



AAHM

American Association
for the
History of Medicine

2014 Annual Meeting
Chicago, Illinois

87th Annual Meeting

of the

American Association for The History of Medicine



Conference Abstract & Program Book
May 8 - 11, 2014

Renaissance Chicago, Downtown Hotel
Chicago, Illinois

Table of Contents

- Logo
- Participant Guide Alphabetical
- CME Information
- Acknowledgements
- Book Publishers Advertisements
- Program Overview
- AAHM Officers, Council, LAC and Program Committee
- Sigerist Circle Program
- AAHM Detailed Meeting Program
- Abstracts Listed by Sessions
- Information and Accommodations for Persons with Disabilities from the American History Association
- Renaissance Hotel Map
- Relevant Chicago Map

Upcoming AAHM Meetings

- 2015 New Haven, CT April 30-May 2
- 2016 Minneapolis, MN April 28-May 1
- 2017 Nashville, TN TBA

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Alphabetical List of Participants and Sessions

Amador, J	D5	Dufour, M	C3	Lanzoni, S	C2	Reinhardt, B	D1
Anderson, W	L5	Dwyer, M	C4	Laveaga, G	B6	Rembis, M	L3
Antonovich, J	L1	Dysert, A	C1	Leja, M	F4	Reverby, S	L2
Aquino, H	E6	Ehrenberger, K	G2	Lemus, C	F1	Rocha, L	L1
Archambeau, N	C5	Espinosa, M	D1	Letocha, P	L4	Rodriguez, J	F2
Armstrong, N	I4	Fairman, J	L6	Li, L	F3	Roebuck, K	F2
Baker, K	L4	Fancy, N	A5	Lie, A	E5	Rosner, L	F1
Barnes, N	I1	Farquhar	L5	Light, T	F3	Ruis, A	E5
Barr, J	G2	Finlay, M	A2	Linker, B	A1	Sappol, M	F6
Bateman-House, A	E3	Freidenfelds, L	G5	Linker, B	L3	Savelli, M	G3
Baum, E	B1	Gabriel, J	H3	Linker, B	L6	Schaub, K	I2
Berkowitz, C	E4	George, M-A	D4	Liskova, K	D5	Scheffler, R	C6
Berman, P	I3	Gibbs, F	F1	Liu, S	G1	Schmidt, M	G6
Biggs, A	B4	Goldberg, D	D6	Liu, Yan	C1	Shapiro, H	B1
Boeck, B	C5	Golden, J	L4	Livingston, J	L3	Shen, W	H1
Boyle, E	F5	Golden, J	F1	Lomi, B	D2	Shotwell, A	B5
Braswell, H	I1	Gomez, P	B6	Lux, M	D5	Smith-Howard, K	A2
Brazelton, M	C4	Greene, J	L5	Ma, Z	B1	Smith, C	F4
Bresalier, M	B2	Greenlees, J	A6	Mantin, M	A6	Smith, J	E1
Brookes, B	A3	Greenough, P	D1	Marland, H	D3	Stahnisch, F	C2
Brooks, L	D2	Guenther, K	C2	Martucci, J	G5	Stamm, C	I2
Brown, M	H1	Gunn, J	L6	McKiernan-Gonzalez,	JE2	Stanley-Baker, M	D2
Buckle, K	F5	Hamlin, D	D6	Medeiros, A	A1	Stark, L	E3
Burney, I	D6	Harris, N	C5	Meli, D	B5	Steere-Williams, J	H2
Burns, S	G1	Hawk, A	C1	Mendelsohn, A	E4	Stern, A	F1
Calabro, C	F5	Haynes, D	E2	Micale, M	A1	Stillwell, D	G6
Cardenas-Navia, J	F2	Herzberg, D	G3	Miika, M	C6	Sufian, S	L3
Chamberland, C	I4	Hess, V	E4	Moore, K	C6	Swartz, S	A3
Chase-Levenson, A	A6	Hoeflmayer, D	E4	Moran, J	A3	Tannenbaum, J	G2
Chenyk, R	B3	Hogan, A	G6	Morar, F	C1	Taylor, S	I4
Choudhury, D	H2	Hook, E	C3	Mosley, K	F3	Thoms, U	A2
Chowkwanyun, M	G4	Hurrell, C	H4	Mukharji, P	F2	Timmermann, C	B3
Clark, C	L1	Imada, A	E2	Mullen, E	L1	Tiquia, R	C1
Clark, C	E1	Inglis, K	G1	Murciano-Goroff, Y	B3	Tobbell, D	L6
Comfort, N	L1	Inrig, S	I1	Nelson, E	C3	Tobbell, D	G4
Condrau, F	E6	Jacobs, D	E1	Nemec, B	F6	Turner, A	F1
Connolly, C	L4	Jeong, S	I5	Novick, T	I2	Varlik, N	F5
Cooper, G	A5	Johnson, D	H5	O'Sullivan, L	L1	Vasilyev, P	H2
Coston, B	A1	Johnston, R	C4	Osipov, R	E3	Wagner, C	F6
Cowgill, B	G5	Jones, M	E1	Packard, R	D1	Wake, N	H4
Cox, C	F6	Jones, S	B2	Palmer, S	D1	Wang, H	H1
D'Antonio, P	L6	Jordheim, H	E5	Pernick, M	L3	Warren, A	B6
Daemmrich, A	I3	Kennedy, M	H3	Perreault, I	I5	Warren, C	A4
Das, D	D3	Kessel, N	I3	Podolsky, S	L4	Wickham, B	D3
Davignon, P	H5	Kim, J	G1	Pormann, P	A5	Winter, E	E6
Dawes, L	F3	Kim, Y	B1	Porter, D	C2	Womack, J	H4
DeNoyelle, A	A4	Kirchhelle, C	A2	Prescott, H	F1	Wood, W	F4
Dentinger, R	B2	Klestinec, C	B5	Pripas-Kapit, S	A4	Worboys, M	I5
DiMoia, J	D4	Kline, W	F4	Radin, J	L5	Yongue, J	H3
Doyle, D	B4	Kudlick, C	L3	Raikhel, E	L5	Young, A	H5
Dreger, A	L2	Kuenhl, N	G2	Raz, M	G3	Yudell, M	F1
Duffin, J	B4	Kushner, H	D4	Reagan, L	L3	Yum, J	B1

Continuing Medical Education Credit Information

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of The **University of Chicago Pritzker School of Medicine** and American Association for the History of Medicine. The University of Chicago Pritzker School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation Statement

The University of Chicago designates this live activity for a maximum of **17.25 AMA PRA Category 1 Credits™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Overall Learning Objectives for the Meeting:

By the end of the meeting, participants will be able:

- To identify historical aspects of the complex interactions between the conceptualization of disease, medical theory and practice, social response and agency, scientific innovation, doctor- patient relationships, and the role of the state in medicine and nursing.
- To ascertain many of the key issues, historiography and methodologies in the history of medicine, nursing and allied sciences.
- To employ historical analysis to discover useful perspective on today's problems and issues relating to health care debates.



University of Chicago, circa 1930; U of Chicago Archives

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Welcoming Reception

American Medical Association

Graduate Student Luncheon

History Department and Institute for the Humanities -
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Program

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“Alone we can do so little, together we can do so much” - Helen Keller

The Local Arrangements Committee Chair would like to thank all of the following individuals for their help and support of this meeting:

Andrew Abbott, Diane Altkorn, Patricia Barber, David Bevington, Kate Blythe, Halina Brukner, Deb Burnet, Brian Callender, Danielle Clay, Fred and Eleanor Coe, Karen Merikangas Darling, Shauna Devine, Alice Dreger, George Dunea, Ari, Emmy and David Ehrmann, Martha Feldman, Jim Franklin, Rondi and David Frieder, Candi Gard, Nancy and Clark Gilpin, Susan and David Glick, Jennie Hart, JN Hayes, Phil Hoffman, Susan Hong, Holly Humphrey, Anne Jordahl, Jen Karlin, Mary and Vincent Keefe, Garrett Kiely, Cindy Kitching, Adrienne Lederer, Wei Wei Lee, Lucy Lester, Marquette Lewis, Jeff Matthews, David Meltzer, Dan Meyer, Gerard Mikols, Christa and John Modschiedler, Seymour and Linda Moskowitz, John Nanninga, Sharon O’Keefe, Scott Osborne, Julia Parzen and Daniel Parzen Johnson, Nancy and Sam Peltzman, Patty Petroccione, Katherine Pollack, Shalini Reddy, Bob Richards, Sarah Rodriguez, Michael Rossi, Joyce Scher, Susan Schlough, Robin Schoen, Chuck and Jeff Schwartz, Nancy Schwartz, Joe Scott, Steve Sennott, Mark Siegler, Ron Sims, Eleanor Smith, Beth Steinhauer, Sandy Sufian, Catherine Uecker, Jim Viccaro, Everett Vokes, Eileen Wayte, Roy Weiss, Deb Werner, Wallene Yang

With gratitude -to the AAHM Secretary Jodi Koste whose commitment to this organization and the time that she has devoted to planning and organizing this meeting are truly exemplary!

Finally, the last thanks goes to to Joyce Feuer & Danny Taylor of Joyce Events – for their attention to details, creative ideas, professionalism, sense of humor and unflinching support and good humor throughout the entire process.

Manuscript Submissions

In an effort to support innovative research, the University of Pittsburgh Press is launching a new initiative to significantly expand its list in history and philosophy of science. The press seeks new books in order to amplify its already strong backlist in philosophy of science and dramatically expand its list into fresh areas of promising historical research. Historical titles that are globally informed and that reach across traditional disciplinary boundaries will be given special attention. The press welcomes proposals that explore the history of medicine in any culture and during any era.

Funded by a major grant from the Mellon Foundation, this new expansion is undertaken in partnership with the University of Pittsburgh's Department of History and Philosophy of Science and the Department of History's World History Center. In addition to producing books, the press and its partners will cooperate in a number of activities to bolster the new acquisitions program, including guest lectures, new conferences, fellowships, and a book prize.

Both experienced and new authors are strongly encouraged to submit proposals for new books and book series.

If you would like to make a submission, have suggestions, or would like further information on the new initiative, please contact Abby Collier, editor for history and philosophy of science at acollier@upress.pitt.edu or 412-383-3174.

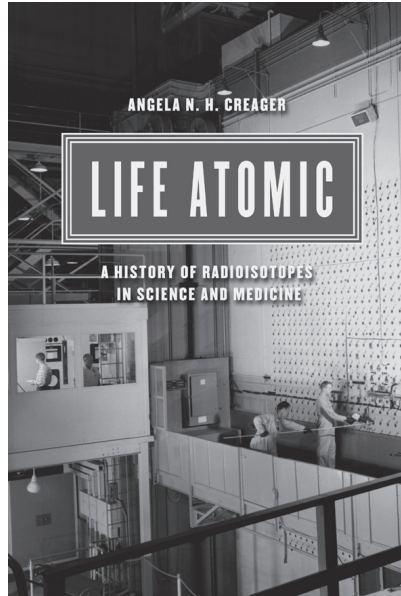
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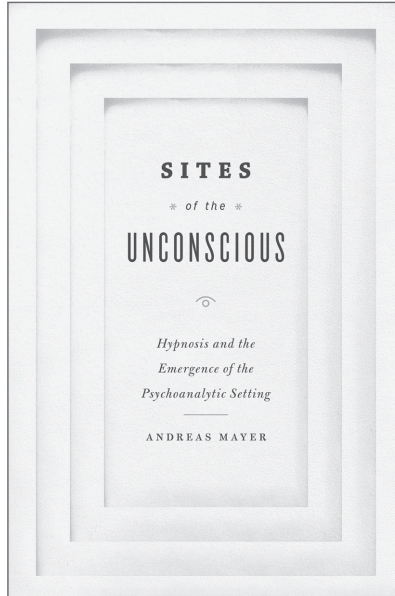
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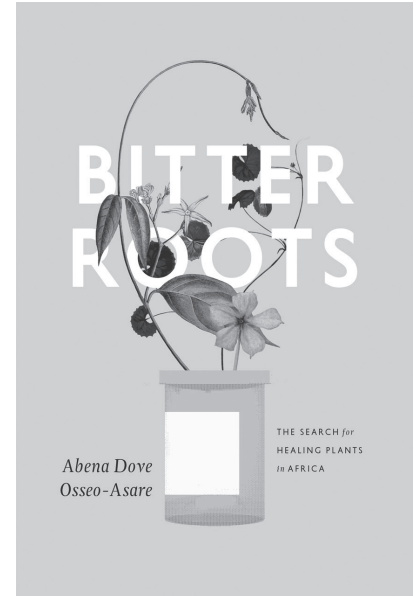
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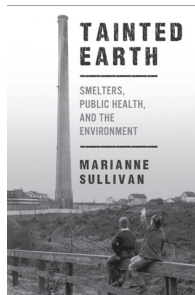
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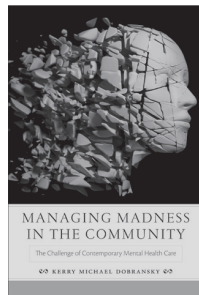


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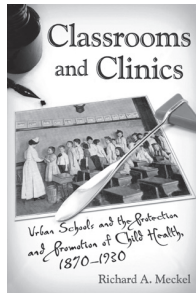
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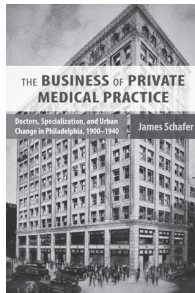
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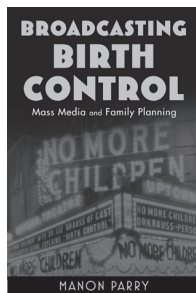
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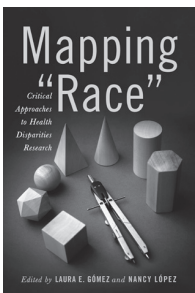
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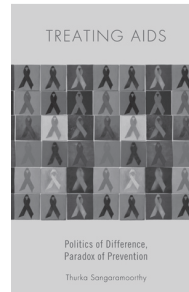
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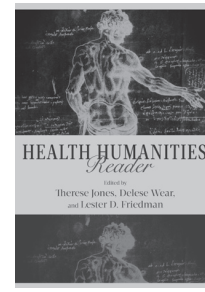
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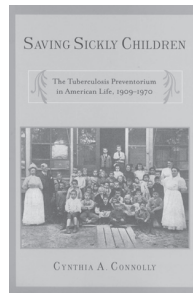


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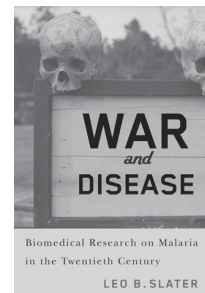


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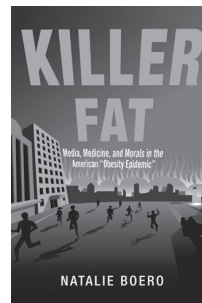
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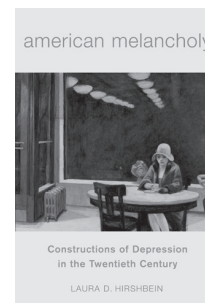
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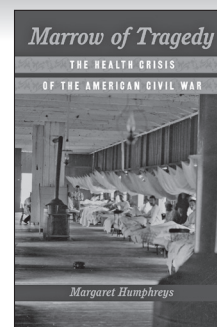
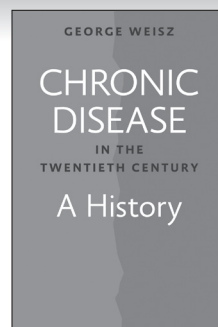
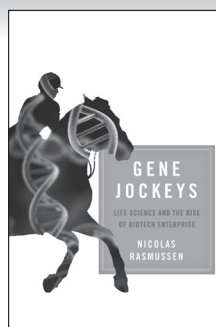
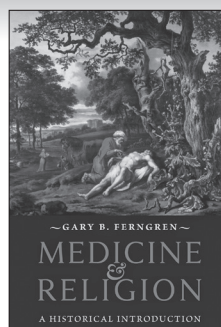
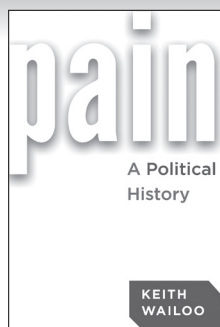
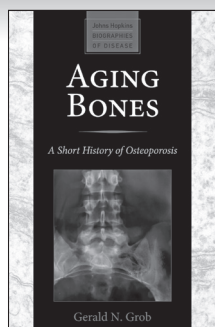
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AAHM PROGRAM 2014

BRIEF OVERVIEW

THURSDAY, MAY 8

10:00am—7:00pm	AAHM Conference Registration <i>Grand Ballroom Foyer</i>
12:30—5:00pm	AAHM Council <i>Dearborn</i>
2:00pm—4:30pm	Sigerist Circle <i>LaSalle</i>
2:00—5:00pm	Tour of the University of Chicago <i>Meet in Grand Ballroom Foyer</i>
2:00—4:00pm	Tour of American Medical Association Archives <i>330 N Wabash</i>
5:30—7:00pm	Special Screening: “Digital Short Films in the History of Medicine” <i>Michigan</i>
7:00—9:00pm	Opening Reception <i>Grand Ballroom Foyer</i>

FRIDAY, MAY 9

7:00—8:00am	President’s New Member Breakfast <i>Discover</i>
7:00—8:00am	<i>Bulletin of the History of Medicine</i> Breakfast <i>LaSalle</i>
7:00—8:00am	<i>Journal of the History of Medicine and Allied Sciences</i> Breakfast <i>Wacker</i>
7:00—8:30am	Continental Breakfast <i>Grand Ballroom Foyer</i>
7:00am—6:00pm	Conference Registration <i>Grand Ballroom Foyer</i>
8:30—10:00am	Presidential Address General Session <i>Grand Ballroom 1-3</i>
10:00—10:30am	Coffee Break <i>Grand Ballroom Foyer</i>
10:00am—5:00pm	Book Exhibit <i>Grand Ballroom 5-6</i>
10:30am—12pm	CONCURRENT SESSIONS A1-A6
12:00—1:30pm	Graduate Student Lunch <i>Bella Bacinos 75 E Wacker Drive</i>
12:00—1:30pm	Luncheon Sessions L1-L3
1:30—3:00pm	CONCURRENT SESSIONS B1-B6
3:00—3:30pm	Coffee Break <i>Grand Ballroom Foyer</i>
3:30—5:00pm	CONCURRENT SESSIONS C1-C6
6:00—7:00pm	FIELDING H. GARRISON LECTURE <i>Grand Ballroom 1-3</i>
7:00—9:00pm	Reception <i>Skyline Terrace</i>

SATURDAY, MAY 10, 2014

7:00am—5:30pm	AAHM Conference Registration <i>Grand Ballroom Foyer</i>
7:00—8:30am	Clinician Historians Breakfast and Clio Initiative <i>Michigan</i>
7:00—8:30am	Women's Historians Breakfast <i>Renaissance Ballrooms A - B</i>
7:00—8:30am	Continental Breakfast <i>Grand Ballroom Foyer</i>
8:00am—5:00pm	Book Exhibit <i>Grand Ballroom 5-6</i>
8:30am—10:00am	CONCURRENT SESSIONS D1-D6
10:00—10:30am	Coffee Break <i>Grand Ballroom Foyer</i>
10:30am—12:00pm	CONCURRENT SESSIONS E1-E6
12:00—1:30pm	Luncheon Sessions L4-L6
1:30—3:30pm	CONCURRENT SESSIONS F1-F6
3:30—4:00pm	Coffee Break <i>Grand Ballroom Foyer</i>
4:00—5:30pm	CONCURRENT SESSIONS G1-G6
5:30pm—6:30pm	AAHM Business Meeting <i>Grand Ballroom 1</i>
6:30—7:30pm	Reception <i>Renaissance Ballroom Foyer</i>
7:30—10:00pm	AAHM Awards Banquet <i>Renaissance Ballrooms A-C</i>

SUNDAY MAY 11 2014

7:00—8:30am	Post-Mortem Breakfast <i>Dearborn</i>
7:00am—1:00pm	AAHM Conference Registration <i>Grand Ballroom Foyer</i>
7:00—8:30am	Continental Breakfast <i>Grand Ballroom Foyer</i>
8:30am—10:00am	CONCURRENT SESSIONS H1-H5
10:00—10:30am	Coffee Break <i>Grand Ballroom Foyer</i>
10:30am—12:00pm	CONCURRENT SESSIONS I1-I5

AAHM OFFICERS:

President: **Nancy Tomes**
Vice-President: **Margaret Humphreys**
Secretary: **Jodi Koste**
Treasurer: **Margaret Marsh**
Immediate Past President: **John Eyler**

Council Class of 2014

Stephanie Brown Clark
Julie Fairman
Richard C. Keller
Elizabeth Watkins

Council Class of 2015

David Cantor
Jeremy Greene
John Swann
Jacqueline Wolf

Council Class of 2016

Paul Berman
Lisa Bob
Erika Dyck
Michael Flannery

Local Arrangement Committee

Chair: **Mindy A. Schwartz**
Sarah Rodriguez
Michael Rossi

Program Committee:

Jeremy Greene, Chair
Shigehisa Kuriyama, Co-Chair
David Barnes
Lundy Braun
Mariola Espinosa
Stephen Casper



Sigerist Circle

2014 Scholarly Session

Thursday, May 8, 2014 @ 2:00-4:30 pm - LaSalle Room
Renaissance Chicago Downtown Hotel
1 West Wacker Drive, Chicago 60601

THE CONTINUING STRUGGLE FOR SINGLE-PAYER HEALTH CARE: UNIVERSAL, COMPREHENSIVE, NATIONAL REFORM

This year the Sigerist Circle will use the opportunity of its meeting in Chicago to collaborate with the Chicago-based Physicians for a National Health Program (PNHP). As the only national physicians organization dedicated to implementing a national single-payer health program (“Medicare for All”), it has educated physicians, other health professionals and the public. PHNP has published original research on the need for fundamental reform in peer-reviewed medical and health policy journals, appears regularly in the national media and participates in a wide variety of public forums promoting the benefits of a single-payer system.

FEATURED SPEAKERS IN THE SIGERIST CIRCLE SCHOLARLY SESSION WILL BE:

Andrew W. Coates, M.D., FACP, Internal Medicine, Albany, NY, faculty member of the Albany Medical College and current president of PNHP

Claudia M. Fegan, M.D., CHCQM, FACP, Internal Medicine, Chicago, IL, Chief Medical Officer of John H. Stroger Jr. Hospital of Cook County, past president and current treasurer of PNHP

ADDITIONAL BRIEF PRESENTATIONS BY SIGERIST CIRCLE MEMBERS:

Ted Brown, Ph.D., Professor of History and Phelps Professor of Public Health and Policy, University of Rochester, NY: “The Middle Road to Obamacare: Healthcare Crisis, Challenge from the Left, and Pre-emptive Mainstream Reform, 1998-2008”

Nadav Davidovitch, M.D., Ph.D., Chair of Center for Health Policy Research in the Negev, Ben Gurion University, Israel: “Privatization Processes in a Single-Payer Universal Health Care System: Israel, 1995-2014”

Jacalyn Duffin, M.D., Ph.D., Hannah Chair for the History of Medicine, Queens University, Canada: “The Ups and Downs of Single-Payer in Canada”

AAHM DETAILED MEETING PROGRAM

THURSDAY, MAY 8

10:00am—7:00pm	AAHM Conference Registration <i>Grand Ballroom Foyer</i>
12:30—5:00pm	AAHM Council <i>Dearborn</i>
2:00pm—5:00pm	Sigerist Circle <i>LaSalle</i>
2:00—5:00pm	Tour of the University of Chicago <i>Meet in Grand Ballroom Foyer</i>
2:00—4:00pm	Tour of American Medical Association Archives <i>330 N Wabash</i>
5:30—7:00pm	Special Screening: “Digital Short Films in the History of Medicine” <i>Michigan</i>
7:00—9:00pm	Opening Reception <i>Grand Ballroom Foyer</i>

FRIDAY, MAY 9

7:00—8:00am	President’s New Member Breakfast <i>Discover</i>
7:00—8:00am	<i>Bulletin of the History of Medicine</i> Breakfast <i>LaSalle</i>
7:00—8:00am	<i>Journal of the History of Medicine and Allied Sciences</i> Breakfast <i>Wacker</i>
7:00—8:30am	Continental Breakfast <i>Grand Ballroom Foyer</i>
7:00am—6:00pm	Conference Registration <i>Grand Ballroom Foyer</i>
8:30—10:00am	Presidential Address General Session <i>Grand Ballroom 1-3</i> Presiding: Margaret Humphreys, AAHM Vice President, Duke University Introductions Mindy Schwartz, Chair, Local Arrangements Committee, University of Chicago Welcome Holly J. Humphrey, M.D., Ralph W. Gerard Professor of Medicine Dean for Medical Education University of Chicago “Whatever Became of Good Old Doc?” The Image Crisis in American Medicine, 1945-1965 Nancy Tomes, AAHM President, 2012-2014, Stony Brook University
10:00—10:30am	Coffee Break <i>Grand Ballroom Foyer</i>
10:00am—5:00pm	Book Exhibit <i>Grand Ballroom 5-6</i>

10:30am—12pm CONCURRENT SESSIONS A1-A6

- A1. **ROUNDTABLE: “Without Men would There Be No “Other”?: Using Masculinity as a Category of Analysis for the History of Medicine | *Gold Coast***
Chair: Elena Conis, Emory University

Half a Man: The Science and Symbolism of Masculinity and Disability
Beth Linker, University of Pennsylvania

Western Masculinity and Modern Psychiatry
Mark Micale, University of Illinois, Urbana-Champaign

Masculinity and access to health care
Bethany Coston, Stony Brook University

From Boys to Men: The Role of Hegemonic Masculinity in Pediatric Pharmaceutical Advertisements
Aimee Medeiros, University of California, San Francisco

- A2. **Residues, Resistance, Regulation: Transatlantic Histories of Antibiotics in Agriculture | *Bucktown***
Chair: Scott Podolsky, Harvard University

Swann Song? Negotiating Risk, Fears and Prosperity Regarding Agricultural Antibiotics in Post-war Britain
Claas Kirchhelle, Oxford University

An Unholy Alliance? Pharmaceutical Industry, Veterinarians and Meat Production in Germany since 1945
Ulrike Thoms, Universitaetsmedizin Berlin

Risking Professional Identity in an Antibiotic Age: Veterinarians, Antibiotics, and the U.S. Dairy Industry
Kendra Smith-Howard, University of Albany

- A3. **The Colonial Asylum Archive: Papering Over Madness | *Grand Ballroom 1***
Chair: Barbara Brookes, University of Otago

Committed by Paper in Colonial New Zealand
Barbara Brookes, University of Otago

Lunatic Asylums in British Colonies: Archive, Narratives, and Credible Claims
Sally Swartz, University of Cape Town

Bureaucratic Legacies: The Paperwork of the Colonial Asylum in British North America
James Moran, University of Prince Edward Island

- A4. Race and Healthcare in U.S. History | *Grand Ballroom 2***
Chair: Sarah Ross Pripas-Kapit, University of California, Los Angeles
- Jewish Immunity: Tuberculosis, Identity, and Conflict in Early-Twentieth-Century Immigrant New York**
Adrienne DeNoyelles, University of Florida
- The Mismeasure of Woman: The Debate on Pelvimetry, Race, and Obstetrics in the U.S., 1870-1920**
Sarah Ross Pripas-Kapit, University of California, Los Angeles
- Contracted Pelvis, Contracted Labor: A “Race Disease” in a Post-Racial(?) America**
Christian Warren, Brooklyn College, CUNY
- A5. Commentaries and the Transformation of the Islamic Medical Tradition, 1100-1500 | *Grand Ballroom 3***
Chair: Nahyan Fancy, DePauw University
- Questions of Medical Epistemology in the Arabic Commentaries on the Hippocratic Aphorisms**
Peter Pormann, University of Manchester
- Non-Galenic Physiologies in Commentaries on Avicenna’s Canon and Ibn al-Nafis’s Epitome**
Nahyan Fancy, DePauw University
- Ibn Sina’s Canon as a Critical Commentary on Greek Medical Doctrines: The Case of Galenic Crisis Theory**
Glen Cooper, Brigham Young University
- A6. Public and Private Responses to Disease and Disability | *Grand Ballroom 4***
Chair: Sandra Sufian, University of Illinois at Chicago
- Plague and Epidemic Nosology in Early Nineteenth-Century Britain**
Alexander Chase-Levenson, Princeton University
- ‘Ignorant of the dangers of infection and disease’? Factory workers understandings of and responses to ill health, c. 1900-1950**
Janet Greenlees, Glasgow Caledonian University
- “Even a Day out Means that Someone Must Go Short”: The Mixed Economy of Welfare for Disabled People in the British Coalfields, 1880-1948**
Mike Mantin, Swansea University

12:00—1:30pm **GRADUATE STUDENT LUNCH**

Bella Bacinos-located on the ground level of the Club Quarters Hotel, 75 East Wacker

12:00—1:30pm LUNCHEON SESSIONS L1-L3

L1. **Blogging the History of Medicine | Dearborn**

Moderator: Jacqueline Antonovich, University of Michigan and Claire Clark, Emory University

Participants: Claire Clark ; Nathaniel Comfort, Johns Hopkins University; Leon Rocha, Cambridge University; Elizabeth Mullen, National Library of Medicine; and Lisa O'Sullivan, New York Academy of Medicine

L2. **When Good People Do Bad Things: Can History Intervene? | Michigan**

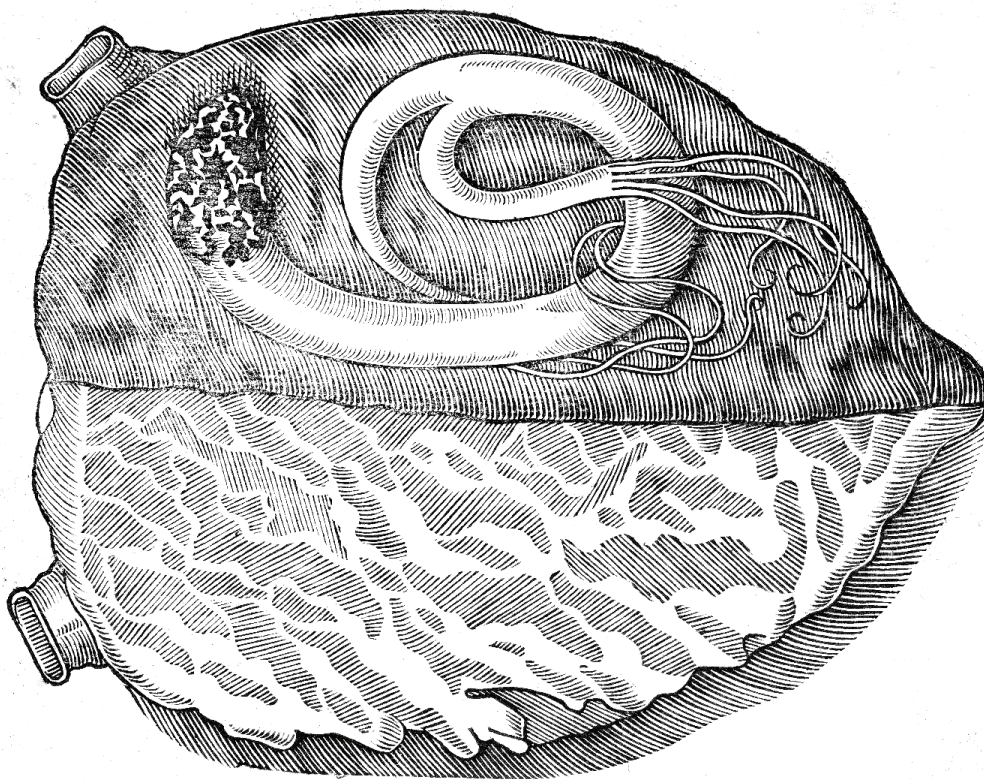
Moderators: Susan Reverby, Wellesley College, Alice Dreger, Northwestern University

L3. **Rival Siblings or Conjoined Twins?: Revisiting the Debate between Medical and Disability History | LaSalle**

Moderator: Beth Linker, University of Pennsylvania and Catherine J. Kudlick, San Francisco State University

Participants: Julie Livingston, Rutgers University, Martin Pernick, University of Michigan, Leslie Reagan, University of Illinois, Urbana-Champaign, Michael Rembis, University at Buffalo, SUNY, and Sandra Sufian, University of Illinois, Chicago.

E. May, "A most true and certaine relation of a strange monster or serpent found in the left ventricle of the heart of John Pennant, gentleman, of the age of 21 years." London: G. Miller, 1639.



1:30—3:00pm CONCURRENT SESSIONS B1-B6

- B1. Beyond Asylum Walls: Institutions of State and Society in the Making of Madness in Modern China, Korea, and Japan | *Gold Coast***
Chair: Yumi Kim, Columbia University

Periodic Crimes: Menstrual Mood Disorders in the Criminal Courts of 1920s Japan
Yumi Kim, Columbia University

Between Illness and Deviance: The Chinese Madman in Sociopolitical Discourse, 1925-1937
Emily Baum, University of California, Irvine

Volitional Possession and Self-Induced Madness in Early 20th-Century China
Hugh Shapiro, University of Nevada, Reno

Crazy in Combat: Case Studies of Mental Breakdown in the ROK Army during the Korean War
Jennifer Yum, Harvard University

Intimate Politics of Life: Mental Health Law Reform and Family-Institution Cooperation in Contemporary China
Zhiying Ma, University of Chicago

- B2. Global Ecologies of One Health | *Bucktown***
Chair: Abigail Woods, King's College London

Partners through Evolution: Linking Humans, Animals, and Parasites in the Early 20th Century
Rachel Mason Dentinger, King's College London

A "Joined" Approach to Disease: Ecology and Collaboration in the World Health Organization's Zoonoses Program, 1950-1976
Michael Bresalier, King's College London

Plague and the Language of Endemic Diseases
Susan Jones, University of Minnesota

- B3. Rethinking Histories of Cancer | *Grand Ballroom 1***
Chair: Elizabeth Toon, University of Manchester

Writing the History of a Recalcitrant Disease: A History of Lung Cancer
Carsten Timmerman, University of Manchester

Cold War Era International Cancer Collaboration
Yonina Murciano-Goroff, Harvard University

Reading Audre Lorde and a Black Lesbian Feminist Epistemology into the History of Breast Cancer, 1970s-1980s
Rico Kleinstein Chenyek, University of Illinois, Urbana-Champaign

- B4. Race and Identity in 20th Century Medical Practice | *Grand Ballroom 2***
Chair: Abena Osseo Asare, University of California, Berkley
- The Queen's Jews: Race, Religion and Change in 20th Century Medicine**
Jacalyn Duffin, Queen's University
- The Unreconciled Legacy of Daniel Hale Williams: Medical Reform in Chicago's Early-Twentieth Century Black Medical Community**
Adam Biggs, University of South Carolina, Lancaster
- Black Celebrities, Selfhood and Psychiatry in the Civil Rights Era: the Wiltwyck School for Boys and the Floyd Patterson House**
Dennis Doyle, St. Louis College of Pharmacy
- B5. The Transformative Role of Images: Anatomy, Surgery, Pathology | *Grand Ballroom 3***
Chair: Domenico Bertoloni Meli, Indiana University
- Illustration and the Changing Nature of Dissection in the 16th Century**
Allen Shotwell, Ivy Tech Community College
- The Renaissance Surgeon at Work**
Cynthia Klestinec, Miami University
- Shifting Perspectives on Pathological Illustrations**
Domenico Bertoloni Meli, Indiana University
- B6. Medicine and the Sciences of Difference in Latin America: Race, Class, Wealth, and Health | *Grand Ballroom 4***
Chair: Mariola Espinosa, University of Iowa
- Measuring Race and Health in the Yale Peruvian Expedition, 1911-1915**
Adam Warren, University of Washington
- Recording Race and Class on the Margins: Medical Commissions in Rural Mexico, 1925-1955**
Gabriela Soto Laveaga, University of California, Santa Barbara
- "La Pieza de Indias:" Quantification, Mercantile Exchange, and Bodies in the Early Modern Atlantic**
Pablo Gomez, University of Wisconsin, Madison

3:00—3:30pm COFFEE BREAK | *Grand Ballroom Foyer*

3:30—5:00pm CONCURRENT SESSIONS C1-C6

C1. **Rethinking Hotness and Coldness of Drugs: A Cross-Cultural Conversation** | *Gold Coast*
Chair: Yan Liu, Harvard University

Japanese Synthesis: The Case of Bagnon
Alan Hawk, National Museum of Health and Medicine

Food and the Humors in Isaac Israeli's "Universal and Particular Diets"
Anna Dysert, McGill University

The Coldness and Hotness of Opium
Florin-Stefan Morar, Harvard University

Reflections on Hotness/Coldness and Toxicity in Chinese and Greek Pharmacy
Yan Liu, Harvard University

Regulating Chinese Materia Medica in Australia: The Yin and Yang of Yao, Du, Poisons and Drugs
Rey Tiquia, University of Melbourne

C2. **Probing the Limits of 'Method' in the History of the Neurosciences** | *Bucktown*
Chair: Frank Stahnisch, University of Calgary

The Process of Forced-Migration as "PR Process?" German-American Psychiatrist Lothar B. Kalinowsky (1899-1992) and the Trans-Atlantic Transfer of the Electroconvulsive Therapy Approach
Frank Stahnisch, University of Calgary

Between Clinic and Experiment: Wilder Penfield's Stimulation Reports, 1929-1955
Katja Guenther, Princeton University

Re-Configuring the Parkinson's Personality
Dorothy Porter, University of California, San Francisco

Imaging Emotions: Reconfiguring the Social in Neuroscience
Susan Lanzoni, Harvard



"How to revive a drowned man,"
Wellcome Library, London
Japanese MS 11

- C3. **Beyond the *Materia Medica* | Grand Ballroom 1**
Chair: Shigehisa Kuriyama, Harvard University
- Bed Therapy and Asylum Reform in the Department of the Seine c. 1900**
Elizabeth Nelson, Indiana University
- The Evolution of Attitudes to Therapeutic Bloodletting for Lobar Pneumonia: 1890 to 1950**
Ernest B. Hook, University of California, Berkeley
- The Embodied Reader: Bibliotherapy and the Clinical Study of Literature as Medicine, 1940-1960** Monique Dufour, Virginia Tech
- C4. **Vaccination and its Discontents | Grand Ballroom 2**
Chair: Laurence Monnais, University of Montreal
- Anti-Vaccination Activism in the Age of Dr. Strangelove: Tales from the Secret AMA Archives** Robert D. Johnston, University of Illinois at Chicago
- Immunization Campaigns and the Politics of Preventive Health in the Early People's Republic of China, 1949-58**
Mary Brazelton, Yale University
- 'This most dreaded disease of childhood': Diphtheria, and the rollout of childhood immunisation programmes in the Irish Free State**
Michael Dwyer, University College Cork
- C5. **The Early Practice of Medicine | Grand Ballroom 3**
Chair: Caroline Hannaway, Baltimore, MD
- What's in a Name: On Ancient Babylonian Medicines**
Barbara Boeck, Consejo Superior de Investigaciones Científicas
- Remedies, Recipes, and Registers: Apothecaries in Seventeenth-Century London and the Popular Practice of Physick**
Nichola Harris, State University of New York, Ulster
- "Healing Tourism" in the Fourteenth Century Mediterranean: Searching for Healing from Saints and University-Trained Medical Practitioners**
Nicole Archambeau, University of Santa Barbara

Kanshir biyo, 1905. A manuscript with details describing techniques to revive a drowned man, with anatomical charts. Two illustrations. Japanese Manuscript 2. Wellcome Library, London



Saturday, May 10

C6. **Africanizing Biomedicine: Research Networks in Kenya and Uganda** | *Grand Ballroom 4*
Chair: Julie Livingston, Rutgers University

Reducing the Social to a Scientific Variable: The History of Anti-Tuberculosis Chemotherapy Trials in East Africa Kirsten Moore, Johns Hopkins University

"Dr. Burkitt, I presume?" Africanizing Cancer in Uganda in the 1950s and 1960s
Marissa Mika, University of Pennsylvania

From Tropical Disease to Molecular Cancer: Burkitt's Lymphoma, Epstein-Barr Virus, and the Global Politics of Biomedical Research, 1958-1978
Robin Scheffler, Yale University

6:00—7:00pm **FIELDING H. GARRISON LECTURE** | *Grand Ballroom 1-3*

Welcome: Sharon O'Keefe, President, University of Chicago Medical Center
Great Doctor History: A Personal Journey
Barron H. Lerner, New York University

7:00—9:00pm **RECEPTION** | Skyline Terrace

SATURDAY, MAY 10, 2014

7:00am—5:30pm **AAHM Conference Registration** | *Grand Ballroom Foyer*

7:00—8:30am **Clinician Historians Breakfast and Clio Initiative** | *Michigan*

7:00—8:30am **Women's Historians Breakfast** | *Renaissance Ballroom A-B*

7:00—8:30am **Continental Breakfast** | *Grand Ballroom Foyer*

8:00am—5:00pm **Book Exhibit** | *Grand Ballroom 5-6*

8:30am—10:00am **CONCURRENT SESSIONS D**

- D1.** **Debating the History of Eradication | *Gold Coast***
Chair: Bob H. Reinhardt, Carnegie Mellon University
- The Failure of Yellow Fever Eradication Efforts**
Mariola Espinosa, University of Iowa
- The Rockefeller Foundation's 'American Method' of Hookworm Eradication**
Steven Palmer, University of Windsor
- Cold-War Crisis, Smallpox Vaccination and the Pre-history of Surveillance: The U.S. Centers for Disease Control in East Pakistan, 1958**
Paul Greenough, University of Iowa
- An (American) Transnational Environmental History of Smallpox Eradication**
Bob H. Reinhardt, Carnegie Mellon University
- "How To Eradicate a Disease, According to the CDC —'Determined and Persistent Firefighting'"**
Randall Packard, Johns Hopkins University
- D2.** **Problematizing the Categories of Medicine and Religion in Pre-modern Asia | *Bucktown***
Chair/Commentator: Anthony Cerulli, Hobart and William Smith Colleges
- Karma as Contagion in Classical Ayurveda**
Lisa Brooks, University of California, Berkeley
- Talismans and the Materiality of Healing in Early Medieval Japan**
Benedetta Lomi, University of London
- Collapsing Dualisms of Religion and Medicine in Chinese Medicine**
Michael Stanley-Baker, Max Planck Institute for the History of Science
- D3.** **Labors of the Insane | *Grand Ballroom 1***
Chair: Erica Dyck, University of Saskatchewan
- Labour of the 'Insane': Therapy or Affliction?**
Debjani Das, Vidyasagar University
- "It would unseat the reason of nine out of ten prisoners": Penal Servitude, Prison Regimes and Mental Breakdown in England and Ireland, 1850-1900**
Hilary Marland, University of Warwick and Catherine Cox, University College Dublin
- "It is bad for a...person to be idle": A Cross-border Look into Patient Labor at Saskatchewan and Washington Mental Hospitals**
Blaine Wickham, University of Saskatchewan

- D4. Neurology, Psychiatry, and the Family | *Grand Ballroom 2***
Chair: Stephen Casper, Clarkson University
- History as a Research Tool: Norman Geschwind and the Birth of Behavioral Neurology**
Howard Kushner, Emory University
- The Parenthood Paradox: Psychiatry's Impact on Lesbian and Gay Parental Rights**
Marie-Amelie George, Yale University
- "Affirming the Family?": Challenging Masculinity and Redefining the Male Role in South Korean Family Planning, 1968-early 1980s**
John P. DiMoia, Princeton University
- D5. Sex and the State | *Grand Ballroom 3***
Chair: Sarah Rodriguez, Northwestern University
- Changing Sex in Brazil's Military Rule: From the Language of Medicine to the Language of Needs**
Jose Amador, Miami University
- Now You See Them, Now You Don't. Sexual Deviants and Sexological Expertise in Communist Czechoslovakia**
Katerina Liskova, Masaryk University
- Advocating for Control: Aboriginal Women and the Canadian State in the Era of Reproductive Choice**
Maureen Lux, Brock University
- D6. Making Forensic Medical Knowledge 1880s-1930s: Spatial, Technical, and Performative Strategies | *Grand Ballroom 4***
Chair: Michael Worboys, University of Manchester
- Contests Over Railway Spine in Mid-to-Late 19th c. Great Britain and America: Truth, Lesions, and Mechanical Objectivity**
Daniel Goldberg, East Carolina University
- Forensic Pathology and Crime Scene Investigation in Interwar England**
Ian Burney, University of Manchester
- Malarial Psychosis as Medico-Legal Problem, 1880-1930**
Christopher Hamlin, University of Notre Dame

10:00—10:30am

COFFEE BREAK | *Grand Ballroom Foyer*

10:30am—12:00pm CONCURRENT SESSIONS E

- E1. Housing and Health: Historical Perspectives | *Gold Coast***
Chair: D. Bradford Hunt, Roosevelt University
- Selling Synanon: The Residential Addiction Treatment Industry's 1960s Revival**
Claire Clark, Emory University
- Tramps as Vectors of Violence and Contagion: A New Look at Stigma toward the Unhoused Poor in the United States, 1870-1922**
Marian Moser Jones, University of Maryland, College Park
- How Research Connecting Housing and Health Sparked the Rise of the Healthy Housing Movement**
David E. Jacobs, National Center for Health Housing
Janet Smith, University of Illinois at Chicago
- E2. Medical Labor and Medical Gaze: Physicians and the Contours of Race, Disease, and Empire | *Bucktown***
Chair: Richard Keller, University of Wisconsin, Madison
- Physicians as Photographers: Capturing Leprosy in the American Tropics**
Adria Imada, University of California San Diego
- Harnessing the Empire to Buttress the Domestic Medical Profession during World War I: the 1886 Medical Act and the Tactical Use of Reciprocity**
Douglas Haynes, University of California, Irvine
- Family Practices: Cold War Medical Expansion and the Burdens of Latino Migrant Physicians, 1948-1965**
John McKiernan-Gonzalez, Texas State University
- E3. Reimagining the Human Subject | *Grand Ballroom 1***
Chair: Susan Reverby, Wellesley College
- The Death of Frantz Fanon: Reimagining the "Human Subject" for a Global History of Medicine** Laura Stark, Vanderbilt University
- From Unification, Registration: The Genesis of Research Subject Registries**
Alison Bateman-House, Columbia University
- Local Actions, National Concerns: Human Radiation Experiments at the University of Texas, Galveston 1949-1963**
Rimma Osipov, University of Texas Medical Branch

Saturday, May 10

Chicago Memorial
Hospital student
nurses in Groveland
Park, c. 1929.
Courtesy of
Northwestern
Memorial Hospital



E4. Taking Note: Technologies of Representation in Medicine | *Grand Ballroom 2*
Chair: Joel Howell, University of Michigan

Medical Notetaking in the Age of Mechanical Reproduction

Volker Hess, Charité, Berlin

Andrew Mendelsohn, Queen Mary University of London

Charles Bell's Seeing Hand: Teaching Anatomy to the Surgeon's Senses, 1800-1840

Carin Berkowitz, Chemical Heritage Foundation

The changing face of autopsy records in Vienna during two centuries

Doris Hoeflmayer, Kaiser Franz Josef-Hospital

E5. Medical Temporalities | *Grand Ballroom 3*

Chair: George Weisz, McGill University

Understanding Conflicting Temporal Regimes in Medical History

Helge Jordheim, University of Oslo

"Le Feu qui Couve, qui Peut s'Étendre": Pretubercular Children, Latency, and Medical Epistemology in the Early 20th Century

Andrew Ruis, University of Wisconsin, Madison

Time and syphilitic bodies in the 19th century

Anne Kveim Lie, University of Oslo

E6. Contemporary Histories of Medicine | *Grand Ballroom 4*

Chair: Todd Olszewski Providence College

The Pathologic-anatomical Collection of Vienna – the value of medical collections today in teaching, science and for museum purposes

Eduard Winter, Museum of National History, Vienna, Austria

Erwin H. Ackerknecht and the Contemporary History of Medicine

Flurin Condrau, University of Zurich

Speaking of Health: Dr. Leona Baumgartner, from Public Servant to Public Persona

Hilary Aquino, Albright College

12:00—1:30pm LUNCHEON SESSIONS

- L4. **Negotiating Access to Patient Related Materials: A Conversation between Archivists and Historians** | *Dearborn*
Moderator: Scott Podolsky, Harvard University
Participants: Phoebe Evans Letocha, Johns Hopkins University; Janet Golden, Rutgers University, Camden; Cynthia Connolly, University of Pennsylvania; and Kathryn Hammond Baker, Harvard University
- L5. **Medical History and Medical Anthropology** | *Michigan*
Moderator: Joanna Radin, Yale University
Participants: Warwick Anderson, University of New South Wales; Jeremy Greene, Johns Hopkins University; Judith Farquhar, University of Chicago; Eugene Raikhel, University of Chicago
- L6. **Silos or Synergies: Considering the History of Interprofessional Education and Practice in the United States** | *LaSalle*
Moderator: Jennifer Gunn, University of Minnesota
Participants: Patricia D'Antonio, University of Pennsylvania; Rima Apple, University of Wisconsin; Beth Linker, University of Pennsylvania; Julie Fairman, University of Pennsylvania; and Dominique Tobbell, University of Minnesota.

1:30—3:30pm CONCURRENT SESSIONS F

- F1. **Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games, and More** | *Renaissance Ballroom A-B*
Chair: Janet Golden
- Improving and Blogging History: How Blogging and Improv Comedy Can Improve the Dissemination of History**
Michael Yudell, Drexel University
- Medical History Interactive: Dispatches from the Eugenics Debates**
Alexandra Minna Stern, University of Michigan
- It's How You Play the Game: Playtesting Pox and the City, A Digital Role-Playing Game for the History of Medicine**
Lisa Rosner, Richard Stockton College
- Wikiproject Women's History: Closing the Wikipedia Gap**
Heather Munro Prescott, Central Connecticut State University
- Scholarly Societies as Crucial Venues in the Digital Age**
Fred Gibbs, University of New Mexico
- Scholarly Societies as Crucial Venues in the Digital Age**
Cheryl Lemus, Ashford University
- Omeka for Medical History: Digital Collections, Research, and Public Interaction**
Adam Turner, University of Oregon

- F2. Metrics of Race Across Four Continents | *Bucktown***
Chair: Lundy Braun, Brown University
- Looking for Crania Americana: Forensic Anthropology and Craniology between Europe and Latin America**
Julia Rodriguez, University of New Hampshire
- Blood-Size: Race and Haematology in Late Colonial India**
Projit Mukharji, University of Pennsylvania
- Mendel's Children: Orphans and Eugenics in Postwar Japan**
Kristin Roebuck, Columbia University
- Dreaming and Enacting Scales of Difference: Dermatology and Melanin Sciences as Liberationist Tools in Post-WWII United States**
Cecilia Cardenas-Navia, Yale University
- F3. Bodies and the Medical Gaze | *Grand Ballroom 1***
Chair: Bert Hansen, City University of New York
- Gaze from the Interior: The Puzzle of Chinese Medicine**
Lan Li, Massachusetts Institute of Technology
- "Where a fat girl wants to look beautiful": The History of Fat Camps in the United States as a Treatment for Childhood Obesity**
Laura Dawes, Harvard University
- "My brain tells me to look away, but my eyes just keep on staring": Hollywood's Representations of Chemotherapy-Related Hair Loss**
Kasey Mosley, Mississippi State University
- The Beauty of the Cure: The Role of the Visual in Discourses on Cosmetic Surgery in the Canadian Medical Profession, 1900-2000**
Tracy Penny Light, University of Waterloo
- F4. Medicine for the People | *Grand Ballroom 2***
Chair: Arleen Tuchman, Vanderbilt University
- Food for the Body and the Soul: Carolingian Advisory Literature and Medicine**
Meg Leja, Princeton University
- "A correspondence course in intelligent parturition": Canadian Letters to Dr. Grantly Dick-Read**
Whitney Wood, Wilfrid Laurier University
- "Suggestive in itself": The Layman's Medical Journal**
Catherine Smith, University of Wisconsin, Madison
- The Little Manual that Started a Revolution: How Midwifery Became a Hippie Practice**
Wendy Kline, University of Cincinnati

F5. **Medical Pluralism Revisited** | *Grand Ballroom 3*
Chair: Mary Fissell, Johns Hopkins University

Close Encounters of the VisualKind: Oculists, Public Knowledge and the New Science in Early Eighteenth-century England.
 Karen Buckle, Clarkson University

Make no Bones About It: The Celebrity of Sarah Mapp, an Eighteenth Century Bonesetter.
 Cosimo Calabro, McGill University

Medical pluralism or labor pains of professionalization?: Ottoman healing arts revisited
 Nukhet Varlik, Rutgers University

Quackbusters: The Controversial History of the National Council Against Health Fraud
 Eric Boyle, National Museum of Health and Medicine and University of Maryland, College Park

F6. **Art and Anatomy** | *Grand Ballroom 4*
Chair: John Harley Warner, Yale University

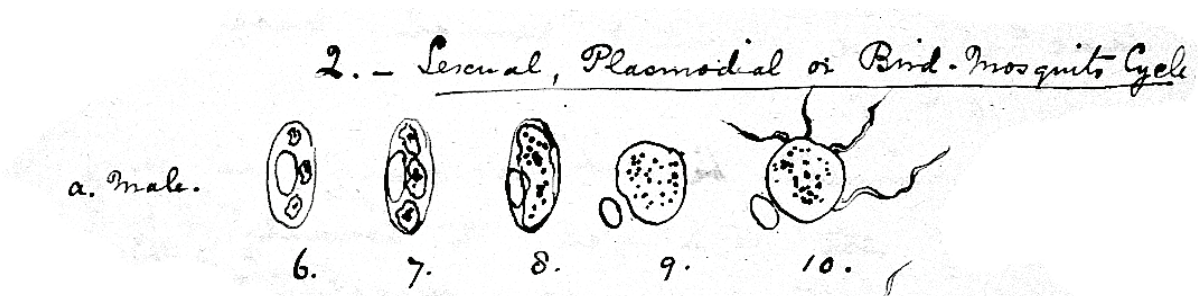
Radiant Modernity: Fritz Kahn's Iconography of Corporeal Energy, 1920-1940
 Michael Sappol, National Library of Medicine

Drawing the Anatomy of the New Man. Visual Cultures of Anatomy in Interwar Vienna, Global Networks of Exchange and the Emergence of a Modern Perspective
 Birgit Nemeč, University of Vienna

Artists, Anatomists, and the Transparent Body: Human Identity and the Categorical Impulse
 Corinna Wagner, University of Exeter

"A spirit of accurate observation": Patient Portraiture, Pathology, and Display in Dublin c.1830-1870
 Catherine Cox, University College Dublin, Ireland

3:30—4:00pm **COFFEE BREAK** | *Grand Ballroom Foyer*



"Scheme of proteosoma from Ronald Ross Letter," Ross Archive. At the London School of Hygiene and Tropical Medicine; Wellcome Library, London

4:00—5:30pm CONCURRENT SESSIONS G

- G1.** **The Afterlife of a Disease in Four Cultures: Leprosy, Social Memory, and Public Health | *Gold Coast***
Chair/Discussant: Warwick Anderson, University of Sydney
- Discourses of Disease: Popular History, Media, and Academia in the History of Leprosy in Hawai'i**
 Kerri Inglis, University of Hawai'i at Hilo
- Coming to Terms with an Invisible Profession: Leprosy Doctors in Socialist China**
 Shao-hua Liu, Academica Sinica, Taipei
- The Politics of Apology, Human Rights and Social Inclusion of Hansen's Disease Patients in Korea**
 Jane Kim, University of California, Los Angeles
- Whose History is this Anyway?: Patient Activism and the Politics of Japan's National Hansen's Disease Museum**
 Susan Burns, University of Chicago
- G2.** **The Practice of Medicine in Wartime | *Bucktown***
Chair: Dale C. Smith, Uniformed Services University of the Health Sciences
- From the Kitchen to the Bedside: Feeding the Sick in Germany during World War I**
 Kristen Ehrenberger, University of Illinois, Urbana-Champaign
- Black Physicians and the Great War**
 Nathan Kuehnl, Wayne State University
- Vascular Surgery in World War II**
 Justin Barr, Yale University and University of Virginia
- The History of the "Revier" or Hospital in the Concentration Camp of Flossenbuerg, 1938 – 1945**
 Jessica Tannenbaum, University of Erlangen-Nuremberg
- G3.** **Governing Narcotics | *Grand Ballroom 1***
Chair: David Courtwright, University of North Florida
- Big Pharma's Real Nemesis? The Federal Bureau of Narcotics as Pharmaceutical Regulator**
 David Herzberg, University at Buffalo, SUNY
- From Methadone Maintenance to the War on Drugs: The DC Narcotics Treatment Administration**
 Mical Raz, Yale University
- "Have You Got Any Grass?" Psychiatric Perspectives on 'Narkomanija' in Communist Yugoslavia (1965-1990)**
 Mat Savelli, University of Pittsburgh

- G4. Problems of Urban and Rural Health Policy | *Grand Ballroom 2***
Chair: Keith Wailoo, Princeton University

The 1960s Urban Riots and Health Care: Race and Metropolitan Health Systems Development

Merlin Chowkwanyun, University of Wisconsin, Madison

Rural Problems, Urban Solutions: The Politics of Medical Education and Health Care Delivery in the Post-World War II United States

Dominique Tobbell, University of Minnesota

- G5. Technology, Consumerism, and Parenting | *Grand Ballroom 3***
Chair: Jeffrey Baker, Duke University

Alarming Babies: Home Apnea Monitors and SIDS in the United States

Brittany Cowgill, University of Cincinnati

Tools of the Trade: Breastfeeding Technologies and the Professionalization of Lactation Support

Jessica Martucci, Mississippi State University

Buying for the Baby Too Soon?: Pregnancy Advice, the Culture of Consumption and Miscarriage in Nineteenth through Twenty-First-Century America

Lara Freidenfelds, Independent Scholar

- G6. Screening and Surveillance | *Grand Ballroom 4***
Chair: Gerald Oppenheimer, Brooklyn College, CUNY

Fragile X Syndrome and the Age of Targeted Prevention

Andrew Hogan, University of Virginia

Eugenics in a multi-disciplinary context: Research of deafness at the Clarke School for the Deaf, 1930s – 1950s.

Marion Schmidt, Johns Hopkins University

“My Mother Has Breast Cancer...What Does This Mean For Me?”: Research in, and Genetic Counseling for, Hereditary Cancers in the 20th Century United States

Devon Stillwell, Johns Hopkins University

5:30pm—6:30pm AAHM Business Meeting | *Grand Ballroom 1*

6:30—7:30pm Reception | *Renaissance Ballroom Foyer*

7:30—10:00pm AAHM Awards Banquet | *Renaissance Ballroom*

SUNDAY MAY 11 2014

7:00—8:30am Post-Mortem Breakfast | *Dearborn*

7:00am—1:00pm AAHM Conference Registration | *Grand Ballroom Foyer*

7:00—8:30am Continental Breakfast | *Grand Ballroom Foyer*

8:30am—10:00am CONCURRENT SESSIONS H

H1. **Affects of Surgery** | *Grand Ballroom 1*
Chair: Chris Crenner, University of Kansas

The Mask behind the Mask: Uncovering Burnout in Contemporary American Surgeons
Wen Shen, University of California, San Francisco

A Theatre of Compassion: Emotion and Affect in Early Nineteenth-Century Surgery
Michael Brown, University of Roehampton

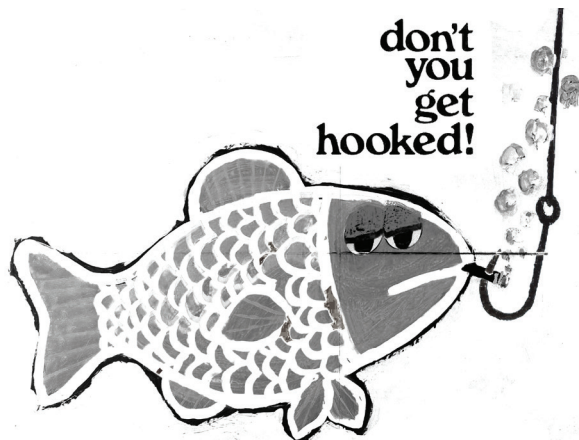
“Atomic Bombs” or the Knife: Competing Treatments for Hyperthyroidism since World War II in Taiwan
Hsiu-Yun Wang, National Cheng Kung University

H2. **New Geographies of Public Health** | *Grand Ballroom 2*
Chair: David Barnes, University of Pennsylvania

Filth, Fever, and the Imperial Social Body
Jacob Steere-Williams, College of Charleston

Commodity Circulation, Infection and the Interpretation of Disease in India in the 1830s: The Plague
Deep Kanta Lahiri Choudhury, Presidency University

Mapping Public Health in an Early Soviet City: Health-Related Institutions of Petrograd-Leningrad in The 1920s
Pavel Vasilyev, Russian Academy of Sciences



"Don't You Get Hooked," U.S.
Department of Health, Education, and
Welfare, Public Health Service, 1970.

- H3. Pharmaceutical Origins | *Grand Ballroom 3***
Chair: John Swann, Food and Drug Administration
- Between Regional Dynamics and Modernity: Tracing the Rebirth of a Japanese
Medicine Industry in Osaka**
Julia Yongue, Hosei University
- Trademark Law and the Nineteenth-Century Origins of Generic Names**
Joseph Gabriel, Florida State University
- “The romance of exploration and emergency first aid”: Tracking the Narratives about
Burroughs Wellcome’s “Tabloid” Medicine Chest**
Meegan Kennedy, Florida State University
- H4. Radiation and Risk: Politics of Health in the Atomic Age | *Grand Ballroom 4***
Chair: David Jones, Harvard University
- Uncertainty Principles: Radiation and Risk in 20th Century Medicine**
Jeffrey Womack, University of Houston
- Gendering the Bomb: Japanese Americans as Patients, Caretakers, and Community Activists**
Naoko Wake, Michigan State University
- “One should neither deride it nor pin any great hope on it”: Medical Responses to
Atomic Energy and Crises, 1945-1961**
Casey Hurrell, Queen’s University
- H5. The Slow Growth of Discipline as a Major Function of State Medical Boards | *Grand
Ballroom 5***
Chair: James Schafer, University of Houston
- Historical Origins and Evolution of the State Medical Board Disciplinary Function**
David Johnson, FSMB
- Disciplinary Actions by State Medical Boards: The Benefits and Challenges of
More Comprehensive Data**
Phil Davignon, FSMB
- Social Media and State Medical Boards: The Prevalence of Unprofessional
Online Behavior by Physicians**
Aaron Young, FSMB

10:00—10:30am COFFEE BREAK | *Grand Ballroom Foyer*

10:30am—12:00pm CONCURRENT SESSIONS I

- I1. **Networks of Charitable Care | *Grand Ballroom 1***
Chair: Theodore Brown, University of Rochester

Dead Father, Resurrected Son: Rose Hawthorne Lathrop, Nathaniel Hawthorne, and the Origins of Catholic Hospice Care in the United States, 1896-1926
Harold Braswell, Emory University

Mission to Sichuan: Medical Activists in Southwest China during the War of Resistance against Japan (1937-1945)
Nicole Barnes, Duke University

Designing Primary Care to Meet the Health Needs of Uninsured People: The Case of Dallas County
Stephen Inrig, University of Texas Southwestern Medical Center

- I2. **Mediating Conception | *Grand Ballroom 2***
Chair: Elizabeth Watkins, University of California, San Francisco

“Turning Urine Into Gold”: Pergonal and the Roots of the Obsession with (In)Fertility in Palestine/Israel, 1934-1968
Tamar Novick, University of Pennsylvania

Minor Access to Emergency Contraception in the United States Has An Historical Foundation in Minor Contraceptive Access Frameworks in England, France, and the United States.
Carol Stamm, University of Colorado Health Sciences Center

Rape and Professional Medicine
Katherine Schaub, Case Western Reserve University

- I3. **Therapeutic Epistemologies | *Grand Ballroom 3***
Chair: Nicholas Rasmussen, University of New South Wales

Hedging Ones Bet: Emil Roux’s 1894 Diphtheria Antitoxin Trial and the Role of Joseph Grancher’s Architectural Design and Hygienic Regulations at the Hopital Enfants des Maladies
Paul Berman, University of Massachusetts

Testing Standards as Regulatory Instruments: A History of Non-inferiority Trials and Dilemmas in Antibiotic Drug Development
Arthur Daemmrich, University of Kansas

A Challenge for European Health? Medicines Consumption, Drug Risks, and Health Policies in Western Europe, 1950-1980
Nils Kessel, University of Strasbourg

14. **Dread, Exorcism, and Addiction | Grand Ballroom 4**
Chair: Alison Winter, University of Chicago

An Enchanting Witchcraft: Masculinity, Melancholy, and the Pathology of Gaming in Early Modern London
Celeste Chamberland, Roosevelt University

Anxiety Weaponized: Dread in the Era of Cold War Politics
Simon Taylor, Columbia University

The “Intuitive” Exorcists: Religion, Medicine and Spirit Possession in 1970s England
Neil Armstrong, Teesside University

15. **Disciplinary Issues | Grand Ballroom 5**
Chair: Michael Rossi, University of Chicago

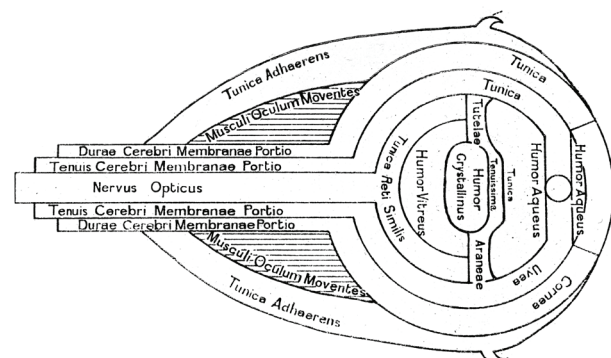
The Meaning and the Domestications of “Tropics” in early 20th century America: Richard P. Strong and the “Department of Tropical Medicine” at Harvard University
Se-Kwon Jeong, Seoul National University

Medical mycology: ‘Orphan Science’ - Specialist Practice
Michael Worboys, University of Manchester

“I’m not insane”: The Medicalization of Suicide in the First Half of the 20th Century
Isabelle Perreault, University of Ottawa and Patrice Corriveau, University of Ottawa



Schematic Eye. From a Manuscript (No. 924 in Constantinople). Wellcome Library, London



Optical diagram of the eye with description in English. After Ibn Al [Alhazen] Haitham, *Opticæ thesaurvs Alhazeni Arabis libri septem. E. & heirs of H.Episcopus Basel 1572*

ABSTRACTS

Listed by Session

A1 "Without Men Would There Be No "Other"?: Using Masculinity as a Category of Analysis for the History of Medicine

"Cultural notions"

Aimee Medeiros; aimee.medeiros@ucsf.edu; University of California, San Francisco, San Francisco, CA, USA

Joan Scott's 1986 article "Gender: A Useful Category of Historical Analysis" challenged historians to extend their interpretation of the past by examining the social organization of the relationship between the sexes and the significance of gender groups. Scott's plea fundamentally changed the way women's history was done by urging for more of a theoretical meaning over a descriptive bias when analyzing women's lives in the past. Or did it? During the past 28 years, many historians of medicine who have adopted gender as their lens of analysis have done so with respect to women—but overlooked men. Historians' failure to consider men in gendered analyses has distorted the past and allowed the category 'men' to remain a silent but powerful normative maker. This session intends to put a stop to this *modus operandi* by asking a fundamental historiographical question: without men would there be no "other"?

Symposium participants will share how their use of masculinity as a lens of analysis has framed their research and understanding of medicine for the better. Participants include historians Beth Linker, Mark Micale, and Aimee Medeiros and sociologist Bethany Coston. Drawing on research concerning post-World War II filmic representations of paraplegic sexuality Linker will discuss how masculinity and femininity are never defined in isolation from one another, but rather relationally; her work has also shown how cultural and scientific constructions of masculinity function as both foils for femininity and disability, as well as methods for differentiating between kinds of men. Mark Micale will comment on how Western masculinity successfully established itself as the voice of reason, knowledge, and sanity – the basis for patriarchal rule – in the face of massive testimony to the contrary and the continued role of idealized masculinity in modern psychiatry. Aimee Medeiros will speak about how cultural notions of ideal male health operate in pediatrics and how the physician's role extends beyond serving as a guardian of children's health but as a consumer and promulgator of social expectations of maleness of the body. Sociologist Bethany Coston will report on how masculinity as a category for critical research has been particularly important (in unexpected ways!) in her sociological examination of intimate partner violence and health care service utilization. Panel chair Elena Conis will urge attendees to share their strategies, apprehensions, and resistance to considering masculinity, and will encourage staunch adversaries to stump participants about the session's premise and claim.

A2 Residues, Resistance, Regulation: Transatlantic Histories of Antibiotics in Agriculture

“Founder of Agricultural Antibiotics or ‘Merchant of Doubt’?: Thomas Jukes and Battles over Antibiotic Feeding in the United States, 1949-1999 “

Mark Finlay; mark.finlay@armstrong.edu; Armstrong Atlantic State University, Savannah, GA, USA

In the first fifty years of debates about the public health and economic impacts of agricultural antibiotics, one scientist stood at the center: Dr. Thomas Jukes. Employed at American Cyanamid Company’s Lederle Laboratories in the late 1940s, Jukes and a colleague discovered what came to be known as the “antibiotic growth effect”—that the feeding of antibiotics at low, sub-therapeutic levels to agricultural animals resulted in enhanced growth. The discovery quickly contributed to a rapid transformation of livestock production in the United States, changes that soon were felt around the world. The immense consumption of antibiotics had predictable implications for public health, however, as scientists began to notice deleterious effects of antibiotic resistance—both the declining effects among livestock and the increasing potential risks for human health.

Controversies about the use of antibiotics in livestock operations have been common ever since. In some European nations, steps have been taken to reduce and in some cases to virtually eliminate the feeding of antibiotics to healthy animals. Efforts to institute similar regulations in the United States, however, have repeatedly stalled. One important reason was the work of Tom Jukes, who as a well-known “public scientist” loudly proclaimed that the benefits of antibiotic feeding far outweighed the risks. As a result, American policy makers have been reluctant to challenge a well-entrenched food production system that relies upon animals’ access to feeds laced with antibiotics.

More significantly, Jukes’s campaign fits in with recent scholarship on the “merchants of doubt,” or those who take advantage of scientific controversy—or perhaps merely the appearance of controversy—to prevent any change in the status quo. Through his battles with those he labeled as “consumer terrorists,” “coercive nutritionists,” and other epithets, Jukes and his allies worked to preserve a system that has helped to increase world meat production, but also has created new levels of public health risks.

Learning Objectives

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

A2 Residues, Resistance, Regulation: Transatlantic Histories of Antibiotics in Agriculture

“Swann Song? Negotiating risk, fears and prosperity regarding agricultural antibiotics in post-war Britain”

Claas Kirchhelle; claas.kirchhelle@univ.ox.ac.uk; Wellcome Uit for the History of Medicine, Oxford, UK

Following the Second World War, agricultural antibiotics were key players in the industrialization of modern farming. Because of their threefold function of combating infectious bacterial diseases, preventing new infections and promoting animals’ growth, antibiotics quickly became a mainstay in the inventory of farmers. Unfortunately, negative side effects of antibiotics’ mass-introduction to human food production – such as antibiotic allergies and resistant pathogens – did not take long to emerge.

Concerned about these developments, British experts and officials pioneered methods of assessing and regulating antibiotic risk during the late 1950s and 1960s. While British regulation of agricultural antibiotics subsequently turned into a global export hit, British antibiotic policy stagnated between the 1970s and the late 1990s.

Employing approaches from environmental and cultural history, my presentation will focus on the factors behind Britain’s emergence as an antibiotic reform pioneer and explore the reasons for its subsequent antibiotic complacency. In particular, the paper will highlight the role that scandals, activists and shifting consumer fears played in motivating or preventing antibiotic regulation.

Learning Objectives

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

A2 Residues, Resistance, Regulation: Transatlantic Histories of Antibiotics in Agriculture

“An Unholy Alliance? Pharmaceutical Industry, Veterinarians and Meat Production in Germany since 1945”

Ulrike Thoms; ulrike.thoms@charite.de; Universitaetsmedizin Berlin, Berlin, Germany

Once introduced as wonder drugs, antibiotic production skyrocketed in the 1950s and 1960s. Surprisingly quickly after their introduction into medicine they made their way into agriculture. While the market for their use in humans was increasingly saturated and prices declined, pharmaceutical companies realized that enormous sales potential remained in the market for veterinary drugs, which is less regulated and still expanding until today.

From the very beginning, the use of antibiotics as growth promoters and disease managers on the farm has been criticized and German Federal institutions have tried to limit their use. The only problem was that producers and veterinarians alike have managed to hide the extent of their use until recent years.

The paper will describe the practices and the extension of the use of antibiotics, before it then turns to the discourse on antibiotics and the positions of the different actors in this field and their discussion in the public. It will especially discuss the role of veterinarians and their in-between position in the control of food and the task to push up food production. The paper will also address a larger question: how the misuse of antibiotics as growth promoters is but one more case of the failure of the German system of drug regulation and control.

Learning Objectives

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

A2 Residues, Resistance, Regulation: Transatlantic Histories of Antibiotics in Agriculture

“Risking Professional Identity in an Antibiotic Age: Veterinarians, Antibiotics, and the U.S. Dairy Industry”

Kendra Smith-Howard; ksmithhoward@albany.edu; University at Albany (SUNY), Albany, NY, USA

Although risks to public health and animal welfare loom large in the analysis of veterinary antibiotics today, a different risk seemed more important at the advent of their introduction in the U.S. dairy industry. Veterinarians worried that the ready availability of easy-to-administer medicines would challenge their professional authority and their central place in diagnosing and treating animal disease. This paper will examine the power struggles and veterinary responses to agricultural antibiotics used for therapeutic purposes in the U.S. dairy industry from the late 1940s through the 1970s.

Learning Objectives

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

A3 The Colonial Asylum Archive: Papering Over Madness

“Committed by Paper in Colonial New Zealand”

Barbara Brookes; barbara.brookes@otago.ac.nz; University of Otago, Dunedin, Otago, New Zealand

The records of asylums have been mined by historians to reconstruct the operation of asylums and the experience of the mentally ill. Often, however, historians have looked through archives rather than at the documents themselves. Inspired the work of Ben Kafka and Matthew Hull on documents and bureaucracy, my argument is that asylum paperwork attempted to make the incoherent coherent, to translate the multiplicity of symptoms – from shouting to silence, from violence to complete passivity – into legible signs. Those signs were then used first, by the state to account for - and count up - both the people and the costs of incarceration. Second, the personnel involved – doctors and nurses – used the signs to classify mental states. Third, these signs, or diagnoses, were sought by those in the community who wished to understand the afflictions which transformed their loved ones into strangers. Paperwork recorded acts of restitution, as well as recording acts of loss. The act of Committal by Paper captured individual misery but it did so because it was part of a system of accounting for the act of denying the liberty of the subject. That system attempted to create method in forms, casebooks, and charts, but the suffering of individuals resisted neat categories just as the paperwork eluded order with pasted-in pages, letters and drawings attached with pins, writing spilling beyond margins, and cases moving between books. The unruliness and fragility of the paper mirrored the very disorders of the people it sought to contain.

Learning Objectives

Develop knowledge about the nature of evidence in administrative records relating to mental health

Develop a nuanced understanding of patients' lives as they moved from the community into the asylum and back to the community

Promote understanding of the relationship between the colonial state's requirements for accountability and administrative procedures around patient care

A3 The Colonial Asylum Archive: Papering Over Madness

“Lunatic asylums in British colonies: archive, narratives, and credible claims”

Sally Swartz; sally.swartz@uct.ac.za; University of Cape Town, Cape Town, South Africa

In the last decades of the nineteenth century, across the British Empire, officials routinely documented the processes through which the insane were committed to lunatic asylums, and this left a substantial archive, including correspondence, lunacy certificates, records of legal procedures, accounts, casebooks and scientific papers. From these, it is possible to construct rich institutional histories, and to discern the attitudes of district surgeons, resident magistrates, and colonial office officials to those identified as insane. Much more difficult is to find archival traces that piece together the experiences of the insane either before or during their periods of incarceration. The voice of lunatic inmates of asylums is sometimes recorded in case notes, letters or appeals for freedom, but is framed as a performance of illness, rather than as information about or reasonable commentary on experience that must have been deeply unsettling. Reconstructing the journeys of the colonized insane from homes and communities and into lunatic asylums is very difficult for two reasons: these men and women were silenced as a result of their compromised mental state, but also because of their powerless status as colonial subjects. This paper explores some of the consequences of this archival imbalance on histories of African lunatic asylums. Scholarship in the area has tended to assume that colonial lunatic asylums were oppressive and racist institutions deployed by colonial governments to maintain public order. There is indeed some evidence to support the view that colonial asylums in Africa delivered services in ways that were fundamentally shaped by racist scientific beliefs. However, the unevenness of the archive, and in particular its bias towards collections which allow readings of institutional activity, as opposed to mapping the experiences of individuals and families, has allowed the construction of a single-stranded master narrative, that does not do justice to experiences of the African insane. The paper gives examples of a method of reading across a variety of archival silos, following the movement of the insane in and out of communities and asylums, in and out of episodes of illness, and in contact with a variety of legal and medical officials and bureaucratic systems, that goes some way towards building an understanding the complex ways in which colonial asylums provided relief and care but also neglected and mistreated these vulnerable colonial subjects.

Learning Objectives

Those attending this presentation will be given:

- (1) a description of the archive that records the history of lunatic asylums in Cape Colony, and the relationship of this to other African colonial lunatic asylum archives
- (2) an overview of the kinds of institutional histories that these archives have scaffolded and
- (3) a method of reading across archival silos that focuses attention on the experience of insane patients and their families as they move between institutional spaces

A4 Race and Healthcare in U.S. History

“Jewish Immunity: Tuberculosis, Identity, and Conflict in Early-Twentieth-Century Immigrant New York”

Adrienne deNoyelles; addenoyelles@ufl.edu; University of Florida, Gainesville, FL, USA

This paper highlights the important contributions of early-twentieth-century immigrant physicians to American public discourses concerning immigrants' fitness for citizenship. Specifically, it discusses the shifting and sometimes conflicted stances of five Russian-Jewish doctors regarding their ethnic group's overall resistance to tuberculosis, and the factors each perceived to be influencing that resistance. In their efforts to redefine the link between tuberculosis and foreign extraction, they forged a delicate balance between race and environment, tradition and assimilation, and their own professional and personal aspirations. Maurice Fishberg, the central figure in this study, provides a particularly in-depth and multifaceted example of how these conflicts unfolded within one person as the 1900s progressed. Until quite recently, immigrant physicians in early twentieth-century America have tended to appear as relatively uncomplicated foils to nativism in broader histories, or profiled largely from an intellectual and professional standpoint in more narrowly focused works. Both of these approaches leave relatively unexplored the tension between their identities as aspiring individuals and as representatives and cultural mediators for a vulnerable minority group. This paper aims to help fill that gap. Taken together, the writings of Maurice Fishberg and his colleagues demonstrate that immigrant physicians did not think and act as a cohesive group when responding to the hostility confronting them and their compatriots in the United States.

Learning Objectives

Acquire a deeper, more nuanced understanding of the contributions foreign-born physicians made to American discourses concerning public health and immigration

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 throughout history

A4 Race and Healthcare in U.S. History

“The Mismeasure of Woman: The Debate on Pelvimetry, Race, and Obstetrics in the U.S., 1870-1920”

Sarah Pripas-Kapit; srpripas@ucla.edu; University of California, Los Angeles, Los Angeles, CA, USA

From the 1870s to the 1920s, obstetricians in the United States formulated a consensus that pelvis size and shape were related to race, and that this difference held implications for obstetrical treatment. The debate over pelvises demonstrates the complexities of translating folk racial “knowledge” into medical research. From the outset, racial pelvimetry was confounded by two contradictory assumptions. Physicians commonly believed that women of the so-called “lower races” had wider pelvises, facilitating easier and shorter labors. At the same time, many physicians also believed that pelvic abnormalities were more common among women lower on the racial hierarchy, including southern and eastern European immigrants. Yet despite this contradiction, and significant technological limitations that impeded accurate pelvic measurement of parturient women, studies of racial differences in pelvimetry flourished during this time period.

Racial studies of pelvimetry differed from craniology and other race-based anatomical investigations in several respects. First, much of the research was conducted on live subjects. Secondly, the topic drew attention from both ethnologists and physicians. Ethnologists believed that pelvis size indicated racial hierarchy, while many obstetricians thought that study of racial differences in pelvic anatomy could potentially have implications for obstetrical treatment. During this era, the obstetrical profession debated contentious issues such as the appropriate usage of forceps during labor or performance of caesarean section, and some obstetricians concluded that a parturient woman’s race should factor into obstetrical decision-making, although there was little consensus about the particulars of this claim.

By the 1920s, scientific interest in racial pelvimetry waned, possibly attributable to anthropology’s move away from biological racial difference and towards an emphasis on cultural difference. However, many of the assumptions of racial pelvimetry have lingered in popular consciousness. This episode in the history of obstetrics and race is worth exploring not only for its continued impact, but also because it constitutes a historical example of physicians attempting the dubious task of creating race-specific treatment protocols.

Learning Objectives

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

A4 Race and Healthcare in U.S. History

“Contracted Pelvis, Contracted Labor: A “Race Disease” in a Post-Racial(?) America”

Christian Warren; cwarren@brooklyn.cuny.edu; Brooklyn College, Brooklyn, NY, USA

The association of childhood rickets with obstetrical complications goes back at least as far the mid 18th Century, when William Smellie’s generation blamed this “new disease” for the distorted pelvises of Englishwomen, hastening the advent of the modern, instrument-enhanced profession of male midwifery. In North America a century later, the rickets-contracted pelvis was more likely to be discussed as a racial disease, with enslaved African-American women composing the most visible population suffering from these sequellae of rickets. Evolutionary biology and the bleak facts of diet and environment support the thesis that dark skin and poor diet (especially during childhood) conspired to produce rickets even in the sun-drenched fields of southern cotton plantations. Physicians in the north commented on the near universality of rickets among black children. Alfred Hess in 1917 estimated the incidence at 90 percent for black children in New York City. The obstetric consequences of all these bent and twisted little frames were obvious—and deadly.

So what became of this presumed “race disease” in the generation after World War II, when vitamin D supplementation became the new normal, and the public health establishment came to describe rickets as a “medical curiosity”? This paper explores the obstetrical, public health, and popular periodical literature of the post-war years to measure the degree to which medical experts drew lines of causality between environment, skin color, and diet to explain the “race-specific” differences in the prevalence of contracted pelvises, and the role rickets ultimately played in differential birth outcomes across ethnic and racial groups. Does rickets make a poor example for challenging outdated notions of health and race, or does a fuller understanding of the interplay of sun, skin, and bone enhance the hard “social constructionist” approach? “The learner will gain familiarity with the historical association of childhood rickets with adult obstetrical complications.

Learning Objectives

The learner will be able to discuss how social ideas about ethnicity have shaped caregivers’ explanations for “race-specific” health outcomes.

The learner will be able to assess the social and health costs of the general perception that vitamin D deficiency and rickets had been vanquished.”

A5 The Role of Medical Commentaries in the Rise of Arabic Medicine, 1100-1500

“Questions of medical epistemology in the Arabic commentaries on the Hippocratic Aphorisms”

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The Hippocratic Aphorisms had a profound influence on subsequent generations; they not only shaped medical theory and practice, but also affected popular culture. Galen (d. c. 216) produced an extensive commentary on this text, as did other medical authors writing in Greek, Latin, Arabic, and Hebrew. The Arabic tradition is particularly rich, with more than a dozen commentaries extant in over a hundred manuscripts. These Arabic commentaries constituted important venues for innovation and change, and did not merely draw attention to scholastic debates, as the example of medical epistemology illustrates. The first aphorism makes the point that ‘experience is dangerous’. The role of experience in producing medical knowledge was hotly debated, not least by Galen, who adhered to the concept of ‘qualified experience’.

Likewise, medical authors writing in Arabic such as al-Rāzī (d. 925) referred to this aphorism in their debates of medical epistemology. In the Arabic commentaries on the Hippocratic *_Aphorisms_*, we also find interesting debates about the role of reason (*_qiyās_*) versus experience (*_tağriba_*). In the present talk, some newly discovered examples will be presented for the first time. They illustrate that the paradigm of decline and fall in the Arabic medical literature of the post-classical era ought to be revised. For instance, al-Kīlānī (14th century) offers an highly original discussion of why experience is dangerous in his commentary on the *_Aphorisms_*.

Learning 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

A5 Commentaries and the Transformation of the Islamic Medical Tradition, 1100-1500

“Non-Galenic Physiologies in Commentaries on Avicenna’s ‘Canon’ and Ibn al-Nafis’s ‘Epitome’”

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There has been a long-standing assumption in the field that pre-modern physicians in Islamic societies never questioned the fundamentals of Galenic physiology. To be fair, the field has long recognized the existence of critiques against several aspects of Galenic medicine, such as Ibn al-Nafis’s rejection of Galenic cardio-vascular anatomy. Nonetheless, even in such cases, historians of medicine have claimed that not only were such critiques exceptional, but that these critiques did not lead the authors themselves (let alone their successors) to challenge the fundamental tenets of Galenic physiology. However, recent work has shown that Ibn al-Nafis, at the very least, had rejected the fundamental principles of, and proposed an alternative to, Galen’s three chief organ physiology. Building upon this realization, this paper will show how some medical commentators during the fourteenth and fifteenth centuries were toying with non-Galenic physiologies, such as the one proposed by Ibn al-Nafis. Passages will be presented from the commentary on book one of the "Canon" by al-Kazaruni (d. 1357) and from the commentary on the "Epitome" by al-Kirmani (d. 1449) to illustrate the creative ways in which pre-modern physicians in Islamic societies engaged with non-Galenic physiologies. The paper will also hope to draw some tentative conclusions about the development of trajectories of non-Galenic physiology and their circulation in both Islamic societies and Latin Europe during the fifteenth and sixteenth centuries.

Learning Objectives

1. To appreciate the dynamic and creative character of medicine in the Islamic world, even in a period (mistakenly) characterized as one of decline.
2. To critically assess our current narratives of medical progress in the pre-modern period.
3. Promote tolerance for ambiguity of theories and the nature of evidence in pre-modern Islamic medicine.

A5 Commentaries and the Transformation of the Islamic Medical Tradition, 1100-1500

“Ibn Sina’s Canon as a Critical Commentary on Greek Medical Doctrines: The Case of Galenic Crisis Theory”

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The monumental "Canon" of Ibn Sina (d.1037), also known as Avicenna, is often characterized as a watershed of medical thought, a systematization of the Graeco-Arabic medical tradition. While it certainly is a conveniently organized presentation of a complex and sprawling subject, close examination of a few medical doctrines reveals that its relationship to the Greek tradition is not so straightforward. It is clear that Ibn Sina sometimes reformulates and simplifies aspects of Greek medical theory, which constitutes an implicit critique of the received tradition. For example, Galenic crisis theory, as originally presented in Galen’s "Crises" and "Critical Days", was given its classic Arabic form during the period of the translations, and became ingrained within medical practice. The classic doctrine appears in major medical compendia: The "Firdaws al-Hikma" of ‘Ali Ibn Sahl Rabban at-Tabari (9th C.), the "Hawi" of al-Razi (d. 925), and the "Kitāb Kamil as-Sina‘a at-Tibbiyya" of al-Majusi (d.c. 994). However, when it comes to the "Canon", Ibn Sina, while presenting crisis theory in an outline resembling Galen’s, simplifies the numerical details, and omits the astrological causation that Galen had associated with the lunar phases. It seems clear that Ibn Sina deliberately pared down the theory to its practical essentials. Building on the author’s editions of these Galenic works in Arabic, and his researches on the crisis tradition in Arabic, this paper examines the passages from the "Canon" that creatively reframe crisis theory, as well as from major commentaries on the "Canon", such as that by Ibn al-Nafis (d.1288), to try to determine how Ibn Sina’s critical simplification may have changed the subsequent medical tradition.

Learning Objectives

- 1) To understand how a complex Greek medical doctrine was transformed in Arabic, in response to the needs of physicians in their practice.
- 2) To appreciate the Canon of Ibn Sina in a new light, as a critique rather than a mere “codification” of Greek medicine.
- 3) To appreciate the dynamic and creative character of medicine in Arabic, even in the period (mistakenly) characterized as decline.

A6 Public and Private Responses to Disease and Disability

“Plague and Epidemic Nosology in Early Nineteenth-Century Britain”

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Plague, indisputably, vanished as a fact of life from the British Isles after 1666 (and Western Europe after the 1720-1 plague of Marseilles). Consequently, there has been a trend in the historiography to cast the contagion debates, encounters with epidemic cholera, and quarantine politics of the early and mid-nineteenth century as oriented towards new epidemic diseases and experiences. But in this paper, I argue that despite plague’s pre-modern pedigree, it was a crucial factor in shaping the public health debates of the nineteenth century. Coming from my work on the Mediterranean quarantine system, I will argue that the Revolutionary and Napoleonic period constituted a public health crisis during which yellow fever and cholera not only began to threaten Europe, but plague impinged on its borders. Second, I will argue that in the contagion debates which followed that period, plague appears as a disease that subsumes and trumps discussion of other epidemics. Here, I will be focusing particularly on the radical, anticontagionist doctor Charles Maclean’s efforts to force Parliament to reconsider the quarantine laws. In addition to the medical and political treatises mobilized in the contagion debate, I will draw on the plague imagery and plague experiences which are presented in Middle Eastern, as well as the diplomatic and administrative history of British involvement with the quarantine system. Throughout I will argue that the imaginative and practical challenge of plague colored the experience of all other epidemic diseases—particularly yellow fever and cholera—and also helped to lay down the political contours for the pioneering public health debates of the 1830s and 1840s. “Deepen understanding of illness and suffering.

Learning Objectives

Promote tolerance for the ambiguity of theories and the nature of evidence

Recognize the dynamic interplay of medicine and society throughout history

A6 Public and Private Responses to Disease and Disability

“‘Ignorant of the dangers of infection and disease’?: Factory workers understandings of and responses to ill health, c. 1900-1950”

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This paper explores New England textile workers understandings of ill health attributable to work and their associated responses. It argues that while most employers believed workers to be ‘ignorant of the dangers of infection and disease’, workers were very aware that certain workplace practices made them feel unwell, but lacked the medical discourse to label it. The dominant workplace health discourses included respiratory illnesses, noise and accidents. Workers adopted multiple strategies for addressing or managing the perceived health risks based on the state of the local economy, personal circumstances and their changing understandings of where responsibility lay for health – with the state, employers or workers. Such strategies included acceptance, spontaneous protests, creating safety measures, exiting the industry and seeking workplace reforms from employers and legislators. Using a combination of sources, including Reports from the State Board/Department of Health, U.S. Department of Labor, industry journals, employers’ association reports, newspapers and oral testimony, this paper furthers existing historiography surrounding occupational health by focusing on workers’ understandings of ill-health and their associated responses rather than employees, government or physicians. The New England textile industry in the first half of the twentieth century provides an ideal case study due to the industry’s influence on early health and safety legislation and the economic boom and recession as the core of the industry moved south during the interwar years. By placing the associated industrial health risks within their broader economic, social and political context, this paper suggests a model of behaviour whereby workers’ acknowledged various health risks, but the risks based on individual understandings of ill-health and risk, social and economic factors.

Hence, this paper moves away from the current polarization found within historiography about industrial illness and injury. Capitalist neglect and official indifference and compensation taking precedence before better standards of health and safety are three dominant themes, although the dynamics of the situation varied according to case study. Instead it provides further insight into the dynamic relationship between medicine and society.

Learning Objectives

1. This paper will deepen our understanding of illness and suffering, particularly at work.
2. It will highlight the dynamic interrelationship between medicine and society.
3. This paper will develop the capacity for critical thinking about the nature, ends and limits of medicine when faced by the challenges of economic necessity.

A6 Public and Private Responses to Disease and Disability

“‘Even a Day out Means that Someone Must Go Short’: The Mixed Economy of Welfare for Disabled People in the British Coalfields, 1880-1948”

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This paper seeks to examine the problems and processes of welfare for disabled people who worked or had worked in the coal mines, one of Britain’s most notoriously dangerous industries. When met with a long-term injury or disease during his work, the coal miner often had to consider the availability of welfare as a matter of necessity and survival. As B.L. Coombes, a former miner in the South Wales valleys wrote in 1939, this process began from the moment a disabled miner stopped working: “most of us are living on our net week’s wages, and that even a day out of that means that someone must go short.

Using evidence collected from three coalfield areas in Britain (South Wales, Scotland and the North East of England), the paper will outline the development of some of the key methods of welfare available to disabled coalminers and some of the ways in which these varied according to region and case. It will be argued that welfare was varied and rarely restricted to one specific source, with miners exercising a degree of agency in planning their own futures. Even before the introduction and spread of state welfare schemes in the late 19th and early 20th century – such as the 1897 Workmen’s Compensation Act, the 1920 Miners’ Welfare Fund and the 1946 National Health Service Act – coal miners used a combination of employer schemes, friendly societies and the support of their local communities to confront the economic effects of disability. Moreover, once miners applied for welfare, they regularly found themselves being surveyed and denied relief due to the nature of their disability or even character. Miners could be excluded from joining welfare societies for “moral” reasons or, conversely, the emotional weight of a particularly “sad case” could ensure compensation.

By way of these examples, the paper will demonstrate the complexity and variability of disability provision in British coalfields and open up a model for a dialogue about the interplay of welfare, work and disability which can be expanded to different industries and countries.

Learning Objectives

- Promote an understanding of the importance of disability and welfare in the history of medicine
- Recognize the dynamic interrelationship between medicine and society through history
- Deepen understanding of illness and suffering

B1 Beyond Asylum Walls: Institutions of State and Society in the Making of Madness in Modern China, Korea, and Japan

“Periodic Crimes: Menstrual Mood Disorders in the Criminal Courts of 1920s Japan”

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A wild-haired, frenzied woman succumbing to her passions and committing an act of violence—such was the image of the female criminal in early twentieth century Japan. When put on trial, she was asked to describe, amongst other things, the timing and nature of her menstrual cycle. Some psychiatrists and criminologists argued that during certain phases of menstruation, women suffered from mood disorders and other forms of psychological instability that made them prone to crime. This argument was often used as a defense strategy to diminish women’s responsibility for their illegal acts and reduce their punishment. Yet it also justified on scientific and legal grounds the image of women as passive subjects of uncontrollable physiological drives and emotions. Using forensic psychiatry reports submitted to the Kyoto District Court in the 1920s, this paper explores the creation of gendered notions of madness at the intersection of criminal law and psychiatric medicine in prewar Japan. It analyzes female defendants’ answers to questions posed by male psychiatrists, situating these exchanges within the broader historical context of the social problems of poverty, debt, and changing gender relations that many of the defendants claimed had triggered their crimes in the first place.

Learning Objectives

- 1) Develop knowledge and understanding of professional behaviors and values
- 2) Contribute to the improvement of patient care
- 3) Develop cross-cultural perspectives of illness

B1 Beyond Asylum Walls: Institutions of State and Society in the Making of Madness in Modern China, Korea, and Japan

“Between Illness and Deviance: The Chinese Madman in Sociopolitical Discourse, 1925-1937”

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This paper examines the ways in which madness was constructed among members of the Chinese political elite in the late 1920s and early 1930s. In spite of the fact that government legislation recognized the pathological basis of mental illness, many members of the KMT government continued to view madness less as a pathological condition than as a conscious orientation toward deviant behavior. Arguing that the corrupt and self-deluding nature of the Chinese individual had led to a stalled modernity, these men upheld the madman as a synecdoche for the cultural failings of the nation, and believed that the only means of attaining national modernity was by “fixing” the psychologically compromised individual. Influenced greatly by behavioral psychology and the Mental Hygiene Movement in the United States, KMT politicians attempted to employ scientific methodologies in order to stifle psychologically deviant orientations and behaviors. Deploying mental hygiene campaigns in schools and universities, promoting the importance of child psychology for the purpose of rooting out compromised behaviors at an early age, and aiding in the establishment of specialized hospitals (such as the Beijing Psychopathic Hospital, which was partially run by the KMT's Ministry of Hygiene), the KMT focused primarily on using psychology and psychiatry for the utilitarian purpose of national self-strengthening. Throughout this prolonged effort, the political elite straddled a blurry line between upholding the pathological basis of mental illness and blaming the madman for his own psychological deficiencies.

Learning Objectives

- 1) Develop knowledge and understanding of professional behaviors and values
- 2) Contribute to the improvement of patient care
- 3) Develop cross-cultural perspectives on illness

B1 Beyond Asylum Walls: Institutions of State and Society in the Making of Madness in Modern China, Korea, and Japan

“Volitional Possession and Self-Induced Madness in Early 20th-Century China”

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This paper analyzes a poorly understood idea witnessed in early twentieth-century China: that a person could willfully induce possession and that this occupied state, deliberately brought upon oneself, could metamorphose, also intentionally, into full-blown, irreversible madness. This notion of psychic disturbance and its etiology differs fundamentally both from the writings of scholarly medicine and from ideas found in popular religion. In China’s scholarly medicine, possession (ping 憑, yi 依, fu 附) and madness (dian 癲, kuang 狂, feng 瘋) were understood as provoked by a diversity of vectors, such as exogenous malevolent forces, as ghostly qi (氣), by thermal eruptions inside the body, fire (huo 火), or by internal physiological accumulations, mucus (tan 痰) (Simonis, 2011). In the religious, popular imagination of late imperial and modern China, menacing deities often coerced a person into the possessed state, first by visiting terrible suffering, poverty, debility, disease, madness, and even death on the person, and then bringing him or her back from the ruined state only to yoke the victim into servitude as a medium (Shahar, 1998). While esoteric Tantric Buddhism and certain sects of Daoism theorized that the possessed state could be willed into existence, and while we do find examples of self-induced possession being used as a weapon against one’s enemies, as a form of “soul-attack” (Strickmann, 2002), little is understood about what might be called the volitional possession-madness continuum in the mainstream imagination. This paper also aims to explore intriguing resonances with ideas circulating in early-to-mid-twentieth-century European and North American neurology, psychiatry, and anthropology: that passively acquired, self-induced, or even feigned possession could eventuate in a lasting insanity or schizophrenia.

Learning Objectives

- 1) Develop knowledge and understanding of professional behaviors and values
- 2) Contribute to the improvement of patient care
- 3) Develop cross-cultural perspectives of illness

B1 Beyond Asylum Walls: Institutions of State and Society in the Making of Madness in Modern China, Korea, and Japan

“Crazy in Combat: Case Studies of Mental Breakdown in the ROK Army during the Korean War”

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At the end of Japanese rule in 1945, only a dozen psychiatrists remained in Korea to treat an estimated population of 200,000 mentally ill. The outbreak of the Korean War five years later only exacerbated the mental health crisis as hoards of soldiers fell to the effects of psychological trauma on the frontlines. Lacking any experience in the subfield of military psychiatry, a handful of psychiatrists in the ROK Army’s Medical Corps looked to their American counterparts for assistance. This cross-cultural alliance between military psychiatrists of the two countries would place Korean psychiatry on a new trajectory closely modeled on the United States.

This paper draws on a collection of medical case studies authored by Korean military psychiatrists to illustrate a phenomenon I refer to as the “Americanization of Korean psychiatry.” Circulated just one year after armistice, it demonstrates how quickly Korean military psychiatrists applied the American frameworks they acquired during wartime in their own work. Psychological evaluations produced in the process emphasize the impact of historical context on the social and medical construction of a new group of mental patients: young men in uniform deemed crazy in combat. The history of psychiatry in South Korea presents a unique instance in which military psychiatry laid the groundwork for a broader civilian psychiatry apparatus in peacetime, not vice versa.

Learning Objectives

- 1) Develop knowledge and understanding of professional behaviors and values
- 2) Contribute to the improvement of patient care
- 3) Develop cross-cultural perspectives of illness

B1 Beyond Asylum Walls: Institutions of State and Society in the Making of Madness in Modern “China, Korea, and Japan

Intimate Politics of Life: Mental Health Law Reform and Family-Institution Cooperation in Contemporary China”

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The first National Mental Health Law in China, effective since 2013, establishes the family as the subject caring for, monitoring, and hospitalizing the mentally ill. The Law confirms Chinese psychiatric institutions’ de facto cooperation with the families since the 1980s, but it rejects other local and global historicities such as the anti-patriarchy discourse or the deinstitutionalization movement. This paper integrates interviews of legislators and medico-legal professionals with archival and media analysis of public discussions surrounding the law reform to examine why the family has become such a pivot in biopolitical governance, and how this selected historicity helps us understand progress and the rule of law in contemporary China. My finding suggests that psychiatry’s reliance on the family results not only from the neoliberal devolution of welfare provision to the private, but also from the translation of Confucian familism to a medical ontology. For both professionals and the populace, this familial love acts to prevent the (post-)socialist public power’s abuse of psychiatry. They also consider the family-institution cooperation as protecting China from the humanitarian tragedy of capitalism, which brings true privation to the vulnerable. I thus argue that a reconsideration of the fractal public/private divide and an investigation of how high politics and intimate politics intertwine are essential in understanding institutional power and the rule of law in contemporary China. I also contend that progress for this post-socialist country is not linear, but a pragmatic response to the imagined contemporaneity of tradition and modernity, capitalism and socialism.

Learning Objectives

- 1) Develop knowledge and understanding of professional behaviors and values
- 2) Contribute to the improvement of patient care
- 3) Develop cross-cultural perspectives of illness

B2 Global Ecologies of 'One Health'

"Partners Through Evolution: Linking Humans, Animals, and Parasites in the Early 20th Century"

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The 'One Health' movement seeks to integrate the fields of human and animal medicine, supporting its aims with a range of arguments about biological similarity and ecological connection between humans and other animals. Despite these appeals to biology, One-Health advocates, often veterinarians, seldom collaborate with biologists. And though they reference the shared biological origins of humans and animals, practical engagement with evolutionary biology is uneven and selective. Moreover, surprisingly little attention has been paid to the long tradition of research on the evolution of disease, in which the relationship between humans and animals has been a core problem. This paper will respond to this disconnect—between One Health and the contemporary sciences that would seem its most natural allies—by exploring research on the evolution of disease in parasitology and tropical medicine from the early to mid-twentieth century. By examining how evolutionary theory has informed animal and human disease research, this paper will find points of continuity between the One-Health agenda and biology, providing guideposts for potential collaboration. In so doing, it will also illuminate critical themes in the history of medicine, including the transmission of concepts and practices through collaborative networks, and the sometimes-fraught relationship between scientific and medical research and ideals.

Learning Objectives

- Understand the dynamic history of medical ideas and practices and their implications for the prevention and treatment of disease
- Deepen understanding of the close historical relationship between research on human disease and animal disease
- Recognize the dynamic interrelationship between medicine and the life sciences through history

B2 Global Ecologies of 'One Health'

"A 'joined' approach to disease: Ecology and collaboration in the World Health Organization's zoonoses program, 1950-1976"

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The World Health Organization is a leading driver behind the recent movement to integrate human and animal medicine under the rubric of 'One Health'. Over the last decade it has worked with animal health and wild-life organizations to produce a global framework for controlling diseases at the human-animal interface. While WHO interest and activities in 'One Health' have been propelled by new zoonotic threats such as avian influenza, they have deep historical roots, running through to the foundations of the organization. Since its inception in 1948, the WHO has maintained a Veterinary Public Health Section specifically dedicated to animal diseases with direct bearing on human health. Until the early 1970s, the Section was headed by the American veterinary scientist Martin Kaplan, who oversaw the development of major programs on zoonoses, food (animal) hygiene, and comparative medicine. During his tenure, Kaplan made the WHO a fulcrum for integrated approaches to human and animal disease control. This paper examines the history of the unit under Kaplan and details how it positioned animal health as a core problem of post-war international health. It highlights the key role of the Section's zoonoses program in forging together two critical ideas: that zoonoses had complex ecologies and that their control demanded collaboration between different organizations and experts. To show how these ideas were practically linked together, it traces the development of partnerships with the Food and Agricultural Organisation (FAO) in the 1950s and 1960s, which drew together experts from the medical, veterinary and biological sciences to set out "joint" approaches to selected zoonoses. The Section's pioneering studies on the ecology of influenza illustrate this approach and how Kaplan and his colleagues ensured that animal health remained a vital part of the WHO agenda.

Learning Objectives

Provide critical historical perspective on One Health and the role of the WHO in its development.

Demonstrate the importance of collaboration in international health.

Deepen understanding of the ecological approaches to human and animal disease.

B2 Global Ecologies of 'One Health'**"Plague and the Language of Endemic Diseases"**

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Between the 1860s and 1950, the "third pandemic" of bubonic plague spread globally via infected rats, ships, and people through urban "plague ports." Public health officials in ports of entry in former settler societies—South Africa and the United States among them—blamed Asian immigration and severely disciplined the "foreign" people, rats and fleas thought to have imported the disease. To their shock, the disease appeared again within a few years, this time among native white farmers living inland, and "sylvatic" (wild) animals. As South African plague investigator J. Alexander Mitchell put it, the discovery of a link between sylvatic plague and human epidemics was a "rude awakening" that "opened a new chapter in the history of plague" and changed the identity of the disease. This paper considers the ways in which biomedical scientists from various disciplines worked out theories of endemic disease to account for the persistence of plague in "new" landscapes. I argue that ideas of endemicity, and the language used to describe this phenomenon, emerged from the attempts of South African, Russian, Chinese, and American physicians, veterinarians, and biologists to explain how bubonic plague and other diseases became established in new places and new species. The problem of understanding plague as a larger biological phenomenon required the cooperation of scientists with differing expertise and disciplinary affiliations, but it also exposed tensions inherent in this "one health" approach. By the 1960s, I conclude, a more coherent theory of disease endemicity had coalesced around the plague investigations of the previous decades. No longer could public health officials hope that "the disease had been completely eradicated from the country," nor was it ever likely to be eradicated—a conclusion that has reverberated through the decades to inform our current concerns over emergent and re-emergent diseases.

Learning Objectives

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

B3 Rethinking Histories of Cancer

“Writing the History of a Recalcitrant Disease: A History of Lung Cancer”

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Much excellent work has been published in recent years on the history of cancer: research, the treatment of cancer, and the history of individual malignant diseases. In these histories, as in the historiography of medicine more broadly, progress narratives easily outnumber histories of failure and disappointment. Historians of science, technology and medicine by and large, tend to display a somewhat paradoxical attitude to progress. While a declared aim has often been to contextualise practitioners’ claims about scientific and technological progress, we have nevertheless tended to focus on stories that epitomize such progress: innovative surgical procedures, artificial organs, the place of the laboratory in medicine, new medical technologies or other science-driven innovations such as medical genetics.

My paper aims to contribute to the history of failure and frustration in medicine and medical science. My case study is lung cancer. Where historians have written about lung cancer, this was mostly on the successful epidemiological work leading to the identification of tobacco smoke as the main cause of this disease, which has indeed acquired iconic status. I will look at clinical research and everyday practices, and the mostly futile quest for a cure. Chances of survival for patients diagnosed with lung cancer have improved very little over the last three decades; surgery as the mainstay of therapy hardly changed between 1950 and 2000. Attempts to apply approaches such as chemotherapy, successful for other cancers, yielded frustrating results. Based on a wide range of published and unpublished sources, my paper discusses how clinical researchers, patients, and others involved in often futile efforts to revolutionise the treatment of a recalcitrant disease, have dealt with this dilemma." "Develop the capacity for critical thinking about the nature, ends and limits of medicine

Learning Objectives

Deepen understanding of illness and suffering

Identify successes and failures in the history of medical research, especially on cancer

Critically appraise clinical management from a historical perspective

Help patients develop realistic expectations regarding treatment outcomes

B3 Rethinking Histories of Cancer**“Cold War Era International Cancer Collaboration”**

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For much of the twentieth century, cancer was thought of as a disease primarily afflicting the denizens of more affluent nations. It was often hypothesized that malignancies were caused by such factors as environmental toxins and lifestyle trends that were characteristics of a specific country or locale. In the wake of World War II, however, a number of organizations dedicated to fostering global collaboration in the fight against cancer gained prominence. These organizations worked collaboratively with national cancer bodies, but also competed with them for governmental and charitable funding. In order for international organizations to thrive, they needed to convince scientists, clinicians, and funding bodies that understanding cancer at home required investigations that crossed borders. This paper examines the burgeoning of international cancer collaboration in the period from 1947-1970, with a focus on the intensive American government support for international projects during the period. Against the backdrop of the Cold War, the US government invested heavily in international cancer organizations that brought researchers from both sides of the conflict into contact with one another. Indeed, during the period, the government officially offered to support the transfer of radioactive isotopes from the US to cancer researchers abroad and even helped front the bill for a major international conference on cancer held at the Kremlin palace. The paper will argue that State Department officials tended to view investment in certain forms of international cancer research collaboration as beneficial to American strategic foreign policy aims. In turn, American munificence would help to entrench a specific set of organizational leadership models for collaborative scientific work traversing international borders. These models would not only aid in the expansion of work on cancer in less affluent settings, but would also contribute to the contemporary advent of so-called “geographical pathology,” a field dedicated to comparing disease rates in disparate locales. The success of international comparative epidemiological work would ultimately have far-reaching implications, leaving an important legacy in terms of the research tools that continue to be used to understand cancer causation and the dangers of environmental exposures.

Learning 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
- Critically appraise clinical management from a historical perspective

B3 Rethinking Histories of Cancer

“Reading Audre Lorde and a Black Lesbian Feminist Epistemology into the History of Breast Cancer, 1970s-1980s”

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More than a decade into the 21st century, breast cancer continues to be a pressing transdisciplinary topic. Histories of breast cancer often take narrative-based approaches to discern historical philosophies of the disease among largely white women patients and/or white male physicians and include Robert Aronowitz’s “Unnatural History” (2007), Ellen Leopold’s “Under the Radar” (2009) and “A Darker Ribbon” (2000), Barron Lerner’s “The Breast Cancer Wars” (2001), and James Olson’s “Bathsheba’s Breast” (2005). White breast cancer histories may mention, if at all, Black Lesbian Feminist Audre Lorde’s narrative of breast cancer through a mere utterance to her journal-style writings, “The Cancer Journals” (1980) and “A Burst of Light: Living with Cancer” (1988). Even Keith Wailoo’s “How Cancer Crossed the Color Line” (2011), which takes the intersection of race and cancer history as its point of departure, barely makes any mention to Audre Lorde. Utterances of Audre Lorde’s works not only erase her from breast cancer historical discourse, but also disregard the Black, Lesbian, Feminist epistemological significance of her critique. While literature remains the dominant field and method of engaging Audre Lorde’s work with respect to narratives and concepts of breast cancer, such as Robina Josephine Khalid’s “Demilitarizing Disease” (2008) and Kristen Gardner’s “Disruption and Cancer Narratives” (2009), it criticizes rather than analyzes Audre Lorde’s philosophies of breast cancer, takes an ahistorical approach, and/or ignores the specificity of her Black Lesbian Feminist subjectivity. It is from this status of the scholarship on Black women within histories and literary critiques of breast cancer that the current paper considers Audre Lorde’s work in the late 70s to late 80s as the seeds of what this paper calls a “Black Lesbian Feminist epistemology of breast cancer.” Following the emancipatory nature of the Black power movement of the late 1960s to early 1980s with which Audre Lorde has been associated, her epistemology is intrinsically oppositional to historical dominant notions that deem breast cancer as a product of civilization and a woman’s individual responsibility, as arising from faults in womanhood, emotional weakness, and risk, and as a metaphor of U.S. wars, particularly the Cold War.

Learning Objectives

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

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

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

B4 Race and Identity in 20th Century Medical Practice

“The Queen’s Jews: Race, Religion and Change in 20thC Medicine”

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Admission practices of medical schools have long intrigued scholars; several studies trace quotas on women and blacks. Although restrictions on Jews and other minorities are known to have existed, few studies address exactly how these policies operated. Using a century of statistics from one Canadian university, this paper begins to fill that gap.

Queen’s University Archives holds the registration cards of all medical students admitted in its more than 150 years. Students were required to state “religious denomination” until the graduating class of 1980. The information was entered into a computerized database. Results were correlated with policies described in the Minutes of the Faculty and university Senate, policies elsewhere, and with the dramatic conflicts and social change of the twentieth-century.

In the collection of 4173 registrations—219 were Jews, unevenly distributed through time. At first, the school accepted no Jews, but it trained a significant number of black students. However, in 1917, the faculty banned admission of blacks, blaming its decision on the hostility of townsmen. The first Jewish graduate took his MD in 1918; the next came three years later. Thereafter, approximately one Jewish student was admitted yearly for a decade.

Numbers of Jewish students climbed into the early 1940s. This openness contrasted starkly with anti-semitic attitudes elsewhere in North America. Students came from other provinces and from the United States. But things changed dramatically after 1942. Queen’s Trustees expressed their disapproval of Jewish students. The University began keeping statistics on race. The number of Jewish students dropped and remained low into the 1950s and beyond.

Interviews with alumni bring the statistics up to the present and reveal another period of restricted entry for Jews, women, and other minorities that affected medical graduates into the early 1990s.

This study uncovers a surprising degree of tolerance in one city during the 1930s. It also shows how that openness collapsed in the 1940s under the influence of affluent alumni who pressured the university to align its policies with discriminatory practices elsewhere. Finally, it provides a methodological example for further exploration of minorities in the academy.

Learning Objectives

1. To understand factors influencing physician identity in terms of race and religion.
2. To explore the social, economic, and political factors that shaped ethical norms in medical education.
3. To identify a method for gathering evidence about medical admission practices.

B4 Race and Identity in 20th Century Medical Practice

“The Unreconciled Legacy of Daniel Hale Williams: Medical Reform in Chicago’s Early-Twentieth Century Black Medical Community”

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Although one of the most noted black doctors in Chicago medical history, the legacy of Daniel Hale Williams is remarkably incomplete. Widely acclaimed for performing the first successful “open heart” operation, Williams’ image as an elite surgeon and representative “race man” has dominated popular historical accounts of his career. But while his professional achievements have garnered respect and admiration, among his contemporaries, Williams may have been equally (if not more) well-known for his controversial efforts to implement major reforms in the black medical communities where he served. While recognized for his professional skill and achievements, Williams’ reform endeavors often evoked bitter resentment from black colleagues who doubted their practical value and questioned his commitment to the education and training of black medical personnel. Exerting a notable influence over his reputation within the African-American medical community, the significance of Williams’ reform efforts have been largely overlooked by contemporary historians exploring his legacy.

This paper examines Williams’ historical role as an advocate for reform during the late-nineteenth and early-twentieth century. It explores his involvement with the founding and administration of Chicago’s integrated Provident Hospital, his efforts to implement modern standards at Freedmen’s Hospital in Washington, DC, and his role in the founding and development of the National Medical Association. Although intended to expand opportunities for black practitioners and to bring black institutions in-line with the reforms championed by Abraham Flexner and the American Medical Association, my work demonstrates how Williams’ endeavors exposed deep divisions within the African-American medical community over competing models of professional legitimacy and divergent rationales for racial improvement. Although Williams’ historic legacy would ultimately celebrate him as a pillar of the black medical profession, Williams’ reform efforts generated such strong resentment that, at the height of his career, he found himself isolated from many of the organizations and institutions he had helped to create. By highlighting these apparent contradictions, Williams’ unreconciled legacy raises meaningful questions about the nature of historical memory, the relationship between racial and medical reform, and the implications of narrative plurality in the study of African Americans in the history of medicine.

Learning Objectives

- Develop a greater appreciation for the historically diverse interests and views found within the African-American medical community.
- Have a more nuanced understanding of the historically complex relationship between models of medical and racial reform.
- Recognize the dynamic interrelationship between medicine and society through history.

B4 Race and Identity in 20th Century Medical Practice

“Black Celebrities, Selfhood and Psychiatry in the Civil Rights Era: the Wiltwyck School for Boys and the Floyd Patterson House”

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This paper contends that a race-neutral psychologization of black interiority constituted one way activists imagined African Americans as both fully human and deserving of equal citizenship during the long civil rights era. Relying upon a mix of institutional records and memoir, the paper makes this case by examining how two black celebrities—Harry Belafonte and Floyd Patterson--constructed their sense of black male subjectivity in psychodynamic terms and publicly endorsed a unique institution, the Wiltwyck School for Boys. Opened in 1937, the Wiltwyck School for Boys, was a privately operated interracial reform school tucked away in New York's Catskill Mountains. At the time, most private agencies handling so-called “juvenile delinquents” in nearby Manhattan racially discriminated against children of color, creating an artificial shortage of spaces in which courts could place black youth offenders. Created largely to help reduce this racial gap in care, Wiltwyck's disproportionately black student body was drawn largely from Central Harlem. Besides working to reduce this racial inequality in juvenile corrections, Wiltwyck's Board of Directors envisioned that the school would also combat racial disparities in mental health care delivery. Between the 1950s and the 1960s, this institution, expanded its therapeutic program into Manhattan, creating one of New York City's first psychiatric after-care programs. Singer-actor Harry Belafonte and the World's Heavyweight Boxing Champion Floyd Patterson, two “race men” linked to the civil rights movement, lent their support to Wiltwyck's fundraising efforts. The public support of heroic black male celebrities helped create the impression that the mental health of black children was a matter of civil rights import, underscoring the black psyche as both the very source of equality between the races and as a site where racial progress could be measured.

Learning Objectives

1. To help expand awareness of the part psychiatry and its concepts played in the construction of African American identity during the civil rights movement.
2. To demonstrate that African American leaders and activists linked to the mainstream civil rights movement did address issues of mental health disparities before Black Power movement made black subjectivity central to its agenda.
3. To insert African American contributions into the ongoing historical conversation about the role of celebrities in medical philanthropy and health awareness.

B5 The Transformative Role of Images: Anatomy, Surgery, Pathology

“Illustration and the Changing Nature of Dissection in the 16th Century”

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The 1530's saw an increasing number of illustrated, printed books devoted to anatomy. Works like Andreas Vesalius's *Fabrica*, Johannes Dryander's book on the head and brain and Charles Estienne's *De dissectione* combined a newfound enthusiasm for illustration with a reinvention of the process of dissection. For these authors, and others like them, dissection meant public anatomical demonstrations in which the range of parts of the body discussed and the methods of presenting anatomical details to the audience differed from what had come before, and illustrations played an important role in that process. Images allowed anatomists to display complete systems (such as the veins, arteries or nerves) to their audiences in a way difficult to see in a dissected body, and provided a method for in-depth exploration of parts of the body normally constrained by time and a limited number of specimens in public demonstrations.

In this talk, I will explore the role of illustrations in the public dissection process, suggesting that it was a new approach to public dissections that caused anatomists in the 1530's and 1540's to emphasize illustrations. Although illustrations in works like the *Fabrica* were often described by the authors of anatomical texts as substitutions for dissection, they actually played an important role in the dissection process as well. Vesalius's dissection at Bologna in 1540 and other sources reveal the number of ways that illustrations in printed books as well as drawings done on the spot during the dissection were used to support demonstrations of the parts of the human body that differed in content and approach from those found earlier in the sixteenth century.

A major emphasis of my talk is understanding the illustrations found in anatomical texts of the 1530's and 1540's in context. This means linking them to the dissection techniques of the time as well as considering famous works, like the *Fabrica*, in relation to less well-studied books, like Estienne and Dryander, to show larger trends in the role of illustration than are generally found by considering Vesalius in isolation.

Learning Objectives

- 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

B5 The Transformative Role of Images: Anatomy, Surgery, Pathology

“The Renaissance Surgeon at Work”

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Publications on surgery took a turn in the sixteenth century, appearing more and more frequently in the vernacular as well as in Latin. These texts contain a wide array of illustrations--anatomy, plants, instruments, and procedures--attesting to the transition of the discipline of surgery. The transition might be cast in overly simplistic terms as a growing unease with the theoretical dimension of learned medicine. Surgeons were thinking and talking about their technical skill in new ways. The Venetian surgeon Giovanni Andrea della Croce published treatises in well known texts by other surgeons (especially by Giovanni de Vigo) and full-scale books of his own. This paper aligns his record of publication with the use of illustrations in order to understand the different functions of surgical illustrations and to locate Croce's 'workshop' images. I focus on his three 'workshop' images, which feature Croce the surgeon in a lavish setting and performing a craniotomy on a patient in three different ways. Given the organization and content of the images, the triptych suggests that both technical skill and technical variety were being advertised as values of the learned surgeon.

Learning Objectives

Develop our understanding of the professional development of the surgeon (in relation to learned or Latin traditions and in relation to the medical marketplace)

Highlight different perspectives on healthcare between physicians and surgeons

Emphasize the changing role of medical illustrations at different times

B5 The Transformative Role of Images: Anatomy, Surgery, Pathology

“Shifting Perspectives on Pathological Illustrations”

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In the early modern period there was no attempt to produce systematic representations of diseased states seen in postmortems. Nonetheless, several illustrations were published in ephemeral publications, collections of Observations, scientific and medical journals, and also in some anatomical and surgical treatises. What was the purpose of these illustrations and how were they received and used in subsequent times? While the initial motivation to publish them may have been to publicize “extraordinary” or even “monstrous” findings, progressively the emphasis shifted towards more representative cases. At the same time, the images produced in the past were reassessed and reinterpreted in a broader context. Bones played an especially important role in these transformations: besides being the most easily preserved body part, bones were often the domain of surgeons, who had a different take on visualization from physicians. My paper examines a small selection of pathological illustrations from the mid-17th to the mid-18th centuries, including those in works by Frederik Ruysch, and William Cheselden, highlighting shifting attitudes and concerns. These reflections point to the need to look at pathological illustrations not statically or exclusively from the perspective from which they were first produced, but also from a perspective evolving in tandem with the changing understanding and classification of disease.

Learning Objectives

Develop our understanding of the role of visualization in pathology

Highlight different perspectives on healthcare between physicians and surgeons

Emphasize the changing role of medical illustrations at different times

B6 Medicine and the Sciences of Difference in Latin America: Race, Class, Wealth, and Health

“Measuring Race and Health in the Yale Peruvian Expedition, 1911-1915”

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This paper examines the work of doctors and scientists who accompanied the Yale Peruvian Scientific Expedition in the exploration of the Andean highlands between 1911 and 1915. Sponsored by both Yale University and the National Geographic Society, the expedition is best known for excavating Machu Picchu and publicizing its “discovery” to the world. The scope of the expedition’s work, however, was much broader. Indeed, sponsors charged its participants with providing a “comprehensive scientific survey of the Andes,” in which medicine would play a key role. Participants not only carried out topographical studies and excavated ruins, but also collected a vast array of medical and anthropological information on contemporary indigenous societies. Comprising surgeons, ethnologists, and osteologists, among others, their branch of the expedition issued reports of illnesses common in specific highland communities and analyses of anthropometric data taken from hundreds of Quichua and Machiganga indigenous peoples. In doing so, and by comparing their findings to archeological data, they sought to determine the racial origins and racial fitness of indigenous peoples at the heart of the former Inca Empire.

By focusing on the writings and photographic records of two participants, surgeons Luther T. Nelson and David Ford, my paper documents the Yale Peruvian Expedition’s role in the development of transnational race science in the Peruvian Andes. Nelson and Ford accompanied the expedition in separate years, but each returned to the United States with anthropometric data as well as information on the prevalence of diseases such as goiter, smallpox, respiratory infections, and sexually transmitted infections. They also compiled hundreds of photos, in which they sought to document indigenous biotypes and problems of disease and poor health among indigenous peoples. Perhaps most importantly, however, both engaged Peruvian race scientists in Cuzco such as the physician Antonio Lorena, who studied the supposed “degeneration” of contemporary indigenous peoples and questioned their descent from the Incas. Through a close analysis of these materials, resulting publications, and communications with Peruvian researchers, my work argues that Yale doctors constructed the indigenous Andean body as a diseased, degenerate organism that bore little relation to its ancestors, and that impeded progress.

Learning Objectives

Understand the historical role of medical and scientific research in the articulation of notions of race and difference.

Acquire a historically nuanced understanding of the role of medical practitioners in scientific expeditions, and the relationship between such practitioners and their counterparts in Latin America.

Acquire a historically nuanced understanding of the uses of indigenous subjects in medical and scientific research in Latin America.

B6 Medicine and the Sciences of Difference in Latin America: Race, Class, Wealth, and Health

“Recording Race and Class on the Margins: Medical Commissions in Rural Mexico, 1925-1955”

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In the first decades of the twentieth century several sanitary commissions fanned out across rural Mexico to study and document cases of malaria, river blindness, and tuberculosis, among other diseases. In careful prose doctors and medical students painted a somber picture of the nation’s unhygienic countryside. Mexico’s southern states received particular attention for it was believed that the nation’s Indigenous were especially unsanitary and prone to disease. Though written in the early twentieth century, reports from these regions followed a narrative style that mimicked colonial accounts of discovery and survival among uncivilized people. The portrayal of Indigenous Mexicans is especially striking because it echoed contemporary academic debates about the ‘Indian problem.’ These reports allow us to chart changing health concerns over time—for instance, alcoholism to diabetes,— and how race was tied to uncleanliness and disease. Yet, one also notes a change in how the nature of the health problem is explained over time. For example, a mere two decades later, in the 1940s and 1950s, culpability slowly begins to shift from a question of race to one of class. Focusing on the reports sent by doctors and medical students this paper examines how health practitioners sometimes used veiled academic language to transcribe racial prejudice into medical reports. By examining the language and the focus of these reports we gain a more accurate picture of how doctors influenced perceptions of rural Mexican and how they, in turn, were influenced by contemporary discussions of race and class.

Learning Objectives

This paper will help us:

- 1) further understand how disease in the margins helped define the role of physician in Mexico
- 2) analyze the practice of medicine in a rural context
- 3) examine the integral role played by physicians in characterizing indigenous populations

B6 Medicine and the Sciences of Difference in Latin America: Race, Class, Wealth, and Health

"La Pieza de Indias: Quantification, Mercantile Exchange, and Bodies in the Early Modern Atlantic"

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From 1662 to 1669, the slave trading company led by Genoese financiers Domingo Grillo and Ambrosio Lomenin held the Asiento de Esclavos, the Hapsburg-Crown contract, giving them monopoly over slave trade to the Spanish colonies. Before being granted the contract, the Grillos' company standardized a set of numeric measurements that allowed them to normalize the value of human bodies and their parts – measurements that became standard practice for the trade in Dutch, French, Portuguese and Spanish slave markets during the following decades. Slave traders had performed physical examinations to appraise human merchandise since the earliest era of written record, but it wasn't until the explosion of the transatlantic slave trade in the seventeenth century that specific units of measurement became an absolute necessity for commercial exchange. The involvement of complex trans-imperial mercantile and financial networks including the Spanish Crown; African traders; Dutch, Spanish and Italian insurance and financial companies; Portuguese, Spanish, Dutch and British slave trading companies and individuals; and a vast intercontinental bureaucracy pushed for the standardization of slave bodies' attributes and their diseases. Using hitherto unexplored sources in British, Dutch, Colombian, Spanish and Portuguese archives, this paper explores how a group of European, African and American slave traders, physicians, financiers and crown functionaries conceived in the 1650s and 1660s of the specific monetary value of the slave exchange body unit of the "Pieza de Indias." The paper examines how these mid-seventeenth-century Atlantic actors made categories of disease, body parts and old units like Pieza de esclavo measurable. This episode in the history of ideations around the human body exemplifies a confluence of different ways of producing knowledge about the body. The Pieza de Indias determined the value - and fate - of millions of Africans sold into bondage during roughly two centuries. Few other contemporary developments in the ideation of the body had a larger impact on the lives of so many people across the Atlantic.

Learning Objectives

1. Understand the dynamic history of medical ideas and practices.
2. Promote tolerance for ambiguity of theories and the nature of evidence.
3. Recognize the dynamic interrelationship between medicine and society through history

C1 Rethinking Hotness and Coldness of Drugs: A Cross-Cultural Conversation

Japanese Synthesis; The Case of Bagnon

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The standard narrative is that the Japanese abandoned traditional medical practices in favor of western, particularly German, medical practice during the Meiji Restoration (1868-1912). How real was this transformation? Did the top-down adoption of western medical practice overwhelm traditional medical concepts?

Bagnon is an injectable pharmaceutical that was a combination of Caffeine and quinine. It was developed by the Japanese to treat malaria in the 1930's and was extensively used during the Second World War. It was a drug that had no counterpart in western practice and was emblematic of the Japanese use of cardiovascular stimulants, such as vita camphor or caffeine sodium benzoate, lobelin or cardiazol, for the treatment of febrile illness, such as Malaria. Western medical practice did not use stimulants in the treatment of malaria, given that there is no reference to it in western medical literature between 1918 and 1955. Comparable American literature did not have a similar emphasis.

This paper, in exploring the implications of Bagnon, will argue that it could represent the persistence of Kanpo (traditional medicine) despite the dominant western model. Kanpo attempted to balance of the life forces of yin and yang. Heat was believed to injure the heart. The way to counteract malarial fever (yang) is to strengthen the heart (yin). Since, according to traditional beliefs, the heart controlled the spirit, Japanese surgeons attempted to ensure their patients' survival by protecting and fortifying the organs that controlled their patients will to live.

Learning Objectives

- Recognize the dynamic interrelationship between medicine and society through history
- Understand the dynamic history of medical ideas and practices and their implications in the practice of healthcare.
- Promote understanding of the theories and their implications toward the practice of medicine.

C1 Rethinking Hotness and Coldness of Drugs: A Cross-Cultural Conversation

“Food and the Humors in Isaac Israeli’s “Universal and Particular Diets”

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Medicine emerged as a rational system of theory and investigation in Europe during the 12th century with the integration of classical Greek natural philosophy as transmitted by the Arab world. In the new model of Salernitan and Scholastic medicine after the 12th century, it was understood that therapeutic intervention needed to be based on an underlying 'scientific' understanding of the humors and structures of the body and the nature of disease. The appearance of theory-driven medical texts during this period was due in no small part to the Arabic to Latin translations of Constantine the African in the late 11th century. This paper is centered on two works adapted by Constantine from the Arabophone physician known as Isaac Israeli (9th-10th c.), whose name is preserved in Latin translation and who thus becomes, in a way, the face of the new Arabic medicine. The works of Isaac are found in wide dissemination in Western Europe by the mid-12th century and formed part of a canon of medical instruction.

This paper will concentrate on the medieval Western understanding of the hot and cold humors, as seen through two of Isaac’s texts. His discussion of foodstuffs and their medical properties, found in the “Dietae universales” and the “Dietae particulares,” provides a lens through which to study the characteristic Western medieval medical treatment—regulation of diet—and the dominant medical theory of the body’s four qualities—hot, cold, wet, and dry. In their analysis of the humors in the body and in food, and the interaction between the two, the “Diets” bridge a gap between theoretical and practical medicine that is concretizing during the 12th century. Isaac’s medical discussions of hotness and coldness and their associate humors are also complemented by his philosophical works, translated by Gerard of Cremona around the mid-12th century, which posit a generative order of the qualities and elements, beginning with heat. This paper will thus discuss and contextualize the “Diets” to analyze the medieval understanding of hot and cold in the body and in the use of food as medicine.

Learning Objectives

1. Recognize the dynamic interrelationship between medicine and society through history.
2. Promote tolerance for ambiguity of theories and the nature of evidence through a historical perspective.
3. Understand the dynamic history of medical ideas and practices.

C1 Rethinking Hotness and Coldness of Drugs: A Cross-Cultural Conversation

“The coldness and hotness of opium”

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Before the international ban on narcotics in the first part of the 20th century, opium was a widely used substance in both Chinese and Western medicine. With the advent of analytical chemistry opium was broken down in active ingredients such as morphine and codeine and its properties were reduced to them. But how was opium understood before chemical analysis? In this paper I will look at materia medica and pharmacological treatise from both China and the West and deduce the drug temperature properties assigned to opium. This comparative undertaking will allow us not only to see how opium was understood by the medical elites, but also to peer into the causes of the divergent cultures of opium in China and the West. The Chinese opium den, for instance was not a mere social place of consumption of intoxicants like the pub. It was equally a place governed by medical rules. Opium’s temperature for instance meant that, nuts and sweets had to be served alongside for the sake of compensation. Because it was considered a stimulant and afrodisiac, it was often associated with prostitution, therefore the presence of women in opium dens. Its poisonous properties (毒) had to be tempered by mixing the paste with orange peel and other substances. In the West, on the contrary, opium was considered, on the whole, not a stimulant but a sedative. Its properties of cooling fevers, acting against diarrhea and malaria were particularly extolled. While in China its weakening effects on the users was ritually cited, the British praised its martial qualities when consumed by their Indian subjects.

Learning Objectives

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

C1 Rethinking Hotness and Coldness of Drugs: A Cross-Cultural Conversation

“Reflections on Hotness/Coldness and Toxicity in Chinese and Greek Pharmacy”

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Classical Chinese pharmacy often prescribes toxic substances, many of which are understood as hot. For example, one of the most commonly used drugs in Chinese medicine is aconite (fuzi), a highly toxic and hot drug that has diverse therapeutic values. This paper intends to explore the logic that connects hotness to toxicity in the fledging era of Chinese pharmacology (3rd to 7th century). I will examine a few medical works and personal accounts of ingesting hot drugs to demonstrate how bodily experiences, often intense ones, generated by these drugs informed a person's understanding of their therapeutic powers in medieval China. The line between remedy and poison, though, is thin, due to the potent nature of these drugs. Improper use of them often led to devastating consequences. As a result, medieval China witnessed heated debates on the use of hot and toxic drugs among physicians, social elites, and religious practitioners. This paper will examine some of these debates and show how they transformed the perception of hot drugs at the time. Finally, I will conduct a preliminary comparative study between Chinese and Greek pharmacology. Classical Greek pharmacy, capably shown by the works of Dioscorides and Galen, often defines poisons as cold substances. The contrast with Chinese pharmacy provokes us to contemplate different bodily experiences induced by drug intake and different understandings of toxic substances in these two cultures.

Learning Objectives

- (1) To understand how bodily experiences inform a patient's pharmacological knowledge
- (2) To explore how debates in the intellectual and social circles transformed the understanding of drugs
- (3) To reveal the divergence of pharmacological tradition in two different cultures

C1 Rethinking Hotness and Coldness of Drugs: A Cross-Cultural Conversation

“Regulating Chinese Materia Medica in Australia: The Yin and Yang of Yao, Du, Poisons and Drugs”

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According to Wu Youxing 吴有性 (c. 1580–1660), the founder of the Wen Bing School of Medicine in premodern China, “things or matter are products of the transformation hua 化 of qi, while qi is a resultant product of changes in things. Hence we can say that qi is matter while matter is qi. Knowing that qi can put matter into order (zhi 治) then we know that matter can put qi into order. Matter or things that put qi into order are referred to as yaowu 藥物 [medicinal] matter.

From this simple, irreductionist understanding of medicinal matter, or yaowu, I see medicinal matter or materia medica as routine therapeutic practices designed to move and transform a patient’s qi. And these therapeutic practices or medicinal treatments and materials include acupuncture, chronoacupuncture, materia medica prescribing, food therapy shiliao, emotional counter-therapy, qi exercises like Taijiquan and qigong, traditional Chinese massage, tuina etc.

The practice of materia medica prescribing involves the use of ‘materialities’ or wu to treat or cure diseases manifesting as ‘clinical patterns’ or “manifestation types” zhenghou. These ‘materialities include plants, animals, grass, trees, insects, stones, grain water, fire, earth, vegetables, fruits and melons, scaled creatures, shelled creatures, fowls, implements and utensils, beasts and human-derived materialities or substances like hair ash which has qi, body, colour, flavour, form, nature, ability and strength.

This paper will look at issues surrounding the regulation of materia medica in Australia such as the differences between drugs and materia medica; the notion of ‘toxicity’ or du in both traditions of health care; and the ancient craft and technology of ‘concocting materia medica’ paozhi.

Learning 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. Critically appraise clinical management from a historical perspective.

C2 Probing the Limits of “Method” in the History of the Neurosciences

“The Process of Forced-Migration as ‘PR Process?’ German-American Psychiatrist Lothar B. Kalinowsky (1899-1992) and the Trans-Atlantic Transfer of the Electroconvulsive Therapy Approach”

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The German-American psychiatrist and neurologist Lothar B. Kalinowsky is an example of a highly innovative and multidimensional researcher of clinical neuroscience, who functioned exceptionally well in both scientific cultures – earlier in the field of neurology (“Nervenheilkunde”) in Germany, as well as during and after his forced exile to the other side of the Atlantic, following a few years in Italy – despite the marked contextual differences, regarding the scientific pursuit, between the Charité in Berlin and his later workplace of Mount Sinai Hospital in New York City.

Kallmann was born in Berlin on December 28, 1899 and attended the Medical School of Friedrich Wilhelms University (now the Humboldt University). In 1926 he became a staff-attending physician in the Berlin Department of Psychiatry under the leadership of the Charité psychiatrist Karl Bonhoeffer (1868-1948), where he received a thorough training in biological psychiatric research methods. With the seizure of power by the Nazis in 1933, Dr. Kalinowsky was forced out of his position and had to leave Germany for the University of Rome. It was during those years in Italy that Kalinowsky learned about the first clinical attempts of neurologist Ugo Cerletti (1877-1963) to apply electroconvulsive therapy (ECT) in psychiatric patients, and he began to apply this technique himself.

Based on archival sources from the “Society for the Protection of Science and Learning” in Britain and the “Rockefeller Foundation Archives” in the United States, this paper attempts to reconstruct the process of Kalinowsky’s resumed migration from Rome in 1939 until he finally reached New York City. The picture that emerges from such an analysis shows Kalinowsky’s appropriation of the forced-migration process as a welcome opportunity to likewise promote electroconvulsive therapy in the various countries through which he migrated. Although his work had been well received by American biological psychiatrists, medical opposition emerged precisely from the strong influence of another group of medical refugees: German-speaking psychoanalysts, who strongly influenced clinical psychiatry in the US until the 1960s. Kalinowsky’s example can thus be interpreted as a double fracture brought about by the historical events pertaining to the forced-migration process.

Learning 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) Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

C2 Probing the Limits of “Method” in the History of the Neurosciences

“Between Clinic and Experiment: Wilder Penfield’s Stimulation Reports, 1929-1955”

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In medicine, the realm of the clinic and the realm of experimentation often simultaneously overlap and conflict, and doctors have to develop practices to negotiate their differences. The work of Canadian neurosurgeon Wilder Penfield is a case in point. Engaging closely with the nearly 5,000 pages of unpublished and hitherto unconsidered reports of electrical cortical stimulation that Penfield compiled between 1929 and 1955, I trace the shifting in his interest from the production of operation records and charts to help him navigate the brains of individual patients, to the construction of universal brain maps. Reading the developments of Penfield’s operation records over time, I show how he developed techniques to standardize and normalize his brain maps, showing the particular ways in which Penfield straddled the individual and the universal, and tried to align his clinical and scientific interests.

Learning Objectives

Learn to think critically about the nature, ends and limits of medicine

Develop an awareness of medicine's multiple, and sometimes conflicting, interests and functions

Get a fuller understanding of the patient and patient care in history

C2 Probing the Limits of “Method” in the History of the Neurosciences

“Re-Configuring the Parkinson’s Personality”

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This paper interrogates the impact of the changing historical discourses on the Parkinson’s personality upon artistic identity and experience of patients. It examines the invention of a Parkinson’s personality in 1913 and the impact of genomic insight and bio-psychological measurement in bringing about cultural shifts in its definition.

The paper argues that post-genomic scientific discourses on the relationship of Parkinson’s Disease and creative behavior contrast dramatically with the narratives of patients about the meaning of artistic endeavor as a transcendent experience.

The paper charts the historical development of two distinct cultural models of the relationship between ontology and emergence in Parkinson’s Disease each containing separate representations of what it means to be human.

Learning Objectives

- 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.
- Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.

C2 Probing the Limits of “Method” in the History of the Neurosciences

“Imaging Emotions: Reconfiguring the Social in Neuroscience”

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In the past decade or more, a spate of recent books and textbooks attest to the growing visibility of social neuroscience, a new sub-discipline in the neurosciences. The journal, *Social Neuroscience* began publishing in March, 2006, and in the early to mid-1990s the discovery of so-called “mirror neurons” by a group of neuroscientists based at the University of Parma, Italy, prompted a bevy of studies attempting to pinpoint the neurological basis for a large set of social emotions including disgust, the perception of pain in others, and empathy. Social neuroscience has been defined by the prominent University of Chicago neuroscientist, and editor of *Social Neuroscience*, Jean Decety, as comprising a confluence of methods from evolutionary, cognitive and social psychology, among other disciplines. This interdisciplinary venture has resulted in a large number of collaborations between neuroscientists and philosophers and psychologists of various stripes. Although much has been made of the current popularization of neuroscience as well as the incorporation of neuroscientific findings in the humanities, there has been much less attention paid to the ways neuroscientists have relied on the terms, language and methods of social psychologists in order to formulate methodological strategies for conducting a variety of imaging studies on the social emotions. This paper explores recent developments in these interdisciplinary ventures in social neuroscience and tracks some of their historical roots, arguing that neuroscientists have attempted to incorporate phenomenologies of a number of social emotions into their imaging studies.

Learning Objectives

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

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

C3 Beyond the Materia Medica

“Bed Therapy and Asylum Reform in the Department of the Seine c. 1900”

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From the standpoint of the twenty-first century, after the development of effective pharmaceutical treatments for mental illness, it is difficult to re-inhabit asylum doctors' enthusiasm about bed therapy at the turn of the twentieth century. Bed therapy consisted of simply keeping mental patients in bed for a period of time (ranging from a few days to several months) with the intention of alleviating psychotic symptoms, but for some doctors this practice heralded “a new era in the history of mental medicine” (Dr. Paul Sérieux, 1899). This paper examines the institution of bed therapy, or “alitement” in the Paris asylum system at the turn of the twentieth century, demonstrating that bed therapy aided asylum management and constituted a major therapeutic advance, enabling a renewed commitment to alleviating acute psychoses among asylum doctors in an otherwise pessimistic era. The paper is based in research conducted in Paris libraries and hospital archives, including medical journals and unpublished institutional records. The employment of alitement was part of a concerted, but since forgotten, movement to transform custodial asylums into treatment hospitals, and depended on the concurrent professionalization of nursing staff as well as the reorganization of the asylum interior. Doctors drew on clinical observation as well as new techniques of physiological data-collection to build support for alitement, and investigations of the effects of bed therapy constituted an integral part of the innovative research programs in the Seine Department asylums. Furthermore, bed therapy can be regarded as a forerunner of later developments, such as sleep therapy and the creation of the first antipsychotic drugs.

Learning Objectives

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

Acquire a historically nuanced understanding of the organization of health care systems

Understand the relationship between administrative concerns and patient care in hospital reform

C3 Beyond the Materia Medica

“The evolution of attitudes to therapeutic bloodletting for lobar pneumonia: 1890 to 1950”

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Today physicians use bloodletting to treat disorders associated with an excess of red blood cells or serum iron. But consecutive editions of textbooks indicate bloodletting survived well into the 20th century for many other conditions, including hemorrhagic stroke (treated by venesection or jugular arteriotomy), emphysema, (what we would term today) right heart failure, sun stroke, and notably, lobar pneumonia. Proponents and critics offered opposing empirical and/or physiological arguments about use in these contested indications. I will consider the evolution of attitudes towards use of venesection in treatment of lobar pneumonia in American textbooks of medicine from about 1890 to around 1950, focusing primarily upon that originally authored by William Osler. During this period, which included the emergence of the germ theory of disease, and the discoveries of the primary causative organism, serotype variation, type specific sera for therapy, sulfa drugs and finally penicillin, this textbook, which went through 16 editions (1892-1947) by three separate authors, continued to advocate bloodletting for lobar pneumonia, long after other widely used texts ceased to do so, if they ever had. Advice varied markedly with regard to early and late bloodletting. Initially Osler endorsed bloodletting in the early stage of the disease, apparently on empirical grounds writing “...a timely venesection may save a life...[But] to be of service, it should be done early.”. He despaired that usually it was put off until later, when, for rational "hydraulic" reasons, it should be successful as it was for what we would term right heart failure in vascular disorders, but, paradoxically, it was not. By the 8th edition 20 years later he was endorsing bloodletting both in the early and late stages. Gradually enthusiasm for early application tempered in the next eight editions, and in the last two, by Henry Christian, the author qualified Osler's "good practice" with "possibly". As far as I can determine, this widely used text was the last in the English speaking world to endorse early bloodletting in lobar pneumonia. When it ceased publication, a long tradition came to an end. I will review the background and apparent rationale for the changes.

Learning Objectives

To instill an improved understanding of the dynamic history of medical ideas and practices, as exemplified by the relatively recent changes in use of one of the most widely practiced therapies of all time.

To instill a greater awareness of the ambiguity of medical theories, and the nature of pertinent evidence.

To instill a greater recognition of the of the failure of “clinical experience” as a basis for medical therapy, as illustrated in the evolution of views of the most eminent clinician of the past century.

C3 Beyond the Materia Medica

“The Embodied Reader: Bibliotherapy and the Clinical Study of Literature as Medicine, 1940-1960”

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How does reading literature affect the mind and the body? Currently, an empirical turn in the humanities promises science-based answers to this question. Neurohumanists study readers by tracking their brain activities with MRI technology. Literary Darwinists claim to explain human responses to literature as functions of biological adaptations. And medical humanities proponents seek to harness reading’s effects to employ them as evidence-based medical treatment. At the same time, recent critiques such as Marjorie Garber’s “Use and Abuse of Literature” and Curtis White’s “The Science Delusion” denounce the medicalization of the humanities as yet another instance of rampant scientism.

The history of bibliotherapy offers a broader context for these recent attempts to study and apply the effects of literature as medicine. Bibliotherapy, “the treatment of patients through selected reading,” achieved prominence as a medical practice in the 1930s US. Librarians, hospital administrators, physicians, and psychiatrists who interacted with patients over books extolled the therapeutic value of fiction, non-fiction, and poetry in explicitly medical discourse. Books were “treatments,” “pharmaceuticals,” and even “cures” for mental and physical ailments. However, initial enthusiasm about bibliotherapy gave rise to concerns about the scientific basis for claims made for effects of reading.

In this paper, I chart the mid-century rise of the clinical study of the “embodied reader.” In particular, I examine the motives, strategies and implications of three influential studies of bibliotherapy: the Menninger Clinic studies of bibliotherapy in a neuropsychiatric hospital (1944); “Bibliotherapy: A Theoretical and Clinical-Experimental Study” (1950); and Veterans’ Administration studies of its national bibliotherapy hospital programs. (1944-1960). I explain the methods used by investigators to visualize and interpret how reading affected the mind and body; I also connect these attempts to the period’s broader cultural interest in understanding and managing the effects of reading, as evidenced by projects such as the Social Science Research Council reading studies. In so doing, I bring history to bear on interdisciplinary approaches to medical problems, especially those that attract humanists to participate on the established terms of research science and institutionalized medicine.

Learning Objectives

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

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

C4 Vaccination and its Discontents

“Anti-Vaccination Activism in the Age of Dr. Strangelove: Tales from the Secret AMA Archives”

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Concerns about vaccination have in recent years erupted on to the public scene with increasing frequency, and even fury. Parents express concerns about the connection between vaccination and autism, religious conservatives resist mandates for teenage girls to receive the HPV vaccine for cervical cancer, soldiers in Iraq protest anthrax vaccines, and thousands of healthcare workers refuse the immunization for the H1N1 influenza.

Such anti-vaccination activism has a long and strong history dating back to the 18th century. Its weakest period, however, was in the so-called golden age of American medicine in the mid-twentieth century. This paper will focus on both right-wing and left-wing opponents of vaccination from the 1920s through the 1960s, revising the standard perspective of these rebels against organized and expert medicine as being only dangerous and deluded cranks and instead revealing the complexities of their frequently democratic thinking.

An important part of the story of this activism is its primary archive. The American Medical Association's remarkable Historical Health Fraud Collection was the result of the decades-long activities of the AMA's Department of Investigation, which for many years was headed by Morris Fishbein. Fishbein and his colleagues spied on anti-vaccine organizations and activists, collected their newspapers and correspondence, and engaged in an active propaganda battle against their enemies. The story of this particular moment in anti-vaccination activism thus tells much about the quasi-state actions of non-governmental organizations, the construction of expertise, and debates about democracy during the twentieth century.

Learning Objectives

Identify successes and failures in the history of medical professionalism.

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.

C4 Vaccination and its Discontents

“Immunization Campaigns and the Politics of Preventive Health in the Early People’s Republic of China, 1949-58”

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Public health became a critical focus for the newly established People’s Republic of China in 1949. War, first with Japan and then between the Nationalist and Chinese Communist Parties, had ravaged China for eighteen years. These conflicts left epidemics in their wake. Cholera, schistosomiasis, syphilis, tuberculosis, and smallpox all threatened China in 1949. Following a directive to prioritize preventive medicine from Mao Zedong, Chairman of the Chinese Communist Party (CCP), China’s new Ministry of Health implemented a series of vaccination campaigns in the early 1950s. These initiatives provided mandatory, universal, and free immunization against a variety of infectious diseases, focusing on smallpox and tuberculosis prevention.

I argue that as mass immunizations popularized preventive health across China, they also became legitimizing tools for the authority of the CCP and an indicator of its growing power. Chinese vaccination campaigns after 1949 reached urban and rural populations on an unprecedented scale. They revealed the ambitions of the new state to eradicate infectious diseases. For example, by 1952, the Ministry of Health reported that it had vaccinated over 512 million people against smallpox in an effort to extinguish the disease. CCP publications in popular health journals argued that state-sponsored immunizations signified the ability of the government to prevent epidemics and provide health services, and that this capacity demonstrated that the CCP was a legitimate authority. The introduction of mandatory vaccinations also indicated the expanding scope of the Ministry of Health. For instance, health officials in the southwestern city of Kunming described incidents of local resistance to mandatory smallpox vaccination, particularly among elderly populations, suggesting that the Ministry used the campaigns to monitor its citizens and enforce compliance with its policies.

This paper draws upon health journals, posters, and archival research in China to propose that the act of vaccination after 1949 was not just a simple preventive health measure. It also subjected and defined Chinese people as citizens of the new People’s Republic. Building upon the works of Miriam Gross and AnElissa Lucas, I suggest that vaccination campaigns in the early 1950s made public health a fundamental component of governance for the CCP.

Learning Objectives

1. To acquire a historically nuanced understanding of China’s current health care system, particularly its preventive health apparatus.
2. To recognize the connections between medicine and politics as reflected in a national preventive health program.
3. To identify a key moment in the development of disease eradication strategies and in the history of global smallpox eradication.

C4 Vaccination and its Discontents

“This most dreaded disease of childhood’: Diphtheria, and the rollout of childhood immunisation programmes in the Irish Free State”

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According to the latest OECD figures relating to vaccination rates for diphtheria, tetanus, and pertussis, Ireland ranked 20th of the EU27 countries, recording a vaccination rate which has fallen below the recommended coverage rate of 95%. If we consider the World Health Organisation’s assertion that diphtheria is a disease ‘controlled by vaccines but waiting to resurface’, then we must consider the growing non-participation in childhood vaccination programmes as something less than a hopeful augury. The success or otherwise of childhood immunisation campaigns has always relied on public confidence. However, concerns propagated through social and news media continually serve to reinforce common misconceptions about immunisation, and undermine confidence in childhood immunisation programmes. In the West, active immunisation is becoming a victim of its own success; its enduring achievement has relegated the status of childhood disease to a level of relative obscurity. Many diseases have been consigned to history, but so too have the horrors and mass fatalities once associated with them. Debate around the safety and role of childhood vaccination programmes is of course necessary, but much of this discussion has taken place in the absence of a full understanding of the historical factors which have determined current polarised views on the issue. The historian of medicine and health is uniquely positioned to contribute to current debates by bringing historical perspectives to bear on present day public health policy issues. In that context, this research undertakes an investigation into the historical significance of diphtheria, and the roll-out of childhood immunisation programmes in Ireland. By undertaking an evaluation of political, medical, and social responses to historical diphtheria epidemics in Ireland, this research not only informs us about disease and medical knowledge at a given moment in time, but it may also offer a wider perspective on the current debate surrounding childhood immunisation programmes.

Learning Objectives

This paper will bring a historical perspective to bear on the current public health debate surrounding childhood immunisation programmes. It will deepen understanding of disease and illness by elucidating the all but forgotten heavy toll, which childhood diseases such as diphtheria levied on infant and child life in the pre- vaccine era. It will also present a historically nuanced analysis of the public health intervention designed to control diphtheria, an intervention which laid the foundation for the childhood immunisation programmes which remain central components of national healthcare systems today.

C5 The Early Practice of Medicine

“What’s in a Name: On Ancient Babylonian Medicines”

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In the study of the history of healing plants the knowledge accumulated by Ancient Babylonian practitioners is usually not taken into account, although Ancient Mesopotamia produced an extensive corpus of both prescriptions and treatises on plants which was transmitted over more than a millennium. The principal reason for this lack of awareness is certainly the state-of-the-art of publications on the pertinent cuneiform material; only 15% of the corpus of medical texts, written down on durable clay tablets, is available in up-to-date editions. One of the salient problems to understand Ancient Babylonian healing practices is usually sought in the sheer amount of terms for healing plants: as is often stated, since the plants cannot be identified, their medicinal properties cannot be corroborated. Another constitutes the fact that – characteristic for ancient and traditional medicines – remedies consist to a high degree of compound medicaments following the motto ‘a little is good, more is better’ and adducing that many diseases heal by time with or without treatment. However, often overlooked, Ancient Babylonian practitioners attributed quite specific properties to their healing plants using them as single ingredient of medicaments and they as well as their patients believed them to be sufficiently efficacious to ease pain and cure symptoms. The present paper focuses on two Babylonian plant terms elaborating the respective plant profiles, which include appearance, range of indications and the preparation methods attested. The aim is to shed light on the Babylonian ideas of healing and the proper workings of the body. In putting forward plausible identifications the possibilities and limitations to analyse the cuneiform evidence shall be discussed.

Learning Objectives

Recognize the dynamic interrelationship between medicine and society through history

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

C5 The Early Practice of Medicine

“Remedies, Recipes, and Registers: Apothecaries in Seventeenth-Century London and the Popular Practice of Physick”

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In the book stalls of seventeenth-century London a battle was fought between the medical establishment, embodied by the Royal College of Physicians, and authors of popular manuals of healing who promised to “make plain the practice of physick” and provide their audience with the means to diagnose and heal themselves. These easy-to-read advice manuals appeared in a wide variety of forms, from handbooks on the practice of physic and surgery to apothecary dispensaries and pharmacopeias. Written by well-known herbalists, physicians, astrologers and apothecaries, cheaply-printed popular medical texts provided readers with information on the specific properties of various pharmaceutical substances along with detailed advice on how to formulate and administer them. When one considers the numbers of titles and subsequent editions of the genre sold in seventeenth-century England, the demand for cheap medical advice by early modern consumers is clear. But how can we know if any of these readers actually followed the directions provided and formulated the various pharmaceutical remedies described?

To answer this question we must look for evidence of popular use in the inventories of a seventeenth-century apothecary shop. What materials were routinely stocked and sold by an apothecary? What was the cost of purchasing ingredients to formulate a cure described in a popular advice manual? From the ordinary to the exotic (and even a few toxic!), this study presents an analysis of the materials available to early modern consumers based on a series of seventeenth-century apothecary inventories. Linking theory to practice, the pharmaceuticals for sale are considered in light of the recipes advocated by popular medical advice manuals being sold in London during the same period. Receipts are also examined in order to determine which remedies were most often purchased directly from an apothecary and what other health services might be provided by these health care professionals. Considered together, popular medical advice manuals and the material content of a seventeenth century offer a surprisingly detailed picture of early modern health and healing.

Learning Objectives

1. Explain the relationship between manuals of popular healing sold in seventeenth-century London and the pharmaceutical cures sold through apothecaries.
2. Analyze the contents of a seventeenth-century London apothecary shop by sorting the contents according to origin, use, price and quantity.
3. Identify the most popular apothecary cures sold in early modern London, as well as the relative cost of pharmaceutical services and formulations."

C5 The Early Practice of Medicine

“Healing Tourism” in the Fourteenth Century Mediterranean: Searching for Healing from Saints and University-Trained Medical Practitioners”

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The title of my paper is an obvious play on the term “medical tourism” - a phenomenon in which people travel to other countries or regions for medication or medical procedures because they perceive they will get something in this distant place that they can't get at home. This could be access to a procedure or type of medication that is regulated where they live. It could be access to what people perceive as better, safer, or more effective treatment than what they have at home. Or health care could be more affordable in a distant place, opening up access to medical treatment that is prohibitively expensive at home.

I'm broadening the idea of medical tourism to the more encompassing phrase, “healing tourism”. This allows me to explore more diverse healing options that sufferers sought out in the fourteenth century. The western Mediterranean in the fourteenth century saw two main kinds of “healing tourism”: the perennial favorite, pilgrimage, and a new type, travel to famous physicians.

The study of modern medical tourism highlights both the advantages and the dangers of travel for health care. Medieval “healing tourism” had similar advantages. But travel in the fourteenth century posed significant dangers and difficulties. Choosing to travel for healing, whether to make a pilgrimage or visit a doctor, was a significant commitment, emphasizing both the great demand and high respect for the type of healing offered in a distant place.

Learning Objectives

Deepen the understanding of illness and suffering

Recognize the dynamic interrelationship between medicine and society throughout history

Develop a historically informed sensitivity to the diversity of patients

C6 Africanizing Biomedicine: Research Networks In Kenya and Uganda

“Reducing the Social to a Scientific Variable: The History of Anti-Tuberculosis Chemotherapy Trials in East Africa”

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Before the advent of anti-TB chemotherapy, medical authorities working in East Africa drew on a variety of explanations for the region’s rising tuberculosis rates. Drawing on reports from other parts of the British Empire as well as local observations, they explained tuberculosis in terms of biology, evolutionary narratives of human progress, and industrial development. However, after British researchers at the Medical Research Council initiated a series of anti-TB chemotherapy trials in the region in the 1950s, medical authorities working in East Africa began to describe the region’s tuberculosis problem in a homogenous way. In the course of these clinical trials, they began to frame tuberculosis in East Africa as a problem of economic scarcity and lack of access to medical resources, particularly tuberculosis drugs. If researchers could adapt technological interventions developed in the West to the resource-poor conditions of East Africa, they would find a way to relieve the developing world’s growing tuberculosis burden. This understanding of East Africa’s tuberculosis problem motivated subsequent anti-TB chemotherapy trials in the region, including the first six-month short-course chemotherapy trials. Researchers then reified and disseminated this depiction of East Africa as naturally resource-poor in their international publications on short-course chemotherapy, portraying East Africa as a proxy for the entire developing world in the process. Using the "East African Medical Journal" as a sampling device, this paper examines how medical researchers involved in the anti-TB chemotherapy trials in East Africa came to reduce social and economic determinants of disease to scientific variables and how such a reduction shaped health officials’ disease control strategies. It shows that the way health authorities conceptualized and described East Africa’s and the developing world’s tuberculosis problem shaped their proposed solutions as much as their proposed solutions informed their discourse. In doing so, this paper sheds light on East Africa’s role as a major site of knowledge production in the sphere of international health, not only in regards to tuberculosis control, but in regards to a generalized notion of the ‘developing world’ as well.

Learning Objectives

1. Critically appraise the relationship between the scientific and the social in medical research
2. Develop the capacity for critical thinking about the nature, ends and limits of medicine
3. Deepen understanding of medical knowledge production and circulation in an international context

C6 Africanizing Biomedicine: Research Networks In Kenya and Uganda

"Dr. Burkitt, I presume?" Africanizing Cancer in Uganda in the 1950s and 1960s"

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In 1958, the British Journal of Surgery published an article entitled "A sarcoma involving the jaws in African children" written by an Irish surgeon working for the British colonial medical administration at Mulago Hospital in Kampala, Uganda. Dr. Denis P. Burkitt argued that this disfiguring, fast growing tumor was the commonest childhood malignancy in Uganda. Although the tumor was fatal, unresponsive to surgical excision, and totally puzzling in clinical presentation, the paper went largely unnoticed. Burkitt spent the next decade or so charting the geographic distribution of the affliction and experimenting with nitrogen mustard and other chemotherapy regimens on patients. Using a camera, Burkitt documented extraordinary tumor regressions with chemotherapy treatments. Going on tumor safari, Burkitt and colleagues drove throughout eastern, southern, and central Africa, using these photographs and hospital records to establish a map of the tumor's geographical reach in sub-Saharan Africa—remarkably similar to patterns seen in yellow fever and malaria.

By the late 1960s, this childhood malignancy was named Burkitt's lymphoma and the National Cancer Institute opened the Lymphoma Treatment Center in Kampala to do randomized controlled trials of chemotherapy on this pediatric lymphoma. Over the course of two decades, cancer transformed in Uganda from a largely invisible and seemingly rare affliction into an exciting and cutting edge set of diseases to be researched, treated, and understood.

This paper explains how and why cancer became a visible object of medical care and research in Uganda in the 1950s and 1960s. I show how Burkitt's discovery of the lymphoma was contingent on the broader culture of medical research in Uganda at the time. I discuss how a fusion of missionary medicine ideals, ongoing hypotheses regarding the linkages between environments, insects, and tropical diseases, and emerging anxieties about postcolonial development and non-communicable diseases converged around the problem of cancer. Burkitt's lymphoma, with its shocking presentation and remarkable responses to chemotherapy alone, made cancer visible in Uganda. Longstanding inquiry into tropical diseases and infrastructure for medical care in the country made cancer research in postcolonial Uganda possible.

Learning Objectives

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

C6 Africanizing Biomedicine: Research Networks In Kenya and Uganda

“From Tropical Disease to Molecular Cancer: Burkitt’s Lymphoma, Epstein-Barr Virus, and the Global Politics of Biomedical Research, 1958-1978”

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During the 1960s and 1970s, the most likely site for proof of the then controversial theory of human viral carcinogenesis lay in the study of Epstein-Barr Virus (EBV) and Burkitt’s lymphoma, a childhood cancer largely found in parts of Africa. Inquiry into this relationship, the Yale physician George Miller noted in 1974, was remarkable for its “multifaceted approach,” combining the “perspectives of the cell biologist, chemist, clinician, epidemiologist, geneticist, immunologist, and virologist.” The “ultimate answer” to the question of human viral carcinogenesis, Miller maintained, would incorporate knowledge from the laboratory and from the field.

What Miller’s comments masked, however, was the degree to which EBV research spanned multiple continents as well as multiple disciplines. The effort to demonstrate a causal link between EBV and Burkitt’s lymphoma was deeply entangled with the politics of African decolonization and international public health. Burkitt’s lymphoma emerged in the context of a prior generation of tropical disease research sponsored by the British Empire and the Rockefeller Foundation. From 1968 to 1978, the International Agency for Research on Cancer and the American National Cancer Institute’s Special Virus Cancer Program oversaw an epidemiological survey in Uganda which sought to demonstrate a causal link between Burkitt’s lymphoma and EBV—an early example of a global health research effort at a time when most histories of biomedicine focus within the national boundaries of developed nations.

In following the material and intellectual circulation of EBV and Burkitt’s lymphoma, we gain insight into how and why biomedical research became a global enterprise. Here, I describe the movement of EBV research from Africa to the laboratories of the United States and Europe. I begin by discussing the regime of imperial public health in British East Africa which allowed the visualization of Burkitt’s lymphoma as a tropical disease. I then describe how the politics of decolonization and the Cold War framed Uganda as a promising site for epidemiological research into the theory of viral carcinogenesis. Finally, I outline the pathways created for the international circulation of EBV and Burkitt’s lymphoma also allowed for the removal of this research from Africa in the 1970s.

Learning 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

D1 Debating Smallpox Eradication

“A Transnational Environmental History of Smallpox Eradication”

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I approach smallpox eradication from the perspective of an environmental historian of the US-in-a-globalizing-world. I argue that smallpox eradication should be understood as a transnational effort to master the nonhuman natural world, animated by the drive to improve human health and the pursuit of US foreign policy objectives. In this story, the virus itself—as both a real thing as well as an idea—is an active character, provoking attention and action. But more broadly, the human/nonhuman natural world dynamic is at the center of this story, and it’s the way of making sense of this remarkable event in human history and all the different contexts in which it took place: the Cold War, American liberalism, postcolonialism, and the age of global terror. What emerges from this approach is both a celebration of the accomplishments of eradication and also a recognition of the limits and complex legacies of the program. Specifically, this story suggests, perhaps counter-intuitively, that the intersection of American liberalism and the Cold War, often framed in catastrophic terms, sometimes fostered remarkable successes—but also troubling limits.

Learning Objectives

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

D1 Debating Smallpox Eradication

"Cold-War Crisis, Smallpox Vaccination and the Pre-history of Surveillance: The US Centers for Disease Control in East Pakistan, 1958"

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In April of 1958 the Government of Pakistan called for international assistance to cope with rampant epidemics of smallpox and cholera in East Pakistan. Under these and other stresses the administration, including public health department, collapsed just as smallpox mortality reached alarming heights. A pro-Bengali political party stepped into this gap to organize a "Citizens Epidemic Control Committee" that assumed responsibility for vaccinating all of East Pakistan. By the time the epidemics subsided in July of 1958, 30 million Bengalis had been vaccinated. This degree of success depended on a reliable supply of vaccine—especially smallpox vaccine—from foreign donor governments and agencies under the auspices of the WHO. Hence the non-official Citizens Epidemic Control Committee was supported for three months by a team of epidemiologists from the US Center for Disease Control (CDC). The CDC had its own motive, which was to demonstrate during an epidemic crisis a novel epidemiological technique called "active surveillance" which, given real-time data on the location and timing of outbreaks, would pin-point where vaccination efforts should be focused most effectively. The actual vaccination work in East Pakistan, however, was in the hands of tens of thousands of enthusiastic student volunteers who had no interest in data collection. The confrontation of these approaches--volunteer-driven vaccination motivated by regional pride versus CDC-style field epidemiology based on timely data-collection and expertise—disturbed and embarrassed the CDC team.

Learning Objectives

Develop knowledge and understanding of professional behaviors and values.

By the end of this activity, the learner will:

Identify successes and failures in the history of medical professionalism

Recognize the dynamic interrelationship between medicine and society through history

Understand the historical impact of the CDC in field epidemiology, especially the application of "active surveillance" to global disease control and eradication programs

D2 **Problematizing the Categories of Medicine and Religion in Pre-modern Asia**

“Karma as Contagion in Classical Ayurveda”

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This paper examines the role of karma in select passages on embryological development in the Caraka Samhita, a foundational text of classical ayurvedic medicine. In classical Ayurveda karma plays a role in disease etiology as well as embryology, and it plays a particularly prominent role when these two intersect in passages describing the developmental etiology of individuals of non-normative genders and sexualities. Though there is traditionally no model of “contagion” understood in the Caraka Samhita, I suggest that in this context karma serves as an analogue of contagion, working both to transmit aberrant qualities to the physical body but also acting on social and moral levels. What is interesting here is that it seems to function this way specifically in relation to sexuality. In his recent book, *Somatic Lessons*, Anthony Cerulli, draws attention to narrative passages in ayurvedic literature that have been relegated to the margins by other scholars, in which the boundaries between the “religious” and “medical” dissolve and one is left with a healing system that can not wholly be accounted for by either term. He argues that these stories are “somatic lessons” written on the part of the text’s male authors to establish prescriptions for socially and ethically normative behavior. Mitchell Weiss argues that the interjection of the notion of *prajna-paradha*, “violations of good sense,” appearing in the Caraka Samhita as a key etiological factor for diseases, shifts the emphasis in discussions of karma to present behavior. Given the emphasis in the Caraka Samhita on the efficacy of action in one’s present life, the passages examined here, in which karma mediates between the behavior of parents and the physical, behavioral, and moral traits of their deviant offspring, seems to serve a similar prescriptive function. Like Cerulli, rather than explicitly distinguishing between the religious and the medical in the passages examined, I propose a softer distinction between the two that enables us to view karma theory as an important part of the conceptual framework around health, healing and illness in classical Ayurveda.

Learning 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,

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

D2 **Problematizing the Categories of Medicine and Religion in Pre-modern Asia**

“Talismans and the Materiality of Healing in Early Medieval Japan”

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This paper proposes to reassess the boundaries between medicine and religion by stressing the material dimension of talismans used for healing purposes in the Japanese early medieval period. The use of talismans and talismanic writing to protect and cure from a variety of afflictions is found across Buddhist scriptures and ritual instructions, as well as in well-known medical collections such as the *Ishinpō*. Drawing key examples from these sources, my paper argues that the therapeutic power of talismans is connected to their material and performative dimension, not necessarily to the symbolic associations they conjure. This material and performative potency is equally connected to the fact that the talismans are physically employed as part of specific therapies (produced, ingested, burned, worn, manipulated); as well as to their ability to create - literally give shape to - the reality of a cure by means of their utilization. In this sense, talismans can be seen to work as Austin’s performative utterances, that is, not by symbolic associations - i.e. they stand for the medicine - but by actively structuring the body as healed. By focusing on issues of materiality in connection to healing therapeutics, I am not referring to the analysis of inherent properties of an object - i.e. with its ‘active principle.’ Following the scholarship of Daniel Miller, I intend materiality as concerned with the agency of objects, and their ability of changing subjects, in this case, by healing them.

By stressing the affectivity of objects, I wish to move away from a strict division between medical strategies, involving the appropriate use of tools (needles, moxa cups) and substances (ointments, herbs and pills), and ritual/religious healing as being concerned with the manipulation of immaterial - at times spiritual – entities. Ultimately, this will provide the opportunity to ascertain the interlocking between sources and techniques belonging to what we may consider distinct field of knowledge.

Learning 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, the nature of evidence, and the evaluation of appropriate patient care, research, and education

D2 **Problematizing the Categories of Medicine and Religion in Pre-modern Asia**

“Collapsing Dualisms of Religion and Medicine in Chinese Medicine”

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The history of “medicine” or “doctoring” yi in China has traditionally centred on core traditions of acupuncture, moxibustion and pharmacology, individuals who wielded these techniques and the texts which theorise and describe them. This has been to the exclusion of a broad variety of therapies which were developed, promulgated and dispensed by a variety of practitioners whose activities are now normally considered the purview of historians of religion. This paper argues that while the category of yi was early known, the means by which it was distinguished from other knowing communities are not clear. Traditional histories which construct textual and intellectual genealogies do not reflect therapeutic realities where monks and priests dispensed the majority of therapeutic care. Modern appeals to Eurocentric notions such as rationalism, empiricism, or to doctors’ “learned” status do not reflect the prevalent ideas in early sources.

To better describe the impact of yi in relation to other knowledge communities local to medieval China, this paper advocates perspectives like those of Ludwik Fleck and Bruno Latour which foreground the temporal, social, bodily and practiced loci of knowledge and its production. It then provides an overview of the features by which different knowledge communities included or proscribed practices normally considered the purview of yi. This gaze reveals that the absence of a central, state-backed medical organization until the 7th century allowed for a much broader admixture of therapeutic strategies, which still characterize Chinese medical thinking today. Medical competition was much more even, and involved a variety of actors—Buddhists, Daoists, transcedents, trance-mediums (wu 巫)—whose textual records remain almost completely untapped in the history of medicine in China.

The paper then analyses a variety of ‘border-crossing’ passages from early medieval sources without prejudice to their “medical” or other origins. These compare, contrast or merge different contemporary epistemes, providing insight into the dominant factors by which different groups defined orthodox repertoires of practice. I argue for the importance of the ‘comparative encounter’ as a modification of Bourdieu’s “competitive field,” one which downplays the role of capitol, and allows for drives such as soteriological and therapeutic efficacy.

Learning 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

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

D3 Labors of the Insane

“Labour of the ‘Insane’: therapy or affliction?”

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This paper looks at occupational therapy, as a form of treatment, of those diagnosed as ‘insane’ in the asylums of Bengal Presidency in its lower provinces during the nineteenth century. The treatment of the insane in the asylums of Bengal during the period could be broadly categorised into three divisions: mechanical, moral and medical. By mid nineteenth century, the medical practitioners, which included Europeans, Eurasians and Indians attempted to supplant mechanical restraint by moral treatment. This shift in practice in the asylums of Bengal could be seen as a reflection of the measures adopted by late 1850s at the York Retreat, England by Daniel Tuke.

Moral treatment constituted of a form of therapy which de shackled chains off the feet of lunatics by engaging them into various activities. Those often included recreational or leisure activities, while the most crucial was the lunatics’ participation in asylum labour. It included gardening, cooking, and working as labourer for road constructions mainly by pounding bricks and production of several merchandised handicrafts. Labour in the asylum was regarded as one of the significant constituents of moral therapy. This paper investigates how ‘insane inmates’ were exploited as ‘prison labour’, without any financial payment, for colonial production. It looks at the engagement of insane in such activities by reinvestigating the existing definitions of insanity as argued by the doctors. It therefore, tries to argue and question the mental stability of a person diagnosed as insane while at the same time engaged in such hard labour. It also looks at the condition of labour in the asylums of Bengal in the twenty first century by taking one of the existing asylums as case study, thereby arguing how far such a practice which was introduced in the mid nineteenth century and is still practiced, as well as the different psychiatric medicines then prescribed and as well as now facilitated the cure of insanity.

Learning Objectives

1. It will provide an insight to the method of treatment in the colonial asylums of Bengal.
2. The study of one of the Asylums of Bengal in the twenty first century would help us to understand how mental illness is presently perceived and question how far the practice has changed since the nineteenth century.

D3 Labors of the Insane

“It would unseat the reason of nine out of ten prisoners’: Penal Servitude, Prison Regimes and Mental Breakdown in England and Ireland, 1850-1900”

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During his confinement in Reading Gaol in 1897, Oscar Wilde castigated prison medical officers for their lack of understanding of mental illness amongst prisoners, pleading for commonsense and pity when dealing effectively with mental disorder. In contrast to the intense scholarly engagement with asylums and mental hospitals over the last couple of decades, research on prisons as sites of mental illness and its management has been limited to a few sociological studies, which have tended to emphasise the impact of discipline and power in shaping interactions between medicine and prisoners. Yet from the early nineteenth century to the current day, reformers, policy makers, prison governors and medical officers have grappled with relentlessly high levels of mental illness among prisoners. They have also debated and contested the detrimental impact of prison regimes – from the separate system to solitary confinement, as well as overcrowding – on the mental health of inmates. Drawing on underexploited prison archives and printed sources, medical literature and the campaign materials of prison reform groups and taking examples from prisons in London and Dublin, this paper explores the management of mental illness between 1850 and 1900, a period which saw the creation of ‘modern’ and specialised prisons and prison regimes in both contexts. During the second half of the nineteenth century, prison medical services were formalised and medical officers compelled to balance their position as prison employers and upholders of discipline with caring for the health of their charges as medical professionals. The paper investigates high levels of diagnosis of mental illness among prisoners, and the association of mental disorder with criminality. It explores debates about the impact of prison regimes on the mental health of their inmates and the adoption of different therapeutic and management approaches for the treatment of diverse groups of mentally ill prisoners.

Learning Objectives

1. To develop an historically informed understanding of the relationship between prison systems and mental illness.
2. To deepen understanding of debates on the high rates of diagnosis of mental health problems amongst prisoners.
3. To consider the complex position of prison medical officers as both medical professionals and employees of the prison service.

D3 Labors of the Insane

“It is bad for a...person to be idle’: A Cross-border Look into Patient Labor at Saskatchewan and Washington Mental Hospitals”

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Since the early 1970s, North American mental hospitals have been the topic of many scholarly works. While the topics have ranged from the social and political as seen in David Rothman’s “Discovery of the Asylum,” to patient experiences in Geoffrey Reaume’s “Remembrance of Patients Past,” the majority of these works focused on institutions in the eastern parts of the United States and Canada. This disproportion in regional focus puts forth the notion that asylums in the west embraced and imitated the practices of their eastern counterparts and evolved at the same rate. From the physical attributes of the building down to the therapeutic regimen, the impression is that the west emulated eastern practices. However, by looking closely at labor, as practiced in one western Canadian and one western American asylum, I argue that not only were principles of moral therapy applied differently as these ideals traveled west, but once adopted they matured uniquely within their respective regions.

While keeping patient labor as the focus, I will show that the advancement of asylum practices were not level across either nation. Western asylums did not progress at the same rate as other asylums in their country, nor did they always attempt, or were able to meet the east in all their therapeutic ideals. The province of Saskatchewan and the state of Washington embraced patient labor in different ways. This disparity varied from country to country on down to individual asylums. Each region defined patient labor based on culture, understanding of asylum practices, government and social influences, but ultimately within the patient-superintendent relationship.

Learning Objectives

By the end of this presentation the learner will:

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

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

Recognize the dynamic interrelationship between medicine and society through history.

D4 Neurology, Psychiatry, and the Family

"History as a Research Tool: Norman Geschwind and the Birth of Behavioral Neurology"

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When Norman Geschwind (1926-1984) attended medical school in the 1940s his professors taught that behavior was unrelated to neuropathology. The focus of neurology remained the diagnosis and treatment of aphasias and epilepsies while cognitive impairments and developmental disorders were classified as functional (psychological) disorders best treated by psychoanalytically-trained psychiatrists. Geschwind was troubled by the fact that many of the patients he saw with neurological deficits also presented with behavioral (developmental) disorders. The idea that behavioral disorders, like autisms, stuttering, Tourette syndrome, and hyperkinesia (attention disorders), were somehow connected to brain pathology was viewed as heresy by psychoanalytic psychiatry. Geschwind's generation also had been taught that aphasias resulted from global rather than localized or focal neurological lesions. The advocates of this view—so-called holists-- targeted the work of aphasiologist Carl Wernicke (1848-1904) as an exemplar of the flaws of the localizationist hypothesis. Thus, there was no reason to read Wernicke or other German neurologists who supported his discredited theories. This view was reinforced by the dominance of psychoanalytic psychiatry of the 1950s and 1960s. Well before he developed his psychoanalytic theory, Sigmund Freud, in his 1891 book, *On Aphasia*, had published a scathing attack on Wernicke's science. In fact, Freud's critique of Wernicke, when carried to its logical conclusion, would ultimately inform his rejection of the physiological basis for developmental disorders in favor of a psychological etiology. Despite his desire to adhere to the dominant orthodoxy, Geschwind was increasingly troubled by the fact that many of the patients he saw with neurological deficits also presented with developmental disorders. Reading Wernicke in the original, Geschwind discovered a complex and multi-layered explanation for aphasias that implicated lesions located in associated pathways that when extensive resulted in behavioral disorders. Geschwind also reread the works of the holists, discovering that while their rhetoric rejected Wernicke, their explanations of aphasias actually reinforced Wernicke's hypothesis. Building on his reading of historical documents and his clinical experiences, Geschwind urged the resurrection of Wernicke's disconnection syndromes that Geschwind labeled as "Behavioral Neurology."

Learning Objectives

1. To demonstrate that historical methods provide crucial tools for diagnosis.
2. Reading classic articles on neuropsychology (and other medical conditions), rather than simply citing them, opens important clues for diagnosis and treatment of medical mysteries.
3. An examination of the creation of Norman Geschwind's "Behavioral Neurology," reminds us that persuasive medical hypotheses must remain tentative.

D4 Neurology, Psychiatry, and the Family

“The Parenthood Paradox: Psychiatry’s Impact on Lesbian and Gay Parental Rights:

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The American Psychiatric Association’s (APA) 1973 decision to declassify homosexuality as a mental illness had a profound effect on gay and lesbian custody rights. Prior to the declassification, few lesbians or gay men sought custody in court, correctly perceiving that, in the eyes of the law, their mental illness prevented them from being suitable parents. The declassification changed the legal landscape, making it possible for gay men and lesbians to assert their legal rights as parents. Gay and lesbian parents seeking custody of their children often relied upon mental health expert witnesses to establish that they were fit parents and that their sexual orientation would not negatively impact the psychological development of their children.

At the same time that gay men and lesbians were establishing their parental rights in courts, legislatures and administrative agencies were acting to prevent gay parents from adopting or fostering children. These legislative enactments and administrative regulations were based in large part on the fear that gay parents would hinder a child’s psychosexual development, preventing the child from achieving normative heterosexuality. States in all parts of the country, including Florida, Massachusetts, New Hampshire, Nebraska, and Arkansas, instituted laws or policies preventing gays from adopting or serving as foster parents, based on concerns for the psychological welfare of the children.

This paper examines these parallel developments, analyzing how psychiatric ideas were simultaneously used to bolster contradictory legal regimes. I will argue that these conflicting developments reflect the deep divisions within the psychiatric profession over the APA’s decision to declassify homosexuality as a mental illness. Drawing on archival material from the National Gay and Lesbian Task Force, the ACLU, the Daughters of Bilitis, and the papers of Judd Marmor, I will show how advocates and their opponents seized upon this fracture in psychiatric opinion to bolster their legal claims, comparing expert testimony and reports in custody litigation to psychiatric theories of child development upon which legislatures relied. In identifying the centrality of the studies to these gay rights battles, I will highlight the very political dimension of neutral, scientific thought.

Learning Objectives

Understand the dynamic history of medical ideas and law

Recognize the dynamic interrelationship between medicine and society through history

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

D4 Neurology, Psychiatry, and the Family

“Affirming the Family?': Challenging Masculinity and Redefining the Male Role in South Korean Family Planning, 1968-early 1980s”

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South Korea's ambitious family planning scheme (1964-early 1980s) has received a great deal of scholarly attention to date, especially in terms of the intervention of international organizations and the wide array of technologies offered, with the “menu” of birth control remedies including the condom, the Lippes loop, and the birth control pill. At the same time, this literature suggests that the program focused almost exclusively on women in their reproductive years as the target demographic, which was far from the case.

This paper addresses the ambivalent role played by South Korean men during the two decades of intense Family Planning activity beginning in the late 1960s. Raised in a stridently anti-Communist, post-colonial society with mandatory military conscription, South Korean men found themselves subject to the message of the state at almost every turn. Along with the expected methods—e.g., the distribution of condoms, increased opportunities for birth control education—the PPFK (Planned Parenthood of Korea) targeted vasectomy specifically (on a “voluntary” basis) as one means to achieve the desired end.

Images of vasectomies from the mid-1960s explain to white collar workers the economic benefits they might receive from consenting to the surgery. Moreover, beginning with the formation of the home reserve army in 1968 (예비군), Family Planning became a major part of conscription, with recruits urged to consider the surgery as one of their duties upon completing service. Incentives included relief from further reserve duty, access to better apartments by lottery, and education incentives. Situated in a fiercely masculinist society, then actively engaged in fighting the Vietnam War (1965-1973), South Korean proponents of the vasectomy chose a carefully defined path, urging its utility, while also providing a reassuring message of comfort, ease, and continued potency through a variety of print materials and campaigns.

Learning Objectives

International Family Planning, Cold War context

Military Medicine

East Asia, Biomedicine

D5 Sex and the State

“Changing Sex in Brazil’s Military Rule: From the Language of Medicine to the Language of Needs
In the 1970s”

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Roberto Farina, the first plastic surgeon to advocate sex change in Brazil, employed craft, cunning, and technology to perform sex-reassignment surgeries. After his first patient requested to change her name in the civil registry, Farina was sentenced to two years of prison based on the notion that sex change operations were a grave “affront to corporeal integrity.” Upon appeal, and with the support of the São Paulo’s medical community, a higher court ruled in 1979 that such surgery was not in violation of Brazilian law or the Code of Medical Ethics. An open opponent of the military regime, Farina challenged the regime’s medical and legal apparatus that construe “biological sex”—and the physical markers of femininity and masculinity—as immutable. His life and work reveals how medical research and technologies gave rise to an idiom that questioned whether it was really possible for a biological male to have a female gender identity and vice versa. As patients learned about new theories and procedures, they demanded access to sex change treatments and to change their legal identity. Drawing on the domains of the biomedicine, the law, and personal testimonies, this paper argues that, at a moment of political opening, the collaboration of medical authorities and transgendered patients made sex change operations legal. While physicians developed a language that understood transsexuality as pathology, patients appropriated elements of this language to satisfy their own needs.

Learning Objectives

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

D5 Sex and the State

"Now you see them, now you don't. Sexual deviants and sexological expertise in communist Czechoslovakia"

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Sexology was created in the 1860s as a field seeking to identify sexual deviance and its bearers. From its inception, sexology was also closely bound to the punitive branch of the state. It is no accident that the subtitle of the founding oeuvre, Krafft-Ebing's "Psychopathia sexualis", was "A Medico-forensic study." Itself an authoritative cocktail of knowledge about practices that constitute the inner-most part of a person, sexology seems to stand ready to serve authoritarian regimes. Surprisingly, in the 1950s Czechoslovakia, during the first decade of communism-building, there was very little interest paid to sexual deviants. Two decades later, the situation was markedly different. In the 1970s, sexologists were treating large numbers of deviants who were locked up on the order of the state in psychiatric hospitals. How to understand this change?

I analyze articles published in Czechoslovak scholarly press (general medical journals *Časopis lékařů českých* and *Praktický lékař*; psychiatry-oriented *Československá psychiatrie*, and gynecology-oriented *Československá gynekologie*) from the 1950s to the 1980s. In the archives of the Sexological institute in Prague I unearthed proceedings from sexological conferences that started in the early 1970s. The section of my paper following the development of the 1970s is supplemented by these papers and discussions.

I want to argue for the importance of changing networks of experts and the shifts in political climate that re-focus attentions and rearrange vocabularies. It was not until after the failed Prague Spring of 1968 and the subsequent period which its very proponents dubbed "normalization" that the non-normal, deviant became perceived as important – as a clear and present danger to the social order. However, the targeting of the deviant would not be possible without the thorough institutionalization of the discipline of sexology and widening of the expert networks beyond sexological and even medical field. Using the tools of Eyal's (2013) sociology of expertise, I want to show that sexual deviants appear on the social radar only under certain conditions.

Learning Objectives

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

D5 Sex and the State

“Advocating for Control: Aboriginal Women and the Canadian State in the Era of Reproductive Choice”

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In 1969 Canadian Prime Minister Pierre Trudeau, in introducing legislation to amend 19th century sections of the Criminal Code to legalize contraception and abortion, quipped “the state has no business in the bedrooms of the nation.” With its liberalizing legislation, the state granted Canadians the freedom and autonomy to control their reproduction. This paper examines how this era of reproductive politics banished the state from some bedrooms, while increasing its presence in others. Urban, middle-class women advocated for greater access to contraception as their due, yet Aboriginal women (‘Indian’ and Inuit) were actively encouraged, even coerced, to limit their fertility as the route to modernity and good health.

The Canadian government’s post-war integration policy envisioned Aboriginal people disappearing into society as ‘normal citizens’; with them would go their reserved lands and claims to treaty and fiduciary relationships with the state. But resistance by Aboriginal communities that demanded the government honour its promises left it with little choice but to deal with the legacy of years of neglect and poverty. By 1965 the Cabinet’s Special Planning Secretariat, in its declared ‘war on poverty among Indians,’ wondered if the size of the prototype ‘Indian house’ might be reduced if birth control techniques were actively advocated in Aboriginal communities. Clearly a hypothetical question since the Criminal Code had yet to be amended, but it signaled to Indian Health Service physicians and bureaucrats that emerging technologies might be used to promote more acceptable family size.

In the 1970s very public controversies over charges that Aboriginal women underwent unwanted sterilization and abortions in government hospitals exposed the paternalism and the politics of health care. But they also highlighted how in the shifting ground of reproductive politics the legal impediments and moral judgements fell away for those self-possessed individuals who were seen to be able to regulate their own reproduction, while marking others for greater state intervention and control.”

Learning Objectives

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

D6 Making Forensic Medical Knowledge, 1880s-1930s: Spatial, Technical and Performative Strategies

“Contests Over Railway Spine in Mid-to-Late 19th c. Great Britain and America: Truth, Lesions, and Mechanical Objectivity”

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The primary historical claim of this paper is that contests over railway spine in late 19th c.-early 20th c. Great Britain and America can only be properly understood in context of the ascent of ideas of mechanical objectivity at the same time. This paper demonstrates how the vehemence of the debate on the subject of railway spine turned on the importance of locating the material pathologies that grounded for both physicians and patients the legitimacy of the disease. Although the significance of a patho-anatomical foundation for railway spine has not been lost on medical historians, this paper argues that precisely why that foundation mattered so much for both professionals and the laity cannot be apprehended without accounting for the increasing influence of ideas of mechanical objectivity in the late Victorian period. The paper builds on prior work regarding the importance of this idea of objectivity in detecting the ‘truth’ of various kinds of pain without lesion during the same period. Drawing on a variety of British and American primary sources including original medical accident reports, medical treatises and journals, popular media, trade industry pamphlets, and legal cases, the paper documents that on both sides of the debate, physicians, lawyers, and juries alike invested anatomical lesions with major epistemic and evidentiary significance. Such lesions, the natural objects of disease, were regarded among both lay and expert as sites of truth, which regard is a central criterion of emerging concepts of mechanical objectivity at exactly the same time. In establishing its thesis, the paper pays special attention to the veridical function of 19th c. scientific imaging techniques such as the photograph and the X-ray in determining the ‘truth’ regarding claims of railway spine. The paper concludes that while the rise of theories of psychoneurosis is explicable in part as a reaction to the inability to locate the relevant lesions, the significance of such lesions in reifying traumatic neurosis persists in Great Britain and America well into the 20th c.

Learning Objectives

By the end of this session, learners will be able to:

1. Define mechanical objectivity in its 19th c. context;
2. Explain the conceptual connections between mechanical objectivity and railway spine in 19th c. Britain and America; and
3. Describe the epistemic and evidentiary significance for both lay and professional of patho-anatomical lesions in detecting the truth of claims of railway spine in 19th c. Britain and America.

D6 Making Forensic Medical Knowledge, 1880s-1930s: Spatial, Technical and Performative Strategies

“Forensic Pathology and Crime Scene Investigation in Interwar England”

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Focusing on interwar English homicide investigation, this paper explores the interaction between two forensic domains: the crime scene and the mortuary. This relationship will be analyzed by focusing on the tools, locations and investigative practices of Sir Bernard Spilsbury, the most prominent contemporary representative of English forensic pathology, an expertise whose epistemic authority was predominantly rooted in isolated post-mortem encounters with the dead body in the mortuary.

Though Spilsbury was a celebrated practitioner of a “body-centered” model of interwar forensics, this paper also shows how specific sets of circumstances and challenges presented by certain types of homicide cases displaced this lone-practitioner from his conventional mortuary domain and projected him into the consultative space of the crime scene. In making sense of this displacement the paper resists seeing it as a straightforward step in the direction of our present-day, trace-centered model of “CSI.” Instead, it seeks to reveal a nexus of pragmatic, conceptual and social factors which (temporarily) created the conditions conducive to the pathologist’s engagement with the crime scene.

The apparent mobility of this forensic expert, the paper suggests, is best understood in the context of cases where there had been attempts made by the assailant to physically destroy or mutilate the body, thus making it difficult to remove and relocate the body for conventional inspection at a mortuary. The inter-war appearance of the forensic pathologist at the crime scene in this sense constituted an attempt to reassert the primacy of “body-centered” forensics, not its replacement by something else. The pathologist at the crime scene represents, in part, a spatial strategy by which to consolidate control over his central object of concern – the corpse. Rather than dichotomizing the mortuary and the crime scene as competing investigative spaces, this paper explores, from the vantage point of forensic pathology, the necessarily adaptive and flexible nature of interwar forensic practices.

Learning Objectives

1. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
2. Recognize the dynamic interrelationship between medicine and society through history
3. Identify successes and failures in the history of medical professionalism

D6 Making Forensic Medical Knowledge, 1880s-1930s: Spatial, Technical and Performative Strategies

“Malarial Psychosis as Medico-Legal Problem, 1880-1930”

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This paper seeks to explain the context for a transitory concern, one remarkable in two respects. The first was the connection of malarial fevers to insanity. While the posited linkages varied, I focus here on post-febrile psychoses, the concern that the delirium that arose during the acute stage of fever might not fully disappear even as seeming normality returned to mind and body during convalescence. The second remarkable aspect was that this phenomenon posed a significant medico-legal challenge for forensic psychiatry. Common features of delirium were hallucinations and paranoia; if these persisted they might lead to psychotic crimes of violence. While most concern was with the immediate post febrile period and in typhoid and influenza, increasing awareness of the latency of malaria made it plausible to think that these effects could erupt at any time. At issue then, were whether such cases could be detected in advance and whether “fever” constituted a criminal defense. While organic explanations of mental aberration were commonplace, little attention has been paid to infectious causes other than syphilis. The possibility that febrile psychosis might be widespread had implications for issues of where criminal insanity might arise, and in whom. It might explain regional or racial traits, for example.

The concern appears to be an international one; the chief puzzle it presents is its temporal span. An 1882 paper by Krapelin drew attention to the general problem of febrile psychosis; W.K. Anderson’s 1927 monograph, *Malarial Psychoses and Neuroses* represents its peak. I see little sense of any public concern in earlier fever writing, even by malarial fearmongers like John Macculloch. And, after 1930, concern appears to have declined rapidly. As a medico-legal problem, malarial psychoses were an offshoot of a larger concern with wholesale intoxication. If alcoholic delirium tremens could be a valid defense it followed that malarial intoxication could be too. In the case of malaria, concern with psychosis was coincident with the brief ascendancy of malarial cachexia, a concern that in some places where it was rife, malaria completely undercut the possibility of any morally adequate social order.

Learning Objectives

- 1) recognition of changing border between the psychological and the somatic
- 2) recognition of challenging moral and legal questions about conditions of personal responsibility
- 3) recognition of past importance of behavioral effects of chronic, involuntary, and sometimes undetectable intoxication

E1 Housing and Health: Historical Perspectives

“Selling Synanon: The Residential Addiction Treatment Industry’s 1960s Revival”

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At the end of the nineteenth century, proprietary institutions for the residential treatment of inebriety flourished. Pricy inebriate farms and private sanatoriums courted clients by presenting a vision of treatment that emphasized domestic comforts over character-building labor. Organizations that catered to clients with means combined claims of treatment efficacy with references to recreation, healthy stimulation, and lush surroundings. By the mid-1920s, however, treatment options for drug addicts had mostly dried up. Specialized treatment providers fell victim to unscientific clinical protocol and ethical challenges, conflicting professional interpretations regarding the nature of addiction (then “inebriety”), and unreliable political support.

The rebirth of destination drug treatment came from an unlikely location: a beachfront California commune called Synanon House, founded in 1958 by an ex-alcoholic named Charles Dederich. Synanon explicitly revived the original values of the early addiction treatment industry: moral hierarchy, spiritual education, rule-ordered domesticity— and profit. Synanon leaders successfully sold the organization’s neo-Victorian treatment model to media outlets like Life and Columbia Pictures, wealthy drug abusers, and respected academic researchers. I draw from fresh archival evidence to investigate the controversial commune’s public relations campaign, which helped build Synanon’s \$30 million residential treatment enterprise and inspired more than 2,000 similar organizations by the end of the 1960s.

Despite much excellent work on addiction research, alcoholism, drug policy, and psychiatric treatment models, medical historians have largely overlooked the history of the addiction treatment industry. I use the Synanon case study to argue that the business of addiction recovery has profitably operated at the fringes of biomedicine by making new “moral treatments” saleable.

Learning 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
- Identify successes and failures in the history of medical professionalism

E1 Housing and Health: Historical Perspectives

“Tramps as Vectors of Violence and Contagion: A New Look at Stigma toward the Un-housed Poor in the United States, 1870-1922”

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There is little doubt that the tramp became one of the most highly stigmatized categories of persons in the late nineteenth-century United States. However, historians have disagreed on the underlying reasons for this stigma. Some have argued that the social type of the tramp—a roving, often hard-drinking man without home, family, or regular employment—posed a threat to the Victorian middle-class ideology of domesticity and to the already eroding notion of American community. Others have argued that the tramp, as a symbol of unfettered mobility and resistance to wage work, primarily threatened capital’s interest in a docile, hard-working labor force. Neither argument, however, rests on very solid evidence. In the study presented here, I investigated this controversy by examining a large national “dataset” of 2,296 newspaper articles on tramps and related social types (hobos, vagrants) retrieved from 88 different U.S. newspapers published between 1860 and 1922. This method enabled me to map the overlapping semantic and social histories of the tramp, hobo, and vagrant as they unfolded over time and were refracted through the changing medium of the mass newspaper. Based on this newspaper analysis, I argue that the tramp became stigmatized primarily as an imminent threat to the safety of the home and as a vector of moral and physical contagion. With tramps reportedly endangering the lives of women and children, the perceived threat to Victorian domesticity was more than symbolic. While tramps were also often stigmatized as lazy and shiftless, this idea of the tramp as undermining the work ethic coexisted with competing characterizations of the tramp as victim – of unsafe trains, of economic hard times, or of human indifference. The related social types of the hobo and vagrant further complicated the picture but did little to dilute the “tramp stigma”. This stigma gradually faded, nearly disappearing after World War I, but I contend that its legacy has lingered on in stigmas toward the tramp’s un-housed descendants – Depression era hobos, postwar Skid Row “bums”, and “the homeless” of the contemporary era.

Learning Objectives

- Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations), and in particular to persons experiencing homelessness.
- Deepen understanding of the historical relationships between home, housing, and health.
- Understand the historically-rooted connections between disease and stigma

E1 Housing and Health: Historical Perspectives

“How Research Connecting Housing and Health Sparked the Rise of the Healthy Housing Movement”

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As Director of Research at the National Center for Healthy Housing and previously at the U.S. Department of Housing and Urban Development, I have worked with colleagues to study the connections between housing and health. Here, I will discuss some of these connections, how research has helped to establish them, and their relationship to current policy and practice. By analyzing national longitudinal surveys of the U.S. population and its housing, we have been able to identify connections between health and housing trends since 1970. We have identified changes in housing, such as the age of a home, construction type, ventilation, pests and moisture, and their relationship to health. Asthma rates, for example, have been linked over this period to ventilation, windows, and age of the home, while trends in overweight have been linked to ventilation; blood pressure trends have followed community measures such as reductions in street noise and bad smells in the neighborhood. In these and other analyses, we have found that basic sanitation, reduced household crowding, housing improvements and housing regulations such as lead poisoning prevention policies have led to advances in children's and population health. In recent years, these and other findings have been accompanied by an international social movement for “healthy housing”, and by the development of a regulatory structure to support this goal. This movement – the latest chapter in the much longer history of housing and health- is becoming integrated with public health, environmental health, and pediatric practice.

Learning Objectives

Acquire a historically nuanced understanding of the connections between housing and public health in the United States and around the world.

Deepen understanding of population health, and its historical and contemporary connection to the well-being of patients.

Understand how new methods of longitudinal analysis have informed health policy, especially in regard to housing.

E2 Medical Labor and Medical Gaze: Physicians and the Contours of Race, Disease, and Empire

“Physicians as Photographers: Capturing Leprosy in the American Tropics”

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Leprosy became a global public health obsession in the late nineteenth century, influencing the epistemology of tropical medicine, race, sexuality, and disease. This obsession produced a vast visual culture of leprosy which has been surprisingly neglected in histories of medicine of this period. Medical photographs of leprosy patients, most of whom were Native Hawaiian and Asian patients incarcerated in leprosy colonies, circulated promiscuously through Western medical literature and vernacular print culture. As this paper demonstrates, the formulation of “tropical disease” was not only a medical enterprise, but an intensely visual enterprise that relied on visual case studies of individual, racialized patients.

This paper examines a significant aspect of this visual economy – the visual case study of leprosy – as produced by European and American physicians who treated and experimented on leprosy patients between 1885 and 1910 in Hawai‘i. Three physicians who exemplify this systematic visual approach to leprosy, Eduard Arning, Sidney Bourne Swift, and George L. Fitch, undertook medical photography and visual archiving during their Hawaiian residencies. Through an examination of their clinical archives, as well as contemporaneous medical journals, international leprosy conferences, and travelogues, this paper reveals how leprosy became a favored subject of the medical camera.

“Tropical-disease portraits” (Stepan 2001) were a critical foundation of the medical case study of leprosy and the surveillance of leprosy in colonial spaces. Furthermore, as these clinical images circulated within and beyond medical outlets, they shaped racialized medical practices, public health segregation policies, and debates about immigration. Fixed upon diseased bodies in their most vulnerable forms, this medical gaze influenced broader ways of looking at colonial populations as potential pathogens: unsanitary, racially subordinate patients who required medical surveillance and geographic isolation.

Specifically, this paper seeks to establish how: 1) medical photographs functioned a practice co-extensive with physicians’ scientific experiments on living human subjects in Hawai‘i, and 2) how physicians created visual codes to interpret germ theory, as well as the race and sexuality of leprosy patients. I will also discuss how exiled patients developed their own visual paradigms of illness and disability that unsettle clinical models of photography.

Learning Objections

- 1) Develop analysis of the nature, ends and limits of medicine in non-Western and colonial contexts
- 2) Develop an historically informed sensitivity to the diversity of patients (including race, gender, socio-economic status, cultural difference)
- 3) Develop analysis of patient-centered visual paradigms of disease and disability

E2 Medical Labor and Medical Gaze: Physicians and the Contours of Race, Disease, and Empire

“Harnessing the Empire to Buttress the Domestic Medical Profession during World War I: the 1886 Medical Act and the Tactical Use of Reciprocity”

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Scholars have overlooked the contributions of overseas doctors to Great Britain during World War I. In relieving pressure on the domestic profession, they reconciled the contradictory impulses of occupational closure associated with professionalization. Drawing on government archives and other primary sources, this paper examines how the 1886 Medical Act both created the conditions for and facilitated the participation of overseas doctors. The act not only increased the standards for entry, but also provided for the mobility of domestic and overseas graduates through state-to-state reciprocity. The mandated integrated qualifications in medicine, surgery and midwifery helped to stabilize the growth of a chronically overcrowded profession. By the outbreak of war, new admissions to the British register exceeded exits due to death and retirement by only 300. Meanwhile, the relentless military demands for medical personnel overtime yielded immediate and long-term effects. These included a reduction in civilian practitioners, an increase in women attending medical school, and a projected decline in the size of the profession. The war, to be sure, opened up opportunities for women in medicine, but leaders were reluctant to maximize them fully.

As this paper will show, Britain turned to reciprocating countries as a tactical resource for medical labor. On the eve of war, Britain reciprocated with well over a dozen territories within the Commonwealth as well as Italy and Japan. Additional territories came to the aid of the mother country. Britain also began reciprocating with Belgium shortly after German occupation. Between 1914 and 1919, overseas doctors accounted for 5% and 34% of new admissions to the register respectively. By the end of the war, they accounted for the equivalent output of a full-size school.

Their participation benefitted Britain in several ways. As qualified doctors, their training cost nothing. As registered doctors, they were eligible to serve in British units and to treat British personnel. Nor did overseas doctors pose a threat to the profession. Unlike women doctors, they were expected to return to their countries after the war. Overseas doctors advanced wartime propaganda aims as well. Their service displayed the international scope of support for the war effort and furnished evidence of the endorsement of Britain’s leadership of the Commonwealth and Empire.

Learning Objectives

- 1) Appreciate the process of professionalization in a wider geopolitical and chronological context
- 2) Understand the forces that cause the territorial boundaries of national medicine to open and close to the world
- 3) Promote an historical understanding of the contemporary use of overseas doctors as a tactical resource of medical labor

E2 Medical Labor and Medical Gaze: Physicians and the Contours of Race, Disease, and Empire

“Family Practices: Cold War Medical Expansion and the Burdens of Latino Migrant Physicians, 1948-1965”

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World War II inaugurated a period of grand institutional expansion, political incorporation, and new forms of exclusion. The federal strengthening of domestic institutions under the Cold War led more Latinos and Latin Americans into American medicine and brought more Latinos into contact with American medical institutions.

As white Americans abandoned cities for the promise of the suburbs, rural Puerto Rican and Latin American labor migrants moved in alongside black Southerners to cities like Chicago, and New York, while Mexicans and other Latin Americans moved to cities like Los Angeles, San Francisco, and Houston. Tejanos initiated their own great migration, moving to urban centers like Houston, Dallas, Chicago, Los Angeles, and San Francisco as veterans and as citizens. Doctors and scientists emerged from all these groups, seizing on the increasing investment in public education by the states and the federal government to obtain medical degrees. Hospitals, for their part, started recruiting across the world to find professionals to help them meet the needs of growing numbers of people with access to medical services in the United States.

This paper explores the ways Latino doctors trained in 40s and 50s Puerto Rico, Mexico, and Texas negotiated the tensions of the 1950s. First moving to complete their education, and then, hired to help urban hospitals address the sudden presence of Latino patients in their midst, Latino physicians participated in the Second Great Migration as professionals and participants subject to American forms of discrimination. Rejecting the endless commodity promise of the 50s and troubled by the narrowing political horizon established by the domestic culture of the Cold War and the creation of the Commonwealth of Puerto Rico, many Latino physicians committed to civil rights organizations and variations of democratic practices. The social worlds and medical marketplaces Latino doctors shared with their patients in urbanizing Texas and Puerto Rico, as well as deindustrializing New York propelled these doctors into civil rights and social justice campaigns. This paper will treat doctors like (Mexican) Jorge Prieto, (Puerto Rican) Helen Rodriguez-Trias, and (Mexican American) Cleotilde Garcia as high-status participants in the politics of the Second Great Migration.

Learning Objectives

1. will develop an understanding of the ways Cold War political cultures constrained and propelled ethnic minority doctors into politics.
2. will consider the ways attitudes toward Mexican American patients affected Latino physicians
3. will begin to consider the ways Latinos were affected by the internationalization of American medical workplaces in the 1950s.

E3 Reimagining the Human Subject

“The death of Frantz Fanon: Reimagining the ‘human subject’ for a global history of medicine”

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Frantz Fanon (1925-1961) was a psychiatrist, political activist, and one of the twentieth-century’s preeminent social theorists. A black native of the French colony of Martinique, Fanon traveled to the Soviet Union in 1960 to get treatment for leukemia — an act of Cold War resistance against the political-economies in Europe and America. Yet Fanon died the following year at the hub of medical care for the system he detested: The US National Institutes of Health’s Clinical Center.

This paper uses the case of Frantz Fanon towards two ends. First the paper develops new analytic devices and methods for studying the history of medicine with a global sensibility. The case is unusually instructive because — as a patient and a social theorist — Fanon allows historians simultaneously to recognize points of contact and communication among medical communities beyond the nation-state; and also to appreciate how theories of the state were embedded within our own field during the 1960s, and in particular within histories of human subjects (e.g., Cooter 2012). The paper argues that the history of medicine has tended to recast *global* history of medicine as *international* history of medicine. By exploring new tools and methods, including social network analysis, scholars are developing new approaches suited to a global history of medicine beyond the nation-state. The paper compares several approaches using the case of Frantz Fanon; it proposes the analytic device of “networks of exchange” (of knowledge and of materials, including human bodies); and suggests conceptualizing global history of medicine through points of contact and communication, rather than through independent, comparative cases.

The second aim of the paper is to contribute a new account to the enriched history of postwar medicine scholars are developing with a global perspective. The paper adds to this enriched history by incorporating new migrants and travelers — both scientists and nonscientists — who shifted in and out of one space, namely the NIH Clinical Center, in post-World War II medicine.

The paper draws from published and unpublished primary sources to develop the case of Frantz Fanon, and published secondary sources to document the theoretical approaches embedded in our own field.

Learning Objectives

- 1) The paper aims to encourage ongoing discussion with and among audience members about how to approach the history of medicine in global contexts.
- 2) The paper will present (and solicit) other examples of analytic devices and methods for doing so (see 1).
- 3) Participants will have an enriched, critical appreciation of what is lost and gained in approaching history of medicine from a global perspective.

E3 Reimaging the Human Subject

“From Unification, Registration: The Genesis of Research Subject Registries”

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Before being tested for efficacy in patients, experimental drugs and treatments are given to a small number of healthy people in a strictly controlled environment so that researchers can evaluate the safety of the new drug/treatment, identify its side effects, and determine a safe dosage range. This type of clinical testing is known as Phase 1 research. In 2011, two prominent voices in American medicine, David Resnik and Greg Koski, called for the creation of a national registry for Phase I research participants in the United States. In arguing for a US registry, Resnik and Koski noted the presence of such registries in the United Kingdom and France. I, too, look to these registries, but in order to ask: what galvanized the creation of these registries, and who was involved? I situate the genesis of these registries in Western Europe in the late 1980s, beginning with a German registry called VIP Check International, which I argue was an expression of anxiety about the impending creation of the European Union (EU) and its impact on clinical research. VIP Check International’s founder feared that opening national borders would enable individuals in EU member states to move from country to country for the purpose of participating in paid Phase I studies. Such a scenario would be dangerous to the research subjects and would taint the data being collected (because these “over-volunteers” would have a financial incentive to conceal recent or concurrent trial enrollment that would, if known, disqualify them from enrollment). Later registries in France and the UK, while not concerned about the specter of “test-subject tourism,” were likewise intended to protect research subjects and research data from the adverse consequences of over-volunteering.

Learning Objectives

By the end of this activity, the learner will:

1. Understand how concern about the use of financial incentives in human subjects research galvanized policy responses in multiple nations
2. Identify the ethical and scientific concerns about “professional” research subjects, “clinical trial tourism,” and over-volunteering
3. Recognize the linkage between anxiety about the conduct of clinical research and the creation of the European Union

E3 Reimaging the Human Subject

“Local Actions, National Concerns: Human Radiation Experiments at the University of Texas, Galveston 1949-1963”

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In 1994, in response to a public outcry over journalistic revelations of Cold War era experiments that had exposed Americans to harmful levels of radiation without consent, the Advisory Committee on Human Radiation Experiments (ACHRE) was tasked with declassifying and contextualizing 30 years of documents on Cold-War era medical experimentation in the United States. The committee found that the great majority of these experiments were neither secret nor government-run, but initiated by researchers at academic medical institutions such as the University of Cincinnati, MD Anderson, and Sloan-Kettering as well as often published in leading medical journals. This paper examines the human radiation experiments from a local context, that of the University of Texas Medical Branch, Galveston, looking at the multiple levels at which a mid-sized institution and its researchers participated in this larger whole. The Human Radiation Experiments can be viewed as an assemblage, a snapshot of the way social, cultural, and political trajectories come together to shape a phenomenon at a given moment. This enterprise took place in the context of its origins in World War II, the Cold War, mid 20th century notions of scientific progress, changing doctor-patient relationships, and the radically burgeoning relationship between government, industry, and academia. UTMB physicians and researchers participated in this enterprise on multiple levels: some joined colleagues in classified national debates over the ethics and practicalities of human experimentation, others became research entrepreneurs, designing experiments to answer military questions, still others, mainly clinicians, took part in a regional training and patient referral network seeking therapeutic applications of this new knowledge. Using this one local lens as a case study both reinforces and nuances some of ACHRE’s interpretations of these Cold War experiments. Although the Human Radiation experiments were a phenomenon on a national scale, they involved physicians, researchers and patients in local, socially-embedded contexts, something that has added to complexity of this legacy, troubling divisions between elements of the ordinary and the egregious, and the experimental and the therapeutic in discussions about this exciting and troubling era in medical research.

Learning Objectives

1. Recognize the dynamic interrelationship between medicine, biomedical research, and society through history.
2. Examine in depth the development of human subjects research ethics from a historical perspective.
3. Critically appraise the potential ambiguity between therapy and experimentation in biomedical and translational research.

E4 Taking Note: Technologies of Representation in Medicine

“Medical Notetaking in the Age of Mechanical Reproduction”

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The later 18th and 19th centuries saw the rise of the so-called blank book, a printing revolution of which historians have taken little note. Forms that notetakers and recordkeepers had previously made individually by hand were now mechanically reproduced: headings, lines and tables, the organization of space on the page. From the 1820s, stationers marketed a variety of specially formatted notebooks for medical practice. Practitioners, we show, used them. Our paper addresses two questions: How did this new kind of recordkeeping affect medical practice and medical knowing? What historical forces worked through its forms? We identify three such forces: (1) machine production, in both its workshop and factory modes, (2) commerce, as both health market and print market, and (3) rationalization, without ideologies of “rationalization.” We trace their effects on practice up to the 1920s. Accounting replaced recounting as the rationale and logic of medical noting. Medical noting was made increasingly uniform and reduced to a limited code of symbols, saving work time and space. Symbolic notation mechanised the basic activity of medical practice. The patient record mushroomed in the hospital – and shrank to a line in private practice. Thus in private practice, supposed bastion of personal doctor-patient relations insofar as they endured, we find reductions usually attributed to the hospital, supposed depersonalizer of illness and care.

Our evidence base consists of (1) systematic survey of blank-book holdings in German and British libraries, which also provide information about the stationer companies producing them and about advertising and the market, (2) reviews and advertisements of blank books in medical journals, (3) use of such notebooks ca. 1790-1920 by English and German practitioners whose papers are preserved in the Wellcome Library and German archives, (4) comparison to earlier manuscript practitioner journals ca. 1600-1850, (5) comparison to contemporaneous hospital casebooks and patient records.

Learning Objectives

1. History of medical notetaking in private practice
2. Function of schemes in medical recording
3. Changes in physician-patient relationship around 1900

E4 Taking Note: Technologies of Representation in Medicine

“Charles Bell's Seeing Hand: Teaching Anatomy to the Surgeon's Senses, 1800-1840”

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Surgeon-anatomist Charles Bell, who taught London's medical men in the early nineteenth century, established a pedagogical philosophy that attempted to establish the status of the hand as a knowledge-making organ of the senses, and along with it, to advance the social status of the surgeon. In his Bridgewater Treatise on the hand, Bell argued that sensory reception must be coupled with muscular action to establish true knowledge, elevating the "doing" hand to epistemological parity with the long-superior "seeing" eye. According to Bell, anatomy simply could not teach the sort of feeling that one would encounter inside a living body. Instead, anatomy taught students to map the parts so that their fingers, moving through a surgical field, could “see” and therefore could know and could act. This apparently academic argument contributed to Bell's reformist politics and attempts to reconfigure the standing of surgeons and their work within the medical community.

Learning Objectives

This talk will allow audience members to:

- 1) Develop an appreciation for the relative roles of the senses in making medical knowledge.
- 2) Recognize the politics of hand-work and of various professional roles within 19th Century medicine.
- 3) Consider the significance of pedagogy in building a research area within medicine.

E4 Taking Note: Technologies of Representation in Medicine

“The changing face of autopsy records in Vienna during two centuries”

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The very last step in the diagnostic work-up of a patient is the systematic morphologic - macroscopic and microscopic - inspection of the corpse during autopsy. The first documented autopsy in Vienna was conducted in 1404. At this time autopsies were not carried out by trained persons systematically. In 1812 the first paid prosecutor started working at the General Hospital. Since then, a standardized autopsy record is mandatory for every dissection, although the content, wording and way it was written changed dramatically over the centuries. The autopsy itself, however, is carried out in essentially the same standardized way as 200 years ago. At the Pathologic-anatomical Collection in the Narrenturm, autopsy records starting from the year 1817 from the University Institute of Pathology of the General Hospital are kept. In addition, autopsy records of several non-academic hospitals in Vienna, the oldest from 1865, are preserved. This outstanding amount of data – more than 300 000 autopsy records – offers the unique opportunity to follow medical understanding and wording, as well as documentation patterns through two centuries and it allows comparisons between academic and non-academic institutions. Until the 1950s almost all patients dieing in a hospital were dissected. The morphologic diagnosis was essential for clinical-diagnostic and therapeutic correlation. 25 years later, the autopsy rate dropped to 50%. Today, although numbers vary between institutions, the clinical autopsy rate is about 20%. The morphologic post-mortem diagnosis is often regarded as having lost some of its importance in an era of sophisticated in-vivo diagnostic tools and biomarkers easily measured in the patients blood during his/her lifetime. However, either autopsy or inspection of the corpse remains the basis for any mortality statistic, which in turn is used for identifying priorities in health care. The continuous documentation of autopsy records of different institutions in Vienna for 200 years offers an unique insight to the changing medical world, the concept of diagnosis and the concept of causes of death itself.

Learning Objectives

- Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, as well as public health decisions
- Critically appraise diagnostic management from a historical perspective
- Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.

E5 Medical Temporalities

“Understanding Conflicting Temporal Regimes in Medical History”

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In this paper, which will serve as an introduction and a tentative theoretical framework for the panel, I will begin by discussing how time – that is different concepts, experiences, standards, practices and rhythms of time – circulate between different parts of society, especially in and out of the medical field. In order to open this discussion, we first need to overcome the belief in an absolute distinction between natural and historical, biological and chronological, or ontological and phenomenological time. In a historical perspective, experienced time, linked to events and actions, has always to a large degree been based on natural time, such as the changing of the seasons, the bodily rhythms, the life-span etc. Recently, however, neither the seasons of nature nor the human body seem to present the same temporal stability as they used to; by means of medical science and, not least, medical technology, new times are produced and constantly renegotiated. To approach the multiple temporalities of medicine in a social and historical context I will introduce the concept of “temporal regimes”, or “regimes of temporality”, in dialogue with recent works by François Hartog, Eviatar Zerubavel, Reinhart Koselleck and others. I will argue that what is targeted by this concept is not just phenomenological time, but also practices, technologies, institutions, linguistic structures etc. Furthermore, I will suggest that “temporal regimes” serves as a viable alternative to Koselleck’s notion of “temporal layers”, which seems, paradoxically, far too static, and thus unable to bring out the conflicts between different temporal regimes that are an integral part of the fabric of modern society. Finally, I will look at some cases where the temporal regime of modern medical technology comes in conflict with other temporal regimes in society, in the past, at present or in an imminent future.

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

E5 Medical Temporalities

“Le Feu qui Couve, qui Peut s’Étendre”: Pretubercular Children, Latency, and Medical Epistemology in the Early 20th Century”

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In the 1890s, physicians were largely convinced that the tubercle bacillus could lie dormant in the body for long periods of time without inflicting symptoms. By 1910, evidence from clinical records, pathological anatomy, animal experiments, and immunological testing revealed that most primary infections occurred during childhood, producing in many a latent state. Tuberculosis was, in effect, a disease of childhood.

The impact of these discoveries on the development of institutions—preventoria, open-air schools, isolation wards—and the removal of “tuberculosis-threatened” children from their homes have been well studied by historians in a number of national contexts, but the epistemological effects of this debate have not been examined. Although concern about “pretubercular” children eventually waned, discourse on latent tuberculosis laid the theoretical foundations for many core elements of modern biomedicine: the tension between etiological reductionism and distributed causation, the centrality of risk, the prominence of epidemiological evidence, and non-binary conceptions of health. Importantly, pretubercular children, and children with concomitant conditions such as malnutrition and anemia, engendered a newly temporal epistemology of health and disease. They existed in a liminal state between healthy and ill, at once both and neither, defined chronistically by the presumption of an incompletely healed past infection and the risk of a debilitating, often fatal future disease.

Latent tuberculosis in the late 19th and early 20th centuries posed a challenging conceptual problem for physicians, one that led to a distinctly risk-based and temporally defined epistemology of disease. Unlike healthy carriers, who were asymptomatic and presumed healthy despite being infected, pretubercular children were presumed to be infected, asymptomatic but at risk of developing tuberculosis. Further complicating the understanding of health in pretubercular children, physicians debated the extent to which a primary infection conferred some measure of immunity against future disease, given that the primary infection was typically the source of that future disease.

Using the United States as a case study, I argue that pretubercular children engendered a new way of thinking about health and disease, helping to explain what David Armstrong describes as pediatricians’ break with clinico-pathological medicine in favor of the analysis of growth and development. Latent tuberculosis stimulated in particular the development of public health nutrition and well child care.

Learning Objectives

By the end of this activity, the learner will:

1. Develop a deeper understanding of medical epistemology.
2. Understand the dynamic history of medical ideas and practices and their implications for patients and health care providers.
3. Develop the capacity for critical thinking about the nature, ends, and limits of medicine.

E5 Medical Temporalities

“Time and syphilitic bodies in the 19th century”

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This paper seeks to explore the production of new temporal arrangements of the syphilitic body in the latter half of the 19th century. I take as my departure the practice of syphilisation, consisting of repeated injections of syphilitic material in order to create immunisation against syphilis. In France, it was highly controversial, and its inventor, Auzias-Turenne lost the ability not only to carry out his experiments, but eventually also to practice medicine in Paris hospitals. However, Auzias-Turenne had followers in e.g Italy, Austria and Britain, and, maybe most importantly in Norway, where syphilisation was practiced by the most respected figure of Norwegian dermatology, the professor at Rikshospitalet, the university hospital in Christiania (current day Oslo) Carl Wilhelm Boeck. In contrast to Auzias-Turenne, Boeck had access to the University hospital, and even ran his own private clinic within the hospital walls. His experiments produced a body literally marked with time. Firstly, it presupposed the classification of syphilis in three stages. Through this classification, time came to dominate the diagnostic, therapeutic and prognostic discussions. So also these experiments: Only syphilitic bodies in the second stage of the disease were given the treatment. Secondly, in repeated experiments, with carefully orchestrated temporal and spatial setups of as much as 450 inoculations of the same patient during a period of months or even years, a syphilitic body was produced where time was at once a cause and an effect.

Boecks follower at the University Hospital, his nephew Caesar Boeck, shared his predecessor’s contempt for the use of mercury against syphilis, but syphilisation as a practice died out with his uncle. Caesar Boeck, in contrast, decided to explore how time produced bodily effects on syphilitic patients in the absence of treatment. Presupposing the passing of chronological time, this project also helped produce a new possible future of the syphilitic body – a future of no disease. The material, collected between 1890 and 1910, included more than 2000 patients and was later followed up in several studies, known as the Oslo Study of Untreated Syphilis, which was repeatedly referred to as a model past when the infamous Tuskegee study was designed.

Learning 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

E6 Contemporary Histories of Medicine

“The Pathologic-anatomical Collection of Vienna – the value of medical collections today in teaching, science and for museum purposes”

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Natural History Museum Vienna ,Pathological

Pathological collections have a special standing among medical museums. The reason is the preservation of wet and dry preparations, some of which are more than hundred years old. They date back to a time when this was the only possibility to show diseases without a patient. Vienna has a long tradition, beginning in 1796 pathological preparations were collected for the use of students and doctors. Especially Rokitansky and his Second Vienna Medical School made a large contribution, and that is why the Pathological-anatomical Collection in the Narrenturm is now the largest of its kind in the world. Some of the oldest preparations were made by Biermayer, Wagner and Rokitansky. The preparations presented in his famous publications are still preserved in the collection. The Fools Tower (Narrenturm), formerly a lunatic asylum, is now the home of more than 50.000 specimens. The largest part is preparations in formaldehyde with more than 25.000 objects including about 7000 dissected brains, 1500 hearts and 1200 lung preparations, followed by macerations – various bones, about 3500 skulls and 300 skeletons with pathological changes. 6000 Moulages (painted wax casts), historical medical instruments and 195 years of autopsy records with over 300 000 copies from Biermayer until today complete the collection. The assembly and different categories of that collection will be presented. Today the Narrenturm is a public museum, but the preparations are also used for medical teaching and scientific research. Examples will be given on different fields of research, for example research on malformations or histological examinations of historical tissues with tumor markers. Since 2012 our collection is a branch office of the well-known Natural History Museum Vienna and this is a guarantee for the continued use for medical history purposes.

Learning Objectives

- 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

E6 Contemporary Histories of Medicine

“Erwin H. Ackerknecht and the Contemporary History of Medicine”

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Erwin H. Ackerknecht (1906-1988) published regularly at the intersection of medicine, history and anthropology. He studied what he called “primitive medicine” in the libraries at Hopkins and the Museum of Natural History in New York; he also voiced strong support to include if not expand the history of medicine within the medical curriculum. But it is less clear what he thought of modern medicine and the medical practice surrounding himself. Making use of the extensive collection of Ackerknecht papers held in the institute of the history of medicine in Zurich, this paper will investigate Ackerknecht’s relation to the project of a contemporary history of medicine.

For Ackerknecht, the interaction between the history of medicine and contemporary medical practice hinged on the importance of history in the medical curriculum. Perhaps somewhat frustrated by a limited uptake of his own lectures, he repeatedly argued that an understanding of history was of vital importance to the education of future medical practitioners. But what kind of history? How did he imagine to influence medical practitioners through history? And did the exposure to medical expertise influence his own writing of the history of medicine?

Another cornerstone of Ackerknecht’s engagement with medicine was his writing on “primitive medicine”. In his time in the US, in particular, he regularly published on medical practices in primitive societies, which he considered to be revealing a fundamental insight into the workings of medicine. But it seems that he never ventured beyond this look at the exotic. His anthropological work remains ambiguous: attention to culture and medicine stood right next to firm beliefs in the obvious superiority of Western medical tradition.

In summary, this paper uses Ackerknecht to trace the roots of the project of a contemporary history of medicine. It seeks to understand alliances, issues and themes that kept Ackerknecht inspired and that are still of relevance for today’s shaping of a relevant and productive field of investigation.

Learning Objectives

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

Identify successes and failures in the history of medical professionalism

Recognize the dynamic interrelationship between medicine and society through history

E6 Contemporary Histories of Medicine

“Speaking of Health: Dr. Leona Baumgartner, from Public Servant to Public Persona”

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This paper discusses the ways in which Dr. Leona Baumgartner, New York City Health Commissioner (1954-1962), was an innovator in combining health promotion with both traditional and new forms of media to reach the greatest possible audience. Dr. Baumgartner, through her extensive use of public appearances and various types of media, became the voice and face of public health to the residents of New York City. Breaking with her male predecessors, as health commissioner she mixed traditional feminine approaches to communication with new media. Because her career developed simultaneously with the transition from traditional to modern media outlets, she, in many ways, pioneered the practice of multi media public health education in the mid twentieth century. Through her transformation from a public servant to a public persona, she became an invited guest into the homes of New Yorkers, educating them towards better health.

I will focus on the New York City polio vaccine campaign (1955-1960) because it serves to illustrate her mastery of communication and her embrace of all forms of media, including print, radio and television. In 1959, a photograph of Dr. Baumgartner vaccinating Elvis Presley with the Salk vaccine received widespread newspaper coverage. She also understood that well into the golden age of television, the 1950s, radio still reached more individuals than television or newspapers. Someone who might not have read a detailed health related article in a newspaper or health pamphlet would more likely listen to a radio show on the same topic. Dr. Baumgartner was one of the first health officials to reach out to the Puerto Rican community. She insisted that many of her talks be translated for Spanish language broadcasts. Television targeted a different audience and she used some of her regular weekly appearances on NBC's television show "Home" to discuss the disease and its prevention. She also appeared on WCBS and other WNBC shows to discuss polio. Such was her success in the area of multimedia that the Health Department's Bureau of Health Education created a radio and television unit in 1958.

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

F1 Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games and More

“Medical History in Other Venues”

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I will coordinate this session on presenting medical history in other venues, including theater, exhibits, digital role playing games, and blogs. This session will include presentations by scholars working in a number of different areas. I will also discuss my own activities as a medical history blogger.

Learning Objectives

- 1) Develop the capacity to understand new interactive and facilitation opportunities for teaching and learning medical history;
- 2) Promote tolerance for the varying and sometimes conflicting responses of audiences to medical histories involved the misuses of genetics, especially when impacted communities are involved in those discussions;
- 3) Provide models of interactive discussion around public health that are valuable to historians and clinical practitioners alike.

F1 Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games and More

“Improv-ing and Blogging History: How Blogging and Improv Comedy Can Improve the Dissemination of History”

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The histories of public health and medicine hold great interest for a public often unfamiliar with the work of our field. The proliferation of blogging and other online resources are becoming increasingly popular dissemination tools. This presentation will characterize my involvement with two non-traditional approaches to dissemination --my involvement as the co-creator of *The Public's Health*, the public health blog of the *Philadelphia Inquirer*, and my work comedians and improv comics to "popularize" history at the Philadelphia Science Festival and Philadelphia FringeArts Festival. *The Public's Health*, the only dedicated public health blog in a major American newspaper, reaches a large audience through both the newspaper's website and periodically in its print version. Blogs are often written rooting contemporary public health challenges in their history, and in addition to my contributions, we have solicited contributions from several medical and public health historians including regular contributions from Janet Golden from Rutgers University. This format has proven to be a challenging, but deeply rewarding way to disseminate history. This talk will examine some of these challenges, including the presentation of historical concepts in a meaningful and accessible way and the challenges of working in a non-traditional "historians" setting. This talk will also examine my work teaming up with comedians to popularize the history of medicine. Since 2010, I have worked with the Philadelphia Science Festival as part of a program teaming historians and comedians to "dramatize" history. In 2013 we expanded our show to be part of the Philadelphia FringeArts festival. In my work with an improv group, I give a monologue on a historical topic; then the improv group does a comedy riff on the historical stories I share. This format has proven to be educational to the audiences that come to see our shows--the audiences get to hear short historical lectures examining events and themes in our field. Challenges and limits of this format will be discussed, including the risks of working in an improv setting and how to help audiences understand different ways of knowing the past. Video of past improv performance will be shown.

Learning Objectives

- 1) Understand new interactive approaches for teaching and learning medical and public health history;
- 2) Explore the challenges of disseminating history in non-traditional settings;
- 3) Discuss strategies for partnering with non-academically trained historians in disseminating history.

F1 Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games and More

“Medical History Interactive: Dispatches from the Eugenics Debates”

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My presentation will explore boundary-pushing events and activities I have been involved in over the past several years, all of which have sought to reflect on the contemporary relevance of eugenics histories and legacies through interactive formats and collaborations. These activities range from blogging in new media sites to helping design events that jettison conventional academic formats and instead utilize facilitation strategies to promote distributed discussion and active listening and learning among diverse audiences. I will highlight two examples: 1) a publicly accessible webinar conversation facilitated by the Center for Genetics and Society focused on recent revelations that California female prisoners were sterilized without authorization in two state prisons; 2) a collaborative conference on disability and eugenics hosted by the Paul Longmore Institute on Disability that was attended by many people with disabilities as well as high school teachers with politically active students, and in which I and other organizers employed several facilitation techniques (such as Learn to Listen/Listen to Learn and Save the Last Word for Me). The goal of these strategies is to deepen conversations and, from my perspective, make history meaningful for people living with its legacies in their daily lives and bodily experiences. What is lost and what is gained by making medical history more interactive? How broadly valuable are these approaches, which might have particular resonance when it comes to contemporary debates about the longevity or proximity of eugenics to technologies such as non-invasive prenatal screening, to other arenas of medical history? In keeping with my theme, I will use facilitation techniques to lead an interactive discussion.

Learning Objectives

- 1) Develop the capacity to understand new interactive and facilitation opportunities for teaching and learning medical history;
- 2) Promote tolerance for the varying and sometimes conflicting responses of audiences to medical histories involved the misuses of genetics, especially when impacted communities are involved in those discussions;
- 3) Provide models of interactive discussion around genetics, values, history, identity, and decision-making that are valuable to historians and clinical practitioners alike.

F1 Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games and More

"It's How You Play the Game: Playtesting Pox and the City, A Digital Role-Playing Game for the History of Medicine"

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As socially responsible historians of medicine, we are often called upon to explicate the historical context of current medical issues to diverse audiences. How can we present complicated and abstruse material in an engaging way, while not oversimplifying or eliminating all nuances?

The answer, according to some educational writers, lies in game-based learning: indeed, game theorists Eric Zimmerman and Heather Chaplin have recently proclaimed our era as "the Ludic Century" (<http://www.kotaku.com.au/2013/09/manifesto-the-21st-century-will-be-defined-by-games/>). The Wellcome Collection has successfully incorporated games for adults as well as for children in its outreach programming (<http://www.wellcomecollection.org/explore/play.aspx>); the College of Physicians of Philadelphia has incorporated a game, "Illsville," as well as other interactive activities into its award-winning History of Vaccines (<http://historyofvaccines.org>).

In developing "Pox and the City", a Flash-based digital role-playing game, my project partners and I harnessed the technological power of adventure-quest games to present the early history of vaccines. "Pox and the City" is set in Edinburgh, Scotland in 1800, shortly after the introduction of Edward Jenner's vaccine for the prevention of smallpox. The player takes on the role of Dr. Adam Robertson, a young physician, eager to use the new medical technique to develop his practice. In order to successfully compete in Edinburgh's competitive medical marketplace, the player must attract patients, diagnose and treat their ailments, and prove his scientific credentials to his medical colleagues – all while dealing with a smallpox outbreak, investigating a murder and courting an eligible young lady.

The game is an innovative collaboration of humanities scholars, science educators, and game specialists, funded through an NEH Digital Humanities grant. It draws on the resources of the College of Physicians of Philadelphia's extensive historical medical collection as well as archival material from the National Archives of Scotland and Edinburgh University.

The proof of any game is in the playing, and this paper will present the results of playtesting carried out with the assistance of students at a range of educational levels. We will explore just how students "played the game," their motivations and gaming styles as well as their understanding of and engagement with the history of medicine.

Learning Objectives

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

F1 Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games and More

“Wikiproject Women’s History: Closing the Wikipedia Gap”

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This presentation will discuss my work with Wikiproject Women’s History (http://en.wikipedia.org/wiki/Wikipedia:WikiProject_Women%27s_History). This project started two years ago in response to the underrepresentation of topics addressing women and people of color in Wikipedia, and the small percentage of Wikipedia editors who self-identified as female. According to a survey conducted by the Wikipedia Foundation in 2011 only nine percent of Wikipedia editors were women, down from 13 percent in 2010.

Wikiproject Women’s History focuses on expanding the number of entries that address the lives, activities, achievements, and experiences of women up to the mid-20th century; the ongoing social and cultural movements and issues that affect women into the present but have historical precedents and origins; and contemporary women as agents of historic change. WikiProject Women’s History also aims to incorporate the perspective of women’s history in overview articles of historical periods or pre-1950 events that may currently lack such coverage.

Contributors to Wikiproject Women’s History view our work as not only a scholarly enterprise but also a feminist act that seeks to remedy gender and racial bias in what “counts” as history on the Web. Historians of science, technology, and medicine have been especially active in the project. Last year, Sarah Stierch, the Smithsonian Archives’ Wikipedian in Residence, hosted “She Blinded Me With Science: Smithsonian Women in Science Edit-a-Thon,” that provided Wikipedians a chance to work with Smithsonian archivists to improve content on women in science. Similar edit-a-thons have been hosted by the Royal Society of London (http://en.wikipedia.org/wiki/Wikipedia:WikiProject_Women%27s_History/Ada_Lovelace_Day_2012) and the Humanities, Arts, Science, and Technology Alliance and Collaboratory (<http://www.hastac.org/blogs/fionab/2013/03/11/toofew-feminists-engage-wikipedia>) Currently there are plans to have an edit-a-thon at the 2014 meeting of Berkshire Conference of Women’s Historians in Toronto.

This presentation will highlight the evolution of Wikiproject Women’s History and show how this can be used as a model for historians of medicine. It will include a short demonstration on how to set up a Wikipedia account and edit entries.

Learning Objectives

1. Understand the origins and evolution of Wikiproject Women’s History and how it contributes to our understanding of medical history of women and people of color.
2. Recognize the importance of increasing the representation of the history women and people of color in Wikipedia and other web-based history resources.
3. Identify how to create a Wikipedia account and edit Wikipedia entries.

F1 Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games and More

“Scholarly Societies as Crucial Venues in the Digital Age”

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The many kinds of venues addressed in this proposed panel illustrate transformational changes in the practice and dissemination of the history of medicine happening within the last decade. New research methodologies encourage both original and reformulated historical questions at large scales; new digital platforms facilitate innovative forms of scholarship; new careers for historians of medicine outside of academia allow for greater engagement with the public. Such innovations present novel challenges and opportunities to scholars and scholarly societies alike, especially on topics such as open access to scholarship, facilitating scholarly communication, engagement with broader audiences, and professionalization practices and services for members who are increasingly likely to work outside of the academy. My panel presentation will address some of the critical intersections of the so-called digital humanities with the role of organizations like AAHM (and its engagement with digital media) with hopes of fostering a critical discussion about how scholarly societies might better function as a venue for facilitating research and scholarship and communication.

Some guiding questions: How might the roles and missions of scholarly societies profitably shift in the digital age? To what extent should societies shift their values from producing academic historians of medicine to bringing the history of medicine to a wider audience? What is the role of scholarly societies in evaluating new (digital) forms of scholarly work? How can AAHM better use technology to attract and retain members? To what extent should AAHM facilitate new digital venues for communication, like Twitter, to complement annual meetings and facilitate engagement outside of them? How can the website be better used to coordinate among members and share useful resources? How can professional organizations encourage open data standards so that historical data can be easily discovered and reused? How can organizations like AAHM facilitate broad, ongoing discussions with its membership about how to address new challenges and opportunities facing its younger members, both those who are doing history of medicine in increasingly non-academic settings and those for whom the academic job market looks quite different from what it has?

Learning Objectives

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

F1 Medical History in Other Venues: Theater, Festivals, Blogs, Digital Games and More

“Omeka for Medical History: Digital Collections, Research, and Public Interaction”

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The rapid pace of technology and the work of digital humanities centers over the past decade has brought an array of tools, applications, and platforms to historians' fingertips. These platforms present historians with new ways to collect and analyze source material, new formats in which to present their interpretations, and new venues in which to share their work with colleagues and the public. However, these tools also present issues -- both familiar and new -- related to methodology, professional expectations, and access. The digital humanities community has been discussing these issues for some time, but many historians remain outside of these conversations.

I will discuss some of the digital platforms and methods I have used over the past several years, with particular focus on the Omeka web publishing platform. I have used these platforms to advance my research into the history of genetic counseling, and also to explore ways to engage with the public and with other communities of scholars and health professionals. Omeka is a free, open source platform produced by the Roy Rosenzweig Center for History and New Media at George Mason University. Its standards-based, flexible structure combines web publishing with collections management, making the program highly effective for both organizing and analyzing research material, as well as crafting dynamic historical interpretations. It also provides tools to foster audience interaction and participation.

My goal in using tools like Omeka is to trace the history of human genetics and genetic counseling with an eye toward disability and reproduction and at the same time highlight the contemporary importance of this history and its relevance to medical and political decision making. This requires a combination of conventional academic formats and new platforms aimed at involving diverse audiences in the process of both exploring and interpreting the past and its relevance to the present.

The presentation will highlight what value platforms like Omeka offer, and what challenges they also present. Particularly in areas such as medical history and contemporary policy, it is critical to attend to both the possibilities digital platforms present as well as the potential issues they raise.

Learning Objectives

Understand the possibilities digital platforms present for developing a historically informed sensitivity to the diversity of patients.

Promote conversations between health care providers, scholars, and the public around historically informed concepts of professional responsibility and patient advocacy.

Recognize the dynamic interrelationship between medicine and society throughout history and today.

F2 Metrics of Race Across Four Continents

“Looking for crania Americana: Forensic Anthropology and Craniology between Europe and Latin America”

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The genesis of the discipline of anthropology in the late 19th century coincided with a renewed and scientific interest in the peoples of the Americas. Latin America, in particular, was seen as a rich site of anthropological data, due not least to the sudden expansion in excavations, which uncovered a treasure trove of new samples of fossils and human remains. My paper will take a close look at a key aspect of this founding moment in the field of Americanist anthropology, when forensic researchers applied their laboratory techniques to human skulls and bones and cast new theories of human evolution and civilization. First, I put the discussion of Latin American data into the larger transnational context, as it followed on the decades-long scientific craze for craniology in the United States and Europe. Next, I focus on one telling episode of this enterprise: the study of human remains discovered in the last three decades of the 19th century in Patagonia, the southern region of Argentina (and a location which remains to this day a rich site of prehistoric and premodern artifacts). In particular, the paper looks closely at the transnational exchange of scientific objects and ideas between German pathologist Rudolph Virchow and Argentine scientists such as Florentino Ameghino and Francisco P. Moreno. Virchow, best known for his pathbreaking laboratory research in Europe, had a keen interest in applying forensic techniques to the study of human evolution and racial classification; he published a large study of based on Native American skulls dug up in Latin America, "Crania ethnica americana" (1892). Virchow never set foot on Latin American soil, and he relied on colleagues in the field, like Ameghino and Moreno, to procure the human evidence and to help him interpret it. Finally, the paper discusses the careers of these Latin American scientists, who while few in number and elite in perspective, brought real life understanding of the region and a different set of assumptions to the debate over human origins and civilization.

Learning Objectives

Identify successes and failures in the history of medical professionalism.

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).

F2 Metrics of Race Across Four Continents

“Blood-Size: Race and Haematology in Late Colonial India”

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The 1920s was a period of rapid Indianization of the Indian Medical Services. Ironically it was also a time when raciology was revived and redeployed in the study of regional and specific caste populations. Much of this new interest in race was operationalized through a range of new technical and conceptual investments in blood. The mapping of population-wise frequencies of blood groups for instance, was enthusiastically pursued for a while as a way of scientifically distinguishing races ever since Ludwig and Hanna Hirszfeld suggested its possibility in 1918-19. This strand usually came to be designated “Sero-anthropology”. A lesser-known strand of blood-based racial studies followed in the wake of the work of Cecil Price-Jones. Usually designated as “haematology” rather than “serology” or “sero-anthropology”, Indian researchers drew on Price-Jones’ attempts to work out the mean size of the diameter of Red Blood Cells. Combining emergent statistical tools and laboratory techniques for visualizing the blood cells these researchers sought to develop Normal Curves for specific racialized population groups. It was believed that such Normal Curves would be useful for diagnostic blood work. Such studies though small in number, continued to be done throughout the 1930s and 1940s, before being gradually eclipsed by more sophisticated genetic studies. This paper has three inter-related objectives. First it will recount the outlines of this forgotten branch of medical research. Second, it will explore the explicit and implicit politics of these studies. Finally, it will use these studies to draw some more general conclusions about the nature of medical research in late colonial India.

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. Examine the relationship between medical knowledge and power in a specifically late colonial context.

F2 Metrics of Race Across Four Continents

“A Disharmony of Blood: Eugenic Research on Mixed-Race Children and the Production of ‘Purity’ in Postwar Japan”

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Eugenics is often held to have vanished as a global force after World War II, even as the notion of distinct human “races,” let alone a hierarchy of races, was losing scientific credibility. Yet in Japan this trajectory is more assumed than proven. In fact, conditions of occupation heightened the relevance of eugenics as a means of defining and defending the nation. In this milieu, *konketsuji*, or “mixed-blood children” born to foreign fathers and Japanese mothers, became a topic of obsessive popular, political, and scientific concern. Thousands of these children ended up in segregated orphanages, not only because of breakdowns in familial care but because they were actively recruited from their families in the interests of returning “purity” to Japanese bloodlines. Institutionalized *konketsuji* were then subjected to countless medical, mental, dental, and blood tests charting the differences between “black,” “white,” and “Japanese.” So many young researchers flocked to study *konketsuji* that Sawada Miki, the Mitsubishi heiress who founded Japan’s largest segregated orphanage in 1948, joked that “healthy children can’t make doctors” so God had placed “mixed” children on earth to fill that need. Innumerable doctors were indeed made in orphanages like hers, and studies conducted on their wards filled the pages of leading journals like *Iden* [Genetics], *Minzoku eisei* [Race Hygiene], *Jinruigaku zasshi* [Journal of Anthropology], *Nihon ika daigaku zasshi* [Journal of Nippon Medical School], and *Jidō shinri* [Child Psychology]. As is common in race science, in a feat of circular reasoning, these studies proved what they had already assumed: that “mixed-blood” children were, by definition, not “Japanese.” Moreover, they depicted *konketsuji* as not only different, but deficient, chronicling such alarming defects as low immune function, low intelligence, abnormal hemoglobin, “primitive” tooth shape, and even body odor. These findings both reflected and reinforced calls by Sawada and others to segregate “mixed” children and put an end to miscegenation. Though some have treated the “purity” of the Japanese as a superstition born of Shinto or fascist wartime indoctrination, eugenic studies on *konketsuji* highlight the role of scientific methods, facts, and authority in generating racial purity and racial nationalism in postwar Japan.

Learning Objectives

Recognize the dynamic interrelationship between medicine and society through history

Identify successes and failures in the history of medical professionalism

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

F2 Metrics of Race Across Four Continents

“Dreaming and Enacting Scales of Difference: Dermatology and Melanin Sciences as Liberationist Tools in Post-WWII United States”

J. Cecilia Cardenas-Navia; cecilia.cardenas-navia@aya.yale.edu; Yale University, New Haven, CT, USA

Debates over human difference have long animated and troubled the realms of physical anthropology, genetics, biomedicine, and medical practice. Technological innovations such as the spectrophotometer, electron microscope, and gel electrophoresis sharpened biomedical understandings of melanin (the primary pigmentation agent found in skin, hair, and eyes), its source, and its function in the 1950s onward. The dawning of this new era – what I term the melanin era – heralded the possibility of defining skin color as solely a biomedical and scientific artifact, one separate from its tumultuous history as an embedded racial marker. Against the backdrop of growing social and political unrest as the long civil rights movement proceeded apace, I argue that developments in dermatology and molecular biology proposed a race-independent assessment of skin color that prioritized sun reactivity over visiocultural affiliation.

The rise of dermatology in the 1960s, associated concerns with rising incidences of skin cancer, and environmental apprehensions about the thinning of the ozone layer contributed to diverse investigations into melanin as a natural sunscreen and a metaphorical radioisotope for human evolution. The dermatological investigations of Thomas Fitzpatrick, Aaron Lerner, Giuseppe Prota, and William Montagna built a fount of rich resources and diverse communities that aimed to evaluate and unseat their scientific racist predecessors. In particular, the Fitzpatrick scale, posited in 1975 and amended in 1988, presented a phototyping classification schema that ordered light and dark-skinned patients into six groupings, privileging photosensitivity / erythema and tanning reactions over ethnoracial attachment.

Drawing on the ""Archives of Dermatology,"" private collections, and photobiology conference proceedings, this paper examines melanin as a powerful visual marker that allowed physicians and scientists alike to further develop a toolkit for examining pigmentation disorders such as vitiligo, albinism, and Addison’s disease and establish a novel foothold on understandings of human difference. I intend to demonstrate how the melanin sciences and medical practice found themselves in a precarious, yet hopeful, position: while taking into account the violent history of skin color-dependent race and power relations, the possibility of medico-scientific emancipation from a misconceived classificatory concept offered (and continues to offer today) a new vision for future generations.

Learning Objectives

1. To highlight significant contributions of dermatologists and photobiologists to understandings of human difference
2. To identify and situate the boundary cases of pigmentation disorders among patients as key corollaries to the melanin sciences
3. To challenge the gnarled tangle of race and culture, concepts that have a stranglehold on cultural studies and history

F3 Bodies and the Medical Gaze

“Gaze from the Interior: The Puzzle of Chinese Medicine”

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At the heart of national and transnational histories of medicine lies a paradox. While the first historians of Chinese medicine the 20th century struggled to negotiate the bounds of tradition and modernity in hybrid identities of “East-West integration,” the same scholars who sought to define Chinese medicine on its own terms were classically trained scientists. How could “traditional” knowledge systems be legitimized without being scientized?

I examine tensions embedded in this question from the perspective of Lu Gwei-djen, one of Chinese medical history’s most influential and often overlooked actors. I argue that to understand contradictions in traversing boundaries between medical regimes, we must first examine the contradictions within the personal experience of the body. Known as the woman who inspired Joseph Needham to write *Science and Civilization in China*, Lu had been a successful biochemist in England before publishing *Celestial Lancets* in 1981, the first comprehensive history of Chinese acupuncture and moxibation. But despite Lu’s attempts to legitimize the technical advancements of Chinese medicine, she ultimately described Chinese medicine as a paradox: clinically proven, but theoretically antiquated—innovative, but ultimately medieval.

Drawing from archival material of Lu’s personal letters and work notes later in her life, I reveal what Lu had hidden in the experience of her own body—a deeper paradox in her way of being that still resonates in debates on hybrid modes of medicine today.

This paper is in conversation with STS scholarship on knowledge production, medical embodiment, and the history of transnational medicine.

Learning Objectives

- Possess a nuanced body-centered history of medicine that can inform current debates about different systems of knowledge and styles of health care
- Evaluate sources of tension that shape medical epistemology and historical evidence in 20th century China and the West
- Develop a capacity to critically assess how personal encounters with the body influence the assumptions made about medical theory

F3 Bodies and the Medical Gaze

“Where a fat girl wants to look beautiful’: The history of fat camps in the United States as a treatment for childhood obesity”

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“Fat camps” (residential summer weight-loss camps for children) started in the United States in 1959. They were (and are) privately run businesses, offering structured diet and exercise as a treatment for childhood obesity. I argue that, as commercial enterprises, fat camps are a useful indicator of popular anxieties and beliefs about child health. They drew on long-held beliefs connecting childhood, the wilderness, and health, and cultural traditions of self-help. But fat camps married these older ideas with a new emphasis on a child taking personal responsibility for their overweight. Earlier framings of childhood obesity had characterized the condition as simply the result of either an endocrine disorder or of parental liability. The focus on fat children themselves as needing to take charge of their treatment had lasting implications for the stigma of obesity in childhood and, more recently, public health responses to the childhood obesity epidemic. In this paper I examine the history of fat camps in the United States as treatments for childhood obesity, with a special focus on the first fat camp, Seascope in Cape Cod. I also consider the position of fat camps in popular culture, and how they changed in response to shifting anxieties about child dieting and eating disorders since the 1980s, and more recently in response to the rising prevalence of childhood obesity in the US.

Learning Objectives

- Develop knowledge and understanding of professional behaviors and values by recognizing the dynamic interrelationship between medicine and society through history
- Contribute to the improvement of patient care by acquire a historically nuanced understanding of the organization of the U.S. healthcare system, including commercial healthcare products and services
- Develop knowledge and understanding of professional behaviors and values by understanding the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

F3 Bodies and the Medical Gaze

"My Brain Tells Me To Look Away, But My Eyes Just Keep On Staring': Hollywood's Representations of Chemotherapy-Related Hair Loss"

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Hollywood is no stranger to the dramatic power of portraying narratives of illness in movies and television shows, depicting everything from long and lingering diseases such as Doc Holliday's battle with tuberculosis in *Tombstone* to the shock and awe of epidemic disease like the dangerous virus featured in *Contagion*. Few illnesses, though, have captured the attention of the entertainment industry with as much cultural and psychological potency as cancer. Though the entertainment industry has tackled cancer storylines for decades, overt portrayals of the disease's symptoms and effects have only become common in the past twenty years. A critical analysis of the television shows *Murphy Brown*, *Sex and the City*, *Weeds*, and *Parenthood* and major motion pictures *Marvin's Room*, *Wit*, *My Sister's Keeper*, and *50/50* reveals the increasingly explicit depictions of cancer's aspects and deeply gendered representations of the disease's sufferers. Using depictions of hair loss as a result of chemotherapy as a focus point, I analyze the ways in which those representations define and interpret health, illness, gender, and beauty to the viewers and argue that the more explicit illustrations of cancer occurred in conjunction with the advances in cancer awareness and reformulations of gender roles of recent decades.

Historians like Leslie Reagan and Nancy Tomes have argued that portrayals of medicine and illness in the media blur the lines between of education and entertainment to provide a greater awareness among viewers, but carry the risk that viewers will misunderstand the reality of fictionalized illnesses if films and television shows present the disease incorrectly. Hollywood's cancer depictions have become more numerous and realistic over the past twenty years while continuing to walk the fine and shaky line between education and entertainment. While historian Susan Lederer has discussed cancer storylines in major motion pictures before 1970, the existing historiography should be expanded to include more recent films and popular television shows that portray less sanitized versions of the illness. By offering an in-depth analysis of these representations of cancer's devastating effects, this study adds complexity to the ongoing discourse concerning the usefulness of Hollywood's treatment of medicine and illness.

Learning Objectives

1. Recognize the dynamic interrelationship between medicine and society through highlighting the important, but complicated, role of media in popular understandings of cancer, chemotherapy, and physical appearance.
2. Deepen understanding of the gendered and racialized conceptions of illness through an analysis of Hollywood's representations of chemotherapy's physical effects (specifically hair loss).
3. Critically analyze the media's representation of hair loss due to cancer treatment to further understand the interplay between public knowledge and medical fact.

F3 Bodies and the Medical Gaze

“‘The Beauty of the Cure’: The Role of the Visual in Discourses on Cosmetic Surgery in the Canadian Medical Profession, 1900-2000”

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In 2002, a photography exhibition review entitled “Foreign Body: Photography and the Prelude to Genetic Modification” appeared in the Canadian Medical Association Journal. The review describes the works as providing “a window onto human pathology and medical intervention from the mid-19th to the mid-20th century.” In pointing to the ways that “...medicine has shaped human identity,” the exhibit documented the inextricable link between the role of the medical profession in defining what is healthy/normal and societal norms and values. Today, current trends around cosmetic surgery that promote that women should alter themselves (even their genitalia) to look “normal” raise questions about the ways that the medical profession constructed gender and sexuality through their professional authority over the body in the past and what the implications of that history are in our contemporary world.

This paper explores the ways that visual evidence of ‘abnormal’ bodies shaped (and even defined) markers of “health” and “illness.” By documenting examples of deviance, moments when the body appears to be “abnormal,” surgeons were able to identify and seek ways to fix bodies with new surgical procedures. Implicit in these practices were the ways that both physicians and the wider society understood normality and the ways that this understanding shifted and changed over time depending on the socio/historical/cultural context in which was defined. The use of the visual as a means of defining abnormality is further problematized today when patients ask for particular treatments that allow them to “...occupy active positions as advocates, consumers, or even agents of change...” rather than being “passive victims of medicalization.” By exploring the role of the visual in medicine we can better understand the perspectives of both physicians/surgeons and patients in participating in these constructions. Indeed, exposing the ways in which the disciplinary power of medical science constructed normal, healthy bodies in the past (and the influence of other discourses on those constructions) may well provide us with the tools to effectively construct alternate discourses about health, particularly in light of consumer capitalist messages about what it means to be “healthy” in our highly visual world today.

Learning Objectives

By the end of this session, the learner will:

Acquire a nuanced understanding of the ways that visual culture played a role in clinical management from a historical perspective;

Develop an historically informed sensitivity to the diversity of patients and the ways that they were viewed by practitioners;

Recognize the dynamic interrelationship between medicine and society through history.

F4 Medicine for the People

Food for the Body and the Soul: Carolingian Advisory Literature and Medicine

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The nobility of the Carolingian empire in the ninth century were eager producers and consumers of advisory literature—this has been well established. Yet, Carolingian scholars and historians of medicine continue to overlook the huge number of medical manuscripts that survive from this period and whose composition has been assigned to diverse locations in the empire. This paper seeks to bring the wealth of medical material into dialogue with other genres of literature that were popular in the Carolingian age, and that modern scholarship has tended to categorize as emblematic of ninth-century belief.

A new genre that appears around the turn of the ninth century is the handbook of advice—advice, in this case, given by ecclesiastics for lay noblemen who were concerned about how they, involved in secular affairs, could lead a life pleasing to God. As the authors themselves state, these texts provided the noblemen with spiritual food, which was designed to ensure the eternal health of the soul.

In this paper, I concentrate on the fact that a primary concern of these handbooks is, however, the daily management of bodily urges and responses, as well as the establishment of a proper relationship between the soul, mind, body and cosmos. This, I suggest, associates the advice handbook with the medical treatise. The two genres are further linked by their shared epistolary form. But the most significant parallel between the two categories of texts is the fact that a reoccurring and underlying theme in both is the governance of the body, and the relationship between the health of the soul and the health of the body.

Thus, I believe that a comparative examination of the advisory and medical literature produced in the ninth century can highlight contemporaries' keen interest in the workings of the inner man, where the physical, moral and spiritual crossed paths. This analysis, in turn, helps to shed light on why the Carolingians preserved the medical material they did and how it can be contextualized within broader histories of medicine.

Learning 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

Become aware of the ways that bodily and spiritual health have been associated in history

F4 **Medicine for the People**

"A correspondence course in intelligent parturition': Canadian Letters to Dr. Grantly Dick-Read, 1946-1956"

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"Anticipating a "long-awaited" fourth pregnancy in the spring of 1948, a twenty-seven year old woman from rural Alberta wrote to Dr. Grantly Dick-Read, British obstetrician and the leading figure in the burgeoning natural childbirth movement. Praising Dick-Read's influential volume, "Childbirth Without Fear", this young wife and mother asked the doctor "to take on a patient 6,000 miles away", and requested "a correspondence course in intelligent parturition." Though Dick-Read responded that the letter writer, was, unfortunately "just outside [his] limit for attending women in labour!" this woman continued with the doctor throughout and following her pregnancy, for a period of approximately eighteen months. While not his patient, this woman, like other Canadian mothers who took the time to write to Dick-Read, was an active and enthusiastic participant in the broader international campaign for "childbirth without fear", one of the first to contest the increasing medicalization of childbirth that had gone largely unquestioned since the late-nineteenth century.

Though historians have examined the impact of Dick-Read's theories in Great Britain and the United States, his teachings have received little attention in the Canadian context. This paper begins to correct this imbalance by examining a series of previously unexplored correspondence between Canadians and Dick-Read. In the postwar years, Canadian mothers (and, to a lesser extent, fathers) wrote to this British physician praising his crusade and expressing a desire to further promote the movement in Canada. Letter writers sought referrals to physicians amenable to the principles of natural childbirth, as well as more generalized marriage and family advice. At the same time, in their engagement with this international movement, Dick-Read's correspondents provided their own critical commentary on the Canadian medical establishment's treatment of parturient women and reception of natural childbirth tenets. More broadly, Canadian mothers used their letters to express their views on the nature of the female body, pain, and giving birth. Although the movement marked a turning point in the history of childbirth and the end of the first heyday of obstetrical anaesthesia, ultimately, both Dick-Read and his correspondents continued to articulate decidedly conservative interpretations of these subjects.

Learning Objectives

This presentation will:

1. Provide evidence of Canadian engagement with and involvement in broader international medical movements.
2. Demonstrate the cyclical nature of historical trends in the medicalization of the female body and of childbirth with reference to a significant counter-movement, the "natural childbirth" campaign.
3. Interrogate existing assumptions about the nature of the doctor-patient relationship.

F4 Medicine for the People

“‘Suggestive in itself’: The Layman’s Medical Journal”

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The problem of how to provide good health information for the public is as old as the demand for health information by the public. In June 1909, at the American Medical Association meetings in Atlantic City, a resolution was adopted by the AMA House of Delegates: that women physicians “take the initiative individually, in their respective associations, in the organization of educational committees, to act through women’s clubs, mother’s associations, and other similar bodies for the dissemination of accurate information touching these subjects among the people.” Sisters Adeline and Julia Riddle of Oshkosh, Wisconsin, responded to the call with the *Layman’s Medical Journal*. The Riddles were graduates of Chicago’s Woman’s Medical College; religious conservatives, but political progressives and woman’s suffragists; proponents of early sexual health education in the public schools, but firm opponents of sex in the city; and a homeopathic/eclectic and “regular” physician, respectively. Their journal was described by Progressive Wisconsin Senator Robert LaFollette as demonstrating “an intelligent and progressive woman’s sympathetic understanding of woman’s needs and viewpoint.” It may have been the first consumer health journal in America, predating the AMA’s *Hygeia* by 14 years. In this paper I will discuss the short, tortured, but illustrative life of the Riddles’ journal.

Learning Objectives

1. By the end of this activity, the learner will recognize the dynamic interrelationship between medicine and society through history.
2. By the end of this activity, the learner will respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.
3. By the end of this activity, the learner will deepen understanding of the ways in which health information provision and health education has always been subject to sociopolitical pressures.

F4 Medicine for the People

“The Little Manual that Started a Revolution: How Midwifery Became a Hippie Practice”

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On Mother’s day in 1970, Joanne Santana, a pregnant, self-proclaimed hippie living in San Francisco, pulled a lightweight paperback book off the shelf at New Age Natural Foods store. Written by Dr. Leo Eloesser, Isabel Hemingway, and Edith Galt, this copy of *Pregnancy, Childbirth, and the Newborn: A Manual for Rural Midwives* was one of 10,000 Second English edition copies printed in Mexico in 1959. Originally written to accompany courses taught by Hemingway and Galt (both certified nurse midwives) in the Shanxi Province of China shortly after World War II, this edition was published in collaboration with the Inter-American Indian Institute (Instituto Indigenista Interamericano) in Mexico with funding from both UNICEF and the World Health Organization. Intended primarily for rural midwives without any previous education or training, the authors “endeavored to make it simple and understandable,” couching their arguments in “everyday popular language.” Taught in China, published in Spanish, English, Korean, and Portuguese, *Pregnancy, Childbirth, and the Newborn* reached a global market.

Drawing on archival material and interviews, this paper explores the unusual group of readers that transformed lay midwifery practice in the United States with the aid of this rural midwifery manual. Shortly after Santana purchased the book, she joined over two hundred followers of Stephen Gaskin on his 42-state speaking tour in a caravan of fifty-odd buses. Eleven babies were born on these buses with no doctor present and Santana’s midwifery manual as the only guide. Since then, these midwives have promoted a birthing style in their own midwifery guide, *Spiritual Midwifery*, which has sold over half a million copies and been translated into six languages. More than a decade before the first edition of *Our Bodies, Ourselves* would offer lay readers an accessible manual on women’s health that triggered a women’s health movement, *Pregnancy, Childbirth, and the Newborn* became a do-it-yourself tool that provided the necessary foundation for a burgeoning home birth movement.

Learning Objectives

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

F5 Medical Pluralism Revisited

“Close encounters of the visual kind: Oculists, public knowledge and the new science in early-eighteenth-century England”

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In private lodgings and public halls, coffee-houses and marketplaces, in print and in person, the population of early-eighteenth-century England encountered oculists: men and women who specialized in the treatment and surgery of the eye, and whose frequent entrepreneurial endeavors could not have failed to bring attention to their practices. To the medical world of the day, it seems, these operators were either dismissed as arrant quacks or grudgingly acknowledged as the purveyors of a lesser manual surgical skill. Certainly, in the mid-eighteenth century, Thomas Gataker of the College of Surgeons candidly argued that the medical and surgical professions' lack of contribution to training in and treating the eyes was partly responsible for the flourishing of quack oculists in the city (a state of affairs he hoped to quickly correct). And yet, through their very visibility in early modern society, oculists occupied a novel space as public experts in the distempers of the organ of sight.

Against this backdrop, this paper examines the way that early modern society (medical men, the enquiring English public, and patients) gained knowledge of the operation and physiology of the human eye. It does so by exploring the contributions made by those practitioners that Gataker sought to dismiss – those oculists and operators who made a living treating the distempers of the eyes, and, not infrequently, performing their surgeries before audiences of the elite and members of the medical establishment as well as their day-to-day clientele. From the perspective of these varied encounters, oculists emerge as a constitutive component of early modern conceptions of sight and of the new structures of empirical (and public) scientific knowledge. Rather than drawing from a position of authority and social credit, however, it was through oculists' ongoing endeavors to carve out a livelihood that they ultimately shaped public and medical understanding of the wonders of the eye.

Learning Objectives

Recognize the dynamic interrelationship between medicine and society through history

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

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

F5 Medical Pluralism Revisited

"Make no Bones About It: The Celebrity of Sarah Mapp, an eighteenth century bonesetter."

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The subject of this paper is the English bonesetter Mrs. Sarah Mapp (née Wallin 1706-1737) one of the most celebrated healers of the eighteenth century. After having obtained initial notoriety in the town of Epsom, Mapp's fame spread to London where since the middle of 1736 numerous newspapers provided detailed favourable testimonies of her practice together with biographical information. While residing at Epsom she weekly attended patients at the Grecian Coffee House in Devereaux Court in London where she successfully treated the young niece of the physician Hans Sloane. Large numbers of curious folk of different social strata witnessed her announced participation in social events and a song, a ballad and a theatrical piece celebrated her skills. Mapp was apparently received by the Queen and she was included in William Hogarth's satirical print *The Company of Undertakers*. News of Mapp's fame and her flamboyant behaviors also reached Jonathan Swift's private correspondence. She died penniless in London in December 1737. Her literary posthumous life reaches our times, surfacing especially in the context of nineteenth and twenty centuries diatribes regarding the legitimacy and therapeutic efficacy of bonesetting, chiropractic and osteopathic practices.

The historical relevance of Mrs. Mapp is threefold: first, it provides a remarkable example for a necessary reconsideration of her historical figure as a healer, especially in considering the range of her reported patients, their ailments and the patronage she received. Thus far she has been generally discussed, with notable degree of historical depth, in the context of quackery. Second: a study of Mapp's detractors (in particular the surgeon Percivall Pott) and supporters illuminates the complex and sometimes ambivalent relationship of bonesetting with general surgical practices, while underscoring the social function of specialized healers during the early modern period.

Third, in addition to a more comprehensive analysis of those medical advertisements that contributed to Mapp's celebrity, I will add several new case studies highlighting the role played by the printing press in constructing medical and scientific knowledge. Finally, Mapp's 'afterlife' will also be synoptically discussed.

Learning Objectives

Recognize the dynamics interrelationship between medicine and society through history.

Deepen understanding of illness and suffering.

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

F5 Medical Pluralism Revisited

“Medical pluralism or labor pains of professionalization?: Ottoman healing arts revisited”

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The scholarship on the history of early modern Ottoman medicine has long suffered from approaches that treated it as monolithic and timeless. According to this, it was imagined to be simply a continuation of either Turkish or Islamic medical traditions. Recently, historians of Ottoman medicine have offered a corrective to this bipolar vision by emphasizing its pluralist and multicultural nature. It was suggested that the learned medicine existed hand-in-hand with prophetic and folk medicine in the early modern Ottoman empire. Notwithstanding the merits of medical pluralism, I contest this vision of peaceful co-existence for it blurs the dynamics of power between different agents. I contend that the Ottoman marketplace of healing arts was highly competitive, in which there were several actors vying to receive a better share. Ottoman sources suggest that the rise of the Ottoman state in the sixteenth century with its claims extending over creating a class of medical professionals and surveillance of medical practice changed the medical scene irreversibly. It appears that the rise of the state co-opted a body of Ottoman-educated Muslim physicians, employed them in its burgeoning institutions, imposed new scholarly and institutional hierarchies, and thus created a group of medical professionals. On the basis of hitherto unexplored cases from the Ottoman archives, this paper will seek to demonstrate how the state actively sought to marginalize and eliminate competitor actors, using methods of surveillance (such as, licensing and examination) and discrediting their reputation (such as, propaganda and banishing from practice).

Learning Objectives

Identify successes and failures in the history of medical professionalism

Understand the dynamic history of medical ideas and practices in different historical contexts

Recognize the dynamic interrelationship between medicine and society through history

F5 Medical Pluralism Revisited

“Quackbusters: The Controversial History of the National Council Against Health Fraud”

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Inspired by James Harvey Young’s book *The Medical Messiahs*, which he described as a chronicle of “government efforts to control health hucksters,” and a 1969 anti-chiropractic book written by a member of the American Medical Association’s Committee on Quackery, Dr. Stephen Barrett incorporated the Lehigh Valley Committee Against Health Fraud in 1970. Barrett, a psychiatrist, eventually joined the AMA’s Committee on Quackery and became a nationally known consumer advocate, author, and lecturer on the subject of health fraud in the 1970s. He also collaborated with two of the other most prominent anti-quackery groups formed independently in California in the second half of the 1970s, amidst the mounting Laetrile controversy. In 1978, these factions merged to become the California Council Against Health Fraud. By 1984, the Council had expanded to the point that a majority of its members resided outside California, so the decision was made to change the name and scope of the organization. By the late 1980s, the renamed and re-energized National Council Against Health Fraud (NCAHF) boasted 2,300 members. Self-identified as “Quackbusters Incorporated,” the NCAHF was made up primarily of physicians, scientists, and educators committed “to exposing medical fraud schemes, alerting governmental agencies to scams, and writing newsletters about the dangers of permitting such practices to proliferate.” With this work, and a tiny budget of \$50,000 annually, collected from small member donations, the NCAHF, more than any other group, assumed responsibility for leading the anti-quackery fight following the closure of the AMA’s Department of Investigation, which had operated as the most prominent anti-quackery organization in the country for much of the twentieth century. Under the Council’s watch, some of the controversial tactics and terms of what had been a decades-long anti-quackery crusade remained the same, while others would fundamentally change as the century came to a close. “Quackbusters: The Controversial History of the National Council Against Health Fraud” unpacks this tale involving undercover operatives, lawsuits, and accusations of misrepresentation and fraud.

Learning Objectives

Develop an historically informed sensitivity to arguments about the role of complementary and alternative medicine in health care.

Acquire a historically nuanced understanding of the history of efforts to combat health fraud in the late twentieth-century United States.

Understand the dynamic history of medical ideas and approaches, including their implications for the therapeutic choices available to patients.

F6 Art and Anatomy

“Representing forces that act upon and within the body: Fritz Kahn’s iconography of corporeal energy, 1920-1940”

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The small body of scholarship on Fritz Kahn (1888-1968) focuses mainly on “Der Mensch als Industriepalast” (1926), a poster that depicts the human organism as an orderly industrial complex. But Kahn and his artists also made hundreds of medical illustrations that model dynamic interior action: in the “Knock-out” (1939) a little swarm of jagged lines spreads between spine and liver; the “Soccer Player” and “Sun Girl” (also 1939) both feature dotted, dashed, wavy lines and arcs. In representing the action of forces on and within the body, Kahn repurposed a well-established iconography of what early modern natural philosophers called “occult forces” — forces hidden, invisible, and / or abstract but also powerful and meaningful. Straight, circular, jagged, elliptical, radiant, these symbols go back to antiquity, the Middle Ages and the early modern era where the iconography of geometry, astronomy, optics, and mechanics converged with the iconography of spiritual power — those radiant haloes, spheres and auras. Alchemy was a particularly rich field for the diagramming of occult forces, a domain of intoxicated representation, but so (with only a little more sobriety) was chemistry, physics, and mathematics. Moveable type and the burin — printing and engraving — also made key contributions and influenced freehand art. Out of all of this there emerged a diagrammatic storehouse of arcs, dashes, lines, lightning bolts, stars, exclamation points, halos, auras, glows, ripples, beads, and droplets. In the 19th-century such symbols appear in all sorts of illustrated medical and scientific texts, especially anything to do with electricity, magnetism, mesmerism. They also frequently appeared in cartooning — Gillray’s prints, E.C. Segar’s Thimble Theatre, Otto Messmer’s Felix the Cat, etc. — where the iconography of hidden forces stocked a parallel iconography of subjective sensation, impulsive action and emotion: the familiar visual vocabulary of emphatic pain, astonishment, fear, disorientation, anger, violence, noise and kinetic movement. This paper focuses on Fritz Kahn’s medical illustrations to think aloud about the visual vocabulary and grammar of forces and feelings as a visual rhetoric of modernity and critique of traditional anatomical representation.

Learning objectives

1. To learn why 20th-century medical illustrations increasingly tried to visually explain the work of forces in the body and on the body, rather than to show anatomical features.
2. To learn how aesthetic modernism and ideological commitments to modernization changed medical and scientific illustration in the 20th century.
3. To learn about the sources that 20th-century medical illustrators drew upon to show the work of forces in and on the body.

F6 Art and Anatomy

“Drawing the anatomy of the New Man. Visual cultures of anatomy in interwar Vienna, global networks of exchange and the emergence of a modern perspective”

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.Anatomists, social policy makers and artists produced in early 20th century Vienna a variety of images of the human body, that had different functions, uses and meanings in changing scientific, political and cultural contexts. Various media of anatomical visualization competed, both in the academic spheres of medical and art schools as well as in several places of popular negotiation and production of visual cultures of medicine, such as museums or public health education.

In my talk I will examine medico-anatomical imaging in the interwar period as a cultural practice. Around 1900 Vienna housed one of the leading medical schools, famous for its rich collections and the production of teaching aids. The First World War however, not only made anatomical visualisation a difficult and precarious endeavour within limited personal and material resources but turned it into a highly political endeavour, engaged in designing future humans and society against the background of key changes in the life sciences, vivid public health debates, aggressive politics and eugenic discourses.

Looking more closely at interwar anatomical image production reveals medical, socio- and biopolitical knowledge in transit. What (epistemic) values determine the specific construction of visual anatomies? What discourses and practices realise actor’s assumptions of corporeality, health, sickness and society and what are the contexts that set the stage for the transformations of knowledge, political, social and symbolic orders, related to image production?

On the basis of five key artefacts - an anatomical atlas, a public health chart, a wire brain model, an oil painting and an x-ray film - I will trace exchange processes between national and global visual cultures to elucidate socio-political and scientific orders at work. Working from and with these artefacts, I plan to tell vivid stories about drawing social landscapes (Latour 2007), producing political images (Rancière 2006), and propagating knowledge about the body. By tracing out these interrelationships, my talk will allow us to take a closer look at urban structures, local milieus and their international networks, thus elucidating, for example, how the first social- democratic anatomical atlas links to hygiene fairs, the global polis and the new visuality of radiokinematography.

Learning Objectives

Recognize the dynamic interrelationship between medicine and society through history

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

Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy

F6 Art and Anatomy

"Artists, Anatomists, and the Transparent Body: Human Identity and the Categorical Impulse"

Corinna Wagner c.m.wagner@ex.ac.uk; University of Exeter, Exeter, UK

In 1801 three members of the Royal Academy – the sculptor Thomas Banks and painters Benjamin West and Richard Cosway – asked the London surgeon, Joseph Carpue, for a fresh corpse. The group obtained the freshly executed body of James Legg, a man condemned to death for murder. They flayed and hung Legg's body on a cross, in order to prove that the great masters, who did not properly understand human anatomy, had inaccurately depicted the crucified body of Christ.

In this illustrated presentation, I will investigate this and similar collaborations between artists and anatomists, who shared a belief that the body's interior structure and its physiological workings was the means of understanding the nature of the human. Two medical art forms in particular – wax anatomical models and *écorchés* – inspired ethical debates about the social and moral effects of dissection and display. How might seeing into the body change the way humans were classified according to developing categories of the normal and the pathological? How did more realistic, accurate representations of the body affect feelings of human compassion, sympathy and communality – among professionals as well as the public? How did developments in anatomy and anatomical representation shape attitudes about race, gender, class, character, intelligence and other markers of identity?

These types of ethical questions, which lie at the heart of the relationship between art and medicine, galvanized commentators throughout the nineteenth century – and they continue to do so today. I argue that the push to render the body transparent has significantly altered the way bodies are measured, practices are evaluated and abilities are judged. My goal is to evaluate this legacy, as well as that of the respective roles of artists and anatomists in this debate.

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) Identify successes and failures in the history of the relationship between medicine and the arts.

F6 Art and Anatomy

“‘A spirit of accurate observation’: Patient Portraiture, Pathology, and Display in Dublin c.1830-1870”

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In 1838, the newly established Dublin Pathological Society, comprising the great ‘innovators’ in Irish medicine and education, boldly asserted they were engaged in the ‘cultivation of Pathological Anatomy’ and exploring ‘it’s bearings on the practice of the healing art’. The members employed the artist, J. Connolly, and between 1830 and 1870, he produced over a thousand paintings of pathological specimens and of patients treated in Dublin’s pauper hospitals. He joined the army of ‘invisible technicians’, operating within a medical marketplace, supplying ‘accurate’ paintings, which were subsequently displayed in medical museums and reproduced in treatises and journals internationally. In contrast to the scholarly engagement with the photographic representations of diseases and patients, medical portraiture and medical museums, research on patient portraits has been limited. Yet before photography, patient portraits were intrinsic to nineteenth-century medical education and, through display, were pivotal in the exchange of medical ideas, nationally and transnationally. Drawing on this underutilized collection of drawings, and other contemporary sources including the records of the Dublin Pathological Society, this paper explores the production and uses of patient portraits. Composed under the direction of leading surgeons and physicians and intended to be viewed alongside detailed clinical records and pathological specimens, the paper asks whether Connolly’s images represent ‘clinical’ patients or disease entities and considers to what extent he imbued them with his own artistic sensibilities thereby complicating our understandings of practitioner/patient encounters and of the ‘medical gaze’. While primarily pedagogical tools, the lay, usually male, population could view Connolly’s paintings in Dublin’s medical museums, periodically opened to the public: in this context, the images lost their pedagogical functions becoming part of the mid-Victorian appetite for ‘freak shows’. Finally, the paper will interrogate the ‘afterlife’ of the images in medical literature, asking whether they explicitly linked Irish patients with diseases of poverty and vice.

Learning Objectives

1. To develop an historically informed understanding of the development of pathological illustrations.
2. To deepen understanding of debates on the power relationship between patients and practitioners and the dignity of patients.
3. To consider the functions of medical illustrations as educational tools, and in the dissemination of medical knowledge.

G1 The Afterlife of a Disease in Four Cultures: Leprosy, Social Memory, and Public Health

“Discourses of dis-ease: popular history, media, and academia in the history of leprosy in Hawai‘I”

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The history of leprosy in Hawai‘i has captured popular imagination since the disease first became a public health concern in the islands in the mid-19th century. Today, popular understandings of the disease and its history prevail, but often in conflict with more recent research and understandings of the events surrounding public health efforts and the community that developed on the Kalaupapa peninsula in the environment of “isolation”. In particular, the patients' experiences have been given little attention until the last decade. A large part of the public's fascination emphasizes the notable sacrifices of Father Damien and Mother Marianne (both recently canonized) to serve the community, but greatly overshadowing the experiences, sacrifices, and efforts of thousands of patients, as well as some three to four hundred kōkua (helpers) who went with their loved ones to the settlement, and the original inhabitants of the peninsula who remained in the settlement area until the 1890s, despite a policy of quarantine.

Whether it be literature that so often portrays those with leprosy as helpless or lawless, or recent films such as, *Moloka‘i: the story of Father Damien*, which in its very title claims to the audience that the real story of Molokai is of Damien – not the island and its rich cultural and social history; nor of the over five thousand Native Hawaiians affected by leprosy in the 19th century, these offerings in popular media often shape the collective memory of society. But as more recent research has been done, especially that which utilizes Hawaiian language sources, a new view of the patients' experiences has emerged. However, these new understandings often create a tension with the myths that have been built over time wherein many popular books, films, and local media coverage continue to focus more on the service of a few, than on the experiences of the patients and their families, and frequently offer a distorted, sensationalized view of the settlement and its past.

This research argues that much of this disconnect between popular understandings of this disease/history and ‘what really happened’ can be understood by examining society's historical discomfort with leprosy.

Learning Objectives

- 1) to deepen understandings of illness and suffering
- 2) recognize the dynamic interrelationship between medicine / concepts of illness and society through history
- 3) develop and historically informed sensitivity to the diversity of the patient experience within an indigenous context

G1 The Afterlife of a Disease in Four Cultures: Leprosy, Social Memory, and Public Health

“Coming to Terms with an Invisible Profession: Leprosy Doctors in Socialist China”

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This paper examines the formation and practice of leprosy control as a medical profession in China from the early 1950s until the 1980s. Leprosy was on the priority list of the newly established socialist state that aimed at eliminating some major epidemics. The professional career of the so-called leprosy doctors was hence intertwined with China's socialist ethos that embodied a unique set of gender and class politics. That socialist ethos conscripted leprosy doctors based on certain socio-political classes; it also doubly marginalized leprosy doctors by de-emphasize the gender issue in disease control that was highly gendered in practice. It was under this context that many women became leprosy doctors and navigated through a life that was full of challenges and hardships. Many male doctors were unavoidably involved in a medical practice that was unlike the usually male hegemonic profession. These doctors have a broad range of backgrounds from well-known medical school training to the state-initiated short-term and often on-site clinic training. In their everyday life practices, they had to maintain the delicate balances between official doctrines, social realities, and their own emotions. Through the life narratives of a few individuals who became leprosy doctors at various points during China's collective era, we may see that their professional memories were virtually invisible to the public because of the enduring stigma associated with leprosy, and that episodic utopian experiment had become part of an invisible macro history of health campaigns in socialist China.

Learning Objectives

- (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) Recognize the dynamic interrelationship between medicine and society through history

G1 The Afterlife of a Disease in Four Cultures: Leprosy, Social Memory, and Public Health

“The Politics of Apology, Human Rights and Social Inclusion of Hansen’s disease patients in Korea”

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On May 16th of 2009, Han Sungsu, then the Prime Minister of Republic of Korea paid a visit to the Sorok National Hospital and in front of the elderly patients, offered an apology for the past discrimination and sufferings. Although his purported apology did not contain actual words of apology, his visit was nonetheless, hailed by the media at the time as an official recognition of the Hansen’s disease patient population in Korea. Coming at a time when the Lee Myung Bak government was being criticized for its curtailing of the autonomy of the National Human Rights Commission and the increasing control of the press, the PM’s visit to Sorok Island helped to negate the negative images the government had been accruing since the massive civil demonstrations against the government’s unpopular decision to import U.S. beef in 2008.

Although the PM’s visit was portrayed as a bold news step taken by the Lee administration in addressing issues of human rights and social discrimination, this paper argues that the visit to the island was noting new, but part of long tradition of mobilizing the Hansen’s disease population to show the humanity of the South Korean state. This practice of using the Hansen’s disease community to ‘humanize’ regime was first initiated by the Pak Chung Hee dictatorship through series of well – publicized visits to patient villages by his wife, Yuk Yongsu. By exploring the long history of the close relationship between Hansen’s disease control and the post – colonial state, this paper hopes to reassess the claims of humanitarian efforts undertaken on behalf of the Korean Hansen’s disease population in the past.

Learning Objectives

- 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.

G1 Leprosy, Social Memory, and Public History: The "Afterlife" of a Disease in Four Cultures

"Whose history is this anyway?: Patient Activism and the Politics of Japan's National Hansen's Disease Museum"

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On March 2007 the National Hansen's Disease Museum of Japan officially opened in a ceremony presided over by Yanagisawa Hakuo, then Minister of Health, Labor, and Welfare. The museum sits on the grounds of Tamazenshoen, one of a national system of leprosy sanatoria created in the wake of the 1931 Leprosy Prevention Law, which required the lifetime confinement of all of Japan's leprosy sufferers. At one time these institutions housed more than 10,000 people; now they are home to a dwindling population of aged and infirm former patients. In his greeting to an audience of journalists, officials, activists, physicians, and some "residents" (as former patients prefer to be known) of the sanatoria, Yanagisawa stated that he hoped that the museum "would become a core institution in the dissolution of prejudice and discrimination." Yanagisawa was followed by Miyasato Mitsuo, the Chairman of the National Conference of Sanitoria Residents. Miyasato seized the opportunity to criticize the museum and declared, "the exhibits are entirely inadequate and conceal the shadow of the patients' own testimony which is like blood spewing forth."

These two contrasting statements—the one blandly optimistic about the resolution of a general social issue, the other angry, specific, and personal—are indicative of the tensions evoked by the museum's portrayal of the history of leprosy in Japan. The museum was established as part of a compensation package to those who were confined under the Leprosy Prevention Law, and patient representatives, disability activists, and historians were involved in planning its exhibits. Nonetheless, upon the opening of the museum, its displays met with a chorus of criticism in both the print media and the blogosphere, with many charging that the museum "white-washed" the human rights abuses leprosy suffered at the hands of the Japanese state. This paper explores the complicated set of interests involved in the establishment of the national museum and argues that the museum was from out the outset shaped by an attempt to relate multiple and irreconcilable narratives—of patient suffering, of medical progress, and of the competing claims of compassion and control.

Learning Objectives

- 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.

G2 The Practice of Medicine in Wartime

“From the Kitchen to the Bedside: Feeding the Sick in Germany During World War I”

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In the early twentieth century—when anesthesia and antisepsis had made surgery increasingly successful—internists treated their patients with some drugs, “physical medicine” like massage or hydrotherapy, and diet. Indeed, diet was supposed to be the primary therapy in conditions as diverse as heart failure, gastric ulcers, kidney stones, and diabetes mellitus. Clinicians prescribed or proscribed foods and drinks for their patients based on a combination of empiricism, biochemical markers like glycosuria, and physiological principles such as irritability (i.e. meat and gout). Equating illness with weakness also ran as an undercurrent throughout the “Krankenkost” (food for the sick) that wives and mothers served to ailing family members.

During World War I, the Allies’ trade embargo led to a severe food crisis in Germany, and the resulting patchwork rationing system challenged medical and traditional practices of feeding the sick. General rations assumed a universal body with homogeneous physiology, but clinical dietetics and sick recipes in cookbooks recommended individualized meal plans that often required less of common foodstuffs (like “war bread” and turnips) and more of scarce foodstuffs (like milk, meat, and butter). Special rations for the sick became a tug of war between preventing the spread of tuberculosis and fueling the on-going war effort, between humanitarianism and the limited food resources of the community. Institutionalized patients suffered most from this political economy.

To characterize the difficulties of feeding the sick in Germany during WWI, I rely primarily on the medical and popular writings of Dresden City Physician Franz Dienemann. Forty memos he circulated to the city’s practitioners with instructions on how to prescribe according to the rules for special rations offer a fascinating behind-the-scenes look at the constant struggle of a local government to feed its citizens—and of physicians to treat their patients. Two editions of Dienemann’s dietary advice book reveal laypersons’ push-back on matters of diet and health. Despite scholarly interest in the socialization of the food system in Germany, I know of no other researcher who has compiled such an in-depth description of sick rations in any locale. This paper thus contributes to studies on the practice of medicine in wartime.

Learning Objectives

By the end of this activity, the learner will:

- 1) Appreciate the dynamic history of clinical dietetics as both theory and practice.
- 2) Understand the interplay between medical practice and social contexts like war and poverty.
- 3) Develop a historically informed concept of professional responsibility and patient advocacy in policy settings.

G2 The Practice of Medicine in Wartime

"Black Physicians and the Great War"

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The Great War represented an opportunity for Black physicians to prove their medical competency in response to the systemic racism they faced within the medical field. When the United States Army requested the services of medical doctors, Black physicians seized the chance to volunteer; yet, many of them were met with discriminatory policies reflective of Jim Crow. The National Medical Association responded by filing complaints with the federal government demanding that the military view Black physicians as medical professionals above all else. These exchanges, along with the rhetoric in the "Journal of the National Medical Association" ("JNMA"), reveal the belief among Black physicians that offering their medical expertise to the war efforts would increase their professional status in several ways. First, it would assert that African Americans were capable of being competent medical authorities. Second, it would prove that Black physicians were patriotic and thus deserving of the benefits of full citizenship in the United States. Third, it would represent another occasion in which Black physicians could pursue development of the medical profession. This paper will explore the rhetoric used by the "JNMA" contributors in their efforts to promote military service to their peers. Additionally, the paper will review the aftermath of the war by analyzing how Black physicians viewed their own service and how they were received by the military and government. Finally, the paper will situate the views and experiences of Black physicians within the broader context of African American involvement in the Great War. The experiences of Black physicians ultimately provide for a more nuanced understanding of medical professionalism, the contributions of African Americans to medicine, and the relationship between race, medicine, and society. Many African Americans criticized American involvement in the war and remained skeptical of their potential role within it. Moreover, White medical professionals, politicians, and military leaders questioned the efficacy of African American war efforts. Nonetheless, Black physicians viewed the Great War as a tremendous opportunity for professional advancement in the medical field, and a chance to prove their worth to the United States.

Learning Objectives

Identify successes and failures in the history of medical professionalism

Understand the relationship between race and the medical profession

Recognize the dynamic interrelationship between medicine and society through history

G2 The Practice of Medicine in Wartime

“Vascular Surgery in World War II”

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In World War II, damage to the vascular system comprised less than 1% of all wounds, yet it accounted for greater than 20% of amputations in American servicemen. These grim statistics – scarcely improved since the First World War a quarter of a century earlier – belie the dramatic improvements made in both vascular surgery and military medicine in the first half of the twentieth century. Drawing on archival records, interviews, and surviving medical literature, this presentation will explore the practice of vascular surgery in World War II and articulate challenges to its implementation.

The rise of modern surgery in the late 19th century fostered a technical revolution for vascular operations, epitomized by Alexis Carrel’s receipt of the Nobel Prize in 1912 for his method of vessel anastomosis. Despite these novel procedures, military surgeons in World War I resorted to centuries-old ligation, which often resulted in amputation. Interwar developments promised improved chances to save life and limb. Arteriograms helped visualize damage; heparin obviated thrombotic occlusion; and sympathectomies promoted collateral circulation. Moreover, the introduction of penicillin, massive blood transfusions, and evacuation by airplane during World War II created heretofore-unknown operative opportunities on casualties who never would have survived in previous wars. Although the theory of vascular surgery approached its apogee, its practice remained relatively (and frustratingly) unchanged. Ligations still comprised well over 90% of arterial operations, leading to amputations in an astounding 40% of patients.

Given the numerous advances in medicine surrounding vascular surgery, the absence of more complex procedures in World War II raises important questions about the development of a surgical specialty and particularly the insufficiency of technical advances alone to change practice, as Thomas Schlich has demonstrated for transplant surgery. The presentation concludes by exploring why vessel repair failed to materialize in the Second World War, with tactical contingencies, command interference, and inadequate training of surgeons all contributing to its absence. Examining these factors highlights the importance of the social, military, and medical milieus necessary to advance surgical practice and foreshadows why arterial repair flourished soon thereafter during the conflict on the Korean peninsula.

Learning Objectives

1. Critically appraise clinical management from a historical perspective
2. Understand the dynamic history of surgical ideas and practices, their implications for patients and health care providers, and a need for lifelong learning
3. Develop the capacity for critical thinking about the nature, ends, and limits of medicine

G2 The Practice of Medicine in Wartime

“The history of the "Revier" or hospital in the concentration camp of Flossenbuerg, 1938 – 1945”

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.The contradictory logic of the national-socialist regime to open hospitals in the inhuman universe of concentration camps is not new, the latter ones having been designed to „exterminate prisoners by work.“ Neither is it unknown that under the totally insufficient hygienic conditions epidemics among prisoners spread easily and often.

In my paper I shall compare two physicians faced with a typhus epidemic in fall/winter 1944 in the camp of Flossenbuerg: Heinrich Schmitz, the only known civilian physician working inside a concentration camp and Frantisek Wenzel Pollak, an imprisoned Czech physician. When confronted with a typhus epidemic Schmitz falsified blood tests and denied existence of clinical symptoms. He banned effective preventive measures, whereas his assistant, Pollak, unsuccessfully tried to convince him that the disease was not influenza, but typhus or fleckfever. He resorted to secretly admitting sick prisoners for care. Estimations range between 600 an 3000 people who died because of this epidemic alone. Little light has been shed on Schmitz’s superiors and their responsibility for negating this epidemic, moreover we know little about the restricted, depressing and life-threatening circumstances, prisoner physicians like Pollak were forced to work in.

I shall analyze archival material that has been discovered recently, among those one preserved patient listing from camp, which will be compared to a listing established after liberation by the 120th evacuation hospital. Furthermore I shall draw details from protocols from the Flossenbuerg trial in 1946/47 and include eyewitness accounts to answer questions like: is it possible to more precisely estimate the number of prisoners who died because of this epidemic? Which preventive and therapeutical means were present at the time and why were they not used? What was the relationship between these two men like and how did it affect the medical care they delivered? What possibilities did Pollak have to possibly counteract Schmitz’s passivity? This analysis fills a knowledge gap about the medical infrastructure in the concentration camp Flossenbuerg during one specific period and relates it to the practice of medicine under the racial hygiene theories of the Third Reich at the end of WW2.

Learning Objectives

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

G3 Governing Narcotics

"Big Pharma's real nemesis? The Federal Bureau of Narcotics as pharmaceutical regulator"

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Federal Bureau of Narcotics (FBN) chief Harry J. Anslinger is a well-known figure in the U.S. and global history of drugs. A savvy bureaucratic infighter, a shrewd international diplomat, and a masterful exploiter of the cultural politics of race and gender, Anslinger helped institutionalize the punitive approaches that marked American drug policy from the 1920s to the early 1960s. Anslinger and his Bureau have rarely figured in pharmaceutical history, however. And yet the FBN had authority over the first prescription-only pharmaceuticals (opiates and cocaine), and actively regulated their extensive legal commerce and medical use. In doing so Anslinger and the Bureau pioneered a range of powers and practices that would only later come to the Food and Drug Administration (FDA)—and some that never did.

Drawing on archival papers from the FBN, the Sterling Drug Company, the Wisconsin State Medical Board, and also from popular and medical media, my paper examines the FBN as an important regulatory actor in American pharmaceutical history from the 1920s to the early 1960s. Anslinger personally scrutinized advertisements for new narcotics and insisted on line-by-line revisions based on Bureau-approved research. He orchestrated federal and state-by-state campaigns to amend drug laws in the face of perceived new threats, such as the synthetic narcotic Demerol and worrisomely popular barbiturates and amphetamines. Anslinger kept abreast of, and responded vigorously to, heretical medical or popular accounts such as Paul de Kruif's 1946 paean to Demerol in *Reader's Digest*. And he directed the Bureau in an often-crude campaign to enforce what it considered to be best practices in the therapeutic prescribing of narcotics—sometimes (but not always) in opposition to medical authorities and individual physicians.

Narcotics are usually seen as an exceptional case in the history of drug regulation. Yet the challenges they presented—of regulating a market riven with conflicts over drug marketing, therapeutic freedom, and patient demand—were hardly exceptional. Adding the FBN to the story of "Big Pharma" and the FDA expands the historical laboratory of pharmaceutical regulation, and gives us a fuller sense on the past and future possibilities (and limitations) of drug control in America."

Learning Objectives

--acquire a historically nuanced understanding of the organization of the U.S. healthcare system, most importantly, of the state regulation of pharmaceutical therapeutics

--develop the capacity for critical thinking about the nature, ends, and limits of pharmaceutical therapeutics

--recognize the dynamic interrelationship between medicine and society through history, most importantly, the social definitions of "therapeutic" versus "abusive" use of pharmaceuticals

G3 Governing Narcotics

“From Methadone Maintenance to the War on Drugs: The DC Narcotics Treatment Administration”

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In 1969, psychiatrist Robert DuPont described astounding rates of heroin addiction amongst inmates in DC prisons, leading him to develop a small-scale therapeutic program. Originally designed as a multi-modality program, highlighting the participation of former addicts and the creation of a therapeutic community, alongside the use of methadone, DuPont’s program soon became synonymous with methadone maintenance. His work gained visibility in a city struggling with addiction, crime and strained race relations, and in 1970, Mayor Walter Washington appointed DuPont to direct the new district-wide Narcotics Treatment Administration. DuPont’s program, which served a population consisting nearly entirely of young African American men, was hugely successful, reporting impressive results including high retention and employment rates and particularly, a drop in DC crime rates. DuPont published widely, promoting a model for combatting for what was seen to be a growing epidemic of drug abuse, and becoming one of the nation’s most prominent experts on drug abuse. In 1973, DuPont was appointed “drug czar” to President Nixon. Yet this was a pyrrhic victory for DuPont’s work and for methadone maintenance programs; while DuPont’s career advanced, his therapeutic approach was effectively abandoned, signifying the Nixon administration’s turn to a punitive approach to addiction and drug control.

This paper examines the Washington DC methadone maintenance intervention program of the early 1970s, evaluating how and why it was embraced by the Nixon administration, which adopted therapeutic approaches toward drug addiction for the end-goal of crime reduction in urban areas. Relying on material from the National Archives and on unpublished mental health studies, I show how mental health providers and policy makers joined forces to shift the focus of drug abuse intervention programs. Together, they redefined drug abuse from a public health problem to a question of urban crime. Methadone maintenance was evaluated and promoted as a crime reduction program. This may have served to strengthen the support for these politically controversial programs, which relied on taxpayer funds to assist society’s most marginalized individuals, yet it ultimately led to a shift towards a “law and order” approach to drug abuse, and was the precursor for the subsequent full-scale war on drugs and mass incarceration. Mixing psychiatry and politics, I will argue, may lead to unexpected outcomes, and is a sobering lesson still relevant to current health politics.

Learning Objectives

Develop the capacity for critical thinking about the nature and goals of addiction medicine

Deepen understanding of interrelations between policy makers and mental health care researchers and providers

Understand the dynamic history of medical interventions and how they may be tied to political goals.

G3 Governing Narcotics

“Have You Got Any Grass? Psychiatric Perspectives on ‘Narkomanija’ in Communist Yugoslavia (1965-1990)”

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During the first two decades of Communist rule, scarcely any mention of recreational drug use appeared in the medical literature of Yugoslavia. Outside of occasional reports warning of the dangers of morphine addiction, drug use rarely entered into psychiatric discourse. Beginning in the late 1960s, however, psychiatrists and other mental health workers started exhibiting escalating anxiety over the issue of drug abuse within their country. The rest of Yugoslav society, they warned, would be shocked to learn of the increasing numbers of (young) citizens that were utilizing marijuana, LSD, cocaine, heroin and other illegal drugs. Others had found novel ways to make use of common chemical substances and prescribed medications. Beyond a basic agreement that drug use was proliferating, however, the psychiatric community remained divided over questions about the causation, classification, social significance, and treatment of drug use.

Drawing upon medical journals, psychiatric textbooks, personal correspondence and conversations with retired psychiatrists, this paper traces the debates over drug use and abuse that captivated the psychiatric community of Yugoslavia during the 1960s, 1970s, and 1980s. It examines the various theories proposed to account for the dramatic increase in drug consumption with musicians, African exchange students, and yoga teachers among those implicated. It situates these debates against the ebb and flow of political and social liberalization that characterized the country during this era, paying close attention to the public unrest of the late 1960s and early 1970s. The paper questions whether alarmist fears over “widespread chemical dependence” were remotely justified and suggests that foreign medical literature was partially responsible for the hyperbolic drug scare. Finally, it analyses the proposed treatment options put forth by quarreling practitioners who could not decide whether drug users ought to be treated like common criminals, like the deviant cousins of alcoholics, or, most daringly, as intellectual explorers.

Learning Objectives

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.

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

G4 Problems of Urban and Rural Health Policy

“The 1960s Urban Riots and Health Care: Race and Metropolitan Health Systems Development”

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The 1960s riots directly impacted health care systems development in several American cities. This paper explores the uneven distribution of medical care resources in Los Angeles and Cleveland. Promises of new infrastructure quickly followed the riots, but translating them into reality proved far more difficult. Conflict erupted over who would call the shots at newly constructed post-riot institutions, as health officials, heads of academic medical centers, and grassroots activists made claims and counter-claims over who most legitimately advocated for distressed “communities” and their health interests. And in the 1970s and 1980s, a new context of fiscal scarcity, including the rollback of federal funds and state anti-tax initiatives, threatened the infrastructural gains of the prior decade. Was it all, to borrow one commentator’s phrase at the time, a “hollow prize”?

This paper explores these themes via case studies of new community health centers and full-service hospital in two hyper-segregated neighborhoods, Watts and Hough, in Los Angeles and Cleveland, respectively, and the fraught tensions between the University of Southern California, UCLA, and the Cleveland Clinic and the neighborhoods that surrounded them. I situate health care politics within larger three ongoing crises in post-WWII medical care that remain within us: maldistribution (who gets it, who doesn't), governance (who makes decisions), and sustainability (how to keep paying for it). The larger story I tell transitions from the first to the third, showing how resolution of one dimension of health care crisis led to others.

I end by considering the limits of the medical care as a political demand given the myriad of other social determinants contributing to population health. Many enthusiastic proponents of new health care facilities for Watts and Hough grew despondent as they realized that the health of neighborhoods residents was rooted in far more than medical care access, however important.

The upcoming 50th anniversaries of the March on Washington (1963), War on Poverty (1964), Civil Rights Act (1964), and the Kerner Commission on Civil Disorders (1968) are an opportunity to reflect on the legacies of these signal events within the health and social service fields.

Learning Objectives

1. Broadens boundaries of “health activism” beyond specific groups (Black Panthers, Medical Committee for Human Rights, Physicians for Social Responsibility, etc.) that have been subject of prior studies.
2. Provides concrete historical cases to complement burgeoning public health literature on social determinants of health and relative contribution of medical care to population health.
3. Examines catalytic role of riots and civil rights foment on metropolitan health services development.

G4 Problems of Urban and Rural Health Policy

“Rural Problems, Urban Solutions: The Politics of Medical Education and Health Care Delivery in the Post-World War II United States”

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Since the 1940s, concerns about catastrophic shortages of primary care physicians have dominated state and federal health policy. Medical leaders, educators, and policymakers have debated how best to increase the supply of primary care physicians and ensure their adequate distribution throughout the country, particularly in underserved rural and nonurban areas. By 1959, the Surgeon General’s Consultant Group on Medical Education had predicted a shortfall of 40,000 physicians by 1975 and recommended the expansion of existing medical schools and the creation of new schools. In 1963, Congress passed the Health Professions Education Assistance Act, which provided matching federal funds for the building of new, and the expansion of existing, medical schools. This paper examines the efforts of three state institutions—the University of California, the University of Florida, and the University of Minnesota—to train greater numbers of primary care physicians willing to work in underserved areas of the state. In the 1940s, the University of California responded to legislators’ calls for greater numbers of physicians serving southern California by establishing a new medical school in Los Angeles. In the early 1950s, the University of Florida, heeding the concerns of legislators that residents in central and northern Florida lacked adequate access to physicians, established a new medical school in the central northern city of Gainesville. During the 1960s, the University of Minnesota doubled the size of its Minneapolis-based medical school and in 1972 established a new two-year medical school in the city of Duluth, which would prioritize preparing medical students for careers in rural practice. In each case, the establishment of a new urban medical school was seen as key to solving the impending crisis in rural health care delivery. The new medical schools balanced the demands of legislators with the professional needs of their faculty, the expectations of the local medical profession, and the needs of their students and patients with mixed results. This paper reveals the ways in which these dynamics played out within different institutions, cities, and states, and assesses what the implications have been for health care delivery in the U.S.

Learning Objectives

1. Discuss and develop a wider critical perspective on the history of medical education and health care that can help inform perspectives on issues related to practice and relevant public debates.
2. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system.
3. Recognize the dynamic interrelationship between medicine and society through history.

G5 Technology, Consumerism, and Parenting

“Alarming Babies: Home Apnea Monitors and SIDS in the United States”

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In 1969 the first formal definition of Sudden Infant Death Syndrome (SIDS)—an infant death “unexpected by history and in which a thorough post-mortem exam fails to demonstrate an adequate cause of death”—propelled the so-called “Nightmare of Crib Death” into new visibility as a medical conundrum and a frightening social phenomenon. As pathologist Lester Adelson asked in 1976, “how do you deal with a disease whose first and only symptom is death?”

This paper explores the ways in which practitioners and parents attempted to answer this question, culminating in the adoption of a controversial technological prescription, the home apnea monitor. Tracing SIDS from its diagnostic origins in the 1960s through the 1980s, I analyze contemporary sources in medical literature, lay media, and archival collections to argue that the overwhelming uncertainties inherent in the SIDS diagnosis consistently burdened its social interpretations. While researchers unsuccessfully investigated the anatomical etiology of “crib death,” social activists endeavored to spread awareness of this “new” cause of death. In the process, American parents increasingly came to fear SIDS as a threat to their children’s lives.

By the 1980s, both medical and lay perspectives emphasized that SIDS was completely unpreventable and unpredictable even while legitimating various strategies to reduce SIDS frequency. Based on the theory that infants suffering from sleep apnea were at-risk for SIDS, home monitors (which sounded alarms after prolonged periods of apnea) offered an intriguing, if imperfect, preventative treatment. Originally designed for use by trained specialists in hospitals, these devices did not translate easily to home life; around them coalesced a fascinating medical-social debate regarding issues of medical technology, patient autonomy, home health care, and investigatory clinical treatments. In the context of these conversations, monitors themselves stood as a physical representation of the risks SIDS posed to a child and emerge as a valuable point of exploration for medical historians. Analyzing SIDS as an enigma conceived of differently both over time and according to varying perspectives, this paper documents how the home apnea monitor came to embody some of both the promises and pitfalls of modern medicine.

Learning Objectives

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

G5 Technology, Consumerism, and Parenting

“Tools of the Trade: Breastfeeding Technologies and the Professionalization of Lactation Support”

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1985 was a big year in the history of breastfeeding. It was in that year that the newly-formed International Board of Lactation Consultant Examiners (IBLCE) administered the first licensing exam to lactation workers. It was also the year that a group of twelve breastfeeding advocates formed the first professional organization dedicated to lactation support workers, the International Lactation Consultant Association (ILCA). The co-emergence of these organizations was no accident, both IBLCE and ILCA owed their existence to the work of La Leche League International, a breastfeeding support organization with origins in the 1940s and 1950s. Though women had been working as volunteer breastfeeding consultants for decades in organizations like La Leche League and the Childbirth Education League, by the 1970s more and more of them sought to improve breastfeeding rates and outcomes by turning their own maternal experiences and expertise into careers. Pioneers in their field, these early lactation specialists worked to persuade nurses, physicians, hospitals and mothers themselves that breastfeeding required a body of specialized technologies in the form of knowledge and devices that they were most qualified to provide. As lactation consultants (LCs) professionalized, however, they confronted new challenges that increasingly distinguished them from their volunteer peers in La Leche League and other grassroots groups. Throughout the 1970s, '80s and '90s, tensions in the breastfeeding advocacy community over issues of technology, consumerism, and maternal employment helped reveal widening ideological gaps between the lay and professional lactation movements. Through an analysis of ILCA's publication, *The Journal of Human Lactation*, the archives of LACTNET, a web-based listserv started in 1995 as a forum for LCs to discuss client issues and professional matters, and the archival collections of the American Academy of Pediatrics' Breastfeeding Working Group, this paper analyzes the emergence of the lactation consultant as a healthcare professional at the end of the 20th century. In doing so, I suggest that lactation consultants struggled as a group and as individuals to reconcile their roots in natural motherhood and feminist ideologies with the rigid structures, scientific perspectives and professional hierarchies of the medical world in which they sought recognition and legitimacy.

Learning Objectives

Identify successes and failures in the history of medical professionalism.

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

Critically appraise clinical management from a historical perspective.

G5 Technology, Consumerism, and Parenting

“Buying for the Baby Too Soon?: Pregnancy Advice, the Culture of Consumption and Miscarriage in Nineteenth through Twenty-First-Century America”

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As I have previously argued, during the twentieth century, Americans developed a new discourse around early pregnancy loss. What had previously been a late menstrual period, or a suspected pregnancy which simply failed to gel, has become an early miscarriage, and for many Americans, the loss of a child. Many social, cultural, medical, technological and demographic changes contributed to this shift. In this paper, I examine specifically the interaction between popular medical advice for pregnant women and a growing culture of consumption, urging responsible parents to prepare for the birth of a child with a panoply of purchases, and tempting expectant parents with the pleasure of buying for the baby.

During the late nineteenth century, popular medical guides for pregnant women began to make purchasing recommendations beyond simple lists of items necessary for the medical care of woman and child during childbirth. This began with elaborate instructions for babies’ clothes and bedding, and by the 1930s included carriages and other gear, and even toys. Baby boom pregnancy guides further reflected cultural enthusiasm for babies and their stuff. In a culture in which rapidly growing consumption on behalf of children was increasingly understood to reflect parental responsibility and emotional investment, pregnancy guides transplanted this aspect of parenting to the months before the child’s actual birth. Buying for the baby became an entrenched part of a medically-approved pregnancy for the rest of the century.

The shift of pregnancy advice onto advertising-driven internet sites in the twenty-first century exaggerated this pattern, contributing to cultural and emotional investment in early pregnancy, and making early losses much more painful. Women often seek internet sources as soon as they have a positive home pregnancy test. Even responsible, medically-accurate content providers have incentives to encourage women’s enthusiasm and emotional investment in their pregnancies, to please their advertisers. Marketers on these sites compete with each other to target women as early in pregnancy as possible, with highly emotional pitches, to stimulate interest and brand loyalty. But about 20% of confirmed pregnancies fail, and the consumption pitches embedded in and surrounding medical advice heighten the pain of those losses.

Learning Objectives

1. Recognize the dynamic interrelationship between medicine and society through history
2. Recognize how medical care and advice may be influenced, even indirectly, by economic considerations
3. Consider the variety of ways in which medical advice, directly and indirectly, contributes to the patient's emotional experience of health, illness and life events

G6 Screening and Surveillance**“Fragile X Syndrome and the Age of Targeted Prevention”**

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In recent years, historians of medicine have examined the continuities and differences between the interwar eugenics movement and postwar medical genetics. During the immediate postwar period, most geneticists felt that achieving eugenic aims through state-sanctioned control over reproduction had limited promise and was socially undesirable. While advances in understanding the molecular basis of disease pointed to significant promise, J.B.S. Haldane suggested in 1949 that human geneticists were about as far from preventing intellectual disability before birth, as Leonardo di Vinci had been from flight. Indeed, for decades to come, the mode of inheritance for most forms of intellectual disability was a matter of debate. It was well known, for instance, that many more males were impacted by intellectual disability than females. Whether this had a genetic or social basis however, remained controversial. With the introduction of new techniques for chromosomal analysis around 1970, geneticists became increasingly confident in their ability to locate markers of disease in the human genome. This would eventually include various forms of intellectual disability, such as Fragile X syndrome.

In this paper, I draw on the published biomedical literature, interviews, and archival resources to explore the visual and diagnostic practices of postwar genetic medicine, with a specific focus on the delineation of Fragile X syndrome – the second most common form of intellectual disability. During the 1970s, medical geneticists brought together a combination of subtle bodily and chromosomal markers, facilitating the clinical, and ultimately prenatal diagnosis of Fragile X syndrome. In the years to come, Fragile X syndrome came to serve as an influential model for the promises genetic medicine to prevent the incidence of intellectual disability. In this paper, I use a case study of Fragile X syndrome to examine the rise of the age of targeted prevention, during the 1970s and 1980s. I argue that the introduction of new, standardized ways of seeing and recording subtle markers of disease, in the laboratory and the clinic, were central to new systems for clinical prevention, which partially replaced older attempts to stop certain groups from reproducing, with more targeted screening and intervention.

Learning Objectives

For the learner to think critically about the nature, ends, and means of genetic medicine.

For the learner to understand the dynamic history of medical ideas and practices, and their implications.

For the learner to recognize the dynamic continuity between medicine and society through history.

G6 Screening and Surveillance

“Eugenics in a multi-disciplinary context: Research on deafness at the Clarke School for the Deaf, 1930s – 1950s”

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In the 1930s and 1940s, the Clarke School for the Deaf (Northampton, MA), was a key player in the debate over the prevention of genetic deafness that had raged since the 1880s, when A.G. Bell had warned that deaf intermarriage would eventually lead to a 'deaf race'. In 1930, the school opened a new research department which approached deafness from the angle of psychology, audiology, and heredity. Hereditary research at the Clarke School took place in a context of scientific optimism that combined child psychology, mental testing and eugenic expectations to reduce the impact of deafness. Learning more about the psychological, educational and audiological implications of hearing loss, the school believed, would normalize the deaf and restoring them to society. Heredity research and eugenics would allow long-term prevention.

Even though small, the department attracted renowned scientists such anthropologist Morris Steggerda, geneticist Madge Macklin or Gestalt psychologists Kurt Koffka and Fritz Heider. With the help of these outside scientists, the school collected medical, audiological and genetic data from students and their families, aiming to categorize different hereditary forms of hearing loss. The results remained unsatisfying, yet pedigree data was nevertheless used for heredity education and counseling. At the Clarke School, education and eugenics intertwined. It thus offers an important nuance to historiographic analyses of eugenicists' focus on biological limits and educators' emphasis of human malleability as incompatible. While in the 1920s and '30s discussion of feeble-mindedness increasingly turned to sterilization and institutionalization, educators of the deaf by and large refused such coercive measures. They believed that oralism – teaching speech and lipreading – would humanize the deaf and remove the stigma of being “dumb.” Transformed into responsible and productive citizens and counseled on their hereditary make-up, the educated deaf would refrain from passing on their defect.

Clarke's research lies at the intersection of eugenics, psychology and education that medicalized childhood and disability in the first half of the 20th century. Examining this interdisciplinary nexus helps understand how the social and genetic worth of deaf people and other “defectives” were negotiated in an interdisciplinary framework that determined eugenic and educational policies.

Learning Objectives

By the end of this activity, the learner will:

Deepen their understanding of the social and cultural meaning of disability in 20th century history.

Reflect on the diversity of patient perspectives in defining their condition.

Understand the connections between eugenics, special education and psychology in influencing the medical care for deaf and disabled people.

G6 Screening and Surveillance

“My Mother Has Breast Cancer...What Does This Mean For Me?”: Research in, and Genetic Counseling for, Hereditary Cancers in the 20th Century United States”

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Dr. Mark Skolnick of Myriad Genetics announced in 1994 that his lab had successfully located and sequenced the BRCA 1 gene, a discovery that represented a watershed moment in the “war on cancer.” More recently, Angelina Jolie’s May 2013 disclosure of her own BRCA mutation and prophylactic double mastectomy ensured for hereditary cancers a continued place in the scientific and popular spotlight. In the 20 years since Myriad’s announcement, oncogenetics has garnered increased interest and funding, while cancer cases have gained ever-greater representation in the workload of genetics professionals like genetic counselors. In this paper I argue, first, that interest in hereditary cancers (and often breast cancer specifically) is intimately connected to a 20th century history of genetic counseling that long predates well-known genetic discoveries of the 1990s. I trace this history from the Eugenics Record Office’s trait files on cancer to geneticist Sheldon Reed’s mid-century research on breast cancer at the Dight Institute. I further connect this work to Henry T. Lynch’s studies of “cancer families” since the 1960s, and to contemporary research in, and genetic counseling for, hereditary cancers. Secondly, I pursue the argument that the history of hereditary cancers became predominantly a history of cancer risk as cancer research entwined itself with genetics and especially genetic counseling. I situate genetic counselors as key actors in a system of risk management and pre-disease detection. I explore their roles within the cancer-prevention mantra of early diagnosis and surveillance, and participation in the definition of a liminal risk category between health and illness. Here, Ulrich Beck’s “risk society” and Abby Lippman’s concept of “geneticization” provide tools for considering what it has meant to live “at risk” with a genetic predisposition to disease; when and why cancer researchers have emphasized hereditary risk factors; and the relationship between cancer, pre-cancer, and genetic science. This paper is part of a new, more comprehensive project on Huntington’s disease, cancer, and genetic counseling for adult-onset conditions that examines the socio-cultural meanings of hereditary disease, and the relationship between histories of genetic counseling and genetic research.

Learning 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) Recognize the dynamic interrelationship between medicine and society through history.
- 3) Deepen understanding of illness and suffering.

H1 Affects of Surgery

The Mask Behind the Mask: Uncovering Burnout in Contemporary American Surgeons

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American surgery is in the midst of a wide-ranging series of changes in culture and practice that have altered many long-held beliefs regarding the attributes defining the “ideal surgeon.” Prior generations of surgeons took great pride in their indefatigability and stoicism. Within the past two decades, new data has emerged showing that a significant proportion of American surgeons are suffering from emotional exhaustion, depression, and problems with substance abuse, a syndrome better known as burnout. Recognition of this widespread problem has prompted significant changes in training programs, implementation of counseling services in surgery departments (and de-stigmatization of those seeking help), and a wholesale “look in the mirror,” as the profession seeks to identify and address the factors leading to this burnout crisis.

In this paper I use medical literature, personal interviews, and articles from print media to examine the historical background to this recent recognition of surgeon burnout. I first highlight the relative paucity of materials relating to surgeons’ emotional health during the first half of the 20th Century; while many surgeons undoubtedly experienced difficulties in coping with the challenges of their profession during this period, they largely suffered in silence, as any admission of weakness was perceived as incompatible with the heroic image surgeons were supposed to emulate. I then describe the experiences of 2 well-known Midwestern surgical training programs, the University of Michigan and the University of Wisconsin, who contacted their alumni in the late 1990s and early 2000s and queried them regarding professional and personal well-being. The results were shocking: a large number of graduates of these prestigious programs were struggling with psychological problems, substance abuse, failed relationships, and overall poor health. These findings presaged those of an even wider-ranging American College of Surgeons survey in 2008, which revealed a 40% burnout rate in the nearly 8000 surgeons studied and was the largest cross-sectional investigation of physician burnout ever conducted. Through this series of reports, a bleak picture of the emotional health of American surgeons emerged, and prompted a series of changes that have dramatically altered the image, identity, and expectations of the profession.

Learning Objectives

To demonstrate how prior generations of surgeons stigmatized and hesitated to acknowledge the existence of emotional health problems in their profession.

To examine the historical factors leading to increased recognition of surgeon burnout in the 1990s and 2000s.

To demonstrate how realization of the emotional difficulties of surgical practice has impacted residency training, patient expectations, and the professional identity of American surgeons.

H1 Affects of Surgery

“A Theatre of Compassion: Emotion and Affect in Early Nineteenth-Century Surgery”

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In 1828 the Lancet ran a sensational account of a badly-botched operation conducted by the surgeon Bransby Cooper in front of a large audience at Guy’s Hospital. The procedure, the removal of a bladder stone, should have taken no more than ten minutes, but in Cooper’s case it took nearly one hour. However, it was not simply the duration of the operation which made it so shocking to Cooper’s audience and to the readers of the Lancet. Rather, it was the apparent loss, not only of Cooper’s nerve, but of his emotional and psychological control of the patient. During the course of the operation, the patient screamed in agony, begging Cooper to let his stone ‘keep in’. Meanwhile, Cooper, apparently flummoxed by his inability to locate the offending calculus, repeatedly expressed his dismay at the situation and even turned to apologise to his audience.

Cooper’s case may have been an extreme one, but what it demonstrates is that a time when operations were conducted without aesthetic and often, especially in the case of teaching hospitals, in front of an audience, the performance of surgery was just that, an elaborate array of practices and physical attitudes structured by a complex, though largely unwritten and unspoken set of rules and expectations. For the most part, this performance was calculated to ensure a swift resolution to the operation, but, more than this, it was conceived as a way of disciplining pain and its emotional and psychological correlates, fear and anxiety. This paper examines the performance of nineteenth-century surgery and will focus in particular on an underdeveloped aspect of the historiography, namely the critical emotional intersubjectivity between practitioner and patient.

Learning 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) Recognize the dynamic interrelationship between medicine and society through history

H1 Affects of Surgery

“Atomic Bombs” or the Knife: Competing Treatments for Hyperthyroidism since WWII in Taiwan”

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This paper examines the history of the treatments for hyperthyroidism since WWII in Taiwan. Sources include medical journals, newspaper reports, and oral history interviews of surgeons and patients. Surgical removal of the thyroid gland was first offered by medical missionaries in the early twentieth century, and western trained Taiwanese surgeons continued the trend. Beginning in the 1950s, radioactive iodine (RAI) treatment (imported from the US) also became available and was presented by its promoters as one of the major breakthroughs in the nuclear age. Even though the ROC (Taiwanese) government-in-exile upheld RAI as the medical counterpart of nuclear power and ushered it in with staged rituals, RAI did not overtake the surgical approach as it did in the US. As late as the 1990s, surgery was still the major treatment option for this common disease in Taiwan. The common people also supported the surgical option. In the 1970s, thyroidectomy was one among a number of excessively performed surgeries in Taiwan (the others were hysterectomy, stomach removal, and appendectomy). The surgical clinic was a common establishment throughout Taiwan by the mid-twentieth century. However, RAI was a latecomer and, with the exception of a few prestigious hospitals in Taipei such as the National Taiwan University Hospital, most medical institutions and clinicians were not equipped to use the substance. In the popular imagination, RAI was equated with the aftermath of the atomic bombing of Japan. The ways in which surgery was preferred point to the material conditions of medical practice as well as the post-Hiroshima image of radioactive materials.

Learning Objectives

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.

Recognize the dynamic interrelationship between medicine and society through history.

H2 New Geographies of Public Health

“Filth, Fever, and the Imperial Social Body”

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This paper connects three striking narratives of late Victorian public health in the British Empire: a celebration held at the Unitarian Christian Chapel in Pursewalkum, India in 1872 to honor Prince Albert Edward’s recovery from typhoid fever; the inspection of Chinese lodging-houses by British public health authorities in Melbourne, Australia in the 1880s, and; the practices of ‘dipping’ African migrant workers in the 1890s by British railway medical officers in South Africa. I use these three case-studies to examine networks of public health practice across the British Empire, and to situate the complex ways in which disease practices ordered and disciplined bodies in an imperial framework.

Historians of Imperial Tropical Medicine have tended to focus on colonially-specific sites and colonially-entrenched diseases, such as yellow fever, malaria, and cholera. This paper uses a less-common disease frame- typhoid fever. Understood as the preeminent filth disease of the nineteenth century and endemic to Europe and North America, contemporary British physicians were nonetheless fascinated by the ways in which typhoid fever spread to colonial locations. There was power to reify, and to challenge imperial relations in such transnational disease framing, I argue in this paper, and in this way advance what Roy MacLeod calls the ‘multiple engagements’ of colonial science and medicine. For example, I show that medico-religious celebrations by Indians in 1872 served to forge Indian bodies like British bodies, and to elevate the status of India in colonial hierarchies. The case of British railway officers ‘dipping’ African migrant workers—a common zoonotic practice applied to humans—upheld the racial distinction that African bodies were unlike British bodies. Finally, the inspection of Chinese lodging-houses in Australia served to make white ‘Australian’ bodies like white British bodies but unlike Chinese bodies.

This paper is the first presentation of extensive research trips to South Africa, India, Australia, and Britain. I rely on a wide range of archival sources, from letters, memorandums, and government reports, to public health inspector case-files, diaries, and religious pamphlets. I also have consulted a wide-range of printed primary sources, especially contemporary medical journals and the reports of medical and scientific societies.

Learning Objectives

1. To understand how public health practices served a 'tools' of British imperialism
2. To explain the role of imperial networks in forging a globalized vision public health
3. To complicate our historical understanding of how disease practices contributed to racial identities.

H2 New Geographies of Public Health

“Commodity Circulation, Infection and the Interpretation of Disease in India in the 1830s: the Plague”

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This paper studies the circulation of U.S cotton and its role on the British Industrial Revolution. However, cotton was a commodity that is capable of communicating infectious disease. This paper argues that it might have been a possible source for the injection of plague into India. Plague emerged in the important trading emporium of Pali of Rajasthan amongst the cotton printers, chipahees, who are still there and a mainly Muslim community. Based on archival research and oral interviews, this paper analyses the connections between cotton, imperial trade, routes, quarantine, and the circulation and changing interpretations of disease. It builds upon Mark Harrison's work but uses field research among the Muslim printers and the Jain community as well as the Bikaner State Archive, National Archives of India, and the National Library, Kolkata. This paper shows the decline of a trading emporium and a community. It is relevant in studying trade routes, the British imperial economy and the importance of cotton in the Industrial Revolution in Britain.

H2 New Geographies of Public Health

“Mapping Public Health in an Early Soviet City: Health-related Institutions of Petrograd-Leningrad in the 1920s”

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The existence of private medicine and pharmaceutical business in Soviet Russia in the 1920s is unfortunately chronically understudied – and when mentioned, it is often presented with obsolete ideologically charged clichés – as a chaotic conglomerate of hucksters and quacks, driven only by the desire of profit. Importantly, there are also no works that treat the spatial organization of health care on a local and micro levels, while such studies could in fact answer many essential questions about the effectiveness of the system, regional disparities, and the limits of central planning.

The paper deals with digital mapping of the network of health-related institutions (hospitals, specialized clinics, research institutes, pharmacies etc.) in Petrograd-Leningrad in the 1920s. I intend to make full use of the capacities of Quantum GIS and its compatibility with raster maps. This project will allow to reconstruct the 'medical map' of the city and contribute to solving several problems in the history of early Soviet public health. In particular, I aim to analyze the provision of medical and pharmaceutical services in particular city districts and areas and assess the respective contributions of state, cooperative and private institutions. This will naturally involve studying the evolution of government policy towards the provision of health care and the regulation of clinics and pharmacies, as well as the issues of financing, work motivation and profit.

The initial analysis of the archival documents from the NEP era shows that private clinics and pharmacies, motivated by profit, were at least as successful as their state and cooperative counterparts. Private pharmacies in particular were able to satisfy the consumer demand by radically decreasing waiting times and creating branches in certain areas and city districts where state institutions were lacking.

Learning Objectives

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

Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

H3 **Pharmaceutical Origins**

“Between Regional Dynamics and Modernity: Tracing the Rebirth of a Japanese Medicine Industry in Osaka”

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While the inflow of western medical knowledge into Japan was extremely limited during the Edo period (1608-1868) due to the closing of the country to the outside world, a thriving network of trade in medicinal herbs—some imported from parts of Asia, others locally-cultivated—developed in regions nationwide, the most important one being that of Osaka / Sakai. The situation abruptly changed after 1868 with the efforts of the new central government in Tokyo to impose modern (western) institutions. Members of the recently dissolved traditional medicine merchants’ guild in Osaka were especially unwilling to cooperate with the government’s wishes and showed little interest in undertaking the production of biomedicines.

Taking into account their strong aversion to embrace “modern medicine,” policy-makers opted to found Japan’s first pharmaceutical company, Dainippon, in Tokyo, rather than Osaka. This enterprise, which was overseen mainly by bureaucrats and investors with little knowledge of business or pharmacy, failed, and the government was soon in search of a buyer. Ironically, it was a group comprised of 21 former medicinal merchants from Osaka who decided to purchase Dainippon’s trademark and production equipment and relocate to Osaka. Under new ownership, Dainippon’s medicinal business flourished and still exists today as Dainippon Sumitomo Pharmaceutical Company.

Though some Japanese are aware that the origins of the Japanese pharmaceutical industry can be found in Osaka, few know the reasons why. This paper will provide an answer to this question by considering the advantages of location and its significance in the modernization and economic development of this industry during the Meiji period and beyond. Because most of Dainippon’s corporate archives were lost during WWII, a combination of related historical resources will be incorporated into this analysis including (1) corporate histories, (2) archival information from the City of Osaka and its Chamber of Commerce, (3) personal accounts written by Meiji period policy-makers, (4) government documents, etc. This study on Japan, which seeks to delineate the advantages of location and the synergies that proximity generated, should provide some ideas and implications for similar ones on the early regional development of pharmaceutical businesses in other nations. I am not a health professional and do not request accreditation approval.

H3 Pharmaceutical Origins

“Trademark Law and the Nineteenth-Century Origins of Generic Names”

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This paper examines nineteenth-century American trademark law and the origins of generic drug names. Before the Civil War many, but not all, pharmaceuticals were known by both a common and scientific name. However, the common names of drugs were not equivalent to today’s generic names because they were not effectively linked to legal or scientific mechanisms intended to ensure therapeutic equivalence among products. At the same time, common names were not juxtaposed to distinct commercial names that could be monopolized by individual firms. Early American trademark law offered little protection for drug manufacturers due to the assumption that it was primarily intended to prevent fraud; competitors could therefore freely adopt trademarked names for their own purposes as long as they indicated the true origins of the product in question. As a result, I argue, there was no effective distinction between the commercial and common names of drugs. Although common names were sometimes distinct from scientific names, generic drugs – as we understand them today – did not exist in any meaningful sense.

Over the course of the late nineteenth-century a complex series of legal, economic, and scientific transformations reformulated the relationship between pharmaceutical names and objects. For one thing, a growing recognition of the importance of product reputation in creating markets meant that trademarks were increasingly understood as a form of intangible property and, as a result, manufacturers acquired the ability to monopolize the names of their goods. At the same time, reformers worked to establish therapeutic equivalence among products sold under the same name by linking the standards promulgated in the United States Pharmacopeia to state and local laws intended to suppress adulteration. The result of these two trends was that, by the early twentieth-century, drug names had been bifurcated into two distinct types: brand names that could be monopolized through trademark law and generic names that were applied to drugs that were no longer under patent and that could not be monopolized. Both of these names were, in turn, juxtaposed to increasingly complex scientific names. Although significant difficulties remained, the modern formulation for naming pharmaceuticals had been established.

Learning Objectives

1. Provide an overview of trademark law as it related to pharmaceuticals in the nineteenth-century United States.
2. Discuss the relationship between nineteenth-century trademark law and the origins of generic names.
3. Discuss the role of therapeutic reformers in the United States in establishing generic names during the nineteenth-century.

H3 Pharmaceutical Origins

"The romance of exploration and emergency first aid': Tracking the narratives about Burroughs Wellcome's 'Tabloid' medicine chest"

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The global pharmaceutical firm Burroughs Wellcome (now folded into GlaxoSmithKline) was founded in London in 1880 by two young American pharmacists. With the aid of the pressed-tablet technology that they borrowed, improved, and dubbed ""Tabloid,"" BW enjoyed robust growth and was one of the earliest pharmaceutical firms to sponsor clinical scientific research in chemical and physiological laboratories. Henry Wellcome, sole director after Silas Burroughs' death in 1895, took pains with the firm's advertising to ensure that physicians, nurses, and pharmacists knew of the scientific backing for BW products. The firm photographed its laboratories for the pamphlets distributed at professional meetings; these materials also demonstrate clinical prose in describing BW drugs. Indeed, BW did not advertise its pharmaceutical products in general-circulation outlets but focused on marketing to the profession.

However, the scientific decorum displayed by these promotional texts is more than countered by an increase in romantic narratives about the firm's products. BW materials ostentatiously featured the firm's longstanding association with British exploration, starting with Henry Stanley's use of ""Tabloid"" products in a specially-designed medicine chest during his African expeditions. Despite the need to distinguish BW's products from the absurd and exotic claims of many patent medicines, the descriptions of ""Tabloid"" medicine chests and their fantastic travels become more elaborate and more heightened in rhetoric during the first few decades of the century, reaching a pinnacle in 1934 with the alluringly-titled pamphlet, ""The romance of exploration and emergency first aid."" They offer a useful historical case study of the tensions between scientific and popular success in the pharmaceutical marketplace and demonstrate that, at this time, romance was compatible with science in advertising even to medical professionals.

This paper draws on the work of Roy Church, Ryan Johnson, James Harvey Young, Takahiro Ueyama, and others; and on research in the BW archives at the Wellcome Library.

Learning Objectives

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

H4 **Radiation and Risk: Politics of Health in the Atomic Age**

“Uncertainty Principles: Radiation and Risk in 20th Century Medicine”

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This paper, taken from my dissertation project on the entwined topics of medical ethics and the early development of radiation therapy, explores the ethical debate around X-ray therapy and human experimentation at the beginning of the twentieth century. The possibility of using the mysterious new energy for therapeutic intervention intrigued X-ray enthusiasts. Within months of Wilhelm Conrad Röntgen’s initial announcement of his discovery of a “new kind of ray,” a medical student in Chicago, Émil H. Grubbe’, assembled an X-ray emitter and experimented with X-ray treatment on a patient, Rose Lee, suffering from terminal breast cancer.

Grubbe’ explicitly credited his interest in X-ray therapy to his own experience of painful X-ray dermatitis in his hand, which had been repeatedly exposed to radiation in the course of his experiments with X-ray imagery and photography. Witnessing the damage in his hand, Grubbe’—then a medical student at Chicago’s Hahnemann Medical College—concluded that rays which could cause such damage might have some therapeutic application.

Grubbe’s experience was not unique; working for long periods of time in close proximity to unshielded emitters made erythema and dermatitis a near-universal experience in early X-ray practice. Within a few years the dangers of exposure, which ranged from temporary skin damage to terminal cancer, became so obvious to practitioners that they began to describe themselves as X-ray “martyrs.” But in spite of X-rays’ widely-acknowledged dangers, numerous physicians pushed ahead with human experimentation designed to discover the therapeutic possibilities of X-ray technology.

Building on the work of historians Matt Lavine and Rebecca Herzig, I am trying to understand how early X-ray experimenters thought about the risks of X-rays for patients, experimenters, and research subjects. At a time when the discipline lacked formal protocols, human experimentation provoked a lively debate about what would eventually be regarded as “medical ethics” in professional publications like “The Archives of the Roentgen Ray,” the “British Medical Journal,” and the “American Journal of Roentgenology.” Using this written record, I argue that the particular considerations unique to X-ray technology helped create the impetus for new, codified standards of ethical laboratory practice.

Learning Objectives

Learners attending this presentation will develop knowledge and understanding of professional behaviors and values by:

- 1) Develop the capacity for critical thinking about the nature, ends and limits of medicine.
- 2) Examining successes and failures in the history of medical professionalism, and specifically the area of radiation therapy and human experimentation.
- 3) Develop and discuss a historically informed concept of professional responsibility and patient advocacy.

H4 Radiation and Risk: Politics of Health in the Atomic Age

“Gendering the Bomb: Japanese Americans as Patients, Caretakers, and Community Activists”

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The atomic bombs dropped on Hiroshima and Nagasaki in 1945 resulted in nation-specific, gendered understandings of Americans as masculine victors and the Japanese as feminine victims in political, cultural, and medical discourses at the beginning of the nuclear age. My examination of “transnational” survivors of the Bomb— Japanese Americans who happened to be in Japan in 1945 for a number of different reasons—challenges such dualistic views of the Bomb, helping us to understand the broader contexts that redefine survivorhood outside rigid gender norms and national boundaries. Using oral history interviews with Japanese American survivors as the main historical source, my paper first looks at Japanese American survivors’ memories of the Bomb with regard to a range of folk medicines and treatments that they offered to each other at the cities’ ground zero. In so doing, I illuminate how a majority of caretakers were women, the significance of which has often escaped scholarly attention as it has largely focused on institutional medicine after the war. Second, growing out of this, I consider the rise of the civil and human rights movement among U.S. survivors in the 1960s and 1970s, which attempted to bring recognition and compensation to all survivors residing in the United States regardless of their nationality, race, and ethnicity. In this movement, female survivors and female activists took leadership roles, most notably in their effort to establish access to medical care and treatment specialized in radiation illnesses. Here, I highlight how the female leadership among U.S. survivors was based on both the traditional image of women as caretakers and their emerging gender awareness that women were under-recognized and -privileged citizens. I also show how the U.S. survivors’ movement urged not only the American government but also its Japanese counterpart to recognize them, suggesting that their identities as caretakers, patients, and activists remained distinctively transnational. By examining these aspects of Japanese American Bomb survivors’ history, my paper argues that cross-national memories of the Bomb, as well as women’s activism that kept them alive, helped bring together Japanese and American medicine specialized in Bomb-related illness at pivotal local and community levels.

Learning Objectives

Deepen understanding of illness and suffering

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

H4 Radiation and Risk: Politics of Health in the Atomic Age

“One should neither deride it nor pin any great hope on it”: Medical Responses to Atomic Energy and Crises, 1945-1961”

Casey Hurrell; Queen's University, Kingston, ON, Canada

The detonation of the atomic bomb over Hiroshima in 1945 irreversibly altered the nature of armed conflict, and ushered in the “atomic age.” Societal fascination with the destructive possibility of weaponized nuclear energy was matched in medicine by the sense that harnessing atomic power could lead to groundbreaking diagnostic tools, treatments, and therapies. Despite its potential for medical research and practice, atomic science remained a contentious subject because of prevailing fears about the dangers of radiation poisoning and workplace safety in labs where technologies were being developed. Uncertainty about the future development of the relationship between medical research, clinical practice, and atomic physics abounded. As one 1946 editorial in *The Lancet* aptly observed, when it came to the potential benefit of atomic science for medicine: “one should neither deride it nor pin any great hope on it.” Nonetheless, physicians followed developments in atomic science with great interest, as indicated by the sheer volume of coverage in high-impact medical journals.

This paper examines the published responses of American and British medical professionals to developments in atomic science before the founding of Physicians for Social Responsibility (PSR) in 1961. It considers the intersection of medicine, health, and foreign policy over atomic science — a particularly contentious domestic policy issue that was influenced by international networks of scientific experts and materials, complicated by Cold War politics. Moreover, the omnipresent reality that the same technology used to develop life-saving treatments could be weaponized created a set of challenging ethical considerations in an era characterized by highly-charged international political maneuvering.

This paper raises questions about the ethics of atomic technology: how could the medical profession prepare itself to respond to the type of crisis that would be wrought by nuclear war? Did the profession have a responsibility to oppose the weaponization of technology that had a simultaneous clinical and diagnostic value? How did the successes and failures of atomic science, both in and outside the clinic, influence physicians’ position on nuclear disarmament, in the era preceding the establishment of advocacy organizations like PSR and the International Physicians for the Prevention of Nuclear War?

Learning Objectives

1. Recognize the degree to which Cold War ideology influenced medical practice and research
2. Acquire an understanding of the ethical complexity of the medical profession’s relationship with nuclear technology
3. Develop the capacity to analyze the intersection of domestic health policy and international relations

H5 The Slow Growth of Discipline as a Major Function of State Medical Boards

“Historical Origins and Evolution of the State Medical Board Disciplinary Function”

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This presentation traces state medical boards' evolving role in discipline from its exclusionary focus in the first half of the 20th century to its shift in the 1960s toward greater transparency and more robust activity as boards replaced the profession in assuming primary responsibility for enforcing professional and regulatory standards.

State medical boards have passed through three distinct phases in their approach and handling of medical discipline. The first period (1870s-1962) was one of board autonomy in which board priorities mirrored those of physicians seeking a self-regulating profession. During this period boards targeted unlicensed practitioners and sought to maintain professional boundaries against encroachment by other practitioners (e.g., pharmacists, chiropractors, etc). The second period (1960s – 1986) might be characterized as one of public accountability in which public members were added to medical boards and disciplinary actions were less likely to be private transactions between the board and an individual physician. The third period (1986-present) is characterized as one of consumerism and transparency in which disciplinary actions and data as well as physician profiles were made public.

Evidence supporting this claim was derived from primary source materials in the Federation Bulletin (1913-present) that presented information and data on the changing disciplinary role of state medical boards in the 20th century. This was supplemented by other primary source literature of the day (e.g., JAMA) and seminal surveys by the Federation of State Medical Boards (1959-60) and the American Medical Association (1961). These underscored the shift in medical boards' mindset for discipline and changing attitudes of the profession and the public concerning discipline. A review of secondary literature by Robert Derbyshire, Richard Shryock, Paul Starr, Carl Ameringer, Samuel Baker, Ronald Hamowy, et. al. supports the proposed demarcation of boards' disciplinary role.

The transition to a robust, transparent disciplinary system required a paradigmatic shift. Before medical boards could adequately perform this role, they had to embrace discipline and regulation as primary functions equal in importance to their historical focus on examination and licensure. Attitudinal change was key to creating and sustaining systematic changes within state board and professional circles.

Learning Objectives

- Identify successes and failures in the history of medical professionalism
- Recognize the dynamic interrelationship between medicine and society through history
- Acquire a more historically nuanced understanding of state medical boards within the U.S. healthcare system

H5 The Slow Growth of Discipline as a Major Function of State Medical Boards

“Disciplinary Actions by State Medical Boards: The Benefits and Challenges of More Comprehensive Data”

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Until the 1970s, state medical boards seldom and almost reluctantly took disciplinary actions against their licensees. The annual number of actions numbered in the hundreds. Over the past thirty years, however, boards increased the number of annual disciplinary actions by seven-fold. This shift in priorities has brought newfound attention to the issue of medical discipline and the competency of physicians in the United States. This presentation examines the implications of the renewed emphasis on physician discipline by state medical boards and the improved disciplinary data it helped produce.

Drawing upon information and data collected by the Federation of State Medical Boards, this presentation enumerates physician discipline throughout history. This wealth of data on physician discipline has helped state medical boards to better protect the public through greater awareness of physician competency, especially across state lines. There is, however, variance in the amount of resources available to state medical boards, which limits their ability to undertake disciplinary action. This presentation highlights national trends in state medical boards' disciplinary action, and also identifies the demographics of physicians who are most likely to be disciplined by state medical boards. The presentation concludes by discussing efforts to standardize the collection of physician licensure data, and the possibility of standardizing the collection of disciplinary data.

Learning Objectives

Identify successes and failures in the history of medical professionalism

1. Recognize the dynamic interrelationship between medicine and society through history
2. Acquire a more historically nuanced understanding of state medical boards within the U.S. healthcare system

H5 The Slow Growth of Discipline as a Major Function of State Medical Boards

"Social Media and State Medical Boards: The Prevalence of Unprofessional Online Behavior by Physicians"

Aaron Young; ayoung@fsmb.org; Federation of State Medical Boards, Euless, TX, USA

Investigating and adjudicating disciplinary matters consume the bulk of state medical boards' time and resources, and monitoring physician behavior has recently become more complex. Traditionally, unprofessional behavior by physicians was confined to practice settings, but the rise of social media has brought increased exposure to unprofessional behavior by physicians. Anecdotal evidence from recent years suggests that unprofessional behavior on social media platforms could damage the integrity and reputation of professionalism for physicians.

This presentation draws primarily from a FSMB survey of state medical boards on actions taken for online physician misconduct. A vast majority of state medical boards (91%) indicated that incidents regarding online professionalism of physicians had been reported to them in the previous year. In addition, when presented with vignettes of possible violations of online professionalism, directors of state medical boards reached some consensus as to which vignettes warranted state medical board intervention.

Despite the increased prevalence of online physician unprofessionalism, state medical boards must be careful not to infringe upon physicians' freedom of speech. This presentation concludes with a discussion of the Federation of State Medical Board's Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice, which seeks to maintain the public's trust in physicians by protecting against the unintended consequences of social media and social networking."

Learning Objectives

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

I1 Networks of Charitable Care

"Dead Father, Resurrected Son: Rose Hawthorne Lathrop, Nathaniel Hawthorne, and the Origins of Catholic Hospice Care in the United States, 1896-1926"

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Historians have argued that the "modern" hospice movement of the 1960s secularized what, until then, had been a predominantly Christian tradition. They claim that this secularization led to the loss of the hospice tradition's holistic approach to patient care. And yet, while historians have explored Christian hospices in Europe, there have been few studies of the Christian hospice tradition in the US.

In this paper, I examine the life of Rose Hawthorne Lathrop, the founder of what is generally considered the first hospice in the United States, St. Rose's Home for Incurable Cancer. In particular, I examine why, during the period from 1896 to 1926, Lathrop converted to Catholicism, became a nun, and began caring for people with incurable cancer for free in a small apartment in Manhattan.

Via original archival research in Lathrop's essays, diaries, and correspondence during this period, I argue that she provided care because of her commitment to Christ's resurrection. Specifically, Lathrop conceived of each patient as Christ suffering on the cross, and modeled her care on Christ's return from the dead. Lathrop's Catholic care challenged the conception of death dominant in the medicine of her time: For Lathrop, death was the start of medical practice, with care oriented not toward cure, but rather toward the goal of resurrection. This Catholic framework formed the basis of her hospice practice.

I argue that Lathrop's Catholic rethinking of death must be understood in the context of her relationship to her father, the writer Nathaniel Hawthorne. Specifically, I examine how Hawthorne's prolonged depression and early death—when Lathrop was thirteen—impacted her hospice work. Based on her epistles and writings, I argue that her relationship with Christ provided a means for her to mourn her father's premature death. Catholic carework was thus, for Lathrop, a work of self-healing, as much as one of faith. In my conclusion, I explore how Lathrop's framework has influenced the subsequent development of both the Catholic hospice tradition and the "modern" hospice movement.

Learning Objectives

To gain an overview of the origins and history of the US Catholic hospice tradition

To contextualize new medical and religious paradigms of end-of-life care in the late 19th century US within the larger historiography of death and dying

To examine how religious frameworks impact the delivery and practice of end-of-life care

I1 Networks of Charitable Care

“Mission to Sichuan: Medical Activists in Southwest China during the War of Resistance against Japan (1937-1945)”

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Multiple parties both foreign and Chinese—physicians, public health officials, midwives, nurses, scientists, medical missionaries, charity workers, and philanthropists—embarked on a “mission to Sichuan” during the Japanese invasion of China. These sojourners from outside the southwestern province viewed their temporary home as uncharted territory in which to edify a benighted population through medical evangelism. Far from a tabula rasa, “Free China” became a key center of global public health, and tremendous changes occurred in a relatively short timespan.

Throughout the war, “the China field” attracted the best and brightest medical missionaries. The difficulty of serving during a violent and destructive war, when people so clearly needed their skills and attention, appealed to missionaries for whom hard work and sacrifice affirmed their self-identity as servants of God. Another important factor was the concentration in the southwestern provinces of Chinese medical institutions and personnel. Sichuan, Yunnan, Guangxi, and Guizhou provinces all provided temporary homes to a majority of China’s most well trained and highly skilled personnel and the institutions that employed them. Medical colleges and health institutions located either permanently or temporarily in the southwest provided the essential infrastructure for medical research, education, and services.

In the course of their work to save lives, the newly allied foreign medical missionaries and Chinese state health officials elevated scientific biomedicine to new institutional and cultural heights and changed local medical practice. Chinese reformers and the Nationalist state took active roles in this process, adopting and adapting biomedicine in order to strengthen their nation and race and defend themselves from their modernized and imperialist Japanese neighbors. The relative strengths of an otherwise foreign medical practice appeared all too clear during the war, when a global effort to combat disease among troops and civilians inspired Chinese and foreigners to collaborate in a variety of health projects that received funding, advising, and personnel from diverse national and international sources.

Analyzing the work of both Chinese and foreign actors from multiple angles, this paper illustrates locals’ agency in accepting and adapting to biomedical care, and treats China as a key player in the making of modern medicine.

Learning 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

Identify successes and failures in the history of medical professionalism

I1 Networks of Charitable Care

“Designing primary care to meet the health needs of uninsured people: The case of Dallas County”

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Historically, Americans have lacked a coordinated health system, relying for the care of uninsured patients on institutions that provide access to patients regardless of their ability to pay. Since the patient mix of these “safety net” institutions draws disproportionately from poor and uninsured patients, these providers have faced formidable and chronic fiscal, political, and health market challenges over the years. While a broad empirical literature has chronicled the economic and organizational challenges faced by these entities in the late 20th century, the contexts under which different safety net systems emerge remain underexplored. This paper looks at the unique context of Dallas, TX, which developed an innovative, integrated safety net system: the Parkland Health and Hospital System.

In the mid-1980s, realizing their new hospital had already reached capacity, Dallas leaders decided to decentralize the system they had. In light of the numerous options available, Parkland opted for a unique community-based primary care delivery scheme known as Community Oriented Primary Care (COPC). COPC had originated in China, Britain, and pre-Apartheid South Africa before making its way to the US through champions like Sidney Kark, Jack Geiger, and Fitzhugh Mullan. Parkland leaders, who boasted career experience with the Indian Health Service and Community Migrant Healthcare programs, found the model amenable to Dallas’ healthcare setting and needs. Through several strategic steps – including the repurposing of a faith-based immigrant health clinic and the annexation of preexisting federal clinic space – Parkland demonstrated immediate successes to community stakeholders, leading Dallas County leadership to embrace the system. Despite its flaws, Parkland’s COPC program has become an integral part of a uniquely integrated safety net system that brings a level of coordinated care to uninsured patients that is usually reserved for privately-insured patients in integrated commercial networks. The paper highlights the challenges safety nets confronted in costs, care delivery, and the complex health needs of their target populations in the late 20th Century. It also draws attention to the social capital and infrastructure capacities essential to the delivery of healthcare to vulnerable populations in the late 20th and early 21st centuries in the United States.

Learning Objectives

- 1) By the end of this activity, the learner will identify the tradeoffs associated with the design of different delivery systems in American healthcare
- 2) By the end of this activity, the learner will understand the dynamic interrelationship between medicine and society through history, the dynamic history of care delivery ideas and practices, and the implications of these for patients and health care providers
- 3) Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, particularly the American Safety Net system.

I2 Mediating Conception

“Turning Urine Into Gold”: Pergonal and the Roots of the Obsession with (In)Fertility in Palestine/Israel, 1934-1968”

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Israeli women are known to be the best consumers of fertility treatments in the world. While much anthropological attention has been paid to this phenomenon (Kahn 2000, Birenboim-Carmeli 2010, Teman 2010), very little historical work deals with its emergence. Historians have shown that global research on sex-hormones and fertility exploded in the 1920s-1930s, but that scientific attention moved to controlling reproduction after WWII (Oudshoorn 1994, Gaudillier 2005, Logan 2007, Norlund 2007), only to regain prominence in the late 1970s. Contrary to this global trend, a group of European scientists who immigrated to Palestine/Israel during the war devoted their careers to promoting fertility and battling sterility. As part of their work, urine, and postmenopausal urine in particular, became the main source of hormones for young women (and men) in their attempt to overcome fertility problems.

This paper focuses on the invention and production of the Pergonal drug, a process that combined biomedical, pharmaceutical, religious, and state institutions. This fertility drug, which has been produced from urine of postmenopausal women, was first trialed in Israel in late 1950s, became prevalent in Israel and throughout the world in the mid 1960s, and so it remains to date. Its production, moreover, became an important step in developing IVF treatments. I argue that the extraordinary scientific attention to infertility in British Palestine and the young State of Israel explains much of the recent “fertility craze.” Moreover, I show that this attention could only be understood as part of broader attempts to create a plentiful environment in Palestine/Israel, a modern Holy Land. Finally, I demonstrate how this process was entangled with movement of people, ideas, and materials across the Mediterranean, and more surprisingly, between scientific and religious institutions. In the production of a land of plenty, urine connected the clinic and the lab in Israel with a pharmaceutical industry in Italy; it came from Italian convents and Israeli elderly homes; it had to move between the Israeli Prime Minister’s office and the Vatican. In this collection project (now affecting the whole global south), aging women have become crucial part in the technological production of new lives.

Learning Objectives

Recognize the dynamic interrelationship between medicine and society through history, and science and religion more broadly

Challenge common (historical) conventions about global health policy

Develop an historically informed sensitivity to a current socio-medical phenomenon

I2 Mediating Conception

“Minor Access to Emergency Contraception in the United States Has An Historical Foundation in Minor Contraceptive Access Frameworks in England, France, and the United States”

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Minor access to emergency contraception (EC) has an historical foundation in contraceptive access for minors in three different cultures, England, France, and the United States. Contraception was illegal in the United States and France in the time period up to the 1960s but not in England, although contraceptive access wasn't easy to obtain.

In the 1980s, England marketed one of the first combination estrogen and progesterone emergency contraceptives, but restricted it to prescription. When progesterone-only EC was marketed in England slightly less than 2 decades later, minors less than 16 were prohibited from obtaining it from pharmacies. The British noted some of these changes and a slight shift in policy occurred as a result.

France was late in approving emergency contraception, and in an elegant series of steps, liberalized access to minors in a manner that was practical, but radically different than the United Kingdom had allowed or what the United States would do. They allowed access from school nurses and pharmacists for minors. Within one year, progesterone-only EC was approved and placed in schools. The public was largely supportive of these endeavors.

The United States, led by advocacy groups finally obtained a combination estrogen and progesterone prescription only EC product, Preven, in the late 1990s. It required a visit to both a medical provider and then a pharmacy. A lower risk progesterone only prescription product, Plan B was released a bit later. When Over-the-counter access was initially considered for Plan B, age limits similar to what was enacted in the UK were stipulated, sparking public and health professional outcry. Extensive discussions, judicial rulings, and political squabbling have continued in the United States.

Interestingly, the adolescent pregnancy rates of the United States are much higher than of many other countries, including the United Kingdom, and France. This suggests that protracted wrangling regarding minors access to EC hasn't helped adolescents. It is interesting to speculate that more liberal views of sexuality and contraception have served French society better than the middle approach taken by the United Kingdom and the conservative approach used in the United States." "1. Critically appraise clinical management from a historical perspective regarding emergency contraceptive provision.

2. Acquire a historically nuanced understanding of the U.S. healthcare system, and of other national health care systems regarding contraception.

3. Recognize the dynamic interrelationship between medicine (and contraception) and society through history.

I2 Mediating Conception

“Rape and Professional Medicine, 1800-1910”

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Rape is most frequently considered as a legal, or sometimes political, issue but as a crime inflicted upon a body it also falls within the scope of medical practice. In addition to treating wounds suffered during a rape, physicians and nurses are called upon to collect evidence and provide testimony. Physicians were involved in cases of rape throughout the nineteenth century concurrent with their professionalization. Examining their writings on the subject reveals the high level of scrutiny a woman who had been raped would be subjected to, the sorts of scientific knowledge and technology that was brought to bear in medico-legal cases, and the institutionalization of certain myths about rape.

These doctors examined the bodies of women, and sometimes men, for objective evidence to prove or disprove the accusation. Their investigations and conclusions were greatly influenced by the widespread belief that most claims of rape were false reports. As a consequence, physicians regarded protecting the innocent from false accusations as a major component of their role in cases of rape. As microscopy became a more common activity for practitioners, this device became an important component of forensic examination. Traces of blood and other bodily fluids were highly valued, and their absence regarded as particularly suspicious. The presence or absence of venereal disease was also considered relevant to the case. The aspect of these cases which stands out the most, however, is the persistence of the attitude that women are likely to accuse innocent men of rape for their own nefarious purposes. Physicians also weighed in on the controversy over whether or not a woman could conceive from rape. Despite the hostility towards victims of rape, women still sought out physicians to find physical evidence to back up their claims.

The suspicion cast towards women who report a rape, and the ongoing controversy regarding rape and pregnancy are not recent developments. In order to understand the current interaction between rape and medicine, one must consider the standards set by early professionals.

Learning Objectives

- 1) Develop knowledge and understanding of the evolution of professional behaviors and values in regard to victims of sexual assault
- 2) Contribute to the improvement of patient care
- 3) Analyze the impact of physicians' attitudes regarding victims of rape and sexual assault during the period of professionalization
 - Critique the use of anecdotal evidence to perpetuate widely held myths about rape and sexual assault.
 - Recognize how biases against unsympathetic victims impact quality of care.

I3 Therapeutic Epistemologies

"Hedging ones bet: Emil Roux's 1894 diphtheria antitoxin trial and the role of Joseph Grancher's architectural design and hygienic regulations at the Hopital Enfants des Maladies"

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In 1882, Joseph Grancher (1843-1907), Professor of Pediatrics at the Hopital Enfants des Maladies and a strong advocate of asepsis introduced an architectural design with hygienic regulations which played a major role in Emil Roux's controlled diphtheria antitoxin study of 1894.

At the 18th International Congress of Hygiene and Demography held in Budapest in September 1894 Roux "communicated" his findings of his diphtheria antitoxin study having chosen two children's hospitals in Paris: the Hopital Enfants des Maladies for the experiment and the Trousseau as the control. The trial made no mention of Grancher's aseptic innovations. Roux had to be aware of trials in Germany in 1891 and 1892 in which the anti-sera did not work. I suggest that Roux "hedged his bet" in choosing Enfants, wanting the best results possible: antitoxin plus asepsis. His statistics showed that the pre anti-sera mortality "in four previous years when 3,971 cases were admitted [to Enfants]" was 51.7% while at the Trousseau "of 500 children admitted" the mortality was 63.2%. A yearly breakdown of the Enfants "four previous years" showed a mortality rate of 48% in 1892 and 1893. I argue that the 15% difference from the control hospital was due in large part to Grancher's architectural design and hygienic innovations.

There were, of course, additional factors which affected the diphtheria mortality rates: the geography of the disease; the reliability of the statistics; and the lack of standardization of antitoxin dosing to mention but a few, these will all be addressed in the paper.

This study utilized the archives of Amherst College and Columbia University; minutes from the International Congress of Charities, Corrections and Philanthropy, Chicago's 1893; and Eighth International Congress of Hygiene and Demography in Budapest's 1894 as well as secondary resources and consultation with medical historians.

In conclusion, Grancher's architectural design and hygienic regulations deserves historical recognition for the role they played in the history of diphtheria antitoxin treatment.

Learning Objectives

By the end of this activity the learner will understand the dynamic history of medical ideas and practices.

The learner will recognize the dynamic interrelationship between medicine and architecture through history.

The learner will have a deeper understanding of illness and suffering and its effects on society.

I3 Therapeutic Epistemologies

"Hedging ones bet: Emil Roux's 1894 diphtheria antitoxin trial and the role of Joseph Grancher's architectural design and hygienic regulations at the Hopital Enfants des Maladies"

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Testing Standards as Regulatory Instruments: A History of Non-inferiority Trials and Dilemmas in Antibiotic Drug Development "The seemingly paradoxical simultaneous over-use and under-availability of antibiotics is a major topic in contemporary health policy. This talk focuses on the emergence of non-inferiority clinical trials (which hold that a new drug should be proven as efficacious as the current standard of care within a statistical margin) in the 1980s and their subsequent use as a regulatory tool to manage new antibiotic drug approval decisions at the Food and Drug Administration (FDA) and to influence post-market use of antibiotics. Regulators evaluating new antibiotics have been confronted with the decision to approve many drugs in order to expand choices available to infectious disease physicians or to approve only a few new drugs under a strict efficacy threshold and thereby limit the number of antibiotics on the market. While approval decisions are technically distinct from the public policy question of how to structure the antibiotics market in order to maximize efficacy and minimize the rise of resistance, I find that the two issues became intertwined in the early 2000s.

Source materials from the FDA are integrated with a case study of the testing and regulatory review of oritavancin, a drug invented in the mid-1990s that remains mired in clinical trials after being denied market approval in 2008. Disputes over the testing standard, primarily between statisticians and clinicians, played out not only in medical journals and scientific conferences, but also at FDA advisory committee hearings and in drug approval decisions. The evolution of testing standards over time also shaped competition in the industry as large pharmaceutical firms exited the antibiotics business. I find that changes to testing standards for antibiotics created drug development risks attractive only to small biotechnology firms, rather than multinational pharmaceutical firms with broader product portfolios and deeper manufacturing and distribution capacity. In an ironic development, the collective risk of antibiotic-resistant disease in the United States has become intertwined with the innovative capacity and economic survival of high-risk, small, venture-backed biotech firms. The talk concludes with modest policy recommendations based on the historical evidence and analysis.

Learning Objectives

1. Understand the dynamic history of medical ideas, practices, and regulation; 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. Gain historical analytical insights on changing requirements for biomedical research and the role of government and industry in the setting of standards for clinical trials and medical research.

I3 Therapeutic Epistemologies

“A Challenge for European Health? Medicines Consumption, Drug Risks, and Health Policies in Western Europe, 1950-1980”

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During the last 60 years, pharmaceutical industries in western countries have undergone an enormous expansion. Mass production and health insurance have made drugs easily available, a large range of indications and changing medical practices made it possible to treat a lot of diseases with pharmaceuticals. Thus, they have become important objects of our daily life. But this expansion has also risen increasing doubts on pharmaceuticals' safety, use and abuse. Drug-related catastrophes such as the Stalinon affair (1954) or Thalidomide (1957-1961) added to the awareness for dangers of legal drug use. Epidemiologists and pharmacologists developed both pre-market control instruments and post-market surveillance programs.

If historians and social scientists have intensively studied pre-market testing of “drug safety”, my paper addresses the question how drug-related dangers in consumption and use were transformed into calculable, manageable and finally acceptable risks. The paper analyses the political and scientific strategies which tried to balance safety issues and economic interests in a free market system. It sheds light on data about drug consumption that was used to underline WHO's argument that (legal) drug use was a “major health concern” for Europe and the US. By linking risk regulation and medical consumption, my contribution aims to strengthen historian of science Soraya Boudia and others' argument that risk management should not exclusively be considered as an ahistorical practice of experts and politicians. In the contrary, it can also be seen as a scientifico-political option to deal with ideological constraints during the Cold War. Risk regulation in the pharmaceutical sector thus contributed to maintain a system – including drug producers, prescribers, sellers and consumers – that was fundamentally one of a free market during a period of systemic competition.

Based on archival research in both company and public archives as well as on media documents, the paper shows the strong links between a shift in sociopolitical representations and the new perception of both consumer's behaviour and drug-related risk perception in the historical context of mid- and late 20th century Western Europe.

Learning 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

I4 Dread, Exorcism, and Addiction

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An Enchanting Witchcraft: Masculinity, Melancholy, and the Pathology of Gaming in Early Modern London In the midst of an explosion of card and dice games in seventeenth-century England, the addictive qualities of gambling gained unprecedented attention by contemporary moralists, who typically defined gambling as a curse, a plague, or madness. Viewing gambling as antithetical to social order and Protestant bourgeois mores, critics such as Charles Cotton typically identified games of chance as an enchanting witchcraft and a veritable social cancer that proliferated in the era of speculative capitalism. Whereas existing scholarship in the history of early modern gaming largely focuses on the ways in which attitudes toward gambling intersected with the intellectual milieu of probability theory or the moral objections of religious writers, this paper examines medical perceptions of gambling and nascent concepts of addiction in seventeenth-century England through the lens of medical theory, gender, and early modern etiologies of mental illness. Based on methodology drawn from the social history of medicine and cultural anthropology, this study explores the ways in which competing codes of manhood and an incipient pathology of addiction intersected with transformations in the epistemology and physiology of reason, the passions, and mental health. As scholars such as Michael McDonald and Roy Porter have asserted, novel medical theories that anatomized reason and removed concepts of madness and insanity from prevailing supernatural or humoral modes of explanation began shifting perceptions of mania and mental illness in the seventeenth century. By focusing on the ways in which gaming was pathologized by medical writers and practitioners such as John Bulwer, Richard Napier, and Robert Burton within the shifting framework of madness and melancholy, this paper will shed light on the ways in which the social basis for nascent practices of psychological prognostication and healing and concepts of addiction and mental disorder emerged alongside the unprecedented popularity of gambling in Stuart England.

Learning Objectives

This presentation will contribute to learners' development of knowledge and understanding of professional behaviors by:

1. recognizing the dynamic interrelationship between medicine and society through history, particularly with regard to the emergence of psychology and incipient theories of mental illness.
2. Developing an historically informed sensibility to the diversity of patients, particularly with regard to a traditionally stigmatized population: those suffering from addiction.
3. Deepen understanding of illness and suffering by underscoring the historical conflict between moralizing and therapeutics with regard to mental illness.

I4 Dread, Exorcism, and Addition

“The ‘intuitive’ exorcists: religion, medicine and spirit possession in 1970s England”

Neil Armstrong; n.armstrong@tees.ac.uk; Teesside University, Middlesbrough, UK

For much of the twentieth century, exorcism was a largely dormant practice within the Church of England. However, the 1970s saw a significant revival of interest in the rite. This was due in part to the influence of the Charismatic Revival which emerged in the 1960s, and drew upon Pentecostal forms of worship and ministry. In the early part of the twentieth century Pentecostalism adopted a doctrine of demon possession which, as Rhodri Hayward has shown, had been reinvigorated through colonial missionary encounters, the influence of spiritualism and the ‘appearance of new theoretical models in psychology, science and medicine’. At the same time, certain clergymen turned to exorcism as a form of authentic ministry which would challenge the declining prestige of the churches by demonstrating their ability to cure souls damaged by the perceived excesses of the ‘permissive society’ and the popularity of occult practices. Their activities were seized upon by the tabloid press, whose coverage became more sensationalised following the UK release of the film *The Exorcist* in 1974, and the murder of a woman in Yorkshire by her recently exorcised husband the following year.

The growth of exorcism within the Church of England can be placed within the broader context of the revival of Anglican interest in spiritual or divine healing from the early decades of the twentieth century. As Sheryl Root has demonstrated, the established church saw spiritual healing as a quasi-evangelistic tool designed to counter the appeal of revival denominations and the activities of unorthodox healing sects like Christian Science. In doing so, mainstream Anglicans tended to emphasise the need for co-operation with conciliation towards the medical profession. This paper examines how exorcists active in the 1970s utilised biomedical discourse to justify their practice, demonstrating continuities between the complex interplay of medical and religious healing discourses of the early decades of the twentieth century and later developments. It will also explore the wider debates that exorcism prompted concerning the difficulties of distinguishing possession from various forms of mental illness, and the relationship between the clerical and medical professions.

Learning 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.

I5 **Disciplinary Issues**

"The Meaning and the Domestications of 'Tropics': Richard P. Strong and the 'Department of Tropical Medicine' at Harvard University"

Se-Kwon Jeong; vieclair@gmail.com; Seoul National University, Seoul, Republic of Korea in the early 20th century America

This paper examines the meanings of 'tropics' or 'tropical medicine' in the early 20th century America, by looking to the activities of Richard Pearson Strong (1872-1948) in the Department of Tropical Medicine which was established at Harvard University in 1913 and of which Strong became the first professor. After serving for fourteen years (1899-1912) in the colonial Philippines as multiple roles from a military surgeon to the director of Governmental Biological Laboratories in Manila and American representative at the International Plague Conference in Manchuria (1911) and so on, Strong came back to homeland with a good knowledge of tropics and tropical medicines which had been not established as academically and practically. As the professor of department of tropical medicine at Harvard University, he continued to explore and investigate tropics such as Central/South America and Africa for not only his own scientific enthusiasm but likely political and commercial interests of the United States. In addition, Strong tried to take part in the public health policy of the Boston municipality, emphasizing its own regional features which resulted from the fact that Boston was bordered to the Atlantic Oceans. Strong's enterprises attempted abroad and at home were a kind of strategy to make the unfamiliar 'tropics' be domesticated in the United States and to establish 'tropical medicine' as independent academic disciplines especially within Harvard University. Although his project realized less than his expectations, because of implicit apathies from other public health agents and rare financial supports from governmental, municipal, and philanthropic institutions, the word 'tropics' and 'tropical medicines' could have been made a soft landing in the United States through Strong's activities. This paper will demonstrate the unique meanings and the precarious domestications of the colonial experiences and knowledges of a newborn empire, the United States in the early 20th century.

Learning Objectives

1. To develop the understanding of the relationships between medical knowledges and imperialism of the United States in the early 20th century.
2. To comprehend the process of the introduction of an unfamiliar topics, such as 'tropical medicine' into the public health areas in the United States.
3. To understand the relationships between medical practices and a myriad of sponsoring systems in the United States.

I5 Disciplinary Issues

“Medical mycology: 'Orphan Science' - Specialist Practice”

Michael Worboys; michael.worboys@manchester.ac.uk; University of Manchester, Manchester, UK

Fungal diseases have an unusual profile in the spectrum of infectious diseases. Either they cause relatively minor conditions, as when they develop on external tissues (e.g. athlete's foot or thrush), or very serious, life threatening illness, as when they colonise internal organs (e.g. invasive candidiasis or aspergillosis). The latter became a large and increasingly important type of infection in the last quarter of the century, with the increase in the number of immunocompromised patients due to new treatments and HIV/AIDS. The scientists and clinicians who chose to work with fungal infections had a problematic status throughout the twentieth century. Their attempts to found a specialism of medical mycology were met with indifference and opposition in universities, hospitals, research institutions and professional societies. In this paper, I consider the specific local settings in which alliances between 'botany types' and 'clinical types' (mostly dermatologists) were forged in the 1930s and 1940s. I then consider how medical mycology fared on the national stage, with a particular focus on its position in the National Institutes of Health and the struggle in the 1960s over the creation of a medical mycology section in the American Society for Microbiology. I argue that medical mycology exemplifies a type of specialism that has not been recognised adequately, namely, that it was and is an area of 'specialist practice' that is typically part-time or fractional, and combined with other areas of work. For example, in south western states, where coccidioidomycosis is common, it is linked with pulmonary specialisms and public health, while invasive mycoses interested transplant surgeons, cancer specialists and latterly those treating HIV/AIDS patients. And, of course, fungal disease continues to be an important component in the practice of dermatologists.

Learning Objectives

By the end of this activity, the learner will:

- have understanding of the development of medical specialisms;
- have learnt how and why fungal infections have suffered relative neglect in American medicine;
- have learnt how different geographical, institutional and professional setting shape medical knowledge and practice.

I5 Disciplinary Issues

“I’m not insane’: The Medicalization of Suicide in the First Half of the 20th Century”

Isabelle Perreault; iperreault@uottawa.ca; University of Ottawa, Ottawa, Ontario, Canada

Suicide, seen variously as an expression of criminality, madness or freedom of choice, is the only “truly serious philosophical problem”, according to Albert Camus (1942: 15). From the end of the 19th century, criminal law must increasingly deal with the emergence of a new dominant discourse: psychiatry (Foucault, 1976). Although suicide verdicts from this period indicate that “suicide [was committed] during a moment of madness or insanity”, a growing number of experts in mental illness perform psychological evaluations to determine whether those accused should be considered responsible for their actions or, on the contrary, cleared of responsibility by reason of their mental condition and subjected to medical intervention rather than punitive action. A 1910 note from Doctor Villeneuve concerning a young man who attempted suicide illustrates this: “I would be very pleased if the Honourable Attorney General could issue a declaration of nolle prosequi [will not prosecute] so that the young man may be sent without delay to the asylum” (AHLHL, #18347).

The direct association between suicide and mental illness is eventually called into question, particularly after the Second World War, even by pioneers of suicide prevention like Shneidman (1987: 160), who believed that “absolutely 100% of all suicide victims are perturbed, but perturbation itself is not a disease”. How are the points of tension and elective affinities between legal and psychiatric authorities established? Do institutional discourses differ from the writings of those who attempt or commit suicide? Suicide letters (coroner archives) and the files of patients interned in psychiatric institutions for attempted suicide in Quebec in the first half of the 20th century are used to analyze both the process by which the suicidal act is medicalized and the consequent resistance to such medicalization.”

Learning Objectives

- 1) to question the link between psychiatry and law on suicide.
- 2) to know how the psychiatric discourse on suicide is paradigmatic since decades.
- 3) to understand, maybe modestly, what means the last words of people who committed suicide.

L1 Luncheon Workshop: Blogging the History of Medicine

Jacqueline Antonovich; antonjac@umich.edu; University of Michigan, Ann Arbor, MI, USA

The use of blog-based technologies is thriving as a method of providing access to collections and resources, disseminating research, and providing a portal to individual and group projects in the history of medicine. This session brings together a diversity of voices working in the digital realm, and explores some of the methodological issues and challenges of the medium. Our panel features representatives from a diverse collection of History of Medicine websites with distinct missions, audiences, and production structures. We will introduce the audience to several varieties of blog-based History of Medicine projects, including group blogs tailored to particular subfields (Jacqueline Antonovich of Nursing Clio and Claire Clark of Points: The Blog of the Alcohol and Drugs History Society); individual scholarly blogs (Nathaniel Comfort of Genotopia); blogs dedicated to disseminating fresh research projects (Leon Rocha of Dissertation Reviews); and blogs that highlight and analyze unique archival collections (Elizabeth Mullen of the National Library of Medicine's Circulating Now and Lisa O'Sullivan of the New York Academy of Medicine's Books, Health, and History). Our discussion will primarily concentrate on practical matters such as:

- Building academic and public audiences
- Adapting larger academic projects to the blog format
- Conceptualizing the editorial process
- "Selling Out"
- Blog etiquette
- Blog-based history of medicine projects vs. Mainstream media sites
- Managing public comments
- Social media and building networks

We will leave ample time for audience participation. If you want to learn more about blog-based projects related to the History of Medicine, or have thought about blogging but aren't sure where to start, this is the session for you.

Learning 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. Elicit and write a patient's history worthy of an historian
3. Develop the capacity for critical thinking about the nature, ends and limits of medicine

L2 Luncheon Workshop: When Good People Do Bad Things: Can History Intervene?

Alice Dreger; a-dreger@northwestern.edu; Northwestern Univ. Feinberg School of Medicine, Chicago, IL, USA

The "horror" show cases of the history of medical research -- the Tuskegee Syphilis Study, the Guatemala studies of STDs, Southam's intentional infection of patients with cancer cells, and so on -- exist in two versions. In the version we historians know, people who saw themselves as champions of good science and good patient care paved the road to hell with those good intentions. In the version contemporary medical researchers and physicians know (if they know of these stories at all), terrible Nazi-like inherently-evil clinicians and researchers callously violated basic human morality. The persistence and dominance of the "Bad Apple" narratives over our "Human Like Us" narratives enables exactly the opposite of what we would wish: it permits contemporaries to reassure themselves that, because their intentions (their "souls") are good, they could never commit dreadful ethical mistakes. As historians, we have tried to write and to teach the complicated "Human Like Us" histories, yet we continue to run up against disbelief and outright denial when we point to contemporary unethical acts among well-intentioned clinician-researchers. So what can we do? How can we get contemporaries to believe "good souls" are capable of bad acts? Can history be successfully used for such an intervention? In this lunch session, we'll briefly lay out this problem and these questions and invite discussion.

1. Identify successes and failures in the history of medical professionalism.
2. Recognize the dynamic interrelationship between medicine and society throughout history.
3. Critically appraise medical research from a historical perspective.

L4 Luncheon Workshop: Negotiating Access to Patient Related Materials: A Conversation between Archivists and Historians

Phoebe Evans Letocha; pletocha@jhmi.edu; Johns Hopkins University, Baltimore MD, USA

“Part 1 The Impact of HIPAA on access to Medical Archives: An Archivist’s Perspective”

As Susan Lawrence suggested in her 2007 article, “Access Anxiety: HIPAA and Historical Research,” HIPAA has been a source of anxiety for historians of medicine. Access policies for patient related holdings vary depending upon a repository’s status under HIPAA as a covered entity, business associate of a covered entity, or a non-covered entity. While HIPAA has been in effect for over 10 years, interpretations and misinterpretations of HIPAA and its implications for historical research vary widely. Archivists and historians are still negotiating what can and cannot be done under HIPAA and are sometimes confused about how it applies to their repositories, their research, and to specific collections and sets of records. 2013 changes to the HIPAA Privacy Rule revised the definition of Protected Health Information to exclude information related to individuals who have been deceased for more than 50 years. State laws that may continue to protect medical records vary by state, thus adding to the confusion. This presentation will provide a practical overview of what HIPAA does and does not allow and how that has changed under the revisions to the Privacy Rule. The presentation will be based on my 10 years of experience as part of the Alan Mason Chesney Medical Archives’ compliance team which has taken the lead in crafting access policies that enable research access to patient related holdings. Based on an analysis of applications to the Privacy Board of the Johns Hopkins Medical Institutions in that 10 year period, access to patient related holdings have increased rather than decreased. The HIPAA Privacy Rule and the Privacy Board application process has opened up collections that were previously restricted. By providing a means to regulate and evaluate the risks associated with research access, HIPAA has allowed some archivists to suggest use of collections that would have otherwise remained closed. From the perspective of an archivist who serves as the staff liaison to the Privacy Board and oversees the management and description of collections at a HIPAA covered entity, this presentation will provide practical advice on how researchers can pursue access to these holdings in compliance with HIPAA.

Learning Objectives

1. To educate researchers about the HIPAA Privacy Rule and what can and cannot be done regarding access to archival medical collections in light of the 2013 changes to HIPAA.
2. To identify potential research use of patient related materials
3. To explain how HIPAA impacts archival practice and suggest ways that archivists can better communicate the impact to historians

L4 Luncheon Workshop: Negotiating Access to Patient Related Materials: A Conversation between Archivists and Historians

Cynthia Connolly; cac1@nursing.upenn.edu; University of Pennsylvania, Philadelphia PA, USA

“Part 2: Exploring Access to Medical Archives: A Historian’s Perspective”

Writing the history of clinical practice often demands access to patient records in order to fully appreciate the lived experience of patients, families, physicians, and nurses. This presentation will describe the importance of patient records for a study of children, drugs, and drug policy since the 1930s. It will describe the process of preparing and submitting an IRB/Privacy Board approval (from one’s “home” institution as well as the archival repository housing the patient-related records). The nuances of how applications differ for the same project across different institutions will be detailed using as a case example one researcher’s study. Finally, the types of information researcher need to know about a particular collection in order to weigh whether or not to invest the time and energy into preparing an IRB/Privacy Board application will be detailed.

Learning Objectives

1. Discuss the mechanics of preparing an IRB/Privacy Board application
2. Identify challenges and barriers to submitting an IRB/Privacy Board application for historical research.
3. List common questions researcher often need addressed by archivists as part of an assessment of whether or not patient-related materials will be useful for a particular project.

L4 Luncheon Workshop: Negotiating Access to Patient Related Materials: A Conversation between Archivists and Historians

Kathryn Hammond Baker; kathryn_baker@hms.harvard.edu; Harvard Medical School, Boston MA, USA

"Part 3: Negotiating Access to Medical Archives for Historical Research: A Moderated Discussion"

In a 25 minute moderate discussion period, Archivist and historians will explore issues related to perceived barriers to use of collections with privacy restrictions. They will identify what is stopping researchers from using these restricted records.

Discussion topics will seek scholarly feedback regarding the effectiveness of archival finding aids in addressing those barriers or helping the researcher decide if the collection is worth the effort to pursue access. Is the fact of having to apply for access a barrier? They will examine the length of the IRB and Privacy Board review process by examining repository statistics on how many people are referred to IRBs or Privacy Boards, compared to how many people actually follow through and pursue an application, and the percent who are approved. What information do researchers want to have from descriptions of archival holdings that would improve the decision making process. The audience will be asked to list and prioritize the options that archivists could employ to improve the situation given the limited resources of many archival repositories.

Learning Objectives

1. To educate historians about the barriers to access to archival holdings and ways to overcome them
2. To examine the IRB application process and how archivists communicate access restrictions
3. To identify ways to improve archival descriptive practices"

L6 Luncheon Workshop: Silos or Synergies: Considering the History of Interprofessional Education and Practice in the United States

Jennifer Gunn; gunnx005@umn.edu; University of Minnesota, Minneapolis, MN, USA

Interprofessional education and practice are touted as the future of American health care. The concept is not new, but has been in practice for decades in response to workforce issues and demands for health care delivery. Historically, however, the coordination and cooperation necessary for bridging the silos of health professional education and practice have been easier to conceptualize than implement. This lunch session invites historians to move beyond the disciplinary silos often replicated in our approach to health care history by discussing several historical examples of interprofessional practice. It will be an interactive session: the first part will offer brief examples of team-based practice and education across the twentieth century (30 minutes); the second part will invite allied health practitioners and historians to frame questions and themes for future research.

The case studies cover a range of health professions, models, and time periods. Beth Linker discusses the “team play” concept welding physical, occupational, and speech therapists, and dieticians together in the rehabilitation of WWI veterans. Rima Apple explores how home economists and physicians developed programs for maternal education to combat high infant and child morbidity and mortality and to enlist teachers—not typically part of the health care team—in disseminating ideals of modern medicine. Patricia D’Antonio examines the relationships between nurses and social workers in urban public health practice in the 1920s—relationships that seemed self-evident in theory but proved fractious. In the 1960s-1970s, Dominique Tobbell investigates the interprofessional education of clinical pharmacists, who emerged as a new type of health professional with crucial expertise for the hospital-based health care team in the context of increasingly complex medication regimens. Jennifer Gunn focuses on proposals for rural health care that conceived of allied health professional teams as a solution to physician shortages and maldistribution. Persistent workforce problems, Julie Fairman argues, drove the simple idea of working together. But over time this became a proxy for supervision and a model for payment and practice. Each of these case studies reflects the health care debates of the time and the needs of the professions that believed they should be the designated leaders.” • Through brief case studies of multi-disciplinary approaches to the delivery of health care and health education, participants will gain a historical understanding of the concept of interprofessional practice and education in the twentieth century.

Learning Objectives

- Participants will learn how practitioners from health professions other than their own have viewed the conflicts and obstacles to implementation in team-based practices.
- Participants will be able to apply a historical understanding of the experience and outcomes of team-based practice and education to implications for future development of an interprofessional workforce.

Information and Accommodations for Persons with Disabilities

General Information

Chicago is one of the most accessible cities in the world for visitors with disabilities. Here are resources and general information.

The Open Doors Organization created **Easy Access Chicago** (<http://easyaccesschicago.org>) to provide accessibility information for Chicago. Information is available on the web site and in abridged print versions downloadable in PDF format. The detailed information in the guide enables visitors with disabilities, as well as mature travelers, to decide which restaurants, attractions, and transportation suppliers meet their specific needs. Under the site's "Transportation" subhead, visitors will find information on disability parking placards, accessible taxis and van transportation, and paratransit services.

The city's public transportation system, the **Chicago Transit Authority (CTA)**, has a video on its web site (www.transitchicago.com) with information on how to ride CTA using accessible services. In the site's search engine, type "CTA Accessibility How-To Video." Individuals can view specific chapters online, or order a free DVD copy by contacting CTA at 888-968-7282 at prompt #2 to request.

Chicago's regional transportation authority offers a Reduced Fare Permit to people with disabilities, which provides a discount on rides and transfers. It allows the permit holder and an accompanying personal attendant both to ride at the reduced fare. For more information or to apply, call 312-913-3110 (voice) or 312-836-4949 (TTY).

Airports

O'Hare International Airport has numerous accessibility services, such as TTY telephones, visual paging monitors, and Public Services information booths with TTY. Each bank of pay telephones is equipped with an amplified handset telephone for hard of hearing users. Operator-assisted TTY are adjacent to the airport information booths located on the lower level of Terminals 1, 2, and 3 and on the upper level of Terminal 5, and are available 24 hours a day. A visual paging system in the International Terminal allows airlines and airport operators to send visual messages to the public. The visual paging system is located adjacent to the flight information monitors. Animal relief areas are located curbside, on the lower levels of Terminals 1 and 5. They are gated areas designated for service animal relief and are accessible at all times. All animals must be accompanied and leashed by the owner. For additional information on O'Hare's accessible services, call 773-686-8040.

All points on the Airport Transit System route are fully accessible to persons with disabilities. Elevators are available at each of the five stops.

O'Hare's elevated parking structure (Lot A), adjacent outdoor lots (Lots B and C), the parking lot serving the International Terminal (Lot D), and Economy Lot E have approximately 250 parking spaces clearly marked with the International Access Symbol for Motorists with disabilities. For further information, call 773-686-7530.

Travelers Aid Chicago is a social service agency located at Chicago O'Hare International Airport. The main Travelers Aid office is located in Terminal 2, and is open all seven days. Travelers Aid provides guidance, support or advocacy services for passengers who need it as they travel. Professional staff are available to assist with crisis intervention information, and social services to travelers and visitors at O'Hare, 773-894-2427.

The AHA's two official airlines, American Airlines and United Airlines, each has specially designated lounges to provide assistance to travelers with disabilities. American has a special service lounge in the K Concourse and United has special service lounges in both the B and C Concourses. Both carriers also offer mobile carts in their concourses to transport passengers needing this service. Travelers can contact the airline directly or an airline representative for use of a mobile cart.

The CTA Blue Line train provides 24-hour service between downtown Chicago and O'Hare Airport. The station is equipped with an elevator to take passengers with mobility impairments to and from the platform. Other CTA stations on the Blue Line equipped with elevators from O'Hare to downtown are at Rosemont, Cumberland, Harlem, Clark/Lake, and Jackson. For further information, call 617-222-3200, 312-836-7000, and 312-836-4949 (TTY).

Midway International Airport has accessibility services available to travelers. TTY are located at designated locations throughout the terminal facility. Elevators located in the terminal building provide access to all passenger levels of the airport complex. All elevators have Braille and raised letters/numerals. The animal relief area is curbside, on the lower level. It is a gated area designated for service animal relief and is accessible at all times. All animals must be accompanied and leashed by the owner. Visit the airport's web site for a downloadable *Access Guide for Midway*. For additional information on Midway's accessible services, call 773-686-8040.

Volunteer assistance is available for travelers at Chicago Midway Airport. The personnel are available at designated areas throughout the airport.

There are two parking facilities at Midway airport, terminal and economy parking. Both garages have designated parking spaces for motorists with disabilities located near each of the three elevator cores. Passengers should use the center core elevators to reach the third floor to access the pedestrian bridge to the terminal building.

The CTA Orange Line provides service between Midway International Airport and downtown Chicago. The station is equipped with an elevator to take passengers with mobility impairments to and from the train platform. All stations en route to downtown Chicago are equipped with elevators. For additional information, contact 312-836-7000 and 312-836-4949 (TTY).

General Resources

Scooter and wheelchair rentals are available by contacting **ScootAround Inc.**, toll-free at 888-441-7575, by e-mail at info@scootaround.com, online at www.scootaround.com, or by fax at 204-478-1172.

The U.S. Department of Transportation's Aviation Consumer Protection and Enforcement has an online guide, "New Horizons: Information for the Air Traveler with a Disability" (<http://airconsumer.dot.gov/publications/horizons.htm>). This site also explains how to file a complaint with the department.

A general resource is *Barrier-Free Travels: A Nuts and Bolts Guide for Wheelers and Slow Walkers* (\$19.95; 2009, 3rd edition; <http://barrierfreetravel.net>). It contains detailed information about the logistics of planning accessible travel—whether by plane, train, or bus. The book includes important details about accessible air travel, traveling with oxygen, accessible ground transportation, choosing a travel agent, online booking, accessible recreation, and budget travel. It is available in bookstores, or online at www.barrierfreetravel.net.

Information about Hotels

The information that follows is provided to assist AHA annual meeting attendees with disabilities in obtaining the reasonable accommodations they require. Please refer to this information when making hotel reservations or arrangements to participate in program sessions and other events. In particular, guests should advise the selected hotel about specific needs when making room reservations.

All hotels have accessible lobbies; several have autoslide doors. Thresholds and doormats are in compliance with American with Disabilities Act (ADA) regulations and door-service personnel are available at most properties. Lobbies have marble floors and/or low-pile area carpeting. All hotels have accessible registration desks or provide clipboards to guests to complete registration documentation. Elevators connect all levels of each hotel. Each elevator has a wheelchair-accessible keypad, Braille numerals beside each control button, and audible direction. Restrooms in lobbies and on meeting room floors are wheelchair accessible and have tactile signage.

All hotels have accessible guest rooms. The number of such rooms at each property is noted in the listing below. Among other amenities, these rooms feature: wheelchair-accessible doors, lever/lever door handles, security peepholes, ample room space, grab bars in restrooms, low sinks with insulated pipes, accessible towel racks, and accessible mirrors. The following auxiliary aids are available at most properties: flashing fire alarm, doorbell, and telephone; vibrating alarm clock; closed-caption decoders; Braille signage; and TDD telephones.

Sheraton Chicago

Entrances The hotel's main entrance on East North Water Street is accessible.

Parking: Accessible parking spaces are available, and the hotel has two accessible entrances from the self-parking facilities.

Guest rooms The hotel has 51 king and 3 double/double room accommodations designated for persons with accessibility requirements. TDD devices (printing and nonprinting), knock alerts, telephone alerts, visual smoke alarms, time clocks, and bathtub seats are available upon request.

Restaurants The hotel's five eateries are all accessible: Chi Bar, Chicago Burger Company, Java Bar, LB's Bistro & Pâtisserie, LINK @ Sheraton Café, and Shula's Steak House.

Chicago Marriott Downtown

Entrance: The hotel's Rush Street and Michigan Avenue entrances are accessible.

Parking: Valet parking at the Rush Street entrance. The Self-Park lot is located at the corner of Rush Street and Ohio Street with 20 accessible spots.

Guest rooms: The hotel has 25 accessible rooms, six with roll-in showers. Twelve Assistive Device Kits for use in any guest room with closed caption television decoders, text telephones, audible and visual emergency warning devices are available.

Restaurants Rush Bar and Lounge, Harvest, and Starbucks Coffee House are all accessible.

Westin Chicago River North

Entrance: The hotel's main entrance on North Dearborn Street is accessible with power doors.

Parking: Valet-only parking available, with several accessible parking spaces.

Guest rooms: The hotel has 17 accessible rooms, four with roll-in showers.

Restaurants: The hotel's restaurants are accessible, Ember Grille, Hana Lounge, and Kamehachi Sushi Bar.

Courtyard Chicago Downtown/River North

Entrances: The hotel's entrance on East Hubbard Street is accessible.

Parking: Valet-only parking available at the hotel, and the garage can accommodate accessible vehicles.

Guest rooms: The hotel has 12 ADA-equipped guest rooms, three with roll-in showers.

Restaurants: The hotel's two cafes, Starbucks Coffee and State Street Bread Company, are accessible.

Sign Interpreting

In order to make the necessary arrangements, hearing-impaired members who will need sign interpreting service at the AHA annual meeting must notify the Headquarters Office and register for the meeting by December 1, 2011. After reviewing the program, but not later than December 1, members who have made such requests should inform headquarters of the sessions they plan to attend. Headquarters will then, with the assistance of the Local Arrangements Committee and the Registry of Interpreters, secure the services of appropriate interpreters. The AHA will assume the cost for up to nine hours of interpreting service or a maximum of \$400 per member, whichever is less.

An American Sign Language interpreter will be provided for the General Meeting (Friday, January 6, 8:30M .) and the Annual Business Meeting (Saturday, January 7, 4:45.M.). Contact Sharon K. Tune, Director, Meetings, AHA, 400 A Street SE, Washington, DC 20003, by December 1; stune@historians.org

Transportation to Chicago

Association Travel Concepts (ATC) is the official travel agency for the annual meeting. ATC has negotiated discounts with American Airlines, United Airlines, Amtrak, Enterprise Rent-a-Car, and Hertz Rent-a-Car to bring attendees special air, rail, and car rental rates that are lower than those available to the public. To take advantage of these rates and benefits, e-mail reservations@atcmeetings.com or call 800-458-9383. ATC is available for reservations from 8:30M. until 7:00M. Eastern, Monday through Friday. A link is also available through the AHA annual meeting web page, www.historians.org/annual

By air: By contacting ATC, attendees traveling on American (800-433-1790; Fare code 1112BK) will save up to 5 percent. Some restrictions may apply and service fees will vary. Travelers on United (800-521-4041; Fare code 510CK) will receive up to 15 percent off tickets purchased more than 30 days prior to the meeting. Discounts will apply for travel several days before and after the AHA's meeting dates of January 5 through 8 for service into O'Hare International Airport (ORD) and Midway International Airport (MDW). The discount fare code cannot be used on either airline's web site.

ATC will also search for the lowest available fare *on any* airline serving O'Hare and Midway airports. ATC is a full-service travel agency that provides personalized service, advance seat assignments, special meal requests, frequent flier programs updates, electronic ticketing, e-mail access for convenient booking of tickets, and more.

Train fares: Amtrak offers a 10 percent discount off the best available fare to Chicago between January 2 and January 11, 2012. To book, call Amtrak at 800-872-7245 and refer to Convention Fare Code X57H-932. Please note that this discount cannot be booked via Amtrak's web site—travelers must call Amtrak or their travel agent directly and mention the fare code. The offer is not valid on Auto Train but is valid with Sleepers, Business Class, or First Class seats with payment of the full applicable accommodation charges. Fare is valid on Amtrak Regional, all departures seven days a week, except for holiday blackouts.

Car rental: Attendees can also arrange to rent a car through Enterprise Rent-a-Car (800-593-0505; Fare code 32H7476) and Hertz Rent-a-Car (800-654-2240; Fare code CV#031C0017).

Transportation Services at the Airports

The city is served by the larger O'Hare International Airport and a smaller, close-in airport, Midway International Airport. Both offer excellent ground transportation throughout the day with service available to the hotels. Taxis, vans, public and rental cars are available. Both are served by Chicago Rapid Transit (CTA). To review terminal layouts and ground transportation availability, visit the airports' web sites: O'Hare at www.ohare.com/about/ohare and Midway at www.ohare.com/about/midway.

O'Hare International Airport

O'Hare handles more passengers than any other airport in the world. It has three domestic terminal buildings and one international facility that are linked on the upper level of each terminal to allow passengers quick and easy access between them and the Airport Transit System (ATS). The ATS is a convenient way to get around the airport—it is a free 24-hour rail system operating among all domestic terminals, the international terminal, long-term parking, and the Metra station (a commuter rail line). O'Hare is approximately 17 miles from downtown Chicago.

Taxicabs are located on the lower level curbside of each domestic terminal and are available from 6:00 A.M. to 1:00 A.M. A ride from the airport to the hotels takes approximately 30 minutes and costs between \$35 and \$45, depending on traffic. A shared ride program permits up to four passengers not traveling together to share a cab from O'Hare for a flat fee of \$19 per person. For wheelchair-accessible vehicles, call United Dispatch at 800-281-4466.

GO Airport Express (www.airportexpress.com; 888-284-3826) offers daily, door-to-door service to/from O'Hare airport. Hours of operation are 6:00 A.M. to 11:30 P.M. The shuttle departs approximately every 5 to 10 minutes outside the baggage claim areas of the lower level of the domestic and international terminals. The fare to the city is \$25 one way and \$46 roundtrip. Lift-equipped vehicles are available on request for passengers with disabilities. Advance notice is strongly urged.

Conveniently located at the lowest level of the Main Parking Garage, the **Chicago Transit Authority's (CTA)** Blue Line travels between O'Hare and downtown Chicago. The station can be reached from Terminals 1, 2, and 3 (domestic arrivals), and is accessed from Terminal 5 (international arrivals) by free, frequent airport shuttle trains. The fare is \$2.25 and travel time is 45 minutes to downtown Chicago. Trains leave from outside terminals on the lower level every 5 to 10 minutes, days and evening, and every 30 minutes from 1 A.M. to 5 A.M.

Follow the signs to the CTA Blue Line. Board the train to the Loop (downtown Chicago). O'Hare is the beginning of the line so the only choice is downtown.

- ❖ For the Sheraton, exit at State and Lake Street, and walk upstairs to street level. At this point, you may prefer to take a short cab ride to your hotel, especially if the weather is inclement or if you have bulky luggage. A taxi takes about five minutes and costs approximately \$6. To walk in 15 to 20 minutes, head east on Lake Street (toward Lake Michigan). Turn left or north on Michigan Avenue. Turn right on Wacker Drive (BEFORE crossing the Chicago River). Follow Wacker Drive to Columbus Drive. Turn left or north on Columbus Drive, and cross the Chicago River (you will need to take stairs down to reconnect with Columbus). The hotel will be on the right.

- ❖ For the Marriott, travel to the Washington Street stop. Go downstairs, through the tunnel toward State Street, then back up the stairs. Board the Northbound Red Line train and exit at Grand and State. Exit the subway station and walk two blocks east on Grand Avenue to the Marriott. Alternatively, riders can exit at State/Lake for a short cab ride or a moderate walk to the hotel.

- ❖ For the Westin, exit at the Clark/Lake stop. Walk three blocks northeast to the hotel.

- ❖ For the Courtyard, exit at Washington stop and transfer to the Red Line northbound, exiting at the Grand Stop. Walk south on State Street for two blocks until Hubbard Street. Make a left and the hotel is on the northeast corner of State and Hubbard. Alternatively, riders can exit at State/Lake for a short cab ride or a moderate walk to the hotel.

Midway International Airport

Midway is located 10 miles from downtown Chicago. It is served by seven carriers, with major operations for Air Iran, Delta, and Southwest. The main lobby area at the center entrance of the airport is where the information booth and all vehicle pickup services are available. **Taxis** are available on the lower level of the three-level terminal building. A ride from Midway to the downtown hotels takes between 20 and 30 minutes and costs between \$25 and \$30, depending on the time of day.

- ❖ **GO Airport Express** (www.airportexpress.com; 888-284-3826) also provides transportation to downtown hotels. Vans depart Midway every 15 minutes between 6:00 A.M. and 11:30 P.M. An information counter is located at Lower Level Arrivals door LL3. The pickup location is located outside door LL3, inside lane. The trip to downtown hotels takes 30 minutes and is \$20 one and \$36 roundtrip. Lift-equipped vehicles are available on request for passengers with disabilities. Advanced notice is strongly suggested.

- ❖ **Chicago Transit Authority** offers rapid transit between Midway and downtown Chicago on the CTA's Orange Line. Service operates all day, every day, except during overnight hours (roughly 1:00 A.M. to 4:00 A.M.) or after 11:00 P.M. on Sundays. Alternate overnight ("owl") service is available via the N62 Archer bus. Trains leave from a station connected to the east side of the airport and take 20 to 30 minutes. The fare is \$2.25.

Follow the signs to the CTA Orange Line. Board the train to the Loop (downtown Chicago). Midway is the beginning of the line so the only choice is downtown.

- ❖ For the Sheraton, exit at State and Lake Street (you will be on street level). At this point, you may prefer to take a short cab ride to your hotel, especially if the weather is rough or if you have bulky luggage. A taxi takes about seven minutes and will cost approximately \$8. To walk in 15 to 20 minutes, head east on Lake Street (toward Lake Michigan). Turn left or north on Michigan Avenue. Turn right on Wacker Drive (BEFORE crossing the Chicago River). Follow Wacker Drive to Columbus Drive. Turn left or north on Columbus Drive, and cross the Chicago River (you will need to take stairs down to reconnect with Columbus). Hotel will be on the right.

- ❖ For the Marriott, travel to the State and Lake stop. Walk down to the street level, and enter the subway on State Street. Board the Northbound Red Line train and exit at Grand and State. Exit the subway and walk two blocks east on Grand Avenue to the hotel.
- ❖ For the Westin, exit at the State/Lake stop. Walk two blocks northwest to the hotel.
- ❖ For the Courtyard, exit at State and Lake stop. Walk three blocks north to Hubbard and State. Make a right. The hotel is located at corner of State and Hubbard.

Shuttle Service between Airports

Two shuttles provide service between O'Hare and Midway: Coach USA Wisconsin offers hourly service between 8:00 to 10:00. Pickup is at the Bus Shuttle Center; one-way fare is \$13, roundtrip fare \$23. Omega Airport Shuttle also offers hourly service between the two airports from 7:00 to 11:45. Pickup is located at bus/shuttle center door number 4. The one-way fare is \$16.

Transportation Services at Amtrak

Chicago is known as the hub of all Amtrak transportation with 50 trains arriving or departing daily. The main station is Union Station at 210 South Canal Street. Cabs, the suggested means of transportation to the hotels, are available on the lower level of the station at Adams and Canal Streets. A taxi ride from Union Station to any of the hotels runs between 10 and 20 minutes and costs approximately \$6 to \$8.

Public Transportation in Chicago

The Chicago Transit Authority (CTA) (www.transitchicago.com) operates the second largest public transportation system in the United States (after New York City) and serves the city and 40 surrounding suburbs, operating 24 hours a day. It is by far the most efficient way to get around the city—even in January!—and also the lowest priced. Visit CTA's web site for how-to guides, a downtown transit sightseeing guide, a trip planner, schedules, maps, transit apps, and bus/train tracker information.

Most rides on CTA are taken by bus, on the system's 140 routes. The rail system consists of train lines spanning the city and neighboring communities, and is known locally as "The L." It has eight rapid transit routes with 144 stations. Parts run above ground, in subway tunnels and tubes, as well as at grade or in expressway medians. Two routes—the Red and Blue Lines—operate 24 hours, every day. Free transfer between all 'L' routes is available at designated locations.

The basic bus and train fare is \$2.25. For the bus, you can use dollar bills or coins, but the rail requires purchase of a farecard prior to taking your trip. You can buy farecards at hundreds of locations around the region (including at both airport) or order online in advance.

CTA Passes: Riders can purchase CTA Visitor Passes or CTA One-Day Fun Passes for unlimited rides on buses and trains. The Fun Pass is \$5.75 and allows 24 hours of unlimited rides on CTA buses and trains from the date and time of the first use. The Visitors Pass activates the first time used and is good for the number of consecutive days shown on the front of the pass. Visitors can purchase a three-day pass for \$14 or a seven-day pass for \$23. Once a pass is used, it is valid for the specified number of consecutive days. You can buy passes online, at vending machines at certain train stations, and at retail stores throughout the city.

About Taxicabs in Chicago

Riders may hail a cab or prearrange a trip by calling any one of the hundreds of taxicab companies operating in Chicago. At O'Hare and Midway airports, an employee of the Department of Aviation called a starter is available in case of questions or problems in finding a taxi. In Chicago, you pay the amount shown on the meter, plus any tolls. The meter should start at \$2.25, then increase \$0.20 for each one-ninth mile. In slow traffic, riders pay an additional idling time clock \$0.20 for each 36 seconds. There is a flat fee of \$1 for the first additional passenger and another \$0.50 for each additional passenger after that unless the passenger is under 12 or over 65 years of age. There is no charge for baggage or using a credit card, and tipping is optional. Drivers are not required to carry or to change bills larger than \$20. For trips over five miles, the driver may agree to charge either a flat rate or discount fare. However, the meter must continue to run, and an agreement must be made with the driver before the trip begins. Wheelchair-accessible taxicabs are available. Call 800-281-4466 for a list of all taxi companies operating wheelchair accessible cabs. An additional charge of \$1 is added to the total fare on each trip to or from O'Hare or Midway airports. The tax should appear on the meter as an "extra" charge. Taxicabs must accept credit cards, unless the taxicab is independently owned and operated; if there is no logo on the taxi's door, it is not affiliated.

Parking in Chicago

There are three options for parking in Chicago: at your hotel, at a commercial garage, and on the street. The first two are expensive and the latter can be next to impossible to find. Watch your time when parking in downtown Chicago—parking regulations are strictly enforced through ticketing and towing. There is metered parking on most downtown streets, but parking is in two-hour increments only. If you allow the time to elapse, you will be towed to a city impound lot. Also, watch for signs indicating that parking is not allowed at specific time periods during the day; make sure your car is moved before the time frame starts.

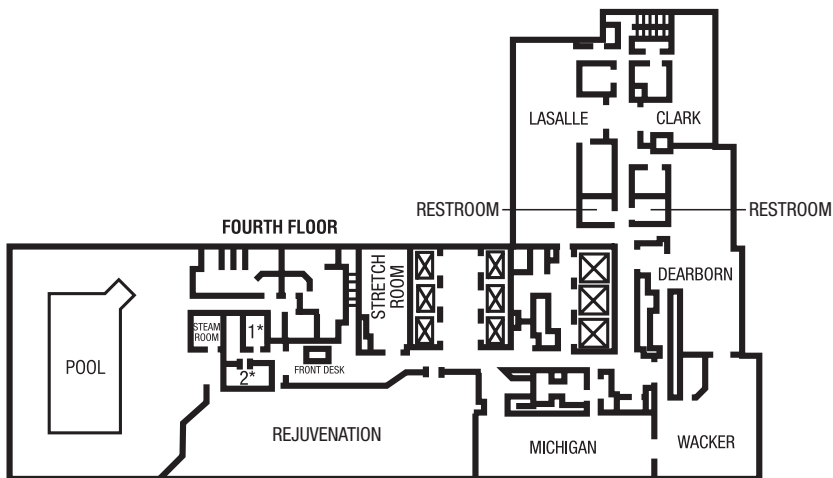
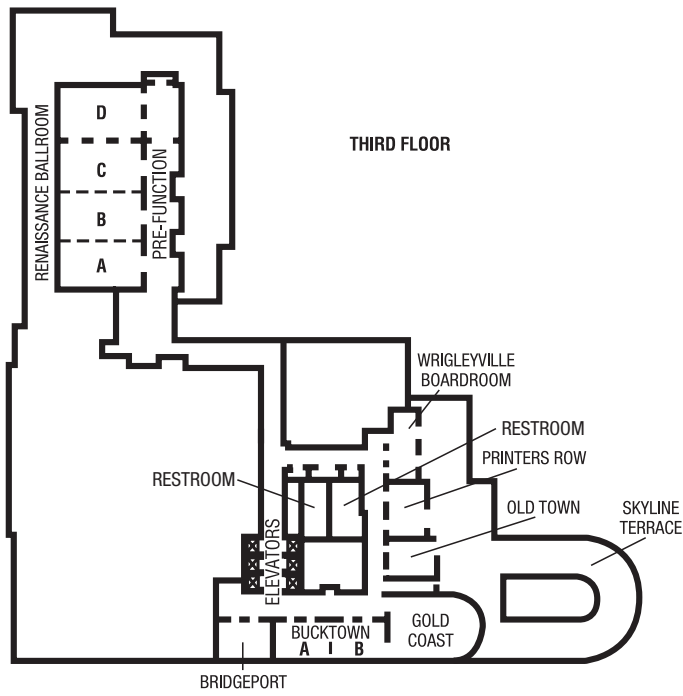
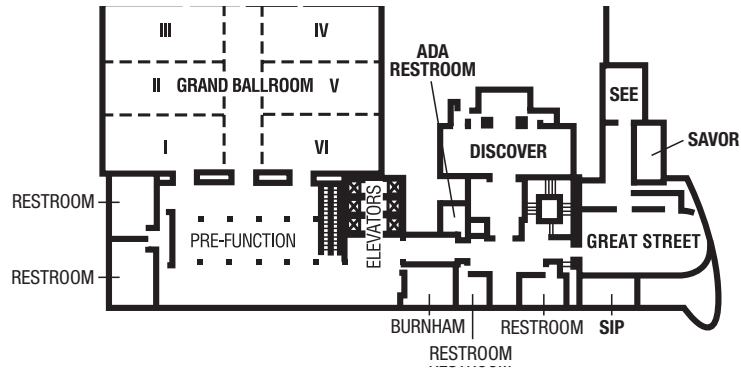
Hotel Parking

Current published rates for a 24-hour period: Sheraton: \$49 valet, \$37 self-park; Marriott: \$48 valet, \$33 self-park; Westin: \$52 valet, \$33 self-park (self-park garages are not on premises but in close proximity); Courtyard: \$48 valet parking only. If you are a hotel guest, charges can be billed to your room or you can pay with credit card or cash. If you are not a hotel guest, you can still park in hotel garages, however, there will be no in-and-out privileges and you may be required to pay at an hourly rate.

Additional Parking Options

The Parking Industry Labor Management Council maintains a Chicago parking locator web site (www.chicagoparkingmap.com) with an interactive map of all Chicago parking garages. Simply enter the target street address and the site provides detailed options.

With advance planning, visitors can apply for a ParkCard (www.parkcard.com). Although it has a \$20 annual fee, it offers a 5 percent discount on all parking charges including daily specials. It is used just like a credit card, so there is no need to carry cash or to find an ATM. It is accepted at InterPark garages located throughout Chicago at both self park and attendant garages. Look for the green sign to locate InterPark garages that accept with no need to carry cash. It takes approximately three weeks from submission of the online application form to receive the card. For additional information, call 877-887-2711.



*MASSAGE ROOMS

