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## **A1 Humanity and War**

Jacalyn Duffin, Queen's University, Kingston ON, Canada

[duffinj@queensu.ca](mailto:duffinj@queensu.ca)

### *Adapting Humanity in the Cold War*

Following the success of the International Geophysical Year in 1958-59, members of the International Council of Scientific Unions and the International Union of Biological Sciences mused about repeating the collaborative exercise for biological sciences. They were concerned with changing environments, water and air pollution (including radioactive fallout), food productivity, human adaptability especially to transmission of microbes and infectious diseases. Soon they realized that biological cycles require a longer span of observation than physical sciences. Consequently, the International Biological Year grew into a Program (IBP), which ran for the decade, 1964 to 1974. It was the precursor for UNESCO's Man and Biosphere program, which still operates in 669 sites in 120 countries around the globe.

With the exception of Frank Greenaway and Toby Appel, few scholars have examined the IBP, although historians of science claim that it helped to raise the visibility of "ecology." Relying on published and unpublished reports, archives, and interviews, this paper will situate the Human Adaptability (HA) arm within the medical history context of its era, focusing on funding and results.

Directed by South African anthropologist, Joseph S. Weiner, IBP-HA sought to address "problems" or "themes," crossing scientific disciplines and national borders to define the global status of human health maintenance. Twelve themes were identified- regionally by climate or geography - or universally, by human biology in terms of growth, fitness, nutrition and genetics. Each collaborative project could address several themes. The products were to be collected in a series of edited volumes although that plan was never realized. Consequently, the products are scattered in a host of unrelated articles – or they were never published at all.

In 1977, Weiner published a list of 232 HA projects from 44 countries, including the USSR and nations behind the Iron Curtain. Database analysis of his list generates a snapshot of anticipated challenges to human existence—on one hand, heralding elements of what would become the social determinants of health and the Sustainable Development Goals – on the other, revealing a glaring absence of interest in microorganisms and the era's false sense of security over the threat of infectious disease.

#### Objectives

1. To recognize the origins and significance of the International Biological Program
2. To explore the difficulties of cross-border collaboration in the Cold War.
3. To identify attitudes to control of infectious disease in the antibiotic era.

## **A1 Humanity and War**

Kishor Johnson, Schulich School of Medicine and Dentistry, Western University, London, Canada

[kjohn243@uwo.ca](mailto:kjohn243@uwo.ca)

*Japanese Biological Warfare and Human Experimentation: An Investigation into Japanese Medical Experiments during World War II and the Subsequent American-Cover Up*

One of the most atrocious crimes against humanity committed during the Second World War was the Japanese Imperial Army Unit 731's Biological Warfare (BW) research program. In fulfilling the aims of the program, which was to test the potential and possibilities of biological weaponry, Japanese researchers conducted medical experiments on human subjects. These experiments ranged from force feeding prisoners with chocolates filled with anthrax to exposing the prisoners to plague infested flea bombs. Rather than prosecuting the Japanese scientists after discovery of the program during the Allied Occupation of Japan, the United States government chose instead to conceal these crimes from the public eye. This demands further investigation, considering the prominent role that the U.S government played in the Nuremburg trials against the Nazis for their war crimes.

With Cold War tensions escalating after the Allied Occupation of Japan, U.S government officials and scientists made it a priority to learn the Japanese secrets of the BW program in advance of the Soviets. While the U.S scientists conducted their own research program at Camp Detrick in Maryland, their BW research was seemingly impeded by the limitations of animal studies. As such, the result of Unit 731's medical experimentation on humans were highly valued.

Drawing largely on recently declassified CIA reports, testimony from the Soviet Union's Khabarovsk War Crime Trials, and the extant secondary literature, this presentation examines the atrocities of Unit 731's BW research and evaluates the controversial medical knowledge gained from the program. The extent to which the U.S government concealed Unit 731's crimes against humanity for their own benefit will also be explored. Although ethical standards in medicine before WWII were not well established, wartime medical practises and experimentation reveal the context in which the pursuit of scientific knowledge or authoritarian power has no boundaries.

Objectives

Key words: human experimentation, knowledge acquisition, cover-up

1. Deepen understanding of illness and suffering
2. Identify successes and failures in the history of medical professionalism
3. Recognize the dynamic interrelationship between medicine and society through history

## **A1 Humanity and War**

Matthew Davidson, University of Miami, Miami, Florida, USA

[mad320@miami.edu](mailto:mad320@miami.edu)

*"To be taken over by the Service d'Hygiene": The Red Cross and the expansion of public health during the U.S. Occupation of Haiti*

On July 28, 1915, U.S. Marines invaded Haiti, beginning what was to be a nineteen-year occupation of the Caribbean country. Shortly after the American Red Cross (ARC) began working there as well. Initially enlisted by U.S. officials to help stabilize Haiti after the invasion caused famine, the venerable charity quickly expanded their operations to include medical activities in addition to food aid. For the next seventeen years the ARC continued to provide medical services in the occupied territory. In so doing, the Red Cross enabled an expansion of Haiti's Public Health Services. Indeed, it was integral to that expansion.

Throughout the occupation, the ARC developed health programs that dramatically enlarged the occupied state's capacity in the field of medicine. The relief organization facilitated immunization campaigns, established a series of clinics throughout the countryside, supported a nursing school, and otherwise bankrolled a significant portion of the Public Health Service's rapid expansion. All of these initiatives were enacted with the idea of catalyzing an expansion of the Public Health Service throughout the country by enabling the Service d'Hygiene (as the Public Health Service was called) to do what it would not have been able to accomplish otherwise. In other words, each of these programs were "to be taken over by the Service d'Hygiene."

The expansion of the Service d'Hygiene was a major boon to the occupation. Public health work is recognized as the one aspect of the occupation that was favourably received by Haitians, so the ARC's assistance significantly helped the U.S. forces secure their hold on Haiti. However, despite being such an important interlocutor, the Red Cross' role has gone overlooked in existing accounts of the occupation. By drawing on ARC records and reappraising other official reports, my paper thus significantly reframes how we understand this important medical feature of occupation, and it calls into question how invested the occupation forces really were in matters of public health. Given that the occupation authorities are often credited with establishing Haiti's "modern" medical system, my paper also challenges how we understand the origins of Haiti's health system.

Objectives:

Keywords: Haiti, Red Cross, Public Health

CME Objectives: 1) Acquire a historically nuanced understanding of the organization of the Haitian healthcare system; 2) Recognize the dynamic interrelationship between medicine and society through history, particularly the ways in which public health is employed as a military technology; and 3) Understand how humanitarian and other non-governmental actors have worked with the state in the field of health and medicine.

## **A2 Research and Technology**

Solveig Jülich, Uppsala University, Uppsala, Sweden  
[solveig.julich@idehist.uu.se](mailto:solveig.julich@idehist.uu.se)

## *Photographing Life Before Birth: Lennart Nilsson and the Rise of Fetal Research in Post-War Sweden*

In 1965 “Life” magazine published “Drama of Life Before Birth”, featuring stunning images of embryos and fetuses by the Swedish photographer Lennart Nilsson. The cover displayed a color photograph of a “Living 18-week-old fetus shown inside its amniotic sac”, and inside the magazine portrayed the stages of human reproduction from conception to birth. This photo-essay was an extraordinary commercial success and gave a major boost to Nilsson’s international career. However, his procedure in photographing these small and inaccessible objects was not clearly explained. Apart from short and vague descriptions the story did not contain anything that informed the readers about how and in what circumstances these photographs had been taken.

Feminist and historical scholarship on Nilsson’s photographs of human reproduction is extensive. However, earlier research has largely focused on the ideological messages of his iconic images of fetuses, often pointing out that the disappearance of the pregnant body in these pictures correlated to the construction of fetal personhood in the United States and Britain.

This paper contributes a fresh perspective by exploring some of the historical contexts and conditions for the making of Nilsson’s fetal imagery. Using visual analysis as well as the methods of social and cultural history, and drawing on the photographer’s work, medical publications, policy documents and interviews I demonstrate how the famous images in Life and the best-selling pregnancy advice book “A Child Is Born” were dependent on Nilsson’s establishment of a network of medical and media partners. A central argument is that Sweden’s abortion legislation as well as the Swedish Medical Research Council’s promotion of fetal research was a crucial precondition for providing him with the human material for the photographs. More specifically I highlight the relation between Nilsson’s work and Swedish endocrinologists’ investigations of the active role of the fetus during all stages of gestation. By collaborating with fetal researchers Nilsson was able to access aborted fetuses used for biomedical research and then reconfigure them into the powerful images of life before birth. Eager to publish spectacular pictures, he was also supported by the major publishing house in Sweden.

### Objectives

Keywords: medicine and the media, fetal imagery, pregnancy, abortion, biomedical research.

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine and biomedical research. 2. Recognize the dynamic interrelationship between medicine, media and society through history. 3. Contribute a historically informed understanding of shifting visual representations of pregnant women and the fetus.

### **A2 Research and Technology**

Peder Clark, London School of Hygiene and Tropical Medicine, London, UK

[peder.clark@lshtm.ac.uk](mailto:peder.clark@lshtm.ac.uk)

*“Status syndrome”?: the Whitehall studies and a new model of stress, c. 1967 - 2006*

The Whitehall cohort studies of British civil servants, running from 1968 until the present day, have been widely acknowledged as some of the most influential in twentieth century public health. While the first Whitehall study brought inequalities in health outcomes to public attention, the second has sought to redefine our understandings of stress and its relationship to work. Consciously investigating the Type A hypothesis – that ‘successful’ men with highly ambitious personalities were more likely to be stressed and consequently suffer heart attacks – Whitehall II concluded that the reverse was true. Those in management positions had lower incidence of heart disease than those in jobs that supposedly had lower pressure and responsibility, lower down the civil service pecking order.

Stress was understood by the researchers to be a potentially harmful emotional state, mediated by the ‘control’ that an individual felt in his or her occupation. The director of Whitehall II, Michael Marmot, corroborated its results with evidence from experimental psychology, arguing in his popular science book "Status Syndrome" that stress was not the unfortunate side-effect of personal ambition but rather a relational response to hierarchical status. Whitehall II attempted to disrupt popular understandings of stress as a primarily male, elite, individualised ‘executive condition’, and posited that it was instead the result of inequalities and the emotional management of the work environment.

This paper builds on recent scholarship by Mark Jackson, Gill Kirby and particularly Debbie Palmer in exploring the cultural and social construction of stress in post-war Britain, and the relationship between emotions and work suggested by Claire Langhamer. It uses the archives of the Whitehall studies newly deposited at the London School of Hygiene and Tropical Medicine, as well as oral history interviews with the researchers that continue to work on the study. It argues that the Whitehall studies have reimagined stress as a function of inequality, and assesses the attempts of Marmot and his colleagues to convince public and political audiences of this new model of stress.

Objectives

Keywords: stress; epidemiology; emotions

- To understand different theories about stress and its posited health effects in historical perspective
- To critically engage with the legacy of what are widely viewed as some of the most influential cohort studies globally
- To assess how scientific evidence is communicated to, and interpreted by, the public sphere

## **A2 Research and Technology**

Cynthia Tang, McGill University, Montreal, Quebec, Canada, [cynthia.tang2@mcgill.ca](mailto:cynthia.tang2@mcgill.ca) and  
Nicholas Whitfield, McGill University, Montreal, Quebec, Canada, [nicholas.whitfield@mcgill.ca](mailto:nicholas.whitfield@mcgill.ca)

*The Complicated Role of Patient Demand in the Spread of Surgical Technology: Minimally Invasive Surgery (MIS), 1980-2000*

The rise of laparoscopic cholecystectomy, or minimally invasive gallbladder removal, in the late 1980s and early 1990s has largely been referred to as a “laparoscopic revolution”. The existing explanations offered by sociologists have not sufficiently taken into account the role of the patient in the rapid acceptance of the new technology. In contrast, surgical accounts of the rise of laparoscopic cholecystectomy, taken from oral interviews, published discussions, and commemorative literature, have predominantly credited its extraordinary uptake to patient demand. This paper examines the role of the patient in the spread of MIS and complicates the notion of patient choice by showing that such choices were not made in a vacuum, but in the context of active solicitation of patients by surgeons and medical device manufacturers. While acknowledging the enthusiasm of patients for this dramatically less traumatizing procedure, we question surgeons’ claims that this was primarily a patient demand-driven revolution. With the use of advertisements found in popular media and interviews with surgeons, instrument manufacturers, and patients, we show that in the American context, conscious efforts were made to market the “latest advance in [gallstone] treatment” to patients. Such advertising demonstrates that patients were seen not only as possessing agency, but also as a consumer. This is in contrast to the British and Canadian contexts where nationalised health services had a tempering effect on the impact of patient demand. Thus this paper will consider the wider context of different health care systems in Canada, the United States, and the United Kingdom, and its impact on what is seen as patient choice, as well as contribute to historical discussions of the “patient consumer”, a recent target for consideration by medical historians. More generally, the example of laparoscopic cholecystectomy allows us to deepen historical understandings of technological change in medicine by incorporating the role of patient choice in the acceptance of medical innovation in a differentiated way.

-Understand the dynamic history of medical ideas and practice and their implications for patients and health care providers.

Objectives

- Recognize the dynamic interrelationship between medicine and society through history
- Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

**A3 Health Work: Struggle and Challenge**

Paul Braff, Temple University, Philadelphia, PA, USA  
[paul.braff@temple.edu](mailto:paul.braff@temple.edu)

*Health and Racial Uplift: National Negro Health Week’s Challenge to the Medical Establishment*  
In 1915, Booker T. Washington told African Americans, “Without health and until we reduce the high death-rate it will be impossible for us to have permanent success in business, in property getting, in acquiring education, to show other evidences of progress.” For Washington, health was the foundation upon which racial uplift rested. My work examines the 35-year public health campaign he launched to improve black health, National Negro Health Week (NNHW).

The goal is to show how African American definitions of health differed from those of the medical establishment and the implications such differences created for the social control over, and empowerment of, African Americans. While most studies about African Americans and medicine have explained how medical professionals defined health, they have not shed light on how, or if, the African American population internalized these definitions. The historical questions that studying NNHW can help answer are: how African Americans outside of the medical profession defined health; and how medical professionals reacted to this challenge to their authority.

Using the NNHW collection at Tuskegee University and a close reading of early NNHW pamphlets, I argue that Washington defined health so whites could assess if blacks had achieved it. In this way, he perceived health as a social construct tied to race. While many historians, such as Keith Wailoo and David Rosner have made this argument, scholars have found few examples of subjects wielding it. Based on his understanding of health, Washington defined it as cleanliness, permitting African Americans of all classes to declare themselves healthy without consulting a physician and challenging the place of physicians as the arbiters of health. However, the NNHW's popularity attracted the United States Public Health Service, which worked to alter the Week's health definition to one based on medicine, reasserting the establishment's control over black bodies.

Exploring the role non-experts play in defining and internalizing proper health allows historians to examine the ways in which social constructions of health can be challenged, and the study of NNHW better positions scholars and public health officials to understand how race and health intersect today.

CME Learning Objectives:

- 1) Develop the capacity for critical thinking about the nature, ends and limits of medicine
- 2) Recognize the dynamic interrelationship between medicine and society through history
- 3) Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

### **A3 Health Work: Struggle and Challenge**

North de Pencier and Gerald McKinley, Schulich School of Medicine & Dentistry and Western University, London, Ontario, Canada, [ndepencier2019@meds.uwo.ca](mailto:ndepencier2019@meds.uwo.ca) and Ian Puppe, Drishti Dhawan and Carrie Davis, Western Univeristy, London, Ontario, Canada

*Indigenous Mental Health Workers and the Challenges of Cross-Cultural Mental Health Care at the Sioux Lookout Zone Hospital, 1969-1996*

From 1969-1996, University of Toronto physicians staffed the Sioux Lookout Zone Hospital, a federal Indian Hospital which served 26 remote indigenous communities in Northwestern Ontario. Physicians and residents travelled in shifts from Toronto to provide healthcare to the

Sioux Lookout Zone communities, and the Zone Hospital served as a teaching hospital within the University of Toronto's medical school.

The cultural differences between physicians and their indigenous patients made mental healthcare challenging in the Zone. In an attempt to improve mental healthcare, the Sioux Lookout Zone Hospital hired indigenous mental health workers. Starting in 1979, their mandate was to provide mental health services in their own communities. The mental health nurses believed that "the etiology of the problems referred is, for the most part, social, and not psychiatric," (Callahan and Aurandt 1981) and therefore, in many cases, indigenous health workers would be better equipped to deal with the complexities of mental health cases than non-indigenous providers.

This project studies the collection of the Sioux Lookout Zone Hospital Program, which is located within the University of Toronto archives and contains primary sources, including letters, case reports and memorandums. Using an archival research method, we will analyze the challenges to mental healthcare in the Sioux Lookout Zone. Our project is a case study that will build on the analysis of this topic in secondary sources, especially James Waldram's "Revenge of the Windigo: The Construction of the Mind and Mental Health of North American Aboriginal Peoples" and Maureen Lux's "Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s." We will evaluate the effect of the indigenous mental health workers in providing compassionate, patient-centered care to the communities that they served.

The history of federal Indian Hospitals in Canada is a vital and unexplored chapter in Canada's medical history. We will argue that the indigenous mental health workers demonstrated the effectiveness of cultural competency in treating mental illness, but that their effectiveness was also limited by conflict between the colonial agenda of Indian Hospital and the indigenous culture of its patient population.

#### Objectives

- Critically appraise clinical management from a historical perspective
- Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
- Acquire a historically nuanced understanding of the organization of the Canadian healthcare system, and of other national health care systems

### **A3 Health Work: Struggle and Challenge**

Juliet Larkin-Gilmore, Vanderbilt University, Nashville, TN, USA

[juliet.c.larkin-gilmore@vanderbilt.edu](mailto:juliet.c.larkin-gilmore@vanderbilt.edu)

*Homesick: Contagion, Mobility, and the Struggle over American Indian Students' Health in the Early Twentieth Century*

In October 1914, high disease rates among students at the Colorado River Reservation's (CRR) boarding school came to the attention of Assistant Commissioner of Indian Affairs, E.B. Merritt. By 1914, sick children were not a new phenomenon to Merritt, and his reply to the agency's superintendent, Omar Babcock, reveals how he likely handled many such reports. Merritt asked Babcock to prevent "promiscuous visiting" between parents and students as much as possible because he blamed Indigenous families for the school's poor health.

In the late nineteenth and twentieth centuries, Indigenous children from CRR (located on the Lower Colorado River between California and Arizona) attended boarding schools both on and off the reservation as part of an explicit effort by the federal government to assimilate their minds and bodies to Euro-American standards. Many became sick while at school and were either kept there despite of it, sent home to die, or transferred to Phoenix Indian School's sanatorium. In this paper, I examine how CRR's Native families encountered boarding school health as well as officials' attempts to blame them for the schools' public health crises. First, I argue that Office of Indian Affairs (OIA) administrators used the rhetoric of contagion and the notion of "promiscuous visiting" to maintain physical distance between CRR children and their families. In the second half of the paper, I turn to resistance strategies that students, especially student-patients at Phoenix, and their families employed to push back against the logic of their educators and imprisoners.

Within the literature on American Indian boarding schools, scholars have identified health as one of several traumatic aspects of boarding school life. This paper supports that notion but seeks to demonstrate how healthcare and public health rhetoric functioned as principal tools of the settler colonial complex. Public health gave OIA officials a new, biomedical rationale for controlling the relationships between Native children and their families. The result was to blame parents and Indigenous home life for students' illnesses—even as the reality of poorly managed school healthcare pointed to other causes. Yet, this paper also argues Indigenous people recognized and exploited this hypocrisy to survive, reunite with loved ones, and challenge federal assimilation policy.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine.
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.
3. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations).

#### **A4 Transnational Perspectives**

Gourav Krishna Nandi, Yale University, New Haven, CT, USA  
[gouravkrishna.nandi@yale.edu](mailto:gouravkrishna.nandi@yale.edu)

*"Brick by brick": How national and global health politics converged around the political career of Rajkumari Amrit Kaur between 1947 and 1957*

On July 12 1953, when Rajkumari Amrit Kaur, India's first Minister of Health, spoke on All India Radio from Delhi, one could have easily mistaken her words -notwithstanding the term "health"- as describing the construction of one the numerous dams or steel factories with which the early postcolonial government had come to associate development and modernity. This paper situates the political career of Rajkumari Amrit Kaur within the politics of health nationally as well as globally, and explores the ways her tenure as the Minister of Health from 1947 to 1957 reflected the politics of health in early independent India.

Postcolonial historians maintain that after independence, "a single, consistent, unambiguous voice" of political elites silenced the differences and divergences in political narratives that were present during the nationalist movement in the early twentieth century. Sunil Amrith, for example, has furthered this argument that the dominant narrative in public health in postcolonial India was "developmentalist in tone." While, it is well established that health was integrated into the broader national project of development during this period, historians have not yet examined the political context of health in which multiple stakeholders made policy decisions. In this regard, given that both global and local nodes of political power and public health converged through Amrit Kaur, there has been surprisingly little historical study of her political career.

In order to undertake this analysis, I utilize the debates during the Constituent Assembly meetings from 1949 and archival materials from the first two meetings of the Central Council of Health in 1953 and 1954. Moreover, to understand the early Cold War context of health policy from an Indian perspective during the 1950s, I examine Amrit Kaur's personal travel journal from her travel to the Soviet Union in 1959 and her correspondences with officials of Technical Cooperation Mission of the United States. These sources show the way Amrit Kaur, a political elite of a Non-Aligned country during the early Cold War, negotiated the hegemony of both the US and the Soviets without compromising exchanges of technology and funding that were vital for public health in India.

#### Objectives

1. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems.
2. Recognize the dynamic interrelationship between medicine and society through history.
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.

#### **A4 Transnational Perspectives**

Lydia Wytenbroek, York University, Toronto, Canada  
[lydia.wytenbroek@gmail.com](mailto:lydia.wytenbroek@gmail.com)

*Professional Nursing in Twentieth-Century Iran: Nursing Work, Social Mobility and Transnational Nurse Migration*

This paper explores the development of nursing as a profession in Iran. American missionary nurses affiliated with the Presbyterian Mission to Iran started the first nursing school in the country in 1916. By 1930, they were operating seven nursing schools in northwestern Iran. Mission-trained graduate nurses were the first women to enter the workforce as paid nurses in Iran. Historian Firoozeh Kashani-Sabet has discussed the development of nursing in relation to the development of a nationalist discourse in Iran that tied women's maternal and caregiving work to the "health" of the nation, but few scholars have written exclusively about the history of nursing in Iran and there is virtually no work that explores individual women's motives for pursuing nursing work. This paper examines Iranian women's reasons for engaging with professional nursing. I use memoirs written by Iranian nurses, interviews that I conducted with the children of Iranian nurses and Presbyterian mission records, including medical reports, hospital reports and nursing school reports, for what these sources reveal about the aspirations of Iranian women who pursued nursing education and work in mission hospitals. I argue that mission nursing offered Iranian women in the first half of the twentieth century one of the only opportunities available to them to further their education and enter public spaces through paid professional work. Iranian graduate nurses were highly employable and highly mobile and many went on to attain prestigious positions in the government and influence the future direction of health policy in Iran. Several Assyrian and Armenian women in Iran used their training as nurses to migrate to the United States. I situate their experiences in relation to Catherine Choy and Karen Flynn's work on the history of nurse migration. Mission-run nursing schools were vehicles for the formation of an emerging middle-class identity for women in Iran. Iranian women embraced the ideals of the nursing profession and used this new professional identity to their advantage. They crafted a new public persona for themselves and used the nursing profession to enter and participate in the public sphere.

#### Objectives

1. Understand the development of professional nursing in Iran
2. Appreciate the ways that gender influenced women's entry into paid professional work in Iran
3. Analyse the impact of broader social and political forces on the history of nurse mobility in Iran and Iranian nurse migration to the United States

#### **A4 Transnational Perspectives**

Anne Kveim Lie, University of Oslo, Oslo, Norway  
[ahlie@medisin.uio.no](mailto:ahlie@medisin.uio.no)

##### *Untreated syphilis – from Oslo to Alabama and back*

In the period from 1891 – 1910, around 2000 patients with syphilis were admitted to the skin department at the National hospital in Oslo, Norway. An opponent to the mercury treatment at the time, the head of department, Caesar Boeck, forbade the use of mercury in his ward, and instead recommended improving the patients' own defense mechanisms. In 1928, his

successor, E Bruusgaard, published an investigation where he had traced approximately 1/5th of the patients. The results travelled across the globe, into textbooks and article journals, and also to the architects of the infamous Tuskegee study. According to historian James Jones, “the importance of these findings for dr. Clark’s proposed study of syphilis in the negro can hardly be overstated” (Bad Blood, p. 93). Two decades later, on the initiative from Johns Hopkins syphilologist JE Moore and the head of the venereal disease section at the US PHS, a Norwegian dermatologist, Trygve Gjestland, received financial support from the Research Grants Division of the US Public Health Service to do a follow up-study of the same patients with a “more rigorous methodology”. The study, being co-supervised by surgeon-general in Norway, Karl Evang, was published in 1954 as Gjestland’s doctoral thesis (“The Oslo study of untreated syphilis”). This epidemiological study is also cited as one of the first studies on social inequality in health. In this paper, I want to explore the coming into being of the Oslo study, and in particular trace the relations between the Oslo study research group and the Tuskegee researchers and PHS division, at a time where the Tuskegee study was under scrutiny. How did the results travel? What kind of translation was necessary in order to make the Oslo study relevant to the American context? And how did the Alabama study transform the re-study of the Oslo “material”? What version of syphilis was produced as an effect? Based on archive material both from the US and Norway, as well as published sources, I will explore the production of “untreated syphilis” in an interaction between two very different contexts, and between past and present

CME objectives\_

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.
3. Recognize the dynamic interrelationship between medical research and society through history, and the ethical pitfalls involved in medical research.

## **A5 Prisoners, Medical Research, Health Care and Justice**

Susan Reverby, Harvard University, Cambridge, MA, USA  
[sreverby@wellesley.edu](mailto:sreverby@wellesley.edu)

### *Prisoner’s Health or the Health of Prisoners*

The eighth amendment to the U.S. Constitution forbids “cruel and unusual punishment” in federal cases. There is no evidence the founders of this country imagined that the denial of decent medical care would violate this clause. Yet when the Bureau of Prisons physician in charge of prison medical care in 1989 claimed they only practiced “community standards,” the question of which community they served was never really addressed. The next year, American federal inmate and self-described political prisoner Dr. Alan Berkman submitted a twenty-five-page statement to the U. S. Senate’s subcommittee on Prisons. Having been in custody for more than six years, Berkman had observed the worst of medical care for prisoners in some of the nation’s most notorious penitentiaries. He himself had almost died, not just because of

medical incompetence, but from the so-called security demands of imprisonment that thwarted any real attempt to structure humane care. In this paper I will discuss Berkman's experiences and observations, his critiques of prison health care, and his differentiation between prisoner's health and the real need of prisoners. I will place his concerns in the context of prison health care reforms of the late 20th century. The paper is based on Berkman's testimony, his written articles on this topic, personal letters, oral histories, prison medical reform primary documents, and unpublished prison autobiography.

#### Objectives

Develop an historically informed understanding of the tensions between prison security and medical care

Recognize the view of prisoners of their health care

Consider the ways of practicing the Hippocratic Oath are thwarted in prisons

#### **A5 Prisoners, Medical Research, Health Care and Justice**

Sydney Halpern, University of Illinois, Chicago, USA

[shalpern@uic.edu](mailto:shalpern@uic.edu)

#### *Redemptive Transformation: Prisoners in Mid-Twentieth Century Medical Research*

Historians are well aware that World War II and early Cold War medical investigators in the U.S. drew a great many research subjects from prisons and reformatories. Critiques of the practice are numerous. Commentators point out that inmates were not in a position to freely consent, and were both a devalued group and a population of convenience. Scholars have paid much less attention to how researchers managed to get access to prisons and persuade large number of inmates to sign up for experiments.

This paper draws on materials from major archival repositories to reveal and well organized and normatively legitimate system for using prisoners in even dangerous medical experiments. Mid-century prisons professionals believed that rehabilitation was a primary goal of incarceration, and that an inmate's participation in medical research was a step toward redemptive transformation. Stanford Bates, who was head of the New Jersey prison system after a stint as director of the Federal Bureau of Prisons, declared that that practice was the most humanitarian thing done in prison work in years. Wardens helped recruit subjects and arranged for researchers distribute commendation certificates to participating inmates—with a copy going to the inmate's file—that applauded their service to science and country. Joseph Stokes Jr., a prolific prisoner investigator, personally distributed such documents at special ceremonies at prisons. The practice of issuing commendations to inmate-subjects after the completion of experiments was very widespread. While many prisoners no doubt saw the certificates as means for getting early parole, others bristled at the suggestion that their motives were selfish. In sum, the prevailing system of medical research in prisons was compatible with the ideologies of both medical investigators and criminal-justice professionals, and also with ideas voiced by a considerable number of inmates.

## Objectives

(1) Familiarize attendees with a mid-century system of medical research in prisons; (2) Provide new insights into how and why this system flourished; (3) Generate better understanding of medicine's relation to another major social institution.

## **A5 Prisoners, Medical Research, Health Care and Justice**

Samuel Scharff, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA  
[sam.scharff@jhmi.edu](mailto:sam.scharff@jhmi.edu)

### *Hervey Cleckley and a Psychiatrist's Pursuit of US Criminal Justice Reform: 1941-1976*

Historians and activists are actively engaging with the question of how the US criminal justice system accelerated its rate of expansion in the middle decades of the 20th century and developed an increasingly penal orientation. How did medicine contribute to this process? Countless words have been written about medicine's capacity for institutionalization and social control. Less has been written about the various methods physicians used to reform American criminal law itself. I use the American psychiatrist Hervey Cleckley (1903-1984) as a case study of a physician who attempted in the mid-20th century to reform the US criminal justice system in pursuit of a conservative vision of law and order. My work traces Cleckley's life of activism through a larger world of competing social reform movements at the intersection of psychiatry and the law using archival sources, oral histories, legal cases, and published literature.

Cleckley used his medical authority to expand and intensify the criminal justice system in three major ways. The first was to redesign a medical diagnosis to provoke a desirable outcome from existing law. In 1941, Cleckley reinterpreted psychopathy into a category that could ensure consistent institutionalization for offenders with administratively confusing designations of medical disability yet legal sanity. The second was to argue for direct reforms to the law in medical language. In the 1950s, he argued for legal changes that would hold all mentally ill offenders responsible for their crimes. The third was to undermine the medical authority of legal reforms he found undesirable. Cleckley's project was nearly derailed when the liberal judge David Bazelon appropriated his words to justify a 1954 landmark reform to the insanity defense, which exonerated offenders with a causative psychiatric diagnosis. In the 1960s, Cleckley responded by joining a conservative anti-psychiatric coalition and attacking the scientific basis of this rehabilitation-minded reform—while publishing medical justifications for his own penal intuition of criminal justice. Cleckley's activism demonstrates how physicians pragmatically selected various reform strategies to defend their ideal visions for criminal justice amidst competing and fluctuating views of how psychiatry, law, and American culture should relate to one another in post-WW2 America.

## Objectives

1. Learn to think historically about the social forces that affect the form and function of a medical diagnostic category.

2. Develop an appreciation for major tensions that have underlain the uneasy relationship between mental health care and criminal justice in the 20th century United States, and how reformers have tried to solve them.
3. Reflect on under-discussed legal and political dimensions of physicians' professional roles.

## **A6 Medical Practice, Medical Knowledge**

Jim Downs, Connecticut College, New London, USA  
[Downjames@gmail.com](mailto:Downjames@gmail.com)

### *Slavery and Scurvy at Sea: The International Slave Trade and the Development of Medical Knowledge*

Historians have been making front-page news by resurrecting old debates about how slavery led to the development of modern day capitalism. They have recapitulated familiar themes: rapacious slaveholders, the commodification of human beings, and the centrality of economics as a key factor in the institution of slavery. Drawing on the spirit of this work, my paper marks a new direction: I argue how slavery led to the development of science and medicine. Slavery created new social arrangements that led to the development of new ideas about disease transmission, therapies, and cures.

In my paper, which is part of a larger book project, *The Laboring Dead: From Subjugation to Science in the Atlantic World*, which is under contract with Harvard University Press, I examine how the crowding together of enslaved Africans in the bottoms of ships combined with poor nutrition led to outbreaks of scurvy. In one particular voyage in 1783-1784, an estimated three hundred enslaved Africans out of a group of around 600 became infected with scurvy, and fifty eight died during the trip. When the boat reached the British West Indies, the surgeon on board, Dr. Thomas Trotter, an Edinburgh educated physician, ordered the crew to obtain fresh fruit and vegetables for the enslaved people. Feeding them oranges, shaddocks, and lime, Trotter noticed that the citrus fruit immediately cured them.

When Trotter eventually returned to Edinburgh, he explained his discovery to his peers in Edinburgh and published an essay in 1786, "Observations on Scurvy," which was later republished in Germany the following year and then in Philadelphia in 1793. Prior to the publication of his essay, many in the medical community believed scurvy was a disease of blood and not of nutrition. For those who believed it resulted from diet, they treated it by giving patients "animal meat and wine" and opium.

The violence of the slave trade however produced a built environment that allowed Trotter to understand the cause and cure for scurvy. His revelation had lasting effects beyond slavery in the Americas. In jails and prisons in Europe, scurvy remained endemic; it baffled physicians and left many dead as a result of poor nutrition. Yet the institution of slavery, which has been seen as providing the roots for capitalism, also provided the roots for medicine.

## Objectives

This paper will reveal how slavery shaped the development of medical knowledge.

This paper will show how physicians developed a cure for scurvy by treating enslaved Africans.

This paper will offer a global history of medicine.

## **A6 Medical Practice, Medical Knowledge**

Annelie Drakman, The Department for History of Science and Ideas, Uppsala University,  
Uppsala, Sweden

[annelie.drakman@idehist.uu.se](mailto:annelie.drakman@idehist.uu.se)

*Bleeding for circulation: Early 19th-century medical practices as flow-management rather than equilibrium balancing*

Historians of early 19th-century therapeutic practices commonly describe them as being meant to restore a lost equilibrium. Historians of medicine such as John Harley Warner and Charles Rosenberg argue that disease was believed to be caused by a state of disequilibrium between bodily fluids; therapeutic measures were attempts to restore a state of balance.

Against that view, in this paper I argue that such practices are better seen as attempts to manage the flow of bodily fluids. Using hundreds of yearly reports from Swedish provincial doctors during 1815-1850 as source material, I show that purging and evacuating practices such as bloodletting, laxatives and purgatives were part of a larger therapeutic belief in the need to manage flows into, out of, and within the body. That is, during the early 19th century, doctors were more concerned with the steadiness and regularity of flows, and with clearing blocked flows by removing obstacles, than with the quantity of a particular fluid in relation to other fluids.

If so, this clarifies why therapeutic practices not ostensibly designed to evacuate fluids, like emolliating foot baths or cooling dressings, were often described and performed as flow-enhancing practices.

The interpretation of purging and evacuating practices as a subset of flow-managing therapeutics also reveals structural similarities in how bodies and environments were managed to improve health. For instance, the swamp-draining activities initiated by the sanitary movement during the first half of the 19th century were based on the same basic principle as bloodletting and other flow-managing therapeutics: that natural flows, whether of air and water or of blood, would, if blocked, stagnate and fester, and that such festering led to the growth and spread of disease. Thus, flow-managing interventions were attempted on both diseased bodies and miasmatic places.

## Objectives

Develop the capacity for critical thinking about the nature, ends and limits of medicine

Deepen understanding of illness and suffering

Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

## **A6 Medical Practice, Medical Knowledge**

Jacob Moses, Harvard University, Cambridge, MA, USA

[jacobmoses@fas.harvard.edu](mailto:jacobmoses@fas.harvard.edu)

### *Radical Regrets: Cancer Surgery, Prostate-Specific Antigen Testing, and the Role of Affect in Therapeutic Reversals*

To surgically cure men of prostate cancer by wholly excising the walnut-sized gland was an ambition pursued with increasing regularity throughout the twentieth century. Dr. Hugh Hampton Young's 1905 report of a "radical prostatectomy" procedure, developed at Johns Hopkins Hospital, opened on a note of regret about "his failure to recognize, and to operate radically in six cases of early carcinoma of the prostate—several of which ought certainly to have been cured." In the fifty years following Young's publication, 357 radical prostatectomies were performed at Hopkins. By the 1980s, some hospitals were undertaking that many operations in a single year, and over 400,000 were performed annually at the peak of the procedure's use in the U.S. The prostate-specific antigen (PSA) assay, commercialized in 1986, figured centrally in early detection programs. Worry about not intervening early and aggressively enough was countered with increasing insistence by commentators concerned about the efficacy of costly surgeries and the sexual and urinary harms they produced. At the close of the century, nationwide use of prostatectomies was declining and several doctors and researchers influential in promoting PSA testing publicly expressed regret for contributing to an era of perceived surgical overuse.

This paper centers on the debates surrounding the introduction of the PSA test and the retrospective judgements of actors involved in its approval process. Published reports, FDA transcripts, and oral history interviews reveal complex ethical and epistemic dynamics concerning the value and harms of surgery, standards of evaluating efficacy, and construction of medical information and uncertainty. The paper argues that appeals to providing patients with risk information served a critical function in delimiting the scope of the regulatory review and located the responsibility of regret in the clinical encounter. Drawing on recent work in the history of surgery efficacy, this paper brings perspective to a carcinoma that gained medical and social visibility throughout the twentieth century but still remains largely unexplored by historians. Finally, the paper contributes to the understating of affect within the historiography of cancer by considering not only hope and fear, but also the role of regret in shaping cancer care.

#### Objectives

1. Understand the historical relationship between debates about prostate cancer surgery and PSA testing.

2. Reflect on the role of affect in shaping medical evidence, practice, and policy.
3. Recognize the dynamic interrelationship between medicine and society through history.

### **Lunch Sessions--Friday**

#### *Luncheon Workshop 1: The Uses and Misuses of Henrietta Lacks as Medical History, Political Symbol and Popular Media Icon*

The session will explore the phenomenon of Rebecca Skloot's *The Immortal Life of Henrietta Lacks* from a history of medicine perspective, seeking to examine the pros and cons of this powerfully individual story as a stand-in for the complex and freighted history of race and medicine in the 20th-century United States. Since its publication in 2010, *The Immortal Life of Henrietta Lacks* has become a worldwide media phenomenon that has powerfully shaped both academic and popular discourses on racial health disparities, informed consent, and the ethical balance between the promise of clinical research and its potential medical and psychic risks to patients. The book has been assigned in countless classes, inspired passionate political debates over the ethics and commercialization of human subjects research, and, in 2017, reached the apogee of popular media exposure when Oprah Winfrey produced and starred in an HBO movie adaptation. Mrs. Lacks' enduring power as a political symbol has led, in 2017 alone, to three different days of the year being declared to honor her in Baltimore City, Baltimore County, and the state of Maryland. To paraphrase literary and legal scholar Karla Holloway, Lacks' private body has become one of the most public texts ever.

Henrietta Lacks has also been a frequent topic of conversation at AAHM conferences, as historians of medicine wrestle with how they can offer a thoughtful critique of the book's (and now the movie's) flaws without undermining these works' valuable affirmation of patients' human dignity or their powerful calling-out of institutional racism and scientific hubris. As the session moderator, I will employ my in-depth knowledge of the institutional history of the Johns Hopkins Medical Institutions and the history of race, medicine and health policy to frame the discussion. Barron Lerner (NYU) is confirmed as a discussant; Karla Holloway (Duke) and Hannah Landecker (UCLA) have been invited but not confirmed.

#### *Lunch Workshop 2: Media Histories of Medicine*

Medicine never takes place in a vacuum. Yet the spaces between patient, doctor, and scientist are not merely social: they are also mediated by textual and visual forms, in paper and increasingly electronic technologies that make possible both intimate and global circulation of medical knowledge and practice. The medical tradition has been rich in specialized communications between doctors and patients, doctors and doctors, and doctors and fellow scientists across many historical periods. As historians, we can trace how the meanings and uses of these communications shift as new media come into use, from the printing press to the .pdf, lithograph to photograph, telegraph to smartphone, paper chart to electronic medical record. Recent developments in media studies offer the potential to rethink our understanding of how changes in medical communications relate to changes in medical knowledge and

practice. To date, however, history of medicine and media history have had relatively little contact.

This roundtable will discuss opportunities for theoretical, methodological, and pedagogical engagements between the study of media and the study of the history of medicine. Panelists will illustrate their own efforts to draw attention to the media in which medical knowledge and practice are stored, transmitted, and put into action: in the archive, in the classroom, and in new media as well. This roundtable will illustrate techniques for attending to the historical specificity of media as medical technologies and finding narrative structures to describe media that do not assume their influence on environments in some predetermined, unidirectional or generalizable way. It is through this attention to particularity, and to the social, cultural and material elements that undergird and inform each mediation, that we seek to uncover a new media history of medicine.

### *Lunch Workshop 3: Why Would a Girl Go into the History of Medicine?*

This lunch workshop draws on the expertise and life histories of four eminent senior women historians of medicine in order to explore the historiographic changes in women's history and the history of medicine. We have asked the four historians – Judith Leavitt, Ellen More, Susan Reverby and Rosemary Stevens – to reflect on their professional careers and the changes in the fields of history and medicine in order to understand our past and consider our future. Some of our preliminary questions include: How did you come to be a historian of health and medicine? What were some of your formative experiences in the field? Can you speak about the place of mentors in your career? How has the field changed over time, especially for women? How have women changed the field? How significant has your identity as a woman been in shaping your own work?

### **B1 Room City Nation: Medical Architecture as Public Outreach, 1925-1975**

Annamarie Adams, McGill University, Montreal, Quebec, Canada  
[annmarie.adams@mcgill.ca](mailto:annmarie.adams@mcgill.ca)

#### *What Art Deco hospital lobbies did for medicine*

This illustrated paper explores the power of lobbies in Art Deco hospitals in Europe, North America, and Australia. Although many public buildings in the interwar era featured elaborate entrance foyers, I argue here that hospital lobbies enhanced the public image of medicine in this era. Engaging the lobby as a primary source in the history of medicine thus offers novel and alternative understandings of the public interface of medicine in the early twentieth century. During the presentation, I will elaborate on 4-5 overlapping functions of the Art Deco hospital lobby. Perhaps most obviously, lobbies enticed guests to visit the hospital. Simultaneously a showcase of design and a history classroom, the decorative programs of lobbies often complemented a narrative about medicine introduced on the facades of buildings. By completing this story, for example, the Art Deco hospital lobby rewarded visitors for coming inside. Secondly, Art Deco lobbies made medicine seem forward-looking, by providing a unified

vision of medical specializations. Carefully-designed lobbies served enormous Art Deco hospitals, comprised of disparate specialties and sometimes merged institutions. Thirdly, Art Deco's potential for narrative was remarkably versatile. Veterans, women, Jews, and masons – to name only four groups—constructed Art Deco hospitals in this period with sumptuous, story-telling lobbies. Art Deco lobbies reached out to middle-class women through subtle links with department store design, one of the few urban building types considered appropriate for women to visit alone. Through this discreet affiliation, patients, staff and visitors felt fashionable, which was especially important for women. Finally, the Art Deco foyer was an important feature of the high-rise medical clinic, a novel building type in the 1920s. Art Deco design demonstrated, dignified, and even glamorized medicine by relying on associations with progress, modernity, and fashion. Additionally, the lobby's subtle message/s were legible to a wide range of users, making medicine accessible to the masses via architecture.

### Objectives

Keywords: architecture; hospital; form + function

1. Develop the capacity for critical thinking about the nature, ends, and limits of medical history.
2. Recognize the dynamic interrelationship between medicine and society through history (in this case through architecture).
3. Understand the important role which architectural settings have played in the development of modern medical knowledge and practice.

### **B1 Room City Nation: Medical Architecture as Public Outreach, 1925-1975**

Joy Knoblauch, University of Michigan, Ann Arbor, Michigan, USA

[jknoblau@umich.edu](mailto:jknoblau@umich.edu)

#### *Mapping Hill-Burton, The Hospital Survey and Construction Act of 1946-1956*

This paper maps and visualizes the regional history of hospitalization and federal agency in creating a national network of hospitals. I explore the role of regional differences in federal funding in expanding hospital-based health care in the United States after World War II. I claim that mapping helps show how regional attitudes and labor unions contributed to national conceptions of hospital medicine, concentrating on the factors that made the rural south both open to federal subsidies for hospital construction and resistant to President Harry Truman's attempts in 1945 and 1948 to create a national health insurance program.

Scholars have studied hospital architecture in terms of efficiency, typology, medical knowledge, and community needs. Less attention has been paid, however, to understanding the way federal standards and construction programs affected the environments in which medicine is practiced, especially the design features characteristic of rural hospitals. Hospitals' locations and architecture are also the result of forces that operate at a very large scale such as accreditation, national funding priorities, and the coordination of services by region. As a first

step to studying hospitals at the national scale, this paper examines data about federal funding and number of adequate beds per capita released by the United States to celebrate the progress of the first ten years of the major hospital construction program that came to be known as Hill-Burton. More formally known as the Hospital Survey and Construction Act of 1946, this federal legislation aimed to standardize hospital beds in terms of quality and to raise the numbers of hospital beds in all US states to 4.5 beds per capita. The paper thus innovates in two ways: by examining an underutilized source of information about hospital architecture and by incorporating mapping methods for visualizing data emerging in the digital humanities today.

#### Objectives

Keywords: architecture, government, regionalism, visualization

1. Consider the value of visualizing hospital data to engage a wider audience in the history of medicine and its regional differences.
2. Discuss the history of American hospitals at the national level, showing what is obscured and what is vivid at the national scale.
3. Recognize the dynamic interrelationship between medicine, architecture, and society as fostered by large national construction subsidies.

#### **B1 Room City Nation: Medical Architecture as Public Outreach, 1925-1975**

David Theodore, McGill University School of Architecture, Montreal, Canada  
[david.theodore@mcgill.ca](mailto:david.theodore@mcgill.ca)

*The Hospital City ca. 1970*

This paper explores the widespread anxiety among mid-century architects, urban planners, and medical authorities concerning how new hospitals might fit into cities. They debated how should hospitals be designed when cities were undergoing their own transformations due to urban renewal and the proliferation of roads and services for automobiles. Jonathan Hughes has convincingly shown the cross-fertilization between city planning and hospital planning in the elaboration of the National Health Service after 1948 in Great Britain. My argument expands on his work by exploring a basic tension between the “inward vision” (Charles Rosenberg’s term) of medical practice in hospitals and a new imperative for medical outreach into the city.

For this presentation I rely on archival architectural visual sources including drawings and photographs, publications in architectural and hospital trade journals, and the considerable grey literature generated by planning consultants in this era. These documents attest to the emerging role of the hospital as an access point between government healthcare services and citizens. They also help to show that this anxiety about hospital design is legible as a change of metaphor. Around 1970, hospital planning switched from a metaphor of circulation—based on parallels between the circulation of blood in the body, the circulation of nurses in the hospital,

and the circulation of cars in the city—to a machine diagram based on charts familiar in the fields of automation and computing.

I examine three case studies: Northwick Park in London, England; the McMaster Health Sciences Centre in Hamilton, Canada; and the University Hospital of Cologne in Cologne, Germany. These projects used a variety of strategies (named, respectively, the “village hospital,” the “community hospital,” and the “drive-in hospital”) to both link the hospital to the city and to organize hospital life. These devices helped to make the inside of the hospital more like a modern city, dividing it into distinct zones with clear separations between services and people, and, at the same time, to integrate the hospital into the broader transport networks within the city.

### Objectives

Keywords: architecture; urban hospitals; city planning; architectural circulation

1. Deepen our understanding of the dynamic interaction of medical practices and cities.
2. Recognize the importance of postwar architectural and urban environments in the delivery of medical care.
3. Gain a historical sensitivity to the continuing significance of community-based hospital models.

## **B2 Marginalized Medicine: Gender, Ethnicity, and Race in Latin American and U.S. Healthcare**

John McKiernan-González, Texas State, San Marcos, TX, USA

[jrm259@txstate.edu](mailto:jrm259@txstate.edu)

*Off Center: Latin American Medical Trajectories and the recasting of Urban American Identity, 1870-1920*

After the United States Civil War, medical schools started accepting women, Africans Americans and European immigrants and their children. This paper focuses on a class of physicians – U.S. or Latin American born Latina/o physicians trained in medical schools based in New York, Pennsylvania, Michigan, and Missouri – and examines their movement through elite medical schools into medical and professional careers. The paper argues that the medical marketplace created by ‘Latin’ communities provided the wherewithal to allow physicians to work in urban industrial America as much as Havana and San Juan. Physicians like William Carlos Williams and Juan Guiteras moved through county medical associations while others, while physicians like Jose Celso Barbosa struggled moving across color lines in the U.S. and Puerto Rico. With the rise of hostility toward others that came with WWI and the Mexican Revolution, Latina/o physicians moved careers and communities to places that treated their presence with more indifference. This paper builds on medical directories, student archives, and recently available digital records of the Spanish language press to argue for a transnational marketplace, and builds on the insights of Charles Rosenberg, Thomas Ward, Nancy Tomes, Alondra Nelson, John Dittmer, Jose Amador, Nicole Pagan, and James A. Schafer jr. to argue for enduring presence of market

connections and xenophobia in making a borderlands for Latina/o physicians in the Urban north.

#### Objectives

Will consider how the story of Latina/o integration and exclusion in American medicine during the Progressive Era complicates the story of Jim Crow medicine.

Considers the way Philadelphia and New York may have been migrant medical Latina/o hubs. Uses the Spanish language press as a significant historical source for public understandings of health and medicine in the United States.

### **B2 Marginalized Medicine: Gender, Ethnicity, and Race in Latin American and U.S. Healthcare**

Lydia Crafts, University of Illinois, Urbana-Champaign, Urbana, IL, USA  
[crafts.lydia@gmail.com](mailto:crafts.lydia@gmail.com)

#### *Claiming Bodily Sovereignty: Guatemalan Interpretations of Bodily Harm in STI Research*

In 2010, the U.S. government formally apologized to Guatemala for experiments directed by the U.S. Public Health Service in the forties in which U.S. and Guatemalan physicians infected more than a thousand Guatemalans with sexually-transmitted infections (STIs). The researchers also had taken blood samples from thousands more Guatemalans in an effort to improve diagnostic tests for syphilis. The survivors included predominantly indigenous and poor Guatemalans. They were registered by the state as sex workers, prisoners, soldiers, hospital patients, orphans, and schoolchildren. The researchers did not provide available treatments to the majority of the people they infected, nor did they obtain informed consent. Since the federal apology, the U.S. Bioethics Commission has blamed individual doctors for transgressing the accepted ethical standards of the time, despite historian Susan Reverby's efforts to point to the systematic nature of the violations. The Guatemalan government has distanced itself from the study by claiming that it constituted a violation of national sovereignty.

My work starts from the premise that the nation-state of Guatemala was just one entity breached in these experiments by exploring Guatemalans' claims to bodily sovereignty. U.S. doctors arrived in Guatemala anticipating a readymade laboratory for medical research, but they soon found that Guatemalans were not the docile "subjects" that they had imagined. Rather Guatemalans had their own healthcare beliefs, ethical understandings, and political views that led them to distrust the doctors. In some cases, Guatemalans refused to cooperate with the doctors and forced them to alter their plans for research. Drawing upon oral histories, anthropological accounts, and medical notes, my paper will highlight moments when Guatemalans managed to claim self-determination within the confines of these coercive experiments. I aim to move the narrative of these experiments beyond a bioethical framework by paying attention to Guatemalans' interpretations of bodily harm.

#### Objectives

Will complicate the bioethical narrative that has been used to explain these experiments.

Examines Guatemala as a laboratory for medical research.  
Highlights Guatemalan perceptions of ethics and the experiments.

## **B2 Marginalized Medicine: Gender, Ethnicity, and Race in Latin American and U.S. Healthcare**

David Carey, Loyola University, Baltimore, MD, USA  
[drcarey@loyola.edu](mailto:drcarey@loyola.edu)

*The Ethnicity of Health Care in Twentieth-century Latin America: Indigenous People and Public Health in Guatemala and Ecuador*

Postcolonial Guatemala and Ecuador both had majority indigenous populations that exerted considerable influence even without equal access to political and economic power in the first half of the twentieth century. As such, they are useful sites for examining how ethnicity influences the dynamic, contested, and negotiated process of health care in developing countries. The interdependent processes of health care and Indian-state relations progressed differently in Guatemala and Ecuador. Based on medical and public health records from the Archivo General de Centroamérica (in Guatemala City) and Museo de Medicina (in Quito), this paper will explore how structural issues (such as a lack of potable water) and perceptions of indigeneity shaped indigenous peoples' access to and experience with health care and public health initiatives. Some health care professionals attributed indigenous illnesses to their alleged lack of hygiene or resistance to modernization while others recognized that poverty and other conditions beyond their control overdetermined individual health.

Geography too mattered. While many indígenas (indigenous people) pursued hybrid health care, their remote counterparts had few choices. When rural healers failed to cure them, poor patients had to travel to urban hospitals. Guatemala City and Quito offered two such destinations. The extent to which indígenas felt like foreigners there emerges in their efforts to gain access to hospitals to consult with doctors or visit ill relatives. In Ecuador, ill indígenas and their families long resisted hospitals. Not until the 1930s when officials strove to address indigenous suspicion and mistrust of state-sponsored public health and health care overtures did indígenas welcome hospital care. Perhaps distinguishing themselves in the eyes of hospital staff, some indigenous patients evoked and/or earned the respect to merit being called doña—a title that conveys a woman's honorable position.

### Objectives

- To understand how indigeneity shapes public health and health care.
- To explore hybrid health care options and choices in Latin American societies.
- To conceptualize hospitals as placing of alienation as well as healing.

## **B3 Malleable Boundaries: Medical Science, Geopolitics, and Categories of Exclusion in Colonial and Cold War Korea**

Sonja Kim, Binghamton University (State University of New York), Binghamton, NY, USA

[skim@binghamton.edu](mailto:skim@binghamton.edu)

### *Investigating the Health of the Urban Poor in Colonial Korea*

Over several months in 1940, medical students of Keijō Imperial University surveyed the health and living conditions of the urban poor in Keijō (Seoul), the capital of the Japanese colonial state in Korea (1910-1945). With an understanding that the t'omangmin, as these residents were labeled by local authorities, were part of the "population problem" whose burgeoning numbers and needs the infrastructure of the city was unable to handle, the student investigators detailed the minutiae of their subjects' everyday lives, gathering information that ranged from their occupation, residence, education, substance use, and financial situation to health conditions, water quality, and physical measurements. The deployment of methods used in physical anthropology to compare collected data against other populations managed in different parts of the Japanese empire indicates an attempt to racialize or differentiate the abject bodies of the t'omangmin.

Situating the investigation in the dislocations and urbanization produced by the colonial economy and mobilizations catalyzed by Japan's military escalations during the Pacific War, this presentation explores the t'omangmin's emergence as a new social category of persons/bodies in colonial Korea and the participation of physicians (in this case medical students) in the biopolitics of the Japanese empire in the late 1930s. An examination of the investigation's 1942 published report juxtaposed against public health campaigns, city planning, social welfare programs, and medical research agenda of Keijō Imperial University suggests ways the health investigation (re-)produced certain forms of knowledge that opened possibilities to serve assimilationist and health administrative interests.

#### Objectives

1. Identify ideas about populations used in formulating medical research or health investigations
2. Observe individual experiences with one's health and access to services shaped by social variables such as socio-economic class, status, gender, and age.
3. Understand how political agenda guide medical education and the profession

### **B3 Malleable Boundaries: Medical Science, Geopolitics, and Categories of Exclusion in Colonial and Cold War Korea**

Todd Henry, University of California, San Diego, San Diego, CA, USA  
[tahenry@ucsd.edu](mailto:tahenry@ucsd.edu)

### *Intersex Diagnoses and the Parameters of Normality in Cold War South Korea, 1950s-1980s*

Since its founding in 1948, the explosive outcome of 35 years of Japanese colonialism and an internecine politics that led to national division, South Korea has largely defined its national culture in terms of heterosexual purity and gender normativity. In spite of these self-images of

the nation, discussions of “problematic” bodies proliferated in the mass media and among medical professionals, especially as the country embarked on a rapid program of industrial capitalism under the military dictatorship of Park Chung Hee (r. 1961-1979) and his successors. Focusing on the sexual sciences of urology, endocrinology, psychiatry, gynecology, and pediatrics, this presentation traces one particularly voluble node in this national debate by examining the medical and social significance of intersexuality in Cold War South Korea. Using an archive of medical reports on the diagnosis and treatment of intersex people that I have collected from this period, I ask why and how these particular bodies became such a heated matter of discussion among civilian and military doctors, as well as journalists who translated scientific knowledge of intersexuality into newsworthy stories for public consumption. Through an analysis of South Korean medical professionals and their training across the post-colonial divide (1945), I pay special attention to the shifting paradigms of diagnosis and treatment that doctors deployed in identifying and seeking to normalize “problematic” bodies. In addition to situating their clinical practice within these global frameworks, I also investigate the social value that intersex diagnoses produced for a country pursuing the nationalist goals of capitalist development and militaristic anti-communism under authoritarian regimes. To this end, I trace the frequent traffic that circulated between civilian and military doctors in South Korea (and beyond), as they encountered bodies that disrupted binary understandings of biological sex in such contexts as hetero-marital reproduction, military service, and the work force.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
3. Recognize the dynamic interrelationship between medicine and society through history

### **B3 Malleable Boundaries: Medical Science, Geopolitics, and Categories of Exclusion in Colonial and Cold War Korea**

John DiMoia, Max Planck Institute for the History of Science (MPIWG), Berlin, Germany  
[jdimoi@mpiwg-berlin.mpg.de](mailto:jdimoi@mpiwg-berlin.mpg.de)

*Mobilizing the Disabled: the Korea Child Welfare Committee and the “Internationalization” of Disability, (1961- early 1970s)*

In the mid-1950s, UNKRA (United Nations Korea Reconstruction Agency) reports were filled with images of smiling children, typically those with congenital difficulties, or injured in the recent Korean War. With the founding of a National Rehabilitation Center (Tongnae), these children became tied to an ambitious domestic and international agenda, one linked to the national image of recovery during the Rhee administration.

In 1961, the Korea Child Welfare Committee, a body of advisors, consisting of members from international voluntary agencies, as well as Korean and US government officials, drafted a

survey report. The report urged the adoption of child welfare laws, thereby creating an institutional and regulatory basis for the education and treatment of disabled children. This work built upon earlier work from the mid-1950s, following a similar committee gathered under the auspices of KAVA (Korea Association of Voluntary Agencies).

Recent scholarship including Eunjung Kim's *Curative Violence* (2017) and related work on the context of international adoption (Arissa Oh's *To Save the Children of Korea*, 2015) has suggested that a hierarchical perspective held by committee members shaped a culture of "redemption" and a need for the "cure," leveraging (and obscuring) conspicuous power differences, a statement true for the early 1960s, and still holding an impact today. In this sense, the formative context for a rehabilitative medicine, along with a related impulse to displace children, opting for a "better" environment, was situated within the intersection of domestic, international, and Cold War politics. Work with children's rehab after 1945 has to be understood much more broadly, not just in national contexts.

#### Objectives

1. To understand the bilateral ROK-US context for disability / rehab after 1945
2. To offer a broader context for disability in the East Asian region (regional, international, transnational)
3. To better understand Cold War biomedicine and technology

#### **B4 Sex and Reproduction in Nineteenth-Century Medicine**

Claire Cage, University of South Alabama, Mobile, AL, USA  
[ccage@southalabama.edu](mailto:ccage@southalabama.edu)

##### *Detecting Deception: Gender, Malingering, and Legal Medicine in Nineteenth-Century France*

Malingering, or feigning physical or mental conditions, became a pressing concern in nineteenth-century France. In response to the introduction of conscription during the Revolutionary and Napoleonic wars, the state enlisted doctors to determine whether conscripts and soldiers truly had conditions that disqualified or released them from military service. Doctors' approaches to the problem of malingering and their attitudes towards patients whom they suspected of deceiving them were highly gendered. The growing body of medico-legal literature of the period primarily framed the problem in terms of doctors outwitting the men who sought to deceive them for reasons that were rational and understandable, namely to avoid military service or criminal punishment. Doctors viewed malingering among women primarily through the lens of either hysteria, the dissimulation or simulation of pregnancy and parturition, or "rape blackmail." Medico-legal experts used this latter term when they discounted the bodily signs of sexual assault in women as feigned or self-inflicted. Doctors' concern with women's faking the signs of sexual assault became a significant theme in a growing body of medico-legal literature. This paper argues that doctors' efforts to detect malingering played an important role in the social construction of medico-legal expertise and in shaping the lives of ordinary men, women, and children. It demonstrates the centrality of

gender in not only doctors' efforts to detect malingering among men and women but also legal medicine more broadly and the construction and contestation of medical expertise.

#### Objectives

Develop the capacity for critical thinking about the nature, ends, and limits of medicine

Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

Recognize the dynamic interrelationship between medicine and society through history

### **B4 Sex and Reproduction in Nineteenth-Century Medicine**

Jessie Hewitt, University of Redlands, Redlands, CA, USA

[jessie\\_hewitt@redlands.edu](mailto:jessie_hewitt@redlands.edu)

#### *Crazy in Love: Debating Marriage and Mental Illness in Nineteenth-Century France*

The stigmatization of mental illness increased during the final third of the nineteenth century, as the degeneration theory of Benedict Morel gained influence within medical circles and French society at large. In 1857, Morel argued that insanity was a hereditary affliction that signaled the degeneration of the French race, a belief that influenced everything from the practice of psychiatry to the political and literary sensibilities of the early Third Republic (established in 1870). In the increasingly anxious atmosphere of the fin-de-siècle, many French came to view the fate of the nation as dependent on society's ability to control the sexual behavior of all "degenerates," including people deemed mentally ill (as shown by Robert A. Nye in his path-breaking "Crime, Madness and Politics in Modern France: The Medical Concept of National Decline").

This paper examines medical and popular understandings of sexuality and degeneration through debates over mental patients and marriage. In so doing, I attempt to pinpoint the precise moment in which doctors' fears of degeneration overrode their previous desire to reincorporate patients back into French society by reestablishing their positions within the family (as husbands, wives, and even as parents). French asylum doctors clearly attempted to inhibit the sexuality of their patients, both before and after the rise of degeneration theory: they regularly pathologized particular sexual behaviors (by linking lesbianism to hysteria, for example) and eventually discouraged all sexual activity among anyone labeled mad due to concerns over hereditary transmission. However, my evidence shows that doctors also tried to manipulate their patients' sexual behaviors by suggesting that the participation in heterosexual acts within the confines of marriage constituted proof of cure. Indeed, doctors could conceive of transferring their patients from the mental ward to the marriage bed until the 1870s. This timing testifies to the importance of both medicine and sexuality to the broader sweep of French history, suggesting that psychiatric understandings of madness and sex simultaneously influenced and were influenced by the sense of anxiety occasioned by the Franco-Prussian War and the Paris Commune.

## Objectives

Recognize the dynamic interrelationship between medicine and society through history, in this case the relationship between psychiatry and its nineteenth-century historical context

Develop an historically informed sensitivity to the diversity of patients (especially an appreciation of class, gender, and sexuality)

Develop the capacity for critical thinking about the nature, ends and limits of mental medicine

## **B4 Sex and Reproduction in Nineteenth-Century Medicine**

Caitlin Lansing, Johns Hopkins University, Baltimore, MD, USA

[clansin1@jhu.edu](mailto:clansin1@jhu.edu)

*“To Married Women”: Gender, Knowledge, and Abortion in Nineteenth-Century New York City*

From 1839 until her suicide in 1878, New York City resident Madame Restell was condemned as “the wickedest woman in New York” for her abortion and reproductive control practice. Her story is typically used as an example of vice and corruption that permeated the underbelly of contemporary New York culture, but this interpretation ignores the frequency of abortion and transfer of reproductive knowledge that sustained her practice. Examining Madame Restell’s career through a gendered lens shows how women gained knowledge of and participated in abortion and other reproductive services in early nineteenth-century New York.

This paper uncovers a hidden, female-centric network of knowledge about abortion and reproduction through examining the 1841 trial in which Madame Restell was accused of performing an abortion that allegedly resulted in the death of working-class woman Ann Maria Purdy. The trial is typically included in short biographical accounts of Madame Restell to mark the first time that she evaded the justice system, but none of these works has examined the trial closely or used it to investigate otherwise hidden practices. This paper uses close readings of the trial’s transcript and Purdy’s deposition to show how the all-male justice system strategically manipulated the trial to cast “respectable” women’s participation in abortion and reproductive control as a threat to the morality of New York City, and thus illuminate larger relationships among gender, power, and the law. It will also show how the narrative produced there transformed the meanings of abortion from a procedure reserved for innocent seduced women to a threat to the stability of marriage, prompting novel male surveillance over female reproduction.

## Objectives

KEY WORDS: Abortion; reproductive knowledge; nineteenth century

- Describe the cultural meanings of abortion in nineteenth-century New York City.
- Identify the roles of women in a particular reproductive marketplace.
- Recognize the dynamic interrelationship between medicine and society through history.

## **B5 Sites and Stories of Treatment for Physical and Mental Impairments in the United States, 1760-1860**

Laurel Daen, Massachusetts Historical Society, Boston, MA, USA  
[laureldaen@gmail.com](mailto:laureldaen@gmail.com)

### *Disabled Producers and Consumers in the Early Nineteenth-Century Medical Marketplace*

When George Hale of Brattleboro, VT commenced haying in the summer of 1836, he felt a pang in his abdomen “so painful,” he described, “that I was obliged to quit work.” Upon discovering that it was a hernia, Hale tried several kinds of trusses. The most effective, he found, was a “conical” model made by Isaac Thompson, also from Brattleboro. Thompson had experienced a hernia two years prior, during which time he had designed a truss with an easy-to-wear “spring and lock.” This invention, Hale testified, “enabled me to labor daily” and “I found no more inconvenience in wearing it than in wearing my stockings.” Within three weeks, Hale pronounced himself “cured” and “laid aside the Truss” for the foreseeable future.

Hale and Thompson were two of many early nineteenth-century Americans who turned to the marketplace to purchase and produce technologies designed to accommodate or alleviate their physical impairments. Therapeutic devices--from trusses to crutches and bed-chairs--had been made and used during the colonial period; however, economic and cultural developments in the early republic created the context for a fast-growing industry. To the extent that scholars have studied this burgeoning market, they have missed the degree to which people with impairments participated in it as both consumers and producers. Like Hale, customers selected from a multitude of appliances intended to assuage their physical conditions. And, like Thompson, inventors claimed that their past and present experiences of debility led them to create superior products.

This paper examines this market for assistive technologies as a site of self-care and personal healing in the early nineteenth century. Drawing on advertisements, patents, and surviving objects, it recovers the dozens of curative contraptions that linked impaired inventors to impaired clients, noting how disability served as a shared experience and discourse that facilitated these transactions. The paper also demonstrates how disabled producers and consumers lost control of this industry towards the mid-nineteenth century. As regular physicians professionalized their practice, they worked to bar those without medical training from selling therapeutic devices to the public. Medical involvement shaped the designs of assistive products. While early nineteenth-century technologies tended to promote user comfort and autonomy as a means to appeal to customers, later nineteenth-century items prioritized the needs and desires of doctors and caretakers, promoting medical control and manageability.

#### Objectives

(1) Acquire a historically nuanced understanding of the organization of the U.S. healthcare system. (2) Recognize the dynamic interrelationship between medicine and society through history. (3) Identify successes and failures in the history of medical professionalism.

## **B5 Sites and Stories of Treatment for Physical and Mental Impairments in the United States, 1760-1860**

Susanna Blumenthal, University of Minnesota, Minneapolis, MN, USA  
[blume047@umn.edu](mailto:blume047@umn.edu)

### *Accounting for Insanity: The Paper Economy within the Bloomingdale Asylum*

Early in his tenure as the assistant physician of the Bloomingdale Asylum for the Insane in upper Manhattan, the alienist Pliny Earle sounded a note of skepticism about the epistemological foundations of his own profession: "Science is at once lost in mazes of uncertainty and ignorance whenever it attempts to fathom mind itself." Earle's consciousness of the problem of consciousness was reflected in his extensive published writings on the curability of insanity, which provide an illuminating vantage point from which to gauge the powers and limitations of the new medical psychology as it was mobilized in everyday clinical interactions between doctors and patients. Reading these sources alongside surviving registers, ledgers, casebooks, and court orders from the Bloomingdale Asylum, this paper is broadly concerned with the fabrication of expert knowledge: medical, legal, and historical.

Opening its doors in June of 1821, the Bloomingdale Asylum was among the earliest institutions in the United States to adopt a program that combined medical and moral treatment, one premised upon the restorative "power of judicious kindness." Mindful of the extent to which "the state of madhouses" was attracting the attention of legislators, physicians, and social reformers both within and beyond the state of New York, Bloomingdale's medical superintendents were strategic in their publication of statistical tables, which were intended to demonstrate the usefulness of the institution not only as a means of curing or at least ameliorating the condition of the insane, but also as a site for the production of medical knowledge.

By the time Earle arrived at Bloomingdale in 1844, asylum cure rates were already coming to be viewed as suspect and he accordingly introduced new taxonomies and bookkeeping methods for purposes of more accurately tracking admissions, discharges and readmissions. Much was lost in the translation, however, as can be seen upon closer inspection of the leather-bound volumes that tracked the movement of the asylum population. These volumes tell a more complicated story about the dilemmas of diagnosis daily faced by doctors who had to construct patient histories upon the basis of fragmentary, unreliable narratives provided by their charges and other interested parties, always under the shadow of the law.

#### Objectives

- 1) Develop the capacity for critical thinking about the nature, ends and limits of expert knowledge.
- 2) Understand the dynamic history of medical ideas and practices, particularly those borrowed from legal professionals, statisticians, and businessmen.
- 3) Deepen understanding of illness and suffering.

## **B5 Sites and Stories of Treatment for Physical and Mental Impairments in the United States, 1760-1860**

Cornelia Dayton, University of Connecticut, Storrs, CT, USA  
[cornelia.dayton@uconn.edu](mailto:cornelia.dayton@uconn.edu)

### *An 'Open' Asylum: Seeking Treatment in Andover, Mass., 1770-1840*

In the north parish of Andover, Massachusetts, several generations of physicians with the surnames How, Osgood, and Kittredge were well-known throughout New England for treating patients who had particularly difficult conditions and needed care over several weeks. Some but not all were experiencing serious mental affliction. Salem minister and diarist William Bentley knew at least five adults seriously disordered in mind who had “recovered with Kittredge at Andover” after living there a few months. “Frequent use of evacuations & the country air,” Bentley wrote, “have not failed to restore the patients, after fair experiments.” One former patient wrote to Thomas Jefferson, recalling his time in Andover and referring to it as “the Massachusetts Bedlam.”

We can think of the village as an open asylum because these cure seekers boarded with local families, not with the physician. The physicians’ records are not known to survive, but from a variety of sources I have partly reconstructed how the place/space of north Andover worked as a therapeutic site. As someone under Thomas Kittredge’s care in the 1810s, you walked a short distance every day to visit him or he came to see you. In the many daytime hours remaining, patients (white men and women) visited with a wide range of residents, borrowed books from local scholars, bought trifles at the store, and, if perceived to be of possible danger to themselves or others, were closely supervised (‘watched,’ ‘tagged’) by youths belonging to their landlord’s household. One patient’s detailed journal allows us to map his daily activities and interactions. I emphasize the tolerance of the townsfolk for some patients’ bizarre behavior but also their methods for bodily control and containment.

Andover as a therapeutic site straddles the divide between the much-studied institutional asylums and the patterns of lay, familial care ‘outside the asylum’ that have attracted recent attention especially from scholars of eighteenth- and nineteenth-century Britain. It enriches our cross-cultural and cross-temporal investigations of humans’ responses to and understandings of mental and cognitive impairments, including glimpsing the extent to which stigma or compassion characterized particular cultural moments.

#### Objectives

Critically appraise clinical management from a historical perspective

Assess and appreciate the role of lay people and family and community members in therapeutic strategies

Revisit the ethics and pragmatics of using physical restraint with mentally distressed patients through the window of a historical site-study

## **B6 Medical Commodities in the Longue Durée**

Kirsten Moore-Sheeley, Johns Hopkins University, Baltimore, MD, USA  
[kmoore44@jhmi.edu](mailto:kmoore44@jhmi.edu)

### *Making insecticide-treated nets into biomedical commodities in late twentieth-century Africa*

People around the world have used mosquito nets, or bed nets, to protect themselves from insects and malaria for centuries. This includes people in China and West Africa, who purchased and exchanged bed nets for public health and non-public health purposes into the 1980s. However, insecticide-treated bed nets—now a cornerstone of global malaria control—took on a distinctly new character in the 1990s: these mundane tools had become global health commodities, purchased and circulated by major development agencies for consumption by African populations at-risk for malaria. How did this transformation occur and what consequences did it have for public health programs in malaria endemic Africa?

Using archival, published, and oral sources from Europe, Africa, and North America, this paper answers those questions, showing how randomized controlled trials and economic analysis of insecticide-treated bed nets (ITNs) constituted these objects as global health commodities. Biomedical evidence of ITN efficacy by itself did not lead to the widespread adoption and circulation of the tool in global public health, as scholarship on global health suggests. Rather, this paper argues, biomedical evidence defined a new use value for ITNs—individual, biological survival—that appealed to development donors looking to intervene on the continent without building centralized, state-run health infrastructure. Together with calculations of cost-effectiveness, which showed ITNs were a cheap way to save the lives of African children, biomedical evidence constituted ITNs as commodities in the “global health economy.” As such, ITNs could be easily equated with and exchanged for child-saving vaccines or drugs. This transformation, very much a product of structural adjustment policies of the late twentieth century, attracted new international investment in malaria control, specifically through ITNs. However, it significantly circumscribed how African public health programs could combat malaria in the twenty-first century.

#### Objectives

Key Words: insecticide-treated nets, global health, Africa

1. Explain the role of biomedical sciences in constituting insecticide-treated nets as global health commodities.
2. Explain how the context of structural adjustment shaped efforts to turn insecticide-treated nets into global health commodities.
3. Articulate the consequences of constituting insecticide-treated nets as global health commodities for African public health programs.

## **B6 Medical Commodities in the Longue Durée**

Elizabeth Semler, University of Minnesota, Minneapolis, MN, USA  
[semle006@umn.edu](mailto:semle006@umn.edu)

*Food as Commodity/Food as Medicine: Cardiovascular Disease in the Global West, 1950-2000*

Throughout the history of Western medicine food has always played a central role in understandings of health and disease. The rise of germ theory and allopathic medicine in the late nineteenth century, however, centralized microbes as the ultimate source of ill-health. Doctors, public health workers, and government programs began to focus largely on links between germs and health; proper nutrition was important, but mainly inasmuch as it allowed the body to fight off dangerous microbes.

The epidemiological shift from acute to chronic illnesses around mid-century in the global West brought food to the fore once again. In the early 1950s, for instance, American physiologist Dr. Ancel Keys linked rising rates of cardiovascular disease, in part, to high-fat, high-cholesterol diets. Although many scientists and public health workers questioned Keys' conclusions, his ideas soon filtered into public consciousness, and food quickly regained its place at the table. While renewed perceptions of food as hazardous concerned many agricultural producers and companies, others saw opportunity in these perceptions. By the late 1950s consumers in the U.S. could easily find food products that claimed to lower the risks for developing heart disease. Although medical organizations argued against these (often unfounded) claims, they struggled to control the proliferation of products. In Finland, public health workers tried to control the medical narrative by working with food producers to create genuinely healthful products. In so doing, however, they legitimized food producers' larger efforts to pander to consumers concerned about heart disease.

This paper retools the larger panel's focus on the commodification of medical objects, arguing instead that the global West's heart disease crisis shifted food from an everyday commodity into a special kind of medical object. Still a commodity, but apparently condoned by the medical community, this shifting understanding of food gave food companies an unprecedented opportunity to rework consumers' conceptions of health and disease, centralizing their own products in the process.

Objectives

Keywords: Diet, cardiovascular disease, food industry

1. To show the historical development of the science linking diet to heart disease.
2. To highlight the power of food producers and food companies in constructing public narratives of health and disease.
3. To demonstrate the contradictions inherent in creating public health programs today -- their success is culturally contingent but also must take into account the global proliferation of (health) knowledge as well as commodity (health) products.

**B6 Medical Commodities in the Longue Durée**

Matthew Crawford, Kent State University, Kent, OH, USA  
[mcrawf11@kent.edu](mailto:mcrawf11@kent.edu)

### *Quina as Commodity: An Andean Medicament in the Atlantic World, 1630-1750*

In the 1630s, colonial officials and Jesuits missionaries returning from Spain's Viceroyalty of Peru introduced a new drug to Europe. This drug was 'quina,' a medicinal tree bark harvested from various species of the cinchona trees growing in the forests of the Andes and also the Amazon Basin. Healers throughout the Atlantic World soon recognized what Andean curanderos had first figured out: that cinchona bark was an effective treatment for intermittent fevers, a prevalent and deadly cluster of ailments in the early modern world that we now recognize as symptoms of malaria. By the middle of the eighteenth century, quina was one of the most important and valuable medical commodities in the Atlantic World. This paper will examine the epidemiological, economic, and environmental factors that contributed to the remarkable and rapid transformation of cinchona bark from local remedy to global commodity by juxtaposing contemporary accounts of the bark and its healing properties with existing data on the volume and value of trade in the bark. In particular, this paper will argue that 'quina' was as much a product of the Atlantic World as it was a product of the Andean World by showing how interrelated processes that lay at the heart of the Atlantic World were integral to the quina's transformation into a commodity. Beyond this historical narrative, this paper will also reflect on how much quina's success as a commodity can be attributed to its recognized medical virtues as opposed to the other factors that contributed to its career one of the major medical commodities of the early modern world.

#### Objectives

Key Words: Materia Medica, Quinine, Commodification

1. Explore the medical, economic, and political factors that facilitated the transformation of cinchona bark into a medical commodity
2. Explain how specific historical contexts shaped the commodification of materia medica.
3. Explain how patterns of economic and intellectual exchange in the Atlantic World shaped later networks of global health

#### **C1 People and States**

Anne-Emanuelle Birn, University of Toronto, Toronto, ON, Canada  
[ae.birn@utoronto.ca](mailto:ae.birn@utoronto.ca)

### *Mismatch? The Soviet Union and the 1978 Alma-Ata Conference*

In September 1978, the World Health Organization (WHO) convened a momentous International Conference on Primary Health Care (PHC) in Alma-Ata, the capital of the Soviet republic of Kazakhstan. This gathering of thousands of representatives from 134 countries, most UN agencies, and dozens of civil society organizations signaled a break with international health's longstanding technically-oriented and top-down disease eradication basis. Instead,

Alma-Ata promoted a community-based, social justice oriented approach to health that drew from demands of Third World countries for the reorientation of international health –and the international economic order writ large– to respond to the needs and conditions of low and middle-income countries and populations.

Curiously, existing historical accounts of the Alma-Ata conference, largely based on WHO sources, have assumed it to represent a Soviet triumph. Such reasoning, still embedded in Cold War logic, contradicts both the decision-making processes in Geneva and Moscow that led the conference to be held in the USSR and the reality that the highest Soviet authorities did not consider it a significant ideological or political opportunity.

To redress such misrepresentations, this talk examines the planning and repercussions of the Alma-Ata conference in the context of Soviet political and health developments, drawing from both Soviet and WHO archival sources, published books and memoirs, official reports, and oral history interviews with key Soviet and Kazakh protagonists. The talk begins by outlining the USSR’s complicated relationship to WHO from the 1940s through the 1960s, touching upon Soviet international health activities outside of WHO’s ambit. Next, it traces the genesis of the proposal for –and realization of– a PHC meeting framed by Soviet, Kazakh, and WHO politics. It argues that the Soviets did not effectively <capitalize> on their hosting of the PHC conference, resulting in a mismatch with Alma-Ata’s considerable global resonance. The talk suggests that this missed opportunity for the Soviets was based on different expectations around the meaning and importance of primary health care.

#### Objectives

Keywords: primary health care, Soviet Union, World Health Organization

- 1) Recognize the dynamic interrelationship between public health and society through historical analysis
- 2) Acquire a historically nuanced understanding of the priorities and approaches of international and global health approaches and agencies
- 3) Develop the capacity for critical thinking about the nature, ends, and limits of global public health

#### **C1 People and States**

Dorian Deshauer, York University, Toronto, Canada

[deshauer@yorku.ca](mailto:deshauer@yorku.ca)

*From Demerol to Prozac: Pharmacological Reason and Medical Licensing Reform in Ontario (1990-2009)*

Medical licences in the late 20th and early 21st century came to certify compliance with a broad surveillance network that extended to physicians’ mental health. Ontario’s medical regulator developed in the early 1990s a generous administrative category, “the impaired physician” to flag doctors with potentially impairing mental health issues. Initially, the category was occupied

by physicians who practiced medicine while addicted to alcohol or drugs but it later expanded to include any mental illness. Faced with the need to find a cost-effective way to screen licensing applications, adjudicators at Ontario's medical regulator turned to a clinical form of reason described by the anthropologist Andrew Lackoff as pharmacological reason; doctors who used psychiatric drugs to maintain their mental health were assumed to require special assessment and potential oversight.

This presentation is part of my dissertation project, which looks more broadly at the weaving of pharmacological reason into various forms of institutional risk management. Drawing on professional archives, oral histories, and court cases, I will show how psychiatric drugs became for Ontario's medical regulator cost-effective, if problematic, markers of occupational risk. Identifying a turn toward physicians' mental health as an object of professional governance, the presentation extends the work of historian Rosemary Stevens, who has focused on the role of continuing medical education in late 20th century North American medical licensing.

The extension of pharmacological reason into Ontario's medical licensing policies exposes a broader problem in medical governance. On the one hand, maintenance psychiatric drugs in the late 20th century were widely used as tools of risk reduction. On the other hand, regulators mistrusted the durability of mental health achieved and maintained pharmaceutically. The surveillance of doctors who use psychiatric drugs to maintain their mental health marks a recent development in medical licensing that tests the boundaries of public accountability and personal secrecy.

#### Objectives

Promote an understanding of the complexity of mental health risk as an object of professional regulation.

Appreciate problems arising when clinical logic is applied at a population level.

Reflect on the limits of self-disclosure as a tool of professional governance.

#### **C1 People and States**

Sandra Lewenson, Pace University, Pleasantville, NY, USA

[slewenson@pace.edu](mailto:slewenson@pace.edu)

*The "A" List: African-American Nurses and the American Red Cross Town & Country Nursing Service, 1912-1949*

Between 1912-1949 the American Red Cross (ARC) offered public health nursing services to rural communities throughout the U.S. Few African-American nurses were accepted during the early twentieth century. This paper explores the racialized experience of African-American nurses in the ARC rural public health service. Frances Davis, considered the first African-American nurse to be accepted into the ARC Town & Country Nursing Service (as it was first named) in 1917, serves as an exemplar. Davis fulfilled all the requirements for admission into the ARC, including the additional post graduate course in public health nursing. She attended

Teachers College, that offered one of the few programs that admitted Black students. Yet, in 1918, Davis headed a list that was started by the ARC designating African-American nurse applicants with the letter “A”. This list enabled the ARC, the Town & Country, and the Army Nurse Corp to maintain the status quo of segregation until 1949 when this practice finally ended.

Little is known about the ARC experiment that offered rural communities access to public health nursing services. Existing histories of the ARC rarely, if ever, include this history. The literature either focuses on the international role of nurses in the ARC, but omits the domestic story; or they include the relief piece, but excludes nursing’s contribution. Records from the National Archives, Rockefeller Archive Center; and the the National Organization of Colored Graduate Nurses provides insight into the ARC and African-American nurses’ experiences. Secondary sources offer insight into the experience of these nurses.

African-American nurses faced obstacles in their professional efforts to serve in rural communities and in the military due to segregation and unrelenting racist attitudes. As a result of the barriers encountered when entering the ARC, African-American nurses looked to other organizations to serve. The Circle for Negro War Relief organized in 1917 to care for Negro soldiers and their families provided such an opportunity. Although attempts were made to establish links between the ARC and the Circle by the National Organization of Colored Nurses, it did not come to fruition as a result of the persistent racism.

Learning objectives:

1. To explore the life of Frances Elliot Davis and her entrance into the American Red Cross, Town & Country .
2. To discuss the separate list of African-American nurses designating their race and the barriers that these nurses experienced in entering the American Red Cross.
3. To consider the ways in which African-American nurses addressed the health care needs of the African-American community.

## **C2 Medical Expertise during Historical Transition in 20th Century China**

Joshua Hubbard, College of William and Mary, Williamsburg, VA, USA

[jahubbard@wm.edu](mailto:jahubbard@wm.edu)

*Measuring the Mundane: Expertise, Demography, and Reproductive Health in Post-Colonial Taiwan*

Scholars have shown the disciplinary aims and effects of demographic research and the public health policies it informed in post-colonial Taiwan. This paper highlights the limits and unintended consequences of those attempts by demographic and public health experts to understand and manage populations.

After World War II, the Nationalist government of Taiwan partnered with the World Health Organization and UNICEF to manage reproductive health, seen as critical for continued

economic development and political stability. The data, personnel, and infrastructures left by Japanese colonizers soon attracted U.S.-based demographers from the University of Michigan and the Population Council, who saw Taiwan as a potential laboratory for developing a model of “demographic transition” and capitalist modernization that could be reproduced throughout the developing world. The claims and ambitions of these experts rested on quantifying and classifying local, individual, and everyday practices and correlating them to universalized measures of the population as a whole, namely mortality, fertility, and nuptiality.

Based on oral histories, health guides, and demographic surveys, this paper will argue that local practices in Taiwan, though critical for the development of demographic science and global reproductive health, ultimately eluded classification, quantification, and control. In attempting to reduce mortality rates by quantifying and reforming hygiene and childrearing practices in the later 1940s, experts failed to account for local norms surrounding sexuality and family structure, contributing to higher population growth rates and new fears of Malthusian catastrophe. In response, researchers and policy makers then promoted contraception and consumption beginning in the later 1950s, to encourage locals to find meaning and fulfillment outside the family. However, these endeavors produced a new crisis of below-replacement birth rates, first discovered in the 1980s. Demographic and global health experts thus remained in a dialogic relationship with local conditions and practices in Taiwan, often responding to the very crises they helped create. The universal and abstract claims of science repeatedly proved vulnerable to the local and the everyday.

This presentation presents a historically nuanced understanding of the organization of the Taiwanese healthcare system. It discusses the successes and failures of a program that emerged out of a partnership between officials from the Republic of China, the World Health Organization, UNICEF, and university researchers to manage Taiwan’s population growth. Through discussion of how these organizations failed to account for local practices around sexuality and family structure, the paper recognizes the dynamic relationship between medicine and society.

## **C2 Medical Expertise during Historical Transition in 20th Century China**

Peiting Li, University of California, Berkeley, Berkeley, CA, USA  
[peiting.c.li@berkeley.edu](mailto:peiting.c.li@berkeley.edu)

*From Druggist to Pharmacist: government regulations and professional associations in 1920-1940s Shanghai*

This paper looks at the rise of the pharmacist as a professional figure during 1930-1940s Shanghai. After successfully ending a period of disunity marked by warlordism, one of the objectives of the new Nationalist state was to consolidate power over matters of health. In 1929, just after the founding of the Ministry of Health, the Nationalist government passed regulations requiring the registration of physicians, dentists, pharmacists, nurses, and midwives. Scholarship on this set of laws has generally highlighted the attempts of reformers to

exclude Chinese medical practitioners from being recognized as medical professionals. In this paper, instead, I focus on the subsequent emergence of the pharmacist vis-a-vis the doctor as delineated in law and embodied in professional associations for doctors and pharmacists. Drawing on national and municipal regulations, newspaper reports, medical journals, and advertisements, I trace the rise of the pharmacist as a professional figure of its own. I argue that the expertise and authority of pharmacists vis-a-vis doctors increasingly rested on the pharmacist's authority over drugs, that they were involved not just in filling prescriptions but also making drugs, doing chemical experiments, carrying out inspections, and participating in the sale and management of drugs.

### Objectives

This paper contributes to CME learning objectives by exploring the organization of the Chinese healthcare system during the Republican period, understanding how healthcare practitioners were defined and how healthcare was administered. The paper promotes tolerance for the ambiguity of theories by examining how Chinese medical practitioners interacted with the national healthcare system, and it identifies successes and failures in the history of medical professionalism by examining how medical professionals were defined and recognized during a period when political consolidation and the administration of healthcare were linked.

## **C2 Medical Expertise during Historical Transition in 20th Century China**

A.C. Baecker, University of Michigan, Ann Arbor, MI, USA  
[abaecker@umich.edu](mailto:abaecker@umich.edu)

*Laboring Medicine: Barefoot Doctors and Revolutionary Cultures of Medical Practice in the People's Republic of China*

In this presentation, I explore the figure of the barefoot doctor, paramedical workers installed at the village level across the P.R.C. from the late 1950s to early 1980s. Defined in opposition to the urban doctor, barefoot doctors were integrated into national policy beginning in 1968. Promoting basic hygiene, preventative healthcare campaigns, and family planning in the Chinese countryside, barefoot doctors were integrated into national policy beginning in 1968, and quickly became a storied feature of the socialist Chinese healthcare system.

Although previous scholarship has evaluated the success of the barefoot doctors as a feature of the national healthcare system, I focus on their representation in popular culture, examining works of literature, art, and films that depict barefoot doctors during the Cultural Revolution, such as the films "Chun Miao" and "Hong Yu," as well as novels and profiles of barefoot doctors carried in national press. Depictions of barefoot doctors in these cultural texts constituted a powerful cultural phenomenon of the time, and in these works, I find that the barefoot doctor is situated in new cultures of labor and vocation that emerged during the Cultural Revolution out of on-going attempts to merge mental and manual labor. Barefoot doctors were celebrated for their unique status as both working members of rural communes as well as trained

healthcare workers, and in my analysis I examine the cultural logic through which the figure of the barefoot doctor made claims to social legitimacy and medical expertise.

Through an examination of cultural texts depicting medical work across the socialist period, I argue that popular depictions of barefoot doctors brought a new visibility to medical work that proposed new narratives for who could perform medical work and who deserved to receive it. I conclude with remarks on how the revolutionary expertise and medical authority embodied by barefoot doctors transitioned into Reform era cultures of medical professionalism.

This paper promotes CME learning objectives through its historically nuanced presentation of the organization of the socialist Chinese healthcare system from the late 1950s to the early 1980s. It develops a historically informed sensitivity to the diversity of patients by considering rural healthcare practice in China during the Cultural Revolution, and recognizes the dynamic interrelationship between medicine and society by considering how the socialist Chinese state understood and administered healthcare.

### **C3 Nature, Deviance, and Disability**

Rachel Louise Moran, University of North Texas, Denton, TX, USA

[rachel.moran@unt.edu](mailto:rachel.moran@unt.edu)

*“He Cannot Confine His Interests Solely to the Pelvic Outlet: The Rise of Psychiatric Screening in Obstetrical Practice, 1955-1995”*

This paper traces the rise of psychiatric screenings in obstetrical practice, especially around issues of perinatal mental illness, between the 1950s and 1970s. Psychiatry and asylums had managed some women with severe mental health issues related to pregnancy and childbirth during the 19th century, especially those diagnosed with puerperal mania. As these diagnoses morphed during the first half of the 20th century, the emerging specialties of obstetrics and gynecology generally even pregnancy-related mental health issues to be outside of their realm. Beginning in the 1950s, however, as psychology gained broader cultural cache, American obstetricians also slowly increased their attention to the relationship between the mental and physical aspects of their profession. This manifest in part through the rise of interest in psychosomatic medicine among obstetricians, and in part through more attention to emotion in obstetric texts and articles. While it was a minority of OBGYNs rethinking questions of emotion, mental health, and obstetrics, this still marked the beginning of a shift in the orientation of obstetrics toward diagnoses like postpartum depression. As this interest strengthened, psychosomatic gynecology moved from a special interest group into a specialization by the 1970s. When by the 1980s the idea of psychosomatics in particular declined, the understanding there was a critical relationship between emotion and OBGYN work remained.

Professional groups like the American College of Obstetricians and Gynecologists (ACOG) then developed practitioner and patient education tools. As OBGYNs increasingly functioned as

primary care providers for their patients, these practitioners were called upon to screen for, diagnose, and sometimes even treat mental health problems. At the same time, the definitions of pregnancy-related mental health problems grew more expansive, and were often ascribed to biochemical causes.

This paper is based in archival work at ACOG and period medical journals and obstetrical textbooks. It argues for the importance of understanding the moments when the histories of various medical specialties were intertwined and co-determinative. It also argues that the history of psychosomatic gynecology and the history of perinatal mental illness/postpartum depression, often imagined as having diametrically opposed orientations towards women, are related.

### Objectives

By the end of this activity, the learner will:

- 1) Identify successes and failures in the history of medical professionalism
- 2) Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
- 3) Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

### **C3 Nature, Deviance, and Disability**

Katherine Sorrels, University of Cincinnati, Cincinnati, OH, USA  
[katherine.sorrels@uc.edu](mailto:katherine.sorrels@uc.edu)

#### *Countercultural Communities and a New Approach to Disability in mid-twentieth-century Europe*

In April of 1939, nine-year-old Peter Bergel and his parents set out from Amsterdam for a small village in northern Scotland. This was not their first choice. Jewish refugees from Frankfurt, they had fled to Amsterdam in 1937 and applied for visas to the United States. Peter's parents' applications were granted, but entry restrictions for "defectives" scuttled Peter's application. The boy had contracted encephalitis when he was three and it had resulted in permanent brain damage. The British Home Office granted Peter a visa because his parents had found a doctor in Scotland willing to care for him. In a small village outside Aberdeen, a German Jewish refugee physician had just secured permission to open a residential care community for children with disabilities. Peter was to be his first patient.

In an era when the response to disability was shame, blame and institutionalization, the community's principles were that disabled children could enrich communities and that doctors should abandon the search for cures. Parents of disabled children welcomed this message and the community soon expanded into a global movement of more than 100 communities for people with disabilities which continues to thrive today. The founding principles seem to align with recent developments such as the philosophy of neurodiversity and the understanding of autism as difference rather than disability. Yet the movement originated in the era of eugenics

and as Douglas Baynton has noted, eugenicist concerns about disability were inseparable from concerns about race.

Last year at AAHM, I presented on the ways in which German racial thinking structured the founders' thinking about ability and disability. This year, I would like to present on Peter Bergel and the first generation of refugee patients. My sources are oral history interviews with older community members, genealogical research, and archival research conducted at the United States Holocaust Memorial Museum Archives. This work raises questions about how progressive the community's approach to disability was (and is). And such questions shed light on current historiographic discussions about the origins of the disability rights movement, the roots of the counterculture, and the intersections between the two movements.

#### Objectives

1. Reflect on the origins of the disability rights movement and the historical context for contemporary debates about neurodiversity.
2. Articulate intersections between the histories of the disability rights movement and the counterculture.
3. Describe how race, ethnicity, religion and class have factored in the appeal of the counterculture, alternative medicine, and special education (and continue to do so).

### **C3 Nature, Deviance, and Disability**

Theodore Porter, University of California, Los Angeles, Los Angeles, California, USA  
[tporter@history.ucla.edu](mailto:tporter@history.ucla.edu)

#### *Inherited Mental Illness: The Rise and Fall of Disease Specificity (ca. 1900-1920)*

For a century beginning in the 1830s, recordkeeping on mental illness and "feeble-mindedness" provided the principal basis for investigations of human heredity. This topic was simultaneously medical, social, and statistical, based mainly on routine data recording on newly-admitted patients of mental institutions. Emil Kraepelin's apparent breakthrough in disease classification in the 1890s gave hope of a similar leap forward in medical heredity. Psychiatric Mendelism, which first took off in the USA 1908, allied the genetic ambitions of Charles Davenport's Eugenics Record Office with institutional data and expertise. Davenport, in alliance with Aaron Rosanoff at nearby King's Park State Hospital, hoped to show that the new disease categories were transmitted as Mendelian units. This "American work" inspired German psychiatrists like Ernst Rüdin, Kraepelin's Munich colleague, to carry out a massive study on the Mendelian inheritance of schizophrenia. But Davenport and Rosanoff soon abandoned their original program, asserting instead the Mendelian inheritance of an all-inclusive "neuropathic make-up." It appears that the thousands of eugenic pedigrees, which often showed an uncontrollable variety of defects within a single kin group, undermined the push for specificity of inheritance. The skepticism of English statisticians (biometricians), who preferred from the start to speak of diathesis or constitutional weakness rather than to rely on specific disease categories, had only a secondary role. Rüdin, who at first blamed Davenport's failure on misdiagnosis by the female

labor force of eugenics fieldworkers, soon had to face results that were radically incompatible with expected Mendelian ratios. He began speaking of general degeneracy, and shifted to "empirical heredity prognosis" based on conditions that were neither specifically medical nor Mendelian. I call it a resurfacing of the asylum traditions of data work on heredity. Medical traditions, especially of asylum medicine, shaped as much as they were shaped by the genetic science. The rise of human genetics appears here not as an outcome of brilliant scientific discovery, but as a practical, medical-social tradition with an unmistakable bureaucratic dimension.

#### Objectives

Key words: medical genetics, disease classification, asylum data

Develop a sharpened understanding of the roles of data practices in medicine.

Learn to recognize the historical role of doctors and medical institutions not only in creating as well as deploying genetic categories.

Develop the capacity for critical thinking about the nature, ends and limits of medicine.

#### **C4 New Directions in the History of Venereal Disease**

Elliott Bowen, Nazarbayev University, Astana, Kazakhstan

[elliott.bowen@nu.edu.kz](mailto:elliott.bowen@nu.edu.kz)

*"In Search of Sexual Health: Examining America's Turn-of-the-Century 'Venereal Peril' From the Perspective of a Syphilitic Patient"*

Within the United States, the late nineteenth- and early twentieth-century was a time of growing concern over venereal disease (VD). In their analyses of this subject, historians have focused largely on the state, linking its repressive campaigns against prostitutes and other marginalized groups to syphilis' and gonorrhea's construction as stigmatized diseases of the "other." While these accounts reveal the gendered and racialized nature of contemporary public health policy, they tell us little about the lived experiences of people with VD. What meanings did sufferers attribute to their venereal illnesses? What curative strategies did they employ in their attempts to restore health? And more generally, how did the era's venereal stigma impact their lives?

In answering these questions, this study draws upon the writings of a turn-of-the-century syphilitic named Archie Cowles. A middle-aged man from Cleveland, Ohio, in 1907 Cowles traveled to Hot Springs, Arkansas in order to be treated for syphilis. While there, he regularly corresponded with friends and relatives, and his illness narrative challenges existing interpretations of the era's "venereal peril" on several fronts. First, although historians often contend that its status as the "wages of sin" meant that responses to VD were primarily of the moralistic sort, Cowles' writings show that syphilis' religious identity did not prevent the disease's victims from seeking out bodily remedies for their ailments. Second, whereas scholarly analyses typically frame this period's struggle with VD as a battle of "Science v. Sin," Cowles' experience shows that medical and moral responses often overlapped and

complimented each other. Like many of the venereal health-seekers who journeyed there, what drew Cowles to Hot Springs was the resort's status as a site of sacred healing, as a place whose divinely-endowed waters offered the promise of both restored health and forgiveness. Within Hot Springs, there was no strict divide between “science” and “sin.” In highlighting these themes, this study shows how localized, patient-centered analyses can lead to a richer, more complex understanding of the history of sexually-transmitted infections.

#### Objectives

By the end of this activity, listeners will:

- 1) Deepen their understanding of venereal disease and how individual patients suffered from this
- 2) Understand the dynamic history of medical ideas and practices, and their implications for patients and health care providers
- 3) Gain an ability to critically appraise the clinical management of syphilis, from an historical perspective.

#### **C4 New Directions in the History of Venereal Disease**

Pamela Maddock, University of Sydney, Sydney, NSW, Australia

[pamela.maddock@sydney.edu.au](mailto:pamela.maddock@sydney.edu.au)

##### *VD Control in Local Context: the Case of the US Army-regulated Brothel in Chihuahua, 1916*

The social history of venereal disease in modern America is a well-known military-public health story. Focusing on social trends and public health decisions, conventional narratives have foregrounded national policy and military decisions made in Washington. In examining VD in the army over the Mexican border, this paper looks at the influence of geographic, military, racial, and political contexts. What is clear from an examination of the US Army's brothel in northern Mexico in 1916 is that the people located in the vicinity of the American soldiers played a greater role in decisions of venereal disease management than did official army policy or the agenda of social hygienists. Villistas waging guerrilla war, destitute indigenous Mexicans and Chinese migrants fleeing horrific violence, and Mormon settlers managing lucrative farmland - through their presence, their circumstances, and their written words – shaped the army's regulation of sexual conduct and commerce.

The army camped in Chihuahua in something of a military holding pattern, having paused their pursuit of Francisco “Pancho” Villa. General John J. Pershing, at the request of a nearby Mormon bishop, commissioned a Chinese businessman to construct adobe huts for the army-run brothel in which American soldiers paid women for sex under strict regulations. Both the Mormon bishop's request and Pershing's private justification for the brothel centred on the presence of African American soldiers at the camp and relied on racist notions of hyper-sexualized black bodies. The paper will show how military insecurity in a politically and environmentally hostile context, racist panic in nearby white settlers, and atrocities committed in nearby villages from which refugees fled all contributed to the army's strict regulation of

sexual commerce in shoddy adobe structures. Indeed, the army's approach to venereal disease in this case exploited Mexican refugee women in order to placate white neighbours on whom they depended. The paper thus aims to bring new understandings to the American military-public health narrative of venereal disease control by foregrounding the local context and the role of non-state actors.

#### Objectives

Identify the impact of local cultural, economic, and military factors on venereal disease control in northern Mexico in 1916.

Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations).

Recognize the dynamic interrelationship between medicine and society through history.

#### **C4 New Directions in the History of Venereal Disease**

Anne Hanley, Birkbeck, University of London, London, UK

[a.hanley@bbk.ac.uk](mailto:a.hanley@bbk.ac.uk)

##### *Women doctors and their patients in the British VD clinics, 1918–39*

The interwar years were a watershed moment in the treatment and prevention of VD. In 1916 the Royal Commission on Venereal Diseases laid down a comprehensive series of recommendations, representing the first systematised state intervention for three decades to prevent the spread of infection among British civilians. What followed were free, universal healthcare provisions. At the heart of this new scheme was a nation-wide network of clinics, which offered unprecedented diagnostic and therapeutic services while also promising confidentiality. Having declared VD a national emergency, health authorities viewed the new scheme as integral to safeguarding the nation's future.

Yet, with only a few notable exceptions, these great infrastructural, ideological and clinical shifts have been overlooked. The essential role of women medical professionals has been especially obscured. Female VD medical officers emerged as a professional group in the aftermath of the First World War, offering vital care to women and children. They constituted about twenty-two per cent of interwar appointments to the VD clinics—an extraordinarily large percentage, given that, by the mid-1930s, women made up only ten per cent of the Medical Register.

The focus of this paper is twofold: to explore how women doctors carved out a unique professional territory in the VD clinics and how their patients, whose understanding of their own health and wellbeing often differed from the clinical metrics used by doctors, experienced the care on offer. Venereology, with its emphasis on hygiene and moral regeneration, was thought to benefit particularly from the intervention of medical women. At the same time, it gave women space to cultivate their professional identities. Venereology may have started life as a marginal and distasteful specialism, but the clinics offered women opportunities to build

up the necessary practical experience to pursue careers in gynaecology, obstetrics or genitourinary medicine. Moreover, the legitimisation of venerology did much to improve the experiences of women seeking treatment. But the terms on which treatment was offered were severe. The VD clinics may have offered infected persons free, universal care, but, as this paper demonstrates, there were also subtle forms of coercion and surveillance bubbling under the surface.

### Objectives

To identify the impact of local political and socio-moral factors on the development of the VD service in interwar Britain.

To develop a historically informed understanding of the experiences of infected persons who sought treatment in the VD clinics.

To recognise the important political and professional decision-making processes that facilitated the movement of women doctors into venereology.

## C5 The Gendered Culture of Pediatrics

Sandra Eder, University of California, Berkeley, Berkeley, CA, USA

[s.eder@berkeley.edu](mailto:s.eder@berkeley.edu)

*'Happy and Well-Adjusted.'* *Measuring Gender in Mid-Twentieth Century Pediatric Endocrinology*

Gender was not just an organizing principle in American Pediatrics. The very concept of gender was actually first formulated within the new subspecialty of Pediatric Endocrinology. Pediatrician Lawson Wilkins established the first clinic at Johns Hopkins Harriet Lane Home for Invalid Children in 1935 and published the first textbook of the new field. At his Pediatric Endocrinology Clinic in Baltimore, a team of pediatricians, surgeons, psychologists, and psychiatrists developed new treatment protocols and recommendations for intersex children in the early 1950s. They claimed that the majority of their patients had adjusted to the sex that had been assigned to them at birth regardless of biological factors such as gonads or sex chromosomes. Psychologist John Money, subsequently, coined the term 'gender role' to argue that these children learned to be boys or girls. To ensure proper 'gender role' development, the team recommended early sex assignment, genital surgery on infants, and not to change sex after a critical two-year period.

A great body of literature has revealed how intersex patients were (and are) forcibly normalized into male and female bodies. But how did pediatricians measure "gender role" and treatment success in these instances? How did they integrate the new idea of a learned gender role with already existing notion of (mal)adjustment? Using patient records, roundtable discussion transcripts, textbooks, and published papers, I explore how pediatricians measured the new categories of gender role in the clinic. I show how Wilkins and his team measured proper gender role through an assessment of femininity and masculinity that stemmed from clinical and parental observation of patients' behavior and appearance. Most notably, sex and gender were assessed in terms of psychological adjustment and happiness. I argue that 'happiness'

played a crucial role in the measurement of treatment success and that by the 1950s, there was a shift in the medical conceptualization of sex. Biological markers no longer solely defined the 'correct sex' but the decisive indicator was to choose the sex that allowed a child 'to grow up happily.'

#### Objectives

- Develop the capacity for critical thinking about the nature, ends and limits of medicine
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
- Recognize the dynamic interrelationship between medicine and society through history

### **C5 The Gendered Culture of Pediatrics**

Aimee Medeiros, University of California San Francisco, San Francisco, CA, USA  
[aimee.medeiros@ucsf.edu](mailto:aimee.medeiros@ucsf.edu)

#### *Pink and Blue: The History of the Gendered Framework of the Growth Chart*

Since the beginning of the 20th century, a cornerstone of the American well-child check up has been the assessment of height and weight measurements. Starting at birth, a young person's data are tracked and compared to synthetic averages serving as healthy norms by use of a growth chart. With each visit, the chart is updated and a new dot is plotted and connected to previous points that make up a curve intended to determine normalcy and health. While some pediatricians consider this process the best way to measure a child's vitality, ample consideration should be given to what also is measured and conveyed as this diagnostic technology produces multiple meanings, most of which are gendered.

"Pink and Blue" investigates the growth chart as a gendered information management system. This paper will look at the power of this device not only in establishing notions of normal stature and growth but also its ability to convey, confirm, and produce gender differences and hierarchies. It pays particular attention to the origins of the implementation of this diagnostic tool in clinical care and public health by examining it as a feature in the early twentieth century pediatric textbook by L. Emmett Holt, "The Diseases of Infancy and Childhood," and the US Children's Bureau's National Year of the Child Weighing and Measuring Campaign (1918). In both cases, gender played a role in how data was organized and used. Also, as other factors, such as race and class, had at times influenced the framework of this diagnostic tool, gender persisted to dominate its shape and formation. By critically analyzing the dichotomous gender framework of growth charts, this paper aims to contribute to existing historical scholarship on the role of metrics in pediatric care and child's health. In doing so, it aims to destabilize the assumption that the physical development of the child is best understood with growth charts organized by sex – girls and boys, pink and blue.

#### Objectives

Recognize the influence cultural notions of gender had on the creation of pediatric growth charts.

Relate how sociological conditions can influence medical innovations.

Identify the power of this gendered information management system in pediatrics and public health in a contemporary context.

## **C5 The Gendered Culture of Pediatrics**

Jessica Martucci, University of Pennsylvania, Philadelphia, PA, USA

[martucci@gmail.com](mailto:martucci@gmail.com)

*“A habit that distresses me very much”: Pediatricians, parental anxieties, and perceptions of self-stimulation in very young children*

In 1957, a concerned mother sought advice from the famous pediatrician, author and advice columnist, Dr. Benjamin Spock. Mrs. P had a 17-month-old daughter who she described as “healthy, normal,” and “quite smart for her age.” Despite these reassuring qualities, Mrs. P was troubled by one of her daughter’s idiosyncrasies. “About six months ago,” she wrote, her 11-month-old daughter “discovered that she felt some sensation from her organs.” “She does not touch or play with herself,” she quickly added, “but she crouches down on her hands and knees and moves back and forth.” The action itself, Mrs. P admitted, was not odd, but she could “see that she is getting some sort of a satisfactory feeling from this motion and gets quite angry when you try to distract her attention.” Upon seeking help from her child’s own doctor, he advised her simply “to ignore it.” Unfortunately, she wrote, the behavior was “getting worse instead of better.” She ended with a plea, writing “I would be deeply indebted if you could possibly help me.”

Through an analysis based on mothers’ letters, popular magazines, and published pediatric literature, I examine the mid-century medical management of sexual behaviors in very young children alongside the anxieties expressed by parents. By the 1950s, pediatricians had begun to embrace a developmental perspective on human sexuality championed by psychology, psychoanalysis, and the work of sex researchers. In response, a growing number of pediatricians began to oppose harsh measures to prevent children from acts of self-stimulation. Instead, as one physician put it, “self-stimulation in infancy is neither harmful nor significant of abnormality,” and required no real treatment. Despite this, pediatricians continued to hear from parents concerned about these behaviors. Building on works in the history of pediatrics, childhood, and sexuality, I explore how postwar pediatricians and parents understood masturbatory behaviors in very young children during a time when ideas about the relationships between gender, sex, culture and science were very much in flux.

### Objectives

1. Recognize the dynamic interrelationship between medicine and society through history.
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.

3. Understand how ideas about gender and sexuality in medicine and culture interact to influence medical norms and practices.

## **C6 Institutions: Design and Function**

Kylie Smith, Emory University, Atlanta, GA, USA

[kylie.m.smith@emory.edu](mailto:kylie.m.smith@emory.edu)

*Jim Crow in the Asylum: Silence, Segregation and Psychiatry in Alabama 1945-1980*

In June of 2017, US District Court Judge Myron Thompson ruled that Alabama Department of Corrections' failure to provide its prisoners adequate mental health care violated the Civil Rights Act. Thompson's judgement referred to earlier cases over which he presided, particularly *Wyatt v Stickney* (2003) brought against Alabama in 1972. The original case, per Judge Frank Johnson, held that minimum standards of treatment must be applied to all people in the state's mental hospitals. Alabama failed to meet Johnson's standards, and conditions for the mentally ill in both hospitals and prisons remained dire throughout the 20th century. This paper explores the long, complex history of Alabama's failing mental health services while shedding new light on the implications of racial segregation for southern psychiatry.

Historical literature generally does not explore the philosophy or practice of Southern psychiatrists, and histories by Grob, Hale and Halliwell remain silent on the peculiarities of Southern psychiatry around race. Where considerations of race and psychiatry co-mingle is largely in the context of Harlem's racial liberalism and is focused on private practice rather than state institutions. This silence ignores the significance of Alabama for the development of African-American psychiatrists and hospitals, and the connection between psychiatry, psychology and Civil Rights.

This paper results from work conducted as the Reynolds-Finley Fellow at the University of Alabama, Birmingham (UAB). It uses sources from UAB Archives, the Reynolds Finley Historical Library, Alabama state mental hospitals and the Alabama Department of Archives and History, and is supported by collaborations with the Equal Justice Initiative and the Southern Poverty Law Center in Montgomery, Alabama.

This research makes direct links between the history of mental health services and the experience of patients in Alabama psychiatric hospitals and prisons today. Contemporary patient outcomes are inordinately impacted by past state refusal of federal funds to maintain racial segregation, and by psychiatric practices based on racist views about the psyches of African Americans. Jim Crow was alive and well in Alabama's mid-twentieth century asylums, and this legacy has cast a long shadow over the mental health of all Alabamians.

### Objectives

1. Understand the development of psychiatric practice in the South
2. Appreciate the impact of structural and medical racism on approaches to patient care

3. Analyse the impact of broader social and political forces on the history of psychiatry

## **C6 Institutions: Design and Function**

Jennifer L. Thomas, University of Illinois at Urbana-Champaign, Illinois, USA

[jlthoma2@illinois.edu](mailto:jlthoma2@illinois.edu)

*An Exemplar Design Turn: Early Landscapes of the Pennsylvania Hospital for the Insane and Thomas Story Kirkbride*

An increased interest in the institutional histories of American mental health facilities—notably insane asylums built during the nineteenth-century—has produced an array of publications, exhibitions, and adaptive reuse site projects. Attendant narratives often highlight exceptional buildings, doctors, staff, or patients, while framing the beneficence of asylum landscapes as inherently evident and as locales of nostalgic garden or park-like experiences and farming practices. These landscapes were crucial for patient treatment under moral therapy, as well as vital for asylum management and function; however, the significance of American landscape design analysis to asylum studies remains underrepresented in the literature. Highlighting the importance of key landscape and design elements from the 1840s and 1850s at the Pennsylvania Hospital for the Insane implemented under the direction of chief physician Thomas Story Kirkbride (1809- 1883), this paper—through a qualitative design analysis of primary sources and secondary texts, landscape and architecture plans, and perspectival illustrations—argues that asylum superintendents and design professionals in emerging nineteenth-century subspecialties were interdependent, striving to assert professional legitimacy and improve social ills, by imperfect means through institutional landscape and building design.

Kirkbride was a well-known figure, in part because of his influential treatise “On the Construction, Organization, and General Arrangements of Hospitals for the Insane” (1854), the schematic and verbose manifesto outlining essential design and administrative components for a conjectural State hospital for 250 patients. Kirkbride introduced readers to an ideal, staggered hospital building type, a structural shape that became synonymous with his name and nineteenth-century American asylum design. Yet he was not an architect, engineer, or landscape designer; he was a doctor who collaborated with other professionals like Samuel Sloan and Andrew Jackson Downing in order to realize limited versions of the idealized asylum. This detailed exploration of landscape elements at the Pennsylvania Hospital for the Insane site enriches the contextual understanding of nineteenth-century patient treatment methods and the insane asylum construction movement more broadly, which further encourages it as a methodological approach for current and future studies.

### Objectives

- Deepen an understanding of the interconnectedness between the rise of American psychiatric and design professionalism in the mid nineteenth century

- Identify and apprehend contributing nineteenth-century asylum landscape elements believed to be essential for patient treatment and hospital function
- Recognize the dynamic interrelationship between medicine and design through history

## **C6 Institutions: Design and Function**

Melissa Lo, Cedars-Sinai Medical Center, Los Angeles, USA  
[melissalo@gmail.com](mailto:melissalo@gmail.com)

### *Filling in the Blanks: Form as Function in the Eighteenth-Century London Dispensary*

Tucked away in the Wellcome Library is a blank form, or “ticket,” that structured pivotal interactions between patient, midwife, and the Surrey Dispensary in London, circa 1780. Printed in order to assign a midwife to a pregnant “Object of Charity,” this document collated multiple genres of writing: the letter of recommendation, the list of rules, and the care-taker directory. My talk centers on the seemingly minor medical know-how transmitted by this ticket, especially in light of the circuitous itinerary of care it was meant to initiate. Drawing on the Surrey Dispensary archives, those of analogous clinics, as well as printed books describing in- and out-patient care from the period, and building on studies of the late-eighteenth-century London dispensary movement by Irving S. Loudon and Bronwyn Croxson, I argue that the patient was a critical protagonist in the administration of this type of institution, and that she was reminded of her role through surprisingly ephemeral paperwork. To deepen this discussion, I rely on the work of media studies scholars Benjamin Kafka and Lisa Gitelman, in addition to recent studies of gender, paper, and print across early modern English medicine, especially those of Elaine Leong and Mary Fissell. By way of conclusion, I touch on this ticket’s afterlife as a portable synopsis of medical administration. For this unused paperwork survives today because Thomas Adams, the late-eighteenth-century agent for the Duke of Northumberland and owner of Eshott Hall, was looking to establish his own charitable dispensary. His act of preserving this document argued for the blank form as epistemic exemplar.

#### Objectives

- Recognize multiple genres through which medical care was codified in the early modern period
- Think critically about the role of healthcare’s bureaucratic and administrative strategies
- Understand the dynamic relationship between gender and early modern medical institutions

## **D1 Media and Medicine**

Bert Hansen, Baruch College of CUNY, New York, NY, USA  
[bert.hansen@baruch.cuny.edu](mailto:bert.hansen@baruch.cuny.edu)

### *Medical History in the Movie Palaces: Hollywood’s Ten-Minute Films of the 1930s and 1940s*

Around 1940, Hollywood studios released at least a dozen medical history films as dramatic “short subjects” that were screened along with newsreels and cartoons, filling out the program for a feature-length movie. They were shown in neighborhood theaters; they were not made for schools. Major studios like Warner Brothers often used these professional, but low-budget shorts to try out new actors and directors. Fred Zinnemann was one of those unknown newcomers, and he won an academy award for directing an Ignaz Semmelweis story, “That Mothers Might Live.” He followed this with shorts on sleeping sickness, insulin, the pioneering ovariectomy by Ephraim McDowell, and the pellagra work of Joseph Goldberger. Today Zinnemann is better known for directing such landmark films as “High Noon,” “From Here to Eternity,” “Oklahoma,” and “A Man for All Seasons.” Other medical history short subjects of that era dramatized the work of Clara Barton, Christiaan Eijkman, Edward Jenner, René Laennec, and Philippe Pinel—each in less than ten minutes.

An examination of these hard-to-find films and a viewing of excerpts will enrich our picture of the general public’s awareness of medical history in the era before our discipline became professionalized. They deserve their place next to the better known feature films about Louis Pasteur, “Dr. Arrowsmith,” Walter Reed, Florence Nightingale, Paul Ehrlich, and Elizabeth Kenny. And their stark black-and-white images merit an aesthetic recognition alongside the era’s medical history stories in LIFE magazine and in fine art photography, New Deal murals, children’s comic books, and stained-glass windows.

Excerpts from these often melodramatic films will illustrate not only the now-dated historiography of larger-than-life heroes overcoming professional and popular resistance, but also the films’ success in bringing the medical past to life for lay people in just a few minutes. This presentation argues that, despite some stylistic and conceptual limitations, these films can be useful in the classroom because they tell a story so concisely. Students can also discuss how we might tell the story differently today. Further, these dramas remind us as scholars that our readers, like students and audiences, often respond well to biography-based stories.

### Objectives

To appreciate the popularity of medical history in the mid-twentieth century

To understand the power of a biographical approach to story telling.

To discover historical sources that can be stimulating in the classroom.

### **D1 Media and Medicine**

Fabiola Creed, University of Warwick, Coventry, UK

[f.creed@warwick.ac.uk](mailto:f.creed@warwick.ac.uk)

*From “overuse” to “addiction”:* Translating medical sunbed health advice to national television, England, 1990s.

Kelly Loughlin remarks that “audio-visual media ...[became] the means of communicating ideas and information about health and medicine to a mass audience” in the late twentieth century. Health-related news reports broadcast on national television, were far easier for the public to

access, than the medical articles which underpinned them. Yet, as Loughlin notes, “medical historians rarely draw upon ... television ... as historical source material.”

At the end of the 1980s, sunbed studies and anxious commentaries spiked in the British Medical Journal. A more extreme narrative emerged in newspapers, written by medical correspondents who used the BMJ as a ‘credible’ source. Over time, these newspaper reports increasingly framed sunbed consumption as a “narcissistic” and “self-destructive addiction”. An undesirable ‘Tanorexic’ stereotype emerged – commonly a young working-class woman or a flamboyantly homosexual man. This stereotype was reinforced in ‘health education’ reports presented on national television. Although the aim was to decrease skin cancer rates and improve the long-term health of the British public, this highly biased depiction stigmatized and alienated sunbed users, who also failed to recognise themselves in the stereotype. Therefore, this paper suggests that these broadcasts were more likely to create anxiety and secretive behaviours, rather than reduce sunbed use.

This paper will focus on the context, visual representations and rhetorical content of two influential anti-sunbed TV news reports. The first report, "Addicted to sunbeds", aired in October 1996; the second, "Sunbeds and skin cancer", in May 1997. Both reports will be compared to the original BMJ papers which prompted them, while oral histories will illustrate the ways in which the public received these news reports. Drawing on these rich examples, I ask, first, which aspects of the sunbed-related medical research attracted media coverage, and how did media officials translate them into ‘educational’ audio-visual accounts? Second, did this choice of television as a medium affect interpretations, or indeed the credibility, of anti-sunbed advice? Third, how did these reports change public opinions towards the sunbed phenomenon; and finally, how public and medical opinion influence sunbed users – did overall consumption rates eventually change?

### Objectives

1. Recognize the dynamic interrelationship between health experts writing for medical journals and ‘media medics’ presenting on national television.
2. Critically appraise medical theories linked to sunbed consumption from a historical perspective.
3. Identify successes and failures in the history of public health campaigns.

### **D1 Media and Medicine**

Mirela David, University of Saskatchewan, Saskatoon, Canada  
[mirela.david@usask.ca](mailto:mirela.david@usask.ca)

### *Exhibiting health and hygiene in The New Life Movement in the late 1920s-1930s Republican China*

This paper examines a series of national and local health campaigns from 1930s China. I pay particular attention to the Industrial Hygiene exhibition in Nanjing in 1928, as well as the Health

Exhibition in Shanghai that was part of the 15th Health Campaign in 1936. I analyze the colonial authorities' reticent involvement as well as the larger New Life Movement Organization in charge of this campaign. I frame these campaigns within the larger commitment of the Nationalist government to national hygiene and public health, while also acknowledging that this commitment was framed within the dialectical move between personal hygiene and national hygiene goals. I also inquire into the ideological matrix of the New Life Movement, in particular the emphasis on hygienic projects and its intersections with eugenics. Through the implementation of public inspections and policing of personal hygiene habits, the New Life Movement could certainly be seen as a form of what Foucault calls "authoritative biopolitics," in which the boundaries of what constitutes privacy become less and less visible. The display of diseased people and organs at the hygiene exhibition suggests the parading of life itself in all of its diseased manifestations, and in so doing dehumanizing the very subjects they sought to display as a social warning. The procreative role of women was a main feature of the Shanghai Health Exhibition, because of the concern of the Nationalist state for safeguarding the future health of the nation. The display concerning "pregnancy hygiene" went beyond pictures, to also feature "models" of female reproductive organs including "the uterus" in various stages, such as "an impregnated uterus," and fetuses in various gestational stages and shapes, such as "abnormal fetuses." Because the National Government named the year from August 1935 to July 1936 "The Year of the Children," the campaign was addressed to children and their parents, and aimed to provide women with "maternal hygienic knowledge." Lastly I will analyze a few better baby contests such as the one held in Suzhou in 1932, when the organizers inspected the children's health and cleanliness for 3 days because of the high number of contestants.

Key words: Hygiene exhibitions, The New Life Movement, eugenics

#### Learning objectives

1. This paper is about the Nationalist Government's New Life Movement and its emphasis on promoting hygiene and public health.
2. This paper is of interest to global histories of eugenics and public health.
3. This paper uses Chinese language print media sources from the 1930s and archival material.

## **D2 Concussions: Histories, Cultures, & Violence**

Stephen Casper, Clarkson University, Potsdam NY, USA  
[scasper@clarkson.edu](mailto:scasper@clarkson.edu)

*Punch-Drunk and Dementia: A Cultural History of Concussion in Boxing and Domestic Violence, c1928, c1990*

The story of concussions is at once an intellectual history of medicine and at the same time a cultural history of violence, accidents, entertainments and litigation in the English-speaking world. It is a history of dialectics and tensions: medical knowledge and public ignorance; physical trauma and psychosomatic illness; and real suffering against supposed malingering. Medically, it is possible to follow concussive injuries out of the nineteenth century worlds of pathological anatomy and asylum psychiatry and end up in twenty-first-century sports medicine

and neuropsychology. Culturally, the topic moves easily from worlds of bare-knuckle fighting and factories in the nineteenth century, to automobile accidents in the interwar and early postwar period, to battered women and children, and, finally to football fields and hockey arenas by the 1990s and after.

This lecture follows these intersecting stories of culture and medicine simultaneously through two paradoxically disconnected sites: On one hand, boxing, where the question of brain injury and its sequelae were analyzed from 1928 on, often on profoundly somatic grounds. On the other hand, domestic violence, where the question of brain injury and its sequelae appear to have been first examined after 1990 and symptoms were often cast as functional or even rational in specific psychiatric nomenclatures. It is the object of this lecture to examine that chronological and epistemological disconnection between forms of violence that appear otherwise highly similar even if existing in profoundly different spaces. This study therefore focuses on what the medical profession knew and when. But it also follows sources in culture that rendered head injuries in domestic violence invisible until 1990, the year they first came to the foreground.

#### Objectives

Audience members will better understand the history of concussive head injuries; (2) Audience members will develop an appreciation of the variety of sites and circumstances in which head injuries occur; (3) Audience members will be able to connect past clinical and scientific research on concussions to immediate social and medical policy concerns.

## **D2 Concussions: Histories, Cultures, & Violence**

Lynsey Shaw Cobden, Air Historical Branch (RAF), Middlesex, UK  
[lynsey.shaw@wolfson.ox.ac.uk](mailto:lynsey.shaw@wolfson.ox.ac.uk)

*'The Nutcracker Suite': Concussion and The Military Hospital for Head Injuries (Oxford), 1940-45*

From the "commotio cerebri" of the First World War (1914-18) to mTBI in the modern era, concussions and closed head injuries have confounded military medical professionals. While moderate and severe head traumas were easily identified and rapidly treated by combat medics, concussions or mTBIs were often regarded as inconsequential. Historians of medicine in Britain have also overlooked this form of brain injury, with discussions of mild trauma mostly confined to studies of 'shell-shock.' This represents a critical lacuna in the historiographies of military medicine and neurology, for these injuries were matters of grave concern to the British armed forces, state, and military medical professionals. In the post shell-shock era, concussions and closed head injuries represented a threat to military manpower and a potential financial burden. With these problems in mind, the armed forces engaged neurologists, neurosurgeons, and neuropsychiatrists en masse to treat head injuries and their adverse effects. During the Second World War (1939-45), these medical specialists were permitted to establish a dedicated head injuries centre, which allowed for the collaborative study of head trauma, brain function, and disease. This paper will examine the clinical work and research of this hospital, with

reference to the challenges presented by concussion and closed head injuries. Affectionately known as 'The Nutcracker Suite', the Military Hospital for Head Injuries (Oxford) treated 13,000 military patients, under the leadership of Brigadier Sir Hugh Cairns. This innovative facility is often associated with his pioneering neurosurgical achievements but its remit was far wider. This paper will argue that research into concussion and closed head injuries were of equal importance for these patients had a greater chance of returning to duty and a productive working life. It will examine the clinical challenges presented by concussion and the application of innovative technologies in its research and diagnosis. Drawing upon contemporary research papers, administrative records, and patient case notes, it will conclude that concussion was not merely a medical challenge, its diagnosis was a national concern with social, military, and economic consequences.

### Objectives

Audience members will better understand the history of concussive head injuries; (2) Audience members will develop an appreciation of the variety of sites and circumstances in which head injuries occur; (3) Audience members will be able to connect past clinical and scientific research on concussions to immediate social and medical policy concerns.

## **D2 Concussions: Histories, Cultures, & Violence**

Kathleen Bachynski, New York University, New York City, NY, USA  
[kathleen.bachynski@nyumc.edu](mailto:kathleen.bachynski@nyumc.edu)

*"A Clear Conscience": Setting Helmet Standards and Responsibility for Football Injuries, 1960s-1970s*

At the American Medical Association's 1962 conference on head protection for athletes, attendees expressed skepticism about the effectiveness of helmets. The introduction to the proceedings emphasized "that we are severely limited in the protection which can be afforded even with ideal materials and design." Furthermore, doctors expressed concerns that recently introduced plastic helmets in fact increased injury risks. Nonetheless, eliminating football helmets was not considered as an option. Instead, by the 1960s, product safety research and the development of football helmet standards were promoted as a leading solution to address head and neck injuries in football.

Using the methods of social and cultural history, and drawing on court cases, football league publications, medical journals, and newspaper accounts, this presentation examines how this focus on helmets as the key to safety, particularly the process of setting helmet standards, shaped attitudes about responsibility for the physical risks of football. Several non-profit voluntary standards associations formed by scientists and engineers began devoting attention to protective football gear in the 1960s. Ultimately, however, a new organization funded by sporting goods manufacturers, the National Operating Committee on Standards for Athletic Equipment (NOCSAE), proved most influential in establishing football equipment standards in the 1970s. Ironically, the NOCSAE helmet standard was quickly developed and adopted by

leading football leagues amid ongoing uncertainty about how effectively lab-tested standards might translate into on-field protection, particularly with regard to preventing concussions. Sporting goods manufacturers' influence on the development of helmet standards was spurred by changing ideas about who could be held responsible for harms caused by consumer products such as helmets. New legal principles had led to an increase in the number of lawsuits against football helmet manufacturers. The sporting goods industry in turn sought to limit its liability by framing football injury prevention as the responsibility of individual players, parents, and coaches. Manufacturers insisted that their voluntary adoption of helmet standards, and their avoidance of government interference, would save football. But the industry's efforts to limit its liability made individual players and families responsible for managing the consequences of devastating, lifelong, sports-related injuries.

#### Objectives

(1) Audience members will better understand the history of concussive head injuries; (2) Audience members will develop an appreciation of the variety of sites and circumstances in which head injuries occur; (3) Audience members will be able to connect past clinical and scientific research on concussions to immediate social and medical policy concerns.

### **D3 Medical Diplomacy in the Cold War**

Dora Vargha, University of Exeter, Exeter, UK  
[d.vargha@exeter.ac.uk](mailto:d.vargha@exeter.ac.uk)

#### *The Roots of Socialist International Health: View from Eastern Europe*

Shortly after the establishment of the World Health Organization (WHO), the USSR, Albania, Czechoslovakia, Bulgaria, Poland, Hungary and Romania withdrew from the organization. The Soviet Union and the above Eastern European countries were inactive members of the WHO until 1957 when most of them returned to the organization, with Hungary being the last to re-join in 1963. There has been very little historical discussion on this episode, and even less on how Eastern European countries grappled with the withdrawal. Based on governmental archives, news media, personal correspondence and conference proceedings, this paper argues that throughout the 1950s Eastern European countries were far from isolated in terms of international health. Data, knowledge, practices and specimens circulated among members of the Soviet Bloc and beyond in the socialist world, while scientific and technical exchange characterized relations with the West. Eastern European countries maintained interaction with the WHO, especially regarding epidemic reporting, while establishing an alternative international health system through bilateral and trilateral agreements and fostering co-operation through a high number of international conferences.

Eastern Europe's role in international public health and the rise of socialist internationalism within the years spent outside of the WHO reinforce the importance of regional perspectives in historical research. Scholars such as Sanjoy Bhattacharya and Sandrine Kott who have argued for shifting focus from Geneva to local networks and regional centers when examining

international organizations, and historians such as Marcos Cueto have demonstrated the importance of regional policies in shaping global health programs. Building on this historiography, the paper shows that geographically and conceptually de-centring narratives of internationalism and global public health, especially ones tied to the Cold War, is crucial for a nuanced understanding of this formative era. By bringing Eastern Europe into the focus and considering alternative internationalisms, new faces, practices and relationships become visible, which, in the end, can help us piece together a more comprehensive picture of international and global health in the 20th century.

#### Objectives

Recognize the dynamic interrelationship between medicine and society through history  
Acquire a historically nuanced understanding of the organization of other national health care systems  
Identify successes and failures in the history of medical professionalism

### **D3 Medical Diplomacy in the Cold War**

Heidi Morefield, Johns Hopkins University, Baltimore, MD, USA  
[heidi.morefield@jhmi.edu](mailto:heidi.morefield@jhmi.edu)

#### *Transplanting Technology: Dr. DeBakey in Cold War China and the USSR*

At the height of the Cold War, Dr. Michael E. DeBakey, one of the most prolific American surgeons of the 20th century, made several trips to China and the USSR to survey the medical landscape on the other side of the Iron Curtain. He toured clinics and medical schools and met with barefoot doctors. DeBakey became a broker of valuable medical information, teaching new techniques and introducing new machines in the USSR and China, while reporting on the conditions of Chinese and Soviet medical institutions back home to the American public. His diplomatic success was possible in part because of his willingness to take less high-tech medical systems seriously—he praised the barefoot doctors and was “impressed” with Russian medical inventions that were showcased during his visits. DeBakey became so trusted in the East that decades later when one of DeBakey’s Russian disciples, Rinat Akchurin, was faced with treating the ailing President of the Russian Federation Boris Yeltsin, he called DeBakey in for assistance with the complex multiple-bypass operation.

This paper draws from archival and oral historical material in Dr. DeBakey’s personal papers to consider the ways in which he was able to gain mobility between the Cold War East and West through his expertise in medical technology. It shows that while DeBakey was undoubtedly a technologist—he was well known for his invention of the Dacron graft, a left ventricular assist device, and the artificial heart—he did not necessarily see the more advanced technology of his clinic back in Houston as superior to some of the simpler devices and systems he encountered overseas. Rather, DeBakey understood medical technology as being appropriate only in context. With rich diary entries describing his visits, DeBakey situated both the Western technology he helped transplant to the East as well as that which he encountered there within

the topography of the Soviet and Chinese medical systems. In reflecting upon DeBakey's Cold War travels, this paper seeks to interrogate how his influence and mobility shaped perceptions of both American and communist-sphere medical technology.

#### Objectives

Keywords: appropriate technology, cold war, cardiac surgery

1. Recognize the importance of individual physicians as medical diplomats
2. Understand the role of medical technology in facilitating exchange between the Cold War superpowers
3. Identify successes and failures in the history of Cold War medical collaborations

### **D3 Medical Diplomacy in the Cold War**

Emily Harrison, Harvard University, Cambridge, MA, USA

[harrison@post.harvard.edu](mailto:harrison@post.harvard.edu)

*Measured Diplomacy: Leona Baumgartner and the Metrics of Infant Mortality in the Global Cold War*

“Soviet authorities have promised to send to Dr. Leona Baumgartner, New York’s Commissioner of Health, hitherto unpublished Soviet health statistics,” announced the New York Times in its June 12, 1958 edition. Baumgartner, who had induced this promise while on a twenty-five day tour of the Soviet Union, was a rising authority in international health development. With a worldview characteristic of mid-century U.S. social medicine, a marginal field within institutions of biomedicine, Baumgartner’s authority rested on her expertise in the reduction of infant mortality. As a visiting health expert, she expected the infant mortality rate to be a tool of health diplomacy: a mediator of cooperation across vast sociopolitical differences. Appointed Assistant Secretary of State and Administrator of the new United States Agency for International Development in 1962, she would abandon the metric as she observed its failure to attract her vision of “human development.”

Historical work on infant mortality has compared social responses to infant death and highlighted cases of international influence on the deployment of the metric, yielding insights into the production of policies and inequalities. Critical scholarship on the metric itself, however, is limited. Using archival materials collected in personal, medical, state, and national archives in Ecuador, India, and the United States, this presentation describes and explains the shifting metrics of infant mortality in the context of the global Cold War. I argue that the meaning of the infant mortality metric changed amidst the politics of global development, from a social index to a proxy for a more individualized conception of public health. These changes in international development were intimately related to the loss of a social way of knowing in biomedicine not only in international settings abroad, but contested politics of health within the United States. The presentation discusses the consequences of a diplomatic approach to international development for not only the metric of infant mortality but also Baumgartner’s broader vision, focusing on the role of infant mortality in the rising racial tensions visible in the

encounters between academic medicine and the neighborhoods of Boston, Massachusetts where Baumgartner ended her career in the early 1970s.

#### Objectives

- \* Understand health metrics as historically contingent objects
- \* Destabilize increasingly popular historiographical boundary between the “global north” and the “global south”
- \* Critically examine the rise of quantitative methods in the health sciences as a global phenomenon

#### **D4 Waters, Wounds, and Hospitals**

Valeria Finucci, Duke University, Durham, NC, USA  
[vfinucci@duke.edu](mailto:vfinucci@duke.edu)

##### *“The Wound that Will not Heal: Vesalius and Brain Injuries”*

This paper will examine the never ending cultural fascination with the brain by looking back in time at one instance in which a brain injury advanced the surgeons’ knowledge of this organ. Andreas Vesalius had fully illustrated the anatomy of the human brain in his *Fabrica of the Human Body*, but had had no access to the brain of a living human being and no tool to unlock its features. It is with this hand-on but perhaps inexact expertise in his background that one day he was called to Paris to address what was going wrong with King Henri II of Valois, who was lying in bed in a semi-conscious state after a splint in a tournament had entered his eye. In a series of consults with the array of doctors and surgeons called in by the French court, opinions on what to do varied greatly. Vesalius’s diagnosis—that this patient was beyond a cure—came as a result of what I will argue is the first test of meningitis that has been recorded; and his understanding that paralysis on one part of the body means that different parts of the brain govern different bodily motions was important in understanding neurodegenerative conditions. Lastly, Vesalius’ autopsy of the king’s brain after death provides a better understanding of how what killed him—infection as it turned out, for which no cure was available at the time—manifests itself in the eyes, face, neck and head. King Henri died on July 10, 1559.

#### Objectives

- to develop an appreciation of the workings of the brain as they were understood in the 16th century
- to retrace the relationship between medicine and politics in society
- to understand the importance of physical examination

#### **D4 Waters, Wounds, and Hospitals**

Andrew Wehrman, Central Michigan University, Mt. Pleasant, MI, USA  
[wehrm1am@cmich.edu](mailto:wehrm1am@cmich.edu)

## *Yellow Springs and the “Indian Hut” Hospitals: American Hospital Design and Innovation During the American Revolution*

The American Revolution is not usually remembered for its innovations in the field of medicine. The Army’s Medical Department was under-equipped and suffered from bitter feuds among its leaders. Typically historians of medicine look to the Civil War for innovations in hospital design, such as improved ventilation and separate wards for patients. While most of the ill and injured during the American Revolution were housed in existing buildings: churches, barns, college dormitories, and etc., Americans did create two new hospitals whose innovative designs were meant to better serve the stricken soldiers of the Continental Army within the American environment.

Drawing on native influences and emphasizing natural environments, the first truly American hospitals—designed and constructed during the American Revolution by the Army’s Medical Department—countered previous European models by crafting a holistic, patient-centered convalescence that reinforced longstanding colonial experiences and aesthetics. This paper argues that the Revolution provoked a provincial response to European hospital design resulting in innovation that some Americans hoped would define medical practice in their new nation.

My paper will focus on the design of these two innovative hospital structures. The only hospital commissioned by the Continental Congress to be built during the war was Yellow Springs Hospital in Pennsylvania. The mineral springs, once used by the Lenape, were sought after for their medicinal powers. The three-story hospital built near the springs in 1778 gave patients access to the healing waters, and also featured wraparound balconies providing patients with fresh air without compromising quarantine restrictions.

Even more experimental was the design of Dr. James Tilton. Dr. Tilton experienced first hand the horrors of the Continental Army’s hospitals. While overseeing the hospital at Princeton, Tilton contracted “hospital fever,” or typhus and nearly died. Afterward Tilton visited dozens of makeshift hospitals and declared that soldiers died like “rotten sheep” upon spending any time in them. Tilton devised an innovative alternative. Tilton supposed that the American environment required an American hospital, and he designed his “Indian Hut Hospital” after Native American longhouses. Made from roughly hewn logs with bare earth floors, the hospitals were designed to reduce infection.

### Objectives

- Acquire a historically nuanced understanding of the organization of the U.S. healthcare system
- Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

### **D4 Waters, Wounds, and Hospitals**

Walton Schalick, Department of Orthopedics and Rehabilitation, University of Wisconsin,  
Madison, WI, USA  
[schalick@wisc.edu](mailto:schalick@wisc.edu)

*“Wonder Water: The ‘Marvels’ of Medieval Medicine”*

A Brugeois manuscript from April, 1275 thrilled to a certain, “secret, wonder water, by which a doctor performs marvels. If he can make it, he will not be called a doctor, but propheta!” The text described how ‘wonder water’ could be used for treating leprosy, relieving blemishes and conserving youth. A comparable Cameracum manuscript focused on other practical topics, describing a “marvelous water” that the doctor should tailor to “divicias patientis.” That author also teased, “I know many other secrets about this liquid water, nevertheless I will remain silent about them, [for] a doctor having this water will be elevated...”

In this paper, we will examine the development of ‘aqua mirabiles’ against changes in high and late medieval alchemical medicine and theology, paying particular attention to the balance of theory and practice. Using a rich database of original manuscripts, as well as primary texts in manuscript and edited formats, from Latin, and multiple vernaculars, I will suggest that medieval physicians first struggled with and then vigorously embraced the wondrous as a tool for market control.

Situated between the miraculous analyses of scholars from Brown to van der Lugt and pivotal alchemical studies from Newman to Calvet, recently joined by McVaugh, this paper blends macro-theoretical/practical shifts of the 13th-15th centuries against the micro-market-maneuverings of author-practitioners.

What emerges is a ‘fluid’ progression of the ‘marvelous’ within medieval medicine. Based on manuscript and text counts, descriptions of ‘wondrous’ waters and other remedies increased geometrically through this period and became a new feature of late medieval medicine. There was a clear ambivalence among theologians and natural philosophers to leave wonders unexplained. Despite this ambivalence, the ‘medici’ were willing to appeal to the subliminal market power of wonders. And where theologians emphasized marginalization, physicians doubled down, making the wondrous central. In a fashion, wonders were a means for physicians to have their cake and eat it too.

Finding a way to harness the totemic power of wonders was critical for these early professionals. The wondrous became a cross-over product, one with sufficient intellectual puissance that yet retained the sparkly cache craved by the marketplace.

Objectives

1. The auditor will be able to describe changing roles of (al)chemical innovation in medieval medicine.
2. The auditor will be able to describe an interface of religious and natural philosophical explanations of healing.
3. The auditor will be able to identify the growth of wondrous remedies in medieval medicine.

## D5 Gender and Transformation

Winifred Connerton, Pace University, College of Health Professions, Lienhard School of Nursing,  
New York, NY, USA  
[wconnerton@pace.edu](mailto:wconnerton@pace.edu)

### *Nursing the Transformation Zone*

Professional nurses began traveling the world shortly after the profession came into existence. American nurses went with the Army and colonial governments to the newly occupied U.S. territories after the Spanish-American War; with Protestant missions to India, China and Syria; and with international philanthropies like the Rockefeller Foundation projects throughout South America and the Caribbean. American Nurses were everywhere – working with local populations in clinics, birth rooms, operating suites and nurse training schools. Wherever they went nurses established communities of practice who shared a common language of health and treatment. This paper argues that nurses' intimate contact with local populations offered a unique opportunity for the exchange of ideas, and created a zone where all participants were transformed.

Studies of colonial medicine often omit nurses as a locus of investigation. This creates the impression that nurses were either not present, or that they had no influence on colonial interactions. Studies that do include nurses often present them as simple agents of empire, which negates nurses' agency as well as that of their patients and students. This paper builds on the Comaroffs' idea of a colonial conversation in which all parties contribute to the colonial experience. Using records from the Army Nurse Corps, the Philippine and Puerto Rican colonial governments, Presbyterian and Episcopal missions, the Puerto Rican Nurses Association, and a Hawaiian settlement house, I explore facets of American nurses' colonial presence and the multiple exchanges that took place across social, racial, political and territorial boundaries as transformative zones of colonial interaction.

American nurses influenced the developing nursing profession around the world, and each locale adapted the tenets of professional nursing education and practice to their own particular cultural and political landscape. American nurses, in turn, leveraged their colonial experiences for their own social and professional advancement at home. Whatever ideology undergirded nurses' colonial work, they occupied a pivotal position at the site of intellectual and cultural exchange where ideas and experiences were incorporated and adapted by everyone involved. This site, the transformation zone, was marked by acceptance as well as rejection, and no one was left exactly the same.

### Objectives

1. Recognize the dynamic interrelationship between health care and society in colonial settings.
2. Deepen understanding of the role of nursing education in colonial territories.
3. Recognize the similarities of colonial health care goals across multiple territories and colonial agencies.

## D5 Gender and Transformation

Shenglan Li, Wheaton College, Norton, MA, USA

[li\\_shenglan@wheatoncollege.edu](mailto:li_shenglan@wheatoncollege.edu)

### *Nursing, Gender, and State Medicine in Wartime China, 1925-1945*

In the late 1920s, medical reformers in China promulgated a system of State Medicine as the blueprint for national healthcare. Inspired by European and American models, the State Medicine centralized the government's role in the top-down health planning and activities. The system eventually received the Chinese Nationalist government's endorsement in the next decade, when the country was fraught with both domestic strife – partisan rivalries between the nationalists and the communists – and the menace of foreign invasion. Existing scholarship has interrogated the visions and policies of the State Medicine as well as its legacies during the PRC era. However, little is known about the system's gendered implications and quotidian implementation during wartime, the critical phase of modern China.

Drawing upon medical professionals' reports, correspondences, official documents, and contemporary publications from archives in mainland China, Taiwan, and the U.S., this paper uncovers nurses' significance in the fledgling state-sponsored health care. The increasing visibility of nurses, public health nurses in particular, intertwined with the State Medicine taking shape on China's path to wars. In response to the outbreak of the Second Sino-Japanese War (1937-1945), projects under the State Medicine were reorganized, relocated, and exposed to different demographics. Approaching the local population – rural housewives, children, and headsmen in particular – to acquire vital data, disseminate hygienic knowledge, and provide unsolicited medical services posed challenges and demanded strategies. Through home visits and health education, nurses demonstrated their instrumental roles in transforming Chinese women's and men's attitudes towards biomedicine and healthcare habits. Their practice also carved out a critical venue for channeling the wartime impulses of rejuvenating national health and strength into Chinese daily lives. These encounters, in return, informed and refueled debates regarding gender roles in constructing both Chinese nursing ideals and civic values. In sum, this paper suggests that wartime nursing, by virtue of its capability to address gender-specific challenges, provided a critical vehicle for instituting state-sanctioned medical care and established a precedent for the infiltration of primary care into villages.

#### Objectives

- Understand the dynamic history of public health ideas and practices, their implications for patients, health care providers, society, and politics.
- Develop a historically informed sensitivity to gender, class, ethnicity, and culture that shaped both caregiving and care-receiving experiences.
- Acquire a historically nuanced understanding of Chinese national health care systems and global currents of biomedicine.

## **D5 Gender and Transformation**

Sara Farhan, York University, London, Canada

[sfarhan@yorku.ca](mailto:sfarhan@yorku.ca)

*Ḥakimmāt Baghdad: Colonial Medicine and Women Practitioners amidst Transition  
(Late-Ottoman to British-Mandated)*

Until recently, Baghdadi women had been an ancillary part of health care systems as medical practitioners and consultants. In the late Ottoman period, Baghdad's female practitioners were regionally renown for their skills as they provided services within and outside of their Willaya. Yet, during the British Mandate, Baghdadi women were gradually excluded from the medical profession in Iraq through the process of reconfiguration of the medical field. British-pedagogical re-meritocratization of Baghdad's existing health systems reoriented the gender of medicine and discredited non-western credentials and experience-based qualifications. While both Baghdadi men and women were targeted under these systems of reorganisation, women specifically were excluded. This reorientation process was not so fixed; however. Negotiations in the form of cooperation, opposition, and compromise allowed female practitioners to elbow their way through colonial red-taping of the medical field.

The history of Baghdadi female medical professionals and their targeted exclusion from the field tells us more about the conceptualisation of medicine in Ottoman Iraq and the rigorous transition the discipline underwent during the British mandated period. Analysing memoirs, medical journals, archives, and personal interviews, I attempt to reframe our current understanding of colonial medicine. The claim that colonial medicine encompassed and/or altered all aspects of its subjects' lives is inapplicable in the case of Baghdad.

This paper, then, is a counter-narrative: While health care systems in post-Ottoman Iraq was restructured with the guise of British being its main architects, directors, and advisors – female medical professionals, who felt the blunt of this transaction, acted as its subjects, collaborators, and opponents.

### **Objectives**

Shedding light on history of medicine in Iraq

Shedding light on role of women in medicine during late-ottoman and British mandated Iraq  
countering the narrative that colonialism made and unmade medicine and health systems in the colonies

## **D6 Health Policy in Britain and New Zealand, 1938-2000: exploring the 'families of nations' approach**

Martin Gorsky, London School of Hygiene and Tropical Medicine, London, UK

[martin.gorsky@lshtm.ac.uk](mailto:martin.gorsky@lshtm.ac.uk)

*Culture, language and networks: 'families of nations' and the making of health policy in Britain and New Zealand since 1938.*

Comparative history has been widely used as an approach to understanding health policy-making. Typically scholars identify common variables discernible across different nations, such as the power of organized medicine, the mobilization of labor, or the role of institutional legislative structures, and then assess their relative importance at particular junctures. An alternative framework, as yet marginal, is that of 'families of nations', which foregrounds the causal significance of ideas diffusing across states with shared linguistic and cultural attributes. This paper discusses the potential of this approach to health politics in Britain and New Zealand, 1938-2000. The timeframe opens with major health system reform, inaugurating universal, comprehensive, predominantly tax-funded services in both countries. It covers the accelerating policy quest for efficiency, equity and cost-effectiveness, as medical technologies proliferated and populations aged. It closes with the internal market reforms that followed the 'neoliberal' policy turn, in which the governments of Margaret Thatcher (UK) and David Lange (NZ) stood at the vanguard.

The first section employs secondary literature review to introduce the historiography of comparative health politics, and unpack key features of the 'families of nations' thesis. It also observes cognate literatures, such as histories of medical migrations, trans-national policy exchanges and centre-periphery relations in medical innovation. The second section draws on original policy documents and synthesizes national histories to construct parallel timelines for the two countries. These make the case for distinct commonalities in their health politics. Finally the existing state of knowledge about flows of policy ideas between the two nations is surveyed.

While it is unlikely that 'families of nations' considerations will displace structural factors as explanatory tools, consideration of these two countries suggests they can play a crucial role. This preliminary overview points to some of their mechanisms, in professional interchanges, vectors of intellectual dissemination, and the contingent agency of key individuals. These are themes explored further in the panel through the more detailed studies that follow. Taken together, they underscore the importance of considering language, culture and networks, as the impetus towards global history increasingly lifts the study of organized medicine out of national silos.

#### Objectives

By the end of this activity, the learner will:

1. Understand the dynamic history of ideas and practices in health policy making and their implications for health care providers.
2. Promote tolerance for ambiguity of theories and the nature of evidence.
3. Acquire a historically nuanced understanding of the organization of different national health care systems, and the reasons for their similar or different developmental trajectories.

## **D6 Health Policy in Britain and New Zealand, 1938-2000: exploring the ‘families of nations’ approach**

Linda Bryder, University of Auckland, Auckland, New Zealand  
[l.bryder@auckland.ac.nz](mailto:l.bryder@auckland.ac.nz)

### *New Zealand’s National Health Service, Sir Douglas Robb and the ‘Family of Nations’*

This paper engages with the ‘family of nations’ concept which is used to help understand the development of health systems across the globe. Specifically it provides a case study of New Zealand’s health system set up by the first Labour Government in the 1930s and 1940s. Widely celebrated as an example of the mid-twentieth century classic welfare state with universal free health care, the system was severely critiqued by a local surgeon and health reformer, Dr (later Sir) Douglas Robb immediately after it was established. In this paper I consider the nature of his criticism, its impact and in particular the ways in which he formulated his ideas with constant reference to overseas examples. I show how he perceived the problems as the result of historic divisions between preventive and curative, and public and private medicine, with little long-term planning. For him, the goals for future reform were ‘Quality, economy, efficacy and efficiency’. Sources for this analysis include his own publications, and his voluminous international correspondence. I argue that his criticisms throw light on New Zealand’s mid-century health system, and that he was significant in seeding ideas for reform. Robb himself has been notably absent from academic writings on the history of New Zealand health systems and health reforms; in one of the most recent histories of hospital and health reform in New Zealand, by Miriam Laugeson and Robin Gauld (2012), he did not even warrant a mention. This paper will show, by studying the ideas and impact of Douglas Robb, how health reform does not occur in isolation but is rather part of an ongoing conversation across nations.

#### Objectives

- Acquire a historically nuanced understanding of the organization of other national health care systems
- Recognize the dynamic interrelationship between science, health systems and society through history
- Understand the role of individuals and their networks in influencing broader health policy

## **D6 Health Policy in Britain and New Zealand, 1938-2000: exploring the ‘families of nations’ approach**

Hayley Brown, London School of Hygiene and Tropical Medicine, London, UK  
[hayley.brown@lshtm.ac.uk](mailto:hayley.brown@lshtm.ac.uk)

### *Neo-Liberal Ideas and Policy-Making the United Kingdom and New Zealand’s National Health Services in the 1980s*

Using a comparative and trans-national approach to examine attempts to reform the national health systems of New Zealand and Britain in the 1980s, this paper explores whether the history of the neo-liberal turn in both countries supports Francis Castles's idea of a family of nations. From 1979 Conservative politicians in the UK, and from 1984 Labour politicians in New Zealand, increasingly supported by business leaders, advocated reforming the universal health care systems which were funded primarily from general taxation in both countries. While the history of health reform in 1980s Britain has been examined by historians, the same cannot be said for New Zealand, and there has yet to be any histories written of the 1980s that draw explicit comparisons between the two countries and highlight their many similarities and interactions in the field of health systems.

While the rise of neo-liberal ideas is attributed to the economic downturn of the 1970s and the perceived pressure this placed on social spending, including health, the family of nations concept would suggest that the similarities in response to this problem seen in Britain and New Zealand is also related to their shared history and similar Beveridge-styled health systems. By examining the government responses to the supposed crisis in health financing, as evidenced in the Centre Policy Review Staff (CPRS) paper in 1982 in Britain and the Health Benefits Review in 1986 in New Zealand which were followed by the Griffiths Report in 1983 and the Gibbs Report in 1988, both on hospital management, this paper examines the political and intellectual environments which produced these responses and the degree to which the recommendations of these reviews were implemented or not. Drawing on oral history interviews as well as a close examination of government archives this paper will explore how neo-liberal ideas were expressed in the context of health system reform in the UK and NZ and the extent to which this is evidence of a family of nations.

#### Objectives

Keywords: health reform, health financing, neo-liberalism

- Acquire a historically nuanced understanding of the organization of other national health care systems
- Recognize the dynamic interrelationship between science, health systems and society through history
- Understand the role of individuals and their networks in influencing broader health policy

#### **Lunch Sessions--Saturday**

##### *Luncheon Workshop 4: A Second Helping: Researching at the Intersection of Medical History and Food Studies*

This luncheon workshop investigates the intersection of the history of medicine and food studies. The field of food studies examines food-related topics from a wide range of perspectives, considering topics like the cultural meanings of food and foodways, food production and consumption, and broader food systems issues. Studies of food and diet are increasingly common in work on the history of medicine as well. Historians of medicine have focused largely on diet in terms of disease and health, examining, for example, vitamins, school

lunch, malnutrition, food safety, and occupational health. Codified in the fields of food studies and medical history, these efforts have largely developed separately, yet they have much to gain from more explicit and stronger engagement with each other.

Building on a successful panel on this topic at AAHM 2017, this workshop provides a second helping, as it endeavors to identify new research directions and to formulate an agenda for the rapidly expanding scholarship on the histories of medicine, food, and nutrition. The workshop will begin with participants discussing how they each navigate the intersection of medical history and food studies in their own research and teaching. The participants will then discuss one or two pre-circulated questions, before opening the workshop up for a community dialogue on these topics. The workshop aims to consider the collaborative possibilities for how the studies of food and nutrition have been, and can be, productively brought to bear across disciplinary boundaries.

#### *Lunch Workshop 5: Public Discourse on Race and the History of Medicine*

Discussions involving race and the history of medicine have long held a meaningful place in the public imagination. They play significant roles in debates over public monuments, drug use and criminalization, medical exploitation, health care, and understandings of disease and disability. This panel will explore the various ways AAHM scholars have taken part (and seek to engage) in these conversations, examining the risks and benefits, challenges and opportunities, that come with such endeavors. This lunch session will be a bona fide round-table discussion, consisting of four panelists and a moderator. They include: Samuel Roberts, Associate Professor of History and Socio-medical Sciences in the Mailman School of Public Health at Columbia University. He writes, teaches, and lectures widely on African-American history and the history of public health. He is currently writing a book which examines the policy and political history of heroin addiction treatment, 1950s-1990s.

Deirdre Cooper Owens, Assistant Professor of History at Queens College, writes about the intersections of race, gender, and the history of professional women's medicine in early America. She is a scholar-activist who works with non-profit organizations, journalists, and museums on controversial issues around representation, equity, and heritage.

Ayah Nuriddin is a PhD candidate in the Department of the History of Medicine at Johns Hopkins University. Her dissertation analyzes African American engagement with eugenics, hereditarian thought, and racial science as part of a broader strategy of racial improvement and black liberation. She will discuss how, in this current political moment, graduate students of color navigate questions of race in their scholarship and professional development.

Richard M. Mizelle, Jr., Associate Professor of History at the University of Houston, is currently writing a book on the history of race and diabetes in the twentieth century. Mizelle will discuss how he engages public audiences about the complicated history of diabetes, often combating long-standing mis-conceptions about the disease.

Adam Biggs is an Instructor of African American Studies and History at the University of South Carolina Lancaster. His research examines black doctors and the desegregation of Harlem Hospital. He will serve as chair and moderator.

## *Lunch Workshop 6: Reading Psychiatric Case Files in East and Southeast Asia: New Methodological Approaches*

Following the recent opening of new archives in China, Taiwan, Vietnam, and Indonesia, historians of madness in East and Southeast Asia have benefited from a treasure trove of previously-unread source materials, including patient files from local asylums. While such records have enabled historians to produce vibrant social histories of madness in colonial and post-colonial Asia, to date no work has emerged that specifically discusses the methodological problems these historians have encountered – as well as the strategies they have used – in analyzing, translating, and making sense of these complex and multifaceted documents. In this roundtable, five historians will discuss the tactics and research methods they have employed to evaluate and productively utilize clinical case files from East and Southeast Asian asylums and psychopathic hospitals. In so doing, they will also elaborate on the benefits, pitfalls, and methodological difficulties they have confronted while reading medico-legal documents produced in non-Western contexts. Given that psychiatric ideas, vocabularies, and institutions were all imported to Asia from abroad – and considering how these ideas were then forced to confront sophisticated preexistent medical traditions – case files from regions like China, Taiwan, Vietnam, and Indonesia present unique analytical, political, and linguistic complexities for historians of medicine.

Claire Edington will discuss the merits of reading patient case files from two colonial era asylums in Vietnam as not only clinical records but also forms of bureaucratic paperwork. Sebastiaan Broere will show how he reconstructs colonial hospital life in the Dutch East Indies “from below” on the basis of patient records from the Magelang Mental Hospital. Using clinical files from psychopathic hospitals in Taiwan, Harry Wu will address the complexity of writing medical history while psychiatric theories are still evolving and many important figures are still living. Emily Baum will analyze police records from the Beijing Municipal Asylum to evaluate ways by which historians can potentially resurrect the voices and experiences of the Chinese insane. And Hans Pols will speak on the difficulties involved in connecting practices of institutionalization within Indonesia asylums to colonial governance more generally.

### **E1 Organization of Medical Practice**

Nandini Bhattacharya, University of Dundee, Dundee, UK  
[n.s.bhattacharya@dundee.ac.uk](mailto:n.s.bhattacharya@dundee.ac.uk)

#### *Disparate Remedies: Making Medicines in Modern India*

This paper will seek to explain the great heterogeneity that existed in medical therapies in modern India in terms of potency, epistemic hybridity and scale. It will argue that this disparateness can only be grasped when we look at two distinct sites simultaneously; the medical marketplace and the sites of production of the pharmaceutical products. The heterogeneity of medical commodities was constituted both by the ways in which they were

produced as well as the means by which they were distributed and displayed in the market. Medicines sold in the Indian market were often considered adulterated. This paper argues that adulteration or its inverse: purity, which is the critical denominator of the modern pharmaceutical industry, needs to be situated within specific historical and cultural contexts. The critical problematic is not whether drugs produced and sold in Indian markets were mostly adulterated but that the norms of purity or adulteration could not be established in a market and an industry that needed to produce and sell medicines of various potency, denomination and therapeutic cultures. The disparateness in the market existed because there was disparateness in production. There is therefore a need to understand both these sites simultaneously. A multitude of drugs were collected and therapeutic commodities were processed, manufactured, patented, packaged which then reached the Indian and the global markets in a profusion of forms in the early twentieth century. In this context, the question of legitimacy haunted the drugs industry and indeed, the practice of medicine itself in modern India. It permeated the differences between the so-called western and indigenous medicines and treatments, between practitioners and patients, and competing therapies whether patented or generalised. It resonated deeply and repeatedly in public discourse and political rhetoric. Finally legitimacy is what each medical therapy claimed for itself, in the absence of the legislation for or against one particular system of medicine. Implicated in colonial India's conflictual relationship with modernity itself, the drugs industry represented one of its most significant sites of contestation as well as its potential for vindication.

## Objectives

This presentation will:

1. Acquaint the audience with the historical trajectories of the contemporary multifaceted and pluralistic Indian drugs market
2. Problematize the question of legitimacy of both indigenous and western drugs in nineteenth and twentieth century India at both the sites of their production and marketing.
3. Present an overview of how the drugs market defined the praxis of medicine itself in modern India

## **E1 Organization of Medical Practice**

Todd Olszewski, Providence College, Providence, RI, USA  
[tolszews@providence.edu](mailto:tolszews@providence.edu)

*Bridging the Gap: Biomedical Research and Clinical Consensus at the NIH, 1977-2013*

The 1970s marked a nadir in the relationship between Americans and their government, as well as the medical profession. While the military was mired in Vietnam and the details of Watergate became public, Americans were also learning about the deception of the Tuskegee Syphilis Study and demanding more bodily autonomy. It was in this hostile environment that administrators at the National Institutes of Health (NIH), which at the time funded almost half of all American biomedical research, founded the Consensus Development Program (CDP) to communicate the knowledge produced to practicing physicians and the public. From 1977 until

its dissolution in 2013 due to perceived redundancy, the CDP held conferences on critical and often controversial topics and produced "consensus statements" reflecting the collective opinion of expert panels convened there. During this time, the program produced 159 consensus statements on topics as varied as acupuncture, gastric bypass surgery, and cochlear implants.

Using previously unaccessed NIH archival sources, medical literature, and popular media coverage, I argue that the CDP represented an attempt by the federal government to depoliticize and guide biomedical research and medical practice at a particularly controversial time in American medicine. While the NIH's postwar rise as a major patron of biomedical research has been well documented, historians have just begun to examine the efforts of NIH officials to bridge scientific research and clinical practice. By actively inserting the NIH into routine questions of medical practice like the optimal frequency of mammograms or pap smears, administrators were challenging the traditional role of the agency as a mere producer of biomedical knowledge. Could the government find a place near--but not quite at--the bedside?

This paper uses the CDP program to examine how NIH administrators sought to define the agency's role at a time when calls for public accountability in science were becoming increasingly frequent. Some consensus conferences directly led to changes in clinical practice and insurance coverage of new procedures, while others sparked strong discord; many had little or no influence. This new archival history of the CDP demonstrates the continually negotiated role of the federal government in health care.

#### Objectives

1. Trace the development and history of the NIH Consensus Development Program.
2. Situate consensus development within broader context of biomedical research politics.
3. Examine debates about the mission and purpose of the NIH as a major patron of biomedical research in postwar America using the CDP as a case study.

#### **E1 Organization of Medical Practice**

Meg Vigil-Fowler, University of California, San Francisco, San Francisco, CA, USA  
[meg.vigil-fowler@ucsf.edu](mailto:meg.vigil-fowler@ucsf.edu)

#### *Hidden From History: Mapping African American Women Physicians' Medical Educations*

In 1864, Rebecca Lee Crumpler became the first African American woman physician when she graduated from the New England Female Medical College, and roughly two hundred more had joined the medical profession as physicians between the mid-nineteenth century and the outbreak of World War II. Yet, despite the significant role these women often played in their communities and profession, details about them remain scarce, and only a select few appear anywhere in the now extensive historiography on women physicians. My prosopographical research identifies nearly all these women and where they attended medical school for the

period 1864-1941. Using school catalogues and matriculation and alumni records, especially from Howard, Meharry, and the Woman's Medical College of Pennsylvania, as well as surveys and articles created by African American physicians to record their history, I map where these women received their degrees and analyze which schools proved the most popular choices at particular historical moments and why. My paper demonstrates that the separatist schools of Howard, Meharry, and the Woman's Medical College of Pennsylvania played the most significant role in training practitioners who held the dually marginalized identity of African American and women. Despite their willingness to enroll African American women, however, these students often experienced discrimination from both their peers and instructors. Examining African American women physicians' educations from 1864 to 1941 provides a novel perspective on the history of professionalization that makes a group normally peripheral to this standard narrative central.

### Objectives

Keywords: African American women, professionalization, medical education

Develop an understanding of the role of African American women in the medical profession

Deepen understanding of the history of American medical education

Recognize the complicated relationship between professionalization and the marginalization of women and people of color

## **E2 Evolving Knowledge**

Tatjana Buklijas, University of Auckland, Auckland, New Zealand

[t.buklijas@auckland.ac.nz](mailto:t.buklijas@auckland.ac.nz)

### *California to London circa 1975, and the origins of epigenetics*

The new and fast expanding field of epigenetics is currently generating much interest. While epigenetics continues to study the recruitment of genes in development, in line with the meaning given by Conrad Waddington around 1940, the greatest excitement surrounds the proposition that environmental influences can be inherited through molecular mechanisms (methylation marks on DNA, spatial organization of chromatin and RNA networks) that modulate and/or supplement the information encoded in the sequence of DNA. Phenomena such as pollution, nutrition, stress, deprivation and even parental care are now understood as "molecularly embodied". This shift could change the way that public health and clinical medicine approach the prevention and treatment of many conditions. Many social scientists see epigenetics as a bridge between "nature and nurture", weakened or even destroyed by genetics; for some scholars epigenetics offers a chance to rescue the controversial history of "soft heredity"; yet others see it as "business as usual" in genetics. Such diverse claims may have consequences for the public understanding and reception of this new field.

This presentation situates the beginnings of modern epigenetics in the early 1970s in two institutions with different histories and locations: the City of Hope in Duarte, California and National Institute of Medical Research in London, United Kingdom. For all the differences, they

both nurtured research cultures that married experimental research with big theoretical questions in biology, in order to solve medical problems. In the City of Hope the evolutionary genetics of Susumu Ohno inspired the self-described “physical chemist” turned geneticist Arthur Riggs to propose that the addition of methyl groups inactivates X chromosome. At NIMR under Peter Medawar, the geneticist Robin Holliday and his student John Pugh proposed that the switching on and off of certain genes during development may be modulated by methylation. Both papers were published in 1975. Their reception was initially modest but steadily strengthened through the 1980s. In the paper I want to discuss how these early beginnings, within genetics but also in relation to other areas and especially evolutionary biology, shaped epigenetics as a field.

Objectives:

- To explore and situate the history of epigenetics
- To develop an appreciation for the multidisciplinary, exploratory and unexpected nature of scientific research
- To reflect on the role of historians of science and medicine in public debate

## **E2 Evolving Knowledge**

Kristy Wilson Bowers, University of Missouri, Columbia, MO, USA  
[bowersks@missouri.edu](mailto:bowersks@missouri.edu)

### *Expanding Knowledge and Improving Practice: Surgical Education in Renaissance Spain*

That the sixteenth century was an era of growth in vernacular medical texts, most specifically surgical texts, has long been recognized and attributed (at least in part) to the expansion of armies and use of gunpowder weapons, which inflicted wounds of new kinds and in new numbers. The works and innovations of diverse European surgeons such as Ambroise Paré and Hieronymus Brunschwig have been among those often recognized in this light. Less recognized (outside of Spanish scholarship) has been the work of Spanish surgical authors, as well as the unique intellectual context in which they worked. In Spain, the proliferation of surgical texts in the vernacular (both Castilian and Catalan) coincided with royal intervention, as Philip II issued a series of royal decrees mandating not only that universities offer courses in surgery but also eventually that all medical students be required to complete these courses. The interconnection of these royal and private efforts is evident in the fact that several of these authors served Philip II at court, including Dionisio Daza Chacón, Francisco Díaz and Juan Frago. Others, however, such as Juan Calvo at the University of Valencia and Bartolomé Hidalgo de Agüero at the Hospital del Cardenal in Seville, were outside the royal circle. Unlike other well-known surgical authors of this era, such as Paré, these Spanish authors were university educated and fluent in Latin. Upon completing their education, they chose to practice surgery and subsequently chose to compose texts in the vernacular in order to raise the knowledge level of existing practitioners who could not read Latin, known as "romancistas." This generation of Spanish surgical scholars is additionally important for their innovations, offering new approaches and methods to wound treatment, amputation, and urology, as well

as treatments for diseases including syphilis and plague. This paper reflects work from a larger project that analyzes the work of these Spanish practitioners within the broader European context of sixteenth century intellectual changes.

### Objectives

- \* Recognize different national contexts in which professionalization of surgery took place
- \* Understand the changing role of texts for surgical education in the Renaissance
- \* Recognize the wide variety of health issues that surgeons have dealt with historically

## E2 Evolving Knowledge

Trevor Engel, University of Texas at Arlington, Arlington, Texas, USA

[tengel@uta.edu](mailto:tengel@uta.edu)

### *“Classifying for the Sake of Preservation: Anatomy, Disability, and Eugenics”*

A child born with “no head or upper extremities,” the “trunk and lower extremities [being] of a size corresponding to those of a well-formed foetus of seven months,” “lumpy” lower limbs, feet turned inwards, and “external organs of generation [that] are those of the female.” This is how a member of the Biological Society of Philadelphia described a “monster of the Genus Peracephalus” in 1858. The author noted that a twin sister had been born twenty minutes earlier; she had “perfect” form except for a club foot. What led anatomists to literally classify the less fortunate twin as outside the bounds of “human”—a classification that soon led to a careful dissection aimed at “the sake of preserving the original appearance of this monster” for the Philadelphia Biological Society’s anatomical collection?

This paper highlights the spread and lasting influence of French zoologist and teratologist Isidore Geoffroy St. Hilaire’s classification system for “monsters.” Based off of Carl Linnaeus’s system and widely used in nineteenth century medical journals, advocates of teratology and anatomists alike employed these classifications to describe people with congenital impairments such as anencephaly and missing limbs, as well as conjoined twins. I contend that such classifications not only justified the collection of such “specimens” in medical museums—where they did crucial work after death illustrating pathology and defining normality—but may have also helped to lay the early groundwork for the eugenics movement.

Disability studies scholars have examined how asylums and freak shows claimed live bodies with disabilities but have paid less attention to the simultaneous emergence of anatomy, professional medicine, and the practice of displaying “freaks” or their body parts. Historians of medicine and science have investigated medical museums in depth but have largely sidestepped disability and the consent issues involved in the collection of disabled people’s bodies, seeing it as a scientific and social good.

This paper draws on lectures, student notes, transactions of medical societies, correspondence letters, and surgical and medical memoirs from the Mütter Museum and College of Physicians of Philadelphia, as well as nineteenth century U.S. medical journals and popular newspapers. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

#### Objectives

Recognize the dynamic interrelationship between medicine and society through history

Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations, and disability)

### **E3 Health Care Systems**

Andrew Simpson, Duquesne University, Pittsburgh, PA, USA

[simpson4@duq.edu](mailto:simpson4@duq.edu)

*The Business of Caring for the Heart: Innovations in Pricing and Prevention for the 1970s to the 1990s*

The history of cardiology and cardiovascular surgery have emerged as two exciting areas in the recent history of medicine. Scholars like David S. Jones and W. Bruce Fye have illuminated how each specialty developed at a national level, while other recent work demonstrates how local factors, combined with the work of individual surgeons and physicians, also advanced cardiac care. As important as this robust literature is for understanding each area's technical and professional development, the transition between the bedside and the billing office is often understudied. Drawing from archival records and newspaper articles, this paper will show how caring for the heart evolved as a business from the 1970s to the 1990s.

It will focus on two examples from Houston, Texas. The first is CardioVascular Care Providers, or CVCP, which was an innovative pricing package for cardiac care pioneered in the mid-1980s by Dr. Denton Cooley at the Texas Heart Institute. Initially built around a model that shared the risk and cost of many types of cardiovascular surgical procedures with participating physicians and surgeons, CVCP allowed Cooley to offer lower-cost surgical intervention to self-insured companies and Preferred Provider Organizations. As a result, CVCP, as well as an earlier contracted service offered by Cooley to the Dutch government, helped to expand the market for cardiovascular surgery by providing clarity about pricing. Surgical intervention was only part of the evolving business of cardiac care. Around the same time as CVCP was being created, Houston's Methodist Hospital was attempting to monetize preventing cardiac incidents. Though the construction of amenities like the Total Health Center, which featured a heart-smart restaurant named Chez Eddy, the hospital's investment in prevention balanced the need to find new ways to generate revenue in the face of a more difficult reimbursement stream for cardiovascular procedures.

The story about building a business around caring for the heart helps historians to understand the linkage between disease prevention, surgical intervention, and health care payment. It also shows how two important ideas at the center of contemporary health care reform, cost control and patient satisfaction, were addressed in the past.

#### Objectives

1. To gain a better understanding of how past medical practices have related to issues of pricing and access to care.
2. To understand how the evolution of particular models of cardiac care relates to health care reform efforts in the present.
3. To understand the important linkage between medical decision making and the business of medicine in the late 20th century.

### **E3 Health Care Systems**

Julia Marino, Dartmouth College, Hanover, New Hampshire, USA

[julia.elizabeth.marino@dartmouth.edu](mailto:julia.elizabeth.marino@dartmouth.edu)

*Designing America's Healthcare System: Basil O'Connor, Public Relations, and the Crusade to End Polio in America*

Basil O'Connor, the philanthropist who directed the American polio crusade, had a vision for national medical policy. As president of the National Foundation for Infantile Paralysis (NFIP) from 1938 to 1955, O'Connor claimed to have invented a new public health model: no non-profit had ever before or ever since launched such a complete assault on a single disease. The National Foundation guaranteed free patient care to any American victim of polio and financed all research necessary to come up with a vaccine. O'Connor boldly claimed the NFIP was a system for future assaults on diseases through voluntary citizen groups. But the significance O'Connor's model rests in the context into which it emerged in postwar America: with Truman's proposed National Health Plan in 1946, tides were turning towards increased governmental control. O'Connor set out to demonstrate that both patient care and scientific research could be provided by a non-governmental organization and that federal contributions to public health were unnecessary.

"Designing America's Healthcare System" seeks to complement the existing literature on the history of polio. Original, extensive archival research from eleven different repositories in this presentation will reveal how O'Connor colluded with allies in the American Medical Association and hired a department of Foundation staff to thwart effective government contributions on both a federal and state level to preserve the Foundation's total control of the polio effort. Historian Naomi Rogers examined the NFIP's corporate bureaucracy and high-powered publicity in response to Elizabeth Kenny. Historian David Rothman demonstrated how the NFIP's provision of iron lungs shaped public perceptions of the power of philanthropy. Neither Rogers nor Rothman have explored O'Connor's public claim to the invention of a new "model" for healthcare or his anti-government efforts. Historians Angela Creager and Daniel Kevles have

even argued that the National Foundation's biomedical research program and publicity paved the way for increased government involvement in basic research. This paper goes against this common historical understanding and argues that O'Connor's mastery of public relations and anti-government agenda led a generation of Americans to believe that the voluntary health organizations could offer a solution to American public health challenges.

### Objectives

To illustrate how philanthropist Basil O'Connor worked tirelessly to impose his volunteer-based vision for American healthcare on national postwar medical policy.

To understand the role of the National Foundation in shaping American perceptions of healthcare of the postwar period.

To examine the antagonistic relationship between the National Foundation and the federal government in the 1940s and 1950s and O'Connor's collusive attempts to block effective government contributions to the polio effort.

## **E3 Health Care Systems**

Barbara Bridgman Perkins, retired, Berkeley, CA, USA

[BarbaraBridgmanPerkins@comcast.net](mailto:BarbaraBridgmanPerkins@comcast.net)

### *Health Care Policy and the Financial Industry*

This paper explores evolving activities of the financial industry in shaping twentieth-century health care organization and policy in the US. Wealthy firms and foundations emulated Progressive Era industrial planning in the 1910s and 20s when they consolidated medical services in highly-capitalized (academic) hospitals. The insurance and hospital industries worked with voluntary hospital councils in the 1930s and the postwar Hill-Burton hospital construction program in developing what would become Certificate of Need programs requiring state approval of major hospital expenditures.

The 1960s also brought an alternative planning movement. Committed to equal access and a healthy environment, but also to controlling costs, the federal Comprehensive Health Planning (CHP) program tried to balance social needs with financial strategies. CHP had no powers of implementation, however, and the health insurance industry, led by the then not-for-profit Blue Cross group, designed a new (1974) program that linked health planning to Certificate of Need. While the linkage provided muscle, it subordinated planning to finance-oriented Certificate of Need.

But there was conflict within the financial industry. While the insurance sector used Certificate of Need to (try to) restrict hospital expenditures, the investment banking sector expanded debt-financed construction of high-cost specialty services. The US Public Health Service reiterated banking firm Goldman Sachs' advice that Certificate of Need administrators should use tools of financial analysis to approve only services that could generate sufficient revenues to pay their expenses—including their debts.

Using published reports, training materials, and government documents, this paper investigates how different elements of the financial industry collaborated with government in shaping health care policy (and medical organization) in what Rosemary Stevens calls the “American public-private health care state.” While Evan Melhado (not inaccurately) saw a “decline of public-interest policy-making” over the 1966-1986 planning programs, a longer historical trajectory shows that finance-driven hospital capital planning comprised the warp and woof of health planning throughout the century, and that community initiatives intermittently, but rather ineffectively, embroidered public interest values onto the underlying tapestry.

#### Objectives

Analyze dynamic relationships between health policy and economic forces

Identify financial actors and actions in the development of health planning and Certificate of Need

Understand how financial analysis can be used to shape health care organization and policy.

#### **E4 Image, Wax, and Spoon**

Cosimo Calabrò, McGill University, Montreal, Quebec, Canada

[cosimo.calabro@mail.mcgill.ca](mailto:cosimo.calabro@mail.mcgill.ca)

*"Getting a grip: Constructing, Imagining and Visualizing Diocles of Carystus' Surgical Spoon(s)."*

This presentation focuses on a Greco-Roman surgical instrument generally known as the Diocles' spoon and /or scoop intended for the extraction of large missiles, such as spearheads, embedded in the body. Writing in the first century CE Cornelius Celsus provides the only explicit textual source describing the instrument and attributing the invention of it to the famous Greek physician Diocles of Carystus, active in the fourth century BCE. Celsus underscores the uniqueness of the Diocles' spoon, distinguishing it from other instruments apt for the removal of different projectiles and for diverse wound circumstances.

However, the opacity of Celsus' description has resulted in different translations and at least since the sixteenth century several conceptual, physical and visual reconstructions of the instrument have been produced. Despite a crucial and tantalizing archeological discovery in the Italian city of Rimini between 1989 and 2006 (Ortalli 2007), no surviving Diocles' spoon has been definitively authenticated thus far (De Carolis 2007 and 2009; Bliquez 2015). Analysis of the historical trajectory involving the multiple attempts to discern the Diocles' spoon, its precise applications and effectiveness encapsulates fundamental issues related to the dissemination of both surgical technologies and practices. Indeed, the initial textual description is mediated by both translations and experiential knowledge, as well as historical methodologies with different perimeters of inquiries. For instance, the different visual representations of the Diocles' spoon represent a striking example of being paratactically situated in the context of lexical nuances, Greco-Roman military surgery, as well as specific argumentative sources.

In this presentation, I will problematize when the complex interplay between literary, visual, archeological and experiential knowledge all of which point to the need for historians of medicine to expand disciplinary inquiries considering multifaceted narratives such as those of surgical practices and surgical technologies.. To this end the Diocles' spoon case study offers a very rewarding and challenging opportunity for probing the concreteness and/or aspirational nature of ancient surgical texts in the context of diverse historiographical practices

#### Objectives

KEY WORDS: Greco-Roman Surgical Instruments, History of Surgery, Historical Methodologies

- 1] Critically appraise the historiography related to the reconstructions of ancient medical and surgical practices.
- 2] Acquire a historically nuanced understanding of surgical narratives especially with regard to textual descriptions and visual representations.
- 3] Appreciate the necessity for a multidisciplinary approach in dealing with the ambiguities of surgical and medical artifacts.

#### **E4 Image, Wax, and Spoon**

Sandra Guevara, Independent Scholar, Mexico City, Mexico

[sandraelena.guevara@gmail.com](mailto:sandraelena.guevara@gmail.com)

##### *Images and Words: An approximation to Cocoliztli's diagnosis through Indigenous codices*

From 1545 to 1548, an epidemic of an unspecified disease, characterized by profuse nose bleeding, affected the indigenous population of New Spain. The governors asked indigenous doctors to propose its diagnosis and treat the patients. Because the disease was unfamiliar, physicians decided to name it Cocoliztli, a generic nahuatl word meaning "disease, illness or epidemic".

Five centuries later, the identity of cocoliztli remains undetermined. Currently, historians of medicine are trying to identify the disease through the study of historical records belonging to the second outbreak of cocoliztli in the year 1576. Such methodology has been adopted due to "lack of historical sources" from the disease of 1545. Nevertheless, the efforts have been rather unfruitful because researchers have ignored the conceptual framework used by native practitioners to construct Cocoliztli as a disease entity, and have not used indigenous codices as primary sources.

Indigenous codices or "painted books" are documents produced by Mesoamerican societies in order to preserve their history. Conformed by figural components and glyphs, they represent a system of writing that allows us to interpret a world that has perished in time.

The proposed paper will be based on the analysis of indigenous codices to study the sociocultural construction of cocoliztli made by indigenous physicians during the outbreak of

1545. Through the application of rhetoric and semiotic analysis to indigenous codices, we have dealt not only with native physicians conception of the disease, but also with the influence of European medical tradition in it. We will also address the importance of considering the society in which the disease appeared and was constructed. Finally, the paper will emphasize the use of indigenous codices as valuable documents to understand the medical situation of the New Spain during the first half of the sixteenth century.

#### Objectives

Key words: Cocoliztli, Indigenous codices, rhetoric and semiotic analysis

- 1) To recreate conceptions of diseases in their original time and space.
- 2) To assess the information of native documents for the history of medicine in non-Western societies.
- 3) To promote the study of the medical situation in the Spanish colonies of America from 1521 to 1560.

#### **E4 Image, Wax, and Spoon**

Jennifer Kosmin, Bucknell University, Lewisburg, PA, USA  
jfk018@bucknell.edu

##### *Modelling Wonder: Obstetrical Waxes between Instruction and Awe in Eighteenth-Century Italy*

Since at least the seventeenth century, medical practitioners in Europe have employed obstetrical models to aid the instruction of midwives and, over time, male surgeons and obstetricians. Made variously from wax, leather, clay, and other materials, models ranged from doll-like manikins to fully mechanized machines. While some models visually represented the stages of fetal development or positioning of the fetus in utero, obstetrical machines were constructed with the intended purpose of being touched and manipulated. Such machines allowed for the practice of obstetrical techniques like version or the use of forceps, providing students with valuable experience in a safe environment. At the same time, obstetrical models also facilitated the entrance of male practitioners into the management of childbirth by divorcing training from the kinds of hands-on learning to which traditional midwives were accustomed. For male surgical and obstetrical students, whose access to live women's bodies was often limited by law and social convention, obstetrical models reinforced a theorized conceptualization of childbirth and sanitized delivery of its unpalatable fluids and tissues. Apart from their instructional capacity, wax anatomical and obstetrical models became during the eighteenth century objects of wider cultural appeal and fascination. Wax models awed viewers with their verisimilitude to the living human body and became spectacles in themselves. In fact, models of pregnant women were increasingly displayed in popular anatomy museums and travelling shows with dissected wombs and slit-eyed faces attached to real human hair. In this paper, I explore the use of obstetrical models in the context of both eighteenth-century Italian midwifery schools and popular anatomical museums to consider the gendered intersections of medicine, culture, spectacle, and religion that were embodied in wax. I argue that the popular fascination with life-like wax anatomical models in eighteenth-century

Europe reflected deep cultural anxieties about the relationship between life and death, soul and matter, nature and artifice, just as Enlightenment thinkers were reevaluating the roles of religion and science in everyday life.

### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Recognize the dynamic interrelationship between medicine and society through history
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

### **E5 Women's Health and Activism**

Ayesha Nathoo, University of Exeter, Exeter, UK

[A.Nathoo@exeter.ac.uk](mailto:A.Nathoo@exeter.ac.uk)

*"You Must Relax": Women and contagious tension in the twentieth century*

Based on the premise that it is impossible to be concurrently tense and relaxed in body or mind, neuromuscular relaxation strategies have been widely adopted by Western populations over the last century. 'Therapeutic relaxation' has been promoted as a skill to be learnt, a way of life to be cultivated, and a means of preventing and treating a range of common ailments including migraine, anxiety and insomnia. With a focus on Britain, this paper examines the popular uptake of relaxation strategies, especially amongst women in the course of the twentieth century. For what reasons have different groups of women been encouraged to manage their tension through learning and practising relaxation?

Relaxation instruction was notably developed within antenatal care, becoming an integral component of the postwar 'natural childbirth' movement, and later promoted as a safe and effective alternative to pharmaceutical drugs such as minor tranquillisers. But moving beyond dominant historical narratives of relaxation as a set of highly individualised self-help methods, this paper covers new ground in extending the analysis to relaxation's proposed socio-political and collective modes of operation. Tense wives, mothers, teachers and healthcare professionals have variously been held responsible for generating tense households, classrooms and patients. In turn, relaxation strategies have been advocated as a means of positively changing entire cultures of care.

The paper will draw on a wealth of previously untapped archival resources of twentieth-century relaxation and stress-management organisations, and the recently catalogued National Childbirth Trust (NCT) archives, together with magazine, radio and television sources. Of particular interest are personal narratives of women seeking relaxation instruction to better manage relationships within domestic and working environments. Through developing a critical historical understanding of how notions of relaxation and tension have been understood as 'emotional contagions', this work documents the changing responsibilities that have been assigned to women for affecting the health and wellbeing of those around them. It will

contribute to recent scholarship within the history of medicine, women's health and the emotions, and help to contextualise pressing issues regarding stress, burnout and compassion within caregiving.

#### Objectives

Keywords: Women; therapeutic relaxation; wellbeing

Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

Recognize the dynamic interrelationship between medicine and society through history

Deepen understanding of narratives of illness, suffering and wellbeing

### **E5 Women's Health and Activism**

Judith Houck, University of Wisconsin, Madison, WI, USA

[jahouck@wisc.edu](mailto:jahouck@wisc.edu)

#### *Building Women's Health Clinics: Four Models of Feminist Activism, Four Models of Feminist Politics*

In the late 1960s and throughout the 1970s, United States feminists demanded and won attention for many causes that centered on women's bodies. From safe and legal abortions to donor insemination for lesbians, from natural childbirth to sexual self-determination, feminists insisted that the ability to make decisions about their bodies provided the essential foundation for the larger liberation of women. These disparate efforts comprised a women's health movement.

Over the last decade, historians have described and analyzed the efforts of health feminists. This body of work has significantly expanded our understanding of feminist activists' efforts to create knowledge about the female body (Kline, *Bodies of Knowledge* and Murphy, *Seizing the Means of Reproduction*). Other historians have focused on the creation and travails of feminist abortion clinics (Morgan, *Women's Health in Women's Hands* and Schoen, *Abortion after Roe*). These important works document the importance of feminist abortion provision in the broader women's health movement. The focus on abortion in these latter histories, however, allows their readers to equate feminist health clinics with abortion, although most women's health clinics of the 1970s and 1980s did not provide abortion.

#### Objectives

To better understand the range of feminist health provision associated with the women's health movement, this paper provides an overview and an analysis of the founding politics that animated four feminist health clinics in California: The North Country Clinic for Women and Children (Arcata), Chico Feminist Women's Health Center, Santa Cruz Women's Health Center, and Lyon Martin Women's Health Services (San Francisco). By looking at how women-centered health care developed out of a variety of political and geographical locales, this paper expands our understanding of the goals and practices of health feminists. Based primarily on internal

documents generated by these clinics and on oral interviews with clinic founders and subsequent workers, this paper demonstrates the range of gender politics working under the health feminist umbrella. It demonstrates that while abortion inspired some clinic-centered health services, it did not dominate feminist health provision.

#### Objectives

- 1) To provide historical context to the women's health clinics and women's health professional practices that have now become part of mainstream medicine in the twenty-first century;
- 2) To develop historical understanding of medical institutions beyond hospitals
- 3) To highlight the influence of society on medical practice and institutions

#### **E5 Women's Health and Activism**

Susan Smith, University of Alberta, Edmonton, Alberta, Canada  
[Susan.L.Smith@ualberta.ca](mailto:Susan.L.Smith@ualberta.ca)

##### *Women's Peace Activism, Chemical Weapons, and Public Health in the 1980s*

On August 20, 1988, over one hundred peace activists gathered at Suffield, the location of a Canadian military research facility in Alberta. Their protest was led by the Alberta Branch of the Canadian Voice of Women for Peace (VOW). The VOW members organized local, national, and international campaigns to raise awareness about the public health consequences of Suffield's activities, especially the open-air testing of nerve gases. The year 2018 marks the 30th anniversary of this key moment in the history of women's activism against chemical weapons. The records of the Alberta VOW demonstrate how chemical weapons became a public health issue on the prairies in the 1980s. Members of the Women's International League for Peace and Freedom (WILPF) had made a similar argument during and after World War I. They had warned that the use of poison gas meant that people on the home front were now at risk. WILPF activism contributed to chemical arms control through the establishment of the Geneva Protocol of 1925 under the auspices of the League of Nations. Over sixty years later, members of the VOW were stunned to learn that scientists at Suffield had released Sarin, Soman, and Tabun, deadly nerve gases, into the atmosphere. The tests were part of the Canadian contribution to the modernization of American chemical weapons under President Ronald Reagan during the Iran-Iraq war. Canada performed the open-air testing for the U.S. after it was banned in that country. Activists criticized the Alberta and Canadian governments for permitting the military to risk the health of residents and wildlife living downwind of Suffield. Furthermore, they used the issue of public health to critique the dangers of chemical weapons and Canadian complicity in American war-making. Finally, members of the Alberta VOW linked the local health risks of weapons development to the need for enhanced international arms control. They reported on Suffield's activities at United Nations meetings on disarmament in New York City and Geneva. VOW activism contributed to the creation of the 1993 Chemical Weapons Convention, a multilateral treaty that added new rules to prohibit the development and use of chemical weapons

## Objectives

Deepen understanding of how war shapes government health policy  
Recognize the dynamic interrelationship between medicine and society through history  
Develop an historically informed understanding of the health risks of weapons development

## E6 Institutional Change

Philip Begley, University of Liverpool, Liverpool, UK  
[p.begley@liverpool.ac.uk](mailto:p.begley@liverpool.ac.uk)

### *Learning to Manage the Medics? Administrative Training and Clinical Autonomy in the National Health Service*

In Britain Ministers are, at least in theory, democratically accountable for the successful running of the National Health Service. It is centrally funded and universal. But it is also diverse, increasingly autonomous and locally administered away from Whitehall. This tension has been inherent in the service since its inception. The need to ensure that it is run effectively and efficiently, meets patient demand as much as possible whilst also providing value for money for tax payers, has long underpinned an official interest in ensuring that administrators in charge on the ground are well trained.

In the years immediately after the Second World War, the King Edward's Hospital Fund for London awarded small numbers of bursaries in hospital administration, before opening its own Staff College in 1952. Following the 1956 Guillebaud Report, a National Administrative Training Scheme was established at the King's Fund and the University of Manchester. This central scheme continues to the present day, although in a much altered form. Since the mid-1980s the focus has turned towards 'general management' and there have been changes to the size of the scheme, its structure, the selection processes and the qualifications that trainees emerge with. These changes appear to reflect the wider shift from 'administration' to 'management' over time in the NHS. Among the consequences has been a concomitant shift in authority away from medical professionals towards managers. Using an empirical approach underpinned by detail archival research, to what extent can we trace this important change through administrative training programmes? Medical professionals have long valued their independence in deciding what happens to their patients and when, but what have trainee administrators learned about their relationship with clinicians at different times? When does clinical autonomy appear to become more open to question and control? How was it thought that conflicts with medical professionals might be resolved? When did trainees start to learn about measures – performance indicators, regulations, incentives – which might be used to exercise managerial control? Tracing this history can help us to better understand significant changes in the NHS and many ongoing debates today.

## Objectives

- Acquire a historically nuanced understanding of the organization of national health care systems, particularly the provision of administrative training.

- Understand the dynamic history of medical practice interacting with managerial trends, and the implications for patients and health care providers.
- Critically appraise the concepts of clinical autonomy and managerial control from a historical perspective.

## **E6 Institutional Change**

Febe Pamonag, Western Illinois University, Macomb, IL, USA  
[F-Pamonag@wiu.edu](mailto:F-Pamonag@wiu.edu)

### *The “Unruly Inmates” of Culion*

Beginning in 1906, American colonial officials ordered the mandatory confinement of leprosy patients to the island of Culion, in western Philippines. Colonial authorities had downplayed Filipino opposition to the leper segregation policy. This paper explores female as well as male patient activism at the Culion leper colony during the early twentieth century. I explore this theme through an examination of the patients’ reaction to restrictions on marriage and cohabitation, which were first implemented in 1907. These regulations generated several protests, including the 1932 protest dubbed “The Manchuria.” There is a paucity of sources on patients’ responses written by the patients themselves, but there are newspaper articles, government reports, accounts of colonial officials, and accounts by the nuns and priests who lived at the leper colony. These materials provide a valuable window into the actions patients took and they can be analyzed for how they presented the protests that ensued. Some Philippine newspapers downplayed the significance of the 1932 protest by referring to the patients as a “mob.” Newspaper articles and government reports also tended to characterize the male patients as the leaders. Accounts of nuns and priests illuminate their paternalistic view of female patients as wards who needed to be protected from the male patients. Meanwhile, a close reading of several sources, including accounts of health officials and admission records, reveal the presence of “unruly” women and the consequences of their participation in these “disturbances.”

This paper seeks to advance our understanding of Filipino leprosy patients’ engagement with American colonial authorities. This is an understudied theme in the existing literature on empire and public health policy and U.S. colonialism in the Philippines. The existing literature on leprosy patients’ resistance tends to focus on men. In this paper, I argue that both male and female Filipino leprosy patients staunchly opposed colonial authority. Some female leprosy patients asserted their sense of self and in so doing, rejected the notion of women as weak, mere followers of male patients and wards of the nuns and the state.

### Objectives

1. Deepen understanding of Filipino leprosy patients’ activism during the American colonial period

2. Understand how gender-based assumptions as well as state policies and practices that criminalized leprosy influenced government and media reports and individual accounts about how the patients responded to government restrictions
3. Recognize the dynamic interrelationship between medicine, culture, and society through history

## **E6 Institutional Change**

Molly Ladd-Taylor, York University, Toronto, ON, Canada  
[mltaylor@yorku.ca](mailto:mltaylor@yorku.ca)

### *Sex, Birth Control, Disability: Parents and Teens in the 1970s*

In 1978, Ontario Health Minister Dennis Timbrell ordered a moratorium on sterilizations of children under sixteen. This historic action, taken in response to the disturbing news that two years earlier more than 300 Ontarians under 18 had been surgically sterilized at the behest of their parents, was both celebrated as a human rights victory and denounced as a dangerous incursion into parental rights. Almost all of the sterilized minors had intellectual disabilities (ID). Today, these operations seem like a shocking remnant of eugenics, but most experts in the 1970s considered sterilization appropriate in certain cases, and parents were divided. This paper explores the debates over sterilization and birth control for people with ID as a window on changing attitudes toward youth, sexuality, disability, and eugenics in the first decade of deinstitutionalization.

Much has been written about “normal” teen sexuality in the postwar period, but the sexual and reproductive health concerns of adolescents with intellectual disabilities have been largely invisible in the historical scholarship. When disability is mentioned at all, the focus is almost entirely on state policy and eugenics. This paper, in contrast, asks why some parents wanted to sterilize their own children and explores the complex power dynamics between patients, parents, health professionals, and the state. It provides a historical perspective on debates over who has the authority to make decisions about “appropriate” sexual information and medical treatment, and how efforts to protect adolescents with ID from sexual abuse and unwanted pregnancy should be balanced with their rights to sexual pleasure and procreation. Through examination of expert advice to parents caring for “children” with ID and (2) the heated debates over sex education and sterilization on both sides of the U.S.-Canadian border, this paper explores shifting ideas about adolescent sexuality, reproductive health care, informed consent, and eugenics.

#### Objectives

Keywords: contraception, sexuality, intellectual disability

1. To develop a nuanced understanding of historically changing attitudes toward intellectual disability, adolescent sexuality, and eugenics, and the impact of these changing attitudes on sexual and reproductive health care during the 1970s;

2. To acquire a historically informed understanding of medical responsibility and decision-making regarding “appropriate” sexual information, contraceptive care for people with intellectual disabilities, and consent;
3. To understand the dynamic history of relationships between health professionals, patients with intellectual disabilities, parents, and the state.

## **F1 Medical Materialities**

Mindy Schwartz, University of Chicago, Chicago Illinois, USA  
[mschwart@medicine.bsd.uchicago.edu](mailto:mschwart@medicine.bsd.uchicago.edu)

### *Object Lessons- The Surgical Kit and the Clinical Trainees*

Scholars, including James Edmondson and Shelley McKellar, have shown the value of using artifacts such as medical instruments, in medical education. This paper will advance their claims by featuring a previously uncatalogued surgical kit found in the University of Chicago Collections.

For more than ten years an amputation set used by Dr. Thomas W. Burrows in 1887 has been a staple part of a medical history course for senior medical students at the Pritzker School of Medicine. An original manufacturer’s label locates it to Hausmann, McComb and Dunn, an instrument maker in Chicago 1876-1900. The box contains more than 30 instruments, each of which was identified through the secondary literature and instrument catalogues. It is clear that the objects were acquired over a period of time from at least two different manufacturers, although half bear similar markings and fit into the original case. Unexpected findings included an undated vial of pills labeled Parke Davis “aposthene and adrenaline,” and a Baunscheidt’s lebenswecker, a homeopathic instrument popular in the 1870s.

Drawing on the extant secondary literature and archival materials from the University of Chicago Special Collections and Rush Medical College archives, this paper examines both the process of discovery and identification of the instruments as well as their use as a resource for teaching medical history and current clinical practice. Tactile experience encourages active learning by stimulating the imagination and raising questions. First, descendants of these objects continue to be used in modern surgical practice for identical purposes although they may have changed physically. What is the difference between these items and those used now? How are they similar? How do the differences reflect changes in medical knowledge, practice, and production? Second, their combination in a single box invites questions about ownership and practice. Who was Burrows? How can we explain the presence of a homeopathic instrument? What does the collection suggest about practice of medicine in Chicago in the late nineteenth century. Does it challenge accepted historical views of the past in our time?

### **Objectives**

1. To describe the use and value of medical artifacts in medical education

2. To consider the ways in which physicians in the late nineteenth century used instruments as a means of medical and therapeutic intervention
3. To understand medical practice and medical identities in late nineteenth century Chicago

## **F1 Medical Materialities**

Iris Clever, UCLA, CA, USA  
[irisclever@ucla.edu](mailto:irisclever@ucla.edu)

*Reinventing the Caliper: Transforming Physical Anthropological Practices after World War II.*  
Iris Clever, UCLA PhD Candidate

Historians have long argued that physical anthropology and study of race disappeared from science after World War II. More recent studies, however, question this perspective and have complicated the picture of the rise and fall of physical anthropology, arguing that its theories and methods persisted after 1945. This paper follows this revisionist trend by tracing the history of the caliper, a crucial instrument to racial scientists, throughout the twentieth century. It will argue that the caliper is a fluid, flexible technology which boundaries move when it travels to different times and places (Mol & de Laet 2000).

While the caliper was the anthropologist's most prized possession for measuring skulls in the early twentieth century, after World War II, racial science was denounced, its credibility tainted, and the caliper had come to represent everything that was wrong with the study of race. But while physical anthropology transformed into biological anthropology, the caliper, however, survived in a new form in the post-war scientific landscape. As the study of health and nutrition had become of greater interest during World War II, the caliper was reintroduced to assist studies of human growth. A new caliper hit the market in the 1950s: the skinfold caliper. Similar in design to the classic skull caliper, it would now pinch the skin and measure subcutaneous fat so as to judge overall body fat.

This paper will discuss how skull measurers such as British scholar G.M. Morant moved into the field of growth studies after the war. Morant joined the Committee on Growth and Form, set up by the British Medical Research Council in 1950. The MRC instructed this committee to design a new standard skinfold caliper, which was developed during the first British longitudinal child growth study at Harpenden by committee-member and physiologist J. Tanner. The Harpenden skinfold caliper is still in use today and remains "the gold standard." Thus, studying the caliper's history-in-use (Edgerton 2010) complicates the narrative of the "rise and decline" of anthropometry and shows the transformation of anthropological methods and expertise after World War II.

Objectives

Keywords: anthropometry, instruments and technology, health and growth studies

Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

Recognize the dynamic interrelationship between medicine and society through history  
Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

## **F1 Medical Materialities**

Sarah Rose, University of Texas at Arlington, Arlington, TX, USA  
[srose@uta.edu](mailto:srose@uta.edu)

*"Why won't they get hearing aids?" Insurance, Age, Disability, and Medical Technology*

"Why won't they get hearing aids?!" So goes the perennial lament of adult children and grandchildren frustrated with elders who no longer hear well. Indeed, hearing loss is one of the most common and most undertreated disabilities among the aged, affecting over 25 million people over 50 years, only fourteen percent of whom use a hearing aid. Inevitably, a second lament follows: "They cost WHAT and aren't covered by insurance?!"

In the past decade, researchers have identified untreated hearing loss as a major public health crisis associated with depression, dementia, and a heightened risk of falls. Yet why has the Center for Medicare and Medicaid Services (CMS)—the entity that decides what Medicare and insurance carriers will and will not cover—explicitly excluded hearing aids for over 50 years, despite repeated attempts at reforms? And what does this exclusion tell us about changing definitions of age, hearing, cognition, and prostheses?

This paper questions the shifting explanations historically provided for the persistent exclusion: that hearing aids cost both too little and too much, that they help not enough yet have evolved rapidly and, that unlike glucose testing strips, do not constitute "durable medical equipment." Instead, I highlight audiologists' longstanding absence from the CMS decision-making process, only recently remedied, in ensuring coverage for invasive cochlear implant surgeries over hearing prostheses. I also point to the persistence of Enlightenment-era notions associating the inability to hear with cognitive incapacity in spurring persistent qualms about hearing aids' appropriateness and in hampering "hard-of-hearing" people from organizing an effective political lobby.

In recent decades, disability historians have produced a cavalcade of innovative works on cultural notions of deafness and the experiences of physiologically deaf people, especially those who identify as "culturally Deaf." Yet, far less attention has been paid thus far to the millions of "hard-of-hearing" people or to how investigating the history of hearing impairments offers a lens into the intertwined histories of age, medical technology, and disability. This paper draws on oral histories; popular newspapers; Congressional records; audiology, medical, and hearing aid journals; hearing aid trade journals; hard-of-hearing and deaf advocacy magazines; and CMS publications.

Objectives

- 1) Develop knowledge and understanding of professional behaviors and values, specifically recognize the dynamic interrelationship between medicine and society through history
- 2) Contribute to the improvement of patient care by acquiring a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems and develop an historically informed sensitivity to the diversity of patients (including appreciation of class, disability, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
- 3) Contribute to the improvement of patient care by acquiring a firmer grasp of the complexities of how and why medical technologies are adopted or not.

## **F2 Great Britain: Systems of Care and Knowledge**

Erin Spinney, University of Saskatchewan, Saskatoon, Saskatchewan, Canada  
[erin.spinney@usask.ca](mailto:erin.spinney@usask.ca)

### *Hospital Ships within a System of Care and Control: British Naval Medicine 1790-1815*

Studying naval medicine means shifting our gaze beyond the ship or the hospital to consider the interconnectivity of naval medicine as shown in the cyclical nature of care provision. This medical system was exemplified in the journey of the sick or wounded seamen from his ship to hospital and back. Conceiving of naval medicine as a system of care allows for equal weight to be given to each stage of medical care delivery, re-integrating hospitals ships, hospitals, and convalescent ships into the naval medicine narrative. Historians of naval medicine, like Patricia K. Crimmin, Laurence Brockliss, and Kathleen Harland, have examined the formation and operation of naval hospitals and shipboard surgery. However, scholars in these fields have not yet adequately addressed the provision of naval medicine as a system of care. Several repositories of archival sources prove useful for my study of naval systems of care. The first are log books for hospital ships kept by Lieutenants (National Maritime Museum) and Captains (National Archives) contain detailed information about patients received on board, medical supplies transported, and the daily location of the hospital ship while at sea. Using the longitude and latitude coordinates for hospital ships, I will map their location using HGIS. These sorts of records are supplemented by correspondence of the Royal Navy's Sick and Hurt Board and hospital inspectors.

This paper demonstrates both the importance of hospital ships to British naval medicine in the late-eighteenth and early nineteenth centuries and showcases the wide variety of medical care provided at these installations. Hospital ships functioned as medical transports for the sick, floating sites of control for patients deemed a desertion risk, and as overflow hospitals. Most significantly from a historiographical perspective, this paper considers how hospital ships acted as transports for the sick. Previously, analyses of this sort have been confined to the modern period, but as the mapping of the turn of the nineteenth-century hospital, ships will show, such conceptions pre-dates industrial warfare.

Objectives

Keywords: Hospital Ships; System of Care; British Naval Medicine

- To connect medical theorists and clinicians working on present-day systems of care with an historical example of a functioning model that could be applied to contemporary debates
- To reconfigure our understanding of late-eighteenth and early-nineteenth century naval medicine by highlighting its connected system of care
- To utilize Historical Geographic Information Systems (HGIS) to visually showcase the interconnectivity of the Revolutionary and Napoleonic War naval medical system, particularly through the movement of hospital ships

## **F2 Great Britain: Systems of Care and Knowledge**

Stephanie Snow, University of Manchester, Manchester, UK

[stephanie.snow@manchester.ac.uk](mailto:stephanie.snow@manchester.ac.uk)

*Rationing in a Universal Health System: The treatment of renal failure in Guy's and St Thomas', London, 1970s-1990s*

The rationing of care is a reality in all modern healthcare systems however the day to day processes of the phenomenon have received little attention from historians. The UK National Health Service (NHS) was created in 1948 by a socialist government on the basis of universal healthcare for all citizens. From the 1950s onwards, the rapid growth of new medical technologies to treat renal failure through transplants and dialysis created intense economic pressures for all health systems but local responses differed. The US introduced legislation in the 1970s to give patients rights to dialysis and transplantation whereas many European countries rationed access to treatment. Nevertheless by 1980, it was harder for older patients to get treatment in the UK than in comparable countries such as France, Germany and Italy and male patients enjoyed better access than females. But how was rationing carried out in a universal health system underpinned by socialist principles?

I explore how clinicians and patients articulated and negotiated the technical, ethical and economic dilemmas created by the new renal treatments using oral history interviews and archival evidence from a study of Guy's and St Thomas' in London from the 1970s onwards. Value judgements concerning the contribution that patients were making or might make to society played a part in committee decisions to provide or withhold treatment. In some cases, decisions were made on clinical grounds. At other times boundaries were less obviously defined. When rationing treatment clinicians sometimes responded by seeking ways of expanding access; alternatively they took the decision that a particular patient's life was expendable and often, patient commitment to the process of dialysis was factored into the decision-making processes.

The paper illuminates the paradox of the NHS: a state-controlled system that has been infused with neoliberal ideology from the 1970s onwards. It reveals some of the complex dynamics informing clinical decision-making processes and clinician-patient relationships during the period. And it speaks to the ways in which local responses to universal economic pressures

during the late 20th century were determined by the local social and cultural specificities of the particular local context.

#### Objectives

1. Deepen understandings and gain historical perspective on the rationing of care which is a key issue for many modern health systems.
2. Develop historically nuanced understandings of the complexities of decision-making processes around renal dialysis, especially clinician-patient interactions.
3. Contribute to the wider historiography on medical technologies and health systems through building a historically nuanced understanding of different national healthcare systems.

## **F2 Great Britain: Systems of Care and Knowledge**

Seth LeJacq, Duke University, Durham, NC, USA  
[ssl35@duke.edu](mailto:ssl35@duke.edu)

### *Bodies Made Knowable: Sexual Crime and the Emergence of Published Sexual Forensics in Britain, 1780-1840*

Historians have long believed that early forensic medicine played important roles in British trials for sexual crimes. Establishing those roles and determining the actual content of sexual forensics before the mid 19th century has been challenging, however, in large part because British practitioners lacked a tradition of publishing about forensics before 1800. This paper provides the first account of the emergence of published sexual forensics in Anglo-American jurisdictions.

Drawing on a database of over 750 trials dealing with sexual violence from the late 17th century to the early Victorian period, I show that published forensics emerged at a time in which practitioners were increasingly involved in investigations and trials, and yet articulated persistent concerns about the limits of their investigations and knowledge about sexual violence. Practitioners almost always restricted themselves to a narrow range of topics (defloration, disease transmission, signs of physical injury) and frequently pointed to serious limitations in their abilities to offer useful testimony, raising concerns about the very possibility of knowing about crimes.

Drawing on a comprehensive survey of early Anglophone forensics texts, I show that early published works increasingly sought to allay such fears for readers and yet continued to reiterate them. Epistemic instability and the notion that there were severe inherent limitations to medical contributions therefore remained a key theme in sexual forensics. These ongoing concerns were reflected in judicial frustrations over medical witnesses, especially as courts grew more and more suspicious of women's testimony about sexual matters and unwilling to hear women speak about them.

I argue that these findings push us to revise our understanding of the character of sexual forensics before the medicalization of sexuality. Influential historical accounts have suggested that medical testimony and discourses increasingly displaced and crowded out other, often older, ways of knowing about sexual violence. I show, however, that elite forensics continued a long tradition of deep uncertainty about the possibilities for forensic investigation and testimony. Courts and individual practitioners therefore pushed the limits of the nascent field when they claimed certainty, and tentative medical witnesses left space for a variety of other forms of knowledge and knowledge-making.

### Objectives

- To learn about the history of legal medicine as an area of practice and specialization.
- To see how medical research and writing was translated into theory and practice in other fields. In particular, to see that medicine and law have historically had a dynamic relationship, and that in the pre-modern era law was discursively more powerful than medicine and therefore dictated much of how it operated in judicial contexts.
- To explore the ways in which practitioners interacted with survivors of sexual violence before codification of ethical standards and practices relating to such work in either law or medicine.

### **F3 Children as Historical Actors**

James Stark, University of Leeds, Leeds, UK

[j.f.stark@leeds.ac.uk](mailto:j.f.stark@leeds.ac.uk)

#### *The Cult of Youth: Growing Young in Interwar Britain*

The twentieth century saw an unprecedented increase in life expectancies in the developed world. Alongside this trend, numerous different methods of slowing, halting, or even reversing the aging process have been touted as possible ways of extending life without the need for the micromanagement of lifestyle. Focusing on the transformative interwar period, and in particular the “decade of rejuvenation” in the 1920s, this paper asks how the different ways that people have attempted rejuvenation – the restoration of youth or the appearance of youth – have changed over time, and what they can tell us about our shifting relationship with ageing and our bodies. Whilst there were numerous different methods and products which claimed to achieve rejuvenation for the anxious ager, this paper concentrates on the central role of everyday methods, such as hormone creams, electrotherapy devices and dietary supplements, and in particular the ways in which daily, domestic routines drew inspiration from spectacular and sensationalized surgical interventions which promised to make the old young.

By using advertisements, promotional pamphlets, company records and medical texts on aging I bring together diverse perspectives on rejuvenation from manufacturers, physicians, entrepreneurs and users. Drawing on the work of Ina Zweiniger-Bargielowska, Chandak Sengoopta and others who have examined the physical and sexual body of the early twentieth century, I argue that our understanding of the social and physiological dimensions of ageing and rejuvenation were fundamentally changed by new anxieties about bodily and social fitness. This

highly gendered process drew on scientific ideas of regeneration and development and were amplified by commercial interests, giving rise to the pluralistic landscape of rejuvenation products and practices which we see today. As a result, the centuries-old, fantastical preoccupation with elixirs, philosopher's stones and "cures" for ageing was gradually transformed into pragmatic, everyday solutions designed to restore lost vitality, extend fertility, and present a more youthful face to the world.

#### Objectives

Develop the capacity for critical thinking about the nature, ends and limits of medicine;  
Recognize the dynamic interrelationship between medicine and society through history;  
Identify successes and failures in the history of medical professionalism.

### **F3 Children as Historical Actors**

Ida Milne, Maynooth University, Maynooth, Ireland  
[ida.milne@mu.ie](mailto:ida.milne@mu.ie)

*Using oral history to explore the long term emotional impact of serious childhood illness on families: Abigail and her siblings narrate her story.*

This paper will discuss a case study on a family whose childhood lives and lifelong emotional relationships were essentially altered by disease. When Abigail caught rheumatic fever as a child and was being rushed off to hospital, she knew, from observing her parents' faces, that they understood her life to be in danger. "I had to be so brave, because I knew Mammy and Daddy were so worried." But her child's eye, while aware of the intensity of the situation, did not share the knowledge her parents had of previous family disease events. Abigail's experience of becoming acutely and then chronically ill, shaped her ongoing emotional relationships with her siblings, as well as dramatically altering expectations for her own future. This paper explores the impact of her illness on her life and on the family relationships through interviews with different members of the family, each with their unique perspective. Abigail's experience of illness is particularly interesting as it occurred at a time of rapid improvements in outcomes for serious childhood illness in the middle of the 20th century in Ireland, as elsewhere. Getting ill just after those improvements - chiefly the introduction of antibiotics - meant that she and others born around that time represent a dividing line between a high risk of death from certain infectious diseases and a strong chance of survival. But yet, they still carried forward a burden of continuing damage from these diseases, which has all but disappeared in the modern era. Her story of suffering acute and then chronic disease - which shaped the rest of her life - is at once unique and also typical of the experiences of many working class families at the time. Through these oral histories, we gain a perspective of human suffering from disease that is not possible from other sources.

#### Objectives:

1 This paper will promote understandings of the long term emotional impacts of chronic and acute diseases of childhood on both the sufferer and on their family.

2 It will show how improvements in healthcare in the 1950s and 1960s radically changed Irish family life and society

3 it will draw attention away from the death statistics to the long term damage caused by childhood illness, an added burden on healthcare as well as on the individual and on families,

### **F3 Children as Historical Actors**

Laura Kelly, University of Strathclyde, Glasgow, Scotland, UK

[l.e.kelly@strath.ac.uk](mailto:l.e.kelly@strath.ac.uk)

*“A youthful, revolutionary zeal for bringing about real and sustained change”: Youth health activism, contraception and sexuality in Ireland, c.1984-1994*

Contraception was illegal in Ireland until 1979, after which it was possible to obtain contraceptives (including condoms) on prescription for bona fide family planning purposes only. Moving into the 1980s, access to contraception depended on class and location, and many doctors and chemists refused to provide contraception for moral reasons. Fears around the widening of access to contraception largely centred on concerns that it would lead to increased promiscuity among young people, while adolescents struggled to gain access to sex education. However, existing research has not addressed the importance of youth in discussions around contraception, nor the role of young people themselves in reproductive rights activism in Ireland.

This paper therefore explores the significance of youth in debates on reproductive rights in 1980s and 1990s Ireland, in particular, the role of a youth activist group, established by the Irish Family Planning Association (IFPA) in 1985. The IFPA youth group created an adolescent telephone service and sex advice column in popular music magazine, Hot Press. They gave talks to high school students and later set up their own youth clinic. The group not only played an important role in health activism during its existence, which coincided with the AIDS crisis, but also helped to alter the conservative image of the IFPA. From 1988, the group set up their own stall in the Virgin Megastore record-shop in Dublin, where they sold condoms illegally every Saturday. Their activities resulted in backlash from several conservative Catholic groups and a major court case ensued in 1991. This activism contributed to the relaxing of Irish family planning laws in 1993.

Through the use of the group's records, newspapers, and oral history interviews with former members, this paper will highlight the important role that young people played in debates around sexuality and contraception in Ireland. Utilising the youth telephone service logs, as well as the group's regular advice columns, it will also illuminate the sexual concerns of young Irish people. Ultimately, through an analysis of the IFPA youth group's activities, this paper will establish the contribution of young activists to reproductive rights in late twentieth-century Ireland.

Objectives

1. Analyse the significance of youth in debates around contraception in 1980s and 1990s Ireland as well as the role of young Irish activists in reproductive health activism and sex education in a country with a strong conservative and Catholic ethos.
2. Consider the strategies utilised by Irish youth activists and how these were shaped and influenced by both the international reproductive rights movement and by local and national circumstances.
3. Understand the complex history of reproductive rights in Ireland and the role of youth activists in bringing about change in Irish family planning laws.

#### **F4 Caring for Body, Mind, and Soul**

Brendan McHugh, University of Minnesota, Minneapolis, USA  
[mchug103@umn.edu](mailto:mchug103@umn.edu)

*"Neither Nurse Nor Volunteer: Shanti Project's Hospital Counselors Program and the Place of Spirituality in AIDS Care, 1983-1995."*

In 1983, San Francisco General Hospital announced it would be opening an inpatient AIDS unit named Ward 5B. This twelve-bed unit was the first of its kind in the United State, especially through a multidisciplinary effort that was run by nurses, staffed by social workers and counselors from the Shanti Project. It would later expand to a twenty bed unit named Ward 5A. This paper recounts the important role that Shanti Project counselors played on Ward 5B/5A and the peer support they provided to both patients and staff. The Shanti peer support model was deeply spiritual and influenced by the grief recovery and hospice movement of previous decades. Studying Shanti illuminates the shifting politics of patient care brought on by the AIDS crisis. These changes include an emphasis on providing individualized care centered on the needs of people with AIDS regarding their gender, race, sexuality, and class background. Shanti counselors fiercely advocated for such care through spiritual and emotional peer support to patients and their kin. This resulted in a rewarding but equally tense partnership with the nurses on Ward 5B/5A from 1983 to the end of the Shanti program in 1995.

The AIDS Ward has been documented as an integral component in the celebrated San Francisco model of comprehensive AIDS care. Shanti Project counselors remain marginal, if not completely absent, from the historical narrative. This reflects a trend in histories of AIDS activism that elide the history of Shanti Project; the oldest AIDS volunteer counseling organization in the U.S. In examining the role of Shanti counselors on Ward 5B, the importance of emotional peer support work in medical facilities and in the lives of people with AIDS and their kin is clear. It was incredibly political in that it insistently acknowledged the humanity of people with AIDS and thus changed important aspects of patient care for those with terminal illness.

#### Objectives

- 1.) Understand the impact of AIDS on patient care
- 2.) Recognize the importance of spirituality in medical history

3.) Consider social contexts that impact health care

#### **F4 Caring for Body, Mind, and Soul**

Leah Astbury, The Huntington Library, San Marino, CA, USA  
[la320@cam.ac.uk](mailto:la320@cam.ac.uk)

##### *Pregnancy, birth and after-birth care in the seventeenth-century English home*

Giving birth in early modern England has been represented by historians as a wholly female experience. Adrian Wilson has commented that once a woman felt the pangs of labour, she moved 'into a different social space: away from the world of men (centrally, her husband) and into the world of women'. Birth -- like nursing, caring and tending to others -- was historians have argued women's work. These were activities that excluded men and the larger family. More recently, scholarship has highlighted that the distinctions between female and male employment whether formal or unofficial were ambiguous in the early modern world. Furthermore, social historians of medicine such as Elaine Leong, Lisa Wynne Smith and Alisha Rankin have shown that medicine was a household affair, in which men were active and knowledgeable. Drawing on family correspondence, life-writing and recipe books, this paper argues that bearing children in early modern England was similarly a domestic event. This paper demonstrates that historians ought to shift their focus from the ritual of delivery to consider the ways in which families worked collectively to ensure infant and maternal health from pregnancy to after-birth recovery. By considering the long durée of birthing, I hope to offer a fresh perspective on the practice of early modern medical care and suggest that the chronologies imposed on patient narratives might influence the perception of who and how medicine was practiced.

##### Objectives

- \*Understand the dynamic relationship between domestic medicine and family structure.
- \*Think critically the chronologies historians place on patient narratives.
- \*Recognize the ways in which childbearing in early modern England was a collective activity.

#### **F4 Caring for Body, Mind, and Soul**

Lisa Brooks, University of California, Berkeley, Berkeley, CA, USA  
[labrooks@berkeley.edu](mailto:labrooks@berkeley.edu)

##### *Physician's Sensory Perception in Classical Āyurvedic Diagnosis*

The sensory perception of a physician (pratyakṣa) is one of the four means of valid knowledge (pramāṇas) for a physician diagnosing a patient according to classical Āyurvedic treatises. This paper examines descriptions of the use of the physician's senses in the diagnostic process in early to mid first millennium Common Era. classical Āyurvedic Sanskrit treatises, noting a difference in the ordering of importance of sensory perception across the schools of general

and surgical medicine and a possible reduction in the number of senses used by the physician in the chronologically later passages. The two most important surviving classical Ayurvedic treatises, the Carakasamhitā and the Suśrutasaṃhitā are understood by scholars and practitioners of Āyurveda to represent related but distinct arenas of medical practice in early India, general medicine and surgery. First, I examine in detail differences in the role the physician's sensory perception in diagnosis across these treatises, as well as the slight later Aṣṭāṅgahṛdayasaṃhitā and Aṣṭāṅgasaṃgraha, through my own Sanskrit translations, noting the greater importance accorded to sensory perception in the surgical school. Second, I study the lists of the senses to be used in diagnosis across the passages, including, which of the five senses are used, how they are to be used, what kind of information they yield, and noting cases where the senses of other humans or animals are used as diagnostic mediators. This study suggests increasing sensitivity to the boundaries of the physician's body over the course of the early to mid first millennium and supports the possibility that surgical physicians may have had a distinct social status and relationship to the senses in the practice of diagnosis in early India.

### Objectives

Key Words: diagnosis, Āyurveda, sensory perception

The learning objectives of this paper are 1) to understand the the early history of diagnosis as part of the culturally varied history of medical ideas and practices, their implications for patients and health care providers today, 2) to recognize the dynamic interrelationship between medicine and society through history, particularly in South Asia, and 3) develop a historically and culturally informed understand of the different ways that the physicians body and training has functioned in diagnostic practice.

### F5 Eugenics and Prohibition

Paul Lombardo, Georgia State University, Atlanta, GA, USA  
[plombardo@gsu.edu](mailto:plombardo@gsu.edu)

*"The Great Experiment in Eugenics"*

*Caleb Saleeby, Racial Poisons, and the American Campaign for Prohibition*

Dr. Caleb Williams Saleeby stood alongside Francis Galton at the 1907 founding of London's Eugenics Education Society. By 1909, Saleeby was a Fellow of the Obstetrical Society of Edinburgh, member of the Society for the Study of Inebriety, and author of Parenthood and Race Culture, one of the first monographs on eugenics and the book that popularized the term "racial poison."

Some racial poisons were diseases—like syphilis or gonorrhoea—that could kill off a population by causing sterility. The phrase also encompassed environmental toxins like lead, nicotine, and alcohol. Saleeby's coinage became shorthand for conditions and substances that simultaneously poisoned individuals and their "germ plasm," the cellular repository of heredity. Eugenists like Saleeby knew that alcohol lowered moral inhibitions and provided a gateway for familial destruction through interpersonal violence, promiscuous sexuality and subsequent

disease. As Saleeby said, drinking was like “soaking the germ plasm in alcohol.” Its effects cascaded from users to their mates, ultimately leading to more “ill-born” children.

The goal of eradicating the racial poisons and the harm they caused provided common ground for early 20th century reformers, linking the movements for social hygiene, public health, and temperance. In the United States, the phrase “racial poison” became a rallying cry for eugenic enthusiasts fearful of decreasing fertility among the “better classes” which they condemned as “race suicide.” Their concerns fed the growing support for legal prohibition of alcohol. When Prohibition became law in the U.S., Saleeby called it America’s “Great Experiment in Eugenics.” This paper will detail Saleeby’s focus on alcohol as the premier racial poison linked to the societal maladies of crime, disease, poverty, and welfare dependence. It will explore how fears of alcohol as a racial poison drove medical attitudes, urban Vice Commissions and political posturing, as Prohibition became a reality in 1920s America.

#### Objectives

- 1) Participants will recognize the term "racial poison."
- 2) Participants will remember the role of Caleb Saleeby in the eugenics movement.
- 3) Participants will understand the influence of eugenic arguments to the success of the prohibition of alcohol.

#### **F5 Eugenics and Prohibition**

David Korostyshevsky, University of Minnesota, Minneapolis, Minnesota, USA  
[koros003@umn.edu](mailto:koros003@umn.edu)

*Poisons, Artificial Appetites, and Intemperance: Production and Circulation of Medical Concepts of Intoxication in the United States, 1800-1840*

This paper examines the medical dimensions of intemperance during the early American period, a concept typically analyzed by historians in religious terms (Norman Clark, William Rorabaugh, Ian Tyrrell, Jack Blocker). The eighteenth-century idea that alcohol (used outside the prescription of a physician) was a poison that physically degraded the body and mind became a cornerstone of temperance rhetoric. While the initial act of drinking represented a choice to engage in morally bad behavior, physicians, such as Benjamin Rush, Daniel Drake, Thomas Sweetser, and Reuben Mussey, recognized that repeated drinking—intemperance—changed the body’s natural physiology. This change generated an artificial appetite over which the drinker gradually lost control, eventually losing all capacity for volition, morality, and citizenship. Temperance-minded clergymen, exemplified by Lyman Beecher, appropriated this formulation into their sermons, defining intemperance as a sin, disease, and crime at the same time. This paper, therefore, challenges prevailing historical narratives (David Courtwright, Sarah Tracy, Caroline Acker, Nancy Campbell) in which the medicalization of intoxication began with the emergence of concepts of inebriety and addiction at the end of the nineteenth century. Focusing on professional medical writing, medical temperance addresses, and sermons about intoxication, this paper uncovers the ways in which medical ideas contributed to temperance

ideology during the first half of the nineteenth century. Doing so complicates historians' understanding of medicalization as a process in which non-medical problems gradually become defined as disease. I argue instead that physicians and clergymen engaged in an iterative process that coproduced intemperance as a simultaneously religious, medical, and legal concept. Understanding intemperance as a multivalent category that explains the tangled relationship between volition, habit, and disease underscores why modern disease concepts of addiction remain saddled with moral judgements and social stigmas.

Objectives

Keywords: Intemperance, Medicine, Religion

This paper fulfills CME requirements by, presenting a nuanced assessment of interdisciplinary professional behaviors contributing to early medical understandings of intoxication; (2) interpreting the coproduction of complex medical concepts of intemperance as an understudied example of the dynamic interrelationship between medicine and other segments of society in the early American period; and (3) pointing out that early coproduction of intemperance explains why the social stigmatization of patients struggling with substance use disorders continues to persist.

## **F5 Eugenics and Prohibition**

Lauren MacIvor Thompson, Kennesaw State University, Atlanta, GA, USA

[lthom182@kennesaw.edu](mailto:lthom182@kennesaw.edu)

*"When Laws Prohibit": Margaret Sanger, Eugenics, and Contraceptive Information in the Age of Prohibition*

In the 1920s, both the American birth control movement and the crusade for Prohibition coalesced around fears of the degenerative effects of alcohol. Both movements tied immigrant and working-class alcohol use to weak, disabled babies, warning of the resultant dysgenic consequences for society. Similar to the success of the temperance movement, which had long relied on nativist and racist sentiment, the birth control movement's adoption of a similar strategy was quite effective. Margaret Sanger and her fellow birth control reformers skillfully adopted the moral rhetoric of the temperance movement to persuade the public of the merits of their own cause. They argued that legalizing birth control would broadly prevent the birth of the "wrong" kind of children and help victims of domestic abuse prevent unwanted pregnancies by their drunken husbands. Yet the overlapping politics of alcohol reform and the birth control movement often resulted in complex divisions, wherein temperance supporters frequently were outspoken opponents of legal birth control. Further, although anti-Prohibition supporters often shared many of the same arguments made by birth control reformers for women's rights and autonomy, there were many in the birth control movement who sharply criticized them for their insistence on making alcohol a personal right, while refusing the same for birth control. Sanger, in numerous publications throughout the 1920s, pointed out the double standard of Americans breaking both alcohol and birth control laws "with equal vigor," but noted there was a very different price for women seeking reliable medical information on contraception. By

framing the need for birth control through the moral and eugenic politics of alcohol use, Sanger was able to attract enormous support for her American Birth Control League by the end of the 1920s, and firmly link in the public mind the use of birth control with the prevention of disability in society.

#### Objectives

1. Identify the relationship between social movements and medical authority.
2. Recognize the dynamic interrelationship of medicine and society.
3. Understand the complex history of reproductive medicine and rights.

### **F6 The Political Economy of Health and Development: International Organizations in the later Twentieth Century**

John Manton, London School of Hygiene and Tropical Medicine, London, UK  
[john.manton@lshtm.ac.uk](mailto:john.manton@lshtm.ac.uk)

#### *International assistance, health planning and the New Economic Policy in Malaysia, 1971 to 1990*

In the aftermath of decolonisation, newly independent states in Asia and Africa increasingly sought international assistance from the World Health Organization (WHO) and other bodies in developing health systems and planning priorities, and financing medical and welfare services. By 1970, a succession of largely unimplemented experimental planning regimens in Asia, Africa, and Latin America began to prompt a methodological and technical reassessment of the bases of health systems planning for development, with the emerging – and ostensibly Cold War neutral – disciplines of operational research and systems analysis to the fore.

Malaysia was a key location for the elaboration of operational research and systems analysis methodologies in health planning for development in the 1970s and 1980s. It was one of seven pilot countries for the WHO Project Systems Analysis programme beginning in 1969, and the location of a key 1973 Workshop on the development of these methodologies. It continued to pioneer health sub-sector specific approaches to operational research throughout the next two decades, in the context of both rapid economic development, and broader national planning commitments to poverty alleviation through social engineering and affirmative action. The period in question was characterised by the Malaysia New Economic Policy (NEP, 1971 to 1990, comprising the Second through Fifth Malaysia Plans), which sought to link economic diversification and growth, to a reduction of ethnic compartmentalising of economic sector and function. Policy and planning instruments in health, education, poverty alleviation, and access to economic opportunity were assessed and deployed according to the overarching principles of the NEP. This paper considers illuminating and as yet poorly-understood intersections between international developments in health systems and financing, and Malaysian priorities in economic development, and health and medical resource allocation.

#### Objectives

Keywords: Malaysia, global health, systems analysis

1. Develop the capacity for critical thinking about the nature, ends and limits of systems thinking in health planning for development
2. Critically appraise the economic, political and social contexts of health planning from a historical perspective
3. Acquire a historically nuanced understanding of the organization of the Malaysian healthcare system, in relation to international health systems planning

## **F6 The Political Economy of Health and Development: International Organizations in the later Twentieth Century**

Janelle Winters, University of Edinburgh, Edinburgh, UK

[janelle.winters@ed.ac.uk](mailto:janelle.winters@ed.ac.uk)

### *Onchocerciasis and the World Bank's 'Investing in Health' Business Model, 1974-2002*

The World Bank began lending for post-war European reconstruction in 1946, and gradually shifted its focus to infrastructure projects in 'Third World' countries in the 1960s. Bank President Robert McNamara's (1968-1982) focus on alleviating poverty can be seen as an attempt to capitalize on this shifting market base; agricultural technology and better roads could help feed the masses, and population control could reduce their size. The Bank's entrance into health and social services in 1974 was more internally controversial. Many staff viewed McNamara's decision to invest in the Bank's first formal health project – the Onchocerciasis Control Program (OCP) – as at best a gamble and at worst a gross corruption of its mandate. How could economists at an international finance institution justify a program to donors, if they could not guarantee a rate of return or place a numerical value on 'good health'?

Yet, since the late 1980s, the Bank has hailed the OCP as one of the most successful development assistance programs in history, and the Bank is now the largest multilateral funder for global health. This paper tracks the financing of health at the World Bank since 1974, to provide a context for the Bank's overall health priorities. It then explores the Bank's evolving justification of onchocerciasis investment from the early 1970s to 2002. Its central argument is that the OCP contributed to what A.E. Birn has called the Bank's 'investing in health' business model, by integrating theories of human capital and cost-effectiveness into health project proposals and impact assessments.

Specifically, the paper raises three major points: that the Bank's onchocerciasis justifications drew on and extended earlier attempts to measure the economic impacts of smallpox and malaria control; (2) there was tension between the Bank and WHO about their roles and the importance of socio-economic aspects of the program; and (3) the program's widely cited success is the product of the specific business model and metrics put forward by the Bank. It draws on extensive primary research, including archived letters, memoranda, media, and reports at the World Bank and WHO; World Bank financial data-sets; and oral history interviews.

## Objectives

1. To understand the World Bank's role in financing health since the early 1970s, and the ways in which its investment priorities have shifted.
2. To identify how economic ideologies have contributed to the framing of disease and rationales for investing in global health.
3. To develop a critical understanding of the concept of 'success' in global health history and policy, and how it has been constructed by international organizations.

## **F6 The Political Economy of Health and Development: International Organizations in the later Twentieth Century**

Christopher Sirrs, London School of Hygiene and Tropical Medicine, London, UK  
[christopher.sirrs@lshtm.ac.uk](mailto:christopher.sirrs@lshtm.ac.uk)

*New Frontiers: The ILO and Health Systems Financing, c. 1952–1992*

The 1952 International Labor Conference marked the end of the International Labor Organization's (ILO) wartime dreams of universal health coverage. Propagated via the 1944 Philadelphia Declaration and its accompanying recommendation, the ILO had promoted comprehensive medical care, funded by public taxation or social insurance, and covering the entire population, 'whether or not ... gainfully occupied.'

This paper analyses the ILO's approach to health financing in the forty years following the 1952 conference, with special attention to low-income countries (LICs) and the transition economies of Central and Eastern Europe. It argues that the ILO continued to actively promote the risk-sharing and revenue-generating functions of social health insurance, positioning it first, as a relatively inexpensive way to provide coverage, in comparison to private care, then, as a vehicle to finance basic health services and extend coverage to rural areas. As concerns mounted about national debt in the 1980s, however, the ILO reluctantly accepted a pluralistic model of health financing, where social insurance played an important, but attenuated role in extending coverage to populations. Other financial mechanisms, such as community-based health insurance, were promoted as part of a progressive push for universalism.

Contributing to the growing literature on the politics of global health (Packard, Cueto, Brown and others), this paper asserts that the ILO's role in global health has been under-appreciated by historians to date, especially in terms of the organization and financing of medical care in LICs. Examining the ILO's relationship with other major international actors, including the World Health Organization (WHO), the paper questions whether the ILO's policy shift was a case of institutional adaptation to a new global political reality (namely, the growing influence of the World Bank from the 1980s), or, in a field where transnational movements of experts have long been crucial, capture by the new dominant logic of neoliberal health economics. To illuminate the political and economic forces that have shaped ILO health policy, this paper draws upon

oral history interviews and an extensive analysis of archival material from the ILO, WHO and World Bank, including reports, correspondence, and memoranda.

#### Objectives

Keywords: Social insurance, global health, health financing

1. To develop understanding of the ILO's role in global health: specifically, its expertise in the organization and financing of medical care under social security systems.
2. To illuminate the broader political and economic forces that shaped global health policy in the second half of the twentieth century.
3. To understand the role of transnational expert communities in giving direction to global health policy.

### **G1 Medicine/Meditsina: Russian Encounters with Western Medicine and Practice**

Matthew Romaniello, University of Hawaii at Manoa, Honolulu HI, USA

[mpr@hawaii.edu](mailto:mpr@hawaii.edu)

*"For the good of mankind in General": Inoculation and the Practice of Medicine in Eighteenth-Century Russia*

Catherine the Great invited Dr. Thomas Dimsdale to inoculate her court in 1762, the first documented instance of the practice arriving in the Russian Empire. Catherine rewarded him with the title of baron in 1769, given "in justice to the rare Merit and skill of Thomas Dimsdale English gentleman & Doctor of Physic, whose humanity, Virtue & laudable Concern for the good of mankind in General, induced him long since to apply all his Thoughts, & Faculties towards improving and perfecting the Inoculation of the small Pox." While Dimsdale may be one of the more prominent Western physician in Russia, he was only one of approximately 400 hired by the state during the century. These men carried Western medical knowledge into the empire, arriving in large numbers from Leiden, Gottingen, Jena, Halle, and Strasbourg. Western medical practices were not unusual in Russia, but Dimsdale's prominent role in the court as an English physician was atypical.

This paper will analyze the implementation of new medical practices in Russia as a way to understand the exchange of medical science across Europe the eighteenth century. There is only one short article on the history of medical education in Russia in the eighteenth century, and there is no previous prosopographical study of the medical community at work in the empire. By drawing upon physicians' memoirs and published studies of their work in Russia, as well as a statistical analysis of their educational background and employment in Russia, this paper will suggest that Russia was an integral part of the medical community across Europe. The state's adoption of inoculation in the 1760s was only one of the changes implemented its medical corps, and their correspondence with their colleagues in Britain, the Netherlands, and Germany provided new evidence for the treatment of several diseases as well as innovative regulations for public health. Rather than an outlier of Europe's scientific community,

eighteenth-century Russia was an integral part of the improvement of state medical practice in an era of significant change across Europe.

#### Objectives

Identify successes and failures in the history of medical professionalism

Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

Recognize the dynamic interrelationship between medicine and society through history

### **G1 Medicine/Meditsina: Russian Encounters with Western Medicine and Practice**

Tricia Starks, University of Arkansas, Fayetteville, AR, USA

[tstarks@uark.edu](mailto:tstarks@uark.edu)

#### *“Soviet Post-war Tobacco Response in International Context”*

In 1968 the Soviet Union’s premier intellectual journal, *Literaturnaia Gazeta*, published an article by their number one demographer entitled “Save the Men!” The essay exposed fears of the declining life expectancy of Soviet males due to excessive drinking and smoking with an opening bemoaning how women lived substantially longer than men and with an appeal for women to help men to take hold of their health. Contemporary sociologists Elena Zdravomyslova and Anna Temkina argue that this critique of the status of the Soviet male veiled a larger criticism of the moribund and declining Soviet system. But this paper reveals that this was more than just a discursive ploy. The Soviets had posted an impressive turnover in social health from the inception of their national health service in 1918 but by the 1960s these strides were growing shorter and in the 1970s, things were beginning to slide backward. Health was in decline for a number of reasons -- problems in supply and medical expertise, increasing alcoholism and poor diets, but an as yet unexplored and important issue was widespread smoking of poor quality tobacco of high nicotine content.

Using medical texts, newspaper reports, and international comparison, this paper analyzes the ways in which tobacco impacted the Soviet demographic problem, the means by which medical and production authorities responded, and the ways in which foreign research, especially the groundbreaking tobacco research of the 1950s and policy strides of the 1960s, influence Soviet response to tobacco morbidity and mortality.

#### Objectives

Identify successes and failures in the history of medical professionalism

Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

Recognize the dynamic interrelationship between medicine and society through history

### **G1 Medicine/Meditsina: Russian Encounters with Western Medicine and Practice**

Greta Bucher, United States Military Academy, West Point, NY, USA  
[Greta.Bucher@usma.edu](mailto:Greta.Bucher@usma.edu)

*Discussing Health: Popularizing Modern Healthcare for Women in Late Imperial Russia*

Russian engagement with modern, western healthcare practices and theories flourished in the late imperial period. Drawing on the newest theories of social hygiene, education, psychology, eugenics and sexology, much of the new literature was focused on raising and educating children and youth and on the proper hygiene practices that would enable women to produce healthy children; as in western Europe, much of this literature is couched in the language of strengthening the nation and Empire. This literature is largely ignored by the historiography on healthcare in the late Imperial period, which focuses instead on the discourse among medical professionals rather than their attempts to reach the public through educative and self-help literature.

Using the medical press, ethnographic accounts, Imperial archival records and popular literature on child rearing and women's health, this paper will analyze the attempts to popularize modern healthcare and hygiene. Both professional and non-professional authors wrote to a variety of audiences: other medical professionals, education professionals, women, mothers, and the general public. I argue that this literature casts health, and especially women's health, in terms not only of women's relationship to medical personnel, but as a site of women's agency—women should know how to take care of themselves and understand how their bodies worked—while reinforcing the patriarchal understanding that men also needed to understand women's bodies in order to protect the health of their women and by extension, their country. The authors saw themselves as the agents of modernity, bringing enlightenment to the people of Russia not only by providing the latest scientific information on women's health to the educated public, but also by keeping one another informed of the progress--or lack thereof--in penetrating peasant prejudice against modernity's invasion of the countryside.

Objectives

1. Develop the capacity to think critically about gender in the medical profession.
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
3. Recognize the dynamic interrelationship between medicine and society through history.

**G2 Pediatrics in a Global Context**

Hughes Evans, Emory University, Atlanta, GA, USA, [hughes.evans@emory.edu](mailto:hughes.evans@emory.edu) and Sarah Rice, University of North Carolina at Chapel Hill, Chapel Hill, NC, [sarah.rice@unchealth.unc.edu](mailto:sarah.rice@unchealth.unc.edu)

*Doctor/Parent Communication and the Institutionalization of Down Syndrome Newborns in the Mid-20th Century United States*

From the 1930s to the 1960s physicians in the United States overwhelmingly advised parents of newborns with Down syndrome to institutionalize their infants as soon as possible. The most common cause of congenital mental disability, Down syndrome affected about 1 in 700 births and was easily diagnosed shortly after birth. Like many disabling conditions, the diagnosis was shrouded in stigma and haunted by outdated yet common eugenics notions. Physicians warned parents that if they chose to keep their affected baby at home, the mother would be overwhelmed by the care required for her baby and unable to attend to her maternal and wifely duties. The family's other children would face neglect and stigma, and the community would shun the family. Often doctors conferred first with the father and advise that the mother not see her affected newborn. Doctors reasoned that the child with Down syndrome was "hopeless" and that an institution would be preferable. Ironically, many institutions were severely overcrowded, far away from families, and ill-equipped to provide the attention and care infants and young children require. Children with Down syndrome reared in institutions had much poorer developmental outcomes compared to similar children raised at home. In addition, the young institutional inmates frequently suffered from infections, and mortality rates skyrocketed. During the 1950s parents began to organize into support groups like the National Association for Retarded Children that were critical of the approaches doctors had taken. One parent, Dale Evans Rogers, wrote a bestseller, "Angel Unaware," about her family's experience caring for her daughter with Down syndrome. These parental voices led to calls for doctors to change their language, include parents in decision making, and recognize the benefits of raising a child with a mental disability. This study examines doctors' advice as portrayed in medical journals, textbooks, and popular magazines and notes the changes that occurred that led more parents to opt to raise their children at home. It analyzes the roles that gender and traditional notions of the family played in shaping the way the advice was both given and received.

### Objectives

Key words: Down syndrome, institutionalization, disability

Analyze the role that traditional notions of the family played in physicians' advice to parents of newborns with Down syndrome.

Evaluate the roles that gender roles played in physicians' advice to parents of newborns with Down syndrome.

Describe how confessional literature and parental voices impacted physicians' advice and the decision to institutionalize a newborn with Down syndrome.

### **G2 Pediatrics in a Global Context**

Sayaka Mihara, Keio University Graduate School of Human Relations, Tokyo, Japan

[sykmihara@keio.jp](mailto:sykmihara@keio.jp)

*"They Are Not Just Miniature Adults": Under-five Morbidity and Household Resources for Sick Children in 1930s Japan*

This paper examines the 1938 Takinogawa Health Survey that provides historiographical evidence for the biopolitical, biomedical, and culture-bound gaze towards children's illness in Japan just before World War II. Led by the newly established Ministry of Health, the urgent mission of the twelve-month prospective study in a Tokyo suburb was to estimate the nation's medical expenditures in wartime. Children's morbidity and therapeutics were also of great concern, given the nation's regrettably high infant mortality rate and the deteriorating physical strength of young adults. The survey committee made monthly home visits to interview subjective morbidity and treatment choices of all ages, and parents answered for their children. However, very basic analyses of children have been provided thus far without clarifying medical, socioeconomic, and cultural factors that influenced children's illnesses experiences. Hence, I conducted quantitative and qualitative analyses to investigate how children's illnesses were recognized, explained, and allocated healthcare resources in urbanized households. My statistical investigation revealed age-dependent therapeutic behaviors, illuminating under-five children as the most prominent age group in the medical market. They were the largest consumers of doctoral care. Home medication was even more common, with a plethora of commercial and kitchen-prepared remedies of indigenous or Western origins. The most frequently used drug for under-five illnesses was the commercial Kyumei-gan (Life-Saving Pill), a traditional cure-all herbal medicine just for children. In some cases, religious therapies were provided at shrines and temples.

Obviously, families' conception of children's illness and therapeutic choices were mutually interrelated. For example, certain parental terms, like "kataru" (catarrh) and "-en" (-itis), were used almost exclusively in cases seen by doctors. These biomedical concepts could be a consequence of and motivation for seeing a doctor. Conversely, temper tantrums were attributed to kan-no-mushi (tantrum worm) without doctoral consultation and were treated with cure-all Life-Saving Pills, "warm-sealing" magics, or anthelmintics, illustrating intertwined body images of holistic, magical, and parasitological etiologies concerning children's irritability. As broadcasted by contemporary pediatric authorities, children were "not just miniature adults," demonstrating an embodied illness experience both quantitatively and qualitatively unique for the age.

#### Objectives

- 1) Recognize the dynamic interrelationship between medicine and society through history
- 2) Deepen understanding of illness and suffering
- 3) Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

#### **G2 Pediatrics in a Global Context**

Lisa Pruitt, Middle TN State University, Murfreesboro, TN, USA  
[Lisa.Pruitt@mtsu.edu](mailto:Lisa.Pruitt@mtsu.edu)

*The Child Amputee Prosthetics Project, UCLA, in Post-World War II America*

Before 1945, children with amputations (congenital or acquired) received scant attention in medical literature. The extensive charitable enterprise that had arisen around the cause of the “crippled child” since the mid nineteenth century had to cope as best they could with surgical procedures and prosthetic limbs designed for adults. Little to no consideration was given to the child amputee as a distinctive class, with its own physical and psychological needs. This began to change in 1945, however. Atha Thomas and Chester Haddan’s classic work, *Amputation Prosthesis*, was published that year and included a separate chapter on the child amputee. The next year, orthopedic surgeons Charles Frantz and George Aitken of Grand Rapids, and Carlton Dean, Director of the Michigan Crippled Children’s Commission, established the first Juvenile Amputee Training Program at the Mary Free Bed Hospital and Orthopedic Center. This was soon followed by a similar program at NYU, and then in 1953, the Child Amputee Prosthetics Project at UCLA. In 1954, these programs began to coordinate their efforts and ultimately revolutionized the treatment and rehabilitation of child amputees and profoundly influenced the development of pediatric prosthetics.

This paper will focus specifically on the development and influence of the Child Amputee Prosthetics Project at UCLA. CAPP became one of the most influential of the child amputee programs in the US during its 30 years at UCLA; it ultimately moved to Shriners Los Angeles where it continues to play an important role serving child amputees. By examine the research papers produced by the CAPP team, this paper will explore the questions and challenges faced by that team in attempting to understand both the physical and psychological needs of children affected by amputation. Although a growing literature exists on the history of prostheses, including the work of scholars such as Katherine Ott and David Serlin, I have found no other historical treatment of the subject of child amputees and prosthetic design for children. This project is an effort to uncover the historical factors behind the post-World War II emergence of particular interest in the treatment and rehabilitation of the child amputee.

### Objectives

1. Understand the origins and development of the Child Amputee Prosthetics Project at UCLA.
2. Explore the post-World War II context that gave rise to CAPP and related programs in the US.
3. Develop an understanding of the post World War II differentiation of the medical and psychological needs of child amputees from the needs of veterans and other adults

### **G3 Early Modern Medicine and its Paper Trails**

Cynthia Klestinec, Miami University, Oxford, OH, USA  
[klestic@miamioh.edu](mailto:klestic@miamioh.edu)

#### *In Agony: Illustrating Surgery in the Renaissance*

The study of human anatomy underwent its own Renaissance in the early modern period, first in Italy, and Andreas Vesalius’ “*De humani corporis fabrica*” (1543) is usually taken as a watershed in that historical development. Although Vesalius and others helped to illuminate the workings of the body, they did not typically situate their findings in light of practical

medicine. This may come as a surprise because we take human anatomy to be a basic building block for much of medicine today. Before anatomy assumed that foundational role, however, there were many arguments against it, based on its perceived cruelty--it trained practitioners to "treat their patients like the chops of a pig"—and on the claim that it was impossible to know the inner workings of the body from a corpse (when by definition, function ceased). How was anatomy promoted rather than denigrated? This paper traces the reception of classical and post-classical texts on fractures and dislocations. These texts were associated with Hippocrates, Galen, and Oribasius, and as Vivian Nutton explains, constitute a tradition of humanist surgery. In the sixteenth century, they were elaborately illustrated to show bandaging techniques and a wide variety of traction devices for broken bones and dislocated joints. This paper will show how the images emphasize the practical implications of anatomy and the technical skill of the practitioner. The work of Pamela Long and others has indicated the rising status of the technical arts in the period, especially in mining, warfare technology, and urban architecture. Considering medicine in relation to this history, this paper emphasizes the ways that medical texts began to illustrate *techne*: some approached *techne* through the concept of imitation, imitating nature as a way to restore the body, as the case of prosthetic limbs illustrates; others cast medical *techne* as an "agon" where the practitioner's "techne" was locked in a struggle against Nature (the *physis*) of the body. This paper considers the surgeon's "techne" as agonistic and reflects on the consequences for the practical utility of anatomy and for the relationship between the practitioner and his patient.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine.
2. Recognize the dynamic interrelationship between medicine and society through history.
3. Recognize multiple ways in which medical knowledge was transferred and codified in the early modern period.

### **G3 Early Modern Medicine and its Paper Trails**

Gideon Manning, Claremont Graduate University, Claremont, CA, USA  
[gmmannin@gmail.com](mailto:gmmannin@gmail.com)

#### *False Images Do Not Lie: Using Anatomy in Rene Descartes' Treatise on Man*

Illustrations and paper technologies contributed to and enhanced the study of anatomy during the sixteenth century, not least by providing more accurate representations of the human body and allowing for the dissemination of consistent images. This paper documents a moment in anatomical illustration involving the disputes over Rene Descartes' posthumously published *Treatise on Man* (1664), a work with its own convoluted paper trail involving multiple manuscripts, a Latin translation published in 1662, and three sets of illustrations made by three different physicians: one set for the Latin edition and the two others for the French edition. Focusing on these illustrations, in the French edition in particular, in the text they appear to model how the visible movements of the body might be caused, with little attention to accurately describing the parts of the body. In other words, these illustrations were about actio-

-action or function--and were conceived as an answer to the question of how the body might operate and not necessarily how it actually does. In this way, they provide an alternative to traditional anatomical illustrations focused on historia and how the body is actually structured. Thus the Treatise is an especially interesting work for its paper trail, for the disputes and rationale that led to its famous images, their reproduction both in later published works and in students' notebooks throughout Europe, and for the demarcated role given to anatomical illustrations apart from an accurate description of the human body.

#### Objectives

Recognize the multiple epistemic and pedagogical roles played by anatomical illustrations when accuracy is abandoned.

Appreciate the competing values editors must navigate when dealing with posthumous incomplete manuscripts.

Recognize the growing significance of illustrations in shaping a text's reception history in the early modern period.

### **G3 Early Modern Medicine and its Paper Trails**

Scottie Buehler, UCLA, Los Angeles, CA, USA

[scottiecpm@ucla.edu](mailto:scottiecpm@ucla.edu)

#### *Aborted Dreams and Contested Labors: Surveying Midwives in the Société Royale de Médecine's 1786 Provincial Survey*

In 1786 Charles Alexandre de Calonne, Controller-General of Finances, requested surveys of midwives from all regions of France beyond Paris, which represented an expansion to the Société Royale de Médecine's (SRM) survey of provincial surgeons. He specifically argued that the addition of midwives to this project would increase its "perfection" as his intendants informed him of the evil that results from "midwives' too great reliance on their abilities...and the ignorance of most of them." These common charges of incompetence and ignorance motivated the desire for government- and church-funded educational programs for midwives, but what constitutes a "proper" education remained contested. Contrary to the dominant Anglo-centric historiography of midwifery, these surveys demonstrate that the SRM sought to bring midwives into the medical fold, not eliminate them.

I use the paper trails of the data gathering process, including accompanying letters, preparatory documents, and draft forms of the surveys, to illuminate the underlying epistemological assumptions amid the wealth of demographic information provided. The data gathering practices—and their failures—reveal the absence of a common framework, including disagreement on the goals of midwifery education and even the definition of a midwife. Thus, the varied survey responses often betray fractured concepts of midwifery throughout France. Additionally, by focusing on the data gathering process the encounters between the Parisian medical institution and provincial medical and political actors emerge, bringing into focus otherwise hidden conflicts, negotiations, and historical actors. The SRM's Nouveau plan de

constitution pour la médecine en France (1790) represents the result of an inference from the specifics of the survey to broader generalizations about medicine and midwifery in France. While this plan failed, it created a vision for the future of midwifery under centralized control by the SRM, attempted to demarcate proper educational practices, and idealized the demographic distribution of midwives.

#### Objectives

This paper seeks to 1) examine the concept of professionalization through a historical lens, 2) promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of research and education, and 3) recognize the dynamic interrelationship between medicine and society through history.

#### **G4 New Actions, New Actors**

Kuan Ting (Michael) Chen, University of Western Ontario, London, Ontario, Canada  
[kchen2018@meds.uwo.ca](mailto:kchen2018@meds.uwo.ca)

*A Panel Decision for Every Woman: The History of the Therapeutic Abortion Committee at London Health Science Centre (London, Ontario), 1969-1988*

In 1892, the Criminal Code of Canada made abortion an indictable offence and those guilty were liable to imprisonment. Abortions were banned until 1969 whereafter the Criminal Law Amendment Act, 1968-1969 (Bill C-150) decriminalized therapeutic abortions in specific cases. Women had to apply to the Therapeutic Abortion Committee (TAC) of an accredited hospital, where the procedure would be performed only if the TAC determined that continuing the pregnancy would endanger the patient's life or health. Abortions were not legalized in Canada until 1988, in the wake of the R. v. Morgentaler decision in which the Supreme Court of Canada ruled that abortion laws in the Criminal Code were unconstitutional.

Between 1969 and 1988, accessibility to abortions and regulations varied greatly across the country. Only a fraction of accredited hospitals appointed TACs, and while some TACs liberally approved almost all requests (such as in Kingston, Ontario), others refused to comply with the laws. This paper examines the abortions performed in London, Ontario between 1969 and 1988. Drawing on the extant secondary literature, patient case histories and the Therapeutic Abortion Committee records from the London Health Science Centre, along with oral interviews with retired physicians involved with abortions of the era, this paper analyzes the demographics of those women seeking abortions, the number of applications received and approved, as well as the standards and protocols adopted by the TAC. Furthermore, because the definition of "health" was not clearly stated in the law, it meant TACs were free to interpret which conditions would "endanger the patient's health". Hence, this paper also explores the conditions under which abortions were approved and whether they were more commonly granted on medical or psychosocial grounds.

Through the examination of these archival sources from the London Health Science Centre, this research will not only provide the groundwork for a new understanding of lay and medical conceptions of abortion in London, but will also provide a lens to understand the larger medical history of reproductive health in Canada.

#### Objectives

KEY WORDS: Abortion, Therapeutic Abortion Committee, Morgentaler

1. Understand the nuanced and complex history of abortion laws in Canada
2. Analyze the function of Therapeutic Abortion Committees to contextualize their history within the larger story of reproductive health in Canada
3. Recognize the dynamic interrelationship between medicine and society

#### **G4 New Actions, New Actors**

Steven Server, University of Chicago, Chicago, IL, USA

[sserver@uchicago.edu](mailto:sserver@uchicago.edu)

#### *Forjando salud: Anthropology and Public Health in post-Revolutionary Mexico*

What is the relationship of anthropology to medicine? Is anthropology meant to enhance the persuasive power of biomedicine, a tack favored by noted anthropologist and physician Arthur Kleinman? Or, as anthropologist Michael Taussig has written, is applied anthropology simply a way for clinicians to flatten the complex social relations imbricated in an individual illness experience into an object more easily manipulable by the clinician? This paper aims to probe this tension by means of a case study. In the mid-1930s, the Mexican government established a public health program called the servicio medico-social (SMS). The SMS aimed to bring senior medical students into the rural countryside for a period of at least five months, serving as the town doctor for hamlets which may have never experienced biomedicine before. Part of these young students' charge was to send regular reports back to Mexico City: details of water quality, nutrition, hygiene in the region. But a critical element of these reports were the detailed ethnographic pictures painted of a town's customs, language, and beliefs. How was this information to serve Mexico's larger public health endeavors?

In this paper, I hope to contextualize the SMS to begin to understand the Mexican government's unique take on the relationship between anthropology and public health. By examining the work of famed anthropologist Manuel Gamio, I hope to show that anthropology was seen to be one of the sciences of vital importance to Mexico's project of post-Revolutionary developmentalism in the wake of their 1910-1920 Revolution. As seen in medical journals of the time, Gamio's allies in the medical community believed in the need to study Mexico's rural populations—in their minds, long oppressed and misunderstood by both the Spanish colonial regime and the dictatorship of Porfirio Diaz—in order to better integrate them into a modern, scientific Mexico. The SMS was one way to serve this goal, for better or worse. I hope to begin to tell the story of a complicated, conflictual relationship between Mexican anthropology and public health that oppressed as much as it empowered, obscured as much as it revealed, created as much as it destroyed.

## Objectives

- Recognize the dynamic interrelationship between medicine and society through history
- Acquire a historically nuanced understanding of the organization of the Mexican health care system
- Develop the capacity for critical thinking about the nature, ends and limits of medicine

## G4 New Actions, New Actors

Christine Tarleton, UCLA, Los Angeles, CA, USA

[ctarleton@ucla.edu](mailto:ctarleton@ucla.edu)

*“But You Cannot Sell People a Lemon”: The Selling of Deinstitutionalization as a New and Improved Model of Service Provision in California, 1965-Present*

In 1970, Dr. William Keating, Chief of California’s Bureau of Mental Retardation, spoke with Parents and Friends at their monthly meeting at Porterville State Hospital about the 1969 Lanterman Mental Retardation Services Act. This bill established the regional center system, which is the current delivery system for community-based services for developmentally disabled individuals in California. Dr. Keating spoke freely, and like many of the parents present, he believed that Porterville State Hospital’s current institutional program was better than the proposed community services. He compared deinstitutionalization to the State selling people a lemon, saying that, “But you cannot sell people a lemon. It has to be a Sunkist orange.” An unidentified individual surreptitiously recorded this meeting of at least 125 people with a tape recorder placed in a shopping bag, and then, he mailed an unedited transcript of the meeting to Sacramento to warn the authors of the Lanterman Act that a large group of parents from Santa Clara county actively sought to add amendments to weaken the bill. This individual claimed that he could not reveal his identity because he would be banned from attending similar events in the future, and he wrote that, “it would be a shame were the Bill sabotaged at the outset by disgruntled parents.”

Current historical narratives nearly always imply that parents readily accepted deinstitutionalization. What is missing from the story are these “disgruntled parents” who preferred institutionalization for their children. In this paper, I use state documents, public hearings, and citizen letters to demonstrate how California packaged and sold deinstitutionalization to its skeptics. In 1965, according to state surveys, only 51 percent of parents with a child on a waiting list to a state hospital favored community services compared to the 49 percent that preferred institutional care. Consequently, many families opposed deinstitutionalization, despite their absence from historical narratives.

I grouped my findings from these state documents into three overarching ways that the State sold deinstitutionalization to its skeptics: the civil rights argument, the “it isn’t working” argument, and the efficiency and economy argument. The “disgruntled parents” response to

each of these arguments suggest important policy implications for California's current regional center system.

#### Objectives

Three Key Words: Developmental Disability, Deinstitutionalization, Public Service Delivery Systems

- Think critically about how historical narratives include or exclude certain groups of people
- Explain state rationales for deinstitutionalization and how parents responded to them
- Understand the Lanterman Act and how it created California's current regional center system

### **G5 Madness, Race, and Masculinity in Late Imperial Asylum Spaces**

Hilary Buxton, Rutgers University, New Brunswick, NJ, USA  
[hb169@history.rutgers.edu](mailto:hb169@history.rutgers.edu)

*Transient Patients, Traumatized Empire: the 'Military Insane' in British Colonial Asylums during the First World War*

The First World War is widely recognized as a watershed for military psychiatry, as well as a feat of imperial mobilization. The several million non-white veterans mobilized from the British colonies remain absent from histories of trauma, yet they too suffered and were hospitalized for the "war neuroses" that devastated the ranks of their metropolitan counterparts. While histories of colonial medicine and psychiatry have cultivated a well-developed literature on the power and politics of colonial asylums, they have largely bypassed the military patients who floated in and out of imperial health systems. Considering colonial soldiers from across the Empire, from Jamaica and Barbados to the British Raj, this paper examines the creation of spaces for mentally-ill non-white colonial troops. What spaces did British officials make available to treat mentally ill colonial servicemen? Where, and how, did they receive therapy once they were repatriated to their home colonies? How were these spaces, and the care soldiers received there, shaped by British preoccupations with ethnicity and subjecthood? Segregated from their European brethren, West Indian and South Asian troops received psychological treatments in a new network of facilities set up to heal the non-white wounded. Once they returned home, many were received in local asylums intended for civilians. In both South Asia and the Caribbean, military patients constituted a liminal population in civil asylums. Their background and condition differentiated them from local residents, and bureaucratic officials traded responsibility for their fiscal upkeep. They rarely received specialized care that attended to their unique condition. Yet their status as veterans also afforded some privileges, at times granting them opportunities for special outings, allowances, and therapies. Through a transcolonial exploration of the military patient in colonial asylums, the paper interrogates the privileges and limitations of this liminality. In doing so, it considers the colonial asylum as a space in which bureaucratic, military, and medical interests collided to shape treatment of patients who were both loyal soldiers and racialized subjects.

#### Objectives

1. Critically appraise the role of therapeutic space in promoting and hindering patient care
2. Develop a historically informed sensitivity to the diversity of patients
3. Recognize the dynamic interrelationship between medicine and society through history

## **G5 Madness, Race, and Masculinity in Late Imperial Asylum Spaces**

Jade Shepherd, University of Lincoln, Lincoln, England, UK  
[jshepherd@lincoln.ac.uk](mailto:jshepherd@lincoln.ac.uk)

### *Treating Male Insane Convicts in Britain, 1864-1900*

This paper compares how criminality was pathologised and treated in Victorian England and Wales within two different institutions: the prison and the criminal asylum. It focuses on the representations, treatment and experiences of two classes of male insane convict transferred from prisons to Broadmoor Criminal Lunatic Asylum between 1864 and 1900: the recidivist (repeat offender) and sole offender. I trace convicts' journeys: their committal into Broadmoor (and reasons for this)—their treatment—the means of their release from Broadmoor—and where applicable, reasons for their re-admittance. At each stage, I examine how convicts' mental and physical states were represented, and how convicts' themselves reflected upon their condition and treatment.

This paper highlights the extent to which broader social, cultural and medical representations of criminality were reflected inside institutions. It shows that while sole offenders were represented sympathetically, and could be 'cured', recidivists' behaviour was deemed problematic, and their presence perceived as being disruptive to the proper ('curative') functioning of Broadmoor. Recidivists' presumed innate mental weakness meant they could not be cured, and they sometimes found themselves (repeatedly) readmitted to Broadmoor. It is shown that representations of the recidivist corresponded with the damning image of the male criminal that emerged in scientific and legal discourse during the late 1860s and early 1870s. The differences in the representations and treatment of sole offenders and recidivists reveal not only conceptions of criminality and deviance, but also ideas regarding appropriate male behaviour.

This research contributes to historians' understandings of insane convicts, a group underexplored in the histories of psychiatry, prisons and crime. It also deepens understandings of how Victorian Broadmoor was run and experienced by some of its patients. The project utilizes an array of rich—and under-explored—sources. These include the Broadmoor records, comprising a rich collection of convicts' letters, medical notes, memorandums and correspondence to and from prison medical officers and Broadmoor's superintendents. Published medical, legal and criminological works are also examined, as are Home Office (Government) records.

Objectives

1. Broaden our understandings of how criminality was conceptualized and treated as a medical problem in Victorian Britain.
2. Deepen our understanding of the workings of—and life inside—Broadmoor Criminal Lunatic Asylum. This remains an underexplored institution, but it has a rich and revealing archive.
3. To develop our understanding of how ideas about gender and class intersected with, and influenced, discussions about and treatment of criminal lunacy in Victorian Britain.

## **G5 Madness, Race, and Masculinity in Late Imperial Asylum Spaces**

William Horne, The George Washington University, Washington, DC, USA  
[wihorne@gwmail.gwu.edu](mailto:wihorne@gwmail.gwu.edu)

*'Peculiarly Disposed to Insanity': Race, Nationality, and Madness in Postemancipation Louisiana*

In 1858, the state of Louisiana published *A Memoir of the Insane Asylum of the State of Louisiana, at Jackson* by renowned physician Stanford Emerson Chaillé. Though brief, the 27-page pamphlet gave an overview of the asylum—one of the first in the American south—providing information on its founding, operation, expenses, population, and treatments. Chaillé, who gained national acclaim for his study of yellow fever, argued in the Memoir that foreign-born migrants and free persons of color were significantly more likely to develop mental illness than native-born white Louisianans. His theory, which tied ideas of agency to Louisiana's racialized systems of labor, found expression in the state's asylums well after emancipation.

The essay draws on patient records, medical literature, legislative reports, and newspapers to examine the ways that deviance became synonymous with foreign-born migrants and free persons of color. Works like Chaillé's and its implementation in the asylum system indicate the extent to which students of race and labor would do well to examine popular, racialized, and nativist notions of intellect alongside one another. These ideas, produced by the interacting demands of Louisiana's medical and labor establishments, were reinforced by the state through systems of confinement and publicized widely in local newspapers.

### **Objectives**

1. Recognize the dynamic interrelationship between medicine and society through history.
2. Identify successes and failures in the history of medical professionalism, particularly regarding race and class.
3. Illuminate the ways that medical practitioners and literature contributed to misconceptions about working-class folk.

## **H1 Eating is Believing: Intersections Among the History of Nutrition, Health, and Systems of Belief, 1780s-1980s**

Travis Weisse, University of Wisconsin-Madison, Madison, WI, USA  
[tweisse@wisc.edu](mailto:tweisse@wisc.edu)

*Separating the Wheatgrass from the Chaff: Dissecting the Fight Against American Nutritional Quackery, 1955-1985*

On 6 October 1961, the AMA, FDA, Department of Education, Health and Welfare, and a legion of allied organizations and medical professionals convened the first National Congress on Medical Quackery, formally rejuvenating the fight against an age-old villain. Though medical quackery was eclipsed in the 1930s and 40s by pharmaceutical advances, the AMA estimated it had ballooned into a billion-dollar industry by the mid-1950s. So-called food faddism, or nutritional quackery, was responsible for fully half of that business.

For the AMA and its allies, nutritional quackery was not merely an umbrella term for such dubious products as mail-order vitamin powders, seawater, and royal jelly. In addition to the legitimate consumer safety concerns with health fraud, the AMA and its allies also branded as faddist such things as organic, health, and diet foods, as well as diet books, lectures, radio programs, and TV shows, because they encouraged consumers' suspicions that industrial food production was harmful. Academic nutritionists were even critical of early scientific studies showing connections between diet, food additives, and/or agricultural chemicals and chronic disease—links that food faddists had been promoting for decades—maintaining that the statistical evidence was not sufficiently robust to make public recommendations.

As medicine entered the era of chronic diseases, this generation of quack-busting academic nutritionists remained entrenched in the post-war rhetoric of the scientific superiority of the American dietary. The older model of nutrition to which these professionals were beholden stressed that obtaining adequate nutrients was the greatest challenge facing the nation, a mission that relied on maintaining strong allies in the food industry. This commitment eventually came at the expense of public health (the supposed motivation behind quack-busting), as these same nutritionists campaigned to keep known carcinogens, junk foods, and misleading advertisements on the market.

This paper will use pamphlets, journal articles, and private correspondence between prominent academic nutritionists Frederick Stare, William Jefferson Darby, Howard Appledorf, and others to argue that the manner in which these nutritionists demarcated science from pseudoscience was rooted less in scientific principles and concerns for public health, and more in conservative political attitudes and professional interests.

Learning Objectives:

1. Recognize the dynamic interrelationship between medicine and society through history
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
3. Identify successes and failures in the history of medical professionalism

**H1 Eating is Believing: Intersections Among the History of Nutrition, Health, and Systems of Belief, 1780s-1980s**

Molly S. Laas, University of Göttingen Medical School, Göttingen, Germany  
[laas@wisc.edu](mailto:laas@wisc.edu)

*The Morality of Consumption: Temperance Reform and Nutrition in Nineteenth-Century America*

As one doctor noted in 1835, the US temperance movement brought about an unparalleled change in the daily habits of nineteenth-century Americans. Teetotaling reformers turned the public's attention to their own errors in eating and drinking, and made physicians consider the effects of alcohol in the body. This paper will tie the development of nutrition in antebellum America directly to the temperance movement. It will trace the ways in which Methodist, Presbyterian, and Baptist revivalists focused their religious fervor on the virtues and behavior of the middle classes, and in doing so, offered a framework for moralizing the consumption of both drink and food alike. Stemming from Benjamin Rush's 1784 "Inquiry into the Effects of Spirituous Liquors on the Human Body" and reinforced through natural theology and materialist explanations for organic disease in the nineteenth century, temperance advocates increasingly had medical ideas about the effects of alcohol in the body at their fingertips to buttress their moral claims against the use of alcohol. Their physiological arguments about the debilitating effects of indulging in strong drink were grafted onto diet; this move offered a scientific justification for older moral concerns about gluttony, a problem that was known to plague the American middle classes. The temperance movement's political and social force in the US allowed these concerns wide currency and influence. My work will draw on temperance pamphlets and journals, books of medical advice, and professional medical texts to analyze reformers' use of physiology to justify temperate dietary habits and abstention from alcohol. In doing so, this paper will add to recent work on nutrition as a historiographic category within the history of medicine by linking the development of the moral valence of food and diet in the US explicitly to a movement designed to bring religious and moral beliefs to bear on the public's consumption habits.

1. Understanding the dynamic history of social, medical, and religious ideas about diet and nutrition
2. Recognize the changing interrelationship between medicine and society through history
3. Develop the capacity for critical thinking about the nature, ends, and limits of medical science

**H1 Eating is Believing: Intersections Among the History of Nutrition, Health, and Systems of Belief, 1780s-1980s**

Kristen Ehrenberger, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania, USA  
[ehrenbergerka@upmc.edu](mailto:ehrenbergerka@upmc.edu)

*What is a "Balanced" Diet? The Moral and Political Economy of Vegetable Cookery in Early Twentieth-Century Germany*

“The boiling of vegetables like the blanching of canned vegetables damages the national health as well as the national economy and must therefore be forbidden by law,” declared chemist and alternative nutritionist Ragnar Berg in 1921. He believed that the human body requires a delicate pH balance for optimal functioning but also understood the body as a virtual “test tube” that cannot regulate its own internal environment. Physical and mental health therefore depended upon healthful food choices (fruit and vegetables over meat or bread) and conscientious meal preparation (raw or steamed rather than boiled and strained) in order to cultivate an alkaline physiological milieu. Berg’s zeal was rooted in feeding experiments, laboratory analyses, and the cherry-picking of facts and speculations from the alternative and mainstream scientific literature. He was convinced that the seemingly mundane practice of cooking cabbage or parboiling peas was of such importance to individual health and collective well-being that it should be regulated by the German government. To this effect, Berg waged a campaign from the 1900s to the 1930s over the harm of canned fruits and vegetables from his laboratory post at Heinrich Lahmann’s naturopathic sanatorium outside Dresden. His opponents were nutritional experts in Berlin, academic physicians in Munich, and scientists employed by industrial canning operations centered in Braunschweig who believed that a “balanced” diet consisted of moderate amounts of a variety of foods prepared in conventional ways. This debate in personal letters, trade and scientific journals, the popular media, and public exhibitions combined digestive physiology, home economics, and (inter)national agribusiness and connected the pH of the average German’s dinner to the nation’s moral and economic balance sheet. In examining Berg’s scientific and political arguments about the nature of the human body as a biochemical entity, my paper complicates the usual dichotomies between “quantitative” and “qualitative” nutrition and between “mainstream science” and “alternative quackery” and contributes to the evolving discussion of how personal beliefs shape political actions when individual practices are scaled up to social expectations.

### Objectives

Appreciate the multifarious connections between diet and health  
Understand the dynamic history of medical ideas and practices  
Promote tolerance for ambiguity of theories and the nature of evidence

## H2 Disease and Diagnoses

Christopher Kindell, University of Chicago, Chicago, Illinois, USA  
[kindell@uchicago.edu](mailto:kindell@uchicago.edu)

*“The Brothel of the Pacific”: Syphilis and the Urban Regulation of Prostitution in Honolulu*

During the first half of the nineteenth century, the interisland spread of syphilis greatly contributed to the decline of indigenous Hawaiians. By 1860, the Hawaiian population had plummeted by about 75 percent when compared to its estimated pre-contact level. According to legislators, medical professionals, and public health officials, depopulation was intensified by a growing number of “licentious” Hawaiian women traveling to Honolulu to engage in

prostitution with foreign sailors and local laborers. After contracting syphilis in Honolulu, many women returned to their rural communities where they unwittingly spread the disease. Through an analysis of legislative debates, public health and medical reports, and periodicals, this paper examines the 1860 Act to Mitigate the Evils and Diseases Arising from Prostitution, arguably the Hawaiian Kingdom's most comprehensive response to its own national demographic catastrophe. As a secular backlash to failed missionary policies that sought to ban prostitution on a national scale, the Act to Mitigate assumed a regulatory approach by compelling prostitutes in Honolulu to enlist on a government registry and undergo a strict regimen of invasive medical examinations. To stymie the spread of syphilis and ultimately rein in depopulation, the government relied on its newfound ability to police the social interactions, geographic mobility, and physical bodies of women within a conspicuous and well-defined urban environment.

The Act to Mitigate became a dead letter in the 1870s due to religious backlash, underfunding, and an inability to actually cure those infected with syphilis. Nevertheless, the law established a conceptual framework that public health officials would adhere to when confronting other infectious diseases in the ensuing decades. The epidemiological relationship between Honolulu and the archipelago's peripheral communities would remain an enduring principle of public health discourse in Hawaii. Understanding how a porous seaport could operate as a generator, incubator, and conveyor of contagion would emerge as a foundational building block in the design and implementation of Hawaii's future public health programs.

#### Objectives

Key Words: syphilis, prostitution, urbanization

Critically assess the dynamic interplay between the demographic effects of syphilis and a country's unique geographic landscape.

Understand how legislation is integral to the design and implementation of public health programs that target the spread of infectious diseases.

Appreciate how the commercial and urban development of a city can facilitate the regional spread of infectious diseases.

## H2 Disease and Diagnoses

Thomas Helling, University of Mississippi Medical Center, Jackson, MS, USA  
[thelling@umc.edu](mailto:thelling@umc.edu)

### *Milieus, humors, and hibernation: theories of shock from Bernard to Laborit*

Towards the end of his life in 1885 Claude Bernard formally introduced the concept of a milieu interieur as an explanation for the constant physico-chemical adjustments of an internal environment to a changing and sometimes threatening milieu exterieur. This relationship, while seemingly in conflict was, in his estimation, actually a harmonious effort – even vitalistic – to maintain constancy within the organism. Furthermore, Bernard went on to say that the interaction of interior and exterior environments was mediated by sensory and motor nerves.

“In the perfect animal”, he wrote, “the nervous system itself regulates all these mechanisms and harmonizes them . . .” Indeed Bernard fueled decades of efforts to refine humoral approaches to modify the milieu interieur by mollifying sensory and motor ramifications of nervous stimulation.

The enigma of traumatic shock was, researchers surmised, an overindulgent reaction to external stress. Prevailing opinions of the early 20th Century promoted shock as a massive response of the milieu interieur, mediated by an autonomic nervous system that, if unchecked, could wreak fatal havoc on the organism. In fact, spillage of blood, if not immediately fatal, was thought of secondary importance to an exaggerated nervous activity triggering a hugely reactive humoral effect.

Through utilization of primary sources and scientific publications, the theme of this discussion centers on efforts of investigators to quell this internal response. Disciples of Bernard – Crile, Reilly, Cannon, Selye, Leriche, and Laborit – labored under the supposition that external stressors produced a humoral adjustment of the milieu interieur ultimately injurious to the host if allowed to progress unabated. Although parallel investigations firmly established the primacy of blood loss and blood replacement in treatment of shock – a more mechanistic approach – there were cardinal theories that culminated in Laborit’s efforts to blunt an over-indulgent autonomic system through processes of neuro-vegetative dissociation and artificial hibernation. Later therapies for shock incorporated both mechanistic and humoral approaches. Blood and fluid replacement in addition to restoration of the milieu interieur have had additive and complimentary contributions to survival. Yet the stress response, including the autonomic nervous system, continues to weigh heavily in outcomes of the critically ill.

### Objectives

1. The learner will understand Bernard’s role, including fading concepts of vitalism, for providing a basis for later humoral explanations of traumatic shock
2. The learner will understand the role “humoral” investigators played in a multifaceted approach to the treatment of traumatic shock.
3. The learner will understand the evolution of humoral theories culminating in Laborit’s desire for artificial hibernation as a means of quieting the adaptive stress response.

## H2 Disease and Diagnoses

Elena Conis, University of California, Berkeley, Berkeley, USA  
[econis@berkeley.edu](mailto:econis@berkeley.edu)

### *Triana's DDT Problem: Race, Class, and Environmental Health after the DDT Ban*

In 1938, President Franklin D. Roosevelt declared a network of sloughs branching off the winding Tennessee River in northern Alabama a national refuge, to provide sanctuary for the tens of thousands of migratory birds that passed through the area each year. Three years later, as the U.S. entered WWII, the Army opened the Redstone Arsenal, named for the region’s rocky

red terrain, just upstream. Redstone quickly became a production site for wartime chemicals: Lewisite, mustard gas, and, later, the pesticide DDT. As the arsenal's operations grew, so did the small town of Triana, located halfway between Redstone and the refuge, on the banks of the Tennessee. Seven days a week for 23 years, Redstone produced up to two million pounds of DDT per month. But not until the late 1970s—several years after a national ban on DDT—did Triana residents learn what regulators and manufacturers had long known: birds in the refuge, fish in the river, and soil and water throughout the area were heavily contaminated with DDT. In short order, an investigation by the Centers for Disease Control revealed that Triana residents themselves, who often subsisted on fish from the river, had some of the highest bodily levels of DDT ever documented. This paper, based on an analysis of local media coverage and extensive court records, examines the federal and local response to these body burdens, which included biomedical studies on the residents themselves. It examines the construction of health knowledge along lines of class and race in the industrial, post-civil rights era South. It analyzes the Tuskegee Syphilis Study's influence on interpretations of and responses to the body burdens at Triana. And it examines the politicized deployment of animal evidence in human health controversies. The town's experience provides insight into the the gulf between the largely suburban, middle-class environmental movement's demands and the chemical encounters of the working class and rural poor; the role of health evidence in the rise and demands of the environmental justice movement; and the complications associated with using evidence from nature and evidence of carcinogenicity as signals of environmental harm.

#### Objectives

- Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
- Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.

### **H3 Family Planning**

Jennifer Nelson, University of Redlands, Redlands, CA, USA

[jennifer\\_nelson@redlands.edu](mailto:jennifer_nelson@redlands.edu)

*Feminism and Abortion Law Debates in Mexico, 1974 to the present: Religion/Secularism/Human Rights/Neoliberalism*

Themes fundamental to transnational feminist debates provide a historical context for the feminist movement for abortion rights and improved women's reproductive health in Mexico. These themes include discussion of the historical influence of religion on the "secular" state which has influenced the state's continued opposition to legal abortion, as well as feminist and grassroots political demands that link struggles for human rights, democracy, and women's reproductive health. My paper engages with these themes in relation to the historical links among Mexican feminism(s) and the development of a neoliberal democracy in Mexico and

globally, which has transformed the debate about legal abortion and reproductive health (including both support and opposition to it). Particularly important to the paper is the feminist use (since the 1970s) of transnational human rights and democracy arguments to build a case for legal abortion, while during the same period, conservatives in the Partido Acción Nacional (PAN) made parallel transnational claims about strengthening Mexican democracy and human rights while opposing legal abortion and envisioning a stronger political role for the Catholic Church in government. The paper will also discuss how transnational neoliberal economic and democratic debates both supported and undermined the struggle for legal abortion and improved access to reproductive health care. By pulling apart these intricate historical threads in Mexican political history (focused on the 1970s to the present), I hope to provide a better understanding of the complex transnational positions taken by Mexican feminists on issues of abortion and women's reproductive health during this period.

Research for this paper will be drawn from the following government and non-profit organization archives in Mexico City: Consejo Nacional de Población (CONAPO), Instituto Nacional de las Mujeres (INMUJERES), Centro Nacional de Derechos Humanos (CENADEH), and Grupo Interinstitucional de Salud Reproductiva (GISR). I also draw from several feminist periodicals dating from the 1970s to the present; these include "Debate Feminista" "FEM," and "La Correa Feminista."

#### Objectives

Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

Recognize the dynamic interrelationship between medicine and society through history

Acquire a historically nuanced understanding of the organization of the relationship between health care systems, the state, and social movements for improved patient care

### H3 Family Planning

Yi-Tang Lin, University of Lausanne, Lausanne, Switzerland

[yi-tang.lin@unil.ch](mailto:yi-tang.lin@unil.ch)

*Statistics in-between Demography, Family Planning Fieldwork, and National Economic Planning: How the US-based organizations collaborated with the Republic of China's experts to transform a political taboo into national policy (1949-1969)*

In his lecture entitled "The Principle of Nationalism" in 1922, Sun Yat-Sen, the first president and founding father of the Republic of China (ROC), advocated for a larger Chinese population to preserve the Chinese nation. In 1953, ROC President Chiang Kai-Shek, by that time governing only Taiwan, further condemned any attempt to limit the population size as an attempt by communist China to weaken the ROC. Interestingly, despite Sun and Chiang's firm stance against population control in any form, in the mid-1950s, some public services within the ROC administration were tolerant of private organizations' initiatives promoting child spacing. The Taiwan Provincial Health Administration also took part in implementing family planning

programs starting in 1960. Why this discrepancy between the ROC central government's official stance and the actions of its subsidiary organs?

This paper draws from archives collected in Taiwan and the US, oral histories of family-planning experts and argues that the statistical practices of a range of public health experts working for US-based organizations (i.e. the Population Council, the Population Studies Center of the University of Michigan, and US aid agencies) together with ROC public services, pushed the ROC government to integrate a family-planning action into its Four-Year Economy Planning Policy. This paper will delineate how experts of both sides used statistics to justify the implementation of family planning programs in Taiwan by integrating family planning into macroeconomic modeling, and how they practiced statistics to translate local family planning fieldwork into knowledge, which in turn contributed to population control studies and campaigns at the international level. Taking the perspective of the social history of statistics led by works of Theodore Porter and Alain Desrosières, this paper further demonstrates that, statistics, with their double aim of increasing knowledge and guiding action along with their transferability and robustness, helped family-planning actors transform a political taboo into a national policy. Just as important, as statistics were omnipresent in family planning programs, a focus on the statistical practices of actors also remedies the lacunae between two groups of historiographies respectively focused on Taiwan programs and their foreign sponsors that have rarely been interconnected.

#### Objectives

1. Identify the variety of statistical practices involved in the debates of family planning programs at local, national, and international levels.
2. Recognize the key actors and their practices in implementing family planning programs at local, national, and international levels.
3. Develop the capacity for critical thinking about the use of statistics within public health programs.

### **H3 Family Planning**

Kathryn Lankford, Michigan State University, East Lansing, MI, USA

[lankfor4@msu.edu](mailto:lankfor4@msu.edu)

#### *Personal, Professional, and Political Motivation in the Puerto Rican Clinical Trials of the First Birth Control Pill*

American physicians Edris Rice-Wray and Adaline Pendleton Satterthwaite directed the Puerto Rican clinical trials of G.D. Searle & Co.'s Enovid from 1955 through the 1970s. Rice-Wray in suburban Río Piedras, and Satterthwaite in rural Humacao, received scientific guidance and financial support from colleagues in the states. Both women worked alongside Puerto Rican medical professionals and social workers to distribute Enovid and characterize Puerto Rican women's experience with the drug. Their labor led to Food and Drug Administration (FDA) approval of Enovid as a menstrual disorder corrective in 1957 and as the first oral contraceptive

in 1960. Using Rice-Wray's and Satterthwaite's oral histories, scientific articles, and personal reflections, this paper narrates their motivations for leading the field trials of the first birth control pill. Rice-Wray's and Satterthwaite's hopes for the trials suggest that personal experience and professional drive, racialized and classed notions of womanhood and reproduction, and changes in Puerto Rico intimately shape the development of oral contraception.

Considering the breadth of literature on the pill, as oral contraception is popularly known, the relative dearth of information on the clinical trials of Enovid is surprising. Despite this imbalance, historians of the pill rightly illustrate the colonial underpinnings of the clinical trials in Puerto Rico. For example, scholars use Rice-Wray's and Satterthwaite's mainland U.S. origins and location of the trials in Puerto Rico as a starting point to examine U.S. imperial power and actions. Yet, the clinical trials were more than a unilateral imposition of mainland ideals onto passive Puerto Ricans. To the contrary, Rice-Wray and Satterthwaite responded directly, though often problematically, to the local context to justify the development of oral contraception. They became involved in the clinical trials due to their personal experiences in Puerto Rico. Hence, attending to how two, mainland U.S. doctors interpreted and responded to their adopted homes complicates our understandings of medical innovation in colonial contexts, as well as provides space for the subjective in analyses of medicine.

Objectives

Keywords: Oral contraception, clinical trials, and Puerto Rico

Critically narrate the origins of the clinical trials of the first birth control pill from a ground-level perspective

Recognize the imbrication of personal experience in the development of medical therapies

Complicate understandings of power dynamics in medicine

#### **H4 Sexuality, Identity, and Health**

Michael Sappol, Uppsala University, Uppsala, Sweden

[mike.sappol@gmail.com](mailto:mike.sappol@gmail.com)

*Queer anatomies: Perverse desire, medical illustration & the epistemology of the anatomical closet*

We're accustomed to reading about queer spaces in cultural geography, art history, sociology, literary studies, and of course queer theory, but not in the scholarship on anatomical representation. Focusing on the anatomical plates of William Cheselden (1710s-40s), Jacques Fabien Gautier d'Agoty (1740s-70s), N.H. Jacob (1820-60s), Joseph Maclise (1840s-50s), and lesser-known works, this paper will argue that over the centuries the anatomical illustration has been made to serve as a queer space and a closet.

The talk is inspired by Eve Kosofsky Sedgwick's *The Epistemology of the Closet* (1990), one of the foundational texts of queer theory. In that book, Sedgwick argued that gender performances—hetero/homo, normative/abnormative—are always in fluctuating push/pull

dialogue with one another, always make sense or nonsense in relation to each other, always contain the Other. If so, then “queer” doesn’t just belong to, or explain, self-identified “queers.” Queer belongs to and explains everybody.

Queer theory also supplies us with useful descriptive terms for situations, settings and tactics: such as “the closet”, “queer space”, “panic”, etc.. The “closet” especially helps us think about what libidinal investments might be expressed or buried in the anatomical illustration—how anatomy might be a place where the love that dare not speak its name could show itself, even flaunt itself.

But this desire and its objects are covered up. The evidence is obscured. Which is the problem so cogently addressed in *The Epistemology of the Closet*, where Sedgwick argues that we should not look for epistemological certainty when it comes to a system of meaning that is strongly semantic and yet concealed in a system of plausible and implausible deniability. If we only credit what is epistemologically secure, we miss the whole show. In such circumstances, an insistence on epistemological certainty is obtuse or, worse, no fun.

This talk will focus on historical images of dead and dissected people and body parts, which feature provocative views of genitalia, breasts, and anuses. My method will be to read those images closely and situate them in larger professional, aesthetic and social contexts, within tangled thickets of perverse desire, same-sex erotics, connoisseurship, medical politics and social performance.

#### Objectives

- 1) Develop the capacity for critical thinking about the nature, ends and limits of the production of medical knowledge in anatomy and surgery:
  - Deepen understanding of visualization technologies and tactics in production of medical knowledge
  - Give insight into ambiguity of theories and nature of evidence
- 2) Give attendees an overview of the history of 17th-, 18th- and 19th-century anatomical illustration and anatomical book collection.
- 3) Sensitize attendees to the ways in which medical illustrations and books carry significant meanings in addition to their role of mapping the structure of the human body for anatomist, physician, surgeon, and student.

#### **H4 Sexuality, Identity, and Health**

Richard McKay, University of Cambridge, Cambridge, UK  
[ram78@cam.ac.uk](mailto:ram78@cam.ac.uk)

*“In delicate country”*: responding to “the homosexual VD problem” in post-war California, 1945-1965

This presentation explores concerns surrounding an apparent rise in syphilis and gonorrhea transmission in California during the two decades following the Second World War, an increase that contemporaries would eventually attribute to urban networks of male homosexuals. Although this was the first sustained instance of what would later become a widely accepted truth—that men who had sex with men were at increased risk of acquiring and transmitting venereal disease (VD)—historians have paid this period relatively little attention.

I draw upon newspapers reports, city and state health department files, institutional records of the American Social Health Association (ASHA), and papers and publications of homophile activists and organisations. Using these sources, I track key shifts in medical, media, and public awareness that gathered force after Kinsey and his associates published “Sexual Behavior in the Human Male” in 1948—that American men not only had more same-sex sexual contacts than previously imagined, but that these illicit connections might also conceal a substantial burden of venereal disease. My presentation moves from scattered reports in the early 1950s that male homosexuals were transmitting a significant amount of VD in the San Francisco area, to internal debates within the ASHA regarding their “taboo” on homosexuality, to an intense 1963 campaign against “sexual deviates” waged by a Hollywood newspaper. Overall, I aim to demonstrate that concerns about VD were frequently part of the struggles facing early homophile organisers in America, and a complex challenge for other social reformers and public health workers.

The presentation advances three main claims: first, civic public health workers took a proactive role in addressing this delicate situation, one which required them to reckon with their historically close-knit collaborations with law enforcement officials, and to face the inherent political vulnerabilities of providing VD treatment. Second, the situation in California contributed to a substantial shift in mission focus for the ASHA by the early 1960s. Finally, homophile organizers initially wrestled with how best to incorporate a response to VD into their activism, yet by the mid-1960s established a multifaceted response including community education, public relations, and cooperation with public health workers.

#### Objectives

- Develop a historically informed sensitivity to the diversity of patients
- Recognize the dynamic interrelationship between medicine and society throughout history
- Acquire a historically nuanced understanding of the role of confidentiality in public health practice

#### **H4 Sexuality, Identity, and Health**

Rodion Kosovsky, Yale University, New Haven, CT, USA  
[rodion.kosovsky@yale.edu](mailto:rodion.kosovsky@yale.edu)

*Lesbian Battering: Gender, Domestic Violence, and Psychology in the US 1980-2000*

The discovery of domestic violence in the lesbian community in the 1980s shattered feminist dreams of a lesbian utopia and shook gendered based theories of domestic violence. While feminists brought the problem of battered wives into the public conscious in the 1970s, abuse in the lesbian community remained undiscussed until the early 1980s. The very nature of same-sex abuse undermined the dominant idea that abuse was a man deliberately harming a woman. LGBT and allied psychologists and psychiatrist struggled to explain the violence within their community and provide services for their abused clients.

Drawing upon numerous archives as well as primary literature, I explore four major responses of the psychiatric profession to lesbian battering in the 1980s: denial of the problem, mutual battering, internalized homophobia, and power. When the problem first emerged, some members of the LGBT community urged victims to remain silent to preserve the image of the community. As an already besieged minority, they worried that anti-gay organizations would exploit lesbian battering as proof of the “deviancy of homosexuality.” Since many lesbian used self-defense skills learned in feminist classes to protect themselves during attacks, a few psychiatrists argued that both parties were equally responsible. They called this theory mutual battering. Other psychiatrists were more supportive of victims. In 1981, A. K. Maylon published a seminal article that argued that internalized homophobia—the adoption of negative social attitudes about lesbianism by lesbian—explained lesbian battering. Homophobia caused domestic violence among gay men and lesbians. This remained the unofficial position of the American Psychological Association until the mid-1990s. The fourth major theory sought to replace gender with power as the cause of domestic violence. It argued that abuse happened not because of a patriarchal society that used violence to control women but because of individual decisions to harm partners. Lesbian battering brought power into the mainstream psychiatric discourse on domestic violence and permanently altered the debate. My research is the first major historical work on domestic violence within the LGBT community. It shows how LGBT psychiatrists challenged feminist theories on domestic violence than emphasized gender and created a new LGBT psychiatric discourse.

#### Objectives

- 1) Deepen understanding of the impact of psychiatric theory on the lives of patients.
- 2) Develop greater sensitivity to the challenges of providing psychiatric care to LGBT patients and minorities more broadly.
- 3) Examine the interaction between feminism, LGBT activism, and the psychological and psychiatric professions

#### **H5 Mobilizing Medicine in War and Peace**

Fedir Razumenko, University of Saskatchewan, Saskatoon, Saskatchewan, Canada  
[fedir.razumenko@usask.ca](mailto:fedir.razumenko@usask.ca)

*Development of the First Cooperative Clinical Cancer Trial in Canada and the Canadian-American Nexus, 1965-1976*

Clinical cancer research in Canada entered a new phase in 1971. That year, the National Cancer Institute of Canada agreed to launch and support a multidisciplinary cooperative clinical trials program. The first collaborative randomized controlled trial (RCT) for the treatment of advanced Hodgkin's disease got underway in medical centers across the country in December 1971. At the same time in the United States, the National Cancer Act came into effect. To what extent were these Canadian and American developments coincidental? I argue that the advent of cooperative clinical trials program in Canada was not a coincidence but a corollary of the US declaration of war on cancer. Evolution of the Hodgkin's disease trial serves as a good example to demonstrate how a growing collaboration among Canadian and American doctor-investigators brought about a large-scale national study. The latter became a prototype of further cooperative RCTs in Canada over the 1970s.

Although major Canadian cancer specialists collaborated sporadically in clinical trials conducted by American NCI-sponsored groups since at least the mid-1950s, conditions to organize the cooperative clinical trials program became optimal later. I analyze constituents of this favorable situation historically to explain why a relatively rare lymphoma, Hodgkin's disease, came into focus for leading Canadian therapeutic radiologists and chemotherapists in the process of their interaction with American colleagues in the late 1960s. I conclude that certain professional interests and practices in radiotherapy and medical oncology became accommodated within one cooperative group owing to a particular Canadian-American nexus. Importantly, the Hodgkin's trial protocol development reconciled contending evidential paradigms of radiotherapists and chemotherapists through epistemological and political means.

I build on the work of Peter Keating and Alberto Cambrosio to show how the RCT method made it possible not only to sideline inter-professional disagreements on innovative cancer treatment modalities, but also to cross borders and form clusters of investigators in a transnational network. Drawing on archival records from the clinical trial committees, doctor-investigators' correspondence, and institutional papers from associated Canadian and American medical centers, I trace the emergence of the cooperative clinical trials program in Canada.

#### Objectives

Keywords: cooperative clinical trial, Hodgkin's disease, cancer research.

1. Appraise a historical significance of the cooperative clinical trial programs in both Canada and the United States, which reflects a cultural embeddedness of scientific medicine.
2. Recognize the role of innovative methods and procedures in creating epistemological imbalances and presenting challenges to medical professionals in terms of reconfiguration of their authority.
3. Appreciate how conceptual disagreements stemming from competing evidential paradigms in oncology can prevent development and implementation of clinical trials.

#### **H5 Mobilizing Medicine in War and Peace**

Kelly Urban, University of Pittsburgh, Pittsburgh, PA, USA

[klu11@pitt.edu](mailto:klu11@pitt.edu)

## *“Streptomycin and Body Politics in Cuba, 1945—1959”*

The ambitious health programs of socialist Cuba need no introduction among the global health community. Historians of health on the island have contended that after the 1959 revolution, the state embarked on an unprecedented campaign to not only improve access to health services, but also to produce new kinds of medicalized subjectivities. These studies assume that no biopolitical project was attempted by the previous “fragmented” Cuban state and that after 1959 citizens represented a tabula rasa for the state’s social engineering. Furthermore, scholars argue that the “right to health” in Cuba was bequeathed by the socialist state, which mirrors a broader tendency in the historiography of medicine and public health to portray the extension of health rights as automatically accompanying greater enfranchisement.

This paper asks if there was a biopolitical project before 1959 in Cuba, and, if so, what its form and consequences were. It explores these issues through the case study of streptomycin—a widely known “cure” for tuberculosis—which arrived on the island in the late 1940s. Drawing on official medical reports, editorials, newspaper coverage of sanatorium strikes, letters from marginalized citizens, and pamphlets from civic streptomycin banks, I analyze both state health efforts and grassroots definitions of medical success, and compare empirical data about health indicators with the critical public discourse surrounding the “miracle drug.”

I contend that the republican state attempted a biopolitical project as it tried to distribute, regulate, and shape consumption of streptomycin. However, even though tuberculosis mortality had begun to drop rapidly by 1953, citizens denounced the state health sector throughout the 1950s. Frustrated by their difficulties in accessing the expensive drug, the sick (along with physicians) began to articulate the right of the poor to free or state-subsidized medicine. These citizens-turned-health-activists thus pursued a biopolitics from below, expanding the definition of citizenship and politicizing state drug policy. Following the 1959 revolution, the new regime crafted a biopolitical project that grew out of and responded to this pre-existing body politics.

### Objectives

Key Words: Cuba, biopolitics, streptomycin

1. Recognize the dynamic interrelationship between medicine and society through history
2. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

### **H5 Mobilizing Medicine in War and Peace**

James Schafer, University of Houston, Houston, TX, USA

[jschafer@uh.edu](mailto:jschafer@uh.edu)

## *American Medical Mobilization for the First World War, 1916-1918*

During the final stages of American preparedness for the First World War, editorials in popular periodicals and medical journals alerted readers that thousands of civilian doctors would be needed to voluntarily enlist as medical officers in various branches of the United States Army and Navy Medical Corps to support the millions of American men who would be drafted or who would volunteer for regular military service. Shortly after declaration of war in April 1917, as military and medical mobilization kicked into full swing, Dr. Charles H. Mayo made an impassioned plea in his Presidential Address at the annual meeting of the American Medical Association: "...Medical men, your country needs you now and always. You must remember that the state is permanent and does not exist for the good of the individual, but that the individual exists for the good of the state." Reflecting the fervent nationalism of the day, his comments nonetheless raise important questions about American medicine, militarization, and the state. In particular, what did it mean for medical leaders, like Dr. Charles H. Mayo, to preach wartime volunteerism and self-sacrifice to a medical profession that valued individualism and protected the economic interests of doctors in private practice? How did the unprecedented and sudden mobilization of 32,000 medical officers (22 percent of the entire civilian profession) affect the careers and lives of these doctors during and after the war? Finally, what lasting effects did the war have on the organization American medicine as a whole?

Based upon published accounts in medical journals, organizational histories, and the unpublished correspondence and memoirs of civilian doctors and medical officers, this paper examines the AMA-led mobilization of American doctors for the First World War from fall 1916, through the declaration of War in April 1917, to the deployment of the first base hospital units in late spring 1917. Delivered at the centenary of American entrance into the war, this paper argues that there were tremendous pressures upon civilian doctors to enlist, both from within and from outside the medical profession, indicating that wartime hysteria shaped medical mobilization and the decision-making of individual doctors.

### Objectives

1. Understand the relationship between medicine and modern warfare.
2. Understand external factors influencing professional decision-making in American medical history.
3. Understand the causes and effects of American medical mobilization for the First World War.

### **Poster Session A**

Helen Bradshaw, Johns Hopkins University, Baltimore, MD, USA

[hbradsh3@jhmi.edu](mailto:hbradsh3@jhmi.edu)

*The Art of Science and The Science of Art: Robert Latou Dickinson and Sex Research in Interwar America*

In 1912, Robert Latou Dickinson wrote, “I believe in pictures.” He was an artist and a gynecologist; art infiltrated every aspect of his medical practice. He mentored Alfred Kinsey and was one of the first to elicit detailed sexual histories, amassing more than 5000 interviews. Each contained drawings. This paper analyzes Dickinson’s use of art in his clinical practice and research. Artistic practice played unexpected, and hitherto unknown, roles in the foundational years of sex research in America.

I analyzed 22 boxes of archival materials at Harvard’s Countway Library, including correspondence, drawings, photographs, pamphlets, publication drafts. Sketches across multiple realms of Dickinson’s work (anatomy textbook illustrations, patient notes, research studies) enabled me to analyze the multiple roles of art in Dickinson’s research and practice. The act of drawing was integral to Dickinson’s research and practice. He saw the observational practices drawing entailed as a crucial form of knowledge-making. Earlier scholars have emphasized the objective nature of art but my research suggests a strong role for the ambiguity of art in Dickinson’s advancement of the field of sexual research. Artistic depiction allowed Dickinson to preserve the ambiguity of a subject while he wrestled to understand it. For him, language served to define, and thus limit, while sketches permitted ambiguity and contingency. Furthermore, the artistic nature of Dickinson’s drawings was important in addressing what some considered the “repugnant” (sexual) nature of his field; in drawing he was able to “clean up” what would otherwise be considered by the public eye as “dirty”. The visual language Dickinson created to catalogue sexual ambiguity also enabled him to open up conversations about difficult subjects with colleagues and the public, and even facilitated clinical interactions. Dickinson’s boyhood training in art was rapidly becoming a thing of the past, but ironically his insistence on the value of sketching, and his refusal to endorse what he called a “hush-and-pretend” culture also look to the future. Dickinson’s work speaks to a continued role for art in medical education and practice in the present day.

### Objectives

Key words: sexual health, gender ambiguity, art, objectivity, medical education

Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

Recognize the dynamic interrelationship between medicine and society through history

Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education.

Alfred Freeborn, Humboldt-Universität zu Berlin, Berlin, Germany

[alfred.cheesman@hu-berlin.de](mailto:alfred.cheesman@hu-berlin.de)

### *Measuring the “Broken Brain”: Neuroimaging and the “biological revolution” in American and British Psychiatry*

In 1984, the American psychiatrist Nancy Andreasen published a book entitled *The Broken Brain: The Biological Revolution in Psychiatry* in which she announced ‘a new mode of perception’ for psychiatry, in which mental illnesses are to be understood ‘in terms of how the

brain works and how the brain breaks down.’ Central to this ‘revolution’ was the use of imaging technologies to, in Andreasen’s words, ‘look directly to the brain.’ Over the next thirty years, Andreasen and her colleagues in Iowa used imaging technologies to investigate schizophrenia in the living brain, yet their attempts were plagued by complexities, and the existence of a specific brain disease underlying schizophrenia remains a hypothesis. This paper focusses on the specific experimental designs that used new imaging technologies to measure psychiatric illnesses; in light of ongoing uncertainty, these case studies enable a subtler understanding of how clinical expectations and techniques for visualizing the living brain intersect.

The first study to assess brain abnormalities in schizophrenics with computed tomography (CT) was published in *The Lancet* in 1976, suggesting a connection between schizophrenia and ventricular enlargement. Between this paper and the end of the 1990s, the field of brain imaging was transformed; while the presence of ventricular enlargement had been confirmed by other studies with CT, it offered no pathogenesis, and the depth of information made available by more recent imaging technologies dwarfed that of CT. Despite the ingenuity of the attempts to integrate new data into a model of schizophrenia using imaging, the turn to direct observation of the living brain yielded no aetiology of the illness, and by the 2000s had rather returned focus to the validity of the diagnostic category of schizophrenia itself.

Psychiatry is experiencing yet another crisis. The recent move by the NIMH in 2010 to replace the DSM with RDoCs (Research Domain Criteria) in its research funding policy suggests a slower and harder trajectory for the understanding of mental health through the brain. The optimism of the Broken Brain must be critically re-assessed if we hope to understand the present relationships between basic neuroscientific research and psychiatry’s role in society.

#### Objectives

1. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education.
3. Recognize the dynamic interrelationship between medicine and society through history

Jillian Hinderliter, University of South Carolina, Columbia, SC, USA  
[hinderlj@email.sc.edu](mailto:hinderlj@email.sc.edu)

#### *Our Bodies, Our Jewish Selves: Jewish Activists of the Women’s Health Movement, 1968-1980*

In the late 1960s, women’s health activists began to redefine the relationship between patient and healthcare practitioner. Spearheaded by women in New England, the women’s health movement challenged healthcare to become a proactive, informed process for all patients. The Boston Women’s Health Book Collective (*Our Bodies, Ourselves*) and the National Women’s Health Network (NWHN), and others, laid the groundwork for a nationwide movement emphasizing health education, empowerment, and advocacy.

While historians are familiar with this broader narrative of second wave feminism, few realize that many American Jewish women were active as founders, healthcare providers, and volunteers in the women's health movement. Histories of health activism often overlook the fact that eight of the twelve founders of Our Bodies, Ourselves were Jewish, as were four of the five founders of the NWHN. Utilizing archival evidence and oral history interviews, in this paper I consider Jewish women of the "founding generation" of feminist health activists from 1968 to 1980. When possible, the voices of Jewish women are at the forefront of this paper. My aim is to understand the extent of Jewish women's participation and ask if Jewishness informed their work as health activists. I argue it is necessary to study the feminist health movement as more than the related activism of white, African-American, and Chicana women. Including Jewishness as an influential feature of identity for many activists is essential for accurately characterizing the health politics of women like Barbara Seaman, Rose Kushner, and Paula Doress-Worters.

For many American Jewish women, Jewish identity informed their dedication to social justice and healthcare reform. Some activists even used language from religious practice to discuss women's liberation and health education together. The dedication of Jewish women to the women's health movement points to more than coincidence; there is a link between personal understandings of Jewish identity and each activists' brand of health advocacy. Though American Jewish identities are multifaceted, interdisciplinary methods drawn from women's and gender studies and Jewish studies provide a framework to analyze the role of Jewish identity and culture in shaping widespread change in women's healthcare.

#### Objectives

- Acquire a historically informed understanding of the interrelationship between personal identity and women's health activism since the late 1960s
- Deepen knowledge of Jewish women's roles in shaping the feminist health movement as it evolved into a nationwide movement
- Reflect critically on the development of women's health advocacy in the twentieth century United States and recognize the roles of health activists in shaping women's health politics and policy

Andrew Hogan, Creighton University, Omaha, NE, USA

[AndrewHogan@creighton.edu](mailto:AndrewHogan@creighton.edu)

#### *Defining and Redefining the Medical Model: Postwar Formulations of Disability and Health*

"The medical model" of illness and disability has been widely criticized by sociologists, psychologists, and disability advocates, who have highlighted various perceived faults including stigmatization, a focus on pathologies not persons, and overly reductive perspectives on causes and effects. This presentation examines postwar critiques of "the medical model" and responses by the medical community, including the World Health Organization (WHO). While some physicians argued that their approaches were being unfairly characterized and maligned, others called for expanding the medical gaze to better consider the role of social and

environmental factors in illness and disability. Notably, in doing so, medical professionals rarely embraced the term medical model, reflecting their awareness of its often-pejorative connotations.

Historians of medicine, including Beth Linker and Naomi Rogers, have examined alternatives to medical model perspectives, and how physicians, as well as historians, have responded to them. My presentation draws on archival sources, published literature, and interviews to show that there is no one medical model; rather, “the medical model” refers to a collection of disparate, but overlapping, critiques of what is perceived to be a socially dominant narrative of illness and disability. Specifically, I focus on evolving medical conceptions of disability by examining the contents, and responses to, two editions (1980 and 2001) of the WHO’s classification of disablement. I argue that the evolving WHO system offers historians insight into how medical professionals sought to redeem their perspectives and approaches.

Physician and epidemiologist Philip H.N. Wood, who authored the first WHO classification of disablement, had sought to extend the WHO’s focus to include the consequences of disease. Though Wood highlighted social and environmental factors in his classification scheme, social scientists and disability advocates criticized it as a continuation of “the medical model”. The WHO responded by publishing a totally revised second edition under broader authorship in 2001. While many acknowledged that the updated version was significantly improved, some remained concerned about lingering medical model assumptions. I suggest that debates about what “the medical model” is and how it might be reformed offer a valuable perspective for defusing unproductive tensions between providers and medical model critics.

#### Objectives

By the end of this activity, the learner will:

- Develop the capacity for critical thinking about the nature, ends and limits of medicine
- Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
- Recognize the dynamic interrelationship between medicine and society through history

Jianan Huang, Zhejiang University, Hangzhou, China

[jiananhuang@zju.edu.cn](mailto:jiananhuang@zju.edu.cn)

#### *The World History of a Chinese Herb: Mythologies of Ginseng and Its Modern Crisis*

Classified as one of the most precious and effective herb in Traditional Chinese Medicine (TCM), ginseng meets great doubts on its potency from the pharmacopoeias of Europe and America. Although the anti-cancer effect of ginseng extract has been highlighted recently, there remains a lack of literature attempting to carry out a historical studies on the changeable concepts of people on ginseng. According to materials from ancient medical books and modern pharmacopoeias of Europe, America, Japan and China, the history of East Asians’ knowledge on ginseng is consisting of four phases: initial treated ginseng as food; fabricating the mythologies of ginseng in imperial period; subsequent uncertain of its effect in early global age; and finally

trying to re-maintained the mythologies by introducing molecular chemistry into TCM studies. The Clashes between American Ginseng, Korean Ginseng and Chinese Ginseng enhance people in modern time to rethink the unnecessary deification of a large range of traditional health products, as well as enable people to examine the different mode of thinking between west and east medical culture. Contemporary China anchor its hope on Ginsenosides Rh2/Rg3, Artemisinin and so on to recapture national identity, reflecting quests of the third world countries to connect medical knowledge with state-making.

Objectives

Keywords:

Modernization of Traditional Chinese Medicine; Cross-cultural History of Medicine; National Identity

1. Provide a critical perspective for people's prejudices or predilections to traditional health products.
2. Deepen the biased definition of ginseng in different pharmacopoeias from Europe, America, and Asia.
3. Develop an historically angle for medical experts' understanding of ginseng and other national herbs.

Kimberly Killion, University of California, Berkeley, Berkeley, CA, USA

[kkillion@berkeley.edu](mailto:kkillion@berkeley.edu)

*The Chemist at the Table: Alternatives to "Nutritionism" in the USDA Dietary Surveys, 1894-1904*

The ideology of "nutritionism" —a reductionist view that portrays food as a combination of chemical components without considering taste, culture, or social context— has become a key target in recent scholarship on the American diet, particularly as advancements in nutrition science have paralleled a rise in dietary-related diseases. Scholars root "nutritionism" in the development of American nutrition science in the late nineteenth century, when chemists like Wilbur Atwater began to break down food into calories, fat, protein, and carbohydrates. Historians have criticized early scientists for their reductionist view of food, as well as their portrayal of the working class as uneconomical and their bias toward white, American diets. However, this scholarship has focused on a nutrition scientists working in urban centers on the East Coast. By expanding the geographic scope to the West Coast, I reveal a diverse landscape of scientists who are not so easily vilified, including scientists whose understandings of nutrition ran counter to the ideology of "nutritionism."

I will examine the USDA dietary studies conducted in the 1890s. These studies used an anthropological/sociological approach to studying nutrition that combined laboratory and field practices. Chemists would visit, and sometimes share meals with, their research subjects while measuring their daily food intakes. The studies focused on working-class and immigrant diets, but researchers often concluded that these groups were resourceful, and that foreign foods were just as nutritious as familiar American foods. The studies critically examined the social contexts of their subjects' diets, including their living and working situations. They described,

and often validated, the role of taste in shaping dietary preferences. They also recognized the limits of their own knowledge, discussing how their subjects' preferences revealed some unknown value in certain foods. Place, discipline, and funding shaped the various approaches of the scientists who conducted these studies, particularly as those at public universities were tied to serving their state's constituents.

These alternative and holistic approaches to nutrition science reveal that there were multiple directions the science could have taken, and thus raises the question of why and how "nutritionism" came to be the dominant ideology of the science today.

#### Objectives

- Understand the diverse approaches to research in the early history of nutrition science
- Recognize the complex relationships between researchers and subjects in constructing medical knowledge
- Develop critical thinking about the practices and goals of research in the health sciences

Caroline Lieffers, Yale University, New Haven, CT, USA

[clieffers@gmail.com](mailto:clieffers@gmail.com)

*"Compelled by Necessity": Disability and Agency in the Medical Technologies of the Neonatal Intensive Care Unit*

In the United States, infants born too early or with dramatically low birth weight are considered by the Social Security Administration to be "presumptively disabled." Usually clinging to life in neonatal intensive care units (NICUs), their tiny and underdeveloped bodies are cared for by the intersecting efforts of nurses, physicians, parents, and medical technologies. This presentation draws from the records of Small Beginnings, Inc., founded in 1997 to provide specialized products for the NICU, to examine how medical objects that were first improvised by nurses were transformed into medical commodities. As Small Beginnings sought to distribute its offerings to more NICUs, the company relied on a discourse that subsumed its own business interests to the practical and emotional needs of NICU staff, parents, and infants. The complex environment of the NICU, importantly, complicates the category of "user" in the study of disability technologies. I argue that while nurses were ostensibly the user-innovators of Small Beginnings' many products, which included feeding tubes, positioning pillows, and suctioning devices, these tools were in fact prostheses for the bodily operations of both mother and baby. At the same time, Small Beginnings aimed to highlight the importance of the infants' preferences and individuality. Nurses and parents were instructed to detect the faintest signals of infant stress and distress, seeking to understand and respond to the personal expression and agency of these tiny actors with the right commodity. The category of "user" grows even more blurred, as the NICU—more than the sum of its technological parts—choreographed the behaviours of staff, parents, and infants alike. Thoroughly embedded in a medical model of disability, these various actors largely resisted a long-term disability identity for the infant patients. But in the prosthetic space of the NICU, they also embraced the elegant intersection, commodification, and potential of user needs and technological assistance.

## Objectives

- To develop a critical understanding of the nature, means, and ends of nursing practice and medical technologies
- To deepen knowledge of the role of business and marketing in the practice of medicine and nursing
- To develop a critical understanding of disability in social and historical context

Nona Lu, Vanderbilt University Medical Center, Nashville, Tn, USA

[nona.lu@vanderbilt.edu](mailto:nona.lu@vanderbilt.edu)

### *A History of the Development of a Symptom: Burnout in Physicians in the United States (US)*

Burnout was described by Dr. Freudenberger in 1974; one conceptualization of it is that it is a triad consisting of emotional exhaustion, depersonalization, low sense of personal accomplishment related to work. In 1981 Christina Maslach and Susan Jackson developed a instrument used to assess burnout; The Maslach Burnout Inventory (MBI) is used commonly in health-care workers but also expanded to other occupations. Around this time period the federal government was offering Medicare managed care options in the 1970s and 80s and managed care in general expanded in the United States during the 1980s and 90s with resulting changes in physician's roles including an emphasis on gate-keeping of resources and prior authorizations.

There is no code for burnout in the standard Diagnostic and Statistical Manual of Mental Disorders (DSM) or The International Classification of Diseases, Ninth Revision (ICD-9) which are used by healthcare providers to code and organize all diagnosis, symptoms, and procedures, until ICD-10 (finished in 1992) came with the code Z73.0 Burn-out. Though the US transitioned to using from ICD-9 to ICD-10 in 2015. Burnout, however, is not considered a disorder, though a simple search in PubMed for the terms "burnout physician" returns 4352 results. Given the overlap of burnout with symptoms of other mental health diagnosis one wonders how burnout became thought of as a symptom from 1974 to now and under what forces. This is an examination of the history of the birth of a symptom and the examination of the overlap between a symptom and a diagnosis.

This paper will use statistical analysis of research papers published with established medical databases that chart the increased growth of research on burnout in physicians and analyze the historical forces taking place in the United States healthcare marketplace.

In conclusion, burnout in physicians is a symptoms, that can be theorized by it's gradual inclusion in the same classification as disorders (e.g. ICD-10), was birthed around the same time the rise of new health care models were emerging the United States along with other changes in healthcare and it could be theorized that the latter predisposes the recognition of the former.

## Objectives

Recognize the history of the naming and recognition of the symptom of burnout  
Appraise current burnout interventions, prevention initiatives from a historical perspective.  
Deepen understanding of the changes in the medical health care system in the United States from the 1970s to now.

Christopher Lusty, Schulich School of Medicine and Dentistry, London, Ontario, Canada  
[christopherlusty@gmail.com](mailto:christopherlusty@gmail.com) and Estabrook Genevieve, Schulich School of Medicine and Dentistry, London, Ontario, Canada, [lori.muir@lhsc.on.ca](mailto:lori.muir@lhsc.on.ca)

## *Gynecological Surgery for the Insane*

The gynecological surgical program at the London Insane Asylum has been a topic of study as a microcosm of Victorian Canada. Some works have discussed the historical, social and political climate surrounding surgeries performed at the Asylum. Investigations tend to focus on the claims of the medical superintendent of the Asylum at the time with respect to the mental outcomes of the patients at the Asylum who underwent gynecological surgery. A paucity of literature exists examining the gynecological complaints, treatments, and outcomes of the patients operated on at the asylum. Available primary records of the London Insane Asylum were examined through the Archives of Ontario at York University. Records were manually digitised and examined to find the case histories of women who underwent gynecologic surgery. This revealed information that sheds light on potential non-psychiatric objective and subjective reasons for surgery. This work complements the work done so far examining the psychiatric outcomes of patients treated with surgery at the London Insane Asylum, and the work done examining the social context of the surgical program.

## Objectives

- Be able to describe the social context of Gynecological Surgery at the London Insane Asylum
- Know the findings and complaints that were used as the basis of surgery in the program
- Know the types of surgery that were offered to women at the London Insane Asylum

Sara Meloni, University of Pennsylvania, Philadelphia, USA  
[sameloni@sas.upenn.edu](mailto:sameloni@sas.upenn.edu)

## *"No harmful chemicals": ingredients databases, online communities, and the search for safety through consumption*

The paper analyzes the emergence of online communities of consumers concerned about the safety of personal care products in Italy in the late 1990s. In some cases, the people who access these communities are responding to debilitating chronic disease; in other cases, they are just willing to enact preventative practices to protect their health and that of their families. Environmental historians, STS scholars, and historians of medicine and public health have written about the risks posed by the pervasive presence of manmade chemicals in the environment and in our bodies, focusing on the interplay of scientific uncertainty and politics in

the regulation of substances such as tobacco, lead, vinyl chloride, asbestos, DES, and BPA. Focusing on the phenomenon of online communities on safe products contributes to this conversation and offers insights into the changing moral and political economy of health and consumption from the point of view of the patient/consumer.

Starting from the broader history of consumer movements and scientific and civic concerns about toxicity in consumer products, I will ask what motivates people to join these communities, how scientific information on ingredients and health risks is discussed by this lay audience, and what are the implications of this instance of “precautionary consumption.” The paper employs both historical and digital ethnographic methods, and the sources used include scientific publications on safety in consumer products, newspapers’ articles, consumer advocacy journals, laws and regulations on chemicals and consumer protection, and digital archives of online discussion forums on “natural living” and ingredients in consumer products. A great amount of emotional and economic resources goes into the search for the “right” product, and the ultimate responsibility of reaching safety is placed on the individual consumer. The pervasive use of the privative claim—focusing on what a product does not contain—highlights the ultimate assimilation of anxieties around the health risk of chemicals in the workings of the market. As safety is commodified, the experience of consumption not only becomes fragmented and dependent on different levels of information and economic possibility, but also generates reflections on the role of producers and the state.

#### Objectives

Key words: consumption, risk, digital communities

- Understanding the role of online forums of in the natural/organic market
- Reconstructing the cultural and political changes occurred in the regulation of consumer products in Italy between the 1970s and the 1990s.
- Understanding the meaning of “precautionary consumption” in historical context

Jole Shackelford, University of Minnesota, Minneapolis, Minnesota, USA  
[shack001@umn.edu](mailto:shack001@umn.edu)

#### *The Medicalization of Biological Rhythms, from Circadian Rhythms to Chronoastrobiology*

After his formal retirement in 1990 from the medical faculty at the University of Minnesota, Dr. Franz Halberg, M.D., who coined the term “circadian” rhythm and reframed the field of biological rhythms research as “chronobiology,” increasingly thought of biological rhythms in humans as dim reflections of the cosmic environment. Once hailed as “Father Time” and for more than a decade president of the International Society for Chronobiology – and one of the last recipients of an NIH lifetime stipend – Halberg in his later life focused on what he called “chronoastrobiology” and situated humans in the “chronosphere” – a modification of a term and concept introduced by Henri Bergman, Pierre Teilhard de Chardin, and Vladimir Vernadsky in the early years of the twentieth century. What took him in on this trajectory from novel biological science to the fringes of pseudoscience? This presentation will chart the course of this development and offer some possible explanations from Halberg’s life’s work and historical

circumstances and aims to shed some light on this controversial figure in the history of biological rhythms research.

### Objectives

By the end of this activity, the learner will:

Develop the capacity for critical thinking about the nature, ends and limits of medicine.

Recognize the dynamic interrelationship between medicine and society through history.

Identify successes and failures in the history of medical professionalism.

Fei Fei Shao, Western University, London, Ontario, Canada

[fshao2019@meds.uwo.ca](mailto:fshao2019@meds.uwo.ca)

### *From Foundling Asylums to Storeyed Institutions: An Architectural History of the Canadian Pediatric Hospital*

In 1802, the first free-standing hospital for sick children, L'Hôpital des Enfants-Malades, was established on the Rue de Sévres in Paris. The rest of the world was slow to follow suit and it was not until 1855 that the first paediatric hospital in North America, the Children's Hospital of Philadelphia, was founded. Inspired by this model, a group of Toronto women converted an 11-room house "for the admission and treatment of all sick children," and the Toronto's Hospital for Sick Children, Canada's first pediatric hospital was opened in 1875.

From their modest conception, Canadian pediatric hospitals have changed significantly in both structure and function. Three major forces shaped this development: the emergence of pediatric medicine as an organized specialty, public health reforms, and improved health statuses of Canadian children. Over the course of the 20th century, Canadian pediatric hospitals made the remarkable transition from small, charitable almshouses offering limited acute treatments, to large publicly-funded centers of specialized care.

Using journal articles, government reports, and case studies, this presentation explores the origins, development, and evolution of Canadian pediatric hospitals. The first pediatric hospitals were products of an alliance between social reformers working to decrease the high rates of childhood mortality and physicians seeking to legitimize the fledgling pediatric specialty. As the provision of care improved and public funding established universal healthcare, innovations in hospital architecture including more modern buildings and sub-specialty wards reflected the maturation of pediatric medicine. Concomitant nationwide vaccination campaigns helped re-orient the focus of pediatric medicine from acute, in-patient care to preventative and chronic ambulatory care, further supporting the development of pediatric medicine. The architectural history of Canadian pediatric hospitals offers a unique lens into the history of pediatric medicine itself, revealing an interrelationship between medical knowledge, social practice, and physical hospital space that is still relevant today.

### Objectives

1) Develop knowledge and understanding of professional behaviors and values

- Understand the dynamic relationship between medical knowledge, social practice, and physical hospital space in the history of the pediatric specialty
- 2) Contribute to the improvement of patient care
- Critically appraise the clinical management of the pediatric patient population through the lens of architectural history
- Understand the organization of the Canadian health care system

Catherine Smith, University of Wisconsin-Madison, Madison, WI, USA, [catherine.arnott.smith@wisc.edu](mailto:catherine.arnott.smith@wisc.edu) and Jennifer Arnott, Perkins School for the Blind, Watertown, MA, USA, [jennifer.arnott@perkins.org](mailto:jennifer.arnott@perkins.org)

*Medical Terminology for Historical Context: The Case of the Perkins School for the Blind Archives*

The Perkins School for the Blind welcomed its first students in 1832. Few educational institutions for children living with disabilities have retained their historic records; Perkins has done so from its beginning in order to better understand the population it serves. For example, Perkins Director Samuel Gridley Howe collected statistics from other blind schools in the US as early as 1847 to explore connections between blindness and predisposition to disease. Eighty years later, ophthalmologist and eugenicist Lucian Howe used Perkins' own records in support of his arguments about hereditary blindness. Today, historical records can facilitate understanding of curricula, employment opportunities for students at graduation, and changes in societal attitudes towards blindness, all over time. But to understand the documentation of blindness, and the context in which this documentation was used and wielded power, we must understand the terminology of blindness.

Four different sets of Perkins records for the period 1880-1900 attest to 460 individual students' causes of blindness. We focus in this analysis on two specific record types: student files, and ledgers with a student register and detailed examination notes made by consulting ophthalmologists affiliated with the Massachusetts Eye & Ear Institute.

Cause information was transcribed by Author 2 and analyzed using the text mining tool OpenRefine. Causes were categorized by Author 1 and a second coder into Diseases and Accidents and then further analyzed as follows. Disease causes were matched to Medical Subject Headings [MeSH], the detailed and well-curated controlled vocabulary used in one form or another since 1879 to index the literature of biomedicine.

For causes identified as Accidents, the two coders compared them to the International Classification of Diseases and Related Health Problems, series 10 (ICD-10; World Health Organization).

Eighty percent of the "causes of blindness" present in Perkins student records from 1880 to 1900 were consonant with contemporary MeSH vocabulary (e.g., consanguinity; nystagmus). Only 15% were unmatched (e.g., sympathetic inflammation, slow meningitis). Terminology for

accidents was even more consistent, with 92% directly matching ICD-10. This suggests that the terminology of blindness has remained relatively stable over time.

### Objectives

1. Critically appraise clinical management from a historical perspective
2. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

Aelwen Wetherby, Defense POW/MIA Accounting Agency, Omaha, NE, USA

[aelwen@gmail.com](mailto:aelwen@gmail.com)

### *Cultures of Anatomy: A Comparison of U.S. Army Identification Efforts in the European and Pacific Theaters of World War II*

This paper will explore both similarities and differences in the practices and policies of the American Graves Registration Service (AGRS) in Europe and in the Pacific in the immediate aftermath of World War II. During World War II, the AGRS had been tasked with recovering and identifying U.S. casualties of the war. As remains of servicemen were recovered from battlefields, aircraft wreckage, and isolated burials of Europe after the end of hostilities, the AGRS recognized the challenge of identification facing them. In response, Europe's American Graves Registration Command reached out to anthropologist Dr. Harry L. Shapiro for assistance. Shapiro spent several months touring Europe's former battlefields. Following his visit, he made a number of recommendations for adapting wartime graves registration activities to meet higher scientific standards and increase the number of positive identifications. These recommendations would lead to the development of a Central Identification Point (CIP) in Strasbourg for unidentified remains being processed in Europe's U.S. cemeteries. Staffed by European anatomical specialists, remains and associated material evidence underwent detailed scientific analyses.

Before long, a similar structure was developed across the Pacific, revolving around Honolulu, Hawaii's Central Identification Laboratory (CIL). But how much did Europe's system of identification points ultimately affect the development of the Pacific's own parallel network across a dramatically different geographic region? And, furthermore, how many of the discrepancies in practice that ultimately followed could instead be traced to different resources and cultural attitudes on the role the scientific expert was seen to play in the military's identification efforts? This paper will explore both questions by first providing an overview of AGRS efforts and history in both the European and Pacific regions. It will follow by highlighting key differences, citing both AGRS sources and the experiences of the anthropologists and anatomists who worked as consultants for the U.S. Army in Europe and the Pacific. And, finally, it will offer reflections on the ways in which the distinct cultures of AGRS activity may have ultimately affected the application of medical knowledge to the U.S. military's task of identifying and returning fallen soldiers to their families.

#### CME Objectives:

- Recognize the dynamic interrelationship between medicine and society through history
- Develop the capacity for critical thinking about the nature, ends, and limits of medicine
- Promote tolerance for ambiguity of theories and the nature of evidence

#### Poster Session B

Joshua Bauchner, Princeton University, Princeton NJ, USA

[bauchner@princeton.edu](mailto:bauchner@princeton.edu)

#### *Josef Breuer on Balance: The Aural Labyrinth, the Split Mind, and the "Talking Cure"*

The encounter between the doctor Josef Breuer and his patient Bertha Pappenheim from 1880 to 1882 has always occupied pride of place among the many foundational myths of psychoanalysis. In this paper, I approach this encounter through a much less considered aspect of its history: Breuer's physiological investigations into the aural labyrinth and its relation to the sense of balance. His first major paper on the topic was published in 1874 and he remained devoted to it throughout his life. Though he is much better remembered for his contributions to psychoanalysis, his work in investigatory physiology—specifically of the labyrinth of the inner ear—was the major scientific project of his life.

By reading from Breuer's physiological research through to his work in "Studies on Hysteria," with regular recurrence back to the physiology, I propose that running throughout his corpus is a three-sided concept of balance, loosely but significantly related: physical equilibrium, mental equilibrium, and affective interpersonal equilibrium. While the first emerges most clearly in the physiological work and the third in the psychopathological work, the second comes equally from both aspects of his work and acts as a lynchpin. What ties the three together and makes the larger concept of balance so potent is Breuer's understanding of equilibrium and balance as a process. His balance wasn't the end point of two scales sitting still but rather the mobile and uncertain swaying that led to that point. Moreover, the ultimate point of balance is in fact the process itself rather than the still end; physical, mental, and interpersonal equilibrium are all unending processes of feedback and adjustment. The variations within this conceptual unity reflect the distinctions Breuer did in fact make between his medical, scientific, and personal lives. Most important for these distinctions was the question of the patient, the "dear person" to whom he was obligated as a doctor but whose health was not of concern to the physiologist. From this obligation arose the affective interpersonal balance that undergirds his encounter with Pappenheim and launched the analytic therapy that psychoanalysis drew upon.

#### Objectives

1. Understand the historic interplay between scientific concepts and medical treatment.
2. Highlight the importance of interpersonal relations between doctor and patient in medical theory and practice.
3. Recognize the dynamic interrelationship between medicine and society through history.

Po-Hsun Chen, Tainan Hospital, Ministry of Health and Welfare, Tainan City, Taiwan  
[sim298@hotmail.com](mailto:sim298@hotmail.com)

*Turn the Crisis of the Herbs: The Risk Governance of the Aristolochic Acids Event in Taiwan*

The Aristolochic Acids event broke the myth of harmlessness of traditional herbs in late 20th century. This event forced many countries in Europe and America, which just welcomed the traditional herbs, to consider the regulations of traditional herbs and made a big shock in East Asia. From the view of co-production, this study argued that Aristolochic Acids event is to the regulation of herbs in Taiwan what Thalidomide Crisis is to the regulation of drugs in the world. Thus, the documents from science research, official authorities and the mass about the Aristolochic Acids event were included.

Aristolochic Acids (AAs) are in the Aristolochia herbs, which are known for the renal toxicity and carcinogen. Since the Chinese Herb Nephropathy events occurred in Belgium in 1993, AAs had been so deeply concerned about the toxicity. Thereafter, many cases of nephropathy were discovered in Europe, America, and Asia. As a result, AAs-contained herbs were banned consequently. Due to the Aristolochic Acids event, take Taiwan for example, there was an enormous dispute between modern medicine and traditional medicine for banning it in 2003. The authorities and public were alert to the risk of AAs and traditional herbs.

For encountering the international policies of World Health Organization in 2002 and World Trade Organization in upcoming 2005, the Taiwan authorities could not avoid the risk governance of herbs. Therefore, the Committee on Chinese Medicine and Pharmacy integrated pharmaceutical technology and material medica to make three governance strategies for AAs-contained herbs: distinguish the true from the false, use alternatives, change the medicinal part of herbs. In this way, the new herbal knowledge and the new regulation were produced. Moreover, according to the knowledge and the regulation, the government could not only resolve the doubts from the public but also claim the high quality of Taiwan-made herbs goods to the international markets.

In sum, Aristolochic Acids event was a turning point of traditional herbs regulation in Taiwan. In order to participate in the international herbs markets, the government cannot but mobilize all resources to turn the crisis into the chance by the co-produced knowledge and regulation. Aristolochic Acids event, co-production, risk governance

Jean-Yves Durand, Universidade do Minho, Braga, Portugal, [jydurand@yahoo.com](mailto:jydurand@yahoo.com) and Manuela Ivone Cunha, Universidade do Minho, Braga, Portugal, [micunha2@gmail.com](mailto:micunha2@gmail.com)

*Comparative history of vaccination reception and present public health controversies.*

Historians of medicine have scrutinized the modalities of vaccine reception almost exclusively through an attention to a relatively limited set of more or less massive vaccine resistance

movements: 19th century anti-vaccination leagues in the United Kingdom and the United States; a few French doctors' opposition, in the same period, to a "dreadful English invention"; the "vaccine revolt" which caused serious unrest and resulted in about 30 casualties in 1904 in Rio de Janeiro; and a few localized cases with much lesser international visibility.

Writing mostly from medicine's standpoint, they focus on what they label as "vaccine refusal", "resistance", "skepticism", etc., sometimes qualifying the critics of vaccination in pathologizing terms: the French historian Pierre Darmon thus writes about "vaccinophobes". As in any controversy of the same kind, explicit accusations of irrationality are sometimes made against who doubts the hegemonic narrative of vaccination's success.

Only recently have social sciences started to adopt a more diversified stance, shifting their attention from "vaccine resistance" to a dialogic notion of "acceptability" or a neutral "reception". Our ethnographic research about attitudes toward vaccination in France and in Portugal has shown the need for an approach that does not reduce to a narrow set of fixed social types what is in fact a wide variety of opinions and attitudes, with diverse and sometimes conflicting motivations that can evolve in time.

The sometimes reduced information on the context and methods of production of the data it relies upon makes it more difficult for historical comparatism to be framed by a similar methodological relativism. This should nevertheless be attempted, in order to help shed light on the origins of different present public policy traditions (for instance in terms of voluntary or compulsory vaccination), and therefore also on the roots of current controversies and their serious consequences. Incidentally, such an effort would also be an opportunity to strengthen the dialogue between history and anthropology, two disciplines that have known periods of closer collaboration.

### Objectives

To think critically about the approach to vaccination reception that has been prevalent in history of medicine.

To assess the benefits and limits of methodological relativism for the history of vaccination.

To examine how dominant historical interpretation of vaccination reception informs present controversies on public policies for immunization.

Hannah Elizabeth, London School of Hygiene and Tropical Medicine, London, UK  
[hannah.kershaw@lshtm.ac.uk](mailto:hannah.kershaw@lshtm.ac.uk)

*'What can I do about AIDS?' The creation of texts to meet the educational and emotional needs of HIV-affected children and adolescents in Britain in the 1990s*

In the early 1980s, the complex needs of families affected by HIV in Britain were not prioritised. Though HIV's emotional and social impacts were rapidly identified as formative aspects of its effect on individuals and communities, any public health and social care responses to these experiential facets of HIV infection were superseded by a public health response aimed at

transmission prevention. It quickly became clear however that the social aspects of HIV infection were detrimentally affecting the success of the public health response. Assumptions about who got the disease, how it was transmitted and its trajectory affected the allocation of resources and the impact of education, leaving the needs of key groups – such as women and children – at worst neglected, and at best misunderstood.

Recognising that the needs of HIV-affected families were unfulfilled, the HIV positive and the social service sector began to address the problems associated with the social costs of HIV, producing materials for the consumption of the HIV positive, their families and communities, including materials specifically for HIV-affected children. These texts addressed the education and emotional needs of the audience, giving voice, returning agency and respecting the dignity of those affected by the virus.

While previous histories have addressed Britain's policy and public health response to HIV (Berridge), and more recently the emotional history of AIDS (Cook), very little has been written on HIV's effect on childhood. This paper builds on research conducted during my PhD, combining approaches from the history of emotions and childhood with visual studies and discourse analysis, to address this lacuna. Deploying archival research, oral history and two representative texts, the picture book 'It's Clinic Day', and the leaflet 'What can I do about AIDS?', the paper recovers how AIDS was framed and represented to children affected by HIV in the 1990s, identifying how, and why, educators depicted the emotions which surrounded growing-up with HIV. It argues that texts like these were intended to serve the needs of HIV-affected adults as much as they were children, scripting responses and empowering parents to discuss HIV's emotional and medical aspects sensitively and competently.

#### Objectives

KEY WORDS: emotions, HIV/AIDS, childhood

- To understand how the needs of HIV-affected children were imagined and met by adults in the 1980s and 1990s
- To understand how histories of childhood and emotion add a new perspective to those histories of AIDS which have already been written.
- To critically examine the history of Britain's public health response to AIDS in light of the needs of the HIV-affected, particularly women and children.

Hsin-Yi Hsieh, University of California, San Francisco, San Francisco, CA, USA  
[hsiehshinyi@gmail.com](mailto:hsiehshinyi@gmail.com)

#### *Fight against the Invisible Risk: The Sociotechnical Trajectories of Dust Mite Allergy in Taiwan*

Childhood allergies have been a crucial health concern in East Asian countries. In Taiwan, dust mite has been considered the most important risk of allergic diseases. This paper investigates the sociotechnical trajectories of dust mite allergies in Taiwan, and examines the knowledge production and health communication of dust mite allergies through scientific and commercial practices during 1960–2014. The data used in this study was obtained from historical archives

from scientific literature, governmental publications, commercial advertisements, newspapers, and magazine articles. The major findings are described as follows: First, the discourse of dust mites as a major risk has not been demonstrated as a permanent fact; in contrast, it has been an intricate historical construction involving scientists, medical professionals, mass media, and commercial industries among Taiwan, Japan, Australia, and the United States after World War II. Dust mites have been a significant research topic in Taiwan since the late 1970s as a result of both the interactions among global allergy and microbiology communities and the allergy statistics and research in local Taiwanese communities. Medical professionals also initiated translating these medical and scientific findings into the strong statistical claim that almost 90% of Taiwanese patients are allergic to dust mites. Moreover, concerns about dust mites have resulted in an increased number of commercial products for household environmental control during the late 1980s. Various Taiwanese and Japanese manufacturers of electronic household appliances have re-invented many common products to include novel anti-dust mite functions. Concerning dust mite risk prevention, all detailed discourses and products have not only illustrated the indiscernible dust mites but also improved parents' dust mite risk awareness, although the efficiency of dust mite avoidance measures has been highly debated at the international level. In conclusion, regarding the multiple risks associated with allergies, the solutions have been often reduced to a specific range of "environmental" controls combined with individualized behavior management since the 1990s. The strategies recommended by medical experts lead to greater focus on specific dust mite avoidance and household environmental control.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
3. Recognize the dynamic interrelationship between medicine and society through history

Junho Jung, Seoul National University, Seoul, Republic of Korea, [parasite@snu.ac.kr](mailto:parasite@snu.ac.kr) and Ock-joo Kim, Seoul National University, Seoul, Republic of Korea, [ockjoo.kim@gmail.com](mailto:ockjoo.kim@gmail.com)

#### *Mobilizing Voluntariness: the Role of US Population Council in Population Control in 1960s Korea*

Bernard Berelson from the Ford Foundation, at a US Congressional hearing in 1965, emphasized that Korea "demonstrate for the first time in history that a deliberate program to spread voluntary contraception can bring down a nation's birth rate." This showed the transition of the landscape in population control programs from coercive top-down approach prevailed in the 1950s to the emergence of voluntariness in 1960s. The voluntariness of the nation and the public in Korea, however, did not arise spontaneously. It was rather a carefully planned and coordinated mobilization.

The international population control network, spearheaded by the Population Council, provided the wide range of expertise and skills needed for mobilizing voluntariness from national policy-making to designing and implementing 'action research', training and monitoring professionals,

and biomedical contraceptive technologies such as Intra Uterine Devices. Thus, it drew out voluntariness of not only the people but the nation as a whole. Successful implementation of the family planning program in the 1960s provided an empirical, technological, and academic basis for effective intervention in the body of the people beyond the biotechnological means. Knowledge accumulated from the family planning in the first half of the 1960s also influenced the public health activities involving mass mobilization in the 1960-1970s Korea, such as the parasite eradication program. Furthermore, the successful examples of the Korea that brought about the mobilized voluntariness through the detailed planning provided new role models to other third world countries in the 1970s.

While recent historical works have successfully shown population control movement in global context, how the layers of the international network, nations, experts, and people interacted and coordinated for such transnational phenomenon requires further examination. Drawing on the archived government and organization records, historical newspapers, and oral history interviews, this study provide an example how the interaction between international and local actors in population control had the lasting impact on mass mobilized public health program in third world countries in the late twentieth century.

#### Objectives

1. Understand the local population control program in context of global population control movement.
2. Assess the lasting impact of mass mobilized public health program which developed from population control programs in third world countries.
3. Deepen understanding of the medical and social intervention from international-local interaction.

Matthis Krischel, Heinrich Heine University, Düsseldorf, Germany  
[matthis.krischel@hhu.de](mailto:matthis.krischel@hhu.de)

#### *The dental professions in Nazi Germany: Competition – Self-coordination – Exclusion*

Before the 1950s, two dental professions existed in Germany: university educated dental surgeons and skilled dentists. Both groups were equally allowed to treat patients and were generally reimbursed by public health insurance. For this reason, they were in economic completion.

During the 1930s, another important division within the dental professions came to light. This was on the political spectrum, which included right-wing nationalists and early supporters of the Nazi party on one hand, and social democrats, socialists and communists on the other hand. Some of their political conflicts also directly influenced their views of how dental care should be organized: either in private practice or in clinics operated by the state or public health insurers. Those in favor of social dentistry and public dental health were found on the left of the political spectrum. Often, they were Jewish as well and were excluded after 1933.

With the rise of the Nazis to power in 1933, both academic and skilled dentists tried to strengthen their relative positions in the health system by quickly falling in line with new National Socialist health policies. Two parallel bureaucracies were established. Members of the dental professions lobbied against insurance-operated dental clinics. This led to privately owned and operated dental clinics to become the norm.

Until the end of the war, academic and skilled dentist continued to work side by side, including the military. It was only after 1945 that the skilled dentist profession ceased to exist. Those who remained received licenses to practice dental medicine and received the same legal status as dental surgeons.

This contribution highlights the mutual interaction between the dental profession and their interactions with the state in Weimar era Germany (1918-1933), Nazi Germany (1933-1945) and early post-war Germany (1945-1952). Their radicalization can be understood as a polycracy of competing bureaucracies, which was common in Nazi Germany. The end of the professions of skilled dentists after 1945 can be explained as a late success of professional politics of dental surgeons, as well as bringing German dentistry more in line with organization in neighboring countries.

#### Objectives

Nazi Medicine - History of Dentistry - Medical Specialization

To understand the history of dentistry in mid-20th-century Germany

To understand how dentists were involved in Nazi medical crimes

To understand how medical practitioners were radicalized in order to strengthen their profession

Molly Nebiolo, Northeastern University, Boston, MA, USA

[nebiolo.m@husky.neu.edu](mailto:nebiolo.m@husky.neu.edu)

#### *Surgery as a Science: The Intellectual and Practical Evolution of European Surgery from the 16th to the 18th century*

This paper explores the transition of surgery from a collection of skills and techniques used on the battlefield to its acceptance as a medical profession. Opinion was shaped through advances in technology, use of anesthesia, and surgical practices. This success prompted a shift in public confidence facilitated by the Church's funding of public autopsies led by surgeons. Once the public understood the greater effectiveness of surgeons, their status changed from butcher to doctor by the early 18th century. Previous research has focused on the technological advances behind the professionalization of surgery and the sociological change in beliefs, but this article will incorporate elements of both.

#### Objectives

What technical adaptations assisted in the professionalization of surgery.

How public opinion and societal changes provided a cultural foundation for surgery to build itself onto.

What determines the success or acceptance of a medical career in early modern Europe.

Lynda Payne, UMKC, Kansas City, MO, USA

[paynel@umkc.edu](mailto:paynel@umkc.edu)

*“Shunned as a loathsome object”: The invention of a mechanical bed to aid bedridden patients in nineteenth-century England.*

In 1808 the well-known London surgeon, Sir James Earle, appended “An Account of a Contrivance to Administer Cleanliness and Comfort to the Bed-Ridden or persons confined to bed by Age, Accident, Sickness, or any other Infirmary” to an essay on treating patients with multiple fractures. The contrivance he referred to was a double plane bed that had been invented by Earle’s son Henry, also a surgeon. Using diagrams, Earle explained how it consisted of an upper bed that could be raised and a lower bed, which was stationary. This apparatus enabled nurses or family members to change bedding, insert bedpans under patients and move the position of the bed to ease suffering. Earle financed construction of the beds and promoted their use in hospitals, workhouses, insane asylums, on board ships, and as stretchers for long journeys. He and his son displayed their invention at a showroom in London and used their connections to sell a considerable number of beds across England. In 1821 Henry Earle received the “large gold medal” from the Royal Society for the Encouragement of Arts, Manufactures and Commerce.

This paper analyzes what the invention and marketing of what came to be known as the “Earle Bed” tells us of the experiences of those who were confined to their beds and frequently “shunned as a loathsome object” in early nineteenth-century England. Being bedridden was a physical, sensual, emotional, and economic state that many would have experienced at some point in their lives, due to illness, accidents, violence, insanity and old age. This is a subject that has not been studied in any detail save for works on the concept of the cult of voluntary invalidism among some middle and upper class women in the Victorian era. Analyzing the rationale behind the invention and success of a contrivance to aid the bedridden by a family of London surgeons offers glimpses of the physical and mental worlds of those who were forced, rather than chose, to take to their beds.

Develop the capacity for critical thinking about the nature, ends and limits of medicine

Deepen understanding of illness and suffering

Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

Simon Purdue, Northeastern University, Boston, MA, USA

[purdue.s@husky.neu.edu](mailto:purdue.s@husky.neu.edu)

*Giving Life and Limb for the Empire: Occupational Health in Industrial Belfast, 1870-1914*

In the later years of the 19th Century, Belfast experienced an industrial boom that saw the city become one of the foremost hubs of manufacturing and industry in Europe. The burgeoning shipbuilding and textile trades soon became the principal employers of the able-bodied men and women of the city, and brought new prosperity to the city that would soon be named 'The Workshop of the Empire' and 'Linenopolis'. However, along with the growth that accompanied the rise of these industries came a myriad of new occupational hazards which daily threatened the lives and limbs of Belfast's workers. Working life had never been so dangerous. This paper will explore the hazards facing the working men, women and children of the city in this period. It will examine the most prevalent causes of accident, injury and death for those working in the factories, mills and shipyards of Belfast, charting how changes in law and industry standards affected the safety of the trades across the period in question. The paper will call into question the effectiveness of the measures that were taken to improve safety in the workplace for Belfast's labor force, and explore the ways in which legislative and practical efforts were deeply gendered and unequal. The paper makes use of Factory Inspector's reports, personal accounts of working life and the minute-books of some of the city's largest employers to paint a picture of the many dangers facing Belfast's workforce, and the seemingly futile attempts to mitigate these threats.

#### Objectives

- The ways in which occupational health was deeply intertwined with issues of gender in industrial Belfast
- How protective legislation was deeply gendered and unequal
- The extent to which workers had the agency to accept or resist change in the workplace

Savitri Das Sinha, All India Institute of Medical Sciences, New Delhi, India  
[savitrisinha21@gmail.com](mailto:savitrisinha21@gmail.com)

#### *Cholera in colonial India and Britain: Contrasting views on causation and containment*

The water borne spread of cholera was not accepted by health administrators in colonial India for decades after it became the mainstream view in Britain. This was in contrast to other medical advances that were quickly accepted, at least formally by the colonies, even though their implementation may have been delayed. However, this view of health administrators, was continuously challenged by several prominent members of the Indian Medical Service (IMS)-- the same cadre from where these administrators originated. A major journal carrying articles in favor of the 'water theory' was the Indian Medical Gazette (IMG) that was under the overwhelming editorial control of IMS officers. These officers also expressed their opinion in other contemporary journals and relevant reports.

This presentation analyses differences in the approach of health administrators in Britain and colonial India and the scientific arguments marshalled by both sides. It addresses the reasons for the same, including economic reasons and the entrenched differences in perspectives on the implementation of public health. The tensions between the imperatives of colonial

administration and emerging modern scientific knowledge are also analysed particularly with reference to the opposition from the IMS itself. The study is based on publications in contemporary journals such as the *IMG*, *The Lancet*, *Indian Annals of Medical Sciences*, and the formal reports such as those of the Sanitary Commissioners and official inquiries.

To conclude, the contrasting views and actions towards the spread of cholera provide an informative perspective on the differences of approach towards health between Britain and the colonies, where emerging scientific knowledge intersected with colonial compulsions and attitudes. This was based on the historical development of cholera research in India as well as on economic compulsions. The contemporary writings highlight the importance as well as the limitations of academic debates in a set up where the hierarchy in the colonies contrasted with the democracy at home. The study has relevance to the adoption of evidence based medicine and public health in developing countries, where there are contrasts between international and national approaches towards health related issues.

#### Objectives

1. Cholera as a model for studying global implications of an infectious disease in different historical contexts
2. How the dissemination of public health in the colonies was affected by the context and economic and organizational dynamics
3. The role and limitations of medical academics and scholarly publications in contesting official doctrine in a colonial background

Chuanhao Wang, National Academy of Innovation Strategy, China Association for Science and Technology, Beijing, China

[ccw32@163.com](mailto:ccw32@163.com)

#### *The Scientization of Traditional Chinese Patent Medicines in 1920s and 1930s*

The Cuihua Pharmaceutical Factory (粹华药厂), which opened in 1921, was the pioneer of the manufacture of Chinese patent medicines using Western technology. Despite receiving solid support from all sections of the community, it only lasted about three years. Soon, however, the Great China Chemical Works Ltd. (佛慈大药厂), as its successor, was founded in 1929, and has been committed to this for decades. Both factories adopted western machines for the production of Chinese patent medicines. And they also made some changes in the form of drugs. Specifically, the Cuihua Pharmaceutical Factory often used the form of oral liquid. But because the related technologies were not mature in 1920s, these liquids often spoiled after a while. This is one of the main causes of the failure of Cuihua. Having learnt this lesson, the Great China Chemical Works Ltd. often used the form of powder, and did more explorations. But these efforts were too farfetched in many cases, such as that of an electrical tonic jelly prepared from ginseng. In any case, both factories sought to create relationships between their products and science. This paper reviews the background to this change in Chinese patent medicines, and the foundation, main works, and social impact of the two companies. The

author also presents some ideas on the scientization of Chinese patent medicines in 1920s and 1930s.

Spencer Weinreich, Princeton University, Princeton, NJ, USA  
[siw2@princeton.edu](mailto:siw2@princeton.edu)

### *Ecclesiastical Arithmetic: Quantification, Plague, and Theology in Early Modern England*

The enormous toll of bubonic plague in early modern London prompted the institution of the bills of mortality, weekly notices of the city's births and deaths. These ubiquitous documents contributed to the increased currency of quantitative thought in seventeenth-century England, as officials, academics, merchants, and laypeople used numbers to understand and intervene in the politics, economy, and public health of their city. Unappreciated hitherto has been the extent to which these numbers could serve theological purposes. This poster seeks to parallel the more familiar "political arithmetic" with an "ecclesiastical arithmetic," in which early modern Londoners used the data produced in plague-time to substantiate or undercut doctrinal positions. It takes the major seventeenth-century plague years (1603, 1625, 1636, and 1665) as its case studies, as moments of both intensified religious fervor and heightened interest in the bills and other quantitative measures. Drawing on the work of Will Slauter and Mark S. R. Jenner, a holistic analysis of plague-time broadsheets attends to how prayers, figures, and printing techniques in the arrangement of words and data interact to produce a unified religious message. Comparison of the writings of different confessional groups reveals a shared set of maneuvers to coopt the epidemic disaster for political or religious ends. Quantification itself, and the printed forms it took, became material for sermons and treatises, as divines contrasted the panic at the spread of plague with a pervasive indifference to sin. Ultimately, the poster seeks to show that early modern theology was never isolated from either the realities of epidemic disease or the cutting-edge of learned practice, problematizing the dichotomy between religious and empirical approaches to plague charted by scholars like Paul Slack.

#### Objectives

Keywords: plague, quantification, theology

Recognize the dynamic interrelationship between medicine and society through history;  
Deepen understanding of illness and suffering; Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

Moxi Zhang, The University of Hong Kong, Hong Kong, Hong Kong  
[zh\\_moxi@126.com](mailto:zh_moxi@126.com)

*Medical Hong Kong under Japanese Occupation: An Alternative History of Hong Kong, 1941 - 1945*

Hong Kong under Japanese occupation witnessed the drastic shifts of Hong Kong's internal social structure, along with the reorganizations of Hong Kong's external power relations with Britain, Japan and mainland China. The situation in Hong Kong is calmly reflected in a report, with its focus on Hong Kong's medical and health conditions, written by the British medical officer P. S. Selwyn-Clarke in 1946. However, the medical history in occupied Hong Kong, which possesses great potential in shedding new light on the occupation period, has been understudied.

In this paper, to unfold a medical Hong Kong under Japanese rule as an alternative history of Hong Kong at the time, I will analyze three cases selected from Selwyn-Clarke's report, namely, the cholera outbreak (1942-1943,) the takeover of the Bacteriological Institute (1944,) and the Euro-American anti-malaria activities in Stanley Camp (1943-1944,). The existing scholarship on Hong Kong's medical history around the outbreak of plague dated back to the 19th century attracts a number of scholarship and is instrumental in understanding Hong Kong's medical history's further development under Japanese occupation. It informs me to set my analyses in a "transimperial" and "transcolonial" framework, where Hong Kong is in constant interaction with Britain, Japan and mainland China.

In this vein, this paper addresses the respective subjectivities of the mass population and the local medical professionals in Hong Kong, whose formations took place in contexts different from yet related to those in mainland China. It also attends to the interplays of British and Japanese imperial powers, with their resemblance in exerting colonial medical practices to Hong Kong for their own interest. Further, if Japan was one of the first, and arguably most successful, non-Western countries which modernized and Westernized its medical and public health provisions, it is worth considering the question of how to locate Hong Kong's medical history in the world, which can be traced and foregrounded even in the arguably darkest days in Hong Kong.

#### Objectives

Keywords: Medical Hong Kong, colonial medicine, subjectivity

- 1) Recognize the dynamic interrelationship between medicine and society through history.
- 2) Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations.)
- 3) Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems.