Reflection

The woman physician as antidote to the ills of modern medicine

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This article, drawing on the work of Edith Stein, reflects on the feminine aspects of the medical profession, specifically attention to the whole person and personal accompaniment. It presents these feminine aspects, in light of the mechanistic, highly specialized, and often impersonal ethos of modern medicine, as a needed corrective to such an ethos. Finally, this thesis is illustrated with an example from physician Victoria Sweet.

Keywords: Modern medicine, Women physicians, René Descartes, Edith Stein, Victoria Sweet

INTRODUCTION

Is medicine a feminine profession, or is there a feminine way of practicing medicine, distinct from a corresponding masculine way? The question might also be framed in terms of feminine and masculine contributions to the practice of medicine. However, difficulties appear as soon as the question, in whichever form, is posed. Is it not sexist to isolate masculine and feminine aspects of a profession? How could this fail to limit in some way women's (or men's) participation in that profession? A more radical objection comes from those persons to whom any binary division between male and female seems hopelessly backwards. Nonetheless, if such persons are willing to consider what might be gained through attention to the specific contributions of women and men, they may at least begin to understand why some are so unwilling to abandon it. To those who fear that emphasizing the

feminine contribution in any sphere tends to limit or degrade women, I suggest that this only follows if the feminine contribution is presumed to be less than the masculine contribution, or if the masculine and feminine are presumed to be in a competitive rather than a collaborative relation. The only way either to confirm or to discount such fears is to understand what the specific contributions of men and women are thought to be, both in general and within the context of a specific profession, how they are thought to complement each other, and why they are thought to be necessary to the practice of a profession—in this case, of medicine. In the early 1930s, philosopher Edith Stein (St. Teresa Benedicta of the Cross, 1891–1942) suggested that “the medical profession has turned out to be a rich area of genuine feminine activity” (Stein 2017, 110).¹ The present article supports Stein's thesis, arguing that not only is medicine a “rich area of genuine feminine

activity,” but also that a genuinely feminine activity within medicine is a needed counterbalance to the way that medicine is practiced today.

We will begin with the diagnosis: medicine as it is practiced today, thanks to the immense success of the mechanistic approach to the human body, is in one sense flourishing more than ever. Yet the advent of the field of bioethics, the burgeoning of medical malpractice suits, the popularity of alternatives to mainstream medicine, and the disorientation that many patients feel in navigating their own health care, are signs that all is not well.

MECHANISTIC APPROACH TO THE HUMAN BODY AND ITS EFFECTS ON MEDICINE

The practice of medicine today is marked by the mechanistic and experimental approach of modern science, an approach that can be traced back to the thought of Francis Bacon and René Descartes. In the sixteenth century, Francis Bacon attempted to found a new science that would use experimentation to force nature to reveal her secrets, “for the nature of things is better discovered by the torturings of art, than when they are left to themselves” (Bacon 1901, 27). In the same century, Descartes correctly foresaw the benefits that would accrue to medicine by embracing his mechanistic view of the body (Descartes 2006, nos. 62–3). Pre-modern physiology understood the human body as an animated body, as ensouled matter. The soul (*anima*) was the life principle in the body, which possessed by its nature certain powers or faculties: that is, the potential to act or be acted upon in certain ways. Illnesses were identified by means of an imbalance in one of the four humors in the body. This view of physiology, inherited from Galen and Aristotle, reigned throughout the Middle Ages and into the Renaissance (Hall 1972, xxvii).

Cartesian physiology rejected this entire picture in favor of corpuscular mechanism, the “major assumption [of which] is that the physical properties of bodies are reducible to the properties of matter” (Hall 1972, xxix). In order to understand the human body, or any other living body, it was not necessary to refer to a soul and its faculties. Rather, physiology was to be described “in terms of matter in motion” (Hall 1972, xxxv). The body was a mechanism, powered, Descartes thought, by the heat produced in the heart (see Descartes 2006, Part 5).²

Neither Bacon nor Descartes achieved much in the way of explaining particular physiological phenomena according to their methodologies. However, their general approach has undoubtedly prevailed.³ With the application of experimental and mechanistic methods to the study of the human body, the practice of medicine has developed in a way that seems to confirm the hope Descartes expressed in his *Discourse on the Method* of making men “the lords and masters of nature” (Descartes 2006, 47). Such mastery, he goes on to say,

is desirable not only for the invention of innumerable devices which would facilitate our enjoyment of the fruits of the earth ... but also, and most importantly, for the maintenance of health, which is undoubtedly the chief good and the foundation of all the other goods in this life. ... If it is possible to find some means of making men in general wiser and more skilful than they have been up till now, I believe we must look for it in medicine. (Descartes 2006, 47)

Descartes’s optimism regarding the future of medicine was not to be fulfilled for several centuries, but in the last century we have seen the fruits of his mechanistic turn in the great technical advances of medicine. Along with these advances, however, has come a growing discomfort

with some aspects of modern medicine and medical technology. The field of bioethics was born in response to this discomfort, and with it the emphasis on patient autonomy.⁴ One of the practical results of the emphasis on patient autonomy has been the commoditization of medicine. The view of medicine as a commodity, with the patient as autonomous consumer and the physician as paid provider, has been astutely and accurately critiqued by Catholic bioethicist Edmund Pellegrino, who argues that “substituting words like ‘consumers’ for patients, ‘providers’ for physicians, ‘commodities’ for healing relationships, or speaking of health care as an ‘industry,’ or of ‘product lines’ or ‘investment opportunities’ inevitably distorts the nature of healing and helping” (Pellegrino 2008, 114). Yet, consumerism in medicine cannot simply be dismissed as a negative outgrowth of materialism. It is also a reaction against a style of medicine that would see the patient as a technical problem to be solved, as mere matter to be manipulated by the physician with his multitude of technical instruments.

Against such an ethos, the patient says: “No; I do not exist to serve the good of medicine. Medicine exists to serve my good. The physician, as the concrete embodiment of medicine for me, is to serve my good.”⁵ The patient is now in control of the direction of his medical care; he is autonomous consumer. It is his good that is being served by the medical professional (or “provider”). In this way, the consumerist model of medicine reasserts the primacy of the patient’s good against the tendencies to be carried away by technique and the desire to advance the fund of medical knowledge. Putting the patient in control of his medical care by making him the “consumer” may thus be a corrective, but only a limited one. The most obvious limit is the patient’s own ignorance. The reason he goes to a physician in the first place is that he lacks the science

and the skill needed to understand and treat his own body. Even more importantly, the consumerist/autonomy-based approach to medicine is limited because it presupposes the very way of thinking about medicine against which it reacts.

The mechanistic and the consumeristic models share a common assumption, that is, that medicine is essentially a *technê*, a craft. Aristotle defines *technê* as “a certain state involving reason concerned with production” (Aristotle 1999, bk. 6, chap. 4, 1140a7). One who possesses *technê* possesses skill in making some sort of product, combined with knowledge about the product and the process of making it.⁶ Classically, however, crafts such as carpentry or masonry were distinguished from professions. Philosopher Robert Sokolowski argues that the professional is distinguished from the craftsman not so much by the possession of useful knowledge, since craftsmen also possess this, but by the fact that the knowledge the professional possesses and shares with another pertains to that person himself, and not just to his possessions. For example, Sokolowski says,

If I go to an automobile mechanic, all I entrust to this person is my automobile, but when I approach a professional, I subject something more than a possession of mine to the professional’s expertise: in a distinctive way, I subject myself and my future to his or her assessments and to his or her judgement. (Sokolowski 1991, 27)

Hence the practical knowledge required by the professional goes beyond *technê* into the realm of what Aristotle calls *phronêsis*. *Phronêsis* or prudence, like *technê*, is a practical form of knowledge, but unlike *technê* it is directly related to the moral life; Aristotle defines it as “a state grasping the truth, involving reason, concerned with action about things that are good or bad for a human being” (Aristotle 1999, bk. 6, chap. 5, 1140b5). The professional does not share just any practical knowledge

with his client; he shares his knowledge about how to live well, with respect to one or another aspect of the good life. Thus, Sokolowski concludes that professions (such as medicine) are fiduciary in nature; they are based on a relationship of trust.

The mechanistic view of medicine thinks about the body as a thing to be worked on, as the automobile is worked on by the mechanic; the consumerist view thinks about medicine as a product to be selected from a variety of different options. Both views think of medicine primarily as *technê*, as human activity directed toward a product. The only difference is whether the product is viewed from the perspective of the producer or the consumer. Missing from both views is the understanding of medicine as a relationship of trust between two persons. For the patient does not merely entrust some “thing” to the physician, but his own person; hence, the need for the relationship between them to be based not merely on technical acumen or on the leveling power of the market, but on trust in a person who possesses scientific knowledge, practical skill, and moral goodness: in other words, on a person who both knows and loves the patient in his care.

WOMAN’S NATURE AND VOCATION

In her talk “The Ethos of Women’s Professions,” Edith Stein discusses the idea of a “feminine profession” as an outgrowth of the natural vocation of woman. By “natural vocation,” Stein means the calling that belongs to woman not by virtue of her individual gifts, but by virtue of her nature as woman (Stein 2017, 44–7). This point is easily misunderstood: to say that woman is by nature called to be wife and mother is not to say that all women must be wives and mothers, nor to say that other callings are somehow inappropriate or ad hoc with respect to women. Rather, the natural

vocation of woman is based on the idea that human beings possess, in addition to those characteristics that belong to them as human (for example, rationality), a set of individual characteristics, both innate and acquired, which will tend to lead them toward certain kinds of activities, responses, and attitudes, and away from others. Some of these characteristics are based on individual temperament, others on upbringing and culture.

In between the characteristics shared by the species as a whole and those particular to individuals, we also find characteristics common to men as men and to women as women. Woman’s nature, body and soul, is oriented toward receiving from another, and toward gestating and nurturing new life.⁷ The “spiritual attitudes” oriented toward this goal are twofold. First, Stein writes,

Woman naturally seeks to embrace that which is *living, personal, and whole*. To cherish, guard, protect, nourish, and advance growth is her natural, maternal yearning. Lifeless matter, the *fact*, can hold primary interest for her only insofar as it serves the living and the personal, not ordinarily for its own sake. (Stein 2017, 45)

An “orientation to the whole,” especially the whole human person, is the first attitude belonging to woman’s natural vocation. One of the consequences of this attitude, Stein adds, is that “*abstraction in every sense* is alien to the feminine nature. The living and personal to which her care extends is a concrete whole and is protected and encouraged as a totality (Stein 2017, 45). Clearly, woman is capable of abstract thought. It is not in this sense that abstraction is alien to her nature. Rather, it is alien to her to remain in abstraction, or to treat abstraction as an end in itself. Woman’s “theoretical and ... practical views correspond,” Stein continues, and her “natural line of thought ... is directed intuitively and

emotionally to the concrete” (Stein 2017, 45). This tendency aids her in the nurturing of new life within the family.

Stein describes the second attitude or characteristic proper to woman’s natural vocation as the “gift of companionship”:

It is [woman’s] gift and happiness to share the life of another human being and, indeed, to take part in *all things* which come his way, in the greatest and smallest things, in joy as well as in suffering, in work, and in problems.... It is natural for woman, and she has the faculty to interest herself empathetically in areas of knowledge far from her own concerns and to which she would not pay heed if it were not that a personal interest drew her into contact with them. (Stein 2017, 46)

This characteristic plays an important part in family life, allowing woman to participate in the interests and activities of her spouse and children, accompanying them in their affective, intellectual, and spiritual progress.

The characteristics proper to woman in her natural vocation are also found in certain professions, which Stein calls feminine professions:

This would mean all vocations depending on sympathetic rapport such as nursing, education, and social work ... the vocation of doctor and nurse, teacher and governess, housemaid, and the entire range of contemporary social services. In scholarship it would be those branches dealing with the concrete, living personal element, i.e., the arts and positions wherein one may help and serve, such as translating, editing, and, possibly, guiding a stranger’s work appreciatively. (Stein 2017, 49)

In general, professions that demand the exercise of “the same spiritual attitude which the wife and mother need” are feminine professions, wherein this spiritual attitude “is extended to a wider working circle and mostly to a changing area of people” (Stein 2017, 49).

Stein does not understand the feminine professions to be limited to women, just as she does not understand the typically masculine professions to be limited to men. Sex does not dictate the choice of activity; women as well as men are free to take up whatever work for which they are qualified and which is available to them. Often, in fact, the choice of work is determined more by availability and opportunity than by any other factor. Nonetheless, some professions rely on aptitudes which women tend more characteristically to possess, and virtues which they tend more easily to acquire, precisely because these characteristics and virtues are the ones needed for the natural feminine vocation (Stein 2017, 49). Woman’s nature, when not obstructed or overruled by other factors, will make itself felt in her choice of work. There is nothing surprising about this; individual and cultural attitudes and dispositions also make themselves felt in the choice of work, where there is a choice.

In her catalog of “feminine professions,” Stein includes the vocation of doctor (as well as of nurse). We will now consider the basis for identifying the medical vocation in general as a feminine vocation, with particular attention to the practicing physician.

MEDICINE AS FEMININE PROFESSION

As noted above, to say that a profession is feminine is to say that it draws on attitudes also required of woman’s natural calling. In what ways, then, is the vocation of physician similar to the vocation of wife and mother? First, the physician, like the mother, is called upon “to cherish, guard, protect, nourish, and advance growth” in “that which is living, personal, and whole” (Stein 2017, 45). In her practice of medicine, it is alien to woman’s nature to treat her patient as a diagnosis (an abstraction) or not to perceive and attend to the emotions that her patient experiences, for

example, in considering the choice of a particular treatment. Stein writes:

The human being, especially the invalid, needs sympathy in his total condition. The widespread method of modern specialization does not satisfy this need in treating a limb or an organ while disregarding the rest of the person, even though the specific treatment is pertinent.... Counteracting this abstract procedure, the specifically feminine attitude is oriented towards the concrete and whole person. The woman doctor has only to exercise courage in following her natural inspiration and liberating herself whenever necessary from methods learned and practiced according to rule.... It is not only a question of summoning up the patience to listen to much which is absolutely irrelevant to the subject. The intent must be to understand correctly the whole human situation, the spiritual need which is often greater than the corporal one, and perhaps to intervene helpfully not only by medical means but also as a mother or a sister. (Stein 2017, 111–2)

Second, the physician must be ready to accompany her patient, “to interest herself empathetically” (Stein 2017, 46) in whatever her patient does and suffers, as a woman does with her husband and children. Pope Francis recommends this sort of disposition, this “art of accompaniment,” to those responsible for the spiritual good of others; what he says can also be said of those responsible for others’ physical well-being. The “art of accompaniment,” Francis says, “teaches us to remove our sandals before the sacred ground of the other (cf. Ex 3:5)” (Francis 2013, no. 169). Its pace “must be steady and reassuring, reflecting our closeness and our compassionate gaze which also heals, liberates, and encourages growth” (Francis 2013, no. 169).

The art of accompaniment requires the associated art of listening, “which is more than simply hearing,” as the pope notes (Francis 2013, no. 169). For the physician,

listening means not only hearing what the patient says, but also what he does not say; it means perceiving his tone and posture, as well as the words themselves; it means listening “to much that is absolutely irrelevant to the subject” (Stein 2017, 112), but which develops a trusting relationship. By such “respectful and compassionate listening” (Francis 2013, no. 171), which requires openness, patience, and time, the physician can gain the trust of her patient and often arrive at a more accurate diagnosis and more complete healing.

In an extended sense, listening and accompanying can also describe the physician’s attitude to nature itself. For the medical art does not replace the operations of the human body, but assists them. The agent of medicine, the physician, is nature’s assistant (*ministra naturae*).⁸ She attends (listens) carefully to what nature is doing in the body of her patient, and she follows (accompanies) nature’s activities, removing obstacles to the full exercise of nature’s own potential. One might even say that the good physician “obeys” nature, drawing on a traditional etymology of “obedience” from the Latin *ob-audire*, “to listen to.”⁹

This does not mean that the physician is a slave to nature, still less a slave to the patient’s will. Her medical science (knowledge) gives her an understanding of nature that allows her some measure of control, and yet she uses this control most effectively precisely by attempting to work with, and not to replace, the workings of nature. With regard to serving the patient’s will, the physician is at the service of the patient’s good, not of the patient’s immediate wishes. Hence, the physician must sometimes oppose the patient’s wishes, for the patient’s good. When the patient is a competent adult, the physician shares her understanding with the patient, with the aim of serving the patient’s good, and the patient ultimately decides whether, for example, he will take a particular treatment. The physician must

accept this decision and seek to work within the patient's understanding of things, as much as she can (without of course violating her own conscience).

The vocation of medicine, then, requires the same dispositions that belong to the vocation of woman according to nature, which we have identified as attending to the whole and accompanying. Medicine is then what Stein calls a "feminine profession," that is, "a profession in which woman's soul comes into its own and which can be formed by woman's soul" (Stein 2017, 57). On the other hand, the whole tendency of medicine toward ever greater dominion over nature through science and technology (and the specialization through which such dominion is achieved) suggests a more masculine attitude. Thus, we have two tendencies in medicine: the tendency to focus on the individual patient as a sick person in need of care, and the tendency to focus on the use of medical knowledge and technique to control nature. Though both tendencies have their place in medicine, the former is primary. After all, the desire to control nature is ultimately motivated by health, if not the health of a particular patient, then at least the health of future patients. In other words, medicine's *telos*, its defining end, is health: the reason that medicine exists is because there are sick persons to be healed. Therefore, the achievement of healing is the ultimate criterion by which medicine is evaluated.¹⁰ There is good reason, then, for calling medicine a feminine profession, since to direct one's own personal resources to the good of another is precisely what characterizes the natural vocation of woman.

What is true of the profession is also true of individual professionals. For the individual physician, male or female, an emphasis on the scientific, rational ethos of the profession must be balanced with, and indeed at the service of, attentiveness to the person and a willingness to listen to and accompany

him. The demands on the woman physician are no different from the demands on her male colleague. Nor is it simply that she will find it easier, because more natural, not to forget the personal dimension of her profession. In fact, given the ethos of contemporary medical education, it may require considerable courage for her to exercise rather than to suppress her desire to develop a personal relationship with her patients and to accompany them throughout their sickness. Yet, in allowing these characteristics to develop within her practice of medicine, without neglecting the scientific and technical requirements of the profession, the woman physician becomes not only an excellent practitioner, but also a sign. Where the profession has given in to tendencies toward ever-greater efficiency and scientific progress, to the neglect of the good of persons, the woman physician may have to be a sign of contradiction. More positively, she will be everywhere a sign of the beauty of the medical vocation, of being called to use her knowledge and skill and energy to serve the good of another.

ILLUSTRATION AND CONCLUSION

A contemporary illustration of practicing medicine in the way previously outlined, without sacrificing the benefits of modern medical technique, may be found in the work of the physician, historian, and author Victoria Sweet. In her account of practicing medicine at Laguna Honda, the last almshouse in America, Dr. Sweet describes the effectiveness of that hospital's "slow medicine" (Sweet 2012).¹¹ The hospital (during the time she narrates) did not have all the most recent technology and resources, although it had what was necessary. The building itself was old and somewhat run down, and in many ways out of line with contemporary ideas of what a hospital should be. For example, the beds

were mostly arranged in common wards, with few private rooms. What made the medicine practiced there effective was in large part the pace. Both doctors and nurses were able to get to know their patients personally, as the patients were able to stay at the hospital as long as needed, and could be seen on a daily basis. This allowed doctors to observe, diagnose, and treat patients over time. One effect of this slower pace was that doctors could prescribe fewer and more appropriate medications. Sweet relates:

Almost every patient I admitted had incorrect or outmoded diagnoses and was taking medications for them, too. Medications that required regular blood tests; caused side effects that necessitated still more medications; and put the patient at risk for adverse reactions. Typically my patients came in taking fifteen to twenty-five medications, of which they ended up needing, usually, only six or seven. (Sweet 2012, 142)

In addition, what Sweet calls “unassigned time” allowed for doctors and nurses to get to know their patients, not just their patients’ diagnoses (Sweet 2012, 85). Sweet found that the slow pace of medical practice at Laguna Honda led to more accurate diagnoses and better care, and sometimes to extraordinary healings. For example, one patient, a 37-year-old drug user and prostitute, diagnosed with transverse myelitis, came with a severe bedsore, an open, infected wound stretching “from the middle of her back all the way down to the tailbone”; the wound was so deep that Sweet could glimpse the woman’s spine (Sweet 2012, 105). With her other medical problems and her life situation, the prognosis was extremely poor. At the other local hospitals, the woman would have received surgery to address the wound and been sent on her way, as had already happened (in fact, the surgeons

now refused to operate on her again, because she would not or could not take care of herself after surgery). However, because this patient was able to remain at Laguna Honda for some two and a half years, under the watchful but low-tech care of doctors and nurses, she healed gradually, without any additional surgery (Sweet 2012, 105–8).

Although Sweet does not frame her solution in terms of the feminine perspective,¹² it is worth noting that her main inspiration, apart from her practice itself, is a medieval nun, St. Hildegard of Bingen.¹³ The negative aspects of modern medicine are precisely the effects common to the unbalanced development of man’s ethos: the drive for knowledge becoming a one-sided specialization, the desire for objectivity becoming an impersonal or even dehumanizing attitude, and the desire to exercise dominion deteriorating into domination (see Stein 2017, 71–3). These tendencies are counterbalanced by woman’s attention to the personal and the whole and her sympathetic accompaniment of other persons. In the practice of medicine, the modern ethos has allowed man’s drive for knowledge and dominion to develop without check, so that mankind might become “the lords and masters of nature,” as Descartes put it (2006, 47), and most especially the lords and masters of the human body itself. The original vocation of medicine, however, is not so much to become the lord of nature as nature’s minister. The physician is more handmaid than master. The woman physician, through her attention to the whole person and her patient accompaniment of others, can be a sign of the original purpose of medicine and a concrete example to all medical professionals of what it is to integrate the best scientific and technical insights with this primary calling. Medicine today needs the contribution of women, not only as technically proficient

and scientifically trained physicians, but precisely as women physicians.

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NOTES

1. Stein herself was trained as a nurse during the First World War and served in a field hospital in Austria (Stein 2016, 318–67).
2. In Part Five of the *Discourse on the Method*, Descartes explains in some detail his understanding of the operation of the heart (Descartes 2006). His explanation turns out to have been incorrect, but the text illustrates well his approach to problems of physiology. See also Hall (1972, xxvii).
3. Bacon himself made few experiments. His explanation of the physiology of the heart, for example, was a creative application of the notion of “trepidation” from ancient astronomy: “It is the motion of an (as it were) eternal captivity; when bodies, for instance, being placed not altogether according to their nature, and yet not exactly ill, constantly tremble, and are restless, not contented with their position, and yet not daring to advance. Such is the motion of the heart and pulse of animals, and it must necessarily occur in all bodies which are situated in a mean state, between conveniences and inconveniences; so that being removed from their proper position, they strive to escape, are repulsed, and again continue to make the attempt” (Bacon 1902, 265). For further discussion of sixteenth-century ideas about the motion of the heart and blood, see Wallace (1996, 350–5; 396–400).
4. Early calls for a new field of study called “Bio-Ethik” were made in the 1920s and 1930s by German theologian Fritz Jahr. In the United States, the field of bioethics came into its own in the 1970s, especially in response to developments such as the Harvard Commission’s statement on brain death (1968) and the Supreme Court Decision in *Roe v. Wade* (1973) (Gordon n.d.).
5. For the idea of the professional as embodiment of professional knowledge, see Sokolowski (1991).
6. This aspect of knowledge distinguishes *technê* from a knack or purely experiential knowledge. The person with *technê* can teach his craft to another. See Aristotle 1979, bk. 1, 981a15–b9.
7. “Only the person blinded by the passion of controversy could deny that woman in soul and body is formed for a particular purpose. The clear and irrevocable word of Scripture declares what daily experience teaches from the beginning of the world: woman is destined to be wife and mother. Both physically and spiritually, she is endowed for this purpose, as is seen clearly from practical experience” (Stein 2017, 45).
8. “It is as a result of some natural power that curing is accomplished with the assistance of art” (Thomas Aquinas 1963, q. 5, a. 1, ad 5).
9. This etymology is mentioned in the *Catechism of the Catholic Church* (1997, no. 144).
10. Regarding the division of medicine into theoretical (knowledge for the sake of knowledge) and practical (knowledge for the sake of the product, in this case, health), Thomas Aquinas says: “when we divide medicine into theoretical and practical, the division is not on the basis of the end. For on that basis the whole of medicine is practical, since it is directed to practice” (Thomas Aquinas 1963, q. 5, a. 1, ad 4). For a more recent articulation of the primacy of the practical end of medicine, see Sokolowski (1989).
11. Sweet published a narrative of her practice at Laguna Honda Hospital in San Francisco in the book *God’s Hotel* (Sweet 2012). A second book advocating for the kind of “slow medicine” that she found to be so fruitful at Laguna Honda is forthcoming in October 2017 (New York: Riverhead Books).
12. Sweet frames her reflections in terms of a contrast between modern and premodern modes of practicing medicine, but the benefits of the latter mode, which she is able to incorporate into her own practice, are the same as those we have been considering as the feminine aspects of medicine.

13. Sweet's doctoral work on Hildegard is presented in the monograph *Rooted in the Earth, Rooted in the Sky: Hildegard of Bingen and Premodern Medicine* (Sweet 2006). References to Hildegard's work are also incorporated into *God's Hotel*.

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