and then

98 Prospero Balbo, “Delle diverse proporzioni tra la mortalità de’ fanciulli e quella delle età superiori,” Memorie
della Reale Accademia delle Scienze di Torino, Tomo XXXIV, 51-60; Tirsi Mario Caffaratto, “Storia dell’assistenza
report in detail on their behavior and mores as well as their relative state of poverty and need, validated further by a certificate from the parish priest. Only those women deemed worthy of the kind of assistance – pious and moralizing - offered by the Compagnia delle Puerpere would have their cases reported to the head or assistance prioress for a final decision on whether they would receive aid.99

The main aim of the association was to provide financial support for poor, pregnant women so that they would not need to take recourse to the public maternity ward at San Giovanni, and so that they could nurse their own newborns, particularly if they did not have the means to send their infants out to a wetnurse. Families selected for assistance would receive monthly contributions somewhere from forty soldi to three lire, for as long as fifteen months, that is the time seen as sufficient to breastfeed and wean an infant.100 However, in cases where the mother was unable to breastfeed, the monthly aid could be applied instead toward the maintenance of a wetnurse. When the family demonstrated particular poverty, as much as six lire might be supplied for the costs of the birth itself.101 Although the original bylaws of the Compagnia are clear that funds may be used for a family to pay a wetnurse, later documents produced at the time of the association’s re-founding in the 1770’s strike a somewhat different tone. The later, modified bylaws continue to note the commendable expression of Christian charity represented in the Compagnia’s work. However, the 1770’s bylaws also emphasize much more strongly the importance of mothers breastfeeding their own children. Not only would the


100 AST, Sezione Corte, Materie Ecclesiastiche, Luoghi Pii di qua dai Monti, Mazzo 16 d’Addizioni, Compagnia delle Puerpere.

charity prevent the unnecessary deaths of innumerable infants in the crowded and unhealthful conditions of the foundling homes, but it would allow,

poor mothers to be able to draw tightly to their breast, and breastfeed the fruit of their own flesh and blood (viscera), according to those tender sentiments that are inspired by nature, and confirmed by religion; and the infants brought up in that manner can know, and love those from whom they were given life, and can later be their support in old age; which everyone can see how much [this] will contribute to the good order of civil society.  

This kind of sentimentalist language reflected the emergence of a new maternal ideal which had begun to shape expectations toward poor and elite women alike. In the half century since the Compagnia had first been formed, Enlightenment thinkers had begun to reconsider the role of the mother and her importance to the state, and to advocate a much more emotive and sentimental basis for the relationship between a mother and her child. Rousseau, for instance, had written that mothers who sent their children out to wetnurses were cruel and unnatural. 

Others, like Marie Angelique Anel Lerebours, believed that wetnursing was a significant factor in the depopulation of modern states. And although the expression of Enlightenment values of maternity and motherhood have been most often associated with French writers like Rousseau and Anel Lerebours, they were not unknown in Italy. Increasingly in Italy as well childbearing had begun to be associated rhetorically with notions of the “public good” and “public interest,” and well-known figures such as Pietro Verri advocated breastfeeding one’s own children. 

102 AST, Sezione Corte, Materie Ecclesiastiche, Luoghi Pii di qua dai Monti, Mazzo 17, “Memoria di Varie Providenze che si Credono Necesarie per l’Opera delle Partorienti eretta nello Spedale Maggiore di San Giovanni della Città di Torino.” “Un aiuto somministrato a tempo alle povere madri farà sì che ciascuna di esse potrà stringere al suo seno, ed allattare il frutto della sua viscera secondando que’ teneri sentimenti che sono insirirati dalla natura, ed avvalorati dalla Religione; ed I bambini in tal guisa allocèt si potranno conoscere, ed amar quelli, da quali ebbero la vita, ed esser poi loro di sostegno nella vecchiaia; il che ogn’un vede quanto contribuisca al buon ordine dello stato civile.”


104 Luciano Guerci, La sposa obbediente: Donna e matrimonio nella discussione dell’Italia del Settecento (Torino: Tirrenia, 1988), 218.
Piedmontese surgeon Giuseppe Maria Reyneri likewise praised examples of Turin mothers who breastfed their own children in his Italian translation of Anel Lerebours work, *Avvertimenti alle Madri che Allattar Vogliono I Loro Bambini*. Benedetto Frizzi, a Lombard physician and proponent of state-supported public health measures, praised both the moral and physical benefits of breastfeeding: a mother’s milk, he wrote, “has greater similarity to the baby” and therefore provides critical health advantages in those most vulnerable days of early infancy. At the same time, the mother herself received benefits, such as faster healing, and the avoidance of fevers, skin inflammations, and other post-partum complications. Breastfeeding he concluded was therefore not only a “sacred duty,” but also a public health necessity.

Advocates of breastfeeding faced a long standing tradition in which sending one’s child out to wetnurse had typically been an indication of social status and wealth. At the same time, indigent women might be forced to wetnurse their children in order to work themselves. Increasingly during the eighteenth century, however, critics voiced the opinion that only through breastfeeding could a mother form essential, affective ties with her children and so truly fulfill her maternal duties. Charitable associations like the *Compagnia delle Puerpere* provided support to needy populations while at the same time promoting the kind of maternal values described above. In fact, similar charities in other cities, such as Paris’ Society for Maternal Charity, founded in 1788, demanded that the recipients of their aid satisfy strict guidelines for moral

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106 Benedetto Frizzi, *Dissertazione di Polizia Medica sul Pentateuco in riguardo alle legge spettanti alla Gravidanza, al Parto, Puerperio, all’Educazione della Fanciulezza, ed ai Patemi di animo, etc.* (Pavia: 1788), 85-86.

behavior, including that only mothers with legitimate children would be helped. Although the Compagnia delle Puerpere was somewhat less severe in its bylaws, limited funds meant that only those women deemed most deserving and most likely to benefit from assistance (and the moral message with which it was accompanied) were selected to receive aid. At the same time, it was hoped that the elite women benefactresses and the inspettrici would also promote, perhaps by example, the value of breastfeeding and maternal sentiment among women of their own social class.

Conclusions

After a thorough consideration of the founding and bylaws of the maternity ward and midwifery school in Turin, we must now ask, to what extent were these novel institutions a success? What practical impact did the introduction of an institutional space for childbirth and the formal instruction of midwives have on the practice of midwifery in eighteenth century Piedmont? On the women who gave birth in the confines of the hospital? To begin, the maternity ward was not without its fair share of internal discord in its first years of existence. For instance, while the first head midwife was trained at the Hotel-Dieu in Paris, perhaps the most advanced center of obstetrical learning in Europe at the time, she quickly became a target for some of the hospital board’s residual irritation at being strong-armed by the Royal government. Protest was kept up until 1740, when the French woman, Chevassus, was replaced by a native Turinese woman – a foundling who had herself grown up in the hospital.

The petition to oust Chevassus was itself part of a larger call for reform in the ward, only a decade after its opening. The hospital board cited “grave disorders” which had arisen during the maternity ward’s short existence, many of which stemmed from the lack of discipline and

control exhibited by the head midwife herself. Among the charges leveled at the French woman were claims that she had administered excessive doses of medicine causing sicknesses and even deaths in the ward, that she accepted women before their seventh month of pregnancy, that she was lax about preventing unwanted visitors to the ward, and indiscriminate about the women she allowed to train at the midwifery school, and finally, that she was taking in her more than her fair share of the food and resources dedicated for the entire ward.109 On one point, the head midwife may not have been wholly to blame: a number of pregnant women had apparently attempted to bypass normal registration protocol, including the stipulation of admittance only after the seventh month, by feigning labor pains.110 Additionally, the board noted that the twice yearly anatomical demonstrations had fallen off, as had the use of any written lessons for the training midwives.111

Together, these abuses underscored two particular areas of concern. First, and most troubling, was the demonstrated lack of discretion practiced by those in the ward, particularly the head midwife. The presence of unwarranted visitors, perhaps even men, to the ward represented behavior “in prejudice of decency” and counter to the protection of female honor that the Royal government had so wished to establish.112 The abuses originating with head midwife during Chevasuss’ time also indicate that male oversight of the ward by either the director or head surgeon was minimal, if it existed at all. Although the midwife’s decisions regarding the

110 AST, Sezione Corte, Materie Ecclesiastiche, Luoghi Pii di qua da Monti, Mazzo 17, Fasc. 8.
111 Ibid.
112 AST, Sezione Corte, Materie Ecclesiastiche, Luoghi Pii di qua da Monti, Mazzo 17, Fasc. 7.
admittance of pregnant women to the ward or novice midwives to the school should all have been approved by the director, it appears that she had ultimate authority in most cases.\footnote{Ibid.}

Second, the midwifery school was clearly not living up to the standards of the kind of scientific institution Victor Amadeus had envisioned in his initial proposals. Anatomical instruction by the hospital surgeon had become sporadic, if not absent entirely by the late 1730’s. The standards by which new trainees were chosen had become permissive as well, with the head midwife reportedly admitting “anyone [she wanted] and even girls.”\footnote{Ibid.} The earlier requirement that students be able to read was apparently ignored. Explicit in the administrators’ report, labeled “Concerns,” was also a note of dissatisfaction with the lack of clinical training in the ward, though, as noted above, this was always an area where the hospital was hesitant to push too far. Although the 1739 report does not go so far as to invite male trainee surgeons into the ward to observe the patients and deliveries, it does recommend that “in order to instruct [the training midwives] it is useful to adopt the practice of Paris of operating on the pregnant women uncovered.”\footnote{Ibid.} The report further called for the reinstatement of anatomical lectures, now twice a week, with the task assigned to Professor of Anatomy Alberto Verna.\footnote{Ibid.} Nevertheless, real changes in the educational program at the maternity ward did not come until 1761, when the teaching of obstetrics was instituted at the University of Turin and a closer relationship between the two institutions was solidified by royal decree.\footnote{F.A. Duboin, Book XIV, 625, “Regio Biglietto,” 17 March 1761.}
If the maternity ward’s medico-clinical ambitions were ultimately modest, it’s charitable and moral interventions were more significant. From the limited documentation available, we can determine that recourse to the hospital maternity ward grew almost immediately. From an initial outlaying of eight beds, arrangements for an additional twelve beds were underway already by 1729, and grew steadily from there. By 1782, the ward’s total beds had increased to 125. Furthermore, for the ten year span of 1736-1745 we know that 936 women delivered children in the ward. For the next period we have accurate accounts, the seven-year period from 1760-1766, 847 women gave birth, an annual increase of 27 births. By the end of the century, those numbers had risen even more dramatically. From 1788-1800, over 3600 women gave birth at San Giovanni, 282 per annum on average.118 The majority of the babies born at the hospital were, moreover, illegitimate children born to single mothers. Across the period from 1736-1800, for instance, approximately 73% of the women who gave birth in the hospital were single women.119 By 1739, reformers effusively praised the maternity ward’s success in preventing infanticides, though whether the sentiment was more political rhetoric than fact is of course impossible to determine for a crime which was likely committed many times without ever being brought to light.

These numbers make abundantly clear that the maternity ward was serving a palpable social need. It is no surprise that historians locate in this period meaningful shifts in traditional forms of social control and the management of female and sexual honor, and reproduction. According to Silvana Baldi, the traditional community was subject to disruptive forces from multiple sources during the eighteenth century, all of which had the similar result of weakening traditional bonds of cohesion and self-regulation. During the course of the century, for instance,

118 Baldi, 129.

119 Ibid, 136. According to Baldi, 28.5% of the babies born in the hospital in that period died.
“the ‘promise’ that fiancés exchanged prior to marriage…progressively lost its protective function with respect to female honor and of control and legitimization of pre-marital sexual practices.” Additionally, the rural population became increasingly mobile, migrating toward the city for greater job opportunities, and at the same time “rendering…more difficult a paternity search.” Together, these disruptions of traditional practices meant that no longer could illegitimate births be made acceptable through subsequent marriages, and “much less with a simple declaration of paternity on the part of the mother,” (as had often been sufficient in the past for a father to recognize a bastard).\footnote{Baldi, 127.} If, along with the Church’s more militant stance on pre-marital sex and proper marital procedure, these changes had begun to introduce a new sexual ethics and morality into society, the maternity ward at San Giovanni represented a public institution of reclusion and rehabilitation that could both hide and absorb the effects of social and sexual deviance. Indeed, had Appolonia and the priest Giovanni Caomina’s love affair, with which this chapter opened, been carried out some months later, the two lovers may have arranged for the young woman to give birth at the city’s new maternity ward. For the first time, a state institution was attempting to act as custodian of female honor and sexual morality.
CHAPTER 4

MILAN AND ENLIGHTENMENT-ERA PRO-NATALISM, 1767-1796

Francesca Mazzuchelli, a peasant woman from Gallarate, a rural community northwest of Milan, was among the first class of midwives to be trained at the city’s new midwifery school. Established in 1767 in Milan’s central hospital, the Ospedale Maggiore, the midwifery school was the first of its kind in the Milanese state. Reformers were particularly intent on recruiting women from the countryside, who, they hoped, would act as ambassadors, bringing to remote communities the new knowledge of childbirth gained in the city. Despite her success at school (Francesca had “gracefully completed her final exam”), however, Mazzuchelli’s return home was met with disillusion and despair. Instead of the expected benefits of formal education and official license, such as increased pay and a wider client base, Mazzuchelli found herself in a losing competition with two other midwives, Camilla Ceriana and Orsola Brambilla, both of whom had continued to practice “without approval or study” in Francesca’s absence. Mazzuchelli discovered that she was rarely called on to act as midwife and so had “hardly enough food for her numerous family.” In fact, Mazzuchelli’s experience was one that would be repeated over and over when the school’s newly trained midwives returned to their home communities. Rather than embrace this new corps of ‘professional’ midwives, women in the countryside shunned something they viewed with suspicion and doubt. Neither the theoretical training of the university nor the shiny patents of approval made much of an impact on women

1 ASM, Sanità, Parte Antica, c. 269, Complaint of F. Ponti Mazzuchelli, 11 October 1768.
who judged the skill of their birth attendants by trusted recommendation earned through years of practice and intimate knowledge of the community. Although the new medical field of obstetrics, of which the course Mazzuchelli attended was an extension, claimed for itself a “position of universality” premised on an internal conviction that it represented the rational view of the female reproductive body, Francesca’s fate reminds us that there are and were multiple, competing ‘rational’ understandings of childbirth and the female body.

In this chapter, I aim to sort out and interrogate the reasons behind resistance to the new knowledge of childbirth embodied by the licensed midwives returning from Milan’s first midwifery school. In the preceding chapter, I explored the societal pressures for and institutional expansion of midwifery education and public maternity assistance in Turin in the first half of the eighteenth century. In the first part of this chapter, I examine the development of midwifery education in Milan and consider the continuities and divergences between experiences there and in Turin. While Savoy in the second decade of the eighteenth century was intent on reform, it lacked the more radical illuministi associated with Hapsburg Milan in the second half of the century. If the opening of a maternity ward in Turin in 1728 was a demonstration of chairtable benevolence by an absolutist state intervening for the first time in the tutelage of female honor, the emergence of midwifery instruction and maternal assistance in Milan reflected an Enlightenment-era confidence in the power of science, the necessity of the State to involve itself in public health, and in the State’s ability to utilize the biopower of its subject population to buttress it in international competition.

In the second part of the chapter, I add a new dimension to the present historiography of early modern midwifery by questioning the spatial and epistemological foundations which underpinned the above developments. At a most essential level, the epistemology of childbirth
upon which the emergent medical field of obstetrics was based privileged theory and a universalized conception of the female body. Although what I am terming ‘traditional’ midwifery practices were themselves neither transhistorical nor a distinct corpus, they did— I argue— oppose the subjection of the female reproductive body to reductive, universalizing principles. Milan presents an instructive test case for understanding the interactions and divergences between these two knowledge systems. Home to innovative initiatives in both midwifery instruction and maternity care, Milan often served as a model for other Italian states experimenting with similar programs. Furthermore, in Italy more than elsewhere in Western Europe, the management of childbirth was left largely in the hands of women throughout the eighteenth century. Thus the midwifery school project at the Ospedale Maggiore, as in Turin, was aimed from its inception at training female midwives. At the same time, however, the knowledge and praxis of childbirth as taught at the Milanese school was indicative of a new scientific epistemology that would shape the ways in which childbirth was understood, embodied, and assisted in the Western world down to the present day. According to the fundamental organizing principles of obstetrics, childbirth could be rationalized and universalized in a way that contradicted much of traditional midwifery’s concern with the individual female body and woman’s unique experience of labor.

The third part of this chapter then moves from the instructional space of the midwifery school to the maternity ward in order to consider the role the built environment and the politics of space played in the processes of knowledge formation and transmission discussed above. I maintain that the spatial dimensions of birth have been as important as the intellectual ones in the development of its ‘modern’ management and performance over the last three centuries. As Robyn Longhurst notes, “embodied subjectivity and spatiality are intimately entwined. Bodies
both produce space and are produced by space.”² In other words, a woman’s experience of maternity is at once influenced, and in part constructed by, her physical environs and her interaction with those environs. At both the midwifery school and maternity ward in Milan, training midwives, male doctors, and pregnant women negotiated various visual and spatial cues which were encoded with particular understanding of childbirth, reproduction, and the female body. Such cues, while they might overlap with, were necessarily distinct from, those associated with traditional home births. Yet the various individuals who navigated such spaces were active participants in the ascription of meaning to the environments they inhabited. For instance, while the hospital represented for medical men the opportunity to confine birth and the pregnant body in a controlled, bounded space, the continuous reports of “abuses” arising in these spaces demonstrate that the mothers-to-be, midwives, and wetnurses there were not just passive bodies waiting to be acted upon. Instead, they appropriated spaces for their own purposes and needs and applied their own value judgments. Finally, although it was the ultimate aim of male medical writers to pathologize childbirth, the built environment of birth in eighteenth-century Milan frequently belied other, competing interests and ideologies, many of which were medical in only a peripheral sense.

The final part of this chapter moves beyond Milan to assess the Hapsburg government’s project to expand midwifery education into the provinces. Fearing a limited impact of a single training center in the capital, authorities in both Vienna and Milan proposed a network of midwifery schools to be established in several regional centers. Pavia, where the University was located, was an obvious choice; the locations of the remaining schools were debated vigorously, with Como, Mantua, Castelmaggiore, Lodi, and Cremona coming out as forerunners. In this section, I explore the differences in aims and organizing principles between these provincial

schools and the school in Milan. Even with its emphasis on scientific training, for instance, the Opera delle Partorienti in Milan was always cognizant of its role as a refuge for mothers with unwanted pregnancies or those with destitute home conditions. The provincial schools, by contrast, were established, organized, and run with the singular intent of training midwives. At the same time, the establishment of a network of midwifery schools indicated the expansion of “medicalized” care and spaces to regions where health and reproductive care had traditionally been undertaken in the home. A network of regional midwifery schools, furthermore, allowed for new, secular modes of demographic record-keeping by the State. Such a project was, therefore, an expression of an expanded and strengthened state apparatus in Hapsburg Lombardy in the years immediately prior to the French invasion in 1792.

Part I

Debating Midwifery in Milan: Why not instruct them?

In contrast to the situation in other parts of Western Europe, neither state officials nor the medical establishment demonstrated much sustained interest in childbirth in early eighteenth-century Italy. Apart from the precocious example of Turin, where, as we have seen, a school for midwives was instituted in 1732, little changed until midcentury when, in a relatively short span of time, state officials throughout the peninsula began to express deep concern about the condition of birth assistance in their territories.³ In Milan, the state’s heightened attention to the perceived rampant abuses of midwives, the vast majority of whom were practicing without official license, led to the seemingly obvious conclusion: why not instruct them? This was the opinion of the great reformer and historian Ludovico Antonio Muratori: municipal midwives, he wrote in 1749, have a “duty [that] is of such import to the public for the happiness of communities… [that] it is [the] just duty of the city or the prince to assign some physician, or

other person learned in anatomy, and this art [of obstetrics]...who will run a school for the women elected for this office.” Formal instruction, Muratori believed, would alleviate the “not few disorders, and deaths of infants and mothers” which result from the “ignorance and lack of skill of” our present midwives. 4 Taking Muratori’s cue and reinforced by the Teresian reforms sweeping Austrian Lombardy, Milanese officials inaugurated a midwifery school, one of the first on the Italian peninsula, in 1767.

Milanese officials believed the “disorders” cited by Muratori originated in particular in the countryside. The fewer well-trained doctors and surgeons available to support rural populations meant that the vast majority of births there were handled solely by women – whether trained midwives or simply female friends and relatives – even when deliveries proved difficult. State authorities therefore felt that it was above all the women of the provinces to whom they should direct educational efforts. Indeed, in a survey of rural midwifery practices carried out in 1766, one alarmed bureaucrat reported back that the midwives he encountered were “completely ignorant and impudently bold...undertaking operations,” with the use of prohibited instruments which invariably resulted in the deaths of mothers and babies. 5 The re-introduction of women

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4 Ludovico Antonio Muratori, Della pubblica felicità: oggetto de’ buoni principi (Lucca, 1749), 142. “Lo stesso è da dire delle pubbliche Levatrici e Mammane, l’impiego delle quali tanto importa al Pubblico per la Felicità dei paesi. Ben di dovere è, che le Città o il Principe deputino qualche Medico, o altra persone intendente di Notomia, e di quest’Arte...i quali facciano scuola alle Donne elette per tale Ufizio...Non pochi disordini, e la morte o de’Fanciulli, o delle Madri, noi rimiriamo talvolta avvenire per l’ignoranza ed imperizia delle Mammane.”

5 Although midwives were prohibited from the use of obstetrical and surgical tools (stipulations which reflected surgeons’ professional jealousy more than anything), it was nonetheless probably that a midwife, particularly in remote, rural areas would have some kind of ‘instrument.’ Generally some kind of a crotchet, which could be used to extract a dead child piece by piece, there is little evidence that midwives were overly quick to use any such tools, or that a male surgeon’s or physician’s use of them would have resulted in better outcomes (in many cases, instruments were applied only in the event of the fetus’ death in the womb). Male practitioner’s use of the forceps did aid in certain cases of obstructed births, though these were relatively few. In fact, in areas where the struggle between female midwives and man-midwives took a more publicized and virulent expression (such as England), it was invariably the male practitioner who was accused of being too ready and rash with his instruments. See, for instance: Margaret Connor Versluysen, “Midwives, medical men, and ‘poor women laboring of child’: lying-in hospitals in eighteenth-century London,” in Women, Health and Reproduction, ed. Helen Roberts (Routledge: London, 1981), 31; Jo Murphy-Lawless, Reading Birth and Death: A History of Obstetric Thinking (Cork: Cork
trained formally in the city in areas where Milanese administrative control was traditionally weaker thus constituted an additional and appealing benefit of the proposed midwifery school.

**A School for Midwives: Midwifery Education in Milan, 1765-1772**

In contrast to Turin, Milan made no comprehensive efforts to formally instruct or regulate midwives in the first half of the eighteenth century. In the mid-1760s, a report commissioned by the Milanese medical faculty described the process by which most women entered the profession: “For the most part, the priest of the village selects the oldest woman, or the least hampered by a husband and children [to become midwife], he instructs [her] in the formula of baptism, and then publishes her name at the altar” so that she will be known publically as midwife.⁶ At times, the bishop might intervene in this process to confirm the midwife’s capacity in regards to the administration of the baptismal sacrament; episcopal visitations were known to include an inspection of all practicing midwives for just this reason. Beyond this, however, midwifery instruction in the mid-eighteenth century remained much as it had for years, based on apprenticeship and communal forms of regulation and authorization. Only in 1767 did that situation change significantly, when Empress Maria Theresa of Austria, as part of larger efforts to reorganize the charitable and educational institutions in her Lombard territories, issued an edict to Milan “to erect a school in this Venerando Spedal Maggiore, where [midwives] can be comfortably trained.”⁷

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⁶ ASM, *Sanità, Parte Antica*, c. 186, “Relazione della visita fin’ora eseguita nello Stato di Milano dalla Commissione della Facoltà Medica,” 2 May 1767. “Per lo più, il parroco del villaggio prescieglie o la più vecchia donna, o quella che è più disimbarazzata dal marito, e dalla figliolanza, la istrusisce sopra la formula del battesimo, e poi pubblica all’altare il nome, per commune notizia del suo popolo.”

⁷ ASM, *Sanità, Parte Antica*, c. 268, Circular printed in Milan, 28 October 1767.
In the eighteenth century, Lombardy was a part of the Austrian Empire. The Lombard territories had been ceded to the Habsburgs in 1706 during the War of Spanish Succession, ending a century and a half of Spanish domination. Battered by near-constant warfare in the first six decades of the century, Austria found itself by mid-century in critical need of financial and administrative reform. As in Savoy, the extraordinary costs of warfare required more efficient tax collection and administrative centralization. At the same time, such increased bureaucratization demanded educational reforms in order to train and prepare a new class of secular civil servants. The educational and charitable reforms mentioned above were carried out in the Austrian Empire under the banner of Enlightened Absolutism; economic, social, and political reforms were thus self-consciously tied to and justified by the rhetoric of the Enlightenment. Maria Theresa (r. 1740-1780) and her son, Joseph II (co-regent 1765-1780, r. 1780-1790) have traditionally been associated with the concept of Enlightened Absolutism (or Despotism), as they enacted broad reforms in order to modernize and strengthen their state, generally at the expense of the traditional, feudal privileges of the landed nobility and the clergy, as well as of corporate structures like the guilds. In practice, this meant eliminating tax exemptions for the nobility and the Church, and neutralizing autonomous expressions of local

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8 Charles W. Ingrao, *The Habsburg Monarchy, 1618-1815* (Cambridge: Cambridge University Press, 2000), 115. Lombardy remained in Habsburg hands until 1859, though with periodic interruptions: during the War of Polish Succession when Piedmontese troops briefly held Milan (1733-1735), and then under Napoleon from 1796-1798 and 1800-1815.

9 The War of Spanish Succession (1701-1713), the War of Polish Succession (1733-1738), the War of Austrian Succession (1740-1748), and the Seven Years’ War (1756-1763).

10 The reforms of the Austrian Empire are commonly divided into three stages: The First Theresian Reforms (from 1748 to about 1760), the Second Theresian Reforms (1760-1780), and finally the reforms of Joseph II (from 1780-1790), the last of which are considered to be by far the most aggressive, if often continuations of initiatives begun by Maria Theresa. For a more thorough discussion of the terms Enlightened Absolutism and Enlightened Despotism and their historiography (for the Austrian case in particular) see the introductions in Ingrao, *The Habsburg Monarchy*, and Frank A. J. Szabo, *Kaunitz and Enlightened Absolutism, 1753-1780* (Cambridge: Cambridge University Press, 1994) and chapters 2 and 11 in Derek Beales, *Enlightenment and Reform in Eighteenth-Century Europe* (London: I.B. Tauris, 2005).
authority with the expansion of a strong, centralized state apparatus.\textsuperscript{11} Like most European monarchs of the era, both Maria Theresa and her son were particularly anxious to limit the Church’s massive influence. They moved to cut the local clergy’s ties with Rome, undermine the Church’s monopoly on education, dissolve the Jesuits (whose heavy involvement in both government and education was troubling to the monarchs), eliminate excessive religious holidays, and undertake the wide-scale suppression of the monasteries and the repurposing of monastic land for new secular initiatives.\textsuperscript{12}

In terms of education, Maria Theresa aimed to reorganize and modernize the universities, initiate a network of professional schools, and greatly expand primary education throughout the Habsburg territories, endeavors continued under the reign of her son. Simultaneously, legal reforms further reduced privileges and exemptions based on class titles, and functioned to ensure natural rights. Joseph II pushed his mother to fully abolish torture in 1776, for instance. He also intervened in legislating civil matters, particularly with regards to marriage and divorce, a clear encroachment upon terrain typically supervised by the Church. Influenced in part by the Physiocrats, Joseph championed land reform, enacting measures which limited the seigniorial power that landlords held over their peasants, reducing the land tax, and essentially abolishing serfdom in 1781. Although not always compatible in economic theory, Joseph II tended to match physiocratic agrarian reforms with mercantilism. The monarch limited imports, granted industrial entrepreneurs tax exemptions, and worked to bolster exports.

In Lombardy, the Habsburg reforms were aimed above all at expanding and maintaining a sizable tax base and at strengthening central authority in the provinces. Initiatives mirroring those enacted in Austrian lands to create a more equitable tax base, centralize the administration,

\textsuperscript{11} Ingrao, \textit{The Habsburg Monarchy}, especially chapters 5 and 6.

\textsuperscript{12} Ingrao, \textit{The Habsburg Monarchy}, 188; Beales, \textit{Enlightenment and Reform}, chapters 8 and 9.
and limit privilege, all worked to undermine the traditional Milanese patriciate. The government of Lombardy was brought more closely under Viennese control with the establishment in 1757 of the Dipartimento d’Italia headed by the powerful and charismatic Austrian state chancellor, Count Wenzel Anton von Kaunitz. Together with the Austrian governor of Milan, plenipotentiary Carlo Firmian, Kaunitz wielded increasing authority over all governmental activity in Lombardy. In 1760, Kaunitz launched a much more accurate tax-survey which no longer exempted the nobility and clergy. Kaunitz was also a strong proponent of his government’s anti-clericalism in the Italian territories, using a body called the Giunta economale to limit ecclesiastical expenditures and the number of religious institutions. Calls for reform in Lombardy were by no means entirely foreign endeavors. Pietro Verri, author of the famed Il Caffè, the leading enlightenment journal in Italy, was appointed to the Lombardy Supreme Economic Council in 1765 and from there actively supported reforms such as, for instance, Joseph II’s initiative to completely abolish the tax farming system.

Underlying the Habsburgs’ cameralist and mercantilist policies was a basic belief in populationism, meaning that the strength of a nation was critically dependent on the strength, health, and growth of its population. The cameralism and mercantilism of Prussian and French

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14 Beales, Joseph II: Volume 1, In the Shadow of Maria Theresa, 1741-1780 (Cambridge: Cambridge University Press, 2008), 264.

15 Beales, Joseph II, 264-266. Verri was joined by many other representatives of the Lombard Enlightenment and fellow members of the Accademia dei Pugni (as well as Il Caffè contributors), such as Alfonso Longo, Sebastiano Franci, and Cesare Beccaria, who was also named as a member of the Supreme Economic Council, in 1771. Men like Verri and Beccaria, aristocrats themselves, were engaged in what was, according to Franco Venturi and Carlo Capra, a generation struggle against the conservative forces of privilege represented by their fathers’ generation. As such, these lumi Italiani formed an alliance, sometimes tense, with the Habsburg outsiders against the still strong Milanese Patriciate and Senate in order to promote their reformist goals. See Franco Venturi, Settecento Riformatore: Da Muratori a Beccaria (Turin: Giulio Einaudi, 1969), 645-747; Carlo Capra, “Il Settecento,” in eds Carlo Capra and Domenico Sella, Il Ducato di Milano dal 1535 al 1796, vol. 11 of Storia d’Italia, ed. Giuseppe Galasso (Turin: UTET, 1984), 357-367.
enlightenment thinkers, respectively, both sought to manage and mobilize the state’s resources most effectively in order to promote the good of the state. The mobilization of the population for the benefit of the state as envisioned by these men was contingent on the development of abstract notions of “the state” and “society.” The emphasis on procreativity as the path to productivity at the center of such thinking had, however, far reaching consequences for broader attitudes toward and the legislation of various aspects of intimate human relations. As Carol Blum writes of France, populationism in the eighteenth century “drew private sexual behavior into the public arena, judging its worth not on the hallowed teachings of the Church but on the modern criterion of productivity.”16 Although Blum is interested in French discussions of divorce, polygamy, and celibacy, her observation extends more generally to the ways in which eighteenth-century “enlightened” governments became increasingly confident about and justified in their interventions into maternal and reproductive policies as a means to grow the population, and thus strengthen the nation as a whole. New scientific and technological advances, not to mention new methods of statistical inquiry, were also harnessed to promote the well-being of the population at large – in our case, to preserve the lives of mothers and newborn children. This brief overview of Habsburg reforms in the second half of the eighteenth century shall provide a framework in which to consider the emergence of new Milanese policies and institutions relating to midwifery and maternal assistance.

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The earliest mentions of the midwifery project in Milan appear in the first years of the 1760s, when Vienna requested information for its Commission on the Faculty of Medicine, part

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of the monarchy’s larger, ongoing efforts to reform the entire Lombard superior school system.\textsuperscript{17} Representatives of the commission were sent to investigate licensing procedures and the state of medical practice in the region, particularly “in the city and provinces of Pavia, and Lodi, in the city of Milan, and in some of the parishes of the Duchy.”\textsuperscript{18} As part of the report, the royal commission had asked for information on the state of midwifery specifically. The need for improved instruction and an effective licensing system in this area was clear in the report. The women who “take on such an important service to the Republic,” the report began, “practice the Art of Obstetrics without having studied, and the greatest part without having been approved” at all.\textsuperscript{19} Although many contemporaries believed that women in the countryside gave birth more easily than those in the city, as their robust bodies had not been weakened by the decadence of urban living, this natural advantage, it was reported, was nonetheless counteracted by rural midwives who were “completely ignorant, and insolently bold for undertaking operations fatal to the lives of babies and mothers.” As troubling as their purported ignorance, however, was the fact that these midwives dared to use “surgical instruments and hooks,” often of “strange and crude manufacture.”\textsuperscript{20} And although midwives in the cities were subjected to slightly stricter oversight than those in the countryside, the situation there was by no means uniform either.

Some practitioners touted licenses from the \textit{protofisici}, others from the College of Barbers, and

\begin{itemize}
\item[\textsuperscript{17}] The Regia Deputazione degli Studi.
\item[\textsuperscript{20}] ASM, \textit{Sanità. Parte Antica}, c. 186, “Relazione della visita fin’ora eseguita nello Stato di Milano dalla Commissione della Facoltà Medica,” 2 May 1767. “Quantunque alla campagna sieno per molte ragioni meno pericolosi li parti, con tutto ciò essendovene alcune volte de’ difficili, e preternaturali, egualmente nelle Città, la Commissione qual’ora ha conosciute e ritrovate comari affatto ignoranti o soverchiamente ardite, per intraprendere operazioni fatali alla vita delli bambini e delle madri, ha inibito ad esse l’esercizio di levatrici, con formalì precetti del notaro, avvertendone i parrochi, e qual’ora ha trovato tali donne munite di ferri, e di uncini di strana e rozza fattura, le ha private di quelli, ed ha ritenuti presso di se tali perniciosi strumenti.”
\end{itemize}
still others displayed outdated certificates that had been issued to their own mothers or even more distant relatives.21 This multiplicity of potential authorizing bodies – not only the College of Barbers or the Protosfisico but the local parish priests as well – had created a situation characterized by a lack of conformity and agreement on what constituted the proper certification for a practicing midwife.

Much-needed updated regulations for the medical faculty were presented to Maria Theresa in 1767 as part of the efforts of a new reforming body in the area of medical practice and instruction. Named the Royal Medical Directory, the body was headed by the bourgeois physician Giuseppe Cicognini. Obviously interested in correcting some of the above licensing abuses, Cicognini proposed that all “women who want to exercise the Obstetric Art… must be approved by the Royal Directory of the Faculty of Medicine.”22 The new regulations were also intent on delimiting the extent of the midwife’s duties: she was responsible for “assisting at births, ensuring that pregnant women did not come to any harm, or detriment, from any uncertainty… [The midwife should know] about how to deliver the baby, the placenta, how to tie the umbilical cord, how to wash and wrap the baby, and accompany it to baptism.”23 The regulations also demonstrate a wariness about midwives encroaching upon the professional territory jealously guarded by other medical practitioners. Midwives were therefore forbidden to

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21 ASM, Sanità, Parte Antica, c. 186, “Relazione della visita fin’ora eseguita nello Stato di Milano dalla Commissione della Facolta Medica,” 2 May 1767. “È stato ciò pure eseguito con le commari della Città, e quantunque sianesi trovate alcune di queste donne con patenti de’ protofisici, pagate sei zecchini, o con patente del Collegio de’ Barbieri pagate un filippo, o finalmente alcune di queste donne, che si valevano delle patenti di approvazioni, date alle loro defonte madri, avole e bisavole…”


23 Ibid., “L’esercizio dell’Arte Ostetricia consisterà nell’assistere alli partì, nell’impedire che le Partorienti ricevano danno, o pregiudizio dalla ignoranza del loro Stato nel ricevere li Bambini, e la placenta, nel legare il funicolo umbilicale, nel lavare, e fasciare gli stessi Bambini, e nel accompagnarli al Battesimo.”
use surgical equipment (under the penalty of immediate imprisonment), from requesting the patient be bled either before or after the birth, from prescribing internal medicines, and even from applying topical recipes. Certain categories of women were denied access to the profession entirely: women considered to lead scandalous lives, young girls (fanciulle) in general, and women of heterodox religion were all prohibited from acting as midwives. Those midwives who were authorized were nonetheless proscribed from practicing in the same household, regardless of whether they be mother and daughter, sisters, or other co-habitants. In fact, no midwife could “receive in [her house] women to give birth without the notification of and permission from the Royal Director,” again under penalty of immediate imprisonment. Any non-approved assistants who might be present at a delivery were expressly forbidden from partaking in any activities directly related to the birth itself.

While the above regulations demonstrate that midwifery clearly existed within the wider orbit of professional medicine, its place in this context was somewhat ambiguous. By the eighteenth century, European medical practitioners widely agreed that obstetrics constituted a branch of surgery. The relationship between university obstetrics and the everyday practice of midwifery (as practiced by women) was complex, however, providing for a diversity of opinions about how to regulate female midwives. As Cicognini noted in one report for the Royal Committee on Education (Regia Deputazione degli Studi), the regulation of midwifery had been cumbersomely appropriated by several different bodies over the past several decades: “The

24 Ibid.

25 Ibid.

26 Ibid. “Non potranno esercitare nella stessa casa l’Arte Ostetricia la madre, e la figlia, ovvero due sorelle coabitanti, come altrési non sarà permesso alle Ostetrici di avere aiutanti, e compagne, e particolarmente che sieno fanciule, sotto pena di perdere l’Esercizio dell’Arte. Le Ostetrici, o siano comari, non potranno ricevere nelle loro case Donne a partorire senza la notificazione, e permesso del Regio Direttore sotto pena dell’immediata carcerazione.”
College of these surgeons minor, that is the Barbers, have at times attempted to examine and approve the midwives of the city of Milan, and in the same way… the Protofisico has sometimes made” an effort at licensing “the midwives of the provincial cities,” but in neither case had such practices been uniformly or consistently applied. Nor, Cicognini continued, could the College of Surgeons itself undertake the practice of approval, since those surgeons have neither “the instruction nor are examined in this branch of surgery.”

Even with the acceptance of obstetrics as a part of surgery, its formal instruction in universities to male surgical students remained minimal at this point, leading reformers to wonder who exactly should rightfully be in charge of licensing and examining midwives.

It was not only the fact that obstetrics was a newly recognized part of surgery that raised questions over its teaching. Since the students of the midwifery school were women, both state officials and members of the medical faculties agreed that they couldn’t be instructed or examined in the same manner as male university students. As Cicognini wrote, “dealing with women, it doesn’t seem appropriate (decente) to subject them to the examination [administered by] the College, nor [by] a multitude of persons as is done with surgeons.”

Other reformers worried if women would be able to handle the rigors of classroom education and the study of theory at all. In his “Reflections” on the establishment of the school for midwives, Bernardino Moscati, head surgeon at the Ospedale Maggiore in Milan, described an additional complication for the school with respect to licensing which again came down to jurisdictional competition. He argued that since among “the Protofisico, and the Colleges of Physicians and of Barbers,” there

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27 ASM, Sanità, Parte Antica, c. 186, “Avvertenze per le Ostetrici,” n.d. “Ritrovo qualche esempio, per cui vedo, che l’Università di queste Cerusici minori, o siano Barbieri ha tentato qualche volta di esaminare ed approvare le Comari della Città di Milano, e così pure ritrovo, che qualche volta il Protofisico ha fatto con le comari delle Città Provinciali, ma non vedo, che quest’esempio sia stato costantemente praticato, ne lo poteva nemmeno essere dalla Università di questi Cerusici, i quali non hanno ne insegnamento ne esame sopra questa parte della Chirurgia.”

28 ASM, Sanità, Parte Antica, c. 186, “Avvertenze per le Ostetrici,” n.d. “Trattandosi di donne, non pare, che sia decente di esporre queste all’esame del Collegio, ne di una multitudine di persone, come si è fatto de’ Cerusici.”
were “some unresolved judicial grudges surrounding [these bodies’] respective competences, and ability to approve experts in the practice of Obstetrics” there was clearly necessary some outside attention to render the system more uniform and free from abuse.\textsuperscript{29} Even with the introduction of a school for midwives shortly after these reports, midwifery remained in a grey area because its instruction was located in the hospital (rather than the university), an entity defined by its ecclesiastical affiliation and therefore partially immune from the forms of medical licensing overseen by the state.\textsuperscript{30}

The debate over who should have proper authority over midwives reflected the wider struggle to redefine privileges and licensing in the medical and professional trades as a whole, which was taking place in Lombardy at roughly the same time as the midwifery school was opened. Although Maria Theresa had initiated a reform of the universities as early as the 1750s, little had changed by the end of the next decade, due in large part to the intransigence of the Milanese Senate. Up until the mid-eighteenth century, a university degree was only required for a very a limited segment of the medical profession – the physicians. For all others, including surgeons, barbers, and apothecaries, the privilege of licensing was shared between several other bodies – the urban guilds (collegi), the State Supervisor of medical practice, called the


Protofisico, or the hospitals themselves. Most important among these, the urban-based Collegi were powerful organizations based on and restricted to members of patrician status who enjoyed a monopoly of the control of licensing in the cities and subordinate territories in which they were located. In addition to the apothecaries, barbers, and surgeons, the physicians, too, established Collegi, aiming to ensure a relatively closed circle of membership based on elite status and privilege. Officially, the Milanese Senate approved decisions and statutes issued by the Collegi, though the two bodies’ patrician makeup tended to result in a close alignment of interests and familial/patronage ties. For some time, however, the Collegi had been forced to expand their ranks to accommodate the larger numbers of practitioners needed to serve Milan’s growing population. The medical “Faculties” were thus established to contain all those practitioners in the various branches of medicine who were unsuitable to join their respective Collegio but were nonetheless subject to its approval and licensing.

It was the intention of Maria Theresa and reform-minded agents in the Milanese government to overturn the above system quite dramatically. The Austrian government desired to enact anti-corporation policies both at home and in its subject territories that would eliminate the licensing and graduating privileges enjoyed by the urban guilds (Collegi). Instead, the rights of licensing and granting diplomas would be transferred to the State University (the University of Pavia), which would be the “sole holder of the right to give legal value to professional titles and degrees.” In other words, the act of legislating implied in the granting of degrees and licenses

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32 By at least the 17th century, the Faculties contained the majority of the profession, though the Collegi continued to exist and exert a great deal of control over practices through the issuing of Statutes and licenses.
would be “the exclusive prerogative of the State.” The Milanese Senate, whose patrician interests aligned it with the urban Collegi over which it had ultimate control, raised the most strenuous opposition to the proposed reforms, succeeding to limit any significant changes from taking place during the 1750’s and the first half of the 1760’s. The first significant reform was therefore effected only in 1765 when the Senate was stripped of its supreme decision-making powers vis-à-vis the University and the professional Collegi, and these were transferred to a new governmental body, the Committee for School Reform (Giunta degli Studi). From 1771-1773 the University itself underwent significant reforms, and then in 1775, the Giunta degli Studi issued a new, revised set of regulations for the entire medical profession. It was in the immediate context of these reforms that the first midwifery school was opened in the Lombard territories.

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Early discussions of the Milanese midwifery project cited Turin, along with Florence and Vienna, as cities with exemplary approaches to the instruction and regulation of both midwives and surgeons involved in childbirth. By offering the most up-to-date training for midwives and surgeon-obstetricians, and by making all midwifery services rendered without an official license both illegal and subject to punitive measures, such cities had begun to circumvent the severe

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34 In theory, the faculty of Medicine at the University of Pavia would now be the sole granter of licenses and diplomas, and these would be issued only after much more thorough and fair examinations, based on merit rather than noble status. Despite the Austrian government’s best efforts, however, the envisioned reforms never went fully into effect. While the necessary training requirements were increased across the board, in practice it remained the case that only physicians typically attended the University of Pavia to receive their degree. Surgeons and apothecaries could still be educated in the city by attended new urban courses of instruction given by lecturers (often individuals who retained some connection with the Collegi, but ultimately appointed by the government). The 1775 reforms were carried out by a new governmental body, which was a kind of outshoot of the Giunta for the medical professions, called the Medical Directory, headed by Giuseppe Cicognini. The Medical Directory was intended to supersede the decision-making and regulatory authority of both the Collegi and Protofisico, though hospitals and charities remained apart from this schema, owing to their administration by Canon law.

35 ASM, Sanità, Parte Antica, c. 268.
consequences caused by the “ignorance of coarse midwives, and the savage audacity of many inexpert surgeons.” 36 Despite the nod to Turin, the development of maternal assistance and midwifery education in each city developed along quite distinct lines. While Turin had always emphasized the important social welfare role of the maternity ward over the benefits of a formal school for midwives, Milan placed attention first and foremost on educating women in the “art of obstetrics.” Additionally, whereas the Turinese project had been aimed at training women in both the urbana and rural areas, Milanese reformers were particularly concerned with the situation in the countryside from the beginning. After preliminary reports had been compiled, for instance, one of the Royal Delegate Inspectors for Charitable Sites (Regi Delegati Visitatori dei Luoghi Pii) in Milan wrote that the midwifery school should be directed principally at training rural women in the practice of midwifery “since the most urgent need arises in the countryside, where the inexperience in that profession produces a marked prejudice against the good outcome of births, and against the health of mothers.” 37 Finally, the populationist sentiment that arises in some of the later discussions of the Turin maternity ward were front and center in the initial proposals for midwifery education and maternal assistance in Milan. One unsigned proposal in support of the project began,

there is no doubt that in countries especially fertile, and abounding in the things necessary for survival, the happiness of the state grows together with the number of people inhabiting it…Legislators in all times have always efficaciously seen to increase the population of their respective countries, at times through punishing bachelordom with public disapproval, at others [through] moderating the excessive luxury of marital

36 ASM, Sanità, Parte Antica, c. 186, “Relazione della visita fin’ora eseguita nello Stato di Milano dalla Commissione della Facolta’Medica,” 2 May 1767; ASM, Sanità, Parte Antica, c. 268, “...che riguarda la maniera d’aver concorso di Scolari, il vicino, e fresco esempio della Toscana cola somministra facilmente, quando cioe’ voglia il Principe degnarsi con suo autorevole editto di proibito d’ora in avanti l’esercizio di quest’arte a’ tutti quei Cerusici, ed a tutte quelle Levatrici, che non abbian sotto alcuna esperta Levatrice fatta una conviente pratica di essi, e non ne abbiano riportata nelle dovute forme l’approvazione della loro abilità...”

dowries, and at still others by awarding those who bring to the world a great number of children. Now, a powerful means apart from those mentioned for obtaining the same end is to assure, to the extent possible, to make childbirth a happy event, so that fewer future subjects are lost, and as many fertile mothers as possible are conserved for the State; therefore it can be seen in our time many Princes who, for the happiness of their subjects, and for the interest of the public good, have adopted all of the most valuable means with which to efficiently promote the advancement of the Art of Obstetrics.\(^38\)

In Milan, the midwifery project was clearly tied up with the Austrian Habsburg’s constant battle to maintain military readiness and strengthen its international position.\(^39\) Maternal welfare was just one part of a new consciousness of the possibilities of biopower and biopolitics, that is, the extension of state power over the physical bodies of subject persons, emerging in the latter half of the eighteenth century.\(^40\)

Local Milanese officials were quite receptive to the midwifery school project from the outset, in contrast to the heated resistance that Turin’s municipal government posed to the implementation of a maternity ward at San Giovanni hospital. The directors of Milan’s Ospedale

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\(^38\) ASM, Sanità, Parte Antica, c. 268. “Non v’è dubbio che ne’ paesi principalmente fertili, ed abbondanti di cose necessario al vitto, la felicità dello stato cresca insieme col numero degli uomini abitanti di esso...Legislatori di tutti i tempi ’anno sempre procurator efficacemente di accrescere la popolazione di rispettivi paesi, ora punendo col pubblico disprezzo gli scapoli, ora moderando l’eccessivo lusso delle doti conjugal, ed ora premiando coloro, che avessero messo al Mondo un buon numero di figli. Ora un potente mezzo oltre a questi per ottenere il medesimo fine sì è ancora l’assicurare per quanto si può, e rendere felici i parto, accioche’ in tal maniera si perda un minor numero d’ uomini futuri, e si conservino quanto più madri feconde si possono allo stato; quindi poi che sì sono veduti a giorni nostri molti Principi per la felicità de’ sudditi, e pel pubblico bene interessati, che ‘anno adoperati tutti i più valevoli mezzi per efficacemente promuovere l’avanzamento dell’Arte Ostetricia.”

\(^39\) The significance of the project in Austrian eyes can be judged both by the direct involvement of the Habsburg state chancellor, Kaunitz, and the extensive correspondence between him and the Lombard minister plenipotentiary Count Firmian on the topic. Firmian, born into an aristocratic family in Trento, grew up with strong familial ties to the Austrian monarchy. Educated at Innsbruck, Salzburg, and Leiden, Firmian then assumed a post as an ambassador to Naples, where he was exposed to the Italian Enlightenment thought of Muratori and others. As governor in Lombardy, Firmian revealed himself a strong proponent of reform in both social and intellectual life, a proponent of Beccaria, and someone who remained a close, trusted official to Maria Theresa. On Firmian see: Capra, Il Settecento, 340-343.

Maggiore, where the midwifery school would be located, wrote that they felt “truly consistent” with the aims of the proposals and that the plans were “well adapted to the circumstances of this Pious House (Pia Casa).” Thus, on October 28, 1767, an edict announced that Maria Theresa, “commiserating [on]…the inexperience that daily one finds largely in the midwives of the countryside, has ordered that one of the primary responsibilities (provvidenze) of the Government relative to the good regulation of the pious places (luoghi pii) will be to erect a school in this Venerable Ospedale Maggiore where [midwives] can be conveniently trained.”

These students would be welcomed to Milan, where they would be housed at the Ospedale Maggiore during their instruction. Afterwards, officials hoped that recently trained provincial midwives would “aid the poor with their newly acquired knowledge, and from us carry it to distant lands, which are now abandoned to the practice of inexpert and ignorant women.” In anticipation of the imperial project, Prince Kaunitz enlisted the guidance of two noted professors to outline formal bylaws (Istruzione) for the school: Giovan Antonio Galli of Bologna, and Bernardino Moscati from Milan. Galli held one of the first posts of professor of obstetrics (from 1757) in Italy at the University of Bologna and worked closely with the famed female wax

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41 The training midwives, particularly those from the countryside, would also be housed in the hospital. The school would also instruct interested surgeons.

42 ASM, Sanità, Parte Antica, c. 268. “...l’abbiamo trovato veramente consentaneo alla qualita’ della materia, adattate alle circostanze di questa Pia Casa, e in conseguenza corrispondente intieramente alla nostra intenzione, e pero’ siamo passati a pienamente approvarlo...”

43 ASM, Sanità, Parte Antica, c. 268, Printed Circular, 28 October 1767. “Commiserando Sua Maesta l’Augustissima Imperadrice Regina Nostra Augustissima Padrona l’inesperienza, che giornalmente si scuopre maggiore alla Compagna nelle Ostrerici, ha ordinate, che una delle prime provvidenze del Governo relativeamente al buon regolamento de’ Luoghi Pii, sia quella di far erigere una Scuola in questo Venerando Spedal Maggiore, ove possano essere comodamente ammaestrare.”

44 ASM, Sanità, p.a., 268. “...e sovvenire colli acquistati Lumi que Poveri, e da noi lontani Terrieri, li quali ora sono abbandonati alla Condotta di donne inesperte, ed ignoranti.”

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modeler Anna Morandi Manzolini. Moscati, a professor of surgery, was already well-established at the time as the head surgeon at the Ospedale Maggiore in Milan. In contrast to Turin, where a female head midwife directed the education of students midwives, in Milan there was never any question that it would be a male professore to direct the midwifery school.

Nor was much debate required to agree upon the Ospedale Maggiore, Milan’s large, central hospital, as an ideal location for the proposed midwifery school. According to Moscati, no site was,

more suitable…than the Ospedale Maggiore, not only because it is believed to be the largest, and has the greatest number of surgical students in the city, and duchy…; [but] because in the hospital the most zealous and benevolent gentlemen [cavalieri] in the venerable Capital will monitor with their usual commendable attention the students’ attendance and study, the good government of the school, and will direct the women toward the greatest public advantage; but principally because nowhere else is there available the amount of cadavers of pregnant women, and fetuses, or the frequency of occasions to observe the many situations…related to the theory, and practice of childbirth.

From the start then, the teaching of midwifery would be based upon the principles of clinical education and pathological anatomy, rather than the strictly theoretical learning associated with the university. The placement of the school in the city’s main hospital solidified this identity, at a time when the hospital – and its attendant possibilities for clinical education - was just beginning

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to take on a more central role in the instruction and preparation of medical professionals. In fact, the initial regulations drawn up for the school indicate that this kind of hands-on learning would be an important part of the course. Unlike in Turin, where student midwives and surgeons were generally not permitted to attend to laboring women in the hospital’s maternity ward, in Milan, Moscati recommended from the beginning that the training midwives “assist at the births in the ward of the Wetnurses” (delle Balie) under the guidance and discretion of the head professor.

After determining an optimal location for the school, Kaunitz’s next point of action was to begin to recruit students. With the intent to reach as many women from the countryside as possible, Count Firmian ordered a circular to be sent to the “deputies of the city councils (Estimo)” of the various parishes in the surrounding territories. According to the note, the deputies would be responsible for convening to elect one woman for the program, based upon detailed guidelines issued from Milan. Specifically, the circular clarified that “the principal, and most important object, that should interest the persons designated for the selection of the women capable for the Obstetric Art…is that, other than good, and regular health, and stature, they have also a certain natural intelligence, and the capacity to be able with greatest facility to learn, if not the theory, then at least the practical instructions of the Art…and, finally, that they have a natural

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docility and discerning discretion.” In other words, the optimal midwife possessed a combination of physical, intellectual, and moral qualities suggestive of the sometimes delicate situations a childbirth attendant might confront in an early modern society which hinged around sexual and familial honor. Preference was given to women who knew how to read and write. In Moscati’s opinion, literacy was critical. Otherwise, he feared that only a verbal “instruction, even every day, to coarse women, and not [educated] thinkers… could not amount to great advantage, either because of the frequent repetition of the same things [which would be] necessary, or for the easy forgetting of these.” Although Moscati and Firmian both pushed for the ability to read and write to be a requirement of admission, Kaunitz cautioned that too rigid regulations might ultimately limit the scope of the project. How many women from remote regions of the contado would actually be able to read and write?

As in Turin, the bylaws for the new school suggest that reformers in the capital were engineering to refashion the traditional figure of the midwife along more professional lines. Ideal candidates for the school were to be married women (with their husband’s written consent), or widows without young children. In addition to the preference for women with some reading or writing ability, the note to parish delegates requested that nominees be between the ages of twenty-two and thirty-two, though some exceptions could be made for currently active midwives

50 ASM, Sanità, p.a., 268, “Istruzione,” 28 October 1767, “La principale, e più importante oggetto, che deve interessare le Persone destinate alle scelte delle Donne capaci per l’Arte Ostetricia, o sia d’assistere alli Parti, si è quella, che oltre la buona, e regolare salute, e proporzione Organica, abbiano altresì’ certo natural lume, e capacita’ per poter colla maggior facilita’ imparare se non le teoriche, almeno le pratiche Istruzioni dell’Arte, a tale effetto sarà dell’avvedutezza, e diligenza di chi ha tale incarico il ben informarsi del loro temperamento, e abituale stato di buons salute, e che non abbiano difetto Organico notabile, e finalmente, che sieno di un naturale docile, e di un discrete temperamento.”

51 ASM, Sanità, p.a., 268, “Riflessioni di Bernardino Moscati intorno allo stabilimento della nuova Scuola pe’ Parti,” 1767. “Ma un solo intoppo is potrebbe affacciare a quella qualunque persona avesse l’onore di servire in questo impiego; cioè’ il timore che l’insegnare verbalmente anche tutti i giorni a rozze donne, e non pensatrici, le quali nemmeno sappino leggere, potesse riuscire di non molto vantaggio, o per le frequenti repetizioni necessarie farsi delle medesime cose, o per la facile dimenticanza di esse.”
outside of this range. The selected woman should dress “modestly, according to her state; she should have shoes and a sufficient store of linen [to bring with her] for her personal use, and…[her] dress should conform to the custom of [her] home town.” Explicitly forbidden from the practice of midwifery were any women deemed to be of a “scandalous life, or those who [were] wives or widows of husbands who exercise[d] infamous trades.” Prospective midwives would be housed at the Ospedale Maggiore during the length of the school year, which was scheduled to run from November through April, and would be provided with board at the expense of the hospital. The full course of instruction consisted of two years of study, after which the students would undergo an exam to determine if they were sufficiently skilled to practice, and, if successful, receive a license.

Finally, the delegates were directed to provide basic information regarding the selected woman: her given name, family name, place of residence, whether she was currently practicing as a midwife, and if she would be able to present herself in Milan before the start of school in November “where there would be a person set to meet her.” The delegates were advised to send a relative or “other principled person” to accompany the nominated woman to the hospital…and that it would be most “useful, if [each] respective Parish Priest [gave] the [candidate] some benevolent advice adapted to the task ahead of her, especially with respect to prompt obedience,

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52 ASM, Sanità, Parte Antica, c. 268, “Istruzione,” 28 October 1767.

53 ASM, Sanità, Parte Antica, c. 268, “Istruzione,” 28 October 1767. “Il vestire sarà moderato, e adattato al rispettivo loro stato, dovranno essere calzate, con sufficiente scorta di Biancheria per il solo personale uso, e per il restante loro ornamento si conformeranno all’usanza del loro Paese.”


55 For more on the boarding school (convitto) at the Ospedale Maggiore, see chapter 6. Initially, the number of women to be accommodated at the hospital was to be between eighteen and twenty. ASM, Sanità, p.a., 268.

56 ASM, Sanità, Parte Antica, c. 268. Those women deemed insufficiently qualified would be permitted to remain at the school for an additional year, after which they could re-take the exam.
pleasant modesty, and Christian piety.”

Upon arrival at the Ospedale Maggiore, the candidate was required to show four documents: first, the certificate signed by the chancellor and deputies of the Estimo confirming her election; second, a birth certificate; third, a certificate from a local priest attesting to the woman’s good morals, attendance to the sacraments, and abidance of Christian Doctrine; and fourth, a note listing the personal goods and linens brought for the woman’s personal use, signed by herself and a representative of the hospital. The above regulations reveal the ambiguous place of midwives with respect to other medical practitioners. In order to achieve the best results in a professional sense, Moscati and Firmian desired the most literate and practiced midwives to be sent to Milan. At the same time, however, as women, many of whom were travelling far from home and without male supervision, an additional set of considerations arose. Good morals, an impeccable background, and a certain degree of tractability were also necessary qualities to ensure that such an endeavor did not bring great scandal and shame upon either the hospital or the government officials behind the midwifery project.

The hospital governors in Milan were indeed ever attentive to the larger moral implications of housing a midwifery school in the city’s central hospital. Determined efforts were made to ensure that the housing of a number of young, rural women in the hospital would not cause embarrassment or scandal. Thus from the school’s opening, the hospital authorities and governmental officials involved in the project were on constant alert to monitor the actions and interactions of the student midwives and those of the pregnant women and foundlings who

57 ASM, Sanità, Parte Antica., c. 268, “Istruzione,” 28 October 1767. “Potrà essere inviata all’Ospitale prima della Festa di S. Marino, ove vi sarà Persona destinata a riceverla; avvertendo che cadauna sia accompagnata da uno de’ Parenti più prossimi, oppure d’altra Persona proba; e sarà molto conveniente, se il rispettivo Parroco farà loro una caritatevole salutare Istruzione adattata all’Impiego, che vanno ad assumere, massime rispetto alla pronta Obbedienza, convenevole Modestia, e Cristiana Pietà.”

shared both physical and ideological space within the hospital. As in Turin, it was in part the novelty of the kind of public space under discussion which raised anxieties. One report discussing the necessity of the midwifery school and maternity ward noted that the “majority of hospitals in Lombardy refuse to receive pregnant women, or women who have recently given birth.” Unsurprisingly then, in the initial Istruzione for the midwifery school great care was taken to regulate and supervise the daily activity and movement of the student midwives. In fact, the Istruzione deals almost exclusively with the lodging of the female students and the maintenance of propriety in the Quarto delle Balie. Visitors to the ward were kept to a minimum, and men prohibited entirely. Servants and a housekeeper (Guardrobba dell’Ospitale) would be tasked with regulating the entrance and exit of individuals to the dormitory and other spaces reserved for the female trainees. The latter were never allowed to travel alone outside the dormitory, even to attend the obligatory daily mass. In the end, even Kaunitz had to caution that the regulations were so severe that they risked making the hospital seem “more like a prison than a school.”

Despite the school’s promise of more scientific instruction and a professional status guaranteed by the state, the practical impact of formal midwifery education was to limit the scope of midwives’ practice. In addition to repeated strictures to call for the assistance of a surgeon in difficult cases, decrees regulating midwifery issued in the second half of the


60 ASM, Sanità, Parte Antica, c. 268, “Piano per la Scuola delle Ostetrici da erigersi nel Ven. Ospitale Maggiore di Milano.” Issues of space and movement within the midwifery school and maternity ward are discussed more fully later in this chapter.

61 ASM, Sanità, Parte Antica, c. 268, Letter from Kaunitz, 30 November 1767. “Potrebbe sembrar loro più una prigione, che una scuola.”
eighteenth century tended to limit rather than expand midwives’ range of skills and activities. Moscati, always skeptical of the intellectual capacity of women, wrote for instance, that “it doesn’t seem appropriate to permit simple women the use of dangerous surgical instruments (ferri) who are not accustomed to manage them and lack all the knowledge that is considered fit for Surgery.”

Although reformers stressed that a well-trained corps of midwives would be an invaluable asset to the public welfare, particularly in the countryside, there was at the same time clearly a desire by a powerful medical faculty to bring under its purview and oversight a branch of medicine that was just beginning to distinguish itself as legitimate and potentially profitable.

Quite unlike the situation in Turin in the first half of the century, the midwifery school in Milan aimed from the start at training “both surgeons, and midwives” in the art of obstetrics. In the decades between the opening of the midwifery school in Turin and that in Milan a significant transformation had taken place in the social position of obstetrics as a legitimate – and masculine – field of medical practice. Obstetrics, unlike the more practical and experientially based midwifery, had found a place in the universities and was based upon a theoretical conception of childbirth and reproductive anatomy. Not only was obstetrics considered an important and ‘natural’ lower branch of surgery, but its study was increasingly required as part of the surgical degree. Both Cicognini and Firmian were strong proponents of making obstetrics a

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62 ASM, Sanità, Parte Antica, c. 268, fasc. 1, “Promemoria di Bernardino Moscati, per Senatore Santucci,” n.d. “Non pare conveniente cosa il permettere l’uso di questi ferri pericolosi a semplici donne non avvezze a maneggiarli e prive di tutte quelle cognizioni, che degnando dalla Chirurgia.”


64 ASM, Sanità, Parte Antica, c. 268.

65 For the relationship between surgery and obstetrics in Italy see: Tirsi Mario Caffaratto, L’ ostetricia, la ginecologia e la chirurgia in Piemonte: dalle origini ai giorni nostri (Torino: Edizioni Vitalità, 1973), esp. chapter 2; Carlo Decio, Notizie storiche sulla ospitalità e didattica ostetrica Milanese (Pavia: Fusi, 1906); Andrea Verga, Intorno all’ospitale maggiore di Milano nel secolo diciotto. e specialmente intorno alle sue scuole d’anatomia e chirurgia: cenni storici (Milano: Fratelli Richiedei, 1871).
required part of training for all young surgeons.\textsuperscript{66} Thus, while the practice of obstetrics by surgeons remained very limited in Turin, the environment in Milan was somewhat more amenable. In fact, courses in obstetrics had been offered at the University of Pavia even before the midwifery school opened, since 1764. With the opening of the midwifery school in the Ospedale Maggiore, however, Moscati (who trained surgeons in the hospital) and others suggested that the training of young surgeons in obstetrics should naturally and most profitably be a part of the same. As perhaps the first medical specialty to grow up in the era of clinical training, obstetrics was critically dependent on the hospital (particularly the specialized maternity hospital) both to gain access to patients and to distinguish itself from traditional midwifery.

With the distribution of queries about midwifery candidates to parishes throughout the Milanese countryside, Kaunitz, Firmian, and Bernardino Moscati awaited the replies in Milan. It is unclear exactly what expectations these men had in this respect, whether or not they expected rural women to jump at the chance to be trained formally in the city and receive official recognition of their ability to practice; in any event, the response from the provinces was mostly lukewarm. The chancellor delegate form the curacy of Binasco, about fifteen kilometers southwest of Milan, for example, wrote back that despite,

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having made every due diligence in all of the communities of my delegation, up until now in none of these has there been found a woman who wants to come to the Venerable Ospitale Maggiore of Milan to learn such a calling (virtù)… already in all of the communities there is a woman who practices this art, but all these persons are unlearned (grossolane), such that not one knows how to read…but nevertheless in that pious practice the midwives know what they do, and surely all the women who are served by them are content with them.\textsuperscript{67}
\end{quote}

\textsuperscript{66} ASM, Sanità, Parte Antica, c. 269, Letter from Firmian to Kaunitz, 26 May 1772.

\textsuperscript{67} ASM, Sanità, Parte Antica, c. 268, Letter from the Regio Cancelliere Delegato nel Vicariato di Binasco, 10 November 1767. \textit{“In ubbedienza della circolare de 28 Ottobre prossimo scorso, continente l’affare delle ostetrici, si è fatta la possibile diligenza in tutte le communita’ della delegazione mia, ed in nisuna communita’ sin ora si è trovata una donna che voglia risolversi di venir all’ Venerando Ospital Maggiore di Milano ad imparare una tale
In the parish of San Donato, about ten kilometers southeast of Milan, the delegates of the local Estimo encountered a similar lack of interest. No woman could be found who wished to enroll in the course in Milan. The woman currently serving as midwife, a forty-five-year-old widow named Anna Maria Maiocca, was perfectly “ready to submit to any exam, but not to take residence at the hospital, having herself children who need constant care.”68 In Vaprio, on the Adda River, the response again echoed the sentiments above: although the city council had already nominated one woman for the midwifery school, and sent her name back to Milan, the community had to send an additional note soon after. Apparently, the elected woman, though regretful, “absolutely did not want to move [to Milan]…regardless of persuasions made by the deputies [of the Estimo].”69 Many other delegations reported back that they simply could not find any women fitting the description in the circular.70 The potential candidates were too old in some cases, unable to read or write in others, or had never practiced midwifery before.71

Back in Vienna, Kaunitz had anticipated this problem. Tending to view the midwifery school project with a more practical eye than Firmian’s idealistic one, Kaunitz wrote to Milan in November of 1767 in response to the first draft of the midwifery school’s Istruzione. The state chancellor was concerned that the length of the course would be burdensome. The women who

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68 ASM, Sanità, Parte Antica, c. 268, Letter from S. Donato, n.d., “In tutta la detta Pieve non ‘anno i detti Estimati trovata femina, che voglia accingersi a tal professione: Presentemente non vi è che la Vedova Anna Maria Maiocca d’anni circa 45…la quale è bensì pronta a soggiacere a qualche esame, ma non già a dimorarsi dell’Ospitale avendo la medesima figli, che abbisognano assistenza continuata.”

69 ASM, Sanità, Parte Antica, c. 268, Letter from Vaprio, n.d.

70 The representative from Porlezza wrote back, for instance, that Giuseppa Tencalla had been elected “with the consent of her husband,” that she was a woman “of spirit, that knows how to read, but I confess of the age of forty-three, and thus outside [of the age] prefixed in the instructions.” ASM, Sanità, Parte Antica, c. 268, Letter from Porlezza, 28 November 1767.

71 ASM, Sanità, Parte Antica, c. 268, eg. Letter from Rosate, 26 November 1767.
were “to be instructed in the Hospital,” he cautioned, “will be for the most part peasants, and consequently needed for labor in the fields, and for the raising and education of children.” As a result, he suggested the lessons be lengthened and the total duration of the course shortened as much as possible and limited, in any case, to the winter months.\textsuperscript{72} Kaunitz reminded his colleagues that they were dealing with rural, largely agricultural communities, which faced particular constraints and demands. Women in such communities could not simply be expected to up and leave their families for long, protracted periods. Nor could it be assumed that such women would even want to travel considerable distances to live in the wholly foreign environ of the city, facing a completely unknown set of social and professional expectations.

Fortunately, the hopes of the reformers back in Milan were not entirely dashed. Although the response from the parishes was tepid, there were clearly some women who saw the chance to be trained formally in Milan to be a good opportunity. Whether these women were enticed by the prospect of living in the city or by the expected professional and economic benefits of an official license, it is impossible to know. Yet, for women like Catterina Bramano, a twenty-nine-year-old widow from the parish of Incino (near the southern tip of Lake Como) who had never practiced midwifery before and whose two children were already grown, the prospect of travel and the eventual financial security of a paid occupation were evidently appealing.\textsuperscript{73} In fact, several of the women who agreed to be sent to the school were similar to Catterina Bramano in that they had

\textsuperscript{72} ASM, \textit{Sanità, Parte Antica}, c. 268, Letter from Kaunitz, 30 November 1767. “\textit{Le donne di campagna, destinate ad esser istruite nello Spedale, saranno per lo più contadine, necessarie per conseguenza ai travagli della Campagna, all’alimento, ed all’educazione de’ figliuoli.}” Kaunitz recommended lessons in both the morning and afternoon hours, the latter spent in practical training with a practicing physician and expert midwife. In this way, according to Kaunitz, the women should be able to be trained in only three months. In this area, Kaunitz’ recommendations went unheeded – the course of instruction remained scheduled for November through April.

\textsuperscript{73} ASM, \textit{Sanità, Parte Antica}, c. 268, Letter from Incino, 26 November 1767.
never practiced midwifery before. Many others arrived with limited experience. For several related reasons a community’s most senior midwife was rarely selected. Not only was she likely to be older, and therefore outside of the desired age range specified in the midwifery school circular (and often unable to travel because of her advanced age anyway), but as the only midwife around, she was an irreplaceable resource in her community. The absence of such a woman for many months or even several years was unthinkable. Furthermore, it was apparently perplexing to many such women, who had been practicing their art for years, if not decades, that they should be requested to travel long distances and live in a foreign city in order “to learn” a trade they had clearly been “authorized” to undertake by long-established consensus from their neighbors and parish priest. It seems the school had better luck attracting women with little experience in midwifery, and therefore with less sense that they were being forced to relearn an art for which they were already well-trained.

As in Turin, the proponents of the midwifery school in Milan had a vision of the kind of woman they believed should be part of a new, highly trained corps of midwives to assist women throughout the state. Young and literate, exposed to the most scientific and up-to-date instructional methods, the professional midwife would be an expression of the state’s newfound involvement in the areas of public health, maternal welfare, and poor relief. The goal of training women from the countryside would be to extend that involvement and centralized authority into even the remotest areas of the state. In actuality, however, the reformers in Milan had to be contented with a more flexible sketch of the new midwife. Sixty-one women were eventually selected to attend the first session of the Milanese midwifery school. Only forty-five of these

74 ASM, Sanità, Parte Antica, c. 268, eg. Letter from Cuvio, 29 November 1767; Letter from the parish of S. Giuliano Milanese, 28 November 1767; Letter from Bruzzano, 11 December 1767; Letter from Melzo, 11 January 1768. It is true that some of these women had a relative (often a mother) who practiced as a midwife, eg. Letter from Cuvio; Letter from Varese, 30 November 1767.
seem to have accepted the invitation and were present at the school’s official opening on 26 November 1767. Their average age was thirty-four, fifteen were widows and the remainder married women (with written approvals from their husbands). They displayed a range of practical experience, and many could not read or could do so only in a limited manner.\textsuperscript{75} Five of the women left before the end of December, and at the end of the year twenty-four were approved to practice and supplied with an official license.\textsuperscript{76}

In his reflections on the first year of school, Moscati noted the variety of backgrounds and degrees of preparation exhibited by the women. Some of the students were “completely inexpert in this profession” while “others had already a certain degree of instruction, which the practice of some years, and the training under some older midwife had given them.”\textsuperscript{77} As a result, “even in the same school and under uniform direction” the relative benefit of training to individual women was uneven.\textsuperscript{78} Moscati employed a variety of instructional methods in an attempt to accommodate the various levels of training and literacy demonstrated by his students. In addition to the lectures and “repetitions” on anatomy, on the growth of the fetus, and on all the possible positions the fetus might assume at birth, the students were trained with wax and leather ‘machines’, models made to mimic the gravid uterus and allow the women to practice manual maneuvers. Moscati also made sure to allow his students to,

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\textsuperscript{75} ASM, \textit{Sanità, Parte Antica}, c. 268, “Tabella delle Donne Forensi accettate nel Venerando Ospitale Maggiore di Milano.” In addition, six women from Milan (who did not lodge at the Ospedale Maggiore since they lived in the city) joined those selected from the countryside at the school.

\textsuperscript{76} ASM, \textit{Sanità, Parte Antica}, c. 268, “Catalogo delle Donne Forensi admesse nel Venerando Ospitale Maggiore di Milano per la Scuola dell’Arte Ostetricia…Esaminate, ed approvate dal Dottore Bernardino Moscati Lettore Delegato dal Governo.”

\textsuperscript{77} ASM, \textit{Sanità, Parte Antica}, c. 268, Letter from Bernardino Moscati to E.V., 10 April 1768, “…di alcune erano affatto inesperte in questa professione, ed altre avevano gia quella qualunque istruzione che l’esercizio d’aluni anni, e la pratica fatta sotto qualche antica Levatrice aveva potuto somministrarle. Quindi anche nella medesima scuola e sotto una direzione uniforme il loro proffito è stato molto diverso.”

\textsuperscript{78} Ibid.
observe in practice the most interesting cases which the large size of our hospital and the
great number of patients produce yearly, so that the women were able comfortably to see
in life the mole (false conception), mutations, the site of the gravid uterus; the substance,
the joints, the shape, the natural size of the placenta; the various positions of the fetus in
different births with the many ways of manipulating them, as well as the dissection of
many cadavers.79

Those women who had practiced midwifery to some extent prior to school proved,
unsurprisingly, to be most successful. In fact, all the women eventually approved and licensed
after the first year of school had worked as midwives for at least a year before attending the
midwifery course.80 After just their first year in Milan, Moscati pronounced these women very
well able to practice independently as midwives and therefore felt there was no need to extend
for a second year the costs of their maintenance at the school, nor to further “inconvenience their
families with their extended absence.”81

In both Moscati’s and the Austrian Government’s eyes, then, the first year of school had
been a success. A respectful number of women had been judged fully capable of serving the
public through their art, and had been licensed accordingly. Others would need to remain at the
school for the successive year, though, in general, it was expected these women would be
approved in due time as well. The most disillusioning aspect of the midwifery school at this
point and in the years to come was its effect, or lack thereof, on licensing practices as a whole.
Instead of a highly regulated system in which all women would theoretically go through the
midwifery school to be licensed (or at least undergo an official exam, as it was anticipated

79 ASM, Sanità, Parte Antica , c. 268, Letter from Bernardino Moscati to E.V., 10 April 1768, “Nel tempo che si
andavano loro di mano in mano vocalmente spiegando i precetti fondamentali dell’arte non si è mancato di farle
praticamente osservare li casi più interessante che suole l’ampiezza del nostro Spedale, ed il grande numero di
ammalati fornirci annualmente. Sicche’ esse anno potuto comodamente vedere sul fatto la mole, le mutazioni, il sito
del utero gravido, la sostanza, gli attachi, la figura, la grandezza naturale della placenta; varie posizioni di fetti in
varie parti colle varie maniere di operare al qual fine, oltre le frequenti dissezioni di cadaveri.”

80 ASM, Sanità, Parte Antica , c. 268, “Catalogo delle Donne Forensi.”

81 ASM, Sanità, Parte Antica , c. 268, Letter from Bernardino Moscati to E.V., 10 April 1768, “…o incomodare
colla loro assenza ulteriore le loro famiglie…”
certain accommodations would need to be taken in the school’s first few years), the parishes continued to report widespread abuses in this area. A statement issued by the Medical Faculty in 1771, for instance, detailed the “unyielding resistance of many women” to the new regulations for the practice of obstetrics: “these women being even now without the approval to practice in this city [and] state the art of midwifery, cause public scandal and…great danger to the lives of babies, no less than their mothers.” Cicognini himself confirmed this impression, angered that despite his efforts to make the burden of travel and expenses for the midwifery school manageable to rural women (not to mention the repeated circulars sent to the parishes ordering a crackdown on abuses), “a large part” of the state’s midwives “continue audaciously to exercise the art of midwifery” without license, leading to “frequent scandals resulting from badly assisted births.”

Midwives were not always the only source of such abuses, either. In a letter from Maria Teresa to Firmian, the empress noted with disdain that “some parish priests refuse to publish at the altar the names of the midwives, even those qualified to practice that art with patent from the Medical Faculty…[and] that these [priests] presume with undeserved impertinence to be entitled

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82 Kaunitz in particular had cautioned that it would be unwise and reckless to prohibit women with long experience as midwives from practicing, even though their age or personal situation might impede them from attending school. Particularly in the first years of the school's existence, allowances were made for such women who, nonetheless, had to demonstrate their abilities by taking an exam. Of course, many women (who may or may not have had older licenses, either from their parish priest, the Protofisico, or the College of Barbers), simply continued to practice without undergoing an exam or assisting any courses at the midwifery school.

83 ASM, Sanità, Parte Antica, c. 269, Letter 12 August 1771.

84 ASM, Sanità, Parte Antica, c. 269, Letter from Cicognini, 1 August 1771. The Medical Faculty had petitioned numerous confraternities and other “luoghi pii”, both from the rural communities themselves and from Milan, to contribute to the expenses incurred for the midwives’ upkeep in Milan so that many of the women could be trained at no cost to themselves or their families. Cicognini also made it possible for some already-practicing midwives to be approved by local, authorized physicians or surgeons, rather than having to travel to Milan to sit the exam there. 78 out of the 200 midwives approved from 1767-1771, for instance, were exempted from paying the normal seven lire fee for the examination/license.
The priests’ obstinacy was all the more irking to Maria Theresa because she recognized the necessity of their interaction with midwives. It was the priest’s responsibility to instruct the midwife on the correct manner of delivering the baptismal sacrament in cases of necessity, and in guiding the woman’s behavior in a moral and spiritual sense. Yet it was often the parish priest who represented the biggest challenge for the Milanese government in recruiting women from the countryside and in enforcing a more stringent regulation of midwifery. Parish priests frequently advocated on behalf of long-practicing expert midwives in their communities, regardless of whether such women were formally approved and licensed by the medical faculty. In the community of Bosisio, in the parish of Incino, for instance, the local priest petitioned on behalf of the community’s traditional midwife, Cristina Appiana. Appiana, who had trained under her well-respected midwife mother-in-law, was already past the desired age for entrance into the midwifery school when the first announcements reached the small town in 1767. Nor did Appiana, by now advanced in age, necessarily want to undertake the hardship of travel and relocation to Milan even if the school’s director was willing to make an exception for her. Arguing that the parish’s one midwife who did have an official license was not sufficient to care for the entire population, the parish priest pleaded with the medical faculty in Milan to permit Cristina Appiana to continue practicing. She

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85 ASM, Sanità, Parte Antica, c. 269, Letter from Maria Theresa, 13 December 1770.

86 A circular was issued on 15 April 1771 from the Bishopric in Cremona to all parishes reiterating the government’s position on midwives: “Ha pure la M.S. ordinato, che da rispettivi Parocchi sieno ammesse e pubblicate quelle Levatrici soltanto, le quali saranno formalmente approvate con Patente della Facoltà Medica, e ciò per evitare qualunque inconvenienza, assurda”, e abusive pratica, che in contrario potesse essere stata introdotta, e in grazia della quale potrebbe derivare facilmente il fatale pregiudizio di venir preferite a quelle Mammane, che sono istruite, ed approvate.”
would undergo an exam if necessary, but did not desire to attend formal lessons far from home in
Milan.  

At other times, the resistance of potential clients presented an impediment to the
midwifery school project. In the village of Abbiate Guazzone, for instance, Angela Maria Caima
had been selected for and attended the first course of midwifery instruction in Milan in 1767. She
had returned to her home community with official license in hand, only to face determined
resistance from the women there, who continued to prefer the services of a longer-practicing but
unlicensed midwife. In a letter pleading for assistance, the delegates of the Estimo in Abbiate
Guazzone stated that while it was customary practice in the village to pay the midwife 10 soldi
for each birth, in addition to provisions during the labor and immediate pre- and post-partum
periods, the townswomen refused to pay Angela Caima more than 5 soldi per birth and would
not provide her with food or lodging because they found her “disgusting…for having been in the
Hospital and having seen anatomical demonstrations during the time of the [midwifery]
course.” Nor was Angela Maria Caima’s experience an isolated event. In the village of
Binasco, the newly trained midwife Maria Maddalena Oliva found herself in similar competition
with the community’s familiar and long-exercising, but unapproved, midwife, Catterina
Mazzoletti (who in fact had been explicitly warned by the medical authorities to cease all
activity). As in Abbiate Guazzone, the women in Binasco preferred to seek assistance from
midwives whose practice and skills had been sanctioned locally, by the community itself, rather

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87 ASM, Sanità, Parte Antica, c. 270, Letter from Bosisio, n.d. This request was denied and called out as a spurious
attempt to circumvent the newly approved midwife, Isabella Castelnuova, in favor of the long-practicing Appiana.

88 ASM, Sanità, Parte Antica, c. 269, Letter from the community of Abbiate Guazzone, 15 August 1768.
“…adducendo in iscusà d’aver egli in schifo la prefata Levatrice Angela Maria Caima, per esser ella stata nello
Spedale a vedere le dimostrazioni Anatomiche nel tempo della Scuola.”

89 ASM, Sanità, Parte Antica, c. 269, Letter from the community of Binasco, 14 September 1768.
than the unfamiliar and suspicious tutelage of a masculine medical establishment in Milan.

The midwifery school therefore represented an affront to both the traditional authority of the community and to that of the local church. Midwives whose practice had long been authorized primarily by their neighbors and parish priest now found these customary sources of legitimation and approval to be undermined by outside entities. Both a state newly conscious of its moral responsibility toward the welfare of its subjects and the potential biopower of the same, and a jealous medical profession intent on delimiting the sphere of influence of potential competitors, were increasingly interested in having their say about the practice of midwifery. At the same time, the new outside interests in midwifery encroached upon the parish priest’s relationship with his community by weakening his role in a particularly important area of daily life, one which was tied inextricably to matters of honor, status, sexuality, and gender relations. Both the state and the medical profession – represented in this case by an emerging class of surgeon-obstetricians – had to contend with just this kind of intimate knowledge at the level of the community, shared at once by midwives and parish priests and forged from years of experience and tradition. The midwifery school opened in Milan in 1767 was an important moment in and expression of this struggle for authority over reproduction and childbirth, and clearly in its first years acceptance of the school and all it implied was still anything but certain.

II. The Science of Obstetrics: Instruction in the Milanese School, 1767-1796

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As previously mentioned, criteria for admission to the midwifery school in Milan included that the women be married or widowed, between the ages of twenty-two and thirty-two, and ideally from the countryside. In addition to a husband’s approval and a parish priest’s recommendation, candidates were to fulfill certain physical and intellectual requirements suggesting that they would be able to handle the rigors and challenges of an intense, theoretically based course of instruction. The specification of particular physical characteristics, specifically small, strong hands and a robust composition belied the manual component of midwifery. Midwives had to be hardy, given that labor could be grueling and long-lasting, and that it could happen at any moment of the day or night. Most tellingly, however, the midwifery candidates were supposed to be of a “natural docility and discrete discernment.” In other words, officials desired precisely those women who would best conform to the school’s objective of producing a corps of well-trained, modest, and deferential midwives whose loyalty to the state was unquestioned.

By targeting women from the countryside, Count Firmian determined to root out the “perverse popular opinion” of rural midwives and the resulting “inconveniences” and “disreputable” practices. In addition to the unruly persistence of many folk traditions and heterodox childbirth rituals, critics believed that midwives often hesitated far too long in emergent situations to call in medical assistance, that they applied instruments themselves despite prohibitions, and that they were susceptible (as women) to over-excitement and irrational

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91 ASM, Sanità, Parte Antica, c. 268. “Istruzione alli cancellieri e duputati dello estimo per l’elezione delle donne che dovranno essere instrutte nell’Ospedale Maggiore di Milano nell’arte ostetricia,” 28 October 1767. “Il principale e più importante oggetto, che deve interessare le persone destinate alla scelta delle donne capaci per l’arte ostetricia…si è quella che oltre la buona e regolare salute, e proporzione organica, abbiano altresì certo naturale lume, e capacità per poter colle maggiore facilità imparare se non le teoriche, almeno le pratiche istruzioni dell’arte. A tale effetto sarà dell’avvedutezza, e diligenza di chi ha tale incarico il ben informarsi del loro temperamento e abituale stato di buona salute, e che…sieno di un naturale docile, e di un discreto discernamento.”

92 ASM, Sanità, Parte Antica, c. 268, Letter from Firmian to Kaunitz, 31 October 1767. “…perversa popolare opinione reputava disdicevole ed inconveniente l’esercizio suddetto nelle donne del contado.”
behavior during the chaotic time of labor. State officials like Firmian also distrusted midwives’ close ties with their communities, fearing that they would choose loyalty to their clients over, for instance, their obligation to report illegitimate pregnancies. The midwifery course thus represented the efforts of reformers to transform the traditional figure of the midwife. No longer would her expertise and reputation be determined by her own personal experience of childbirth, her long activity within the community, or her access to networks of popular medical knowledge; instead, the new midwife was relatively young and preferably married, cosmopolitan, educated in the institutional setting of the hospital, and her knowledge and status were based primarily on her literacy and ability to understand scientifically the workings of the body.

With the implementation of a training center for midwives underway, Firmian and Kaunitz nominated Bernardino Moscati as future director of the school and tasked him with formulating a course of instruction to train the female midwives. Moscati, a respected professor of surgery at the city’s Ospedale Maggiore, shared Firmian and Kaunitz’ opinion about the need for such a school, though he was initially skeptical about the results that might be obtained. Like Kaunitz and Firmian, Moscati staunchly believed that the management of childbirth required a kind of preparation that went beyond ‘simple’ experience and apprentice-style learning. With this in mind, Moscati produced a comprehensive midwifery curriculum that highlighted “the theory of childbirth.” Carefully defining situations that were normal as opposed to preternatural, Moscati’s course, through the use of detailed charts and diagrams, attempted to quantify and delimit the totality of potential birth presentations and outcomes. Having as his ultimate aim to elevate the “practices” of midwifery into the “science” of obstetrics, Moscati wrote that, in order to undertake “the profession of childbirth,” it is necessary to learn “the exact anatomy of the parts that serve in conception, [the] bones, muscles, [and] veins. And then the trained midwife
should master the mechanism of birth: directions, pushes, forces…passages, stages,” and the “changes that the [anatomical] parts of a woman undergo during birth.” All the things “which escape easily from the individual who, however talented” at anatomy is not trained in obstetrical operations. Yet the possibility of these qualities being present in a woman was, for Moscati, doubtful. In fact, he was wholly unconvinced that the “coarse women” destined for the school, who were “hardly intellectuals” and “barely able to read,” would be successful in an academic course filled with difficult anatomical and theoretical lessons.

What shape, then, did the actual instruction of novice midwives take? There are many details with respect to the daily functioning of the midwifery school on which the historical record is silent. The exact relationship Moscati had with individual pupils, for instance, will likely never be known. Nor do we have reports which reveal the reactions of the female students themselves to the school’s various teaching methods – many of which must have seemed strange to the young, rural women accustomed to learning through apprenticeship. However, through careful reading of letters between state bureaucrats, the various reports from Moscati himself on progress at the school, and the published midwifery manuals which were incorporated into the class, it is possible to reconstruct the overarching intellectual regime and basic assumptions which guided day-to-day instruction and practice.

From the outset, a distinctive feature of midwifery education in Milan was its insistence on boarding-school-style accommodations for the training women. While other midwifery

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93 ASM, Sanità, Parte Antica, c. 268. “…l’esatta anatomia delle parti che servono al concepimento; delle ossa, muscoli, vasi...ed attorniano le parti genitali femminili; una esatta enumerazione delle forze promuoventi naturalmente il parto...le mutazioni che le parti delle donne soffrono nella gravidanza, la reazione che esse oppongono al feto, e cent’altri simili cose relative alle pratica de parti, che s’affacciano ad un perito professore d’arte Ostetricia, e che sfuggono facilmente a chi, quantunque valente anatomico, non è cerusico ostetricante.”

94 ASM, Sanità, Parte Antica, c. 268. Letter from Bernardino Moscati, 1767. “…il timore che l’insegnare verbalmente anche tutti i giorni a rozze donne, e non pensatrici, le quali nemmeno sappino leggere, potesse riuscire di non molto vantaggio...”
schools on the peninsula would eventually come to require similar living arrangements, the Milanese school never considered alternatives. Florence, by contrast, initially favored a kind of apprenticeship structure where trainees from the provinces would live with and be supervised by those already approved midwives active within the city. Such an arrangement would have mirrored much more closely traditional modes of childbirth training and knowledge transmission. In Milan, however, the boarding school was favored specifically for its promise of complete control and disruption of previous, informal modes of learning and instruction, seen by their unregulated nature to perpetuate ignorant and superstitious practices and other abuses.95

Milanese officials together with the hospital board identified as a site in the Ospedale Maggiore well-suited to house the women the “Crociera delle Colonne” (“Transept of the Columns”). Located at the intersection of two longer wings in the women’s ward of the hospital, the Crociera delle Colonne contained sixty-three beds for the poor which could be adapted to provide sufficient room for “that number [of women]” expected to enroll in the midwifery course. Most appealing, however, was the fact that the crociera was “secluded from every sight, and communication with males, especially those young trainees in the hospital.” The crociera was serviced by a chapel and was separate from but within easy communication of the ward known as the “Quarto delle Balie” (“Wetnurses’ Quarter”) which contained the hospital’s foundlings, wetnurses, and pregnant women. Entrance to and exit from the student dormitory was regulated through a single doorway, which was to be kept locked at all times and guarded by a door keeper.96


96 ASM, Sanità, Parte Antica, c. 268. Letter from the delegates of the Ospedale Maggiore, 10 October 1767. “Non si è ritrovato sito più opportuno di quello chiamato la Crociera delle Colonne per essere...secluso da qualunque vista, e comunicazione de’ Maschi, massime de Giovani alunni in detto Ospitale.”
The student midwives’ daily schedule was designed with as little flexibility as their living conditions. Rising at five or six AM depending on the month, the women would have an hour for prayer and housework, a half hour each for mass and breakfast, three or four hours of instruction and study, and finally two hours for lunch and recreation. Lessons would resume in the afternoon, followed by several hours of dedicated study time, an hour and a half for dinner and recreation, and lastly prayers before bed. On Sundays, the late morning hours typically devoted to lessons were reserved for religious education, while after lunch the students were permitted to “take a walk,” provided they “went in company [of another student] and with [a female] attendant” escorting them. “A single time a month,” after completing their duties for the day, the students would be allowed to leave school grounds in the company of a relative or other approved individual.97

Additional regulations set strict guidelines for the women’s dress. The pupils, “as much inside the school as out must dress decently according to [their] own means.”98 Prohibited, therefore, were “low-collared dresses” or other garments that could be considered indecorous or incongruous with the women’s social status. Although Firmian remained stalwart in his conviction that such a highly structured and regulated environment was the only model by which the midwifery program would be successful, Kaunitz pleaded for a relaxing of strictures,

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98 Ibid.; ASM, Sanità, Parte Antica, c. 268, Letter from Kaunitz to Firmian, 1767. “Le Allieve tanto nell’interno del Convitto che fuori devono vestire decentemente secondo i propri mezzi. Sono quindi vietate le vesti a manica corta...”
warning that an “[excessively] rigid…discipline would not do but to dishearten them [the students] and could seem to them more a prison, than a school.”

In spite of these criticisms, the boarding of trainees in a structured, monastic-like setting remained a fixture of Italian midwifery education through the nineteenth century. Beyond simply making a preemptive strike against any potential ills that might derive from a group of unaccompanied young women living together in unfamiliar, urban environs, the arrangements reflected, on the one hand, a broader program of discipline emerging in the eighteenth century and of which both the control of reproduction and formal midwifery instruction were a part. To generate a new corps of trained and approved midwives involved not only the acceptance by these women of a particular kind of knowledge about the body, but also the creation of, in Foucault’s words, “docile bodies” in all areas of life. As such, the women were to conform to the state’s expectations about the proper movement and behavior of particular (that is, of a certain sex and class) bodies in particular spaces. On the other hand, spaces to house and instruct women had a well-established genealogy in early modern Italy. Both convents and the many religious institutions established after the Council of Trent to reform or offer refuge to fallen and at-risk women provided useful models for the housing and training of female midwives in the eighteenth century. Strict regulation and discipline, religious education, and seclusion from a dangerous outside world were all aspects of sixteenth- and seventeenth-century women’s asylums which were also incorporated into midwifery education in Milan and elsewhere.

In an epistemological sense, the most fundamental aspect of the midwifery course was its

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99 ASM, Sanità, Parte Antica, c. 268. Letter from Kaunitz to Firmian, 1767. “Una soverchia, e tanto più una troppo rigida, e scrupolosa disciplina non farebbe, che disanimarle, e potrebbe sembrar loro più una prigione, che una scuola.”

advancement of a “science of childbirth.” Based upon theoretical and observational knowledge, this new science of birth held that childbirth could be reduced to universal axioms and predictable outcomes. An ironic result of this approach was that Moscati was free to devise a course of instruction that involved very little in the way of actual clinical training, despite the proximity of the hospital’s maternity ward in the nearby Quarto delle Balie. Instead, the majority of formal instruction revolved around traditional lecturing and examination. Moscati, like most other male practitioners at the time, had only very limited firsthand experience with childbirth. As such, he was apparently more comfortable demonstrating obstetrical maneuvers and principles on cadavers and models rather than living patients, who might “misbehave,” either vocally or anatomically. Not only would an obstetrical model not talk back, question the doctor’s maneuvers, or resist his touch, it would always conform to the ‘rules’ of childbirth being demonstrated.

In fact, Moscati went to great lengths to acquire an obstetrical mannequin to be used as an instructional aide, claiming that it would make the course more accessible to those students whose reading and writing skills were lacking. Obstetrical machines, which were already commonly in use in Europe as teaching tools by the seventeenth century, were employed in particular by the growing numbers of male midwives, whose practical access to live women’s bodies was necessarily limited. In fact, Moscati himself seems to have used the Milanese obstetrical model for precisely this purpose – training novice surgeon-obstetricians – later on in

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his career. Made from a variety of materials, including leather, cloth, and wax, and often incorporating detachable body parts and fetuses, such obstetrical machines enabled students to gain practical experience in manipulating the female body and in observing the changes and movements of the human corpus during the various stages of labor.

Additionally, the midwifery students were required to attend anatomical demonstrations, though these were by necessity performed on an ad hoc basis owing to the unpredictable availability of cadavers for dissection. In fact, the choice to house the midwifery school in the Ospedale Maggiore was based above all on the fact that “nowhere else is available the quantity of cadavers of pregnant women, or fetuses, or the frequency of occasions to observe the many cases necessarily relative to the theory…of birth.”\footnote{ASM, Sanità, Parte Antica, c. 268. “...ma principalmente perché altrove non è reperibile la quantità de Cadaveri di puerpere, e feti, ne la frequenza delle occasioni per osservare molte cose necessariamente relative alla Teoria, e Pratica de parti.”} The proximity of the students to living patients (clinical instruction) did not make the hospital a prime location for the school, but rather access to the dead in order to facilitate (conventional) anatomical instruction. When the corpse of neither a pregnant woman nor a fetus could be procured, the women could observe the various artifacts in the hospital’s extensive medical collection, or anatomo-pathological cabinet. Here, students viewed preserved fetuses at various developmental stages, as well as those with pathologies such as spina bifida. There were examples of “monstrous” births – including fetuses lacking eyes, nose or other body parts - and a variety of other obstetrical specimens. One catalogue of the cabinet lists, for example, “a fetus of seven months arranged to show the origins of the vessels of the umbilical cord, the urethra, the urinary bladder, etc.”\footnote{Felice De Billi. Sulla I.R. Scuola di Ostetricia ed Annesso Ospizio... (Milano, 1844), 66-67. “Feto di sette mesi, preparato per far vedere l’origine dei vasi ombelicali, gli ureteri, la vescica orinaria...”}
Finally, Moscati recommended displaying the drawings of “the gravid uterus, and positions of the fetus” as depicted in the well-known anatomical atlases and midwifery manuals of famous men-midwives like “[Johann Georg] Roederer, [William] Hunter, [and William] Smellie…on the walls of the school, attached to…a written description beneath, an explanation suitably adapted to the need of the midwives.” Moscati hoped the women would take advantage of these additional instructional aides, observing the images at their leisure and according to their own ability. At the same time, such images underscored the school’s emphasis on observational and visual learning, a hallmark of the new clinical medicine emerging in the late eighteenth century. In contrast to traditional midwifery’s experiential and tactile modes of training, the use of anatomical illustrations reflected clinical medicine’s “belief that visibility itself can reveal the ‘facts’” and reinforced obstetrical knowledge as, above all, “a ‘seen’ knowledge.”

Drilling his students on anatomical details and surrounding them with instructive images, having them manipulate obstetrical machines, and letting them observe the various preserved fetal specimens in the anatomo-pathological cabinet, Moscati was imparting a particular conceptualization of childbirth that was essential to the emergence of obstetrics as a scientific field of inquiry and knowledge production. At the same time, Moscati’s methods must have seemed quite alien to his female trainees – many of whom had been practicing midwives in their home communities. Critical to the advancement of obstetrics was the development of a theory of birth, from which “a set of principles or axioms to underpin practice” could be derived. Ludwig Fleck’s reminder that not only is theory a fundamental part of all sciences, but that

106 ASM, Sanità, Parte Antica, c. 268, Letter from Bernardino Moscati, 1767.
107 Murphy-Lawless, 34.
108 Ibid, 64.
theory is inevitably ideologically laden serves no less for the history of obstetrics.\textsuperscript{109} By defining a theory of childbirth and ascribing to it a series of basic organizing principles, male physicians were attempting a process of appropriation, translation, and reinscription of a set of practices and knowledges already in existence. Although what I have referred to as traditional midwifery practices were in no sense uniform or timeless – indeed birth rituals performed in the Milanese hinterlands might well be unfamiliar to urban practitioners of the same period– they did not, I argue, subject the female reproductive body to reductive, universalizing principles.

By contrast, underpinning the entirety of obstetrical theory from the outset was the division of childbirth into “natural” and “preternatural,” or counter to the ordinary course of events. At once, the natural/preternatural dyad allowed for the rationalization and categorization of childbirth, an increasingly important feature of scientific praxis at the time, and also for the justification of medical intervention during labor, usually at the hands of a male physician. In the event of a birth deemed ‘preternatural’, the management of the labor was seen as beyond a traditional midwife’s capabilities and in need of ‘art’ – obstetrical intervention. However, male practitioners exploited the space opened up by the natural/preternatural division such that the criteria used to judge a ‘natural’ birth became increasingly lengthy. In the Veronese surgeon Orazio Valota’s midwifery manual, \textit{The Modern Midwife}, a work praised by Moscati, there are eight conditions that must be met for a birth to be considered an “easy” natural labor, including a cephalic presentation and a well-shaped pelvis.\textsuperscript{110} All other births are defined as either “difficult”


\textsuperscript{110} Orazio Valota. \textit{La levatrice moderna; opera necessaria alle comari ed utile a principianti d'ostetricia ed ai reverendi parrochi; con le tavole necessarie d'anatomia e delle principali presentazioni de'feti nei parti appartenenti alle levatrici.} (Bergamo: Locatelli, 1791), 16. Valota goes on to further divide ‘natural’ births into “parti naturali facili [easy natural births]” and “parti naturali difficili o laboriosi [difficult or laborious natural births],” both of which could be handled by midwives. Non-natural births, however, were entirely the domain of surgeons, xviii-xxv, 104-105.

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natural births (which include, for instance, breech presentations), or non-natural births, which always require “the aid of the surgical art, without which mother and child would perish.”111 Although Valota does not preclude, as some other obstetrical writers did, that a female midwife might handle on her own a laborious natural birth, he does carve a significant area of intervention for what he calls the “obstetric art.”

From this basic division between ‘natural’ and ‘preternatural,’ obstetrical writers launched a much more pervasive colonization of childbirth as traditionally understood, managed, and embodied. For one, accepting the conditions outlined by Valota and others, it was impossible to judge whether a labor fit the parameters of ‘natural’ childbirth until after the birth was concluded.112 With only a retroactive diagnosis possible, the full realm of childbirth was theoretically open to medical intervention. In other words, medical or surgical involvement in birth, which had traditionally been prescribed only for obstructed labors, could now be “extended to cover what might go wrong.”113 In addition, obstetrics relied increasingly on statistical enumeration114 and preventative techniques based on probability, another form of containment of birth (and the body more generally) that was a feature of the newly emerging science of public health.115 The classification of birth as always potentially requiring medical assistance was ‘needed’ in particular because, as most medical writers themselves acknowledged, the vast

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111 Valota, 104. “Il parto non naturale, ossia contro natura, è quello in cui la natura non è valevole, nè può terminare il parto…richiedendo sempre il soccorso dell’arte, senza del quale perirebbero la Madre ed il Figlio.”

112 Murphy-Lawless, 69. For a ‘natural’ childbirth, the placenta also had to be delivered without delay or obstruction.

113 Murphy-Lawless, 75.

114 Something made possible by the greater institutional control of childbirth (ie maternity wards) in the 18th century.

115 Murphy-Lawless, 159-160.
majority of births did not require “the aid of art.” Without such a broad interpretation, men would rarely be called into births at all.

The movement around this time of childbirth from being performed sitting on a chair or standing up, to a supine position is illustrative of precisely the kinds of shifts in knowledge discussed above. Increasingly, the scientific observation of birth paved the way for the expectation of ‘active’ medical intervention on a ‘passive’ pregnant body. Following the French obstetrician Francois Mauriceau, who popularized the use of the supine (lithotomy) position during childbirth towards the end of the seventeenth century, Valota believed that having the delivering woman lying recumbent, supported with many pillows and with “her legs outside of the bed resting against two stable chairs…[and] with the knees widened [apart] and a little raised” would help to preserve her strength and manage the pain of labor. Due to a woman’s perceived natural physical weakness, male obstetricians introduced preemptive practices based on universalized conceptions of the female body. Thus, even though lying horizontally causes the laboring woman to lose some of the aid of gravity, it was the position recommended in most obstetrical works. In fact, the supine position, mirroring more the rituals of dissection than traditional childbirth, soon effaced all other alternatives, particularly in the institutional setting of the lying-in hospital where the idea of a woman giving birth standing up or kneeling on all fours threatened disorder and seemed “too animal like” and uncivilized. Put most simply, the supine position was the most comfortable for the medical practitioner, regardless of the fact that, as Ludmilla Jordanova points out, it opened the female body to voyeuristic inspection and

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116 Valota, 16; De Billi, 21.


118 Murphy-Lawless, 37.
positioned the laboring woman as a passive body upon which medicine could act.\(^{119}\) We must ask at this point, however, to what extent were changes in the embodiment of birth, in its epistemological foundations and theoretical understandings, internalized, practiced, and applied by the midwives who attended the first public midwifery courses in Milan?

III. With “Piety and Maternal Heart”: Maternal Assistance in Milan and the *Quarto delle Balie*

In addition to returning home and serving rural communities, some of the newly trained midwives were expected to serve in the Ospedale Maggiore’s *Quarto delle Balie*. Also referred to as the *Quarto delle Balie e Partorienti* (Wetnurses’ and Laboring Women’s Quarter), the ward cared for the hospital’s foundling population and provided services to a limited number of pregnant women who otherwise lacked a secure location to give birth. According to one *avviso*, or public announcement, the maternity ward was intended to “graciously provide for the comfortable support of pregnant women, those of whom very often even when not poor, either because of the decrepitness of the habitation, or numerous family members, or for other reasons, lack in their homes the means both to give birth and lie-in [fare il puerperio] without danger to their health.”\(^{120}\) Although historians typically date the emergence of formal institutional care of childbirth in Italy to the 1732 opening of the maternity ward in Turin, care for poor pregnant women had existed in some form in Milan since the early sixteenth century. From as early as 1528, indigent pregnant women had been allowed at the small San Celso hospital, which had traditionally housed foundlings and wetnurses. In exchange for medical care and a secure


\(^{120}\) ASM, *Luoghi Pii, Parte Antica*, c. 389, Avviso, 20 September 1784.
location to give birth, the women who delivered children at San Celso often went on to serve for some period as wetnurses or as birth attendants. In 1671, due largely to limited space, the pregnant women, wetnurses, and foundlings housed at San Celso were transferred to the Ospedale Maggiore. The maternity ward/foundling hospital complex remained at the main hospital until 1779, and came to be known as the Quarto delle Balie. Closely connected to the midwifery school at the hospital, the Quarto delle Balie was nonetheless a distinct operation, older, and much more immune to the masculine and scientific direction of the former. In fact, historians of medicine have traditionally discounted San Celso or the Quarto delle Balie at the Ospedale Maggiore as a lying-in hospital in a strict sense, likely because of the hospital’s initial lack of obstetrical training \(^{121}\) and the absence of clinical instruction.\(^{122}\) Except in the case of emergency, births were handled by “midwives, assistant midwives, and female nurses” (comari, vicecomari, ed infermiere). Day-to-day activities were similarly directed by the female staff with limited male involvement.\(^{123}\)

Yet, the maternity care offered at San Celso and later the Ospedale Maggiore shared more similarities than differences with the other lying-in institutions that began to emerge in Italy during the second half of the eighteenth century. All of these maternity wards remained largely female-controlled spaces, despite the unquestionably masculine identity of the new field of obstetrics. The principal association of these institutions as charitable and religious (as

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\(^{121}\) An obstetrics course for young surgeons was instituted at the Ospedale Maggiore in 1769, at roughly the same time as the midwifery school opened its door. The Quarto delle Balie therefore existed for nearly a century in the hospital before any “scientific” or “instructional” aspects were officially associated with it.


\(^{123}\) ASM, Pii Luoghi, Parte Antica, c. 389, “Istruzione delle Pia Casa degli Esposti, e Partorienti,” 1781.
opposed to medical) was also never in doubt. Long traditional sites of foundling assistance, Italian hospitals began to extend that aid in the eighteenth century to pregnant women as well, but the ideological linkages remained largely the same. Just as foundling homes absorbed the evidence of illegitimate sexual activity and bore the burden of traditional care when the community or individual family could not, public lying-in wards provided spaces which protected female honor and offered a provisional domesticity to impoverished mothers. The foundling home also became reliant on the maternity ward’s clientele in a more practical way: not only were the poor pregnant women who chose to give birth at the hospital likely candidates to leave their babies at the foundling home, they were typically required to serve for a designated period as wetnurses to the infant foundling population in compensation for their care.124 Additionally, while medical men like Valota might try to pathologize childbirth in their writings, the medical status of pregnancy was not stressed in the movement of the ward from San Ceslo to the larger central hospital. In fact, eighteenth-century lying-in wards typically admitted only women who were in good overall health.125

Instead, the movement of the maternity ward from San Celso to the Ospedale Maggiore was compelled by the need for an expansion of services to poor and compromised pregnant women and more space to house an ever-growing number of foundlings. At the same time, the transfer may have served the state’s desire for greater oversight of and administrative control over its subjects’ reproductive behavior. Apart from those women whose home conditions were unsuitable for giving birth, the typical patrons of the maternity ward were unmarried women whose honor had been jeopardized with an illegitimate pregnancy. In an early modern social

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economy which hinged around marriage and inheritance, female bodies and the honor attached to them were an important form of currency. Always “focused more narrowly on sexual concerns” than was male honor, female honor reflected on both the woman herself and her family.126 Thus in the hopes of avoiding drastic measures, such as infanticide or abandonment, to which the loss of honor was seen to drive some women, new public maternity spaces functioned to preserve a woman’s reputation and provide her with the greatest degree of privacy during her recovery. Maternity institutions were, in this way, fulfilling a need for the mediation and management of reproduction and honor which had long been provided by the community, but which, by the eighteenth century, had begun to breakdown.127

And yet, the placement of a maternity ward and, later, a midwifery school in the confines of the city’s central hospital troubled Milanese officials at times. For one, the presence of the type of woman likely to give birth in a public maternity ward – poor and of questionable moral status – among the hospital’s other patients and staff, particularly men, deeply concerned the board of governors. For another, despite careful measures taken to maintain order and propriety, there was a steady stream of “abuses” from the ward, originating variously with the foundling population, the pregnant women, the wetnurses, or the midwifery students. In an attempt to minimize such disturbances, movement into and out of the ward was strictly guarded, especially against male physicians and training surgeons entering a space where women’s modesty was compromised. In the same vein, women were never permitted to leave the ward unaccompanied. Nonetheless, reports accumulated of numerous “disorders”: rowdy behavior by pregnant women


and wetnurses socializing (against regulations) in the parlor, a rogue wetnurse whose milk supply had dried up remaining lodged unnoticed at the hospital’s expense, and an infant suffocated when the wetnurse with whom he was sleeping (due to lack of crib space) rolled over on him.\textsuperscript{128} In addition, critics blamed poor ventilation, overcrowding, and an insufficient availability of wetnurses for the striking forty-three percent mortality rate among foundlings.\textsuperscript{129} Armed with copious accounts and statistics detailing the ward’s deficiencies, reformers had by the early 1770s launched an energetic campaign to transfer the entire operation to a more suitable location.

The convent of Santa Caterina alla Ruota, located on the \textit{Naviglio} (canal) close to the Ospedale Maggiore, presented an attractive choice for the future home of the \textit{Quarto delle Balie}. Positioned so as to benefit from good airflow and sunlight, the site was, according to Bernardino Moscati, particularly “salubrious.”\textsuperscript{130} Kaunitz praised the “roominess of the building” and its “extensive gardens [which] were irrigated by a constant supply of water.”\textsuperscript{131} At Santa Caterina, the “midwives, wetnurses, foundlings, and pregnant women” who occupied the maternity ward would, further, be separated from the Ospedale Maggiore in an ideological sense. As medical care was becoming increasingly specialized and the hospital increasingly medicalized, the support of pregnant women, whose condition was neither fully pathological nor ‘normal’, and foundlings, who were traditionally a focus of charity (rather than medicine), and yet among whom disease was common, troubled categories in a care system that was still working to define

\textsuperscript{128} Carlo Decio, \textit{Notizie storiche sulla ospitalità e didattica ostetrica Milanese} (Pavia: Successori Fusi, 1906), 111.

\textsuperscript{129} The mortality rate among foundlings in eighteenth-, and especially nineteenth-century Milan (when abandonment rates peaked) was higher than in most other large European foundling hospitals at the same time, an anomaly noted by contemporaries. See Volker Hunecke, \textit{I Trovatelli di Milano: Bambini esposti e famiglie espositrici dal XVII al XIX secolo} (Bologna: Il Mulino, 1989).

\textsuperscript{130} ASM, \textit{Pii Luoghi, Parte Antica}, c. 389, Letter from Bernardino and Pietro Moscati, 1774.

\textsuperscript{131} Quoted in Maria Canella and Flores Reggiani, “Il Vecchio e il nuovo brefotrofio,” in “Si consegna questo figlio”: \textit{L’assistenza all’infanzia e alla maternità dalla Ca’ Granda alla Provincia di Milano (1456-1920)}, eds. Maria Canella, Luisa Dodi, and Flores Reggiani (Milano: Skira, 2008), 105.
itself. At once, then, the convent represented a traditional choice for maternal and infant care and an anticipation of trends toward medical specialization. In the same way, the practical functioning of the ward at Santa Caterina revolved around a constant negotiation of interests and power. While the maternity ward, officially opened at Santa Caterina in 1781, was always under the nominal direction of three “gentleman delegates,” the head midwife and her assistant midwives assumed the vast majority of daily responsibilities.

In reality, the complex at Santa Caterina was always as much of a rehabilitative space as it was a curative one. Even before describing the ward’s medical provisions, the official regulations highlight the presence at the “home” of a priest, who would “reside in the same residence, and who will…instruct all the classes of persons in the Christian Doctrine, administer the sacraments, and be ready for any extraordinary occurrence.”132 For the hospital’s directors, both the unmarried mothers and impoverished pregnant women who comprised the vast majority of Santa Caterina’s patients were morally deficient and in need of religious recuperation. Recidivism by unwed mothers, if made known, was deeply frowned upon. Similarly, prejudices abounded regarding the wholesomeness of the wetnurses serving the foundling population, a particularly troubling concern given the widely held belief that moral defects could be passed on through breast milk. The symptoms of syphilis were attended to assiduously, with some physicians recommending frequent, random bodily examinations of wetnurses. It was therefore expected that both mothers and wetnurses be engaged in some kind of productive activity during their stay: menial chores such as cleaning, but also more gainful endeavors, including spinning,

132 ASM, Pii Luoghi, Parte Antica, c. 389, “Istruzione delle Pia Casa degli Esposti, e Partorienti,” 1781, 1. “Sono assistite nello Spirituale dal Sig. Curato, particolarmente a ciò destinato, e domiciliato nel medesimo recinto, il quale fa anche regolarmente la Dottrina Cristiana a tutte quelle classi di persone, amministra i Sagramenti, ed è pronto ad ogni straordinaria occorenza.”
making shoes, agricultural work, or some other “occupation.” The maternity ward’s directors therefore aimed to provide soon-to-be and new mothers with a space that was recuperative in both a medical and moral sense. The fact that the site could be productive as well as restorative took on new significance toward the end of the century. Always under financial duress, the home was further burdened in the last decades of the eighteenth century by dwindling charitable donations and policies aimed at ensuring a recovering mother’s privacy which came to prohibit midwives or others from soliciting information about the baby’s father – effectively cutting off a traditionally critical source of financial support for foundling homes. As such the productive capabilities of the women at Santa Caterina came to serve a much-needed economic role in ensuring the survival of the hospital.

The significant expansion of space at Santa Caterina allowed for a more formal separation than had been possible at either San Celso or the Ospedale Maggiore of the foundling home from “all the sites intended for the pregnant and parturient women, and also the dormitory of the training midwives.” The two spaces shared a kitchen, wardrobe, and several administrative offices, but were otherwise distinct sites. The division likely reflected the hospital reformers’ belief that the proximity of the pregnant women, wetnurses, midwives, and foundlings, and the potential mixing of social classes this implied fostered the abuses which so plagued the Quarto delle Balie. At the same time, the emphasis on physical separation, which both Bernardino Moscati and his son, Pietro, supported may have been an attempt by the medical practitioners to partition the more domestic space of the foundling home from what they

133 ASM, Pii Luoghi, Parte Antica, c. 389, “Istruzioni per la Giunta per gli Esposti, Gravide, e Partorienti,” 1784.

134 Felice De Billi, 12. “Sono totalmente separati dal Luogo Pio degli Esposti, che si estende sul restante di detto Convento, tutti i locali destinate per le gravide, partoriente, e puerpere…”

135 Pietro Moscati (1739-1824) followed in his father’s footsteps, becoming “Regia Professore di Medicina e Chirurgia” at the Ospedale Maggiore in 1772. Moscati assumed his father’s role at head “medico-ostetrico” when the Quarto delle Balie were transferred from the Ospedale Maggiore to Santa Caterina.
viewed as the scientific, rational spaces of the maternity ward and school, in which the principles of obstetrics could be taught and implemented.

The maternity ward and midwifery school occupied two floors in an east-facing wing at Santa Caterina. The ground floor contained “an amphitheater for lectures,” a room for anatomical demonstrations, an anatomical cabinet, a church, and a garden passage to the other buildings of the complex. On the second floor were two administrative rooms, six private rooms reserved for paying pregnant women, and large dormitory-style rooms with up to sixty-sixty beds to accommodate training midwives. There were also two rooms with four beds each for sick pregnant women and three rooms for sick post-partum patients. Finally, the site contained a small, secluded birthing room with three beds and a bath, and a large room with twenty beds and a number of cots for newly delivered women and their babies. The greatly increased square footage provided at the new site thus made possible a more structured division of space. The pregnant women were now separated by wealth and status, as well as by physical condition, distinctions which translated into restrictions on where, how, and by whom certain bodies could be accessed. There was, furthermore, a clear boundary between the instructive spaces of the first floor and the more domestic spaces reserved for the more secluded second floor. Interestingly, birth itself, despite being the object of obstetrical training, was restricted to the upper floor where it remained the spatial and practical reserve of female knowledge and praxis.

As at the Ospedale Maggiore, one of the primary concerns of the directors of the maternity ward at Santa Caterina was for the preservation of privacy and anonymity. Midwives and other attendants were “absolutely prohibited” from inquiring into the personal information of a pregnant woman (apart from her name) or the identity of the baby’s father. Additionally, the directors made it expressly known that, “having given birth in the Pia Casa (Pious House) will
never, by express sovereign will, serve as condition or proof…for judgments hostile to the parturient woman, nor ever will the Casa give testimony or a certificate” stating that that woman gave birth at the hospital. In other words, pregnant women could give birth at Santa Caterina in full assurance that their stay would never be revealed against their wishes, even for legal purposes. In fact, admitted women were requested only to record their full name and bed number on an envelope, which would then be sealed and transported with the patient throughout her stay, to be opened exclusively in the event of her death in order that her husband or relatives could be notified.

The hospital’s concern for secrecy translated into tightly controlled spatial and temporal restrictions. While the hospital’s bylaws (Istruzione) stated that no woman was to be admitted before her ninth month of pregnancy, the directors made clear exceptions for unmarried pregnant women to be admitted at an earlier point in their pregnancies, for “reasons of public propriety.” A secondary provision even stated that, regardless of a woman’s financial means, she might, if she desired and demonstrated the need, “give birth and be lodged separately from the others, and in great seclusion.” For such women, “an enclosure in the pious place [pio Luogo], a separate, private, and secure accommodation, accessible only to the head midwife” could be reserved. More generally, the daily movement of persons within the maternity ward was vigilantly observed. Two female assistants were tasked with guarding the door to the maternity ward, allowing entrance and exit only to those with the proper approvals, signed either by the head physician or midwife. Even sanctioned visitors were to be accompanied by an assistants to the

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136 ASM, Pii Luoghi, Parte Antica, c. 389, “Istruzione delle Pia Casa degli Esposti, e Partorienti,” 1781. “Che daranno solamente il loro nome, e cognome all’ingresso nella pia Casa, rimanendo assolutamente proibita a qualunque persona del Luogo ogni ulteriore domanda intorno alla condizione, o stato.”

bed of the patient in question so as to ensure order and privacy. On the one hand, the strict regulation of movement was intended to prevent any ‘disorders’ that might arise from women of varying social classes sharing the same space, away from the watchful eye of a husband or male relative. On the other, the maternity ward directors felt a pressing need to protect those mothers who had come to the hospital to deliver an illegitimate birth in secret. In order to prevent scandal in their home communities, such women often traveled significant distances to take refuge in the urban maternity hospital’s promise of succor and anonymity; the hospital in turn provided these women with such assistance in order to avoid their resorting to desperate measures like abortion, infanticide, or abandonment.

As indicated above, access to and movement within particular spaces within Santa Caterina was dependent on social class. Newly admitted women were divided into four categories depending on how much they were able to contribute to their own care. At one extreme, the wealthiest patients paid three lire per day and received the comfort of a room “separate and to themselves” and were protected by the most stringent restrictions on who could enter (training surgeons and midwives were strictly prohibited), providing them with the “greatest [secrecy] and confidentiality.”138 Immediately below those (rare) patients of the first class, second class women paid one lira and ten soldi a day and, though joined together in one room, were nonetheless kept distinct from the lowest two classes and “beyond [that]…were furnished with individual beds” and were to be served only by trained midwives and the head physician-obstetrician. These two highest classes of women were also treated to a comfortable lying-in which very much resembled that of a typical mother of the middling classes, with all the

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expected domestic accoutrements. In fact, the highest paying patients were promised “an individual servant, the finest linens, and better furniture.”

By contrast, the poorest women admitted to the hospital paid nothing and were required to present a certificate from their parish priest attesting to their poverty. Further, they were subject to the least hospitable conditions, being housed together with patients of the third class (who paid the relatively meager sum of ten soldi a day), and, depending on the availability of space and linens, might be required to bed together with another patient. Most significant, the women of the third and fourth classes, who comprised the majority of patients, were targeted for visitation by training midwives and surgeons. Clearly, access to and control over a woman’s body was as much an issue of class as it was gender. Considering also that many of the poorest women entering the maternity were immigrants (meaning non-Milanese), the divisions among the women themselves (rather than between men and women) within the context of early modern reproductive care and management becomes clear. Indeed, it was upon the bodies of poor women that obstetrics first advanced itself and eventually gained the practical experience necessary to support its claims to legitimacy.

In addition to class, movement within Santa Caterina reflected important divisions and assumptions based on gender. While always nominally under the authority of a head physician

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139 De Billi, 14. “Le paganti hanno ciascuna uno stanzino separato, possono entrare nell’Ospizio per una porta segreta, e vi sono ammesse in qualsiasi epoca della gestazione...quelle della prima classe hanno ciascuna un’apposita servente, stanza più comoda, biancheria più fina, e mobili migliori.”

140 Eventually, these women were also required to have approval from the “Regulators of Poverty,” a new committee instituted in each parish. ASM, *Luoghi Pii, Parte Antica*, c. 389, “Istruzioni alla Giunta per gli Esposti, Gravide, e Partorienti,” 1784.

141 ASM, *Luoghi Pii, Parte Antica*, c. 389, “Avviso prescritto intorno al metodo.” The only marked difference between women of the bottom two classes was that women of class three paid only half the normal fee in the event that they wished to abandon their child at the foundling home; further, they did not have the obligation to remain at Santa Caterina as a wetnurse. Women of class four paid no fee to leave a child, but were required to serve as wetnurses.

142 Forman Cody, 154.
and the committee of three directors, the maternity ward was, in practice, the reserve largely of women. It was the head midwife’s responsibility, for instance, to determine which women would be admitted: she was the one who performed an examination to confirm that the desiring entrant was in fact in her last month of pregnancy. Nevertheless, the hospital’s statutes did emphasize the male (and medical) oversight of the ward. According to the Istruzione, the “Physician and Royal Professor of Surgery” from the Ospedale Maggiore would visit the ward each morning to attend to all persons “who had need of it…returning also after lunch…when the gravity of sicknesses demanded it.”143 It can be assumed, however, that the ambiguity of the language left room for a wide degree of flexibility in terms of how frequently a professor actually visited the women in the ward. Moreover, these medical men never resided within the complex at Santa Caterina, but rather “nearby.”144 Ultimately, it was the head midwife, her staff of assistant midwives, and, occasionally, advanced midwifery students, all of whom did reside in the ward, who governed the vast majority of daily affairs, including most births. Indeed, the midwife was directed to call for the assistance of a male surgeon only in extreme circumstances, when it became impossible to deliver the fetus without recourse to surgical aid.

Thus, while childbirth had been divorced from its traditional domestic confines at the maternity ward, the divisions of space and labor within Santa Caterina tended to reestablish rather than challenge many customary aspects of childbirth. Precisely because the spatial divisions in the maternity ward potentially fostered resistance to the imposition of a fully scientific or maculinist knowledge regime, pregnant women may have been more willing to accept childbirth in an institutional setting when circumstances left little alternative. In fact, the maternity ward at Santa Caterina saw an annually increasing number of patients, such that by the

143 ASM, Luoghi Pii, Parte Antica, c. 389, “Istruzione della Pia Casa degli Esposti, e Partorienti” 1781.

144 Ibid.
end of the century more than 200 women per year gave birth at the institution, almost double the average number of births seen at the Ospedale Maggiore during the 1770s.  

IV. Beyond Milan: Provincial Centers for Midwifery Instruction in Lombardy

In 1790, Milanese officials, looking to evaluate the impact of stricter midwifery regulation, again distributed surveys to various parishes to enquire about the condition of childbirth assistance in each local community. The questionnaire asked if the district had any approved midwives, if they received municipal salaries, and what the typical compensation was for a midwife’s services. For officials like Kaunitz and Firmian, both of whom had been deeply involved in the project to establish a midwifery school and expand maternity assistance, the results of the survey were disheartening, to say the least. According to the parishes whose responses are preserved, unauthorized midwives outnumbered those with formal approval by a margin of more than two to one. The disparity of the numbers, despite the fact that it had been illegal in Milanese territory to practice midwifery without an official license for more than two decades, seems to have been driven by women’s resistance both to outside intervention in the ambit of childbirth and to the kind of knowledge such involvement promoted. Practicing midwives often did not see the need for further instruction, particularly when their client base had clearly demonstrated its preference for traditionally-trained birth attendants anyway.

Given the less than overwhelming impact of the midwifery school on broader licensing practices in Lombardy, officials in Vienna and Milan had already begun brainstorming a corrective to the situation. The trick was to proceed without entirely dismantling what they

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145 During the years for which detailed records are extant (1775-1776), the Ospedale Maggiore averaged 114 births per year.

146 ASM, Sanità, Parte Antica, c. 269, “Informazioni che si Somministrano dalla Regia I. Politica di Milano sopra i sequenti articoli in esecuzione di decreto dell’Imperiale Regio Consiglio di Governo,” 1 June 1790.

believed to be, overall, a solid basis for the reforming of maternal and infant welfare policies in the territories of Hapsburg Lombardy. Establishing a school for midwives in Milan and narrowing licensing procedures to exclude those women who had not attended lessons, or at least undergone a formal exam, had been, they believed, important measures to reduce the number of infants and mothers lost to ignorant midwives, especially in rural areas. Only in this way, they thought, could the state begin to serve the public welfare in such an important area and protect “future citizens.” The fact that numerous midwives, at times supported by local parish priests, continued to practice without the necessary approvals was simply an unfortunate example of rural backwardness and intractability for which there must be found a solution.

As had been the case in the past, State Chancellor Kaunitz and Count Plenipotentiary Firmian differed on the best strategy to combat the existing abuses. Firmian was the more tentative, arguing that due to various financial and logistical demands it would be best for provincial midwives simply to be trained by the nearest state-sponsored surgeon or physician who had some knowledge in obstetrics. Kaunitz, however, disagreed. To meet the state’s goals of reducing infant and maternal mortality on a large scale, a truly centralized and far-reaching system of midwifery education run directly by the state was necessary. The Milanese school had been an important start, but it had barely been able to attract women from the city’s immediate outlying communities, let alone the provinces further away in the vast Lombard state. Clearly, proximity was an issue that would have to be resolved. It was Kaunitz who won the

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148 The administrative division of Austrian Lombardy changed somewhat in 1786 when the Austrian government divided Lombardy into eight provinces (Milano, Pavia, Mantua, Cremona, Lodi, Como, Casalmaggiore, Varese), each which were further split into fifteen administrative districts, and these further into individual delegations.

149 Firmian was referring specifically to municipal physicians and surgeons (medici e chirurghi condotti) who were supported by their communities in exchange for serving the poor at no cost. ASM, Sanità, Parte Antica, c. 269, Letter from Firmian to Kaunitz, 26 May 1772.

150 ASM, Sanità, Parte Antica, c. 269, Letter from Kaunitz to Firmian, 11 May 1772.
Battle of wills. The most significant proposal to reform the widespread licensing abuses was therefore to expand midwifery education in Lombardy by establishing a network of schools in the larger cities of the state, such as Mantua, Cremona, and Pavia, where the university was located. By doing so, the reformers believed they could prevent one of the main reasons for many women’s lack of interest in the school – the distance required to travel to Milan, which resulted in burdensome periods spent away from families and livelihoods.

By establishing regional centers for midwifery instruction, based in the main hospitals of each respective city, women from the provinces could more easily attend school. The reformers also questioned why had there never been local efforts made to provide communities with salaried municipal midwives (levatrici condotte), just as there had been for surgeons and physicians? Kaunitz was a strong proponent of such a system, suggesting that each town should support a midwife who would serve the local population, both rich and poor, in exchange for a fixed stipend.151 Having agreed on these basic tenets of a new, revised midwifery regulation (regolamento) – including an expanded network of instructional centers and the implementation of salaried midwives - Joseph II invited two experienced professors to draft proposals for a comprehensive system of midwifery education in Hapsburg Lombardy. The first, Antonio Scarpa (1752-1832), was a physician who had studied under Giovanni Battista Morgagni in Padua and who had recently (1783) been appointed Professor of Anatomy at the University of Pavia.152 The second, Johann Peter Frank, was a German physician who also held the position of Professor of Clinical Medicine at the University of Pavia and would become famous for his monumental

151 ASM, Sanità, Parte Antica, c. 269, Letter from Kaunitz to Firmian, 11 May 1772.

152 For more on Antonio Scarpa see Gorgias Gambacorta, Antonio Scarpa: Anatomico Chirurgo e Occulista (Milan: Asclepio Editrice, 2000).
work on public health policy and the development of the concept of medical police. In 1786, Frank was made Director General of Public Health for all of Austrian Lombardy.

The two schematics drawn up by Scarpa and Frank differed significantly, presenting the reformers in Milan and Vienna with a difficult decision. Although the two professors agreed that any plan should include a midwifery school centered in Pavia, at or near the university, they differed on the number of additional schools to be established in the Lombard territories and the length of the midwifery course. For Scarpa, the institution of a comprehensive network of schools was essential to combatting the abuses faced so far in trying to regulate and license midwives. Noting that “many women of diverse cities, and provinces, of the state had difficulty adapting to living far from their hometowns, and families,” Scarpa argued that “it is advisable to found as many schools for midwives as there are principal cities of the State, that is Milan, Pavia, Cremona, Mantua, Lodi, [and] Como,” each one of which would have its own professor expert in the theory and practice of obstetrics. The midwifery schools would work in conjunction with a

153 Johann Peter Frank, System einer vollständigen medicinischen Polizey (1779), published in English as A System of Complete Medical Practice and in Italian as Sistema Completo di Polizia Medica. Frank believed that the State should take an active and wide-reaching role in governing matters related to public health. With enormous influences in the German and Habsburg lands, as well as Northern Italy, Frank proposed initiatives in numerous areas, including: maternal and infant welfare, midwifery regulation, child education, orphan care, sewage and waste disposal, clean water initiatives, hygiene in relation to housing, food, clothing, and the regulation of hospitals and clinics. Additionally, Frank was an early advocate of the importance of keeping vital statistics to better understand and treat disease and to improve conditions in healthcare facilities. Essentially, the government would be responsible for caring for its subjects “from womb to tomb.” For more on Johann Peter Frank and his concept of medical police see George Rosen, From Medical Police to Social Medicine: Essays on the History of Health Care (New York: Science History Publications, 1974); Anita Malamani, “L’Organizzazione sanitaria nella Lombardia Austriaca,” in Economia, istituzioni, cultura in Lombardia nell’età di Maria Teresa, 3 vols., eds. A. De Maddalena, E. Rotelli, and G. Barbarisi (Bologna: Il Mulino, 1982), 991-1010; Anna Parma, “Johann Peter Frank e l’Introduzione della polizia medica nella Lombardia Austriaca,” in Sanità e società: Veneto, Lombardia, Piemonte, Liguria, secoli XVII-XX, ed. Franco della Peruta (Udine, Casamassima, 1989), 95-107; Thomas Neville Bonner, Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945 (Baltimore: Johns Hopkins University Press, 2000), 29-44.

154 ASM, Sanità, Parte Antica, c. 269, “Piano del Regio Professore Scarpa,” 1786. “Molte donne delle diverse Città, e Provincie dello Stato difficilmente si addattano a vivere lontano dal loro paese, e famiglia per mancanza di mezzi, o per altri riguardi...Conviene perciò stabilire, e fondare altrettanto scuole per le Levatrici quante sono le principali Città dello Stato, cioè Milano, Pavia, Cremona, Mantova, Lodi, Como.”
network of maternity wards to be established in the main hospitals of these principal cities.\textsuperscript{155} As in Milan, it would be in the hospitals that the midwifery courses would be held and the students midwives housed. The head professor would live, not in the hospital, but close by “so that he could be ready in any urgent situation to assist the pregnant women.” Scarpa preferred a hospital setting as the site of the schools because (unsurprising given his own training) it was best suited to an excellent preparation in anatomy.\textsuperscript{156}

According to Scarpa, the lack of skillful and well-trained midwives, not only in the Milanese territory, but in Italy in general, was due to overly complacent standards of selection.\textsuperscript{157} Even midwives from the countryside, he contended, should be able to read and write in order to be fully proficient in the art, and those women who were to attend school must not be distracted by concerns about family or livelihood. In order to master any science or art, he continued, it was necessary to begin learning from a young age, and so older women should be excluded from election to the schools.\textsuperscript{158} Scarpa even suggested that it might be profitable to select some of the

\textsuperscript{155} Scarpa suggested that each maternity ward should have room for twenty-four beds for pregnant women, space for the lodging of twelve training midwives, as well as at least one expert midwife, who would share teaching responsibilities with the professor, and who would guide the students in their practical training in the ward. ASM, Sanità, Parte Antica, c. 269, “Piano del Regio Professore Scarpa,” 1786.

\textsuperscript{156} ASM, Sanità, Parte Antica, c. 269, “Piano del Regio Professore Scarpa,” 1786. “Gioverebbe che il Professore fosse alloggiato in vicinanza dello stesso Spedale, affinchè potesse esser pronto in ogni occorrenza ad assistere le partorienti.”

\textsuperscript{157} Ibid. The parishes would continue to play a prominent role in the selection of midwives and local regulation or practice. Circulars would be sent to each parish, much as had been done for the initial opening of the midwifery at the Ospedale Maggiore in Milan, requesting precise information on the size of the community, the number of midwives who practiced there, and what their ability and training were. All ‘large’ community, Scarpa wrote, should have at a minimum two approved midwives to support the local population at the expense of the community. The stipend for these “levatrici condotte” would be fixed. After their instruction at one of the schools, approved midwives would return to their parish priest with a letter from the Medical Directory requesting that the priest assist the midwife in any way possible and properly publicize her name in the church or the customary place for that village.

\textsuperscript{158} Ibid. The women should be under the age of twenty-five. Though Scarpa preferred younger women to older women, he recognized that propriety would demand the women at the school be married or widowed. However, Scarpa also suggested that the government should look into appointing young women who had grown up under the
countless young female orphans who had grown up under state and ecclesiastical tutelage to be trained in the midwifery schools. The most distinctive aspect of the Scarpa plan, however, was unquestionably the proposed length of study. Only after four years of “assiduous application at the school, combined with practical training” would students be allowed to undergo an exam to test their abilities in anticipation of their approval and licensing.\(^{159}\) Only at this time could approved midwives return to their home villages and practice as municipal midwives, with fixed stipends paid for by the community. In this way, Scarpa was aiming to reverse what he saw as the widespread denigration of the figure of the parish midwife by replacing her with the scientific and formally-trained midwife whose status and remuneration were commensurate with her new skills and training.

Johann Peter Frank’s plan was on the whole more conservative. Instead of a wide network of midwifery schools, Frank limited the number to only two – one in Pavia, near the University, and another in Mantua,\(^{160}\) one of the largest of the eight provinces which comprised

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\(^{159}\) Ibid. In Pavia, the exam would be administered by representatives of the Medical Directory (\textit{Direttorio Medico}), the Professor of Obstetrics, and the Head Surgeon of the Civic Hospital. Elsewhere, a delegate of the Medical Directory, along with the Professors of Obstetrics and Head Surgeon of each city’s main hospital would deliver the exam. The only exemptions from attending school in order to be approved were extended to women who could prove fifteen years of successful public practice as a midwife. The Medical Directory in conjunction with individual parishes and provinces, as well as the hospitals, would then keep a precise and annually-updated register of all approved midwives.

\(^{160}\) A midwifery school had in fact already been established in Mantua in 1775. Between 1708 and 1786 the Duchy of Mantua, while nominally under Habsburg control and part of the Milanese State, retained a significant degree of autonomy. Between 1786 and 1791, however, the Duchy of Mantua was briefly united with the Duchy of Milan and it was at this time that the Milanese government became involved with the midwifery school there. By that point, Mantua had also already experimented with a system of municipal midwifery care in its outlying parishes, in which midwives received fixed salaries in exchange for extending their services to the poorest of the community, thus the Mantuan system existed as a model of sorts for some aspects of midwifery reform elsewhere in Lombardy. As for the limited number of schools proposed by Frank, this seems to have been a point about which both the medical director and the Milanese authorities wavered. Although Frank himself would have preferred a school for each province (and eventually came to advocate this position), he was initially cautious, conscious of the government’s financial constraints. An additional impediment to establishing schools in each of the provinces, as stated by both Frank and the Imperial Council, was that not many hospitals in the provinces catered to pregnant women, and thus
Hapsburg Lombardy in the eighteenth century. Acknowledging the burden of extended periods away from families and homes, particularly for rural women whose labor was critical, Frank also suggested an accelerated course of study lasting only three months. This would be run twice a year so as to maximize the number of women trained annually. After three months, assuming a good outcome and a successful exam, the women would be expected to “reside for another three months in some provincial civic hospital of the state in which are regularly maintained at least twelve pregnant women; [the novice midwives] must attend, under the direction of expert midwives, these pregnant women, the newborns, and the post-partum women, in all of their demands related to the art of obstetrics, in order to acquire a practical [clinical] expertise in their profession.” Training surgeons, particularly those studying theoretical obstetrics at the University of Pavia, might also benefit from the school and the introduction of a maternity ward in order to gain clinical instruction.

For the most part, the student midwives would be responsible for their own expenses, even their own cooking. Anticipating the limited means available to the majority of rural

the opportunities for practical training in any midwifery schools set up there would be limited. See ASM, Sanità, Parte Antica, c. 269, Letter from Johann Peter Frank to the Imperial Council, 20 May 1789.

The original midwifery school in Milan continued to operate, though with several transformations in character. When reopened in Santa Caterina alla Ruota, the Milanese midwifery school also operated under slightly different regulations than those discussed below, which were designated specifically for the provincial midwifery schools. On the evolution of the Milanese school see the third section in this chapter.

ASM, Sanità, Parte Antica, c. 269,” Massime da Ritenersi per le Levatrici” n.d. “Quand’anche abbiano riportata la loro qualifica, non potranno ancora intraprendere l’esercizio dell’arte, ma dovranno per altri tre mesi consecutive dimorare in qualche Ospedale Provinciale Civico dello Stato, nel quale siano abitualmente mantenute per lo meno dodici partorienti; dovranno ivi assitere sotto abili Maestre Levatrici le Donne Gravide, le Partorienti, i bambini, le Puoperere, in tutte le occorrenze correlative all’arte Ostetricia, per acquistare la pratical perizia della loro istituzione.”

Frank did propose, however, that the midwifery school might emulate a practice observed in the silk industry, by which pious foundations like confraternities would provide dowries for young, unmarried workers in exchange for their labor. If rural women or even urban orphans with few financial resources agreed to attend the midwifery school with the agreement that they would eventually serve as a municipal midwife, arrangements with charitable organization might be made to support the women with dowries.
women, however, Frank recommended that the communities themselves sponsor students who would ultimately return to serve their home populations. In return for the lire 180 projected as the cost for each individual student, the community could then expect a trained midwife who would serve in a public capacity for a fixed salary.\textsuperscript{164} Although Frank’s proposals appear more modest than Scarpa’s, they would also theoretically be easier and quicker to implement, and be accessible to a wider swath of the population. Indeed, for Frank the state had a primary responsibility to provide for the health and welfare of its citizens. The public health system of any nation would ultimately reflect on the overall strength and power of the same.\textsuperscript{165}

Furthermore, it was not, in the final appraisal, the instruction of midwives that Frank thought was the root of the problems he had observed over the course of some fifteen years in his work in Lombardy. Three to six months of training would be sufficient for most women to be trained, both theoretically and practically, to undertake the practice of midwifery. The larger concern for Frank was how these women would be supervised after this initial period of training. Without regular inspection, Frank was convinced that even approved midwives, and particularly those in rural areas, would “before three years had passed…fall back into their previous ignorance, and… empiricism, terrible for its consequences.”\textsuperscript{166} The only solution was to subject all practicing midwives to regular public examinations, though even Frank acknowledged that the vastness of the Lombard territory would render this task difficult.

\textsuperscript{164} ASM, \textit{Sanità, Parte Antica}, c. 269, “Massime da Ritenersi per le Levatrici,” n.d. Frank proposes a zecchino (ducat), or about 13 lire per month. For comparison, an entire household of field workers in the Lombard provinces rarely made over 200 lire per year during the seventeenth century. See Elena De Marchi, \textit{Dai campi alle filande: Famiglia, matrimonio e lavoro nella “pianura dell’Olona” (1750-1850)} (Milan: Franco Angeli, 2009), 297.


\textsuperscript{166} ASM, \textit{Sanità, Parte Antica}, c. 269, Letter from Johann Peter Frank to the Imperial Council, 20 May 1789.
After careful consideration of the two plans by the committee on university reform, they were given over to Pietro Moscati for his observations and final opinion. Son of Bernardino Moscati, Pietro had served as Royal Professor of Medicine and Surgery at the Ospedale Maggiore prior to succeeding his father as head of the Casa delle Partorienti and midwifery school at the hospital (he continued as head Physician-Obstetrician after the move to Santa Caterina alla Ruota). Moscati, in agreement with the delegates of the Medical Directory, ultimately deemed the plan of Johann Peter Frank most practical and consistent with the interests of the state, not to mention the most economical. The plan was approved by royal decree on 26 February 1787, though with some minor modifications. First, it was left as a possibility, depending on funds, to add more schools in other provinces. Cremona was mentioned in particular as a potential third site for a public school. Additionally, they proposed that the brief course of study indicated by Frank be lengthened to include two three-month semesters, for a total of six months of instruction. They further specified that the costs for the new schools would be split between the provinces themselves and the state, from its funds allocated to Public Instruction. Individual parishes would be responsible for financially supporting the women they sent to be instructed at the schools.

With the approval of Frank’s plan, the midwifery school project received further backing with a royal decree issued on 8 April 1788, a sign of official authorization of the proposals so far.

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167 Ideally there would be one school in each of the eight provinces.

168 ASM, Sanità, Parte Antica, c. 269, Letter from Kaunitz to the Royal Council of Government, 26 February 1787. Much of the money eventually put in by the government came from revenues from recently suppressed convents and monasteries. Some of these building were even repurposed to provide the space for the new midwifery schools, as in the case of Santa Caterina, a former convent, in Milan and the former monastery of Leano in Pavia. On the suppression of the monasteries and the reallocation of lands and properties at this time, see Paola Vismara Chiappa, “Le soppressioni di monasteri benedettini. Un episodio dei rapporti Stato- Chiesa nella Lombardia teresio-giuseppina e napoleonica,” Ricerche storiche sulla Chiesa ambrosiana, 9 (1980): 138-201, and her “La soppressione dei conveni e dei monasteri in Lombardia nell'età teresiana,” in Economia, istituzioni, cultura in Lombardia nell’età di Maria Teresa, 3 vols., eds. A. De Maddalena, E. Rotelli, and G. Barbarisi (Bologna: Il Mulino,1982), 481-500.
set forth. Despite the widespread support for the establishment of provincial midwifery schools, however, Frank noted with disapproval that the Imperial Council (Regio Imperiale Consiglio di Governo) was dragging its feet on implementing the plans. In March of 1789, in his position as Director General of Public Health, Frank wrote to the council, reminding them of the “continued disorders” which compelled him to “respectfully submit once again to the Imperial Council for the prompt erection of the… [midwifery] schools, these being the only means with which the Provinces can be provided with able midwives, of which the same are at present completely, or almost completely lacking.”

When the Imperial Council continued to be unresponsive, Frank wrote again a few months later, emphasizing the urgency of his request: there was not, he wrote, a “Province, or a Village in this land, in which the public is not in a state of anxiety for its pregnant women,” who are “daily exposed to the harassments of the crudest ignorance of their midwives, and who see their breasts ripped apart by men who call themselves obstetricians without having ever assisted a birth.”

The result, Frank reiterated, was a devastatingly high infant mortality in the countryside, the loss of whose labor would ultimately lead to reduced agricultural output and general economic disadvantage for the entire state. Nonetheless, well

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169 ASM, Sanità, Parte Antica, c. 269, Letter from Johann Peter Frank to the Imperial Council, 22 March 1789. “…attese le replicated istanze, che gli vengono fatte dalle Regie Delegazioni Mediche, per le più pronto provvidenze a scaso dei continui disordini, che accadono per ignoranza delle Levatrici, il medesimo si trova in dovere d’inoltrarsi rispettosamente presso all’Imperiale Consiglio all’oggetto di supplicarlo di nuovo per la più sollecita erezione delle nominate Scuole, essendo questo stabilitamento il solo mezzo, con cui si possono provvedere le Provincie di abili Levatrici, delle quali in oggi le medesime sono in tutto, o quasi in tutto mancanti.”

170 ASM, Sanità, Parte Antica, c. 269, Letter from Johann Peter Frank to the Imperial Council, 20 May 1789. “Eppure non avvi Provincia, non avvi un Villaggio in questo paese, in cui il Pubblico non sia in un stato d’ansietà per le proprie partorienti...ch’elleno oltre i pericoli naturali nella grand’opera di procurare nuovi cittadini alla stato, sono esposte giornalmente alle vessazioni dell’ignoranza più grossolana delle loro Levatrici, ed a vedersi lacerare il seno da uomini sedicenti ostetricanti senz ‘aver mai assistito ad un parto.”

171 ASM, Sanità, Parte Antica, c. 269, Letter from Johann Peter Frank to the Imperial Council, 20 May 1789. Frank was a strong proponent of training surgeons in obstetrics as well, arguing that even when the provinces did have a few able midwives, without proficient surgeons to handle emergent situations, the situation would remain much as it “has been for such a long time” in the past, with continued high infant mortality rates.
into 1790, none of the proposed schools had been erected, and Frank could only write again about the “deplorable” situation in Lombardy.

Yet the council, ever interested in minimizing costs where possible, continued to discuss aspects of the project. Was not Frank’s intention to supply every village with a relative number of trained midwives and obstetrician-surgeons perhaps a touch excessive? Concerned about the economic burden such a wide-scale initiative would place upon both the public and the charitable institutions targeted as primary funders of the project, the Imperial Council wondered whether all of Frank’s measures were necessary. To what extent, for instance, was the instruction of male practitioners a wise action? In a letter penned by Kaunitz, the Chancellor questioned whether it was really profitable to train a large number of obstetrician-surgeons, the labor of whom “the women of the countryside,” both in other countries and “even more stubbornly in Italy, have a repugnance to availing themselves of, not wanting to confide in persons except of the same sex.”172 Not to mention the fact, Kaunitz continued, that those difficult births that midwives were unable to manage were truly not so common as to warrant a male obstetrician for every few miles of inhabited space.173

The next movement on the project came on 1 August 1789, when the Imperial Council sent letters to the delegations of the eight Lombard provinces requesting that each council vote on whether it would support a municipal midwife to serve the local population at the community’s expense. It took over a year for all of the responses to be recorded. The sentiment in the provinces seemed to be overwhelmingly in opposition to the establishment of such a

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172 ASM, Sanità, Parte Antica, c. 269, Letter from Kaunitz, 16 August 1790. “L’allegato deperimento di tanti fanciulli, li parti infelici, e li pericoli delle partorienti, giustificano la necessità di provvedere il Pubblico di persone ben istruite nell’arte ostetricia, ma non persuadono il bisogno d’un numero eccedente, tanto meno de’ Chirurghi Ostetricanti, dell’opera de’ quali le Donne di Campagna ne’ pure in questi paesi, e così più difficilmente in Italia hanno ripugnanza di servirsene, non volendo esse confidarsi che alle persone del loro sesso.”

173 ASM, Sanità, Parte Antica, c. 269, Letter from Kaunitz, 16 August 1790.
system. In fact, all but two of the communities that responded declared that the financial investment to fund a midwife’s training and then provide her with a regular salary would be burdensome and, in any case, ineffectual. The city councils voted almost unanimously in favor of maintaining “the present custom of paying [the midwives] individually for each birth, so as not to burden the communities” excessively.

Despite the lack of interest from the provinces in providing salaried midwives to care for the local population, the proposals to establish a school in Pavia and bring the pre-existing school in Mantua under central authority continued to move forward, albeit slowly. In September of 1790, additional modifications to the state-wide midwifery project were set out, revisiting the possibility of opening schools not only in Pavia and Mantua, but in Como, Lodi, and Cremona as well. Again, information was required from the provinces. Circulars were sent to individual delegations, much as had been done prior to the opening of the Milanese school in 1767, requesting detailed information on the current state of midwifery in each community. At this point, with the possibility of additional schools, the government was especially interested in establishing how funds might be appropriated both to instruct novice midwives and to support approved ones. The communities were pressed again on whether they would provide a fixed salary for a public midwife to serve the poor. In addition, were there confraternities or other luoghi pii which might provide assistance, either for the maintenance of individual midwives during their course of instruction or for other aspects of the project? In its final manifestation, the questionnaire from the Regia Intendenza Politica of Milan addressed the following:

1. If the community has approved midwives.

174 ASM, Sanità, Parte Antica, c. 269.
175 ASM, Sanità, Parte Antica, c.269, Response from the community of Badia Pavese, 18 September 1790.
176 The information collected was sorted first by district, then by Pieve, and finally by individual parish.
2. If these had already been instructed with municipal funds.
3. If the community has funds from the municipal treasury, or other allowances, available, and in what amount.
4. If the midwives receive compensation from the women they assist, either those who are rich, or that are not of the poor[est] class, and how much it is thought that compensation can be plausibly valued at.
5. If those communities, which do not have midwives, are disposed to have them, or to assign the same a fixed salary, and what [that salary would be], noting if that allowance will carry a tax.

In addition to the important economic information it solicited, the questionnaire would help the authorities in Milan assemble a comprehensive and up-to-date report on the number of midwives in the countryside, and whether these were approved or acting illegally. Always conscious of its expenditures, the government desired the number of approved midwives and obstetrician-surgeons practicing in the state to be sufficient without being excessive. The new regulations for midwifery practice in Lombardy, issued by Medical Director Frank at this time, recommended that cities or larger villages would necessarily have two or more midwives, while in every district of at least three miles distance there would be a surgeon, “expert in the Obstetric Art, already approved by the medical faculty in Pavia.”

The latter’s role was largely limited, however. The surgeon-obstetrician was strictly to “assist midwives as needed in the most difficult cases, those in which [the midwives] should immediately appeal to the more extensive knowledge” of the surgeon.

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177 ASM, Sanità, Parte Antica, c. 269, “Piano di Regolamento per le Levatrici e pe’ Chirurghi Ostetricanti della Lombardia Austriaca,” 1790. “…un Chirurgo esparto nell’Arte Ostetricia, già approvato dalla Facoltà Medica di Pavia.” Later revisions found that this might result in a much greater number of obstetrician-surgeons than necessary, and that population should also be taken into consideration when determining an appropriate number of practitioners, instead of just geographic size of the community or province.

178 ASM, Sanità, Parte Antica, c. 269, “Piano di Regolamento per le Levatrici e pe’ Chirurghi Ostetricanti della Lombardia Austriaca,” 1790. “…per soccorrere al bisogno le Levatrici ne’ casi più difficili, ne’ quali elleno dovranno immediatamente ricorrere alle di lui più estese cognizioni.”
Again, the response from the provinces was disappointing to Frank and the authorities in Milan. Over and over, individual parishes reported being served by at least one non-approved midwife (at times this was the only assistance available). In the entire Duchy of Milan,\textsuperscript{179} for instance, there were only 62 approved midwives as compared to 132 abusive ones. The situation in the other provinces was even more disheartening.\textsuperscript{180} For instance, in all of District II, comprising some twenty-three parishes, there “were no approved midwives, and so [the parishes] have not lent any funds for the instruction of newcomers to this profession.” Nor could the majority of these parishes support a salaried midwife, given the already aggrieved economic situation in many of these communities.\textsuperscript{181} Thus even when an approved midwife was present, rarely had she been instructed at the expense of the community, which in any case seldom had available funds (or the desire) to salary a municipal midwife.\textsuperscript{182}

With the information, however discouraging, from the provinces in hand, Medical Director Frank determined that it was necessary to revise his original plans and issue an updated,

\textsuperscript{179} Meaning just the province containing the city of Milan, not the entire Milanese State.

\textsuperscript{180} The only exception was in the Mantuan province, where a midwifery school had operated since 1775. The determining factor here seems, however, to be the fact that midwives in Mantua and its contado were provided fixed salaries in exchange for these women’s free service to the poor. Although formally approved midwives in the Mantuan province had at first faced many of the same issues related to competition and initial suspicion of their training by potential clients as had midwives in the Milanese countryside, by guaranteeing their midwives an ample wage, the Mantuan authorities had been able to root out some of the protracted abuses still plaguing other communities in the State.

\textsuperscript{181} ASM, Sanit\`{a}, Parte Antica, c. 269, Responses from the Districts to the five questions outlined in the Governmental Decree of 1 June 1790. “In tutti i Comuni di questo Distretto non vi sono Ostetrici approvate, e perci\`{o} non hanno avuto alcun carico per l’istruzione delle incombenti a tal esercizio, le quali non hanno nessun soldo, ne assegno dalla Cassa Comunale.”

\textsuperscript{182} Some communities reported that their midwife already assisted the poorest of the population for free. The compensation that a midwife might expect per birth varied somewhat by location. In approximately half of the parishes of District I (Milan and its immediate surroundings), for instance, it was reported that a midwife would typically receive between 30 and 40 soldi per birth (which was often in addition to provisions), while a roughly equal number of parishes reported a sum between 20 and 30 soldi. The parish of Segnano stands out on the high end, claiming a midwife might charge as much as 45 soldi. The responses from the parishes further away from Milan seem to reveal more modest fees. Per birth, a rural midwife could generally expect to make 5 to 15 soldi, though her annual pay could vary very widely, as low at 10 lire or as high as 120 lire. ASM, Sanit\`{a}, Parte Antica, c. 269, Responses from the Districts.
comprehensive Regolamento for the practice of midwifery in the Lombard State. He divided the new Regolamento into three sections (“Of the Selection and Number of Obstetricians and Midwives”; “Of the Instruction of Surgeon-Obstetricians and Midwives”; “Of the Order and Administration of the Object of Obsterics”) detailing the general structure and aims of the state in regards to obstetrics and midwifery, as well as a more detailed discussion of the training of midwives. This document therefore represents the first comprehensive attempt by a state in Italy to provide for the maternal and infant welfare of its entire subject population by providing for the state-wide education and licensing of midwives and surgeon-obstetricians. In fact, officials in Milan finally decided in favor of establishing additional schools – first in those provinces which already had some background in obstetrics and would be easiest to bring to fruition – Milan, Mantua, and Pavia – and eventually also in Como, Lodi, and Cremona.\textsuperscript{183}

At the same time, taking into account the suggestions of Professors Scarpa, Moscati and Vincenzo Malacarne, as well as State Chancellor Kaunitz, these new regulations demonstrate a pragmatism conditioned by two decades of passive resistance to the dramatic changes the state had wished to impose on the practice of midwifery back in 1767. All currently practicing midwives, for instance, as long as they were deemed capable, would be allowed to continue working.\textsuperscript{184} In the past, both active midwives and the communities they served had demonstrated opposition to the novelty of scientific training in a hospital setting, at the hands (at least partly) of male surgeon- or physician-obstetricians. The updated Regolamento thus advised that local

\textsuperscript{183} The schools in Milan (at Santa Caterina alla Ruota) and Mantua were already in operation, the former under the direction of Pietro Moscati, the latter under the obstetrician-surgeon Giovanni Battista Concordi. At Pavia there already existed a professorship in obstetrics, led by the acclaimed Vincenzo Malacarne. In Como, also, the central hospital had recently received from Pavia a professor trained in obstetrics – Giuseppe Nessi. Schools in Lodi and Cremona would be developed progressively. As for the remaining two provinces, Casalmaggiore and Varese, since they had neither the personnel nor hospitals which accepted pregnant patients, midwives from these areas would be funneled to other schools (from Casalmaggiore to Mantua or Cremona, and from Varese to Como or Milan).

\textsuperscript{184} It is unclear if these women would need to undergo a formal exam (or by whom such an assessment might be administered), or if their ability would be appraised more casually.
communities would need time and convincing to accept such new methods. In the first years of the new system there would be the “need to content ourselves…with instructing for the benefit of each district a few midwives, and leaving the practice [of midwifery] to those same [women] who are judged imperfect” until that time that there are enough well-trained midwives “who can re-enter in the place of the others when they have acquired enough experience and the confidence of the public.”

The desired age range of the women to be instructed at the new schools was also noticeably adjusted to better fit the reality of the situation. Potential students were expected to fall between the ages of twenty-one and fifty-six, and could even be unmarried women. One point that was not to be compromised on, at least theoretically, was the obligation that students know how to read. The midwifery courses would be based around “printed books” adapted to the abilities and necessities of a female student population. In practice, the stipulation of literacy functioned to create a strict division between urban and rural midwives. While all midwives who were destined to serve in the city were expected, with no exceptions, to know how to read and write, rural midwives were generally granted more relaxed standards – some basic reading ability was all that was expected of them.

Particular attention was paid, furthermore, to ensuring that a prospective midwife’s training at a provincial school would be as minimally burdensome as possible to her family, and that her job when she returned home would be secure and economically profitable. Despite the

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185 ASM, Sanità, Parte Antica, c. 269, “Piano di Regolamento per le Levatrici e pe’ Chirurghi Ostetricanti della Lombardia Austriaca,” 1790. “Bisogna dunque contentarsi ne’ primi anni di far istruire a beneficio di ciascheduna Contrada a alcune Levatrici, e lasciare l’esercizio a quelle medesime che si credono imperfecte sin a tanto che ve ne sia un numero equale di ben ammaestrate, le quali toranate al proprio paese potranno subentrare nel posto di quelle, allorché avranno acquisitata qualche esperienze nell’arte e quadagnata la confidenza del Pubblico.”

186 Additionally, prospective midwives were not to have any physical defect, to be subject to any sickness that would cause fear, such as convulsions or falling sickness (mal caduceo), to not be of a temperament too weak to resist the exertions that the exercise of such a Profession requires.
lack of interest shown by the communities to financially support municipal midwives, the government was ready to push its weight in this regard. In order to facilitate assistance to both rich and poor, each community would be required to pay its midwife a salary of twelve *zecchini* per year.\(^{187}\) Additionally, during each student’s course of instruction, communities would provide their candidate with 20 *soldi* per day for her maintenance and to offset any losses that might result from her absence from her family and residence.\(^{188}\) In addition, the midwifery students were encouraged to engage in some profitable industry, such as sewing or spinning, in the hours of downtime at the school.

While officials limited the midwifery course to just one three-month semester,\(^{189}\) Frank’s suggestion of an annual exam was tentatively accepted in the new regulations. All practicing midwives were expected to undergo an assessment each October to ensure that their skills and knowledge were sufficient. At the same time, the annual exam would serve an information-gathering purpose for the government. The midwives would be questioned on the number of births they had attended in the past year, whether these were natural, difficult, or non-natural, and when the assistance of a surgeon had been required. Midwives were therefore responsible for keeping detailed records\(^{190}\) of all the births they had attended, including tallies of the number of males and females born, whether the administration of the baptismal sacrament had been necessary, if any of the babies delivered were born dead or died shortly thereafter, and of what

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\(^{187}\) One *zecchino* was roughly equivalent to seven *lire*.

\(^{188}\) The costs of providing a suitable space (including all furnishings and other accoutrements) for the training women at the hospitals where the schools would be located would fall on the hospitals themselves, which in turn would receive the free assistance of the students with the hospital’s pregnant population. ASM, *Sanità, Parte Antica*, c. 269, “Piano di Regolamento per le Levatrici e pe’ Chirurghi Ostetricanti della Lombardia Austriaca,” 1790.

\(^{189}\) Four months for the school in Pavia.

\(^{190}\) Surgeons called into assist births were also tasked with keeping detailed records, and of filing an official report with the Medical Director within a few days of any activity.
cause. Similar data would be recorded regarding the mothers – how had they fared before, during, and after the birth? Finally, the examiners would elicit information “on the causes that might explain any of these incidents, and if...the midwife had committed an evident error, or otherwise an action that is worthy of praise, and would make a report in a book that the examiners will keep with themselves.”191 It was even suggested that the midwives deliver the details of especially unusual or difficult cases in front of each other and the examiners. The examiners would evaluate and critique the actions taken by the midwife in question, for the instructional benefit of all present, roughly akin to a modern day morbidity and mortality meeting.

In this way, through annual midwifery inspections, the state aimed to amass for itself an elaborate database of demographic information, especially with respect to statistics on infant and maternal mortality. The above information-gathering also reflected the increased relevance which the medical community was attaching to statistical enumeration. The quantification of disease and mortality had, particularly in conjunction with the shift of focus to clinical training in the setting of the hospital in the second half of the eighteenth century, begun to transform medical inquiry and praxis. Statistical medicine also enabled the first modern large scale public health projects, of which the provincial midwifery schools in Lombardy were a prime example. The proposed annual midwifery examinations implied, finally, an important shift by the state away from the use of ecclesiastical sources – parish registers and baptismal rolls in particular – as a means of keeping track of the population.192

191 ASM, Sanità, Parte Antica, c. 269, “Piano di Regolamento per le Levatrici e pe’ Chirurghi Ostetricanti della Lombardia Austriaca,” 1790. “Si prenderà nello stesso tempo informazione delle ragioni che potevano spiegare tutti questi avvenimenti, e se si raccoglie, che la Levatrice abbia commesso un errore manifesto, ovvero un’azione degna d’essere premiata, se ne farà una memoria in un libro che terranno gli Examinatori presso di loro.”

192 On the development and use of medical statistics, see Ugo Tucci, “Una statistica sanitaria bresciana di fine Settecento” in L’arte di guarire. Aspetti della professione medica tra Medioevo ed Età contemporanea, eds. Maria
Officials in Milan and Vienna were also intent on raising the professional and social profile of the trained midwife. To counteract the anticipated suspicion of a figure – the licensed, scientifically trained midwife – for whom it had already been demonstrated had an uneasy and tense fit back into her local community, Johann Peter Frank stressed the important role such women had for the well-being of the entire state. The authorities in Milan and Vienna would thus put themselves behind efforts to shore up acceptance for trained midwives in individual communities. Such communities, they believed, should demonstrate “all the possible regard” for such a useful Institution, “upon which depends both the fate of Posterity, as well as that of all the Mothers of the Country.” Eventually, it was expected that the trained midwife would,

enjoy all the esteem and distinction that is owed a public figure, who the entire community can trust with issues of much importance. Each approved midwife will therefore enjoy the status of honored citizen within the community, and no one will dare offend her in any manner under a penalty much graver than those which would be merited for persons of lesser distinction.¹⁹³

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¹⁹³ ASM, Sanità, Parte Antica, c. 269, “Piano di Regolamento per le Levatrici e pe’ Chirurghi Ostetricanti della Lombardia Austriaca,” 1790. “Per impegnare le Cittadine ad accettare la Professione di Levatrice, che loro si offer, qualunque Comunità avrà tutti i riguardi possibili, perchè questo utile Istituto, dal quale depende si la sorte della Posterità, come quella di tutte le Madri della Patria, goderà della stima e della distinzione che si deve ad una persona publica, a cui un’intera Comunità possa affidare degli’interessi di tanta importanza. Qualunque Levatrice approvata goderà adunque del grado delle onorate Cittadine nella Comunità, ne alcuno osi offenderla in qualsivoglia maniera sotto pene assai più graver che meritar potrebbe per le stesse offese fatte a persone di diversa condizione.”

This respect would extend even to midwives’ husbands, who should be “immune from public talk if they attend to their families and to domestic affairs when their wives are occupied at the service of the Community.”

Finally, the new midwifery regulations highlighted the necessity of reducing inter-professional rivalries between the midwives themselves. It was deemed of great importance that midwives “live in good harmony with the colleague[s] of their profession,” and not seek to arrogate another’s position or sabotage the public’s trust in her. In the same vein, a midwife should always be willing to assist a colleague when necessary, and to fill in if one were sick or otherwise unavailable. Clearly, Frank and the other reformers were loathe to revisit the kind of confrontations between midwives which had been so prevalent in the years immediately after the opening of the midwifery school in Milan. By ensuring approved midwives’ salaries from the outset and by stressing professional camaraderie as opposed to competition, the authorities aimed to avoid entirely the tense atmosphere which had erupted in previous years as a result of divides between midwives newly trained in the Milanese school and illegally-practicing ones whose traditional experience made them more familiar and often more appealing to prospective clients.

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Throughout late 1790 and into 1791, Johann Peter Frank could finally be content to see real movement on the midwifery schools in the provinces. Able professors had been identified in Pavia (Vincenzo Malacarne), Como (Giuseppe Nessi – who had been sent specifically for the purpose from Pavia), and Mantua (Giovanni Battista Concordi). Beyond this, much time was spent locating appropriate spaces for the schools. Ideally, the structures would be close to but not actually inside the cities’ main hospitals (or, in the case of Pavia, close to but separate from the

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194 ASM, Sanità, Parte Antica, c 269, “Piano di Regolamento per le Levatrici e pe’ Chirurghi Ostetricanti della Lombardia Austriaca,” 1790. “Inoltre, i mariti delle Levatrici saranno esenti dai voci pubblici, onde attendano alla famiglia loro e agli affair domestici, quando le proprie mogli sieno occupate a servizio della Comunità.”
University), where students would eventually receive practical training attending to the parturient women recovering there. Since the schools needed to double as living spaces for the student midwives, these structures had to serve a variety of functions. The desired physical separation from, yet proximity to, the hospital was intended to ensure as much modesty as possible for a largely rural female student population, while at the same time allowing for an easy commute by physicians and surgeons from one to the other. As had been the case in Milan, suppressed convents and monasteries were seen as ideal locations in which to establish the new midwifery schools. In Pavia, Vincenzo Malacarne and the provincial delegation considered the former monastery of San Felice (suppressed in 1785), even contracting the architect Leopoldo Pollack to make some necessary changes to the structure, before eventually turning to the former monastery of Leano as a more suitable location for the school. Unlike San Felice, the Leano had good airflow and several open courtyards, not to mention a suitably large layout to accommodate the students’ living quarters, a maternity ward and delivery room, and the instructional spaces of the school. Identifying and outfitting a space for the school and the students’ lodging proved to be just an initial obstacle, however. Giuseppe Nessi in Como reported to Medical Director Frank in the summer of 1791, for instance, that despite a circular issued to the nearby communities

195 In both Milan and Pavia, the new schools at Santa Caterina alla Ruota and the Leano, respectively, would become joint complexes for both the training of midwives and the care of pregnant and parturient women. These “Case delle Partorienti” or “Case del Parto” were among the first ‘medicalized’, discrete maternity clinics in Italy dedicated to both instruction and medical care. At the same time, theoretical courses in obstetrics continued to be taught separately to male students at the University of Pavia. See ASM, Sanità, Parte Antica, c. 273, Decree of the Conferenza Governativa, 16 June 1791, and Decree of the Magistrato Politico Camerale, 15 June 1791.

196 Access to cadavers at the hospitals for training purposes was another consideration.

197 ASM, Sanità, Parte Antica, c. 273, “Stabilimento della Scuola d’Ostetricia nelle Diverse Città dello Stato, e Destinazioni de’ Locali.” Lodi experienced particular difficulty in this area. When no suitable structure could be found to house the school it was suggested that the midwifery lessons be given in the house of the obstetrics professor himself; the students, with no communal lodging space, were forced to take up lodging along with the pregnant women in the hospital or possibly through arrangements made by their home communities or benefactors; see ASM, Sanità, Parte Antica, c. 273, Decrees of the Magistrato Politico Camerale, 26 June 1791 and 6 November 1791.
advertising the school, “not one woman, either from the city or from the countryside” presented herself for the lessons. Even after further spirited attempts to publicize the school during the summer and fall of 1791, recruitment in Como remained limited. As had been the case in Milan, recruitment for the provincial midwifery schools remained one of the greatest and most persistent impediments to the expansion of midwifery education in eighteenth-century Lombardy.

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In the case of Pavia, for which there exists a detailed description of the finished midwifery school, we have a unique opportunity to recreate spatially and materially daily life in such an institution. The former monastery which had been chosen as the site for the school underwent considerable modification during the summer of 1791 to ready it for its new use. Consisting of a basement, ground floor, first floor, and attic, the school at the Leano would serve not only as an instructional space for student midwives and surgeons, but as living quarters for the female trainees, as well as a small maternity ward for the pregnant and parturient women assisted there. Evaluating the site ahead of the school’s opening term, the head professor, Vincenzo Malacarne, described the “house” as “a quadrilateral site in which, among the livable quarters, there are prudently kept open two ample and airy courtyards, the first of which, more south, is habitable (civile), into which one enters through the main gate, while the other is rustic with a median of various tall and spacious beams.”

There was a basement to store wine for a community of up to fifty persons, a ground floor with eighteen rooms, a first floor housing primarily dormitories, and an attic.


199 ASM, Sanità, Parte Antica, c. 273, Report from Vincenzo Malacarne on the adaptation of the former monastery of Leano for the Midwifery School, n.d.
More specifically, the ground floor would be divided into a cloakroom to the right of the main entrance, two long but compact pantries and a third, larger room to serve as the main dispensary. Off of the rustic courtyard, in the western wing, were two rooms dedicated to preparing bread, while past the secondary (“rustic”) gate was a medium-sized room which could serve for laundry; finally, at the end of this courtyard was a small apartment consisting of a kitchen and two bedrooms which had initially been designated for the director, but upon additional consideration was thought better suited to housing the small number of pregnant women who, paying for their stay, desired to be recovered discretely, apart from the main maternity ward upstairs. At least one of the rooms which had been used for baking bread, further, would be adapted to receive a discrete number of wetnurses and infants who for whatever reason could not be nursed by their own mothers.

Connecting the two courtyards, was a garden with a well, a small room to conserve meat, a spacious kitchen, and a sizable refectory which opened out onto a portico with high arches. At the end of this portico were two tiny rooms, which previously had been dedicated for religious prayers, to be repurposed in time. Next there was a space opportune for the instruction of students, as it already contained benches and chairs accommodating up to twenty-eight persons. Adjacent were two small rooms and several larger rooms, the first of which Malacarne proposed could house the head midwife, the latter the living quarters for the female midwives. The lodging of the female midwifery students in the same location as the school was ideal wrote Malacarne, as it would not only “impede profligacy and any scandals, to which inexperienced women far from their home towns would be exposed in a city full of university students,” but also minimize

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200 The cost for such a woman’s recovery was 3 lire.

201 ASM, Sanità, Parte Antica, c. 273, Report from Vincenzo Malacarne on the adaptation of the former monastery of Leano for the Midwifery School, n.d.
costs, absences from school, and best allow the women to utilize their free time in domestic pursuits. 202

On the first floor of the Leano would be located the living spaces for the remainder of the school’s personnel as well as the maternity hospital itself. To the immediate right of the stairwell landing there was an eastward facing dormitory with a capacity of eighteen beds for the pregnant patients and two for midwives, who would be on duty around the clock in the case of emergency or an imminent delivery. The training midwives would take shifts serving in the ward one day a week for a twenty-four hour period. A second dormitory, with a capacity of fourteen beds, was positioned next to the first, and would serve to separate the pregnant and post-partum populations. Two smaller rooms, with three and two beds respectively, would provide separate spaces for ailing pregnant and postpartum women, also to be overseen by at least one midwife at all times. A governess and cleaning woman would also have a room in this wing. Moving toward the center of the structure, over the kitchen and refectory, were spaces designated for practical demonstrations and operation required for difficult births. Further along away from the maternity ward was a room for the professor and an instructional space for the training surgeons. A small room would store the instruments, books, medicines, and other necessities for the maternity ward. Lastly, an attic would provide additional storage space for the linens, mattresses and other items required for the provisioning of the dormitories. 203

Malacarne then compiled an inventory listing the maximum numbers of personnel and patients to be housed at the Leano and the expected items needed for their provisioning and daily

202 ASM, Sanità, Parte Antica, c. 273, Report from Vincenzo Malacarne on the adaptation of the former monastery of Leano for the Midwifery School, n.d.

203 ASM, Sanità, Parte Antica, c. 273, Report from Vincenzo Malacarne on the adaptation of the former monastery of Leano for the Midwifery School, n.d.
activity. Including the student midwives, the school would be home to as many as forty persons and would require the following furnishings, linens, and instruments:

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Number</th>
<th>Items for the Dormitories and Kitchen</th>
<th>Number</th>
<th>Items for use in the Maternity Ward</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Midwife</td>
<td>1</td>
<td>Beds</td>
<td>40</td>
<td>Cantari di Stagno</td>
<td>6</td>
</tr>
<tr>
<td>Principal Midwives (to staff the maternity ward)</td>
<td>2</td>
<td>Mattresses</td>
<td>40 + 8 extra</td>
<td>Bedside tin or copper vases</td>
<td>6</td>
</tr>
<tr>
<td>Paying Patients</td>
<td>2</td>
<td>Sheets</td>
<td>10 dozen</td>
<td>Syringes for enemas</td>
<td>2</td>
</tr>
<tr>
<td>Student midwives</td>
<td>8</td>
<td>Oak Chairs</td>
<td>40</td>
<td>Stoves</td>
<td>3</td>
</tr>
<tr>
<td>Pregnant Women in at least their sixth month of pregnancy</td>
<td>8</td>
<td>Canvas and Wool comforters</td>
<td>80 + 80</td>
<td>Copper warming pans</td>
<td>4</td>
</tr>
<tr>
<td>Ailing patients</td>
<td>6</td>
<td>Draperies</td>
<td>12</td>
<td>Large copper basins</td>
<td>4</td>
</tr>
<tr>
<td>Governess</td>
<td>1</td>
<td>Loose Cushions</td>
<td>20</td>
<td>Washbins</td>
<td>2</td>
</tr>
<tr>
<td>Westnurses</td>
<td>2</td>
<td>Towels</td>
<td>10 dozen</td>
<td>Sink (for washing hands)</td>
<td>2</td>
</tr>
<tr>
<td>Infants</td>
<td>6</td>
<td>Serviettes</td>
<td>5 dozen</td>
<td>Birthing chairs with cushions which can have the back raised or lowered as needed</td>
<td>2</td>
</tr>
<tr>
<td>Cook</td>
<td>1</td>
<td>Tin plates</td>
<td>2 dozen</td>
<td>Hand lights/lanterns</td>
<td>6</td>
</tr>
<tr>
<td>Servants</td>
<td>1</td>
<td>Tin jugs</td>
<td>2 dozen</td>
<td>Quilts</td>
<td>6</td>
</tr>
<tr>
<td>Doorman</td>
<td>1</td>
<td>Tablecloths</td>
<td>12</td>
<td>Lanterns</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tin bowls</td>
<td>1 dozen</td>
<td>Cradles</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brass silverware</td>
<td>2 dozen</td>
<td>Bedding for cradles</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kitchen Towels</td>
<td>4 dozen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items for use in the Operating Room and in the Midwifery School</th>
<th>Number</th>
<th>Items, cont’d.</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairs <em>di corame</em></td>
<td>6</td>
<td>Glass bottles and bell jars</td>
<td>unspecified</td>
</tr>
<tr>
<td>An oak table with locked drawers, in which would be kept materials needed to write prescriptions, keep records, and 3 white books.</td>
<td>1</td>
<td>Large sponges</td>
<td>8</td>
</tr>
<tr>
<td>A birthing chair specifically for use in difficult births, with removable cushions (modeled after the design made by the surgeon Bruzzani in Turin)</td>
<td>1</td>
<td>Oakum</td>
<td><em>Un rubbo</em></td>
</tr>
<tr>
<td>A movable table to hold surgical instruments</td>
<td>1</td>
<td>Smocks or aprons of dark grey fabric</td>
<td>3</td>
</tr>
<tr>
<td>Brass candleholders</td>
<td>2</td>
<td>Copper ladles</td>
<td>2</td>
</tr>
<tr>
<td><em>Srnoccolatoia</em></td>
<td>1</td>
<td>Long pieces of gauze, 3 finger-lengths wide</td>
<td>12</td>
</tr>
<tr>
<td>Large lanterns (for exams and operations during the night)</td>
<td>2</td>
<td>Pessaries of differing volumes</td>
<td>12</td>
</tr>
<tr>
<td>Candlewicks</td>
<td>3</td>
<td>T bandages</td>
<td>12</td>
</tr>
<tr>
<td>Locked closets in which will be kept the professor’s Obstetrical book to be used in lessons</td>
<td>2</td>
<td>A basket made of long, soft threads</td>
<td>1</td>
</tr>
<tr>
<td>Smellie’s Tables</td>
<td>1</td>
<td>Canvas compresses</td>
<td>12</td>
</tr>
<tr>
<td>Hunter’s Tables</td>
<td>1</td>
<td>Large tablecloths for larger bandages</td>
<td>8</td>
</tr>
<tr>
<td>Basins</td>
<td>unspecified</td>
<td>A chest for the most commonly used instruments</td>
<td>1</td>
</tr>
<tr>
<td>Infant skulls for demonstrations</td>
<td>unspecified</td>
<td>An oak table sealed at the ends, able to be moved and folded</td>
<td>1</td>
</tr>
<tr>
<td>Uteruses in various stages of pregnancy for demonstrations</td>
<td>unspecified</td>
<td>An oak container, long and deep, to hold as much hot water as needed to cover the entire cadaver of a woman, supported on four wheels to facilitate transport</td>
<td>1</td>
</tr>
</tbody>
</table>
Anatomical slabs | 3 | Obstetrical model/mannequin | At least one

Source: ASM, Sanità, Parte Antica, c. 273, “Piano d’Instituzione della Scuola Pratica d’Ostetricia nella Regia Università di Pavia,” 1791.

The students in Pavia were subjected to a comprehensive and rigorous course of study, structured around lessons and demonstrations delivered by the head professor on Mondays and Wednesday afternoons. At these meetings, the professor would “explain the art of obstetrics, not only theoretically, but also practically, as much through the use of machines and models as with cadavers, pregnant and post-partum women,” and even in regards to the care of the newborn infants.204 During times unoccupied by lessons, the training midwives would be expected to practice and review material already learned, either with the aid of the assistant surgeon, or the professor himself. Those students demonstrating the most diligence and learning might then be admitted to observe and assist at the bedside of the pregnant or post-partum women recovering in the hospital. Many students, in fact, were allowed to attend the professor’s “exploration” (esplorazione) of a pregnant women, in which he would point out the parts of female anatomy learned in class and discuss the uterus’ development during pregnancy, explaining to the students how to determine the stage of pregancy and how to look for signs of abnormalities or potential problems.205

At the end of four months of instruction, the students faced a comprehensive exam prior to receiving an official midwifery license. The exam consisted of two parts, one verbal the other practical. The first, delivered in equal parts by the Dean of Faculty at the University of Pavia, the

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205 ASM, Sanità, Parte Antica, c. 273, “Istituzione della Scuola Pratica d’Ostetricia nella Regia Università di Pavia al Leano,” 3 October 1792. For more on the practice of esplorazione see Vincenzo Malacarne’s La Esplorazione Proposta come Fondamento per dell’Arte Ostetricia (Milano: 1791), which is discussed in chapter 2.
Professor of Obstetrics, and two Professors of Surgery knowledgeable in obstetrics, covered a wide range of topics, including female anatomy, the signs of virginity and defloration, the signs of pregnancy and of false pregnancy, the signs and progress of labor, normal fetal presentation and various kinds of mal-presentation and what to do in such circumstances, what to do after the birth, and how to perform a baptism. For the practical exam, the student midwife would select three tickets from a large container indicating a fetal presentation or other labor-related situation. The professor would then (out of sight of the examinee) prepare the obstetrical machine according to each ticket and the student would have to perform the necessary operation to correctly manage the delivery. Examples might include a breach presentation, the delivery of twins, or how to perform fetal version; students were then required to answer corresponding questions as well.  

On the basis of the detailed archival record which exists for the maternity hospital in Pavia, we can make several important distinctions between this provincial institution and either the Lombard state’s main maternity hospital in Milan or the maternity ward opened in Turin in 1728. Whereas charitable and benevolent impulses to provide care for poor mothers and those unfortunate women who needed to give birth in secret had been central to the introduction of maternity institutions in the central hospitals of both Turin in Milan, in provincial centers like Pavia, this consideration was, at the most, of secondary importance. Instead, as Johann Peter Frank and Professor Antonio Scarpa pointed out to Vincenzo Malacarne, “the object of the Pavia house is not to give place to pregnant women in search of seclusion, but to accept pregnant women for the instruction of [student] midwives.” While Malacanre had advocated to expand the institution’s role in maternal assistance, his was a minority opinion. Instead, the medical

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206 ASM, Sanità, Parte Antica, c. 273, “Istituzione della Scuola Pratica d'Ostetricia nella Regia Università di Pavia al Leano,” 3 October 1792.

207 ASM, Sanità, Parte Antica, c. 273, “Istituzione della Scuola Pratica d'Ostetricia nella Regia Università di Pavia al Leano,” 3 October 1792.
authorities in Milan viewed the provincial midwifery project as primarily about instruction and
the extension of scientific and professional training into more distant regions of the state. For
instance, while Malacarne argued that pregnant women should be allowed to enter the maternity
hospital as early as six months into their pregnancies, Frank and Scarpa cautioned that very few
women should be accepted this early, since the later women were admitted, the greater the
opportunity would be to “show a [large] number of births to the [training] midwives during
their” course of instruction.208

The emphasis on training at the provincial midwifery schools reflects a broader shift in
the late-eighteenth century in the state’s attitude towards the public health of its subject
population. As Sergio Onger writes, the provision of state-wide public health measures,
especially in the form of provincial hospitals, were indicative of the transition from the
“territorial state,” to the “population state,” in which “health was a common asset of society and
no longer a blessing allocated to individuals by virtue of Divine Providence: public charity,
rationalised and controlled by the state, overlaid and replaced Christian charity.”209 Thus, as
hospitals became more concentrated on medical care as their raison d'etre, the focus of the
provincial midwifery schools naturally fell on the scientifically up-to-date instruction of student
midwives as their main objective.

At the same time, Vincenzo Malacarne and the authorities back in Milan could not forget
the unique situation with which they were tasked: housing and governing a significant number of
women, some single, most from rural areas, all without male or familial supervision, far from
their homes and in close proximity (in the case of Pavia) to a University thrumming with young,

208 Ibid.

209 Sergio Onger, “The Formation of the Hospital Network in the Brescian Region between the Eighteenth and
Twentieth Centuries,” in The Impact of Hospitals, 300-2000, eds. John Henderson, Pergrine Horden, and Alessandro
Pastore (Bern: Peter Lang AG, 2007), 257-258.
male students. Not to mention the fact that, as much as Malacarne wished to make their presence strictly about training, pregnant women, who were generally poor and at times desperate to hide an unwanted pregnancy, were also important inhabitants of the midwifery school. As a result, the spatial layout of the school at the Leano had to be meticulously designed so as to ensure the propriety and modesty of the female students and recovering patients there, as well as to provide spaces with absolute privacy for those pregnant women wishing to keep their stay and identities hidden. As a result, the Leano had both curative and domestic spaces, with areas for anatomical demonstrations and classroom instruction, as well as living quarters and rooms for the student midwives to undertake productive chores (such as sewing or weaving) in their downtime.

Conclusions

From the outset, midwifery education in Milan was driven more by medical than charitable impulses. In Turin, the establishment of a maternity ward had been the expression of a benevolent state embarking on widespread reforms and intervening for the first time in the tutelage of female honor. In Milan, the introduction of midwifery education was indicative of a more mature, Enlightenment state undertaking to provide for the public health and welfare of its subject population on a grand scale. The initiatives for midwifery education in Milan were often populationist in nature, emphasizing the positive effects of such a program for future strength of the state. Efforts to provide for maternal assistance to poor women were generally of a secondary importance, and remained much longer propelled by private and religious charity. Indeed, the instruction offered at the midwifery school in Milan was driven by a medical profession intent on establishing its own scientific view of childbirth as absolute, and incorporated rationalistic and theory-driven modes of thought familiar to conventional university training but unfamiliar to women whose experience with childbirth was wrought through personal experience and training.
by apprenticeship. The Milanese school’s emphasis on observation, visual inspection, and the non-living body – be it an obstetrical mannequin or a cadaver – represented a pronounced departure from women’s traditional, experiential, and personal style of learning.

As a result, midwives training in the Milan midwifery school were often looked upon with suspicion when they returned to their home communities. For many soon-to-be mothers, the figure of the ‘professional midwife’ signified a disruption of traditional, community-based modes of legitimation. Not only were the formally trained midwives bearers of a new, unfamiliar kind of childbirth knowledge, they were also seen as skirting a customary period of initiation during which their skill and character were evaluated through kinship, gossip, and other community networks.

Despite the Milanese state’s stated goals, it was the maternity ward at the Ospedale Maggiore, and not the midwifery school that was, arguably, the more successful childbirth institution. In the two-year span between 1775 and 1776, 228 women gave birth in the Ospedale Maggiore’s maternity ward.210 The yearly average continued to grow after the transfer of the Quarto delle Balie to Santa Caterina in 1781, so that by the end of the century close to 200 pregnant women each year were cared for at the public institution.211 Although infant mortality rates remained high, the maternity hospital was clearly fulfilling a societal need for assistance to poor mothers and women whose honor had been compromised by an illegitimate pregnancy. Santa Caterina offered women sustenance and care in a setting that was as much domestic as it was medical, and thus, partially at least, familiar. Recovering women were provided with food, linens, furnishings and other trappings of a typical lying-in, and they were physically removed

from the instructional spaces of the midwifery school housed on the lower floor. Moreover, the vast majority of deliveries and daily care resided in the hands of women, as they would have been in a more traditional setting.

Due to a spotty archival record, it is much more difficult to determine the relative success of the provincial network of midwifery schools opened in Lombardy in the 1790s. At least initially, local enthusiasm for the schools, as demonstrated by recruitment, was lacking. Particularly in the most rural areas of the state, far from cultural centers like Milan or Pavia, traditional understandings of childbirth and modes of assistance seem to have shown resilience in the face of advances made by the medical profession. At the same time, these provincial schools were important markers of the state’s new capabilities and interest in providing for the public health of its population on a large scale.
CHAPTER 5

“FOR LACK OF THE NECESSARY THEORETICAL KNOWLEDGE”: TRAINING MIDWIVES BETWEEN THEORY AND PRACTICE IN VENICE, 1770-1797

On the 28th of November 1800, Benedetta Fedeli Trevisan sent a petition to the Supreme Royal Health Tribunal (Regio Supremo Tribunale di Sanità) in Venice, requesting an examination to be granted the privilege of performing certain manual surgical operations in her practice as a midwife. At the time of writing, both manual operations and those requiring instruments were strictly prohibited to midwives, having been defined as surgical procedures only to be performed by surgeons, or, more rarely, physicians. As Trevisan argued in her petition, though, time was the key to successfully managing a difficult delivery. The time it took to call and wait for the arrival of a surgeon in the case of a difficult birth could literally mean the difference between life and death; thus, it was sensible that midwives be allowed to perform certain kinds of surgical procedures in cases of dire urgency. Trevisan, who had been officially licensed as a midwife in 1799, had already demonstrated excellent abilities during her training at the Venetian midwifery school. Not only had she obtained a prize for the highest performance in her class, she had also designed a new kind of obstetrical chair that had received

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1 After the fall of the Republic, the Venetian health board (Provveditori alla Sanità) was reorganized and officially renamed the Royal-Imperial Supreme Tribunal of Health (Imperial Regio Supremo Tribunale di Sanità).

2 ASV, Imperial Regio Supremo Tribunale di Sanità, Terminazioni, 1802, b. 11, Petition of Benedetta Fedeli Trevisan, 28 November 1800. The case of Benedetta Trevisan is also discussed in Camillo Corner, La scuola di ostetricia del collegio medicochirurgo di Venezia tratta degli atti priori dello stesso dissertazione di Camillo Corner (Padova: Tipografia Tenada, 1841), 24-25; Nadia Maria Filippini, “Levatrici e ostetricanti a Venezia tra Sette e Ottocento” Quaderni Storici 58 (1985): 149-180; Nelli-Elena Vanzan Marchini, I mali e i remedi della Serenissima (Vicenza: Neri Pozza, 1995), 154.
much praise from her instructor, the surgeon and obstetrics professor Sebastiano Rizzo.³

Yet, Trevisan’s petition to the health board to be granted permission to perform certain surgical maneuvers, the first request of its kind, caused a great deal of consternation among the officials of both the Venetian health tribunal and the College of Surgeons. In fact, the Venetian authorities would take nearly two years finally to issue a decision on the case. Why had Trevisan’s petition caused such a stir, particularly when midwives had a long history of performing exactly the kinds of maneuvers indicated in the petition – such as the manual version of a fetus in an inopportune position? Benedetta’s supplica had been delivered at a unique juncture in the history of midwifery and of the professionalization and medicalization of childbirth. Only in the last quarter of the eighteenth century had Venetian surgeons even begun to be instructed in obstetrics. In order for the figure of the obstetrician to establish himself, however, it became increasingly clear to professional bodies like the College of Surgeons that they would have to define the practice of obstetrics against deeply rooted cultural understandings of and expectations about midwifery and childbirth. While obstetrics came to be understood as a branch of surgery, midwifery had to be restricted to only those activities which did not threaten the professional prerogative of male practitioners. Increasingly over the eighteenth century, the midwife’s legal scope of action would thus be limited.

This chapter presents a final case study in my comparison of midwifery training and childbirth assistance in eighteenth-century Northern Italy. As Venice has received the most scholarly attention of any Italian state with respect to the history of midwifery and of public health more generally, I have been able in this chapter build upon an already established

³ Corner, La scuola di ostetricia, 24-25.
The Venetian health board, or Provveditori alla Sanità, for instance, has been long remarked as an exemplar of late-Medieval and Early Modern public health management. Begun in the fifteenth century as a response to outbreaks of the plague and other epidemic diseases, the Venetian health board soon expanded its activities from containment and isolation of infected groups to encompass also the management of waste, livestock, cemeteries and commercial activity; the investigation and statistical enumeration of unnatural deaths; and the regulation of prostitutes, the poor, and, eventually, a wide range of health practitioners. Indeed, it was the health board under whose competency first fell the regulation of midwifery (and all those health practitioners who were not overseen by the College of Physicians or the College of Surgeons). The efficiency and extensive reach of the Venetian health board meant that the civic regulation of midwives in Venice was in place long before similar measures were enacted in most other cities. As early as 1624, Venetian officials sought to regulate and examine all practicing midwives. By 1689, the health board made attendance at anatomical demonstrations, the ability to read, and familiarity with Scipione Mercurio’s midwifery manual, La Commare, compulsory for urban midwives to be licensed.

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6 Vanzan Marchini, I mali e i remedi, 128-132, 164-165.
Venice was also significant as one of the premiere centers of anatomical discovery and medical education in the sixteenth and early seventeenth centuries. At the Republic’s university in Padua, the celebrities of post-Vesalian anatomy, such as Gabriele Fallopio, Girolamo Fabrici, Giulio Casseri, and William Harvey, led dissections for medical students and made some of the era’s most important discoveries about the workings of the human body, including its reproductive functions. While some, like Fabrici, remained attached to older modes of approaching and performing anatomies for students—which conceptualized, and ultimately subsumed, anatomy in terms of natural philosophy – newcomers like Casseri emphasized the technical skill and expertise – *peritia* – that was essential to the practice of dissection and discovery. Increasingly, students in Padua at the end of the sixteenth century celebrated the manual skill of talented anatomists, valued practical experience and innovation, and carved room for the figure of the highly trained *medico chirurgo*, or physician-surgeon. These developments not only paved the way for the emergence of obstetrics as a learned field of inquiry (and a branch of surgery) in the eighteenth century, but also contributed fundamentally to the epistemological shifts in medicine in the early modern period which advanced practical learning and improvement beyond the wisdom of the ancients. These shifts further saw elite surgeons rise in social status and engage in both Latin and the vernacular in the vibrant medical print culture of the day.

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This last point further marks Venice as a unique site to explore in this study of midwifery. Venice stands out as perhaps the single most important site of medical publishing in Italy, and one of the most prolific in Europe more generally. Indeed, Venice saw the publication of Italy’s first midwifery manual, Scipione Mercurio’s *La Commare o Raccoglitrice* in 1595, as well as a number of other early printed texts related to women’s health and medicine, such as Girolamo Marinello’s 1574 text, *Le medicine pertinenti alle infermità delle donne*. In fact, the Venetian publishing industry helped produce a kind of hybrid physician-publisher by the fifteenth century. These economically savvy medical practitioners saw the highly lucrative potential of the new print market and contributed to what would be a thriving trade in ‘how to’ and domestic recipe books. Venice was thus distinguished by a highly literate population (Paul Grendler estimates that about one-third of Venetian males were fully literate, and many more functionally so) with access to an extraordinary amount of books on any number of topics. Furthermore, because of the ‘popular’ nature and practical usefulness of many of the above-mentioned ‘how to’ books, their recipes and wisdom may have been distributed orally through a much wider swath of the population than was strictly literate. In short, the Venetian population had particular access to a range of learned and popular beliefs about medicine, generation, childbirth, and women’s health.

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9 In the early sixteenth century, Venice printed as many as one-seventh of all the books printed in Europe. A third of all of Italy’s printers were based in Venice. See Paul F. Grendler, *Books and Schools in the Italian Renaissance* (Aldershot, Hampshire: Variorum, 1980), 5.


11 Paul F. Grendler, *Schooling in Renaissance Italy: Literacy and Learning, 1300-1600* (Baltimore: Johns Hopkins University Press, 1991), 46-47.
Finally, Venice’s political structure and influences distinguish it from those of Austrian Lombardy and the Duchy of Savoy. Traditionally, the Venetian government shied away from large centralized bureaucracies, the health board being a notable exception. In the context of poor relief, Venetian officials preferred a highly decentralized and diffuse network of hospitals and shelters supported financially primarily by private charities or individuals and governed by Venice’s powerful and numerous confraternities. Thus while there was a movement in Turin and Milan (and many other Italian cities) during the fifteenth century toward the consolidation of these cities’ hospitals and hospices into great public hospitals, or Ospedali Maggiori, Venetian officials never attempted such integration. Instead, four large hospitals, the Incurabili (for syphilitics and other chronically diseased patients), the Derelitti (for the sick), the Mendicanti (for the poor), and the Pietà (for foundlings) existed simultaneously throughout the early modern period, in addition to a number of smaller, specialized hospices and asylums. At least early on, only in special circumstances were public funds directed toward such institutions, usually when the Venetian state felt particularly desperate to curry divine favor by demonstrating its piety and devotion to Christian charity. Not until the mid-sixteenth century did Venetian authorities begin to experiment with greater institutional regulation, including poor laws and government

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12 There were four large confraternities, the scuole grandi, in Venice, and numerous other smaller confraternities or scuole piccole. For more on Venetian confraternities see Christopher F. Black, Italian Confraternities in the Sixteenth Century (Cambridge: Cambridge University Press, 2003), 42-43; David D. Andrea, “Charities and Confraternities,” in A Companion to Venetian History, 1400-1797, ed. Eric R. Dursteler (Leiden: Brill, 2013), 421-449.

13 Turin’s hospitals were consolidated in 1440, and Milan’s in 1459. See Sandra Cavallo, Charity and Power in Early Modern Italy: Benefactors and their Motives in Turin, 1541-1789 (Cambridge: Cambridge University Press, 1995), 32.


oversight of hospitals and other charitable sites. Religious fervor in the era of the Counter
Reformation inspired the construction of many new charitable sites in Venice during the
sixteenth century – houses for repentant prostitutes, women at risk, converted Jews and Muslims,
and sufferers of syphilis and other chronic diseases all popped up during this period. However,
the Venetian government was content to allow the confraternities and religious orders, such as
the Somaschians, to handle the day-to-day governance and fundraising for these institutions.

The convergences and divergences in experience between Milan, Turin, and Venice help
shed further light on the forces behind the medicalization of childbirth in late eighteenth-century
Italy, the regional influences in this process, and the facets which were uniquely “Italian” in
nature. While the establishment of midwifery education in Venice was similar in many ways to
that in Milan and Turin, there were both subtle and obvious differences. For instance, midwifery
instruction in Venice was a particularly local and intimate affair. Instead of being trained in a
large hospital, the midwives received their lessons at the private home of their instructor. With
clinical educational opportunities limited, apprenticeship continued to play an important part in

16 Venetian institutions for “fallen” and at-risk women included the Malmaritate (for the poorly married), the
Convertite (for repentant prostitutes), the Casa del Soccorso (a temporary refuge for a variety of ‘promiscuous’
women and abused wives), the Penitenti (another refuge for former prostitutes) and the Zitelle (for at-risk girls). On
the general development of women’s institutions and asylums in the early modern period see Sherrill Cohen, The
Evolution of Women’s Asylums Since 1500: From Refuges for Ex-prostitutes to Shelters for Battered Women (New
York: Oxford University Press, 1992). For the Venetian case specifically see Monica Chojnacka, “Charity and
and Poor in Renaissance Venice, 383-93; Laura J. McGough, Gender, Sexuality, and Syphilis in Early Modern
Venice: The Disease that Came to Stay (Basingstoke and New York: Palgrave Macmillan, 2011), especially chapter
4 and, idem, “ ‘Raised from the Devil's Jaws': A Convent for Repentant Prostitutes in Venice, 1530–1670,” PhD
dissertation, Northwestern University, 1997; Giuliana Marcolini and Giulio Marcon, “Prostituzione e assistenza
a Venezia nel secolo XVIII: il pio loco delle povere peccatrici penitenti di S.Iob,” Studi Veneziani 10 (1985): 99-
136; Vanessa Scharfen Chase, “The Casa delle Zitelle: Gender and Architecture in Renaissance Venice,” Ph.D.
dissertation, Columbia University, 2002; Barbara Boccazzi Mazza, “Govermare i ‘luoghi pii’: La Casa delle Zitelle,”
Studi Veneziani 50 (2005): 293-99; Jutta Gisela Sperling, Convents and the Body Politic in Late Renaissance Venice

17 Pullan, Rich and Poor in Renaissance Venice. David D’Andrea argues, furthermore, that the Venetian Republic in
its last two centuries was generally conservative in its approach to charity. Rather than experiment with new
initiatives or innovation, the Venetian government was content to foster institutions that functioned “to preserve the
political and religious status quo, targeting specific groups considered worthy of Christian Charity
formal midwifery education in Venice. Even more striking a difference is the fact that Venice and its *terrafirma* remained without public maternity facilities throughout the eighteenth and early nineteenth centuries. Thus, even with a strong theoretical obstetrical tradition in Venice and Padua, male practitioners in these cities would find it hard to gain sufficient practical experience in the absence of sites for clinical training. It may have been precisely this consideration which ultimately convinced the Venetian health board to grant Benedetta Trevisan special permission – and the unique title of “*levatrice-operatrice*” – to perform manual operations.

To continue to explore the relationship between center and periphery, I include Padua and other areas in the Venetian *dominio* in my discussion. In Padua, in fact, the teaching of obstetrics predated the instruction of midwives in both Venice and the *terrafirma* and the university there was well known for its obstetrical collection. What impact did the firm establishment of Padua and, to a lesser extent, Venice as centers of obstetrical knowledge have on midwifery instruction in the *dominante* and its *dominio*?

I. Formal Training for Midwives in the Serenissima

With the *terminazione*, or statute, of 2 May 1770, the Venetian health board instituted formal education for midwives with a mandatory two-year course to be run in the city by the surgeon Giovanni Menini.\(^{18}\) The culmination of over a century of increasingly rigorous regulation, the Venetian midwifery school shared much in terms of both ideology and praxis with its counterparts in Turin and Milan. In the opening paragraph of the *terminazione* for

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instance, the Venetian health board lamented the dire situation in which pregnant women and their newborn children found themselves throughout the Republic in much the same terminology as had reformers in Turin and Milan: “The fatal misfortunes (inconvenienti) having occurred in recent times due to the inexprience of midwives, who, for lack of the necessary theoretical knowledge miserably sacrifice the lives of many subjects, and fellow citizens.”\textsuperscript{19} As in Milan, the concerns of the Venetian health board were shaded by economic concerns and a populationist mentality in which the strength of the state was contingent on the strength and numbers of its population. However, the underlining of midwives’ lack of theoretical understanding also represented a specific attack on the traditional training of midwives through apprenticeship and personal experience. As the medical profession became increasingly interested in childbirth, both as a viable professional field and in terms of regulating its practitioners, so too did its smear campaign against midwives’ abilities become more aggressive.

At the time of its introduction, the Venetian midwifery school was far from a novelty. By 1770, schools for midwives in Turin and Milan had been joined by others in Florence (1759), Verona (1763), and Roverto (1770). The presence of obstetrical chairs at universities and courses of instruction for surgeons and physicians had also expanded rapidly from mid-century: Turin, Ferrara, Bologna, Florence, Siena, Pavia, and Padua all had instituted some form of obstetrical training for male students by 1770.\textsuperscript{20} Unlike many of these cities, however, Venice had made substantive attempts to regulate the practice of midwifery from the early seventeenth century. A decree issued in 1689, for instance, required prospective midwives to have a degree of literacy in

\textsuperscript{19} ASP, \textit{Sanità}, b. 152, fasc. 1, 12 April 1774. The document references the earlier Venetian Termination of 1770. “\textit{Li fatali inconvenienti cagionati ne decorsi tempi della imperizia delle Levatrici, quali per mancanza delle necessarie Teoriche cognizioni sacrificianno miseramente le vite di tanti sudditi, e concittadini.”

order to study Scipione Mercurio’s text *La Comare o Raccoglitrice*\(^{21}\) (Venice: 1595), to undergo an initial exam (administered by the Protomedico, officials from the College of Physicians and Surgeons, and two licensed midwives) before they were approved, to have attended for two years anatomical demonstrations (*ostensioni*) of the womb and female genitalia (proof of which was required in the form of a certificate from the instructor), and to have apprenticed for two years with a licensed midwife.\(^{22}\) In addition, a register of all licensed midwives in the city was ordered to be kept by the health board and updated every four years and distributed to each parish so that local priests could report abusive activity.\(^{23}\)

*Terminazioni* to these effects were republished until 1760, although their overall impact, despite the threat of a fifty-ducat fine for a midwife caught without the proper approvals, seems to have been minimal. One survey conducted in 1719 reported that of 132 midwives active in the city, only sixty-three were practicing with the required approvals. Despite the health board’s best (and repeated) attempts at greater oversight, the author of the above report could only lament “the intolerable abuse which wounds not only the dignity of this solemn Magistracy with the scorn of many, many individual laws” but also that, according to “the news heard back from many…of the parishes,” that midwives were “poorly or not at all instructed” in the Baptismal sacrament, thus depriving “many innocent souls of the vision of God.”\(^{24}\) In 1769, the case of a woman from Murano, “midwife in name, but of no experience,” who had attempted to extract a

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\(^{21}\) For more on Mercurio’s text, see chapter 2.

\(^{22}\) Local curates were to play a large role in enforcing the Health Board’s decree: the priest of each *contrado* was requested to provide to the Health Board on the first day of each month a list of all the births which had occurred during the previous month along with the name of the assisting midwife and whether she was approved or not. ASV, *Sanità*, b. 155, Termination 12 September 1695.

\(^{23}\) ASV, *Sanità*, b. 748, Terminazione 5 May 1719.

\(^{24}\) ASV, *Sanità*, b. 748, Terminazione 5 May 1719. “l’intolerabile abuso che ferisce non solo la dignità di si grave Magistrato collo sprezzo di tante, e tante individue leggi…la notizia ritratta da molti dei suddetti parocchi che malamente o nulla istrutte tali donne…prive tante anime innocenti della vision di dio.”
fetus during a difficult birth using methods permitted only to surgeons, resulting in the death of the baby and likely death of the mother, had reignited the concerns of the health board. The incident had, according to a letter to the health board, given motive to revisit the midwifery question, given that many women continued to practice illegally, putting into frequent risk pregnant women and their babies.25

Only months later, the Venetian health board officially approved plans for a midwifery school in the city, charging the respected surgeon Giovanni Menini (1712-1776) with its direction.26 As noted above, the preservation and growth of the population was a common justification in the establishment of midwifery schools in Italy and elsewhere in this period. In Venice, this concern merged with the city’s longstanding investment in the defense and protection of public health. As Nadia Maria Filippini and Tiziano Cappelletto have pointed out, the importance of the midwifery school project in the government’s eyes was amplified by the general downturn and loss of international standing confronting the Serenissima in the second half of the eighteenth century. An empire already under attack on many fronts, including internally, could not risk the threat to morale or the public good represented by high infant mortality and ignorant medical practitioners.27

Although the Venetian school shared much with its contemporaries in Milan and Turin, in terms of both the impetus for its creation and the structure which it assumed, there were some notable differences. For instance, since the school was intended only for inhabitants of Venice,

25 ASV, Sanità, b. 169, 21 August 1769.

26 Giovanni Menini, who had been a student of Sebastiano Melli (author of the 1721 treatise La Comare Istruita nel suo Ufizio Secondo le Regole più Certe e le Ammaestraenti più Moderni) had by this time acquired a somewhat famed collection of obstetrical models and mannequins in his home. See also Luigi Nardo, “Dell’anatomia in Venezia,” L’Ateneo Veneto 21/1 (March-April 1897):173n.1. Initially, the Venetian senate was very clear that it would fall upon Menini’s shoulders to provide the texts and models necessary for instruction at the school. Only the professor’s salary of 25 ducats would be publically funded.

no boarding residence was proposed. Students would commute to school for twice-weekly lessons and otherwise be expected to round out their training by apprenticing with an approved midwife. Even more notably, the midwifery school in Venice never existed alongside any kind of public maternity hospital. In fact, Venice did not open such a facility until 1841, long after most other large, Northern and Central Italian cities had established specialized maternity hospitals or maternity wards in larger, general hospitals.28 Male practitioners were thus even more reliant on models and obstetrical machines for their training. Furthermore, in the absence of an anonymous and secure site to deliver an illegitimate child, there is ample evidence to suggest that midwives often secreted women in their own homes to give birth – either at the pregnant woman’s own initiative or that of her consort – a practice that the Venetian health board eventually outlawed. Thus absent in Venice was some of the emphasis on charity, morality, and spiritual reform found in initiatives for public maternal assistance in cities like Milan and Turin. Instead of a focus on offering assistance to and reforming illegitimate mothers, governmental programs to enhance maternal assistance in Venice concentrated instead on the scientific and theoretical instruction of midwives. Perhaps because the Venetian government was content to let its confraternities and religious orders continue to direct charity in the Republic, it did not feel the need to combine programs of maternal assistance and midwifery education in the same way as the more absolutist regimes in Turin and Milan had.

Initially, the midwifery course was slated to take place twice a week at the college of physician-surgeons (in the San Giacomo contrada, sestiere Santa Croce), on Tuesdays and

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28 Nadia Maria Filippini, “Il bambino prezioso: Maternità ed infanzia negli interventi istituzionali del primo Ottocento,” in Nascere a Venezia: Dalla Serenissima alla prima guerra mondiale, ed. Lia Chinosi (Torino: Gruppo Editoriale Forma, 1985), 36-38. There is evidence to suggest that Venice’s Ospedale Civile may have begun to accept pregnant patients on a case-by-case basis somewhat earlier, likely from 1819 on.
Fridays at the “third hour.”\textsuperscript{29} The entire course comprised two years of study. To be eligible to sit for the final exam the candidate had to have a signed certificate from the director of the midwifery school attesting to her capacity and regular attendance, a certificate from the anatomical instructor,\textsuperscript{30} and finally, a certificate from an approved midwife attesting to two years of apprenticeship.\textsuperscript{31} The exam itself was to be overseen by a health commissioner (provveditore alla sanità), the proto-medico, priors of the two colleges of physicians, and or surgeons, and two licensed midwives. As had been the case in Turin and Milan, then, the formal midwifery instruction instituted in Venice represented a mixture of traditional, apprenticeship based training, and the theoretical instruction of the school and anatomy theater. The lack of practical training among male instructors like Menini meant that both the medical profession and the health board were forced to accommodate women’s traditional modes of learning and transmission of childbirth knowledge.

The qualities recommended for prospective midwives in Venice were also similar to those recommended in Milan and Turin, turning as much on the women’s moral characters as on their professional skills. Prospective midwives were to live an upright Christian life, be honest, and (especially) to be sober, given that they might be called upon at any of the day or night to perform their profession.\textsuperscript{32} As elsewhere, the midwife’s potential role in performing an emergency baptism was of utmost concern; if there was any doubt as to a prospective midwife’s ability to do so, she was directed to meet with her parish priest for further instruction before she

\textsuperscript{29} Later, it became traditional to have the midwifery courses at the private home of the instructor.

\textsuperscript{30} Apparently the practice of stealing and selling such certificates was not unknown; it was enough of a problem, in fact, that the Venetian authorities issued a special notice stating that the anatomical instructor should always pass these certificates individually and in persona to the appropriate student so as to avoid any abuses. ASV, \textit{Compilazione Legge}, b. 277, Terminazione 24 March 1774.

\textsuperscript{31} ASV, \textit{Sanità}, b. 109, Terminazione 14 May 1770.

\textsuperscript{32} ASV, \textit{Sanità}, b. 591, “Riflessioni al Magistrato sulla Scuola di Ostetricia di Sebastiano Rizzo.”
could receive a license to practice.\textsuperscript{33} She was, further, to be both intelligent and discreet in her activities, attesting to the midwife’s role in mediating social situations, especially where illicit pregnancies were concerned. Lastly, the midwife had to refrain from all “superstitious words, gestures, or means, instead extending aid to the pregnant woman with tenderness (\textit{dolcezza}) and discretion, tending to her duties with studied circumspection.”\textsuperscript{34} The suspicion of heterodox practices and beliefs which had so troubled the Counter-Reformation Church thus continued to be of concern to a medical profession with its own set of orthodox techniques and beliefs. Failure to comply with these standards and, in particular, failure to call the aid of a surgeon or physician in difficult cases could lead to “rigorous punishment” and/or the loss of one’s license.\textsuperscript{35}

Aware of the abuses which had persisted despite repeated attempts at regulation, the 1770 \textit{terminazione} authorizing the midwifery school emphasized strict oversight. Menini was to report weekly on the goings-on at the school such that any potential problems could be dealt with swiftly. The health board was particularly concerned with the abusive practice of substitution, wherein an approved midwife lent her name to an unapproved colleague when it came time to record the assisting midwife’s name at the baptismal registration. Here, as elsewhere, the parish priest would assume a role as mediator, in this case one required to facilitate and secure the health magistracy’s policies. A priest who was made aware of any abusive practices such as substitution was required to submit the names of both the approved midwife whose name was

\begin{footnotesize}
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\item \textsuperscript{33} Ibid.
\item \textsuperscript{34} Ibid. \textit{“Avranno nello stesso tempo continua attenzione al grave loro obbligo addossatosi nel prestato giuramento, non si serviranno di nessune superstiziose parole, gesti, e mezzi, porgeranno bensì aiuto alle Partorienti con dolcezza, e discrezione, accudiranno alla lor incombenza con tutta la ricer
cata circonsp
cizione, domanderanno per tempo nel caso di necessità, o nelle circostanze pericolose l’assistenza del medico, e nel caso di trascor
tezza sareanno castigate con pene rigorose anche con per
dita dell’impiego.”}
\item \textsuperscript{35} Ibid.
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used and that of the woman who practiced the art without authorization. Here again can be glimpsed the limits of state authority. As we have seen, parish priests were often loyal to their communities and their traditional midwives over the demands of outside authorities. Reluctant priests and resistance from local women toward institutionally trained midwives often represented considerable impediments to the state’s efforts to regulate midwifery.

For a brief period, the legislation in Venice had the notable effect of ascribing the art of midwifery with a professional, academic status unknown in the past, without greatly infringing upon the scope of practice. In the 1770s, for instance, male surgeons were not required to attend lessons in obstetrics and generally did not seem interested in such pursuits anyway. Thus, when midwives were directed to call upon a surgeon or physician to aid in a difficult labor, rarely did these latter practitioners bring advanced obstetrical knowledge (or even instruments) unknown to the midwife herself. Rather, the therapies applied by male practitioners tended to center on traditional, widely applicable remedies such as bloodletting, which had no specific obstetrical components. This situation began to change, however, with the passage in 1773 of a terminazione which extended access to the obstetrical school to male surgical students who wished to be authorized in the practice of obstetrics. Even then, as Nadia Maria Filippini has pointed out, the number of surgeons who employed forceps and similar obstetrical instruments remained quite small; there were as few as two surgeons actually known to apply them in

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36 ASV, Sanità, b. 109, Terminazione 14 May 1770. Both midwives and parish priests could face up to three months jail time for partaking in or concealing such an abuse.

37 I use ‘professional’ here in only the most general sense. It is impossible to speak of midwives really professionalizing in this period as there were no attempts at organizing or attempting to secure the means of instruction and licensing in their field. Both of these were controlled and directed by the College of Surgeons.

38 Nadia Maria Filippini, “Levatrici e ostetricanti,” 160.

39 ASV, Compilazione Legge, b. 277, Terminazione 15 September 1773. The lessons for surgical students would be held on Wednesdays and Saturdays, a full course consisting of one year of instruction.
practice in Venice in this period. Nonetheless, the scope of the midwife’s practice was subtly becoming circumscribed in the face of competing (male) practitioners and the maturing of the social and professional identity of the surgeon, under whose competencies the practice of obstetrics fell.

During these years the invective against midwives, originating largely within the medical profession, became much more aggressive. Venice provides perhaps the most vivid window onto the partition and redefinition of areas of authority and practice amidst the solidifying professional and social identity of the male obstetrician-surgeon. Giuseppe Zara, a surgeon-physician in Treviso, for instance, wrote in 1778 that he was witness to “the woeful events which derive too often in the city and territory of Treviso because of the inexperience and ignorance of midwives, resulting in the premature loss of many pregnant women and babies.” Zara’s petition (supplica) to the authorities in Venice was in fact part of his efforts to have a midwifery school opened in Treviso, which, of course, he intended to direct. Sebastiano Rizzo, who later

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40 Filippini, “Levatrici e ostetricanti,” 159-160. One of these surgeons was Benedetto Maja, a surgeon who may have been the first to apply forceps in his practice in Venice and who petitioned the Venetian health board to make the instrument widely available in Venetian territory, as, he claimed, no one else’s tools were as safe or efficient as the forceps. Maja included in his petition the signed testimony of four women (or their husbands) who had been successfully aided by Maja’s use of the forceps during delivery. “I can with reason therefore affirm to EEVV of being the first in this Serenissima Dominante to save fetuses when they are blocked in the viscera of the womb with the head in some strange direction with the means of this instrument, and in that way to banish the barbaric custom of Professors to kill them [fetuses] through the use of hooks. There would have been saved many innocent victims sacrificed to their inexperience, if I may say so, had my instrument been validated by the authoritative arm of the Magistrato, and prohibited all the other damaging means to Professors, they would have almost had to refer to me, or to my instrument.” ASV, Sanità, b. 171, 9 May 1776.

41 ASV, Sanità, b. 172, 27 July 1778. “Penetrato io Dottore Giuseppe Zarra Medico Chirurgo della funesti eventi che derivanano di frequente nella città e territorio di Treviso della incapacità ed ignoranza delle Levatrici con imatura perdita di tante partorienti e bambini, credei dovere d’onesto Professore, e di fedele suddito il prestarmi, e far uso delle cognizioni acquistate nello studio da me particolarmente coltivato dell’arte Ostetricia a beneficio dell’Umanità, che però m’offersi volontariamente d’ammaestrare le dette femmine in arte così gelosa.”
succeeded Giovanni Menini as head of the Venetian school, likewise railed against the ignorance and continued abuses committed daily by midwives. At a speech delivered to mark the reopening of the school after Menini’s death, Rizzo lamented that obstetrics had for so long been kept out of the hands of “serious men” due to women’s “irrational modesty,” particularly in Italy (in France, at least, the Royal family set the example of having surgeons and doctors attend births, he pointed out):

This modesty in pregnant women is of grave damage, when dealing with a difficult labor. The midwives finally, for as much skill as they have in their Art, never surpass the knowledge of Obstetrics. It is impossible that they know in the midst of labor pains how to distinguish the symptoms of another disease, which can accompany it. They will never be in a position to discern accurately the various indications, which present themselves according to the circumstances. At times a bloodletting might be necessary, at others fumigations, at others some kind of liqueur…occasions which require surgical help, either of the hand only, or of instruments…how ever could a woman, who lacks medical knowledge, conduct herself at the level required of these cases?

Rizzo was clearly distinguishing the extent and kind of knowledge held by midwives, even those trained by Menini in the midwifery school, from the knowledge of physicians and surgeons, who had undergone rigorous academic instruction over many years. Clearly evident in Rizzo’s words was also the prevalent belief in women’s biologically limited capacity for learning and tendency toward irrationality. This invective was not simply an expression of gratuitous misogyny, however. If Rizzo and other male practitioners were to establish themselves as competent birth

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42 This speech was then printed and published under the title, Della Origine e dei Progressi dell’Arte Ostetricia, Prolusione Recitata il giorno 17 Settembre 1776 (Venezia: Carlo Palese, 1776)

43 Sebastiano Rizzo, Della Origine e dei Progressi dell’Arte Ostetricia, Prolusione Recitata il giorno 17 Settembre 1776 (Venezia: Carlo Palese, 1776). "Questa verecondia nelle partorienti suol essere di sommo danno, quando si tratti di un parto laborioso. Le Levatrici finalmente, per quanto abbiano di lume nella loro Arte, non oltrepassano giamaï le cognizioni della Ostetricia. È impossibile, che sappiano ellene in mezzo ai dolori del parto distinguere i sintomi di un altro morbo, che vi si può accompanare. Desse non saranno mai in grado di ben discernere le varie indicazioni, che si presentano a misura delle circostanze. Talvolta potrà rendersi necessario il salasso, talvolta le somentazioni, talvolta qualche spiritoso cardiaco. Vi saranno quelle occasioni, ove occorreranno gli aiuti Chirurgici o della sola mano, o degli strumenti. Talora non si avrà a far nulla anche a fronte di un laborioso travaglio: e come mai potrà ella una donna, che manca delle cognizioni mediche, regolarsi opportunamente a misura dei casi?"
attendants, they had to work hard to break through centuries of custom and accepted practice.

Unsurprisingly, statutes issued in the years following the opening of the midwifery school had the intention of clearly delineating and often further circumscribing the legal ambit of the midwife’s professional actions. While the health magistracy’s interest was in stricter oversight, the medical profession itself was intent on more specifically defining the curative activities which midwives could and could not undertake. In 1776, when Sebastian Rizzo assumed control of the midwifery school upon Menini’s death, he thus felt it was necessary to make clearer the parameters of the midwife’s role, particularly in light of recent changes in the medical profession itself, such as the training of young surgeons in obstetrics. First, the midwife was responsible for monitoring the pregnant woman’s condition both before and after the birth, anticipating and working to prevent possible complications, without, however, recurring to the use of internal medicines. These long standing prohibitions against giving medicines by mouth (a right which had been guarded jealously for years by physicians) or performing bleedings, were joined in 1780 with a proscription against using any kind of surgical instrument to either rearrange or extract the fetus.\(^4\) In short, a midwife’s activities were increasingly limited to uncomplicated, natural births. At the same time, the potential interventions of the surgeon-obstetrician were becoming better defined and more expansive. By the 1780s, for instance, Sebastiano Rizzo was teaching his male students a variety of obstetrical maneuvers, including: the use of pincers of the kind described by the Parisian obstetrician André Leveret; symphysiotomy; hysterectomy; fetal version; removal of a compacted fetus; manual extraction of the placenta; and control of post-mortem hemorrhage.

Midwives were also strictly prohibited from involving themselves for any reasons, including financial incentive, with abortion:

\(^{4}\) ASV, Sanità, b. 561, Terminazione 19 January 1786.
Experience has often confirmed that some midwives forgotten by God and their duty, blinded by money and the hope of great profits, have been induced to adopt remedies to cause abortion; therefore it comes rigorously entrusted to midwives at the risk of loss of their jobs, honor, and other temporal punishments…and even their own lives…to neither prepare, nor help prepare, nor to provide to any person either married or single, any medicines, potions, powders, or other things to make a fetus, living or dead, come forth.45

As important as the suspicion of midwives’ involvement with abortion, one cited frequently since the Counter Reformation, concerned the new degree of supervision afforded to physicians in such cases. If a midwife was to come upon knowledge of someone planning or having already procured an abortion, she was to report the case immediately to the appropriate Tribunal, which would in turn authorize a doctor to investigate further.46 Increasingly toward the end of the century it was preferred to have a physician’s or surgeon’s expert testimony in trials related to abortion or infanticide, rather than that of a midwife as in the past.47 Thus, while real oversight of midwifery practice in the field was limited, there was in the last quarter of the eighteenth century a real shift in the relationship between midwives, and physicians and surgeons. As the involvement of the latter in the realm of childbirth expanded, so too did their supervisory role over midwives.

Nevertheless, Rizzo and the Venetian health board were practical enough to acknowledge the limitations of the medical profession, which could boast only a few trained surgeon-

45 ASV, Sanità, b. 591, "Riflessioni al Magistrato sulla Scuola di Ostetricia di Sebastiano Rizzo." “L’esperienza ha spesso confermato che qualche d’una delle Levatrici scordata di Dio, e dell’Obligo suo, abbagliata dal denaro e speranza di gran lucro si è indotta ad adoperare rimedi per far disperdere la creatura, vengono pericò rigorosamente incaricate le medesime a scarso del loro impiego, onore, ed altre pene temporali prescritte delle leggi criminali, anche dalla vita stessa secondo la grandezza del delitto, di non preparare, ne far prepare, meno di porgere a persona nessuna sia maritata o libera, delle medicine, bevande, polveri, ad altre cose per far sperdere la creatura sia vivo, o morta.”

46 Ibid.

47 For more on the discussion which occurred throughout the eighteenth century regarding the reliability of midwives as expert witnesses in court, see Alessandro Pastore, Il medico in tribunale: La perizia medica nella procedura penale d’antico regime (secoli XVI-XVIII) (Bellinzona: Edizioni Casagrande, 1998). In some cities, midwives’ testimony in court was prohibited entirely by the end of the eighteenth century.
obstetricians by the 1780s. Rizzo therefore wrote that midwives were prohibited from issuing medicines to pregnant women or infants (or anyone else for that matter), except if some extreme urgency required it, “that is, in the absence of a doctor, or when one would not arrive in time; in that case, a [midwife] has permission to assist them with [good] judgment and the dictates of conscience.”

Indeed, it was sometimes difficult to find a surgeon willing to take on an obstetrical case, even when a midwife acted according to the law and attempted to call for help during a difficult labor. A letter from a priest in 1793, for instance, described a harrowing case of a labor gone bad and the difficulty of finding a receptive surgeon to assist. When the wife of Stuttio Tachinetto found herself in an increasingly desperate condition during her labor, her attending midwife requested the assistance of a surgeon. Tachinetto and his godfather took to the streets to track down help. However, it took the men four hours and two failed attempts before they were able to find an amenable surgeon, at which point the pregnant woman was nearly dead:

In company of his godfather, Girolamo Palladin, he [Tachinetto] went in search of a Professor, in order to call him in to help, to save his poor wife; and at the sixth hour in the night he went to the surgeon Sig. Zuanne Carminati at the Tolentini, begging him as an act of charity to come with them to assist a pregnant woman, who was in danger of death, he [Carminati] responded that he was sick at home, when in reality he wasn’t; neither pleas nor displays were enough to remove him, and, seeing such resistance, they took themselves to another surgeon at San. Tomei, Sig. Carlo Gramarcola, who claimed the same misfortune as Carminati, who responded that he didn’t want to come; finally they went to S. Giacomo dall’Orio, and appealed to the assistance of the surgeon Sig. Sento Novello, who promptly came with them, to find the poor woman nearly dead for having had to wait four hours for help.  

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48 ASV, Sanità, b. 591, “Riflessioni al Magistrato sulla Scuola di Ostetricia di Sebastiano Rizzo.” “Si divieta seriamente alle Levatrici di medicare Donne Partorienti, creature appena nate, o pure altre persone, fuorché se lo richiedesse qualche urgente ed inevitabile necessità, cioè in mancanza del Medico, o quando non potesse giungere a tempo, nel qual caso viene a loro permesso di soccorrerle con giudizio e secondo il Dettame della conscienza.”

49 ASV, Sanità, b. 179, 18 June 1793. “Nelle urgenze in cui trovavasi il povere Stuttio Tachinetto, di avere la di lui Moglie in pericolo di morte per il parto di una Creatura, e gia se la vedeva a mancare, domenica di notte, con tutta sollecitudine, in compagnia di suo compare Girolamo Palladin, andò in traccia di un Professore, onde chiamarlo in aiuto, per salvare la povera moglie, e alle ore 6 si portò dal chirurgo Sig. Zuanne Carminati ai Tolentini,
Perhaps because at the time recourse to a surgeon generally indicated a delivery that was beyond even the surgeon’s aid, it seems many surgeons were hesitant to assist at births, particularly when the delivery was in the home. Whereas the hospital might offer a male practitioner the spatial and epistemological reinforcement of his knowledge, in the home, surgeons were forced to compete with the deeply rooted traditions and expectations of the midwife, female attendants and family members, not to mention the birthing woman herself. In practice, then, the role of the male birth attendant at the end of the eighteenth century was still limited and wrought with connotations of imminent death.

**Progress Reports**

As noted, the reality which emerged in the face of increased midwifery regulation was more complex than can be glimpsed on paper. Some midwives reacted ambivalently in response to stricter controls on practice; in many cases women passively resisted these encroachments by simply continuing to practice without obtaining the proper approvals. With some frequency, such resistance was sustained by the support of clients in the community, who preferred the services of traditional midwives to those educated in the foreign environment of the public school. Parish priests also might advocate on behalf of long-serving midwives unable (or unwilling) to enroll in formal midwifery courses. As a result, those women who did see the midwifery school as an opportunity for increased status and remuneration often faced considerable impediments to success which extended beyond the parameters of the course itself.

*supplicando per atto di carità si portarse con esso loro ad assistere un Partoriente, ch’era in pericolo di morte, fece respondere essere in casa amalato, quando in realtà non vi era, ne le preghiere, ne le esibizioni furono bastanti a rimoverlo, e vedendo una tale insistenza, si sono portati da altro chirurgo a S. Tomei il Sig Carlo Gramarcola, che l’istesa fattalità del Carminati, hanno trovato anche in questo di averli risposto non voler venire; ed in tanto ci ha convenuto passare a S. Giacomo Dall’Orio, e ricorrere all’assistenza del Chirurgo Sig. Sento Novello, che prontamente venne con loro, e trovò la povera donna quasi estinta per esser tardato Quattro ore.*
As in Milan and Turin, in Venice it could be difficult to attract women to enroll in the midwifery course at all. Tasked with reporting on progress at the school amidst rumors of low attendance, the Venetian health commissioner Anzolo Giustinian made several visits in 1785. What Giustinian observed was, in his opinion, not only a frequent lack of attendance, but the “almost total abandon” of the school. According to Giustinian’s report, attendance rarely surpassed six students and was more commonly as few as two or three, despite the enthusiasm and tireless attempts by Sebastiano Rizzo to increase enrollment. However laudable the Venetian health board’s initial impulse “to render midwives well-trained [and] anticipating by their experience an increase in subjects, and the preservation of many lives rendered in previous times victims of ignorance,” may have been, Giustinian rightly acknowledged that no benefits could be expected if they could not find some way to compel women actually to attend the school.50

In response, Giustinian suggested enforcing both stricter penalties on abusive midwives and tighter control of the profession in general, as well as adding some greater incentives for successful midwives who undertook the entire course of study. First, the catalog of approved and abusive midwives should be updated more frequently than the every four years stipulated in previous terminazioni. Moreover, the director should keep a regular register of attendance at the course, such that only those women who had attended at least four lessons per month for two years be allowed to sit for the final exam.51 Finally, the reported practice of approved midwives impeding their apprentices from attending school so as to avoid potential competition had to be stamped out as quickly and harshly as possible, with any offenders liable to be stripped of their

50 ASV, Sanità, b. 176, Report of Anzolo Giustinian, 1 September 1786. “Il provido oggetto dell’istituzione dell’ostetrica scuola fu certamente quello di rendere le mamane ammaestrate contemplando nella loro esperienza l’aumento de’sudditi, e la preservazione di molte vite rese alle volte vittime della ignoranza.”

51 Ibid.
At the same time, Giustinian suggested, incentives might be promised to the top one or two students in the class as judged by their performance on the licensing exam. These women would be exempt from paying the normal exam fee and would also receive a note on their certificate of approval of their superior skills.

As the suggestion of hostility between midwives and their apprentices suggests, the reasons for women’s disinterest in attending school could be multiple and complex. At the most basic level, attendance at school might represent a financial and familial burden for working women or those with children. Rizzo complained, for instance, that some women enrolled over and over again in the midwifery course (at the state’s expense), for as long as ten years or more, because demands at home prevented them from faithfully attending the lessons. Other women resisted the school for a combination of the above reasons as well as a general suspicion of (re)learning a trade for which they already considered themselves well-trained. Supplications to the health board for exemptions from attending school were by far more common for older women with years of practice to their name, while, over time, the midwifery school attracted younger and younger applicants. Even poor weather in a pre-modern city could be responsible for some enrolled women missing school, especially during winter and rainy months.

Nevertheless, by the 1790s, when we have regular reports from Sebastiano Rizzo to the health board about goings-on at the school, the situation seemed to have improved. At the opening of school in March of 1794, for instance, Rizzo could report a number of female

52 Ibid.

53 Ibid.


55 ASV, Sanità, b. 591, Report of Sebastiano Rizzo, 21 January 1795. In January of 1795, Rizzo wrote that “in questa rigida aggiacciata stagione la femmine scolaresca non molto fraquanto la pubblico scola ostetricia. Nel numero di diciasette alunne, che doverebbero intervenirvi in ogni singola lezione ne mancarono molti giorni al di là della metà.”
students that, when combined with those midwives already approved, would be “more than sufficient for not only the Serenissima dominante, but also for the cities of the terrafirma.”

During the previous quadrimester, a woman from Chiozza had been allowed to enroll in the midwifery school given her home community’s lack of a midwife. The woman from the terrafirma showed such great potential that Rizzo even ventured to instruct her in manual operations on the school’s obstetrical mannequin. Attendance in the last decade of the eighteenth century therefore seems to have steadied at around ten to twenty students per course. By this time, at least some of the initial enrollments issues appear to have been resolved as well. At the same time, in Rizzo’s opinion, training women who were coarse and simple remained a constant challenge.

To accommodate such women, many of whom had never had any kind of formal education or training, Rizzo employed a dialogic method. Describing these lessons as a kind of catechism in which the students would study and memorize a series of concise questions and answers, Rizzo reported variable results. Some students succeeded “marvelously,” while others seemed to be “born mute: deaf in the questions, and mute in the responses.” Rizzo was sensitive to the different capacities among his students and tried to adapt his lessons accordingly.

On the one hand, his young students were generally quite successful in comprehending and

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56 ASV, Sanità, b. 591, Report of Sebastiano Rizzo, 22 August 1794. “Furono iscritte alcunne novelle alunne formanti colla vecchia [scolaresca] un numero più che sufficiente per questa serenissima dominante non solo, ma a benefizio ancora delle città del terraferma.”

57 ASV, Sanità, b. 591, Report of Sebastiano Rizzo, 22 August 1794. It is unclear if the midwife from Chiozza was intended/permitted to perform such manual operations in practice; it is possible that Rizzo may have considered her hometown’s access (or lack thereof) to a trained physician or surgeon, and decided to teach her the manual maneuvers typically prohibited to female practitioners.

58 As author of a midwifery manual himself, Rizzo was familiar with the use of the dialogue form as a popular structure for such texts, particularly those directed at female midwives. For more on these texts and the power and gender dynamics inherent in the dialogue form, see chapter 2.

retaining the daily lessons, these “having the organs of memory ready as much to receive the notion as to commit it firmly and strongly…to memory.” On the other hand, the older students tended to struggle. Rizzo noted regretfully that he needed to spend twice as much effort on the older students, repeating lessons over and over such that with time these women would be “reduced…to a servile practice, most useful to the very important aim of the simple, manual practice [of midwifery].” Ultimately, Rizzo could boast that, despite their differing talents, both types of students had successfully passed the obstetrical exam because of his diligence and the diverse plans of study he had devised for each.

As for the actual content of these lessons, Sebastiano Rizzo’s reports give us a rare window onto the functioning of an eighteenth-century midwifery school. The school year started off with a thorough introduction to female anatomy. Both female student midwives and male surgeons would learn the female reproductive organs as they appeared in a healthy subject and also as they did in a woman of “pathological construction,” by studying the works of “worthy masters of the obstetric art.” For his female students, Rizzo made these lessons as simple as possible, often employing the abovementioned question and answer method of teaching. Repetition was key for Rizzo to “instruct that…class of women, in order to render them capable

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61 ASV, Sanità, b. 591, Report of Sebastiano Rizzo, n.d. “Con mia dispiacenza, e sensibile sfortuna mi conviene raddopiar la fattica, ritrovavano un numero di avanzata età non succetibile allo stabilito piano. Mi conviene dunque a forza di voce, e di replicate istruzioni ridurle coll’andar dagli anni ad una servile pratica, utilissima all’importantissimo oggetto del semplice manuale esercizio.”


63 ASV, Sanità, b. 591, Report of Sebastiano Rizzo, 18 May 1796. “Seguendo gli ammaestramenti dei valenti maestri di arte ostetricia, terminate che abbi di perfezionare gli organi alla fecondazione inservienti tanto in stato naturale di donna perfettamente architettata, quanto di morbosa costruzione.”

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of responding well in the private exam to all the questions” which might be posed to them.64

Following a complete study of anatomy in the classroom, Rizzo would have his students attend one or more dissections in the Anatomy Theater at the University of Padua. If possible, Rizzo procured for his lessons the cadaver of a pregnant or post-partum woman who had died of complications. During these occasions, the students would examine both the external and internal anatomy related to generation, as well as practice certain skills, such as inserting a syringe into the bladder to extract urine in the case of retention, and supporting the uterus with a pessary in the case of prolapse.65 On one occasion, Rizzo reported happily that he was able to demonstrate to his students the existence of the hymen on a deceased virgin, which, being very infrequently available for study, provided that session’s students a rare opportunity.66 According to Rizzo, already approved midwives would sometimes attend these anatomical demonstrations alongside the trainees in order further to improve their skills.

Back in the classroom, the remainder of the course focused on practicing obstetrical maneuvers on mannequins and preparing for the various possible complications which might arise during birth. To cap the course, Rizzo spent time dispelling certain myths and superstitions which he believed still prevailed among many of his students. At the end of the school year in 1795, for instance, Rizzo worked to invalidate the “false antique opinion, that the maternal stamps (i.e. birthmarks) on a newborn baby are not products of the capricious desires of women,

64 ASV, Sanità, b. 591, Report of Sebastiano Rizzo, 1 May 1794. “Non ometto in ogni singolo giorno d’instuire quella piccola, e rozza scolarca di donne, onde renderla capace a ben rispondere al private esame a tutto le interrogazioni, che dai destinati valenti professori venissero proposte.”

65 ASV, Sanità, b. 591, Report of Sebastiano Rizzo, 16 March 1796.

66 Ibid.
but rather a natural effect” of the dominant (i.e. male) material in the process of fertilization and the formation of the first cells of the embryo.\textsuperscript{67}

**II. The Terrafirma**

As had been the case in Milan, the introduction of a midwifery hospital in Venice soon led to petitions for the expansion of midwifery training to surrounding territories, in this case the Venetian *terrafirma*. Padua, which had had a university and academic chair in the Diseases of Women, Children, and Workers (*cattedra De Morbis mulierum, puerorum et artificum*) since 1765, was an obvious choice for Venice’s first mainland midwifery school.\textsuperscript{68} In fact, under the direction of Professor Luigi Calza (1737-1784), who had been a student of the famed Bolognese physician and obstetrician, Giovanni Antonio Galli (1708-1782), the university at Padua had begun instructing male students in obstetrics by 1769 and had amassed a significant collection of obstetrical machines, models, and anatomical and pathological specimens in the so-called *Gabinetto Ostetrico* (Cabinet of Obstetrics).

Although male students would likely never take part in an actual birth during their training, they would be instructed with and would have practiced on the university’s collection of wax anatomical models and obstetrical ‘machines.’\textsuperscript{69} As in Turin and Milan, the availability of such models played an important role in facilitating male entrance into the management of

\textsuperscript{67} ASV, *Sanità*, b. 591, Report of Sebastiano Rizzo, n.d. “Ho infine coronato il corso col togliere la falsa antica opinione, che I Materni impressi nel neonato bambino non sono produtti delle voglie capriciose delle donne, ma bensi un natural effetto dello spirito fecondatore.” For more on eighteenth-century attempts to discredit the notion of maternal imagination being able to imprint itself on the fetus, and the more general shift from mechanism to vitalism, see Mary Terrall, “Maternal Impressions: Conception, Sensibility, and Inheritance,” in *Vital Matters: Eighteenth-Century Views of Conception, Life, and Death*, eds. Mary Terrall and Helen Deutsch (Toronto: University of Toronto Press, 2012), 112-114. Rizzo himself was following the English physician Richard Mead, in opposition to the popular opinions on the maternal imagination held by Nicolas Malebranche and others.

\textsuperscript{68} This position was changed to a chair of Obstetrics in 1769 at the same time in which a “Cabinet of Obstetrics” was opened under the direction of Luigi Calza.

childbirth. In Padua and Venice, however, such equipment may have been even more critical due to the lack of maternity facilities in these cities. Eventually, those surgery students who had elected to study obstetrics and who wished to obtain a license to practice the art would undergo an exam administered by professors of anatomy, surgery, and medicine. In a clear exposition of the medical division of labor current in this period, the exam was divided into three parts: the anatomy professor would examine the student on the signs of virginity, sterility, and pregnancy; the surgeon on the indications of pregnancy, on the various presentations of the fetus, and on the operations, both manual and with instruments, which might be applied to different cases; the physician on everything that regards the postpartum patient. Obstetrics, which followed a trajectory from conception to postparturition, and even juvenile medicine, was therefore a relatively novel kind of medical practice at the time as it merged what had typically been discrete medical specialties. Although generally considered a branch of surgery by the late eighteenth century, obstetrics clearly comprised aspects of surgery, physic, and anatomy.

It was in these same years that the governing body of the University of Padua (Riformatori dello Studio di Padova) first proposed the introduction of a midwifery school in the city, though the realization of that proposal would take several more years. Although the Venetian Senate and health board were clearly interested in extending midwifery training to the

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70 ASP, Sanità, b. 152, “Terminazione del Magistrato Eccellentissimo dei Riformatori dello Studio di Padova riguardante ai Chirurghi l’Ostetricia,” 3 January 1768.

71 There were initially three Riformatori which made up this powerful governing body when it was formed in 1516; it soon evolved into an elected body. The Riformatori had both organizational and curricular authority including instruction, course content, and hiring, as well as broad authority over other sites of learning in the city and even the publishing of texts. For more on the Riformatori dello Studio see Sandro de Bernardin, “I Riformatori dello Studio di Padova: Indirizzi di Politica Cultural nell’Università di Padova,” in Storia della Cultura Veneta vol. 4: Il Seicento, part 2 (Vicenza: Neri Pozza, 1984), 61-91; Brendan M. Dooley, “Giornalismo, accademie, e organizzazione della scienza: Tentativi di formare un’accademia scientifica Veneta all’inizio del Settecento,” Archivio Veneto, ser. 5, 120 (1983): 5-39, and Science and the Marketplace (Boston: Lexington Books, 2001); Paul F. Grendler, The Universities of the Italian Renaissance (Baltimore: The Johns Hopkins University Press, 2002), esp. 32-33; Piero del Negro, “Venetian Policy toward the University of Padua and Scientific Progress during the 18th Century,” in Universities and Science in the Early Modern Period, eds. Mordechai Feingold and Victor Navarro-Brotors (Dordrect: Springer, 2006), 169-181.
dominio, as the “disorders” there were “the same, or even greater” than in the dominante, an inability to settle financial issues and difficulty in finding a suitable location to house the midwifery students impeded the establishment of a school until 1774 (the first lessons did not being until 1776). Owing to the differences between urban and rural demands, the Padua school took on a rather different shape than its predecessor in Venice. In the first place, Padua was meant to accommodate both women interested in learning midwifery from the city of Padua itself, and from the surrounding countryside. Thus a structure for boarding students would be required. The health board in Padua determined that it would contribute 300 lire annually to support ten students from the countryside, in particular women from those villages most isolated and with a demonstrated lack of midwives available to attend to local pregnancies. Second, the structure of the course itself was significantly altered. Instead of a two-year course consisting of twice weekly lectures, the Padua course would be intensive, taking place over four months from December to March in order to accommodate a rural work schedule.

As in Turin and Milan, the health board in Padua had to identify a site for housing rural students and adapt it to serve these needs. Unlike the midwifery schools in Milan and Turin, however, the midwifery school in Padua was not held at the same location where the students lived, but rather in Calza’s own house, location of his collection of obstetrical models and machines. After months of searching unsuccessfullly, the health board finally came to the agreement that the Ospitale di San Leonino in Prato delle Valle would provide an adequate housing solution. Although the hospital’s noble patron, Leonardo Bazolo, readily granted permission to the health magistracy to repurpose the site for the boarding of midwifery students,

72 ASP, Sanità, b. 152, Terminazione, 12 April 1774.
73 ASP, Sanità, b. 152, Letter from Anzolo Maria Giacomazzi, 22 August 1774.
74 Ibid.
it soon became apparent that some significant renovations would be needed to enhance the salubriousness of the locale. The most immediate concerns included a floor given to humidity and a lack of good airflow and light, along with inadequate heating. With 1500 lire generously donated from the city for these adjustments, the Paduan health board was finally ready to issue a set of bylaws for the school and to initiate communication with the surrounding villages to identify the ten rural women who would come to the city to be trained. As was the case when midwifery instruction was expanded in the Milanese provinces, the Venetian project demonstrated both the extent and limits of state authority. Although the Venetian government had initiated the establishment of midwifery education in its territories, it was only with municipal contributions and private charity that local schools were able to get off the ground.

As had been the case in Milan and Turin, parish priests in the Paduan territories became the main liaisons between the urban school and remote villages. These priests were tasked with identifying those women who practiced as midwives in their communities and whom they thought would best excel at school; if there were no midwives in their community, they could choose another interested woman. The ten women selected would be requested to arrive in Padua in late November with a letter attesting to their identity and selection, ahead of the school’s December start date. The students had to agree to be lodged at San Leonino and to remain in Padua for the entire length of the course. The women’s first stop upon arrival was San Leonino, at which time they received a bed and trunk for their belongings, and were informed as to the expectations for their behavior during their stay. Visitors, for instance, were strictly limited to family members. Each student also had to be home in the evenings by midnight, after which time the guardian of the house would close and lock the doors. In addition to a female guardian, a

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75 ASP, Sanità, b. 152, unsigned letter, 17 October 1775. Ultimately, the Padua government agreed to contribute 1500 lire to build the needed fireplace, and add several windows.
deputy **Provveditore** from the health magistracy would have the responsibility of monitoring the “conduct and behavior of these women, who would live in a Christian manner, and in peace with one another under the governance of the custodian, and in the case of scandal, or turbulence, the most disruptive would be dismissed” and replaced with another woman selected as above.76 This deputy was required to visit San Leonino at least once a month and be continually updated on the women’s conduct. On feast days, the priest at the church adjacent to their residence instructed the students on the administration of the baptismal sacrament.77

Luigi Calza had complete discretion at the school to establish both the course content and daily organization of his lessons, as well as with respect to rules of comportment for his students. He was directed to send bi-monthly reports to the Padua health board on the progress of these lessons and how well the women, particularly those from the countryside, were faring.78 If it seemed to Calza that any student was entirely unable to profit from the course, then her name was to be presented to the health board so that she could be substituted by another student. Acknowledging both the differing work demands and diverse educational backgrounds among the rural and urban midwifery students, the health board determined that it would be most beneficial to keep the two groups separate. As such, rural midwives would attend school from December to March, while their urban counterparts would have lessons during the remaining months of the year.

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76 ASP, Sanità, b. 152, 11 December 1775. “Una della principale attenzioni del Provveditore deputato sarà quella d’invigilare sulla direzione, e condotta di dette femine, quali avranno a vivere Cristianamente, ed in pace tra di loro, sotto il governo della custode, et in caso di Scandali, o turbolenze, saranno le più inquiete licenziate.”

77 ASP, Sanità, b. 152, 11 December 1775. The students’ instruction in this regard would be guided by the Ferrarese priest Girolamo Baruffaldi’s 1746 treatise on the subject, *La Mammana istruita per validamente amministrazione il santo sacramento del battesimo in caso di necessità alle creature nascenti*. Several other midwifery schools adopted this text as well as part of their instruction.

78 ASP, Sanità, b. 152, 11 December 1775.
Urban students followed a course of instruction very similar to the course for Venetian midwives, and attended classes three days a week for a two-year period. Initially, though, practicing midwives from the city might be able to proceed to the licensing exam at an accelerated pace, if they demonstrated sufficient skill. For the health magistracy, the first goal for the city itself was to correct a situation in which most midwives were acting abusively without licenses (only six of twenty-one midwives practicing in Padua in 1774 had licenses). Rather than rendering this entire body of expertise unavailable to the local population, the health board acknowledged it would be best to facilitate their licensing as soon as possible. More stringent educational requirements would be enforced with the ensuing generation. All students, both urban and rural, would be required, following the Venetian regulations, to present certificates attesting to faithful attendance at school and at anatomical demonstrations, passage of a final exam, to have had an apprenticeship under an approved midwife, and ability to perform the baptismal sacrament.

As we have seen repeatedly, recruitment for the midwifery schools, especially in their first years of existence, proved difficult. In the territory surrounding Padua it was much the same. The logistical and psychological difficulties involved in uprooting oneself from home for an extended period, overlaid by suspicions as to the moral correctness and necessity of such a course, inhibited many women from volunteering to enroll. From Castelbaldo, a community about fifty-five kilometers southwest of Padua, the parish priest wrote to the health magistracy that he had tirelessly tried to persuade the midwife Domenica Ferrari to attend the midwifery course, only to be repeatedly rebuffed. Domenica cited her “poor health, her numerous family,

79 ASP, Sanità, b. 153, Fasc. 2, “Fedi dei RR Parrochi di Padova…le quali dimostrano il numero delle comari esistenti nel 1774 in ogni Parrochi, con l’attestato di quelle, che vi sono nel 1778 abili, e capaci di dare ancora il Battesimo. In fine, una nota delle comari di Padova che hanno il privilegio, e quelle che non lo hanno,” n.d.

80 ASP, Sanità, b. 152, 11 December 1775.
her miserable [economic] condition, and her inexperience in reading and writing” as reasons for her disinterest. A more “lively” woman, also named Domenica, was the priest’s next choice. While Domenica Feltivato was healthier and could read, she refused the nomination as well, arguing that her family was sustained more by her husband’s labor than by the meager earnings she received from her practice as a midwife. Ultimately, the priest could deliver only regrets, and not a candidate for instruction, to Padua.

The parish priest from Carceri, located about thirty kilometers southwest of Padua, responded similarly that his search for a woman to nominate had been unsuccessful, though for slightly different reasons. With 250 families in his parish, some 7000 in the immediate surrounding territories, and only one midwife able to travel (two elderly women also practiced, but due to age had very limited mobility), the priest felt he could not put his community at risk by removing the one childbirth expert available. Even when a woman could be convinced to be nominated for the school, her eventual attendance was still questionable, at least according to a priest from Villanuova. After much effort, he wrote:

I was able to persuade Angela Molesina, midwife in my care, to transport herself to Padua to be instructed in the art of Obstetrics…putting in front of her eyes the obligation of her conscience since, not having the required knowledge in her profession, she is in danger of making great errors in prejudice of innocent infants. For the moment she is persuaded to embrace this encounter, as long as she remains stable in her opinion, of which I cannot assure you, since I know the female sex to be very changeable.

81 ASP, Sanità, b. 153, Letter from Castelbaldo, 13 November 1774. “Dicendomi…che attesa la salute sua cagionevole, la numerosa sua famiglia, e la miserabile sua condizione, e la sua inesperienza nel leggere, e nello scrivere non si sente capace d’allontanarsi.”

82 Ibid.

83 ASP, Sanità, b. 153, Letter from Carceri, 28 November 1774.

84 ASP, Sanità, b. 153, Letter from Villanuova, 30 November 1774. “Dopo qualche tempo, e fatica, m’è riuscito di persuadere dare Angela Molesina, Allevatrice in questa mia cura, a portarsi in Padova per esser istruita nell’arte Ostetricia, caso che sii chiamata, mettendogli avanti gl’occhio il debito di consienza perche non avendo la dovuta cognizione nella sua professione sì pone in pericolo di far grandi errori in pregiudizio dell’innocenti creaturine; gli feci vedere l’acquisito d’una buona fama coll’acquisto delle cognizioni, e per fino che si mette in stato di far il suo
In addition to appealing to her sense of morality, the priest had also made the argument to Angela that her increased knowledge would enhance her reputation, and thus her economic circumstances, which was apparently sufficient to convince the woman.

On the other hand, there were communities that lacked midwives entirely or had only an insufficient number and desperately wanted women trained in the new midwifery school. For instance, the parish priest of Cologna, about 46 kilometers west of Padua, wrote to the health board in Padua in 1780 lamenting the “disorders born even recently due to the inexperience, and lack of able midwives to serve the numerous population of not only Cologna, but also the surrounding territories.”\(^{85}\) Cologna had already sent one woman to the midwifery school, but a single trained midwife proved unable to handle the demands of the entire community. Thus, the parish priest entreated the health board to accept a second candidate, Lucia Regazzi, to the school as well.

Despite the resistance of many women to attending the midwifery school in Padua, it seems that a sufficient number of receptive candidates were able to be identified each year to fill the ten slots allocated for rural women. At least initially, the school seems to have functioned quite well. Reports from Luigi Calza to the health board in Padua suggest that even his rural students achieved much success and were consistently able to complete the course and receive a license to practice. In February of 1777, for instance, Calza wrote that his rural students were
well behaved and “participate with every assiduity and attention at my lessons.”86 Although he had found that “words alone would only commit completely new and unfamiliar ideas in the minds of unlearned and aged women with much difficulty,” Calza was able, by instead “resorting to the help of the senses, endeavor to put before their eyes, and make them touch with their hands” in order to learn the principles he was attempting to teach.87 Thus Calza found that instruction upon the obstetrical machines and models in his care was of great benefit to his students. The professor even took it upon himself to learn and adopt in his discourses the terminology which would have been familiar to his students, however colloquial it might have seemed to a university-trained surgeon. Like Sebastiano Rizzo in Venice, Calza also employed a dialogic formula to his lessons, in which students would memorize a series of brief questions and answers. Ideally, Calza wrote, this meant that in their free hours at San Leonino, one of the women best able to read might repeat these questions to her fellows students until they were all very familiar with the correct answers.88 Ultimately, Calza found not only his methods to be quite efficient, but also that he was rather pleased with the natural ability of many of his students.

Calza’s experience in training the midwives who had been practicing without license in the city itself proved much different. Instead of the deference and malleability of his rural students, many of the urban women at first “demonstrated great resistance…and were determined not to obey.” 89 Although Calza remained steadfast in his resolve to make these

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86 ASP, Sanità, b. 152, Report of Luigi Calza, 13 February 1777. “Esse donne dal Bene...intervengono con ogni assiduità, ed attenzione alla lezioni mie nei destinati giorni, su l'ore prime della mattina.”

87 Ibid. “Esami ben noto, che le sole parole avrebbero a stento imprasse idee tutte nuove e non communi nelle menti di donne rozzze, ed avanzate in età; perció ricorrendo all'aiuto dei sensi, impress a ponere loro sotto occhio, e far toccare con mani, quanto le insegni, e mi studiai sin dal principio di adoperare i termini che da esse apprendo, o almeno li più triviali, affine di spargere maggior chiarezza nei miei discorsi.”

88 Ibid.

89 ASP, Sanità, b. 152, Report of Luigi Calza, 5 June 1777. “Mostravano somma resistenza le comari, ed erano alcune determinate di non obbedire.”
students see the value in his instruction, the professor’s reports indicate that the instruction of urban midwives continued to pose problems for Calza and the health board. Indeed, the continued practice of many midwives in the city without proper approvals remained a constant issue for the next decade. Enough trouble was there, in fact, that when Pietro Sografi assumed direction of the midwifery school upon Luigi Calza’s death in 1784, he felt it was necessary to produce a report on the sources of the continued “very grave disorders, which frequently occur in the practice of Obstetrics because of abuses, and the inexperience of the practitioners of that art.” According to Sografi, at present any woman “at her pleasure can undertake the vocation of midwife, and can practice it without an exam of her moral condition, of the midwifery school, and finally without any obligation in doubtful or difficult cases to call the Public Professor of Obstetrics or another able surgeon to undertake any necessary operations.” Even surgeons, the report continued, who since 1768 should have been required to be instructed and examined in obstetrics in order to practice, were acting without proper approvals, contributing to the general disorders afflicting childbirth in Padua and its environs. Additionally, it appears that many midwives continued to administer internal medicines, use instruments, and practice simple operations independently, such as the extraction of the placenta.

There were problems at San Leonino as well. Intermittent reports of disorders at the

90 ASP, Sanità, b. 152, “Parere del Sig. Pietro Sografi sopra La Scuola di Mammane,” 6 October 1784.

91 Because Padua and its surrounding territories lacked hospitals which accepted pregnant women, it became the duty of the Professor of Obstetrics himself to attend personally any difficult births in the city for which a midwife called assistance. “Siccome poi mancano gli stabilimenti per soccorrere le miserabili che partoriscono, così dovrà il Pio Professore presentarsi personalmente quando sia chiamato, da qualunque allevatrice, ed in qualunque luogo della Città in casi similmente gravi per eseguire le occorrenti operazioni nelle miserabili.” ASP, Sanità, b. 152, “Parere del Sig. Pietro Sografi sopra La Scuola di Mammane,” 6 October 1784.

92 Ibid. “Ogni donna a suo talente può intraprendere il mestiere della Levatrice, e questo esercitarlo senza un’esame delle sue condizioni morali, della Scuola avvuta della pratica, e senza finalmente alcuna obbligazione nei casi dubi o particolari di chiamare il Pubblico Professore di Ostetricia, o altro abile chirurgo, onde eseguire le necessarie operazioni.”

93 Ibid.
house had emerged from time to time after the midwifery school’s opening. By the late 1780’s, however, the lax oversight at the house and blatant disregard for its regulations required more stringent intervention. Much of the responsibility for the lack of discipline was ascribed to the governess, whose “depraved connivance” had encouraged “licentious behavior” among the boarding women at San Leonino.94 Apparently, these rural students often failed to come home by their curfew in the evening, and they received visitors who were not relatives at all hours of the night. To make matters worse, the church of San Leonino, adjacent to the residence, was currently lacking a priest, so the female students were not receiving regular moral and religious guidance as per the health board’s regulations.

As had been the case in Milan, the logistics of midwifery education thus proved difficult in the Venetian territories. The rural women who came to urban schools to be educated had to be protected and governed, though the solution of confinement could prove both unappealing to the women and difficult to enforce. The solidarity among midwives, which the health board intended to foster, was also elusive at times. In addition to the creation of inter-professional rivalries and new divisions based on training and community acceptance, the midwifery school in Padua seems to have highlighted urban-rural divides. For rural midwives, whose remuneration in their home communities was often meager, increased training offered the prospect of enhanced economic gain. For urban midwives, however, whose compensation was likely higher to begin with, the appeal of attending school for two years was limited. Ultimately, while on paper the control over the practice of midwifery had increased significantly, and the legal scope of its practice circumscribed, in reality change was much more gradual and subtle, though not

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94 ASP, Sanità, b. 152, 5 May 1787. “Prevenuti molto sinistramente sulla licenziola condotta delle femine campestri che ad oggetto di ammaestrarle negli studi dell’arte Ostetricia vengono accolte dalla Pubblica carità in cotesto Ospitale di S. Leonino, non deve dal Magistrato Nostro...passarli la viziosa connivenza della custode incaricata precisamente di mantenere in quell ritiro la disciplina, il buon ordine, ed il costume con li dettami della statutaria Term. 1776 13 Nov.”
invisible. These late-eighteenth century developments were critical factors in the increasing medicalization of childbirth and the semi-professionalization of midwifery seen even more starkly in the next century, one which saw the first scientific journal for midwives in Italy and a growing number of successful surgical interventions.95

Conclusion

The Venetian case underlines what has been a major theme in all three of the cities under examination: ambitious attempts at the control of midwifery tempered ultimately by the practical necessity of accommodation. Neither medical elites nor public health administrators were completely successful in their efforts to redefine the parameters of midwifery and its means of legitimation. Ingrained cultural notions of modesty and expectations about childbirth and its management proved more difficult to modify than either group might have imagined. At the same time, practical considerations and a politico-economic driven desire to grow the population meant that reforming governments could not be overly draconian in punishing abusive midwives. Thus, in Turin, Milan, and Venice limited to moderate inroads in scientifically and theoretically training midwives had to be paired with the grudging toleration of “traditional” childbirth practitioners. Despite the spread of chairs of obstetrics in Italian universities, and the training of surgeons in the field, a cultural objection to male birth attendants in Italy was strong enough to impede any major erosion of midwifery there, unlike in France or England.

The late arrival of public maternity facilities in Venice and its mainland demonstrates, on the other hand, that real regional differences existed in Italy. Differing traditions of charity, assistance, and female honor seem to have determined that illegitimacy would remain a local problem in Venice, longer than in Milan and Turin, perhaps due to the stronger centralizing

influence of the state in the two latter cases. Indeed, the examination of the spread of midwifery education to the provinces highlights the continued importance of local, private, and municipal charity in such ventures. In none of the three cases were new facilities built to house maternity wards or schools, and nor were these projects ever entirely (or even mostly) state funded. Thus the success of institutions, particularly those outside of the capital cities, depended considerably on local support. In the same vein, the health boards were reliant upon the aid of mediators to apply their authority, particularly in the provinces. Parish priests were critical in this equation, though it seems their loyalties were divided. While some faithfully reported abusive midwives, particularly those in competition with women newly trained at the midwifery school, other priests advocated on the behalf of ‘traditional’ midwives – either by petitioning the health board for exemptions, or by simply not reporting illegal practices. In short, the sweeping efforts to regulate and control the practice of midwifery undertaken by late-eighteenth century states ultimately proved too ambitious to be enacted successfully; nonetheless, these efforts constitute an undeniably significant moment in the gradual process of the medicalization and institutionalization of childbirth and its management.
CONCLUSION

During the eighteenth century, the professionalization of medicine and the emergence of the state as both moral guardian and motor of public health prompted significant changes in the management of reproduction. The emergence of the hospital maternity ward and formal schools for midwives was the most obvious expression of these changes in medical and political thought during the era of the Enlightenment. Although orphanages and foundling homes had long been focal points of Catholic charity in Italy, the provision of maternal welfare on a broad scale only emerged in the context of the growth and centralization of state administrations in the eighteenth century. At the same time, migration patterns and changing legal and gender norms tended to weaken the once strong community bonds which had traditionally regulated reproduction and sexual relations on a local level. Public maternity wards served women who might previously have been able to rely on a local network for support and to hold the father of an illegitimate child accountable. By the eighteenth century, however, a Catholic Church intent on preserving family integrity and secular governments which increasingly privileged male autonomy and exculpated fathers of illegitimate children combined to leave single mothers dependent on new public institutions, such as the hospital maternity ward, where they could give birth anonymously and abandon the newborn if necessary.

In conjunction with these societal transformations, the medical profession itself demonstrated a newfound confidence and interest in intervening in the traditionally feminine realm of childbirth. Supported by centralizing governments intent on preserving and growing their populations through the protection of maternal and infant welfare, medical men made
strident claims to their superiority in the management of childbirth as a result of their formal education and a superior understanding of anatomy. While traditional midwives based their expertise on experience and their own personal knowledge of childbirth, male practitioners countered this type of knowledge with a conviction in the masculine epistemology of objective, rational science. Through midwifery manuals and other emerging forms of scientific writing, such as the medical journal and the lecture, physicians and surgeons sought to demonstrate their vast anatomical knowledge, emphasize the (generally little) practical experience they did have, and articulate a vision of childbirth which was no longer dependent on women’s subjective and physical experiences of their own bodies. Obstetrical models and anatomical drawings, which were representative of precisely this kind of scientific epistemology, were used increasingly during the eighteenth century to educate midwifery students, both male and female. Additionally, as midwives came under stricter control by the medical profession, their professional activity was correspondingly circumscribed. Not only were midwives prohibited from the use of any kind of surgical tools during deliveries, but their expertise in the legal sphere was devalued as male experts were increasingly favored to testify in cases of rape, infanticide, incest and other kinds of sexual offenses.

The above story of the masculinization and medicalization of childbirth is the one that students of the history of medicine and gender are most familiar. However, this dissertation has also revealed a parallel story of resistance, adaptation, and negotiation. Midwives and mothers in Turin, Milan, and Venice often found ways to challenge the initiatives of state reformers and medical practitioners. Despite legal requirements to do so, many midwives eschewed the process of licensing and formal instruction completely, sometimes with the sanction of a parish priest. The widespread preference of community members for traditional over formally trained
midwives represented another kind of resistance to the intervention of outside forces in an intimate process long regulated and managed locally. Some midwives, though more rarely, willingly enrolled in courses of formal instruction but then petitioned for an expansion of the sanctioned activities allowed to female practitioners (to include, for instance, the use of surgical tools). Furthermore, the elite surgeons who taught the first Italian midwifery courses, men who interspersed Latin into their medical treatises to emphasize their university training, often were constrained to use their students’ own colloquialisms and dialects in discussions of anatomy and physiology. Traditional modes of training, such as apprenticeship with a senior midwife, also remained essential to midwifery education, even after formal courses were instituted. Male birth attendants, though there were always fewer of these in Italy than in the urban centers of countries like France or England by the close of the eighteenth century, as a body tended to be conservative with their use of instruments. Perhaps because they were never in a position – nor seemed to desire - to challenge female midwives on any kind of grand scale, Italian men-midwives did not feel the need to distinguish their practice so starkly from that of the traditional midwife.

Savoy, Lombardy, and the Venetian Republic shared many continuities with respect to the medicalization and institutionalization of childbirth in the eighteenth century. There were, however, notable distinctions. The implementation of a maternity ward in Turin was arguably a purely social, rather than medical, intervention. Initially, the reform measure was an expression of paternalistic munificence on the part of the Savoyard king, and was aimed to alleviate a particular social ill (i.e. the desperate unwed mother) which had emerged acutely due to the breakdown in traditional community forms of support and regulation. Indeed, the founding documents of the maternity ward/midwifery school project in Turin emphasized the ward as a
locale for the protection of female honor. Even some years later, the hospital board of governors recognized that the establishment of the maternity ward had been successful at reducing the number of infanticides. Although the training of female midwives was a stated goal of the project early on, little mention of making childbirth safer or more scientific is ever mentioned. Perhaps unsurprisingly then, there are strong continuities between this eighteenth-century public space for childbirth and the many asylums and refuges for fallen women which were established in Italy in the context of the Counter-Reformation. Like the latter, the maternity ward in Turin had as its expressed aim the moral and religious rehabilitation of women whose physical status seemed to indicate a personal and spiritual failing. While the protection of female honor indicated by the establishment of a maternity ward was now at the behest of the state, rather than the Church, there was much in common structurally and ideologically between these two kinds of institutions.

In Turin, then, efforts to train midwives were secondary to the maternity ward itself, at least in the first half of the century. Because Turin lacked at this time a strong university tradition or a powerful medical corporation, it is not surprising that these early impulses in the realm of maternal welfare were not the result of pressures from the scientific or medical communities. Unlike the midwifery schools in Milan and Venice, which were directed by elite male surgeons from the start, the midwifery school in Turin was run initially by the maternity ward’s head midwife. The only direct male involvement in terms of instruction came from a surgeon who was to provide anatomical demonstrations to the student midwives twice a year (a final exam was also administered by men). Even though the first head midwife was herself trained at the Hôtel-Dieu in Paris, at the time the most advanced center of obstetrical training, she was later replaced over territorial disputes between the hospital board and the Savoyard royal representative. Her
replacement was local and trained internally, suggesting that as yet the introduction of the most scientific midwifery training was not the highest priority of reformers in Turin. Even after the midwifery school in Turin became ‘medicalized’ in the 1760s (when the medico-chirurgo Ambrogio Bertrandi was nominated as director of the school in 1760 he greatly reorganized the curriculum, introducing obstetrical models and midwifery manuals as part of the course), male involvement in childbirth in the Kingdom of Savoy remained extremely limited. In the last decade of the eighteenth century, only six male surgeons were provided with a special license permitting them to practice obstetrics.

Milan and Venice, by contrast, shared a more parallel development with respect to the medicalization of childbirth in the second half of the eighteenth century. In conjunction with the emergence of similar programs in many parts of the Italian peninsula from about 1760 on, Milan and Venice both established formal midwifery schools under the direction of male surgeons. Such schools arose in cities like Florence, Bologna, Verona, Rovereto, and Arezzo, typically within a few years of the introduction of university courses in obstetrics aimed at male surgeons. In the same period, male practitioners across Europe were in effect creating the field of obstetrics through a massive print campaign. Midwifery and obstetrical manuals; treatises on particular childbirth complications, procedures (such as cesarean section), and diseases; and midwifery lectures were all published in Italy (and across Europe) with increasing frequency during the second half of the eighteenth century. Through such media, medical men made claims to their superiority over women in the realm of childbirth owing to their advanced, scientific training in anatomy and generally greater understanding of the physiological functionings of the body. In print, men could counter accusations of inexperience by emphasizing those cases at which they had been present, and, in particular, those which had required the use of ‘art’ to produce a
successful outcome.

If the ultimate result of this interest in childbirth on behalf of the medical profession was not, at least in Italy, a full scale takeover of the profession of midwifery, there were noted increases in male intervention and oversight of the field. The establishment of male-run midwifery schools was perhaps the clearest expression of this. A gradual erosion of the authority held by midwives in the public and legal sphere was another result – increasingly midwives were prohibited from providing expert testimony in cases of rape or infanticide in favor of (male) surgeons and physicians. In cities like Milan and Venice (and Turin, for that matter), midwifery schools were also envisioned to be the key to an effective system of midwifery licensing, controlled ultimately by the universities or the protomedicato. While neither the secular governments nor the medical professions in either Milan or Turin had shown any interest in licensing or regulating midwives prior to the second half of the eighteenth century, Venice, with its long history of innovative public health policy, had made some efforts to regulate midwives as early as the first quarter of the seventeenth century. Indeed, Venice had demanded that its midwives be examined as early as 1624, and by 1689 required midwives who wished to be licensed to be familiar with Scipione Merurio’s midwifery manual, *La Commare o Raccoglitrice* (1595) and to attend anatomical demonstrations. Venice was in fact quite unusual in these early efforts (the Kingdom of Naples, with a medical system influenced much by the Spanish system mentioned above, was another example of an Italian state with early attempts to license midwives), and likely reflective of the city’s well-run and expansive public health office. Nevertheless, because these early regulatory efforts did not derive from the interests of medical professionals, but rather from city officials, they should be seen as separate from the city’s later efforts to formally instruct midwives.
In the same period, Milan under Spanish control did not seem inclined to transplant the type of centralized medical regulation which had been established in Castile from an early date into its own governing structure. Nevertheless, Milan, from at least the early sixteenth century, was home to one of the few charitable refuges in Italy which offered recovery to pregnant women whose honor had been compromised. While the Ospedale di San Celso was unusual in accepting pregnant women, it fit within the Catholic charitable tradition of asylums for fallen women which were prevalent in Italy, particularly in the era of the Counter Reformation. The fact that the recovery at San Celso was eventually transferred to the Ospedale Maggiore and combined with the midwifery school there suggests the same kinds of continuities between the institutionalization of childbirth in the eighteenth century and earlier women’s asylums which were evident in Turin. Only in the context of the Enlightened Absolutism of the Austrian empire under Maria Theresa, however, did Milan attempt in any way formally to control the practice of midwifery. Following the concept of ‘medical police’ devised by Johann Peter Frank, who himself took a direct role in the midwifery school project in Lombardy, Milanese reformers considered the advancement of more scientific childbirth techniques and the stricter regulation of midwifery as essential to the proper ordering of the state and the promotion of public health.

Unlike in Turin several decades before, the stated goals of the midwifery school in Milan were therefore to advance the most scientific practice of midwifery across Lombardy so as to preserve the life of mothers and ‘future citizens.’ This kind of populationist language had been absent in the founding documents of the Turin project, but became common in statues issued in the second half of the eighteenth century.

As would be the case in Savoy, Lombardy, and Venice, the impact of formal midwifery education programs and their attendant licensing schemes always fell well short of the ambitious
goals of the reformers and medical men who had devised them. Although broad minded reformers wished to extend midwifery education and the new scientific knowledge of childbirth far into the provinces, the enforcement capabilities of any of these early modern states was limited. The reformers were placed in a difficult position in any case: even if all unlicensed midwives could have been effectively identified and controlled, it would have been impossible and reckless simply to ban large numbers of midwives, who were of course needed to serve the women in their local communities. From the start, then, many long-practicing midwives were allowed to continue working, with or without formal training. At the same time, the passive resistance of many midwives who simply refrained from enrolling in midwifery schools or appearing for licensing inspections was sustained by the widespread preference of local women for traditional midwives. For many mothers, a license or course certificate meant less than a midwife’s years of experience and local endorsements. Partly because the midwifery schools were especially intent on training younger women, regardless of their own experience (or lack) of childbirth or years of apprenticeship, many potential clients were wary of this new kind of ‘scientific’ midwife who contrasted quite radically with the figure of the mature midwife who had long been a familiar and intimate community figure.

The greatest impact of increased midwifery regulation was surely felt in the cities themselves, where a relatively high percentage of active midwives were licensed and formally trained by the end of the century. In provincial areas of all three states, however, there was often very little change as a result of the midwifery school and maternity ward campaigns. Local contexts could, furthermore, determine quite significantly how much of an impact the midwifery school programs would have. A parish priest who advocated on behalf of a long-practicing midwife could shield his community from this kind of outside intervention, while one who
reported the abuses of unlicensed practitioners might instead reinforce the new expectations about training and education of midwives.

In all three of the states considered in this study, and indeed in Italy more generally, the role of the Catholic Church should not be underestimated as a unifying force. In terms of childbirth, the Church had a long established tradition of intervention and regulation. As early as the 1200s, for instance, synodal decrees mandated that midwives be instructed in the baptismal rite so as to be able to administer the sacrament in cases of emergency. The midwife’s important spiritual duty in this regard remained one of the justifications for a close tie between midwives and parish priests throughout the early modern period. Moreover, priests theoretically worked with midwives to enforce the Church’s policies related to abortion, illegitimacy, and infant abandonment.

Particularly in the eighteenth century, new discoveries in the field of embryology gave way to stringent debates over conception, animation, and fetal development in which the Catholic Church was a vocal participant. Because some of these discoveries were seen to suggest that life began at conception (as opposed to the long-accepted belief, based upon Hippocrates and Aristotle, that there was a period of several weeks between fertilization and animation), they held profound meaning for the Church’s outlook on and involvement in the emerging field of obstetrics. Indeed, the Church sanctioned an aggressive attitude toward cesarean section and began to advocate in favor of the life of the fetus at all costs, even if that meant compromising the life of the mother. By mid-century, several Catholic moralists, such as Francesco Cangiamila, were writing treatises which stressed the importance of baptizing any fetus that was potentially alive – whether in utero or not – and detailed the procedures for baptism in a variety of different childbirth outcomes. Although such authors generally acknowledged that the cesarean operation...
was properly the work of the surgeon, they argued that in his absence a midwife (or a parish priest for that matter) should be instructed in and ready to perform the procedure as well. In this respect, the birth policies advocated by Enlightened clergymen aligned well with the populationist interests of the secular governments at the time. As Cangiamila had begun to write of the fetus as a child even at the moment of conception, a baby deserving of being saved eternally, some secular reformers, like Johann Peter Frank, for the first time articulated a vision of the fetus as a future citizen endowed with rights. Thus the initiatives to establish midwifery schools were supported wholeheartedly by Catholic moralist clergymen who saw the advanced training of midwives as key to the salvation of infant souls, and a greater oversight of midwives as the critical means to reduce sinful acts like abortion and infanticide. The Catholic Church in Italy was therefore an advocate of maintaining women rather than men as birth attendants at the same time that it actively encouraged greater control over midwives’ practice and the medicalization of women’s bodies as a way of achieving spiritual ends.

Despite their diverse ruling structures and degrees of foreign influence, the Kingdom of Savoy, Austrian Lombardy, and the Venetian Republic all developed policies toward maternal welfare and the practice of midwifery which aligned quite closely by the second half of the eighteenth century. Secular reformers in all three regions advanced pro-natalist programs with the intent of growing populations and strengthening their states. To varying degrees, government officials in Turin, Milan, and Venice also began to see the tutelage of female honor and the management of reproduction as a prerogative of the state. At the same time, religion and medicine combined to medicalize women’s bodies in new ways, particularly with respect to childbirth. More than elsewhere in Europe or North America, in Italy this renewed religious influence on the development of medicine and science had profound repercussions for the
management of childbirth. The interests of Enlightened bureaucrats, medical practitioners, and moralist clergymen in Italy thus converged in ways which both protected women as rightful birth attendants and subjected female bodies to a greater degree of medical supervision and intervention. This dissertation has sought to identify these three parallel influences as they existed in different times and places in northern Italy over the course of the eighteenth century, and to suggest that there was indeed a particularly ‘Italian’ approach to the management of childbirth in the early modern period.
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