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Session Abstracts

A1. Demography, Race, and Health in the American West

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A Young Doctor's Casebook: Race in Theory and Practice on the Reservation and in the Post-Reconstruction South, 1883-1896

The medical career of Mississippi native Andrew Bowles Holder (1860-1896) began inauspiciously. After receiving his medical degree at Tulane University, he obtained his first post thanks to his father's efforts on his behalf: a letter to the Office of Indian Affairs resulted in the young Dr. Holder's appointment as physician to the Crow reservation in Montana. Holder thus began his medical career far from home, in a wild country, and facing a set of healthcare challenges in practice—as opposed to in theory—amongst a new, untrusting patient population.

As a doctor at the reservation schoolhouse, Holder faced outbreaks of pneumonia, diphtheria, malaria, dysentery, measles, and cholera, as well as various other ailments and the occasional gunshot wound. A main focus of his practice was obstetrical and gynecological, as well as on childhood diseases. Upon returning to the South after his term on the frontier, he continued to focus on women and children, and his patients were predominantly African-American. As a professor of physiology at the Memphis Medical College in the last years of his life, he produced a series of essays on the diseases, health, and healing practices of Native Americans. This work was a medical protest of the policies of the Office of Indian Affairs, particularly relocation and re-education. In spite of Holder's spirited rebuke of federal tribal policy, his work replicated a number of the assumptions of nineteenth-century racial science.

This paper is a microhistory, which uses the short career of a Southern-born physician to consider the day-to-day practices of medicine in both the post-Reconstruction South and on a Western reservation. Using manuscript sources, particularly Holder's casebook, I illustrate tensions as they arose between theory and practice, when a young physician equipped with scientific theories of race was put to the test in a frontier setting. I use Holder's career to expose the complexity of ideas about race, health, and disease in the last decades of the nineteenth century, and the extent to which first-hand experiences with non-white patients could transform theoretical, philosophical, and political ideas about race and health.

Objectives

- To explore the life and work of Andrew Bowles Holder through newly acquired manuscript sources

- To discuss the daily experiences and challenges of a physician in the reservation setting of the late nineteenth century
- To consider the interaction and intersection of racial theory and the bodies of non-white patients in medical practice in the late nineteenth century

A1. Demography, Race, and Health in the American West

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Assimilation, Contamination, Paralysis: American Indian Health Surveys in the Early Twentieth Century

In 1928, Lewis Meriam's "The Problem of Indian Administration" scandalized the Indian Service's implementation of federal assimilation policy. Since the 1880s, the policy's purpose was to dispossess American Indians of their land, suppress their cultural practices, and disperse them into the wider and whiter populace. However, the Meriam Report emphasized policy's failures, particularly the ignominious state of Native healthcare on reservations. The Meriam Report was one in a long series of surveys that officials pursued in the early twentieth century. These surveys were fact-finding missions to Indian Country, but also served as solutions—or at least temporary stays—to record-breaking Native morbidity and mortality in their own right. Office of Indian Affairs (OIA) officials and other professionals acted within a paradigm in which American Indians—in body or behavior—would eventually “vanish” into white “civilization.” But administrators faced a serious dilemma: sick Native Americans posed a biological threat to white communities, and vice versa, thus postponing physical assimilation. As these surveys illustrated, officials believed American Indians' isolation from white “civilization” was the cause of their hygienic ignorance and morbidity, but that its continuance was also necessary for the (perpetual) time being.

In this paper, I examine the Meriam Report and earlier surveys of American Indian health—an OIA physician questionnaire (1903), anthropologist Aleš Hrdlička's tuberculosis study (1909), the Public Health Service's report on contagious diseases (1913), and the Red Cross's survey (1924)—to understand how racial inter-mixing fundamental to assimilationist goals conflicted with fears of cross-racial, biological contamination to create administrative paralysis.

Historians of late nineteenth and twentieth-century public health have argued officials pathologized nonwhite bodies, behaviors, and the threat of overpopulation in order to rationalize racial exclusion and segregation on national borders and in coastal cities. Yet comparisons with inward-facing health policies like Indian assimilation are wanting. Native Americans were also pathologized, but from the perspective of a “dying race.” Using these surveys and correspondence from the OIA, I consider the ramifications of this paradigm as well as argue public health policies failed to neutralize the perceived threat of Native diseases and thus prevented assimilation from succeeding.

Key Words: assimilation, American Indians, surveys

- Recognize the dynamic relationship between public health policy and the dispossession of American Indians.
- Develop an appreciation for cultural assumptions within health discourse.
- Critically evaluate discussions of clinical management from a historical perspective.

A1. Demography, Race, and Health in the American West

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The Santa Fe Maternal Health Center, Catholicism, and Contraception in New Mexico

My paper is a discussion about the Santa Fe Maternal Health Center, its operation, and interaction with the community and its patients starting in 1937 after a group of socially elite Anglo women founded the organization after learning about the high infant mortality rate in the state from a report by the U.S. Children's Bureau. The Center provided general healthcare to impoverished Catholic, Hispanic women and children in the area and also offered a weekly birth control clinic. The Board felt that both services were vital to their mission to improve the health and economic status of the community.

The clinic, however, quickly marred the Center's reputation following a public denunciation by the Archbishop of New Mexico, who was stationed in Santa Fe. Regardless, the Center continued operation and would become an increasingly crucial community facet. As such, the Center lies at a cross section between racial, economic, and religious tensions and highlights public health and welfare efforts in New Mexico, the power and influence of the Catholic Church in a Catholic-dominated area, and provides an example of how individual birth control clinics that opened following the revision of the Comstock Laws in 1936 interacted and clashed with the communities they sought to help.

My paper intends to contribute to a growing body of work that addresses the operation of such clinics and how their patient population viewed and utilized the services they provided in spite of potential community dissent. My research investigates and problematizes the racial and economic issues and motivations behind the operation of the Center, which was staffed by primarily Anglo women, but served a Hispanic population. This research also expands upon previous studies about Catholic use of contraception, which tend to discuss this from a national viewpoint, but fail to address how its use differs in individual, Catholic-dominated communities or among non-Anglo populations. The presentation as a whole provides new context to view the birth control movement in the 20th century utilizing the Center's patient records and documents and newspaper accounts that track the facility's interaction and operation throughout this period.

Keywords: maternal health, contraception, Catholicism

This session seeks to: 1) Stimulate a more nuanced discussion and understanding about the operation of birth control clinics in the 20th century and how they, historically, may have positively or negatively interacted with individual communities; 2) Develop a historically informed sensitivity to the diversity of patients with a focus on racial, economic, and religious identity; and 3) Recognize the dynamic interrelationship between medicine and society throughout this period, with specific focus on public health and welfare organizations

A2. Child Policy in International Perspective

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“Parents Anonymous” and the Child Abuse Prevention and Treatment Act: Redefining Child Abuse in America

“The problem is us, the abuser... and we have to do something about it,” testified Jolly K. a “reformed” child abuser in 1973, at the hearings for the Child Abuse and Prevention Treatment Act (CAPTA). Jolly K. had founded “Parents Anonymous,” a self-help group for abusive parents who sought to change. The leader of an organization consisting mainly of educated, white middle class parents, Jolly’s testimony influenced CAPTA and helped shape popular portrayals of child abuse.

CAPTA had a profound impact on nationwide child abuse policies, largely by providing federal funding for states to develop local child abuse prevention and treatment programs. Its champion, Senator Walter Mondale (D-MN), advocated distancing perceptions of child abuse prevention from anti-poverty measures. Violence against children was not, he insisted, about poverty, but rather about parental psychopathology.

In this talk, I use material from the archives of Parents Anonymous as well as Walter Mondale’s personal papers to examine how policy makers and physicians joined forces to develop a theory of parental pathology as the main cause of child abuse. Child welfare professionals and policy makers circumvented discussions of racial and socioeconomic inequities as causes of child maltreatment, perhaps in order to garner bipartisan support, or to avoid finger pointing at already marginalized populations. Yet by shifting the focus to the individual psychic makeup of parents, an important opportunity to address the major stressors in the lives of disadvantaged families and communities was lost. Instead, the focus shifted to therapies aimed at changing the behavior of parents, interventions that were later mandated by courts as part of placement plans for children despite the ambiguous evidence of their benefit.

While this attempt to portray child abuse as the result of individual parental pathology may have made for more palatable policy-making in the short run, I argue that it had a long lasting effect on how we think about child abuse to this day. I conclude in questioning the ethical aspects of employing seemingly neutral medical theories to circumvent discussions of structural inequality and social justice.

- Critically appraise the history of child abuse policy
- Develop a historical understanding of development of psychopathological theories of child abuse
- Recognize the dynamic interrelations between medical theories and child welfare policy

A2. Child Policy in International Perspective

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WIC: Its Origin as an Antipoverty Program

Temporarily authorized in 1972 and permanently in 1975, the Special Supplemental Nutrition Program for Women, Infants, and Children, popularly known as WIC, has grown into one of the largest American public health and welfare programs. Approximately half of all infants in the US, a quarter of all pregnant and postpartum women, and a quarter of all children less than 5 years of age participate in it.

It is surprising, then, that the origins and early evolution of WIC have received scant attention from historians of public health, social welfare, maternal and infant health, and nutrition and food assistance policy. As a consequence, the early history of WIC has largely been framed by those government entities involved in its oversight, funding and operation and by various maternal and infant health advocacy groups. Usually deploying one of what has over the years become two standardized origin narratives, these histories teleologically frame WIC as a public health nutrition program that was established to improve birth and maternal and infant health outcomes and has been very successful in doing that.

Drawing on research done for a chapter of a new book project—a reconstruction and analysis of key moments in the 20th and 21st century American sociomedical and policy discourse on the relation between poverty, poor nutrition and poor health in children—this paper will challenge and complicate the official WIC narratives and locate the origins and early history of the program in not only what at the time was a renewed effort to reduce infant mortality and improve infant health, but also in the development, proliferation and employ by advocates of food assistance for pregnant women and their infants of emergent theories on the relationship between in-utero and early childhood nutrition and cognitive development and subsequent life outcomes. In general it will attempt to demonstrate that initially the maternal, infant and early childhood nutrition that WIC would provide was also and indeed primarily framed and promoted as an effective antipoverty measure at a time when both Congress and the Administration were disenchanted with the types of antipoverty programs already in existence.

- To develop a nuanced and historically informed grasp of the origins and early evolution of WIC.
- To develop an appreciation of how social and public health programs are framed differently at different times to maximize their chances of support and funding.

- To be able to historically contextualize current justifications of WIC that stress its positive impact on individual adult well-being and national economic growth.

A2. Child Policy in International Perspective

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New Zealand's Child Health Clinics: an Experiment in Social Medicine

The 1946 Constitution of the World Health Organization stated that 'good health is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity'. One of its principles was that 'Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.' The New Zealand Health Department attempted to realise this ideal through the establishment in the 1950s of Child Health Clinics around the country. Arising out of the international child guidance movement, the New Zealand clinics aimed to be different by providing not just psychological guidance but a holistic approach to child health. Drawing on government reports, the popular media, and archival sources from the clinics themselves, this paper will trace the origins, functioning and outcomes of these clinics which, as one medical officer declared, were a bold experiment in social medicine. The paper will contribute to the international literature emerging on the child mental hygiene movement and the invention of a new medical patient, the 'emotionally disturbed child', as developed in the recent work in the USA by Dr Deborah Doroshow and in the UK by Professor John Stewart. While influenced by broader international trends, I will argue the narrative played out differently in New Zealand, where the clinics won government support because they were led not by psychiatrists, who were identified with mental disease, nor by psychologists who were still striving for respectability, but rather by paediatricians. In the clinics, however, these paediatricians found themselves increasingly turning their attention from physical health to emotional issues, called to make judgements on family dynamics and becoming effectively moral arbiters. How parents, and in particular mothers, related to these new authorities is less clear from the written records but nevertheless I will argue that some conclusions can be drawn from those records suggesting that far from being passive victims parents responded in multifarious ways.

- Develop the capacity for critical thinking about the nature, ends and limits of medicine
- Acquire a historically nuanced understanding of the organisation of healthcare systems in other Western countries.
- Recognize the dynamic interrelationship between medicine and society through history

A3. Toxic Exposures

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The Rise and Fall of the Epidemic of Botulism from Commercially Canned foods in America (1919-1925)

A deadly epidemic of botulism arising from the consumption of commercially canned foods suddenly appeared in 1919 in America. The epidemic, striking 193 victims and causing 125 deaths, provoked panic among consumers nationwide before it ended in 1925. I use periodicals, medical literature, and senate archives to examine the dramatic rise and fall of commercial botulism—a story that medical historians have not addressed.

The technology to mass produce commercially canned fruits and vegetables in California and widely distribute them to consumers throughout America became available after WWI. By 1919, three outbreaks of botulism in separate locales caused by the consumption of canned olives packed in California captured national headlines. In each outbreak, family members, some of whom were depicted as prominent citizens, tragically succumbed after innocently consuming tainted food during a family meal. The press' sensationalistic portrayal of canned food as hazardous aroused alarm among housewives who hesitated to use commercially canned goods in fear of botulism poisoning. Intent on restoring the image of their product as safe and wholesome, canning industry leaders funded a "Botulism Commission" of scientific experts in 1920 to investigate means to eliminate the threat of botulism that had imperiled their business. By 1923, the commissioners identified the scientific elements responsible for the outbreaks and provided explicit recommendations about sterilization procedures to ensure safety. But they did not mandate inspections for all canning factories. When under-sterilized, commercially packed food continued to cause botulism, industry leaders voluntarily lobbied for a Cannery Inspection Act to legally require all California canners to purchase appropriate equipment and follow scientifically validated procedures. The California legislature approved the act in 1925, regulations were enforced, and no further outbreaks occurred.

Commercial botulism is a unique example of an infectious epidemic that was controlled when business interests became aligned with public health goals. To preserve their customer base, businessmen were compelled to acknowledge the public health threat of their unregulated procedures and act upon the recommendations of scientists. Moreover, the press' portrayal of disease sufferers as innocent victims and worthy citizens galvanized businessmen to implement safeguards to protect their consumers from botulism intoxication.

- Develop a capacity for critical thinking about how in the history of infectious epidemics, the relationship of commercial interests and public health goals might affect the outcome of a specific epidemic disease.
- Understand the dynamic history of how and why the findings of science in a particular epidemic may be accepted and adopted by commercial leaders or rejected and ignored by them.
- Acquire a historically nuanced understanding of the how a disease sufferer is viewed by certain sectors of society might affect the response to the particular epidemic disease.

A3. Toxic Exposures

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Race and the "Jake Walk"

During America's Great Depression and before Prohibition was repealed, the popular patent medicine, Jamaica Ginger (JG), became adulterated with a toxic substance that could cause limb paralysis or death. Contaminated JG primarily affected white and African American sharecroppers and mill workers, who sought the medicine during Prohibition due to its high alcohol content. Between 50,000 and 100,000 people became afflicted with Jamaica Ginger Paralysis (JGP), leaving survivors with lasting physical disability, limited economic opportunity, and severe social stigmas. Although white American cases were quickly reported, many African American cases went unnoticed because of prejudice, segregation, isolation, and economics. Even when cases among blacks were discovered, there remained a strong perception among white health officers and medical researchers that JGP only affected whites. Although historians of JGP have briefly examined the clinical, regulatory, and legal perspective of this episode, they have not considered how prevailing conceptions of race affected responses and accounts of this outbreak. Drawing on a collection of oral history interviews, medical journals, historical newspapers, and archived government records, this paper will explore how perceptions of race shaped health professionals' reactions to JGP.

- To provide a historically nuanced understanding of how the ideology of race shaped public health and medical responses.
- To increase historical awareness of social stigmas linked to physical disability and alcoholism.
- To deepen understandings of illness and patient perspectives.

A3. Toxic Exposures

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The Logic of Irritation and Workers' Skin in the Industrial U.S., 1900 – 1930

In 1923, a male employee of a Rochester, N.Y. lithography company developed a severe dermatitis due to chronic exposure to acid in the course of his work. The consulting dermatologist for the subsequent lawsuit, Dr. E. Wood Ruggles, documented a recurrent pattern of attacks that "almost ruined his skin" and eventually extended over the worker's entire body and took a good deal of time to finally clear up. His patient refused to follow his advice to leave the occupation as he could not earn as much elsewhere. Even after his firm transferred the man to a different department, he continued to suffer from dermatitis this time brought upon by contact with benzene and oils.

This case, which went to court over worker's injury compensation, highlights skin as an important site where physicians began to negotiate the friction between fragile bodies and the demands of capitalist modes of production. Dermatological disorders formed a substantial minority of occupational disability claims. Estimates at the time placed the percentage of all skin conditions caused by work anywhere from 5-25% and skin was responsible for a substantial minority of occupational disability claims. Physicians sought to classify the types of inimical skin exposures and develop prophylactic measures while states opened occupational skin clinics to treat afflicted patients. This paper draws upon this published professional literature, archival material and court cases to examine the field of industrial dermatology in the U.S. in the first decades of the twentieth century.

In doing it contributes to a literature on occupational health and embodied histories of industry that have yet to consider the place of skin. In particular, I foreground the ideological work preformed by a pervasive 'logic of irritation' physicians articulated to explain why some workers experienced skin problems and others did not given identical conditions. I argue this framework of irritation directed attention away from removing hazards from the workplace—an approach deemed "impracticable or impossible"—and instead supported the extension of dermatological surveillance into regimes of physician-supervised testing and worker selection. Dermatologists emphasized the contribution their field could make to state aims of enabling a vital productivist economy. And in keeping with a Progressivist ethos, they sought to manage what were perceived as the hazards of modernity not with a wary turn against progress but a further intensification of 'modern' hygienic practice. Irritation provided a flexible conceptual tool that transformed uncertainty and idiosyncrasy into a medically knowable subject and grounded professional claims to expertise.

- 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.

A4. Health and Politics in the Early Modern Town

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Town Physicians in Sixteenth-Century Germany

Learned physicians played a prominent role in early modern German towns. More and more towns appointed them as town physicians, preferring their services to those of a less learned barber surgeon. Against a fixed salary, the town physician was to assure the health care of the population and was usually also held to supervise pharmacies and non-academic healers and to advise the authorities in matters of public health. Employment by a town was, in turn, a major career option for many academic physicians. So far, we know very little about these town physicians, however, about their work, their importance as providers of health care, the

challenges they faced, their interactions with town authorities and patients. In this paper, I will offer a more precise and nuanced picture of the figure of the town physician in 16th-century Germany. My sources will be hundreds of contracts and letters written by acting or prospective town physicians to town officials and colleagues, taken from an online database (www.aerztebriefe.de) with currently almost 30.000 letters written by or to German speaking physicians in the 16th and 17th century that we have built up over the last years in Würzburg. Linking these findings with a detailed analysis of physicians' practice journals from this period, I will argue that town physicians in 16th-century Germany, thanks to their relatively low fees, played a crucial role in making the services of learned physicians accessible, for the first time, to a large part of the population. They paved the way for the growing dominance of “doctors”, of academic physicians in German health care and public health. For the physicians themselves, in turn, an employment as a town physician was frequently the basis for a successful and lucrative practice. For good reasons these positions tended to be very much sought after. The local context was crucial, however. In smaller and less affluent towns with massive competition from other physicians and unlicensed healers, some town physician found it difficult to make a living – and all of them had to adapt to the ideas and preferences of their patients.

Have a clearer understanding of the importance of learned town physicians in early modern health care.

A4. Health and Politics in the Early Modern Town

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Keeping the Grand Dukes Healthy in Early Seventeenth-Century Tuscany

Maintaining the health of the ruler was always of utmost importance in a pre-modern Europe where a ruler's death could spur instability and upheaval of the state. Grand Ducal Tuscany was typical in this regard and employed numerous court physicians whose task was to keep the Grand Dukes healthy. In this essay, I investigate the use of natural thermal water cures as recurring treatments for the chronic ailments of Grand Dukes Cosimo II de' Medici (r. 1609-1621) and Ferdinando II de' Medici (r. 1621-1670). The Medici had a family tradition of taking water treatments that went back to Lorenzo the Magnificent in the fifteenth century. Sixteenth century Grand Dukes issued legislation to protect these precious natural resources while also partaking of the waters. By the early seventeenth century, Medici enthusiasm for thermal water was so well-known that several prominent physicians dedicated their treatises on the benefits of thermal water to specific Grand Dukes and Duchesses. Although the topic appears in history of medicine studies, thermal baths and water treatments are often undervalued as medical options with baths stereotyped as loci for non-medical leisure activity. I place baths at the center of my research in order to argue that baths, in fact, were a significant part of the medical marketplace. For this presentation, my sources include two medical treatises, both published in 1617 by Vittorio Manni and Mariano Ghezzi, and several letters written by courtiers detailing the illnesses of Cosimo II and Ferdinando II. By analyzing the treatises in

tandem with the letters, I trace the recommended uses and prescriptions described by the physicians with the actual treatments the Grand Dukes received. I conclude that Cosimo II's and Ferdinando II's personal use of thermal water treatments impacted the governance of the baths and influenced the culture of scientific patronage within Tuscany. This conclusion fits into my dissertation project in which I investigate the convergence of medical theory, practical medicine, government paternalism, and scientific patronage that contributed to the habitual custom of "taking the waters" in Tuscany during the reign of the Medici Grand Dukes from 1537-1743.

- 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).
- Acquire a historically nuanced understanding of the organization of a health care system.

A4. Health and Politics in the Early Modern Town

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"Infallible medicines" and "poysonous jests": Mountebanks and Medicinal Distribution in Seventeenth-Century England

Seventeenth-century England saw an unprecedented escalation in debates surrounding the preparation and administration of medicines—who was able to compound them, who was qualified to prescribe them, and whose specifications for medicinal concoction were valid. The Royal College of Physicians attempted to exercise regulatory control over medicinal preparation by issuing the "London Pharmacopoeia," its Latin guide to the compounding of medicinal simples, in 1618, as well as by establishing its own public dispensary in 1698. Both of these initiatives were met by intense criticism from apothecaries who resented the College's attempts to monopolize the medicinal market; as a result, medical historians have found in this period rich material for explorations of early modern debates over medical authority and concepts of public health. These explorations have frequently, however, failed to take into account the roles played in these conflicts by medical practitioners who fall outside of the physician-chirurgian-apothecary hierarchy. Among these less visible players is the mountebank: an itinerant performer/practitioner and 'quack doctor' who sold medicines to public audiences and whose existence within the medical marketplace of seventeenth-century England gained increasing—and controversial—attention.

In this paper, I will establish the mountebank as a crucial figure who embodied both the anxieties and potentialities of early modern public health with respect to medicinal distribution. Using primary materials including seventeenth-century satires, pamphlets, and even plays, I will explore two potential and polar understandings of mountebanks' dissemination of medicinal

substances: first, I will analyze mountebanks' self-descriptions as custodians of miraculous and universal medicines whose efficacy they may demonstrate to audiences through elaborate spectacles of healing. Second, I will examine perceptions of mountebanks as potential mercenary agents responsible for dispensing poisons rather than medicines, thus inverting the purpose of medicine to convert illness into health. Juxtaposing these conflicting portrayals of the mountebank's work with drugs will highlight the ambivalences underlying larger questions of medicinal usage in early modern England while drawing attention to an under-studied medical occupation and practice.

Key words: early modern, medicines, quackery

- Understand the dynamic history of medical ideas and practices through gaining insight into the work of a non-traditional medical practitioner.
- Consider literary representations of mountebanks and other doctors as sources of historical knowledge about medical practice and perception.
- Develop the capacity for critical thinking about the nature, ends and limits of medicine.

A5. Innovation in 20th Century Medical Science

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"Chance Favors the Mind Prepared": The Discovery of the Zollinger-Ellison Syndrome and the Birth of Gastrointestinal Endocrinology

A 19-year-old woman was admitted to the Surgery Service at the Ohio State University Medical Center in January, 1954 with intractable ulcer diathesis. By the time of this admission she had undergone multiple surgical procedures at other institutions for complications of peptic ulcer disease, including perforated jejunum, a rare presentation. She was in constant pain, with diarrhea and vomiting, and had lost sixty pounds. She was found to be excreting gastric hydrochloric acid at a rate twenty times normal. Extensive surgical resection of her stomach with division of the vagus nerve diminished her acid output, but it remained abnormally high and her symptoms continued unabated. Antacids, ulcer diets and even irradiation of the gastric remnant were ineffective. As a last resort she underwent total gastrectomy on November 3, 1954 by Drs. Robert M. Zollinger and Edwin H. Ellison. At surgery, nodules in the pancreas were noted and biopsied. These were identified as non-beta islet cell tumors. Ellison recalled a patient from shortly before who had a similar clinical course and identical pathologic findings. Zollinger and Ellison correctly hypothesized that the pancreatic tumors were elaborating a hormonal substance causing massive gastric hypersecretion. In 1959 Rod Gregory and Hilda Tracy of Liverpool identified the hormone gastrin, and subsequently showed that this was the ulcerogenic substance in what had come to be known as the Zollinger-Ellison Syndrome. Although the endocrine nature of the gastrointestinal system had been guessed at before, these events constituted the first clinical and laboratory proof and heralded a revolution in

physiology. This paper will utilize original manuscripts and documents from the Robert M. Zollinger Archives to reconstruct, in the context of mid-twentieth century physiology and surgical practice, the sequence of events surrounding the discovery and elucidation of the Zollinger-Ellison Syndrome, which had deep-ploughing consequences for physiology and medicine.

Learning Objectives:

- Develop the capacity for critical thinking about the nature, limits and ends 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.
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research and education.

A5. Innovation in 20th Century Medical Science

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Etiologic theories of multiple sclerosis between 1950 and 1983: A story of shifting paradigms as told through medical textbooks

In *The Structure of Scientific Revolutions*, Kuhn argues textbooks, in attempting to quickly acquaint students with what the scientific community thinks it knows, render scientific revolutions invisible. Textbooks, he says, wrongly represent science as cumulatively “progressing” towards a paradigm. Contrary to Kuhn’s assertion, however, summaries of multiple sclerosis (MS) appearing in medical textbooks from 1950 to 1983 do not obscure the revolutionary process of paradigm change. Harrison’s *Principles of Internal Medicine* and Cecil’s *Textbook of Medicine* are unique from the textbooks studied by Kuhn—their frequent revisions and brief synopses allow historians to see (practically) real-time changes in the set of habits comprising normal MS etiological research; they refer to failures, anomalies, unsubstantiated data, and modifications to existing ideas, all of which contribute to a generalized representation of how research practices and etiological theories change over time.

In the 1950s, etiological theories of MS abound. Faced with sustained failure to uncover the cause of MS through then-paradigmatic pathological and clinical studies, the field shifts toward increased emphasis on research aimed at understanding the biology of myelin, comparing MS in humans to pathologically-similar diseases generated experimentally in animals, and uncovering the reasons for the unique epidemiologic profile of MS. The result is the 1960s emergence of a competitive (not mutually exclusive) dual-paradigm research program whose products solidify the entrenchment of two (not mutually exclusive) theories of etiology. The first theory assumes MS is caused by an inherent autoimmune deficiency in MS patients that is triggered by exogenous factors. The second assumes MS is caused by an exogenous, probably infective agent. By 1983, the authors of Harrison’s and Cecil’s articulate

coalescence around a single, multi-faceted research paradigm and consensus around a combined theory of MS etiology.

The evolving notion of MS etiology is a complicated story. I argue that distilled textbook representations of MS are necessary to elucidating the paradigm shifts and normal science practices of MS etiological research from 1950 through 1983. Using MS etiology as a case study, this paper intends to provide a proof of concept for tracking periods of normal science and paradigm shifts through twentieth century medical textbooks.

- By the end of this activity, the learner will develop the capacity for critical thinking about the nature, ends and limits of medical science.
- By the end of this activity, the learner will identify successes and failures in the history of medical science.
- By the end of this activity, the learner will understand the dynamic history of medical science ideas and practices, their implications for future research, and the need for historical reflection when developing research priorities.

A5. Innovation in 20th Century Medical Science

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The Sick-Man after the Split-Brain: Clinical and Historical Reconstructions of Patient Experience in American Neurology and Psychiatry, 1955-1965

My paper investigates the social and theoretical impact of the earliest clinical studies on patients with “split-brain syndrome.” In 1962, the American neurologist Norman Geschwind and psychologist Edith Kaplan published a clinical case of what they called “human disconnection syndrome,” or functional disconnection between the two cerebral hemispheres of the brain. Their patient, following surgery to remove a brain tumor, was unable to name objects, like a hammer or a key, and to describe their function when placed in his right hand without looking at them. He could pantomime the correct motions, like swinging the hammer or turning the key, but he said the hammer was to “comb my hair” and the key was for “erasing a blackboard.” Drawing on the recent animal experiments of future Nobel laureate Roger Sperry at Caltech and the late nineteenth-century case histories, Geschwind published his magnum opus in the journal *Brain* in 1965, “Disconnection Syndromes in Animals and Man,” which culminated with his dramatic claim that the patient’s narrative is “of little value” to clinicians and could be “actively misleading.” My paper examines Geschwind’s critique of patients’ self-reporting against the background of a growing rift in the social organization and clinical orientation among American neurologists and psychiatrists in the 1950s and 1960s. I argue that Geschwind’s controversial conclusion that “the patient” is no longer a coherent entity, that she who “speaks to you is not the ‘patient’ who is perceiving,” would help set the terms and raise the stakes in the emerging debate among historians, philosophers, and

sociologists of the 1970s and 1980s over the methodological limits of reconstructing patient experience.

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Critically appraise clinical management from a historical perspective
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

A6. Hospitals: For Whom and For What?

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Nashville: City of Pioneering Medical School Design, 1925-1931

In the early twentieth century, medical schools across the United States rebuilt their facilities as they organized their educational programs along modern lines. My research is the first to examine the new medical schools constructed before 1940. These buildings did more than provide necessary space for the modern system of medical training; medical educators, architects, and donors recognized that the medical schools themselves shaped how students learned and how they practiced medicine.

Medical colleges experimented with different medical school designs. In 1925 Vanderbilt University inaugurated a new building type: a medical school and hospital completely integrated under one roof. Leaders at Vanderbilt believed that the new design would allow for unprecedented levels of integration between laboratory and bedside training that would inform how their students conceptualized medicine. Within the next ten years, seven schools adopted this new design, including Meharry Medical College, one of only two medical schools in the United States dedicated to the education of African Americans. The design at Meharry, however, distinguished itself from the other schools because it provided for the training of pharmacists, dentists, and dental hygienists alongside physicians. This paper investigates these two pioneering facilities in Nashville, drawing on architectural plans, unpublished manuscripts, and historical publications.

While I have already published some of my research on Vanderbilt, this paper places Meharry in conversation with Vanderbilt for the first time and reveals new areas of investigation. John D. Rockefeller's General Education Board helped fund the construction of both institutions and provided access to a critical network of donors and architects during the planning of both projects. Tracing these connections broadens our understanding of why the facilities at Vanderbilt and Meharry diverge and converge. In addition, comparing the two schools underscores the different expectations for the facilities and the students who occupied them. In particular, this paper examines the professional hierarchies embedded in the Meharry facility, which was designed to educate a host of medical professionals simultaneously. In the end, analyzing Meharry alongside Vanderbilt reveals assumptions about race and professional identity dominant in the early twentieth century.

- Recognize the dynamic interrelationship between medicine and society through history. Understand the complex history of medical professionalism.
- Acquire a historically nuanced understanding of the organization of the American system of medical education.

A6. Hospitals: For Whom and For What?

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“The Hospital in the Cotton Field:” Desegregating Hospital Access in the Delta

This paper examines the story of Crittenden Memorial Hospital (CMH) in West Memphis, Arkansas. It is located in the Mississippi Delta, a region historian Nan Woodruff has referred to as the “American Congo” and scholar Fred Hay describes as “an alluvial flood plain of rich black soil and poor black people.”

CMH was the among the first facilities in Arkansas built utilizing funds from the Hospital Survey and Construction Act of 1946. Intended to make hospital care more accessible to all rural residents, in reality the statute did little to reverse the segregationist and exclusionary hospital practices blacks regularly experienced, particularly in the South. It was the only federal act to incorporate a “segregation” clause allowing states to build separate but equal facilities. Arkansas, however, did not choose the “segregation option.” When CMH opened in October 1951, it was the first public facility in the tri-state (Arkansas, Tennessee and Mississippi) area to offer truly equal access to hospital care regardless of “race, creed or color.” In 1953 the Memphis Tri-State Defender, the premier African American newspaper in the mid-south, recognized this anomaly in an article titled “Crittenden Hospital-Fine Treatment For All.” This was in stark contrast to the segregated and often poor hospital care available to African Americans.

CMH provided equal medical care for all, regardless of race, until it filed for bankruptcy and permanently closed its doors in September 2014. While the bankruptcy has made some early administrative records available, they only provide a sterile chronological account of the facility and do not demonstrate the importance of the hospital both in the area and within the context of equal access to medical care. Unfortunately, none of the original proponents are alive. But using a collected memory approach and mining oral stories and informal correspondence, in addition to the surviving records and contemporary newspaper articles, I posit that CMH was a pioneer in providing equal access to hospital care for all citizens in the mid-South before the modern Civil Rights movement.

- 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 and ethnicity.

- Acquire a historically nuanced understanding of The Hospital Survey and Construction Act of 1946. The Federal Government's first foray into the provision of a nationwide healthcare system.

A6. Hospitals: For Whom and For What?

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"Planner as a Change Agent": Hermann H. Field and the Community-Based Teaching Hospital, 1961-1972

In an article published in 1965, Hermann H. Field claimed that accelerated change in scientific, technological, economic, and social practices had broken up the traditional hospital. Field wrote that the hospital had become a microcosm of the surrounding urban area "in all its complexity." The result, he suggested, was that a postwar planner now had to be a "change agent," one who intervenes in urban and hospital politics, so that hospital-building became a political act of community building, responding to and responsible for a range of issues beyond medical practices including urban renewal.

In this paper, I argue that Field's work provides an important but neglected part of the story of medicine after World War II. Examining his planning for the Center helps us understand topics such as the rise in ambulatory care, the increase of technology-based medical interventions, and the development of the hospital as the locus of third-party, prepaid medical care. The argument is based in an analysis of articles in architectural and medical press, architectural drawings, diagrams and photographs, and an abundant grey literature tabled during the decade Field served as Planning Director for the Tufts-New England Medical Center's ambitious redevelopment in downtown Boston.

My central claim is that hospital planning and construction played a crucial role in the postwar realignments of modern medical practice with the modern city. While scholars such as Theodore Marmor, Rosemary Stevens, and Antonia Maioni have examined the postwar era in terms of new forms of medical care management and policy, the new urban environments—the new hospitals—in which medicine was carried out have received little attention. Yet Field's work at Tufts had an immediate and lasting influence on American medical practice. His commitment to research in the planning process is visible in recent preoccupations with Evidence-Based Design, in which planners make decisions about hospital design based on interpretations of scientific research. Moreover, his promotion of community-based planning had an immediate effect on concepts of how medical care should best be delivered to modern urban populations.

- Deepen our understanding of the dynamic interaction of medical practices and urban environments by examining the influential planning process of the Tufts New England Medical Center.

- Recognize the importance of postwar architectural and urban environments in the delivery of medical care and the training of medical professionals.
- Gain a historical sensitivity to the continuing significance of community-based hospital models.

B1. Accountability in British Health Care Systems

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“Now I can say Goodbye to my child:” Autopsies and Child Patients in Great Britain, from Great Ormond Street to Alder Hey

Starting in the 1850s, the managers of the Great Ormond Street Hospital for Sick Children began to establish policies governing the performance of autopsies on deceased patients. Minutes of meetings of the hospital’s committees reveal a heated debate between the medical staff, who were eager to collect specimens for their pathological museum, and the lay managers. In particular, they struggled over how long to wait for, and whether to seek, parental consent. The lay managers feared any negative publicity that would damage the hospital’s reputation among donors, but were particularly sensitive to issues relating to death. Implacably high child mortality rates had hindered the establishment of children’s hospitals in Britain for decades. Public discussion of post-mortems could be their hospital’s undoing.

The Alder Hey Organ Scandal of the 1990s confirmed these early administrators’ greatest fears about public knowledge and perceptions of autopsies. At the height of the scandal, hospitals around Britain admitted to having collections amounting to over 100,000 body parts, including hearts, lungs, and brains, taken from deceased children and infants whose families had no knowledge of and had not knowingly consented to their removal. In addition to paying court-ordered reparations in the hundreds of thousands of pounds-sterling, these children’s hospitals suffered the loss of respect of the general public. Ironically, it was many of the practices normalized in the early history of children’s hospitals to hide the autopsy processes from parents that generated the greatest anger from the families involved in the late 20th-century scandals.

Drawing on materials from the Great Ormond Street Hospital Archives, Alder Hey-related patient advocacy groups, and published testimonials from individual families, this project seeks to situate the Alder Hey Organ Scandal in a longer history of the administration of children’s hospitals and the practice of autopsy on dead children. Although the history of anatomy enjoys a rich secondary literature, it has not yet dealt with the particularities of the child patient. The legal status of children, the changing meanings of childhood, and the unique challenges that children’s hospitals faced create room for further exploration into the practice of autopsying dead children.

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

- Critically appraise clinical management from a historical perspective.
- Identify successes and failures in the history of medical professionalism.

B1. Accountability in British Health Care Systems

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Making Biomedicine Ecological: From the International Biological Program to the Microbiome

The International Biological Program (IBP, which ran from 1964-1974) was a Cold War effort to take stock of the planet's diversity. Consisting of seven distinct sections, only one of which was devoted explicitly to the role of humans in relation to their environments, it served to popularize the concept of the biome as a distinctive ecological realm. Human biologists and physicians collected blood samples from human groups whose lifeways were feared to be disrupted through the encroaching forces of modernity. The ability to freeze bits of human bodies regarded as "primitive" as well as bits of non-human commensal species was seen as an act of salvage—an effort to redirect life in time such that it could serve as a source of biomedical salvation in the future.

Over time, these bits of bodies persisted at low temperature as a form of concealed potential that I call "latent life." In the 21st century, biomedical anthropologists who gained access to these frozen materials have used them to understand the non-human life forms that were incidentally preserved within. In the era of the Microbiome, these scientists have gained funding from the NIH to prospect old blood for non-drug resistant organisms like *Plasmodium falciparum*, the form of malaria most deadly to humans. This historical case study demonstrates how technologies like freezing have rescaled relationships between humans and their environments. The effort to remake the human body itself as a medical archive and a multi-species biome, I argue, is aligned with recent calls for a research agenda known as "planetary health."

- Develop the capacity for critical thinking about medicine and its relation to ecology.
- Promote tolerance for ambiguity of theories, the nature of evidence, and complexity of data.
- Develop a historically informed sensitivity to the relationship of health to environment.

B1. Accountability in British Health Care Systems

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The Politics of Sisyphus: Waiting Lists and Waiting Times in the Battle for Authority in the British NHS 1974-2004

Waiting times for hospital treatment and the size of the lists of patients waiting have often been used as indicators of the efficiency and effectiveness of health systems, especially for taxation-based universal coverage systems such as the British National Health Service. An element of private medicine remained in the UK after the formation of the NHS in 1948, with some hospital consultants providing additional private clinics and treatments in parallel to their NHS contracts. This generated a number of tensions, especially between the medical profession and the government. As NHS financial pressures intensified, waiting times for a range of surgical procedures, and the numbers on the waiting lists, increased. This became a topic for public debate, and a source of political pressure, but sporadic injections of additional funds to clear waiting lists usually only moved the 'problem' elsewhere in the NHS system. Although hospital waiting times and lists have been broadly discussed by NHS historians, to date there has been no sustained historical analysis of the issue from clinical, political and especially economic perspectives. This paper uses archive material from the UK government Department of Health and Social Security, oral history interviews and local case studies. It analyses how hospital waiting times and lists became the focus of national government policies from the 1970s through to the introduction of the Patient's Charter in 2004 which included specific waiting targets. The paper explores two (usually exclusive) contemporary theories: one that blamed individual hospital consultants (and thus legitimised changes to clinical practice, especially through tighter general management). One study in the 1980s found the number of cases treated by orthopaedic surgeons varied between 200 and 1,000 p.a. A second theory identified long lists and waiting times as an outcome of underinvestment in the NHS (a national political issue). This paper discusses key waiting list and waiting time policies, using them to advance a hypothesis that these 'crises' were consciously used by politicians and civil servants, especially those brought into government to implement new economic and managerial strategies, to diminish the autonomy and authority of the medical professional in the hospital environment.

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

B2. Deviant Populations

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Left-Handedness, Homosexuality, and Meta-Analysis in the Twentieth-Century U.S.

In November 2000 researchers at the University of Toronto reported that homosexuals were more likely to be left-handed than heterosexuals. The study's authors explained that,

analysis of data in 20 combined studies over the past 50 years revealed gay men and lesbian women had significantly higher rates of left-handedness than straight men and women. This claim had deep roots. In the late nineteenth century, criminologist Cesare Lombroso connected left-handedness to homosexuality as “social inversion,” placing it with criminal insanity, homicidal monomania, kleptomania, nymphomania, Satyriasis and mental illness. In his correspondence with Sigmund Freud at the end of the nineteenth century, Wilhelm Fliess insisted that left-handers were either overt or repressed homosexuals: “Since degeneracy consists in a displacement of the male and female qualities, we can understand why so many left-handed people are involved in prostitution, and criminal activities.” Less judgmentally, in the 1980s Harvard neurologist Norman Geschwind reported that mothers exposed to uterine stress gave birth to males who had permanently low testosterone levels and homosexual behaviors accompanied by high rates of non-right-handedness. Geschwind admitted that there had been no systematic examination of these claims. However, there was theoretical support for this connection based on animal experiments. The connection between left-handedness and homosexuality was widely held, but the few investigations concluded that there was no relationship between left-handedness and homosexuality. By the century’s end, all studies concluded that there was no statistically significant relationship between sexual preference and left-hand preference. As a result, researchers in the early twenty-first century constructed a new category of analysis, “non-right-handedness,” which when combined with left-handers seemed to demonstrate a high vulnerability to homosexuality. Increasingly relying on meta-analyses, researchers retrospectively reclassified data in a manner that increased the population at risk. How and why they did this, despite the lack of reliability among study data, and questionable categorization of subjects retrospectively as homosexual, provides important lessons for both historians of medicine and practitioners.

- By the end of this activity the learner will understand the basis for the persistence of the belief that left-handedness is associated with homosexuality.
- The learner will confront the data for widely held assumptions about the role of the role of both laterality and hormones in the etiology of homosexuality.
- By the end of this activity the learner will be able to better evaluate the strengths and limits of meta-analyses as appropriate for individual patient care.

B2. Deviant Populations

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Exploring the Visual Rhetoric of Postwar American Asylum Exposés

In the 1940s, Albert Deutsch, Albert Maisel, and other American social reformers attacked the custodial nature of overcrowded state-run asylums in Life magazine, PM newspaper, and other print media. Historians such as Gerald Grob and Steven Taylor have examined how their efforts contributed to the end of the asylum era. These scholars’ focus on

the written content of these exposés has generally overlooked what might be their most compelling aspect: disturbing photographs of asylum inmates that in many ways became the central focus of these articles. While historians have regarded these photographs as potent tools for publicizing asylum conditions, they have not examined how—in portraying asylum inmates as “unsettling” and asylums as beyond repair—these photographs worked to perpetuate deeply negative views of disabled people, especially those with psychiatric diagnoses.

My paper examines over one hundred photographs that appeared in five publications between 1946 and 1951. To analyze these photographs’ visual rhetoric, I apply tools from disability studies scholars such as Robert Bogdan and Rosemarie Garland-Thomson, who argue that photographs of disabled bodies exploit stereotypes of disabled people as being dependent or as being fundamentally different from the rest of society. I argue that these asylum exposés doubly stigmatized asylum inmates, first as objects of pity through their text and then as unsettling “Others” through their photographs. This double stigmatization is evident in Albert Deutsch’s 1948 book “The Shame of the States,” which included a photograph of a naked woman crouching on the floor, eating her meal. Her spine protrudes from an emaciated back. The caption reads: “Like thousands of other neglected mental patients, she was denied the chance of recovery by a community that didn’t care.” While Deutsch’s written words solicited readers’ pity for treating and reintegrating patients, his visual rhetoric played on readers’ fears of impairment. Reformers deliberately used photography as a sensationalistic tool in order to shock the public into demanding improvements. In this and other cases, however, their message may have been undermined by their own visual rhetoric, which ultimately served to dehumanize disabled people and further alienate them from the rest of society.

- To understand public attitudes towards people with mental disabilities
- To understand the effect of visual culture in representing disability
- To develop a critical understanding of medical reform movements

B2. Deviant Populations

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Risk Assessment in an Age of Neoliberalism: John Monahan’s “The Clinical Prediction of Violent Behavior” (1981)

Over the course of the past half-century, evaluating patients for the likelihood of harmful behavior—including assault, sexual violence, and homicide—has become a routine element of psychiatric practice. No longer a specialized venture for those working in forensic or high-acuity settings, risk assessment is now the responsibility of all mental health providers. In this talk, I examine a critical moment in the development of modern violence risk assessment, psychologist John Monahan’s influential monograph on “The Clinical Prediction of Violent Behavior” (1981). Drawing on Monahan’s earlier research and his subsequent reflections on the work, as well as related publications from the period, I argue that the emergence of risk

assessment represents an important and historically underexamined shift in the delivery of mental healthcare in the post-deinstitutionalization United States.

Three major developments set the stage for Monahan's work. First, civil libertarian activists effected a fundamental transformation of commitment laws during the 1960s and 1970s, making dangerousness the dominant rationale for such measures. Second, as debates raged about the punitive as opposed to rehabilitative aims of punishment, a series of empirical studies called into question whether mental health professionals could even identify dangerous individuals with any degree of certainty. Third, following a high-profile murder case in California, the courts determined that mental health providers could be held liable for the violent acts of their patients.

Against this backdrop, Monahan sought to establish robust statistical correlates of future violence. These variables would later come to be understood as risk factors, a term increasingly familiar to physicians in the latter half of the twentieth century. Monahan also grappled openly with the social and ethical dimensions of his work. Ultimately, he recommended that clinicians focus on short-term prediction and restrict themselves to providing estimates of risk rather than recommendations on the type of intervention necessary. The emergence of risk assessment as a routine element of mental healthcare delivery complicates the prevailing historiographic landscape, which has tended to identify psychiatry's social control functions primarily with the bygone era of large-scale institutions. Ultimately, it suggests an underappreciated psychiatric element of the risk society in which we live.

- Be able to identify the changes in treatment context that led to the rise of routine psychiatric risk assessment in the United States.
- Appreciate the historical contingency of psychiatric perspectives on violent behavior, including their relationship with changes in public policy and the law.
- Be able to situate psychiatric risk assessment within larger discourses of risk and vulnerability in the modern United States.

B3. Chinese Public Health Campaigns 1920-45

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Inventing Blindness: The Use of Medical Statistics in the Anti-Trachoma Campaign in Republican China (1920-1940)

In their endeavor to solve China's problem with eyesight, public health advocates in the Republican period used medical statistics to warn of a crisis in the instance of trachoma-induced blindness. Trachoma infection could easily develop from minor symptoms of roughening of the inner surface of the eyelids leading to the breakdown of cornea and incurable blindness. Since the 1920s, the phenomenon of trachoma's spread either directly by hand-eye contact or indirectly by sharing towels in public places gradually defined blindness as a preventive category under the rubric of hygiene. By gathering statistics from medical

investigations in the broader diagnostic space, including schools, workplaces and wartime refugee camps, Western-trained ophthalmologists and hygiene officials shifted the traditional notion of blindness as an irreversible impairment to a disease that called for large-scale prevention and regulation. Their clinical recordings of trachoma further implied epistemic changes in perceiving vision socially. As many eye charts were introduced clinically to measure the stages of trachoma infection and for implementing public health campaigns, the medicalization of trachoma turned people with deteriorated vision into subjects for hygienic control. In tracing the use of medical statistics in clinical and social responses to trachoma, this paper argues that blindness was invented as a social category to be regulated under the scientific management of biomedicine.

- Understand the dynamic history of infectious disease and its complications and (ir)reversibility through looking at the use of medical statistics in clinical and public spaces
- Critically appraise the link between vision and its management in both medical and economic regimes
- Develop a deeper understanding of medical quantification and its constraints on human experience

B3. Chinese Public Health Campaigns 1920-45

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Public Health between Communism and Nationalism in China's Second United Front, 1937-45

Between 1937 and 1945, two major political factions in China—the ruling Nationalist Party, led by Chiang Kai-shek, and the insurgent Communist Party, led by Mao Zedong—united in a tenuous alliance to resist foreign invasion. After the Japanese occupied Nanjing, the Nationalist Party retreated to the western hinterlands of China, while the Communist Party maintained base camps near Yan'an, a town in the arid, mountainous northwest. Both Parties struggled with wartime crises of governance, albeit on vastly different scales given the smaller size of the Communist forces, and health administration was a critical sphere in which each regime exerted political authority. While Kim Taylor has discussed the history of Chinese medicine in Communist Yan'an, and Nicole Barnes, John Watt, and others have argued for the significance of wartime medicine in the Nationalist state, this paper draws together their narratives to consider relationships between public health administrators, programmes, and strategies in Communist and Nationalist territories.

One outsider found himself mediating between these two administrations: Swiss bacteriologist Hermann Mooser, a representative of the League of Nations on a project to provide medical aid to the Nationalist state during the war. Mooser was stationed in the northwestern city of Xi'an, close to Yan'an. An encounter with Maoist physician Norman Bethune led Mooser to provide medical aid to both Communists and Nationalists. Using

archives from the League of Nations and China, as well as published records of the Communist base camps, I suggest that Mooser's difficulties in coordinating with both Nationalists and Communists reflected competing visions for the role of the Chinese state in public—and international—health. While both regimes sought to provide free medical care to the public, Nationalist Ministers of Health discussed an expert-led “state medicine” that sought to integrate private interests and foreign aid with public need, while the Communist leadership sought a fully state-controlled, populist medicine along Soviet lines that nonetheless prioritized the well-being of Party members and leaders. Through Mooser's eyes, we can see that both Communists and Nationalists sought to develop novel systems of public health that would establish hygienic modernity while accommodating political ideology.

- To demonstrate how political ideologies shaped medical policy in wartime China
- To trace the changing roles of foreign aid in Chinese public health
- To understand the potential roles played by individual physicians as mediators between interest groups in public health

B3. Chinese Public Health Campaigns 1920-45

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Colonial Policies on VD Control, Social Hygiene and Wartime Eugenics in Republican China

This paper investigates colonial venereal disease policies in treaty port Shanghai between 1919-1942 and the implementation of Chinese Nationalist Government hygiene politics in Shanghai. I examine primarily the VD policies of the Shanghai Municipal Council, and the French Concession's health policies. During the Japanese occupation (1937-1945), the Japanese military authorities were also interested in venereal disease as part of their platform on hygiene and eugenics. VD was important for the imperialist political economy, which strove to reduce absence from the workplace among colonial government employees and sailors. The advocacy of “social hygiene” meant the application of eugenic principles into colonial government practices: a sanitary engineering project built upon “enlightenment” campaigns that demonstrated practical hygiene measures against VD and a series of measures for policing prostitution. As treatment options, VD clinics were opened specifically for the foreign male population. Their aim was to ensure the efficacy of the imperialist enterprise concerning the smooth functioning of the navy as well as that of the local colonial government.

Previous studies in Chinese history have focused predominantly on the related issue of regulating prostitution, such as Gail Hershatter's study. Little attention has been given to the ideological construction of “social hygiene” and its ties to eugenics. Despite his separate studies on medical knowledge, sexuality, and eugenics, Frank Dikötter's treatment of syphilis as signifying “the cultural degeneracy” of the Chinese nation did not address the issue of colonial ideology and policy. VD was accorded a privileged status in colonial health policies, precisely because of its detrimental effect on the political economy of the Empire.

Although pamphlets on social hygiene warned against the negative effects of syphilis on women's reproduction and hereditary birth defects such as blindness, those issues were not of interest to Colonial authorities, whose VD policies were discriminatory in terms of both gender and race. The local Chinese population was excluded from access to VD treatment facilities and was charged high laboratory fees. By contrast, Chinese female gynecologists prioritized alleviating the devastating effects of VD on the health of mothers and children caused primarily through the transmission of hereditary syphilis.

My paper seeks to explore the connections between medical treatment of venereal disease and colonial policies of containment during 1920s-1940s China. I analyze the impact of these health policies on Chinese society. I also investigate the history of medical ideas pertaining to social hygiene, as well as the ideological underpinnings of venereal disease treatment rooted in eugenics. Finally I identify the reasons why colonial treatment of VD was ineffective. I argue that it was the discriminatory treatment of patients in a colonial setting such as Shanghai that was at the root of this failure.

key words: VD, eugenics, social hygiene

B4. Professionalization: Opportunities and Ironies

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The Making of the Prison Psychiatrist in Late Nineteenth-Century Ireland

More than perhaps any other branch of medical practice, prison medical officers have been subjected to an almost overwhelmingly bad press. Joe Sim, for example, produced a largely negative analysis of the English prison medical service between 1774 and 1989. By reason of the apparent pressures imposed by 'dual loyalty' (loyalty to the prison system vs. obligations towards maintaining the wellbeing of their prisoner patients), prison medical officers are seen as a group unlikely to be creative or ambitious in their practices, their standards of care poor, and to be of low status in terms of professional hierarchy.

This paper, through a close interrogation of Irish prison archives and the published work of prison medical officers, questions these assumptions for the latter part of the nineteenth century. It reveals a mixed picture of commitment to providing psychiatric care and indeed in attributing the mental health of prisoners to the prison environment itself, as prisons came to contain large numbers of mentally ill inmates. It also demonstrates a growing assertion by prison psychiatrists that they were equipped – and increasingly so – to comprehend the particularly potent mix of mental disorder and criminality. Historians of psychiatry and criminologists have largely ignored the institutional work of prison doctors and their dealings with prisoners' minds focusing instead on the impact of continental theories concerning 'criminal types' and the 'criminal mind' such as those of Lombroso and his colleagues. Our paper, in contrast, with its emphasis on institutional examples, particularly Mountjoy, Dublin

(1850), charts the making of prison psychiatrists and the making of prison psychiatry. From the 1860s, increasingly experienced prison doctors argued that their knowledge of insanity within the prison and criminality distinguished them from asylum psychiatrists and other medical witnesses whose expertise was different, limited and partial. Prison doctors routinely assessed cases of mental disease, distinguished between 'real' and feigned cases of insanity, between the 'weak-minded' repeat offender and the incorrigible criminal, determined which cases should be transferred to criminal and district lunatic asylums during or at the expiration of prison sentences, and developed a discrete taxonomy of psychiatric labels.

- To provide an overview of the relationship between mental illness, psychiatry, and prisons in late nineteenth-century Ireland
- To assess how far a discrete taxonomy of psychiatry was produced in prisons
- To re-evaluate the status of prison medical officers in the late nineteenth century

B4. Professionalization: Opportunities and Ironies

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The Vanishing Negro Doctor: Interracial Passing in American Medicine

This paper examines interracial passing in American medicine during the era of Jim Crow. Using accounts taken from personal correspondences, newspaper reports, and other historical sources, it explores the various ways black doctors sought to escape discrimination and advance their careers by obscuring their racial identities. In addition to specific acts of passing, this study examines the larger theme and social implications of passing as it relates to professional medicine. It shows how professional status was intimately tied to notions of race and how celebratory racial anthologies and biographical sketches published during this era frequently affirmed the capabilities of black practitioners by attesting, not only to their skill, training, and achievements, but also to their ability to pass phenotypically for white. In addition, passing occupied a notable place in scientific research conducted by black doctors. Black researchers like Louis Wright and Daniel Williams sought to contest biological theories of racial difference and undermine the rationale behind illnesses and treatments deemed specific to whites. By affirming the physiological similarities of black and white bodies, black medical researchers worked to afford black patients better access to modern therapeutic resources. Lastly, this paper examines the relationship between black doctors and interracial passing in works of African American literature, focusing particularly on George Schuyler's *Black No More* and Charles Chesnutt's *The Marrow of Tradition*. In these works, which feature black doctors prominently, the theme of interracial passing emerges as a means to comment on the problem of race in American society. By examining these works in relation to black medical practices, this paper offers a more nuanced understanding of the fluid and protean nature of race while exploring its underlying impact on the practice of professional medicine throughout the twentieth century.

- 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

B4. Professionalization: Opportunities and Ironies

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“The nurses would like some voice”: Nurse-Physician Relationships in American Psychiatry 1940-1960

American psychiatry expanded rapidly in the period following WWII. Yet many psychiatrists eschewed institutional care, preferring to develop private practice based on psychoanalytic principles. At the same time psychiatric nursing was awarded funding to develop graduate, clinical specialist courses, in order to develop a skilled workforce for institutional care. Nurses themselves sought to control this process, and met with varying amounts of resistance and support from psychiatrists. This negotiation revealed significant tensions in the psychiatric professions, and led to a reconceptualization of institutional workforces and to the development of distinct nursing knowledge in psychiatry.

Despite this significant relationship between nurse and physicians, and its affect on patient care, nurses do not figure in the history of American psychiatry. Historian Gerald Grob has argued that nurses had no influence in this time period due to structures of the work force and a lack of nursing scholarship yet archival research suggests this is not the case.

This presentation draws on extensive research of psychiatric nursing archives including journals, and individual and organisational papers from the 1940s and 1950s. These include minutes and reports of committees on psychiatric nursing from the American Psychiatric Association, the Group for the Advancement of Psychiatry, National League for Nursing Education, the American Nurses Association, National Institute of Mental Health, and the Rockefeller Foundation.

Analysis of nursing sources has revealed the proactive efforts of nurses to resist attempts of organised psychiatry to control nursing practice in the post-war period, and demonstrates the scholarly activity of nurses seeking to develop their own voice in this arena. This presentation argues that nurses saw an opportunity to develop their practice as actively therapeutic, with potential for a meaningful impact on patient treatment and care. They needed to negotiate complex terrains of gendered power hierarchies within psychiatry to do so, yet the knowledge they created at this time continues to influence contemporary nursing practice, and made the development of a distinct professional specialisation possible.

Key words: psychiatry, nursing, therapy, knowledge, practice

- Understand the evolution of nursing theory in psychiatry
- Appreciate the significance of the interprofessional team for patient care
- Analyse continuing gender and power relations in psychiatric teams

B5. Premodern Regimen and Remedies

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Lettuce, Poppy Seeds, and Woman's Milk: Sleep Remedies in Seventeenth-Century English Receipt Books

Keywords: insomnia; household medicine; drugs

Like many of us today, seventeenth-century English folk believed milk to be a soporific, but with a difference – they used human breast milk instead of cow's milk, and they applied it externally to the temples. Why was this regarded as effective in bringing on sleep? This paper addresses this question, amongst others, as it examines the ingredients used in early modern sleep remedies.

Sleep in general in the early modern period is a fascinating and understudied subject, on the cusp of the magic of earlier times and the development of modern scientific methods. Roger Ekirch's ground-breaking research into the history of night suggested that people experienced sleep differently before the development of modern street lighting, expecting to wake up for an hour or two in the middle of the night before falling into a second sleep. This does not mean, however, that insomnia was not perceived as a problem in the early modern period. The wealth and variety of sleeping potions and herbal remedies suggests that combating insomnia was as much a concern in early modern society as it is today.

This paper analyses, for the first time, sleep remedies contained in seventeenth-century receipt collections held in the archives of the Wellcome Trust, the British Library and the Folger Shakespeare Library. Looking back to Anglo-Saxon herb charms, and forwards to contemporary debates about sleeping drugs, it places early modern remedies in the context of the history of sleep medicine as a whole. It demonstrates how the principles of contemporary medical theory, both Galenic and Paracelsian, alongside folk tradition, informed household medicine. It also considers the practical implications of the availability of ingredients such as sugar, the development of diacodium (a syrup made from poppy heads) and the various methods of preparation, such as extracting juice from lettuce.

Lastly, the paper examines the possible effectiveness of these remedies in light of modern medical science, including the placebo effect, and discusses whether modern medicine may be returning to household remedies as a response to concerns about the side-effects of modern sleeping drugs.

- 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.

B5. Premodern Regimen and Remedies

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'Exulting with tuneful harmony: Medicine, Disability, and Disease in Medieval Music

Gerald of Wales (c. 1146 – c. 1223) enthused that, “The sweet harmony of music not only affords pleasures but renders important services,” including healing maladies and soothing pain. Medical music had wider roles too. Lepers carried trumpets to announce their arrival; prestige-conscious faculty hired ‘ringers’ to strengthen their singing; and musical pulse analysis entered the doctor’s repertoire. While medieval historiography describes these and similar topics, the power of lyric and melody to make the nature of disease and disability both familiar and puissant is unstudied.

Congaudentes exultemus (c. 1100) celebrated St. Nicholas’ miracles through, “tuneful harmony.” The metaphors within the musical ‘sequence’ included breast-feeding starvation, developmentalism, and a panacea flowing from Nicholas’ tomb. Guillaume de Machaut (c. 1300-1377), in *Felix Virgo*, used blindness as a metaphor of human life. In *Douce dame* blindness indicated the travails of courtly love, and the ‘cure’ of “ma maladie gfarie” by love. Guillaume du Fay (c. 1397-1474) appealed to the Virgin Mary as a “*medicina dolorum*” in his motet *Flos florum*, and the balladic *Se la face ay pale* offered a diagnosis for the signum of facial pallor, “la cause et aimer.”

In this paper, we will examine the development of medieval music across a breadth of genres, attending to how composers and performers deployed the imagery of medicine, disease and disability. Using a variety of vernacular and Latinic sources from archives, editions and databases, we will see that European Catholic culture was widely exposed to those metaphors. Though changes in the form and medium of music altered the exposure’s structure, the drumbeat was remarkably consistent.

What emerges is a polyphonous, aural landscape to compare with the architectural, the literate and the visual. That landscape covered nearly every sector of the Christian population through church services. The elites had a second layer of contact in courtly music, while the troubadours offered a kind of “public university” for the less elite. Though few listeners would have been able to reduce the many musical elements they heard daily, nevertheless, those subconscious powers infused their lived experience and thus their interpretations of medicine, disease and disability.

- By the end of this talk, the auditor will be able to characterize the various roles of music in medieval medicine.

- By the end of this talk, the auditor will be able to characterize sociocultural dimensions of medicine in the Middle Ages.
- By the end of this talk, the auditor will be able to characterize sociocultural aspects of medieval disability.

B5. Premodern Regimen and Remedies

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Spiritualizing Medicine: Medieval Muslim, Judaic, and Christian Approaches to Female Sexual Pleasure

One need only to open the New York Times and see the current debate about Flibanserin, the (one) drug designed to address female sexual “dysfunction” Hypoactive Sexual Desire Disorder (“Insurance Won’t Pay for Women to Have Pleasurable Sex” one CNN headline reads (June 29, 2016) to get a small taste of the minefield that is part of the debate over women’s sexual pleasure (by the way there are over thirty drugs for male sexual dysfunction). The topic of women’s right to pleasure was at least as vexed (and varied) in the Middle Ages, and no less global. In this inquiry, I look briefly at different, but interacting, perspectives: how did medieval Christian, Jewish, and Muslim medical and religious texts seek to define and manage women’s right to pleasure? In this paper I look Arabic, Judaic, and Christian religious texts (for example, the Qur’an, Prophetic Medicine, the Kabbalah, and Christian patristic writings) alongside medical texts (for example, Provisions for the Traveler, The Book of Women’s Love, and The Viaticum and its commentaries) to answer this question. A comparative inquiry of this type has (at least) two stories. One tells of a complicated past that might belie our modern day imagination about how female sexual desire was constructed, controlled, and represented. The other draws us to our present day narratives about female sexual desire and its medical management. Such a narrative might help us to peel back our own various notions about female sexual desire, and what is behind the various ways we attempt to manage, liberate, and adjudicate it, locally and globally. Cross-cultural inquiry, as Sahar Amer notes, “reveals the historical and ideological power structures that construct discursive representations of sexualities” (“Cross-Dressing” 81). While Amer focuses on the relationship between medieval Islamicate and French representations of female same-sex marriage, the general principle applies to the relationship between the medieval Muslim, Christian, and Jewish women’s right to pleasure—that in exploring the multiple ways in which a women’s right to pleasure was medically and culturally defined, managed, and represented, we can gain a deeper understanding of the power structures at play, as well as modes of resistance to those ideologies.

- 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;

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

B6. Depictions of Disability

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Oh The Sun Shines Bright on My Old Contorted Bones: Climate, Culture, and Race in Rickets and Vitamin-D Deficiency in the South

At the start of the twentieth century, severe rickets emerged as a major medical and public health issue in northern American cities, where smoke pollution and the sun's low daily arc across the southern sky put urban dwellers in perpetual twilight. Unlike their European counterparts who interpreted rickets along class lines, American medical professionals interpreted this health crisis in racial terms—a problem affecting most heavily members of “tropical races” whose migration to northern climates was inevitably unhealthy. Some argued that African Americans “in their natural climate” were not “particularly liable to the disease;” that it “is only in the northern climate that their children suffer.”

This perception ignored centuries of experience. Before the rise of the industrialized north, rickets in America was closely associated with African-Americans, as amply recorded in newspapers, travelers reports, and medical literature from New Orleans to Virginia. Post-bellum migration to cities both north and south probably made matters worse, but rickets was hardly a new problem for African Americans in 1900.

Rickets emerged as a public health concern in the United States at a time when germ theory, food science and biochemistry were all ascendant, a time of unprecedented levels of social agitation for reforms of all sorts. In relatively short order, scientists and the American food industry developed a potentially effective public health intervention in the form of universal fortification of key food staples. Generations after the supposedly “universal” cure for rickets, however, serious cases continued to appear. Paradoxically, rickets persisted among African Americans in the sunny South. The major uptick in interest in rickets in the early twenty-first century, including many published reports by southern physicians, points to a new set of environmental and social realities, involving fear of sun exposure, self-imposed dietary constraints, and shifting diagnostic technology and standards.

This paper explores this seemingly paradoxical story of the South's experience with a disease caused by a deficiency of the “Sunshine Vitamin.” It places the history of rickets in context with the frequently overlapping histories of environmental illnesses, “diseases of poverty,” and so-called “race-specific” diseases. It finds that misguided notions of “universal” cures that ignored cultural and regional differences in food-ways, child-rearing practices, and distrust of established medical practices permitted an outcome that seemed to reinforce “received wisdom” about racial susceptibilities to disease.

- Audience will gain basic knowledge about the history of rickets in 19th and 20th century America.
- Audience will gain perspective on the pitfalls of so-called "race-specific" diseases
- Audience will gain familiarity with concepts of environmental health as applied to race and geography.

B6. Depictions of Disability

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“The Most Common Rare Syndrome You’ve Never Heard Of”: Noonan Syndrome, Parent Advocacy, and Public Awareness in the United States

In 1963, pediatric cardiologists Jacqueline Noonan and Dorothy Ehmke described nine patients with a distinctive set of symptoms constituting a unique syndrome, including pulmonary valve stenosis, hypertelorism, short stature, and mild mental retardation. Researchers quickly came to understand Noonan syndrome (NS) as an autosomal dominant inherited disorder with a wide range of clinical presentations, including frequent congenital heart defects, mild intellectual disabilities, developmental delays, and abnormal facies. Since 1994, causation has been attributed to mutations found in several different genes.

The Noonan Syndrome Foundation (NSF) proclaims that Noonan syndrome is “the most common rare syndrome you’ve never heard of.” Reporting an incidence rate between one in 1,000 and 2,500 live births in the United States, the NSF claims that NS may be as common as Down syndrome. As the CDC reports a Down syndrome incidence rate of one in 700 live births in the US, the NSF purposefully suggests that NS is significantly more common than current diagnoses indicate.

Despite this not-so-uncommon incidence, why is Noonan syndrome so little known? Parent advocates have tried to garner greater public attention and support for the syndrome. However, their efforts have been less than successful. In the mid-90s, a letter-writing campaign to get NS featured on Oprah Winfrey’s talk show failed. In 2013, the Noonan Syndrome Support Group, which supported families with a child with NS and aimed to increase awareness of the syndrome, dissolved after sixteen years due to lack of financial support.

Relying on oral histories with researchers and parents, scientific publications, and institutional records, I will examine the continued lack of public attention for Noonan syndrome against a changing background of perceived congenital risks. Since 1963, while autism has overtaken Down syndrome as the primary childhood disability of note, research on and experiences of NS appear to have lacked a captivating narrative that appeals to the cultural zeitgeist. The case of Noonan syndrome reveals how class privilege and manipulation of existing parental fears, coupled with publicity-seeking by parents and researchers, drive awareness of and support for a congenital disorder.

Key words: Noonan syndrome; congenital disorders; disease awareness

- Develop an historically informed sensitivity to the production and usefulness of awareness of a disorder
- Understand the interrelationship between parents and the medical establishment in constructing a unique diagnosis
- Recognize the dynamic continuity between medicine and society through history

B6. Depictions of Disability

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Pathologizing Locations?: Social Address and the Late 20th-Century Management of Developmental Disabilities

In the late-20th century, there was a major shift in the location of services for individuals with developmental disabilities. Following the deinstitutionalization of psychiatric wards in the 1960s, the management of developmental disabilities was decentralized from large institutions to small community homes and service providers. Deinstitutionalization was promoted for many reasons, including the promise of cost savings and the ideological currents of the civil rights era, which encouraged the integration and acceptance of stigmatized and marginalized people.

During the 1970s and 1980s, clinical psychologists debated whether the deinstitutionalization of individuals with developmental disabilities was a good in itself, or a policy with potentially harmful unintended consequences. Central to this debate was the question of whether centralized service locations, such as institutions and special education classrooms, were themselves pathologizing sites, due to social isolation, stigmatizing identities, and frequent proximity to other devalued locations, such as low income housing and grave yards.

This paper argues that distinctions in primary focus between the empirically assessed quality of services and the physical locations in which they were provided reflected a broader divide between social and medical models of developmental disabilities. Proponents who highlighted empirical quality over location, such as clinical psychologist Edward Zigler, were more likely to highlight the embodied nature of developmental disabilities and focus on the importance of individualized diagnosis and treatment. Those who argued that the stigmatizing impacts of isolated and devalued service locations had more impact than the services provided, including clinical psychologist Wolf Wolfensberger, identified with alternative social models of disability, which highlighted the significance of societal integration and acceptance over medical approaches to improving the lives of individuals with developmental disabilities.

This presentation engages with history of medicine scholarship, including David Wright, James Trent, and Gerald Grob, on the medicalization and stigmatization of cognitive and behavioral disabilities, by examining the evolution of differing social and medical model perspectives on the cause and management of developmental disabilities. The author draws

upon published professional literature and archival resources, primarily the papers of Wolfensberger, to examine debates over the relative significance of empirically assessed quality and physical location for disability services.

- For the learner to think critically about the nature, ends, and means of medical practice and its historical roots.
- 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.

C1. Print and Medicine in Early Modern Europe: New Perspectives

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Monardes on the Move: New World Drugs and the Language of Experience in European Print Culture

In the sixteenth century, numerous European authors touted the wondrous healing potential of previously unknown drugs from the so-called “New World.” One of the most prominent authors on drugs from the Spanish colonies was physician Nicolás Monardes of Seville, who published three books on New World drugs, eventually called the “*Historia medicinal*”, from 1565 to 1574. The work catalogued the marvelous properties of New World drugs, drawn from the personal experience of Monardes and his correspondents, and it presented an unflaggingly optimistic picture of the potential medicinal uses for Europeans. Unsurprisingly, it inspired great interest around Europe, and it was quickly translated into Latin in 1573 and English in 1577. While these translations have received ample scholarly attention, less well known are the full Italian translation of 1575 or the partial translations into French in 1572 and German in 1589. All of these publications went into multiple print editions in their respective languages. This paper examines the myriad pathways of Monardes’ work and demonstrates the varying role of merchants, printers, and physicians in producing the translations, with a special eye to translators’ interpretations of experiential knowledge. While Monardes’ language of experience was prominent in all of the translations, the specific ways in which it was highlighted differed widely. Some translators, such as the English merchant John Frampton, rendered the text more or less directly from the original Spanish, while others relied on the very different Latin translation of Carolus Clusius, and still others, such as the German physician Johann Wittich, chose to translate only certain portions of Monardes’ text for certain specific audiences. Ultimately the translators’ personal investment in the translation – whether as a merchant interested in promoting new wares or a physician looking to share new knowledge – helped influence the way they used experiential knowledge, including varying emphases on indigenous uses of drugs in their places of origin, their documented use on European patients, as well as the practicalities of turning them into European medicaments.

- Think critically about the role of the translator in the transmission of textual knowledge.
- Understand the complexities of print culture and the dissemination of the written word.
- Identify varying uses of experiential knowledge in medical writing

C1. Print and Medicine in Early Modern Europe: New Perspectives

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Printing and Reading Medical How-to in Early Modern England

The early modern household was a bustling site for a range of medical activities from self-diagnosis and medication to nursing and caring for the sick to drug production. To further their knowledge about medicine and the body, householders had access to a wide variety of sources. Many turned to their family and friends for health-related advice; consulted medical practitioners of various sorts and avidly read the abundance of printed medical books offered by contemporary book producers. In fact, printed books occupied a central place in the production and transfer of knowledge in the early modern medical world and, as Mary Fissell has argued, played a crucial role within the medical marketplace. Past research upon vernacular medical books has mainly focused on production; however, as William Sherman has argued, books concerning health and medicine were consistently ‘marked-up’ by readers. This paper analyses medical print production and consumption through one central case study. In the mid-1730s, the Tallamy family obtained a copy of John French’s *The Art of Distillation*. Led by Rebecca, they wrote a cornucopia of annotations and notes into their treasured copy of French’s book including information on the medicinal virtues of herbs and hundreds of additional recipes. Running out of space in the margins, the family bound another 140 blank leaves to the book, allowing them to further expand their collection of medical and culinary know-how. The printed medical book, then, once a conduit for medical knowledge, became the receptacle. References suggest that the Tallamys were, at the very least, reading Nicholas Culpeper and William Salmon alongside John French. Taking this curious volume as a starting point, this paper explores print and ‘medical reading’ in early modern England. Placing emphasis on practices of compilation, translation and appropriation, I trace the adaptation and reuse of textual knowledge across linguistic, geographical, gender and spatial boundaries. In doing so, I hope to offer a fresh perspective to understand the transfer and appropriation of medical knowledge.

- Recognize multiple ways in which medical knowledge was transferred and codified in the early modern period.
- Think critically about the role of reading and note-taking in the production of medical knowledge.
- Understand the dynamic relationship between domestic medicine and early modern medical markets.

C1. Print and Medicine in Early Modern Europe: New Perspectives

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Print, Public Health and Power in Early Modern Venice

In early modern Italy, governments made extensive use of print from the 1570s onwards in their attempts to combat the spread of plague. Yet epidemic disease was not the only public health concern which the rulers of pre-modern cities sought to counter. Focusing on the Venetian Republic, this paper evaluates the growing use of print to promote population-level health in the seventeenth and eighteenth centuries. Print was used to regulate medical practice and practitioners, and to broadcast legislation about matters ranging from food standards to cemetery management. Amidst the extensive literature on the development and impact of printing in early modern Europe, scholars have hitherto assessed how medical practitioners exploited print in a wide variety of ways, from the lavishly illustrated volumes of leading physicians and anatomists to the handbills of travelling charlatans. Less has been said about other authors of medical print and the texts which they produced. By analysing the content and format of broadsheets, pamphlets, and other forms of ephemeral print issued in the name of the Venetian Republic, this paper demonstrates that the primary aim of public health print was to stimulate communication, including information-dissemination, information-gathering and persuasion. It explores how official print interacted with printed texts authored by physicians, as well as the transnational dimensions of public health print due to the movement of texts between cities. The paper charts its course through these issues by focusing on how print shaped and was shaped by changing preoccupations with mortality, from demographic change to sudden death and resuscitation. It argues that print came to be used so extensively because it was flexible and adaptable to emerging threats and concerns, and due to its portability, efficiency and authority. The significance of print's persuasive powers has long been recognised by historians of the Reformation. Its role in the promotion of public health relates to Foucault's arguments about the rise of biopower, but its communicative and cooperative dynamics challenge his linear narrative of the regulation of bodies and populations.

By the end of this activity, the learner will:

- Recognize the dynamic interrelationship between medicine and society through history;
- Develop the capacity for critical thinking about the nature, ends and limits of medicine;
- Understand the dynamic history of relationships and communication between governments, patients and health care providers.

C2. Tradition and Transition: Modes of Medicine in Modern China

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The Communist Way of Healing: "Soviet Medicine" in 1950s China

China in the 1950s not only witnessed a number of political campaigns that have been studied by political scientists, but also various movements on public health that profoundly changed people's daily lives. In order to legitimize its governance, the new communist regime conducted various campaigns on promoting public health, including Patriotic Hygiene Movement, four pests campaign, allegations of biological warfare in the Korean War, and the campaign of the Psychoprophylactic Method of Delivery (PPMD). These political campaigns on public health, whether successful or not, remind us of the medical knowledge used by the state during the cold war context, where the knowledge came from and how it was circulated through these politicalized movements, how medical knowledge helped to strengthen the new regime as the state wanted, how it impacted people's daily lives, both the ordinary people and medical practitioners. This paper examines how Soviet medicine, which not only provided theoretical background for these campaigns, but also thoroughly changed the entire process of diagnosis and treatment, and the interpretation and expression of suffering, by focusing on two Soviet therapeutics, the PPMD, the pain relief method for childbirth and the tissue therapy, which was used to cure numerous diseases by implanting or injecting tissue into the human body. This paper argues that Soviet medical knowledge, and the ways of practicing it, were integrated into the gigantic, ideological state building process, linking the healing experience and propaganda, turning the medical problem into an embodiment of political discourse. This article also discusses how this new ideological categorization of medical knowledge changed the boundaries between medical systems including Traditional Chinese Medicine and biomedicine, and how this change would impact people's everyday life.

- To understand how medical discourse was influenced by bodily experiences and political factors
- To explore the construction of medical boundaries in political and social context
- To reveal the divergence of understanding suffering and pain across medical systems

C2. Tradition and Transition: Modes of Medicine in Modern China

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Who Should Take Charge of External Diseases? The Battle Between Internists and External Medicine Specialists in Late Imperial China

In late imperial China, external medicine specialists (who dealt with diseases that mainly appear at the body surface) were facing increasingly intense competition from the internists (who specialized in the internal diseases) in the treatment of external diseases. This issue has never been carefully studied by historians.

Based on traditional medical texts and case records, this paper investigates the fierce competition and also the limited cooperation between internists and external medicine specialists in the treatment of external diseases in Ming and Qing Dynasty. At that time, internists believed that not only were they capable of treating external diseases, but even better than those who specialized in external medicine, whom they belittled as vulgar and superficial. They tried to legislate themselves by claiming that external diseases were rooted in the internal organs, which was a dominant view in Ming and Qing era. This holistic view of body was also repeated by mainstream specialists of external medicine since they want to divide themselves from their vulgar colleagues and to cling to a more respectable scholarly tradition. However, to address their own authority, external medicine specialists also pointed out that though external diseases were rooted in internal organs, they were still different from the internal diseases thus should be treated in a different way. They insisted that one could not treat external diseases without specialized training. In addition to competition, there was also limited cooperation between the two parties. Internists always left external operations to the external medicine specialists, and two groups of doctors often relegated the responsibility to the other group once they lost confidence in their own ability to treat the patient. This paper suggests that these phenomena extended from the general transformation of medicine in late imperial China and reflected the enhancement of the scholarly tradition of medicine and the declining status of external medicine.

- To show how internists and external medicine specialists competed and cooperated with each other in the treatment of external diseases in Ming and Qing Dynasty.
- To understand the background and causes of these phenomena in the context of the general transformations of Chinese medicine in late imperial China.
- To understand the general transformation of Chinese medicine itself through this issue.

C2. Tradition and Transition: Modes of Medicine in Modern China

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Ideal Forms: Body Mapping and Medical Mediation in China, 1933-1983

The healing arts in East Asia display a wealth of body maps depicting lines that guided diagnostic and therapeutic practice. Scholars often debate whether to discursively interpret these lines as meridians, channels, or tracts; practitioners often debate whether these lines merely visualize nerves to articulate needling and heating practices. Yet, these debates each take for granted the process of representing experience and imagination in medical practice. To reframe these debates, this paper considers body maps as an alternative history of representation, arguing that hand-drawn maps served as a kind of sensory technology. They traced sensations that remained unseen until inscribed on paper. A close study of body maps allows us to understand a range of medical practice and medical theory that remain multiple and contingent. They raise questions of hybridity, translocality, and ontology, appearing as

stable forms of representation, while expressing a deeply transforming landscape of knowledge about the body.

By joining approaches in postcolonial STS and critical cartography, this paper investigates the ways in which historical actors adapted a range of scales—national, transnational, regional, and personal—to elaborate on cultures of epistemology and historical ontology. In particular, it centers on 10th century meridian maps that were mapped onto sensation maps of nerve clusters in the 20th century. It was in the inscription of a line—a graphic line that lacked form, texture, and tangible quality—where ontology lived. These lines took on many different meanings when they were curved, straightened, thinned, thickened, broken, colored or shaded. I show how efforts to standardize body maps across 20th century statecraft intensified the varieties of sensations and bodily experiences. While these maps were essential to projects of governmentality, they likewise evaded complete control, exhibiting agency in spite of attempts to locate, fix and contain the body on paper and in practice.

- To join insights in critical cartography with postcolonial histories of science and reframe histories of representation in science and medicine.
- To compare body maps among different forms of medical practice as a means for understanding historical ontology.
- To introduce the practice of inscription as a form of sensory technology that articulated medical theory.

C3. The Beginnings of the “End-of-Life”: Origins and Trajectories in U.S. Bioethics and Hospice

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From Driver of Care to “Method of Cost Savings:” The Changing Meaning of Familial Caregiving in the Modern US Hospice Movement

Historians have examined how mid-twentieth century changes in end-of-life technology excluded families from the deathbed. This exclusion was one of the factors that led to the rise of bioethics. But while historians have chronicled the role of the family in bioethics, less attention has been paid to the role that the family played in the other mid-twentieth century reaction to new technology at the end-of-life: hospice.

This paper will examine this question through a study of the first “modern” US hospice: Hospice, Inc. Hospice, Inc. was founded in 1971, in New Haven, Connecticut. It was to be the launching site of the “modern US hospice movement,” which was inspired by the work of Cicely Saunders in London. Through examination of the archives of Hospice, Inc.—housed at Yale University—I will reconstruct the organization’s view of the family as it evolved throughout the first decade of its existence: 1970 to 1980.

Throughout this period, Hospice, Inc.’s leaders considered it important that dying patients should be cared for by their family members. But the rationale for the family’s role as caregiver underwent a shift. In the early 1970s, hospice leaders included the family in end-of-

life care because, they argued, doing so would have clinical benefits for the dying patient, as well as the family. But, over the course of the decade, this clinical rationale became accompanied by an economic one: The family was included because their unpaid labor drove down the cost of care.

By the end of the 1970s, these two rationales had begun to compete. The need to cut costs had led to the cutting of services that hospice leaders considered essential for the clinical benefits of familial caregiving. This conflict would come to a head with the passage of the signature piece of legislation in the history of US hospice care: the Medicare Hospice Benefit.

I will conclude by discussing how hospice's model for integrating the family into end-of-life care would both differ from—and depend on—that proposed by bioethicists.

- Examine the origins and early development of US hospice care
- Provide an understanding of the differing, and potentially conflicting, roles that familial caregiving plays at the end of life
- Analyze how early hospice history continues to impact the structure of US bioethics and hospice care

C3. The Beginnings of the “End-of-Life”: Origins and Trajectories in U.S. Bioethics and Hospice

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Prelude to Hospice

A remarkable study of terminally ill people and their families conducted between 1969 and 1971 occupied a central place in the campaign to establish the first U. S. hospice. The principal investigator was Florence Wald, former dean of the Yale University School of Nursing. Although the study never was published, Yale's Sterling Memorial Library has preserved the notes of the researchers' interactions with patients and relatives as well as of the researcher's discussions of the cases with other health professionals and investigators. The 90 files provide a wealth of information not only about dying patients and their kin, but also several other critical issues. One was the values and assumptions of early hospice leaders. Influenced by the Freudian psychology that was popular at the time, Wald framed the needs of the people she studied in therapeutic terms. The records also enable us to glimpse the interactions between physicians and patients at a time when both relationships were undergoing transformation. In addition, the records reveal how Wald applied her beliefs. Some patients and families welcomed the various services she offered, but her intensive involvement in personal lives provoked criticism from several members of her research team and entangled her in family conflicts and tensions. The hostility she encountered from hospital personnel reinforced her belief that the hospice she planned should be completely divorced from the established health care system. She was especially shocked when she suspected that therapies served the interests of researchers more than patients. Wald extensively recorded the experiences of a

one woman who underwent an experimental procedure that violated her dignity and exposed her to harm.

In presentations, Wald made generalizations that had little basis in her data and carefully selected the cases she discussed. The paper suggests that many histories of early hospices ignored the complexities of the daily work of caring for dying people and their families.

- Understand the assumptions and values of early hospice leaders;
- Understand the gap between the rhetoric and reality of early hospice care;
- Understand how the relationship between doctors and both nurses and patients changed during the late 1960s and early 1970s.

C3. The Beginnings of the “End-of-Life”: Origins and Trajectories in U.S. Bioethics and Hospice

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From Letting Go to Holding On: Hospital-Family Conflicts over Life Support, 1975-present

When mechanical ventilators were introduced into widespread clinical practice, a new legal infrastructure was created to manage issues as apparently settled as the definition of death, individual rights to accept or decline medical care, and mechanisms for determining how and who should make decisions for people in these new liminal states between alive and dead. These issues were debated in the pages of newspapers, among theologians, attorneys and physicians, and in the emerging field of bioethics. Scholars have written histories of brain death, bioethics, and transformation of care at the end of life.

The perspectives of families who have a loved one on life support have been less well-studied than those of elite policymakers, medical practitioners, and other scholars. Lawsuits in the 1970s and 1980s generally placed hospitals in the position of defending use of technology as mandated to preserve life without regard to its quality. By the 2000s, most of these lawsuits instead sought to maintain life support for children and adults with devastating injuries, including those who met criteria for brain death.

These conflicts illustrate two important historical trends. First they show the changes in “usual care” since the 1990 US Supreme Court case of Nancy Cruzan, and others of that period, laid out legal criteria for when life support could be stopped. Second, these conflicts illustrate the extent to which the general population has not accepted or fully integrated brain death into their understanding of life trajectories, especially in some religious, geographic, and social subgroups. These changes happened against a background of changing financial incentives in health care. They also draw on and are symbolic of a deep politicization of end of life care as part of conflicts between protection of life at all costs versus support of individuals’ right to be left alone. Vulnerable populations, including low-income and minority communities, and people with long-standing disabilities, have been particularly likely to bring suit, even as their political alliances sometimes cut across these frames.

This paper draws on legal cases, media coverage, survey data, and data and studies on changing performance of the health care system.

- Participants will be able to explain the contemporary standards for who makes decisions for incapacitated adults
- Attendees will be able to describe how political concerns have affected end of life care
- Participants will be able to analyze how strategies of patient and family communication around life support leads to or avoids legal action

C4. New Methods in the History of Medicine: Advancing Digital Humanities towards a Computational Framework

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The Geography of Specialty: Using Computational Approaches to Discover Specialist Distribution across States

Keywords: Specialization, Historical Geographic Information Systems (HGIS), Digital Humanities (DH)

Historical directories of physicians are an underutilized resource for historians of medicine, especially for those interested in the organization of the profession and the rise of specialization. Consisting of a list of physicians, usually along with information about their licensing, their education, and their professional and specialty affiliations, medical historians have used these these directories to explore the consolidation of the medical profession and the emergence of specializations. Scholars such as George Weisz and James A. Schafer, Jr. have used these directories in fascinating research that respectively have explored changing rates and categories of specialization and the geographic distribution of doctors. However, the directories' availability as printed text has limited their accessibility to historians of medicine who could more readily delve their contents in a digital format. For instance, because of the difficulty of manually counting and entering data large amounts of data, both Weisz and Schafer only used limited samples of physicians from specific American cities in the directories they studied to draw conclusions.

For historians of physicians in the United States, the "American Medical Directory" ("AMD") is particularly important because of its completeness and the regularity of its editions. Purporting to list all the registered physicians in the United States and Canada, the American Medical Association published the first "AMD" in 1906, with new, updated editions following every two to three years. This paper makes use of database version of the 1918 edition of the "AMD" produced with mass digitization and computational parsing techniques to examine rates of specialization as well as the geographic distribution of specialists at the state, rather than city, level. It will argue that the current historiographical focus on cities has limited scholars' understanding of patterns of specialization and that specific geographical factors determined

where specialists worked in individual states. Beyond providing a more complete and geographically diverse picture of medical specialization in the United States on the eve of World War I, this presentation will also demonstrate the promises (as well as the pitfalls) of using computational techniques to unlock historical directories' data.

- Recognize the dynamic interrelationship between medicine and society through history
- Expand methodological approaches for understanding the past
- Develop knowledge and understanding of professional behaviors and values

C4. New Methods in the History of Medicine: Advancing Digital Humanities towards a Computational Framework

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The Hidden Healers: Professional Networks and Intellectual Genealogies of Non-Academic Medical Practitioners in Early America

In his epic 1702 work, *Magnalia Christi Americana*, Cotton Mather spoke of an “angelical conjunction” prevalent in the British colonies of North America. There, clergymen “administered unto the souls of the people the more effectually, for being able to administer to their bodies.” While historians of colonial New England like Patricia Ann Watson have long recognized this conjunction of preacher and physician, little effort has been made to recognize or organize the networks of medical practice and training existent outside a university educated elite. Building from interest such unrecognized physicians by Laurel Thatcher Ulrich’s study of Martha Ballard, there remains a need to understand the more rich and diverse reality of medical care practiced in the North American British colonies from the seventeenth through the early nineteenth centuries.

Using advanced database technologies to combine vital records from the early 17th through 19th century with data from church, courts, and personal accounts, I have begun organizing networks and intellectual genealogies of formally and informally educated physicians operating in the North American British colonies and the Early Republic. This includes women and racially marginalized individuals who, if recognized at all, have been saddled by the diminishing term “healer.” This project places all medical professionals within their respective geographic and intellectual networks without bias toward university affiliation, whether from Europe or North America beginning in the late eighteenth century.

- Learn how computational humanities methods facilitate the gathering and analysis of new information existing sources
- Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems
- Identify successes and failures in the history of medical professionalism

C4. New Methods in the History of Medicine: Advancing Digital Humanities towards a Computational Framework

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The New Orleans Mortality Project: Mapping the Connections between Health and Cycles of Poverty in the Mortality Transition, 1877-1915

This paper presents findings from the New Orleans Mortality Project, an ongoing interdisciplinary project that is pushing the methodological frontier of digital humanities and the history of medicine. In particular, this project combines quantitative and qualitative sources in an historical geographic information system (HGIS) to examine how the spatial and temporal patterns of health, environment, and socioeconomics impacted individual, community, and urban development in New Orleans, 1877-1915.

Recent studies suggest that the mortality transition at the end of the nineteenth century would be more appropriately considered mortality transitions. Death rates did not decline uniformly across the U.S. or even in individual cities. Gretchen Condran and Harold Lentzner (2004) compared the temporal patterns of infant mortality in New Orleans, New York, and Philadelphia and found the city-wide decline was delayed more significantly in New Orleans. Susan Leonard, Jeffrey Beemer, and Douglas Anderton (2005) used individual-level mortality data to examine the connections between family wealth and immigration in the mortality transition of two New England towns. They found a complex set of relationships between these factors in the early years of the mortality transition and concluded that the mortality transition was less uniformed than previously thought. These studies have shown that traditional historical methods have been insufficient in examining the evolution of these processes across different temporal and spatial scales, and they demonstrate the emerging revolutionary potential of HGIS and individual-level data to inform great historiographical debates in the history of medicine and the discipline of history as a whole.

The New Orleans Mortality Project builds on the methodological innovations of these groundbreaking studies and incorporates spatial analytical techniques to examine a 50,000-person mortality dataset, socioeconomic data, and a 30,000-record property tax dataset. This presentation promotes the value of continued digitization and standardization of historical health records, which will significantly increase the possibilities for large-scale comparative and collaborative studies. In addition to building seminal datasets for the study of historical health and poverty in New Orleans, this project is a cornerstone in understanding the inter-urban mortality transitions and larger cycles of generational poverty in the United States.

- Learn how computational and digital humanities methods can unlock new information and understanding from traditionally underused historical sources
- Recognize the dynamic interrelationship between medicine and society through history
- Expand methodological approaches for understanding the past

Keywords: Historical geographic information systems (HGIS), Digital Humanities (DH), Mortality Transition

C5. Multi-species Medicine: Valuing more than Human Contributions to Disability, Health, and Well-being

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Becoming Well Together: The Historical Emergence of Therapeutic Animals in Clinic and Laboratory Settings, c.1940s-1970s

In 1962 the clinical psychiatrist Boris Levison outlined his experience of using “the dog as a co-therapist” before proposing – only partly in jest – that a “Canine Counselling Corps” be established to enable nonhuman animals to contribute to the promotion of human mental health. A decade later, the experimental psychobiologist Samuel A. Corson led a pilot study of ‘Pet-Facilitated Psychotherapy’ in a hospital setting to establish evidence of the therapeutic value of nonhuman animals. Whilst nonhuman animals have long been associated with human wellbeing, it is only relatively recently that the ‘human-animal bond’ has been developed as an object of scientific study with medical value.

By reconstructing the history of 'pet' therapy, this paper explores how, why and to what consequence human relationships with nonhuman animals became established as a novel space for therapeutic interventions into human health and wellbeing from the mid to late twentieth century. In doing so, it also considers changing ways of building productive working relationships between therapeutic and experimental research settings. Questions addressed include why and how interest in using relationships with animals as a therapeutic intervention emerged independently in the clinic and laboratory and how the two came to engage with each other. Analysis explores what the animal was expected to bring to the therapeutic encounter and how nonhuman presence was thought to 'heal'. Historiographically, the paper deepens understanding of themes such as touch and affect in medical care and the development and application of attachment theory in psychiatry.

Historical methodology will be applied to interpret empirical evidence drawn from personal and institutional archives, published professional papers and the popular media. Analysis draws on theoretical insights from the interdisciplinary fields of animal studies and disability studies; distinct fields which do not in themselves maintain an easy relationship. Importantly, medical history also contributes distinctively to these two fields by bringing them into dialogue. In this way the paper responding to the call to ‘expand the horizons of medical history and engage related fields’.

- 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.

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

C5. Multi-species Medicine: Valuing more than Human Contributions to Disability, Health, and Well-being

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“Navigating Death Avenue”: Spectacles of Guide Dog Mobility, City Traffic and the Politics of Interdependence in Great Depression-Era America

This paper addresses a critical moment in the history of American disability and the history of dogs as service animals: the establishment of the first American professional guide dog program in Nashville in 1929. It will focus on two charismatic ambassadors of the charitable organisation The Seeing Eye: Morris Frank, the first person in America to live with a specially trained guide dog, and Buddy, a female German Shepherd. Upon his return from Switzerland where guide dog schools were first established and where he was first introduced to Buddy, Frank travelled far and wide amid a carefully orchestrated media frenzy that focused on their navigation of traffic, human and motorised. Frank demonstrated the safety and efficiency of Buddy’s guidance for both dog and “man” in spectacular events staged in hazardous city thoroughfares, even in New York’s West Street, contemporaneously known as “Death Avenue.” The paper will read the inter-war spectacles of seeing-eye mobility against the already well-established rehabilitative regimes designed to ameliorate blindness and dominant medical and social understandings of disability, ability, and impairment. Significant emphasis will be placed on how Seeing Eye established a new relationship between disability and blindness in two main ways. Firstly, they developed and disseminated new ideals of blind people as model, “independent” citizens, and secondly and crucially, this vision of rehabilitative transformation was predicated on “interdependence” with another species -- the systematic training of (primarily male) non-sighted people and dogs to live and move together in harmony. Drawing upon institutional records combined with newspaper reports and autobiography, I will examine how the public spectacles of seeing-eye dog mobility showcased the rehabilitative power of specially trained animals in extending their human companion’s abilities and participation in civic, public and economic life. Yet at the same time the spectacle of newly independent blind men guided by canine partners ran in tension with the dominant images of sighted-male redundancy, dependency and impairment created and maintained by Great Depression-era culture. By combining approaches from disability studies, animal studies and cultural and medical history, I will critically examine how the economic crisis shaped and constrained Seeing Eye advocates’ understanding of independence, interdependence and dependence, leading to uneasy representations of the difference between the sighted dog and the non-sighted human, and the sighted human and the non-sighted human.

- Promote critical thinking about the nature and limits of models of rehabilitative practices.
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education.
- Develop a historically informed sensitivity to the diversity of patients especially the appreciation of disability, impairment and sensory loss.

C6. Medical Pluralism in Latin America Revisited: Chinese Medicine, Homeopathy, and Psychoanalysis in the Latin American Medical Landscape in the 19th and 20th Centuries

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“Defects in the Body”: The Role of Mexico’s Medical Community in Reforming the Deaf, 1870-1900

The nineteenth century witnessed an upsurge in the study of hearing and speech disorders, with doctors and scientists renewing interest in the study of deafness. Many late nineteenth-century científicos believed that environment, climate, and geography might be the ultimate cause of deafness. Similarly, Alexander Graham Bell attributed deafness to environment and geography in 1892. Mexico’s first census was released in 1900, and although the nation’s deaf-mute population arguably had not increased, it highlighted a number of concerns that had preoccupied policymakers for decades. Medical elites, education officials, and policymakers became increasingly preoccupied with solving what they perceived to be a pernicious issue in Mexican society—how to cure the deaf of this “ailment” and transform these potentially idle creatures into productive citizens?

Drawing on archives, advertisements, and medical journals, this paper examines the interactions between policymakers, school officials, and medical experts who waged a campaign to cure deafness—an illness which, in their view, contributed to an already backward population that would pose additional burden on the government and economy. Since many medical professionals held that miasmas and unsanitary living conditions caused and contributed to the spread of deafness, it was commonly believed that contracting the “illness” could be prevented or was within the control of the sufferer. From the late nineteenth through the early twentieth centuries, major Mexico City newspapers experienced a surge in advertisements that boasted cures for deafness, which ranged from quack cures and pills to prototypes of hearing devices. Though the underlying causes of deafness were not entirely understood, a national discourse developed which suggested that deafness was a condition that could be treated and cured—either by sanitizing the environment or through medical intervention. Late nineteenth-century assumptions that deafness was a result of immoral behavior or worse, an “elected” disability, complicate understandings and treatment of deafness as a medical condition, and contribute to discussions of Mexico’s modernizing and civilizing agenda to reform its deaf population.

- Understand the dynamic history of medical practice through gaining insight into strategies medical professionals have used in interacting with groups with disabilities or different abilities.
- Identify successes and failures in the history of medical professionalism.
- Recognize the dynamic interrelationship between medicine and society through history.

key words: deaf, Mexico, public health

C6. Medical Pluralism in Latin America Revisited: Chinese Medicine, Homeopathy, and Psychoanalysis in the Latin American Medical Landscape in the 19th and 20th Centuries

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Freud in the 'City of Kings:' The Reception of Psychoanalysis in Lima, Peru, 1910-1930

Between 1910 and 1930, psychoanalysis arrived in Lima, Peru. Due in large part to the translation, research, and publications of Honorio Delgado, the ideas of Sigmund Freud gained institutional and intellectual traction in a modernizing society seeking a more complex theory of human behavior. Within a larger context of secularization and a rejection of European positivist philosophies, psychoanalysis entered the Peruvian public sphere during a period of relative openness and cosmopolitanism. Although some scholars have illuminated the broader Latin American reception of psychoanalysis—in the cases of Argentina and Mexico—this paper will reveal the specific ways in which a majority indigenous country, located at the periphery of the global system, interacted with a prominent set of medical and social doctrines. By drawing on Delgado's clinical writings, a 1926 magazine issue dedicated to Sigmund Freud, and a variety of journalistic coverage of the psychoanalytic movement, this paper analyzes the specific Peruvian readings and adaptations of Freud's work. Delgado's attempt to link his activities to the International Psychoanalytic Movement reflect the yearnings of the Peruvian elite to make Lima a truly modern city with psychiatric facilities that met global standards. However, this attempt was frustrated by competing, popular notions of psychoanalysis that raised important questions about race and ethnicity. Thus, this paper contributes to the understanding of the complex medical and intellectual relationship between Europe and Latin America and the ways in which medical knowledge is applied to a variety of societal questions.

- Acquire a historical perspective on the development of modern psychiatry in the developing world
- Recognize the differences in how elite versus popular groups understand mental illness.
- Think critically about the exchange of medical ideas between Europe and Latin America.

C6. Medical Pluralism in Latin America Revisited: Chinese Medicine, Homeopathy, and Psychoanalysis in the Latin American Medical Landscape in the 19th and 20th Centuries

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“Hostilidad”, “Desorden”, and “Indisciplina”: The Challenges of Medical Pluralism at the National Homeopathic Hospital during the Age of Institutionalization of Biomedicine in Mexico City, 1893-1934

During the first half of the 20th century, Mexican institutional medicine experienced an unprecedented growth. Backed up by the revolutionary government’s commitment to bring health to the nation, doctors sought to renovate schools and hospitals and create programs to increase the number of trained doctors and spaces where patients received medical care. As doctors increasingly populated state offices such as the National University, the Ministry of Public Health, and the Public Welfare Office, they faced the conflicting political ideologies that marked the post-revolutionary period and pulled state institutions into different directions. The National Homeopathic Hospital is one of these medical spaces where conflicting medical systems, different and sometime opposing state interests, and contrasting doctor’s personalities coincided and collided, revealing the challenges to sustain medical institutions that incorporated different medical systems at a moment of intense political conflict and economic crisis.

Originally installed in 1893 as an experimental facility where homeopathic doctors freely practiced their therapeutic system without objections from positivist doctors, the National Homeopathic Hospital evolved into a homeopathic medical school, a homeopathic clinic, and finally a fully equipped hospital in the early 1930. The concentration of diverse activities -- teaching, clinical training, public health programs, and private medical practice-- in one single facility, the changing health demands of a growing patient population, the challenges of running a hospital in times of increasing demand and economic recession, and doctors’ therapeutic preferences, resulted in the nuanced trajectory of the homeopathic hospital. Using reports, board discussions, official publications, hospital statistics, and doctors’ reports from the Public Welfare Office and the Department of Public Health, this case study shows that even in the context of a revolutionary state that relied heavily on the professional medical class to achieve the new constitutional mandate to bring health to the entire population, professional medicine offered some spaces where both biomedicine and homeopathy were reframed to inhabit one single institutional space. As in other Latin American countries, the institutionalization of medicine during the first half of the 20th century marginalized but did not eradicate and even supported alternative approaches to health, such as homeopathy in Mexico.

- Develop the capacity for critical thinking about the nature, ends and limits of medicine
- Identify successes and failures in the history of medical professionalism in Latin America
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

D1. Gendered Interventions

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Bristling Dixie: Combat Trauma, Masculinity, and the South Carolina Lunatic Asylum, 1861-1881

After First Manassas – the opening battle of the Civil War – Private Thomas E. Jones of the Second Regiment, South Carolina Infantry was discharged from the Confederate Army for “mania.” Months later, in September 1861, Jones was committed to the South Carolina Lunatic Asylum (SCLA). Physicians concluded – as they did for many Confederate Veterans in the years following the war – that the “immediate cause” for commitment was “excitement on the battlefield.” This diagnosis represents evidence of changing medical perceptions regarding the impact of combat upon soldiers’ mental health.

Relying on bountiful extant pension records, a body of military-based scholarship exists concerning the post-war mental health of Union veterans. Some argue that a similar study of Confederate veterans is unfeasible due to a perceived lack of resources – southern states did not institute a pension program until the 1900s. This study goes beyond previous military-based scholarship in using commitment files from the SCLA – combined with Confederate Service Records – to illustrate that a study of combat trauma among southern soldiers is, in fact, possible. Through further analysis of southern newspapers and examination of the science of mental health during the period, this study reveals also a breakdown in popular notions of southern masculinity shared by some historians.

A greater understanding of the medical culture in which Confederate veterans were treated adds vital context to the history of mental health in America and Civil War historiography. The SCLA was one of the largest institutions dedicated to mental health in nineteenth-century America and the post-war growth of the patient population offers a unique sample of Confederate veterans around which to base this analysis. In an era when the horrendous results of war forced physicians to better address physical injuries, this study shows that the effect of combat upon the psyche was, likewise, impossible to ignore.

- Recognize the dynamic interrelationship between medicine and society through history
- Deepen understanding of illness and suffering
- Provide greater context regarding the history of PTSD

D1. Gendered Interventions

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Syphilis and the Intersections of Medical, Gender, and Women’s History: The Case of Helen Hamilton Gardener

In 1893, Helen Hamilton Gardener was one of the most well-known women in America. Her brave novels challenging the sexual double standard were read by activists around the

world, and she delivered three addresses, more than any other American woman, at the 1893 World's Fair in Chicago. Her interest in sex reform, however, was not merely ideological. It was quite personal. A coded set of letters I recently uncovered at the Library of Congress reveal that, just as she became a prominent activist, her husband was losing his mental faculties to syphilis, defrauding her wealthy friends of money, and threatening to sully her hard-earned reputation. In these letters, Gardener reflects on how she coped with her husband's disease and how she managed to avoid contracting it. Her public writings reveal deeper analysis of the state of medicine, the role of religion in maintaining male sexual privilege, and her hopes for feminist change.

If, as Charles Rosenberg argued in "Framing Disease," "disease is at once a biological event, a generation-specific repertoire of verbal constructs reflecting medicine's intellectual and institutional history, an occasion of and potential legitimation for public policy, an aspect of social role and individual—intraphysic—identity, a sanction for cultural values, and a structuring element in doctor-patient interactions," what does the syphilis epidemic of the nineteenth century reveal about gender, sexuality, and women's evolving relationship to and experience of professional medicine? Despite much scholarship on syphilis (focusing on war efforts, public health, prostitution, and Tuskegee), we know little about what syphilis meant for the thousands upon thousands of women in the 19th-century who were introduced to the disease via their husbands. How did women experience syphilis, to what extent did it inform their activism, and, perhaps most importantly, what were their options in dealing this disease before penicillin, widely available birth control, and the right to say no? Using Gardener's letters, sex reform journals including "Lucifer the Lightbearer," 19th-century medical journals, and the digitized syphilis collection available via Harvard's library, this paper explores syphilis at the intersection of medical, gender, and women's history.

keywords: syphilis, sex reform, women.

- 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)
- Deepen understanding of illness and suffering

D1. Gendered Interventions

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Medicalizing and De-medicalizing HIV Prevention: The Case of Male Circumcision in Uganda

Since the earliest investigations into the AIDS epidemic in Africa in the mid-late 1980s, male circumcision has been among the factors that were seen as potentially related to infection rates. Against the backdrop of major clinical trials conducted between 2004 and 2008 designed to demonstrate the efficacy of male circumcision for HIV prevention, the promotion of male

circumcision in Uganda offers an entry point into the complex interactions between basic science investigations, public health, culture, and society during the HIV/AIDS pandemic. Critics have characterized widespread campaigns for male circumcision to prevent HIV as part of the medicalization of HIV prevention efforts. However, the Rakai Health Sciences Program (RHSP) in Uganda explicitly aimed to de-medicalize HIV prevention strategies including circumcision in order to more effectively target sexually active men, who are perceived as unresponsive to health messaging. In 2013 RHSP designed a media-savvy campaign called “Mwami Mulembe” or “Stylish Man” that told Ugandans that stylish, modern, desirable men are circumcised. But other innovations in circumcision promotion from the RHSP invoke old tropes about health, cleanliness, and circumcision, including a pair of music videos in Luganda and English featuring popular Ugandan recording artists. A historical consideration of the ways in which circumcision in East Africa has been understood as health-related or otherwise from the pre-colonial past to the present can inform our understanding of how those legacies shape contemporary debates about male circumcision. Evidence from oral histories, participant observation, promotional materials, medical journal articles, and unpublished documents from the RHSP suggest that the drive for male circumcision in East Africa illuminates the tension between the medical and the non-medical aspects of HIV prevention. It also forms a new development in the longstanding evolution of ideas about the foreskin, hygiene, male sexual health, and masculinity.

- 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

D2. Forensic Anatomies

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Bioarchaeology and Enslaved Communities: What We Learned about the Enslaved People at Grassmere Historic Farm, Nashville, TN

Most enslaved people in the United States from the early 1600s through 1865 were not allowed to read and write and therefore left few written records of their illnesses and general health status. The extant written records of their owners provide us with the biased view of the dominant class commenting on the subordinate class. Public historians at Grassmere, an 1810 farm in Nashville, TN, have no written records through which they can learn about the health of the enslaved population there. When a cemetery for twenty enslaved people was relocated in 2014, the examination of their remains provided us with new knowledge about their lives.

Although the field of bioarchaeology has existed since the 1970s, it has been largely ignored by historians. We will first explain what sorts of illnesses, infections, and other health factors leave marks on bones that bioarchaeologists can find and examine. We will then show how bioarchaeologists can interpret this information to learn more about the health status of the deceased. We will then apply this knowledge to the raw data gathered from examining the remains of these twenty enslaved people from Grassmere. Using research articles written about the bioarchaeology of other enslaved communities we will compare our findings to those at other sites, such as the African Burial Ground in Manhattan.

While this paper will focus on enslaved communities, the methods and interpretation used are applicable to all people. They have proven useful in learning more about other historic communities who did not leave many written records, such as the early residents of Jamestown, VA. The same techniques have also been helpful in more recent times, as when the remains of the Romanov family were identified and when victims of genocide buried in mass graves have been exhumed and examined.

- Show how bioarchaeology can supplement what we learn from the historical record about the health status of the deceased.
- Recognize that the health status of enslaved populations was a direct reflection of their treatment by their owners and that information learned through bioarchaeology may change our view of the history of some sites.
- Showcase a different method of learning about the past that is often overlooked by historians.

D2. Forensic Anatomies

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The Emergence of Forensic Odontology in Disaster Identifications in the Post World War II Era

Although American and European dentists had advocated for the use of teeth in disaster victim identification since the nineteenth century, forensic odontology did not attain its significant role in such identifications until the 1940s. This paper examines the political, social, and cultural factors behind its broader application in the 1940s to explain how and why the existing technique of dental exams, already in use in medico-legal investigations, gained wider acceptance as a disaster tool in this period. I argue that the success of forensic odontology was predicated upon a quick succession of disasters in which the failure of more common identification techniques, specifically sight recognition and fingerprinting, provided dentists the opportunity to demonstrate and publicize the value of their work on a large scale. Using scientific articles, official records and disaster reports, photographs, and film, I will detail the use of dental exams in the identification of concentration camp victims after World War II, explosion victims in Texas City in 1947, and burn victims from the 1949 Noronic ship fire in Toronto to deepen our understanding of the histories of dentistry and forensic odontology in

action. Furthermore, I will situate these successes within dentistry's growing professional standing, as well as the expanding authority of scientific experts in the field of disaster response in the postwar period to articulate why the earlier advocacy for dental exams finally came to fruition when it did.

- Provide a richer understanding of the history of forensic odontology in disaster contexts, rather than medico-legal ones.
- Examine the gap between the availability of a useful technology and the acceptance and applicability of that technology in disaster.
- Analyze the importance of political, social, and cultural factors in the application of existing forensic technologies.

D2. Forensic Anatomies

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Bodies of Knowledge: The Battle for the Science of Anatomy in U.S. Army Identification Efforts of World War II Remains, 1948-1951

In 1948, Dr. Mildred Trotter arrived at the U.S. Army's recently established Central Identification Laboratory (CIL) on the island of Oahu. Assistant Professor of Anatomy at Washington University's School of Medicine in St. Louis, Trotter was tasked with leading the CIL's scientific efforts to identify the skeletonized remains of unidentified casualties from World War II. Working under the American Graves Registration Service (AGRS), Trotter assisted in processing hundreds of remains and redefined forensic standards still in practice today. Outside of being a pathbreaker in a largely male-dominated field, Dr. Mildred Trotter's experiences also reveal a battle over the role of scientific expertise in efforts to identify the remains of fallen servicemen. Medical histories of war typically focus on the systems and methodologies that have developed to preserve and repair the lives of those who are wounded or fall ill in conflict. Indeed, there is a sense that the body, after death, transitions into a realm of expertise outside of medicine -- it is no longer the doctor's domain, but the embalmer's the archaeologist's. However, medical knowledge and expertise did play (and continues to play) an important role in processing the remains of war. In fact, World War II marked a formative chapter in the anatomy and science of human identification, providing a tremendous historical opportunity to explore the beginnings and the ends of medical knowledge.

This paper will first provide an overview of the AGRS in WWII and an examination of the ways in which the bodies of the war dead were processed. Secondly, building heavily from Trotter's personal papers, it will reveal the secondary battles that surrounded identification efforts after the war. As military leaders pressed for identifications, the science of anatomists such as Trotter provided both advances and limitations that sometimes met resistance. Ultimately, this paper will offer a glimpse into the ways in which medical knowledge offered

both contributions and challenges to the U.S. government's efforts to identify and return fallen soldiers to their families.

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

D3. Medicine and Society in the Imperial Century—Pushing Boundaries in Time and Space

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Come-By-Chance: The Peculiar Pull of Medical Practice in Newfoundland, 1951-1961

The transnational migration of physicians figured prominently in twentieth-century medicine. The 1950s and 1960s, in particular, witnessed a dramatic relocation of foreign-trained doctors to the United States and Canada. While some emigrant physicians settled in larger cities, many populated remote areas of North America. The island province of Newfoundland is a striking example of this phenomenon; by the 1960s, immigrant physicians represented almost one quarter of the province's medical profession and were often the sole practitioners for small, isolated communities. This paper takes Newfoundland as a case study of rural medical practice, examining the socio-demographic background and clinical practice of these doctors. In particular, it will analyze the composition of the Newfoundland medical workforce through contemporary Canadian and American medical directories. This quantitative analysis will be supplemented by qualitative sources, including obituaries of Newfoundland physicians in the Canadian Medical Association Journal, reports published in the British Medical Journal, and the testimony of Newfoundland representatives to the Royal Commission on Health Services (1961-64).

As this paper will demonstrate, the majority of the foreign physicians registered in Newfoundland between 1951-1961 had received their training in the United States, Britain and Ireland. Although there was a high turnover rate of medical practitioners, some foreign-trained doctors became permanent fixtures of island medical practice. For instance, Dr. John Olds, a Yale University graduate from Connecticut, participated in the Johns Hopkins School of Medicine summer program in Twillingate, only to find himself returning upon graduation and servicing the area until his death. Though many general practitioners were the only doctors for entire communities, larger towns attracted a variety of foreign-trained specialists. In addition, far from being at the fringes of health services, Newfoundland allowed physicians the opportunity to work in one of North America's earliest systems of publicly-funded health care: Newfoundland's Cottage Hospital system constituted a network of small local hospitals staffed by medical professionals paid for by the province. This study thus provides insights into the dynamics of transnational medical migration, but also illuminates the challenges and

opportunities of medical practice in rural and remote areas in the middle of the twentieth century.

- Understand the evolution of modern medical practice through learning about the transnational migration of physicians in the twentieth century
- Explore the unique circumstances surrounding the Cottage Hospital System and salaried doctors in mid-century Newfoundland
- Appreciate the opportunities and challenges of rural and remote medical practice

D3. Medicine and Society in the Imperial Century—Pushing Boundaries in Time and Space

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Lymphs for Sale: Vaccination and Scientific Authority in British Imperial Africa, 1880-1903

Between 1880 and 1903, white district surgeons feared that arm-to-arm vaccination in South Africa was spreading leprosy in both black and white populations, leading the Cape government to establish a vaccine farm at Grahamstown to manufacture "pure" vaccine lymph. In 1901, the East Africa Protectorate followed South Africa's lead to establish its own vaccine farm in Entebbe, Uganda. However, the Foreign Office in London protested these new research centers, fearing the decreased need for imported English lymph that resulted in a loss of British governance over both indigenous bodies and its own colonies. While historians have previously dealt with vaccination policies in Britain and British India, vaccination in Africa during the long nineteenth-century remains largely untouched. Yet vaccination played an important role in imperial African politics, preventing smallpox epidemics while marking indigenous bodies as colonial subjects. I argue that through vaccination, British South Africa attempted to westernize black African bodies and Anglicize its neighboring territories, the Transvaal and the East Africa Protectorate, as a means of maintaining authority, replacing London as the only source of British influence in Africa and reifying its role as the leading scientific and economic power in the region. My comparative approach uses South Africa, not London, as an origin for medical knowledge, a case study showing how South African British medical officials corresponded with those in the East Africa Protectorate to share knowledge and medical tools like lymph. This paper thus views the British Empire as a decentralized network of ideas and medical knowledge instead of a flow strictly between the metropole and the colony and uses the experiences of British-trained South African district surgeons, East Africa Protectorate officials, and black and white African vaccination subjects – white British and Afrikaner settlers, and indigenous Africans. These views come out of a variety of sources, particularly peer-reviewed medical journals, Royal Commission on Vaccination depositions, and Foreign Office correspondence records. My study thus suggests that South African medical officials used their epistemological authority in order to influence imperial subjects and territories, upholding its status as a leading scientific powerhouse, even as a mere colony.

VACCINATION, AFRICA, EMPIRE

- 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)

D3. Medicine and Society in the Imperial Century—Pushing Boundaries in Time and Space

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Between Sickness and Health: Bounding Convalescence in Late Victorian England

This paper explores the framing of “convalescence” in late nineteenth- and early twentieth-century England. While historians of medicine have devoted considerable attention to the framing and construction of disease, sickness, and illness, comparatively little work has focused on categories of convalescence and recovery. In late nineteenth-century England, hundreds of convalescent institutions were founded to care for working-class patients recovering from hospital stays, surgeries, and illnesses. I argue that designating particular patients as “convalescent” was fraught with complexity. The meaning of convalescence, which occupied the liminal space between illness and health, was subject to constant negotiation and contestation, and convalescent institutions engaged in continual boundary work to control the sorts of patients they cared for. Nevertheless, convalescence operated as a powerful claim on sympathy, charity, and medical care in late Victorian culture, which required new categories in which to place experiences of ill health that were being gradually excluded from the shrinking boundaries of ever-more-specific disease definitions.

Using administrative documents, admissions records, institutional rules, and philanthropic reports, I show that various stakeholders emphasized different characteristics of convalescence. Hospital physicians saw convalescent care as an opportunity to free up hospital beds, while convalescent home governors sought to avoid admitting the chronically ill, patients requiring acute care, the contagious and consumptive, and those who might disturb other patients. Meanwhile, philanthropic groups like the Charity Organisation Society emphasized restricting convalescent relief to only those likely to make a rapid return to health and work. I argue that these tensions helped give shape to a “convalescent role” in late Victorian culture. In contrast to the figure of the invalid, which epitomized withdrawal and stasis, the convalescent implied progress, movement, and resolution, suggesting the possibility of reconciliation between economic progress and social dislocation; between industrialization and individual health; and between urban disruption and family stability. I also examine how changes in medical knowledge and practice—particularly advances in surgical techniques—created pressure for greater provision of post-surgical convalescent care in the first decades of the

twentieth century, expanding conceptions of what sort of patients could properly be considered “convalescent.”

Key words: convalescence, recovery, disease categories

By the end of this presentation, the learner will:

- Deepen understanding of the historical boundaries between illness and health
- Understand the role of convalescent care in the emergence of modern health systems
- Recognize the dynamic relationship between medical care and cultural values throughout history

D4. The Technical and the Ethical in the Medical Cold War

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“One simply doesn’t arbitrate authorship of thoughts:” Socialized Medicine, ‘Medical McCarthyism,’ and Publishing Rural Health and Medical Care (1948)

The blurb for Paul Starr’s book of “Obamacare” notes that in “no other country has health care served as such a volatile flashpoint of ideological conflict... [and] rancorous debate...” Starr himself writes about the “virulence of...political battles over health care,” and the concomitant “ideological warfare...in American politics.” Such 21st-century rhetoric had its analogue in 20th-century “McCarthyist” America, as this study of publishing *Rural Health and Medical Care* (RHMC) in 1948 demonstrates. This discussion highlights how physicians and their ideas, a group often overlooked by historians studying this era, could be political casualties. Drs Frederick Mott and Milton Roemer co-wrote RHMC, a seemingly dry technical monograph that was in actuality a blueprint for socialized health insurance for America. Due in part to his “association” with persons deemed political undesirables, in 1946 Mott gave up his Public Health Service position in Washington, DC to assume, on the personal recommendation of Henry Sigerist, a Canadian provincial civil service position in the new “leftist” Saskatchewan government (becoming Deputy Minister of Health despite holding American citizenship). Roemer, also a Sigerist disciple, would similarly migrate to Saskatchewan, but not before he had defended his loyalty to the US government (as his papers at Yale University attest), only later to have his passport confiscated.

The manuscript of RHMC was the subject of a dispute with the New York Academy of Medicine (NYAM) due to its socialized medicine message. The NYAM appears not to have any documentary memory of this event, but Mott’s documents in the Canadian national archives contain personal and legal letters pertaining to it (augmenting this is private correspondence between Roemer and Sigerist). The book was to be published in a series sponsored by the Commonwealth Fund but administered through the NYAM’s Committee on Medicine and the Changing Order under the general editorship of physician-historian Iago Galdston, who initially

requested that the authors cut sizeable portions. Mott and Roemer, sensing censorship, refused and requested the manuscript be returned. After legal intervention, the NYAM released the manuscript allowing the authors to publish the unexpurgated book through McGraw-Hill. RHMC garnered appreciative reviews in the Canadian, British and American medical press (excepting the AMA). In the end the authors were vindicated, although their vision for healthcare in America was never realized.

- To discuss censorship in medical publishing
- To investigate the phenomenon of medical McCarthyism and its relations to socialized medicine
- To explore the medico-political landscape of 1940s America

D4. The Technical and the Ethical in the Medical Cold War

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Vascular Surgery in the Korean War and the Implementation of Vessel Repair

In World War II, 50% of combat-related vascular injuries resulted in limb amputation. Just seven years later at the end of the Korean War, the amputation rate had fallen to 12%. Vascular surgery – the operative repair of damaged blood vessels – accounted for the difference. Whereas in World War II, literature documents a 1% incidence of repair, by 1953 US military surgeons attempted to fix 95% of torn arteries. Drawing on extensive archival records, interviews, and medical literature, my presentation examines this change.

Modern vascular surgery emerged in the late nineteenth and early twentieth centuries as part of the general surgical renaissance following anesthetic and aseptic technology. Pioneers like 1912 Nobel Prize recipient Alexis Carrel developed new techniques to anastomose and repair vessels. Yet despite broad publicity and demonstrated superiority of these methods, surgeons rarely employed them – until the Korean War. Between 1950 and 1953, repairing arteries transitioned from a rare, remarkable occurrence to the standard of care on the battlefield. Even before official military medical doctrine changed, individual surgeons simultaneously but independently adopted vascular repair techniques. As these interventions proved successful, they spread throughout military hospitals in Korea via both informal interpersonal networks as well as classes organized to educate newly drafted physicians. By the end of the war, uniformed surgeons regularly applied advanced reparative methods like anastomoses and vein grafting to restore blood flow to wounded soldiers and their previously unsalvageable limbs, allowing them to return to society as fully functional citizens.

My talk seeks to recount and explain this transformation. Investigating the application of modern vascular surgery expands the work of other historians, especially Thomas Schlich, in trying to understand the processes of how not only the techniques but also the workaday practice of surgery changes. The widespread, effective use of arterial repair in the Korean War was driven by factors that included superior training of surgeons, stable front lines with a

comparatively low rate of casualties, and ancillary medical advances that enabled surgeons to support patients through complex operations. Examining these factors highlights the importance of the social, military, and medical milieus necessary to advance surgical practice.

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

D4. The Technical and the Ethical in the Medical Cold War

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Veterans' Health Battles: World War II Mustard Gas Experiments and the U.S. Army Archives in the 1990s

In the early 1990s, veterans' health battles erupted in the United States when the government acknowledged that mustard gas experiments had been conducted on servicemen during World War II. This paper investigates the debates over government responsibility for veterans' health needs. After completing my book, "Toxic Exposures: Mustard Gas and the Health Consequences of World War II in the United States," I came across a fascinating set of Department of Defense records online. These 1200 pages of correspondence and reports reveal how the politics of health and war played out in the 1990s in clashes between the Department of Defense, the Veterans Administration, and the White House over "military hazardous exposures."

In 1990, the Veterans Administration announced that it would recognize that the current illnesses of some World War II veterans were associated with mustard gas experiments, notify veterans, and make it easier for them to collect benefits. However, that did not happen. Then political pressure on the Defense Department led to the creation of the "Chemical Weapons Exposure Project" (1993-1997). Staff combed classified records in Army archives across the nation to identify the names of personnel exposed to chemical, biological, and nuclear agents during World War II and the Cold War. This project located the names of 4000 soldiers who were exposed to mustard gas during World War II. Furthermore, in 1993 and 1994 politicians and veterans' advocates warned President Bill Clinton about the potential fate of the mustard gas veterans. They worried that public revelations at the time about American Cold War era human radiation experiments would eclipse recent disclosures about World War II mustard gas experiments. In particular, Senator Porter Goss, a later CIA director, feared that the health needs of "atomic veterans" would overshadow those of "mustard gas veterans." As it turned out, he was right. As a 2015 investigation by National Public Radio (NPR) revealed, justice for mustard gas veterans has still not happened. Today Senator Claire McCaskill, a senior member of the Armed Services Committee and the daughter of a Second World War veteran, is leading a new battle for the mustard gas veterans.

- Deepen understanding of how war shapes government health policy
- Recognize the dynamic interrelationship between medicine and society through history
- Develop an historically informed sensitivity to veterans as patients

D5. Rights and Trust in Global Medicine

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“Rights” of Passage: Terminal Care Reform in the United States, 1960 – 1976

During the 1960s, the U.S. Department of Health and Human Services Division of Nursing funded research on the experiences of terminally ill patients and their families within the social context of hospitals. Jeanne Quint [Benoliel], Anselm Strauss, and Barney Glaser were co-investigators on one of these studies in San Francisco. Research transcripts and field notes from this study offer an in-depth analysis of patterns of communication among patients, family, and health professionals. Florence Wald was the Principal Investigator of another interdisciplinary study of the dying patients and their families in New Haven, Connecticut. Transcripts from this study provide a rare and detailed account of the early years of the American hospice movement. Both studies capture the plight of the terminally ill within an increasingly curative medical milieu and fueled mid-twentieth century terminal care reforms, albeit differently. The significance of these studies remains relatively invisible in the historical record.

This paper draws on archived research transcripts, field notes, team meeting minutes, oral histories and research publications, and correspondence between the researchers and international hospice leaders to critically analyze the cultural politics of mid-twentieth century terminal care reforms. The research records reflect divergent interpretations of the meaning of illness, place, disciplinary function and authority, and dominion over terminal care among professionals, patients and their families. They also evidence the cultural politics some nurses encountered as they sought shared power and interdisciplinary collegiality with physicians and other researchers. These nurses successfully negotiated intraprofessional politics to effect reforms in institutional care for the dying, create alternatives to institutionalized dying, and incorporate elements of end of life care into nursing curricula. Yet, as these reforms gained traction, distinctions of class, gender, and disciplinary authority permeated their negotiations for equitable distribution of power and authority to direct such care and lead interdisciplinary research teams. Findings from this study are particularly germane to contemporary discourse on interdisciplinary models of palliative care for persons with serious and advanced illness.

- Understand the dynamic history of mid-twentieth century terminal care reforms.
- 2. Explicate how shifting professional paradigms, public investment in the health professions, and broad social reform created a rich environment for terminal care reforms to prosper.

- 3. Discuss how and why interdisciplinary politics both supported and thwarted terminal care reforms as they gained traction.

D5. Rights and Trust in Global Medicine

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Doctoring Equivalency: Standardizing Global Medical Knowledge

In 1965, the US Congress passed the Hart-Celler Immigration and Nationality Act to expedite the migration of skilled professionals to the United States and ameliorate a national doctor shortage. Foreign Medical Graduates (FMGs) from predominantly postcolonial Asian nations were amongst the largest groups of immigrants to enter. These physicians completed their medical education and training outside of the United States and joined the US healthcare system as interns and residents. In exchange for their service, they were granted legal status. Although these physicians were invited into the nation to provide medical service in underserved rural and urban communities, their doctoring required management that was different than their US counterparts. Documents were a central mechanism to manage this transition. The foreign physician was required to produce an archive of their expertise, a compilation of documents that vouched for their medical knowledge and simultaneously formed the basis for their entry. In this paper, I analyze the stepwise production of this archive, the process by which an undocumented foreigner lost their postcolonial obscurity to become a documented medical expert. Despite undergoing this process of bureaucratic equivalency, the care provided by foreigners was marked as different, an imperfect facsimile of their US counterparts. For example, often based on their paperwork, foreign physicians were denied hospital privileges or promotion possibilities. In the late 1980s, FMGs became frustrated with discrimination based on the form of their archive and politically mobilized demanding equal documentary requirements as their US colleagues. Although the archive of expertise allowed the foreign physician entry into the United States, it also consolidated their foreignness by affixing them with the classificatory label Foreign Medical Graduate, orienting them always towards the outside. I show how the effects of this bureaucratic translation extended beyond the margins of documents and structured their sense of self, memory, and belonging in the United States.

- 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. Rights and Trust in Global Medicine

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Social Inequality, Adverse Effects of Medical Treatments, and Mistrust in the Medical Establishment: The Case of the Radiation Therapy in the United States and Israel

What is the relationship between unintended adverse effects of medical treatment, social inequality and public mistrust in the medical establishment? How do the impacts of such errors on trust vary between cases and what explains the differences? In this paper we explore the sources of mistrust in the medical establishment that result from the discovery of adverse effects of radiation treatment.

In the early 1970s, medical research confirmed the long-standing suspicion that children and young adults treated with radiation for benign diseases, during the 1950s and 1960s, showed an alarming tendency to develop thyroid cancer and other ailments as adults. The research presents in detail the effect of this discovery on patients who had been treated with radiation in Israel and the United States.

In Israel, most of the patients who underwent radiation treatment were from the Mizrahi ethnic group: Middle Eastern, Asian, and North African Jewish immigrants, most of them from Arab and Islamic countries. The Mizrahi are, mostly from lower socio-economic classes, and believed that they had been singled out for this treatment. The discovery of the adverse effects and the failure to effectively communicate with the group led to broken trust in the medical establishment, suspicion, hostility and conspiracy theories that continue to poison this issue.

In the United States, the private nature of its healthcare system meant that those who underwent radiation treatment were those who could afford it - patients from middle or upper middle classes almost all of whom were white. Unlike in the Israeli case, no such hostility and broken trust observed against US health authorities.

Based on official protocols, interviews, formal announcements, court rulings, newspaper archives, and other documentary evidence, we investigate why similar adverse effects have led to different level of trust toward the medical establishment in both countries. We show that social inequality in society and failure to communicate and effectively alert former patients about the adverse effects, are important factors for understanding mistrust in health authorities that are yet to be examined.

- To examine what can be done to improve the confidence of marginalized groups in the medical establishment.
- To explore how health authorities can effectively communicate with the public after the discovery of adverse effects of drugs and medical practices.
- To understand what are some of the negative consequences of mistrust in the medical establishment.

D6. Radical Health Politics in 20th Century America

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For the Peoples' Health: The Health Activism of the Young Lords Party, White Lightning, and New York City's Radical Hospital Workers, 1969-1978

During the late 1960s and early 1970s, a number of the period's radical left organizations seized upon health as a central issue and sector upon which to agitate. In 1969 and 1970, the New York chapter of the Young Lords Party (YLP), a political organization modeled after the Black Panther Party consisting primarily of young Puerto Ricans, engaged in a flurry of health-related campaigns along with radical hospital workers, physicians, and recovering drug users. Scholarship by Merlin Chowkwanyun and others reveals how physicians allied themselves with the YLP in an effort to improve the deplorable conditions at Lincoln Hospital in the South Bronx. This paper draws from oral historical, archival, and published material to more deeply explore the related activism of the Health Revolutionary Unity Movement (HRUM), a city-wide organization of African American and Puerto Rican hospital workers, and White Lightning, an organization of recovering drug users that emerged from a rebellion within a therapeutic community based in Lincoln Hospital.

Responding to one of Nancy Scheper-Hughes' propositions for a critical medical anthropology, I explore how radical organizations targeted Lincoln not simply to improve its conditions, but also to use it as an experimental space to develop a revolutionary social medicine. The Lincoln Detoxification Clinic provides a striking illustration of how these activists' approach was put into practice. Launched and staffed by YLP and White Lightning members, a key component of the clinic's drug rehabilitation strategy was to provide political education classes indicting capitalism for causing the drug epidemic. In rejecting the Foucauldian medical gaze in favor of a structural analysis, they challenged the misrecognition that addiction was a personal failing and confronted the symbolic violence, as theorized by Pierre Bourdieu, wrought by dominant responses to drug use.

The YLP and their allies provide an early historical example of radical health reformers who have challenged the behavioral etiological framework, as examined by Dorothy Porter. Clinicians and advocates can draw lessons on how organizations have linked health issues to a transformative political agenda, created a popular language for discussing the social determinants of health, and established vibrant alliances between communities and medical professionals.

- 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 the role that social movements have played in shaping public health and medical practice in this country.
- Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.

D6. Radical Health Politics in 20th Century America

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A Load off Whose Heart? Juvenile Delinquents, Unmarried Mothers, and the Politics of Respectability and Race Representation in Harlem, 1943-5

In the United States during World War II, racial liberals, looking to counteract racist skepticism about black fitness for equal opportunities, promoted black subjectivity as normal and respectable in terms of conventional sexuality and gender expectations. As I will attempt to argue, one of the effects of this political strategy was that the civil rights agenda championed the cause of delinquent black males while rendering young unmarried mothers and their needs effectively invisible. This paper examines how one progressive psychiatrist in Harlem, Dr. Viola W. Bernard, sought to present the minds of troubled African American children to the public as fundamentally human without reinforcing pernicious stereotypes about the black race. Between 1943 and 1945, Dr. Viola W. Bernard and New York's charitable Community Service Society (CSS) balanced race and the demands of normative gender and sexuality in determining how to publicly present the cases of a black male teen and black female teen. Throughout, I compare the extensive case files she generated with the record of her published and unpublished attempts to share her findings with others. The young man's race was scrubbed of sexual content intentionally politicized in the ongoing debates over wartime juvenile delinquency. Conversely, in the case of the young unmarried mother, Bernard did not tie her case to those same debates nor racialize her case as strongly when she presented it in the mental health literature. As we shall see from this comparison, the process of transforming personal details from psychological case files into narratives useful to the black freedom struggle, the civil rights era's politics of respectability helped determine what was and was not a matter of racial justice.

keywords: psychiatry, politics of respectability, civil rights era

- Recognize the dynamic interrelationship between patient care and the politics of race and gender that operate within a clinical setting in a specific time period.
- Understand how political pressures specific to a given historical era can sometimes influence the choices that clinicians make when selecting details from patient records to produce published case studies.
- Develop a greater critical awareness and tolerance for the ambiguity that often comes into play when seeking to both demonstrate cultural competency and maintain one's own political and moral integrity in the achievement of optimum patient health outcomes.

D6. Radical Health Politics in 20th Century America

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Building a Farm Workers' Health System: The UFW Clinics in California, 1965-1975

The United Farm Workers (UFW), led by Cesar Chavez and Dolores Huerta, was one of the most influential U.S. social movements of the 1960s. Most famously, they led a nationwide grape boycott that forced employers to recognize farm workers' right to organize and to address the notoriously exploitative conditions of agricultural labor in California and the Southwest. While the UFW's labor and civil rights actions have been extensively studied by historians, no scholar has yet examined the organization's attempts to provide health care to its members.

This paper will discuss the health clinics of the United Farm Workers, which were set up between 1965 and 1975 in several locations in rural California. The UFW first began enlisting volunteer physicians and nurses to provide medical aid to striking workers on the picket line during the famous grape strike in Delano, California. Soon Chavez and other UFW leaders, including nurse Peggy McGivern, decided to establish a permanent clinic in Delano that would serve as a model for future health facilities for farm workers. The Delano clinic provided first aid, emergency care, prenatal and well-baby care, and other types of health services. In addition, Chavez and McGivern believed that a health care system managed by union members themselves would serve as a crucial tool of organizing and empowerment in the farm workers' struggle for human rights.

The paper is based on research in the United Farm Worker Archives at the Walter Reuther Library in Detroit, Michigan, as well as other archival materials in Arizona and California libraries. This research is part of the author's larger project on the history of health care for immigrants and migrants in the United States.

Key words: farm workers, rural health, Latinos/Mexican Americans

By the end of this activity, the learner will:

- Develop understanding of health care provision for farm workers, the most vulnerable group of workers in the U.S.
- Evaluate the roles of patients, providers, and activists in building a community-based health care system
- Understand the leadership of health care providers in a major social movement

E1. A Place at the Table: Researching at the Intersection of Medical History and Food Studies

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"Lose Like a Man:" Weight Watchers, Masculinity, and Health, 1963-2016

Considered a “masculine” endeavor in the later decades of the nineteenth century, weight loss diets narrowed their focus after 1920, predominantly targeting women. In subsequent decades, dieting itself became coded as “feminine” in American culture, as did the fat male body, no longer a symbol of affluence and success. This paper employs the Weight Watchers program (1963-2016) as a case study to examine the role and meaning of men and masculinities within the United States’ most popular commercial weight loss program across the latter half of the twentieth century and into the twenty-first. Such a study demonstrates how commercial weight loss programs have contributed to inter-related cultural definitions of gender, health, and citizenship through the body, food, and ways of eating.

Weight Watchers launched its first “men only” diet program in 2007 with Weight Watchers Online for Men. Seeking to aggressively rewrite gendered dieting scripts, the program admonished male dieters, “Lose Like a Man.” Despite this more recent innovation, men have had a presence in the Weight Watchers program since its inception. Jean Nidetch incorporated Weight Watchers in 1963 with herself, her husband (Marty Nidetch), and Felice and Albert Lippert as the four founding members. All four founders had lost significant weight on the program and endorsed its approach, which combined strict dietary recommendations and in-person group meetings for discussion and social support. Furthermore, press coverage throughout the 1960s, 1970s, and 1980s consistently covered both male and female Weight Watchers.

Drawing from Weight Watchers program advertising, coverage in newspapers and magazines, and cookbooks and other ephemera, this paper tracks and unpacks the undulating role of gender—particularly hegemonic masculinity—in the fashioning of cultural ideas about diet programs, weight loss, food, bodies, health, and biocitizenship.

- Develop an historically informed sensitivity to the diversity of patients, particularly the consideration of gender identity in understandings of the body and health status.
- Develop the capacity for critical thinking about the nature, ends and limits of medicine as they relate to weight management.
- Deepen understanding of overweight, obesity, and weight loss within a cultural context.

E1. A Place at the Table: Researching at the Intersection of Medical History and Food Studies

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The Role of Biography in the History of Nutrition Science: The Case of W.O. Atwater

The chemist and physiologist W.O. Atwater has been a prominent figure in nearly all histories of nutrition science in America in the nineteenth and twentieth centuries. Atwater was a student of the most influential physiologists in Europe, a teacher in his own right, as well as a scientific entrepreneur, political operator, and able publicist of his own work. He also carried on a research program encompassing both field research on popular nutrition and intricate laboratory work on human metabolism. The scientific, political, and pedagogical sides of the

man are well understood; what about the intellectual? Drawing from Atwater's speeches and correspondence, this paper will sketch the outlines of an intellectual biography of Atwater, placing him in the context of late nineteenth-century social and religious thought and situating him within a network of transatlantic liberal reformers. While often considered by historians to have a narrow focus on policing the dietetic mores of the working class, Atwater saw his own interest in the food question as part of a broader effort by economists and sociologists to find "the fundamental basis of human living," as he put it. His work was the American part of a broader international initiative to answer the food question by finding a universal dietary standard. More privately, Atwater was a Methodist of deep religious feeling, and his faith animated his interest in nutrition. He largely kept his faith from his scientific colleagues, preferring to discuss it with his friends in Christian philanthropic circles and the settlement movement. He thought that better nourishment was the ground upon which spiritual and social progress would grow, and his aim as a scientist was to bring this progress about. In framing a narrative of Atwater's life and thought, this paper will consider how scientific biography, and intellectual history more broadly, could be used as a tool for understanding the history of nutrition in America.

Key Words: Nutrition, Biography, Reform

- Understanding the dynamic history of social, medical, and scientific ideas about diet and nutrition
- Recognize the changing interrelationship between medicine and society through history
- Develop the capacity for critical thinking about the nature, ends and limits of medical science

E1. A Place at the Table: Researching at the Intersection of Medical History and Food Studies

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From Galen to Kale'n: The 'Obvious' but Fraught Union between the Histories of Food and Medicine

Food is in vogue. Two publications from this past year—Jeffrey Pilcher's review essay for the *American Historical Review* and Sara Pennell and Rachel Rich's introduction to their food-themed special edition of *Social History of Medicine*—bear witness to the increasing allure of food issues in historical scholarship. In his impressive history of food studies, Pilcher identifies food history as a major academic force to cross disciplinary lines and connect the academy with the public. Although Pilcher sees food history as an ideal marriage between cultural and material histories, culminating in what he calls, 'the embodied imagination of taste, purity, and hunger,' he largely excludes medical historians and medical issues from his assessment of the field.

Though the overlap between food and medicine may seem obvious when we consider the role of the body in history, in their survey of three decades of SHM, Pennell and Rich explain that 'cross-fertilization between the two has remained intermittent and limited.' They point to a fundamental flaw of historians of medicine to draw disciplinary boundaries around what 'counts' as history of medicine, which often excludes the 'soft' science of nutrition, and undervalues domestic, rather than institutional texts or frames.

Food has been primarily used to further existing medical history arguments rather as a site for novel historical interpretations—and vice versa. In tracing these recent publication developments and the traditions that underlie their arguments, this talk interrogates disciplinary boundaries that have limited the potential cross pollination of food history and medical history. Specifically, I will examine the historical overlaps between these two historical traditions, as well as identify potential sites for future inquiry, with a particular focus on the productive interplay between such traditional food studies issues as social distinction, industrial transformation, and food politics and crucial embodied medical concepts like health, nutrition, taste, and digestive physiology. Ultimately, this talk seeks to highlight the unrealized potential for food history to reimagine the core of the discipline.

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

E2. Rediscovering the Asylum: New Institutional Histories

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Crippling the Asylum: Disability Histories of Institutions for the Feeble-minded

Beginning in the 1840s, thousands of American children found their way into institutions for the feeble-minded. They were initially conceived as educational and therapeutic spaces for children who could not meet the standards expected of their age, class, race, and gender. Parents accessed the institutions to provide respite, vocational training, and sometimes outright custodial care; but rarely sought to “hide” their disabled children. By the end of the nineteenth century, however, the institutions formed the cornerstone of the eugenics movement.

Although most nineteenth-century Americans with disabilities did not live in institutions, in this paper, I argue that we cannot understand their lives without institutional histories. Following the intense debates of the twentieth century, historians have largely turned away from institutional histories. This stems from several factors, including concerns that relying on institutional records might reinscribe patterns of oppression. I use critical disability theory to

mitigate some of these concerns, drawing on state institution records, professional and medical journals, and a unique collection of case histories from a private institution in Massachusetts. Institutional sources can overcome historical invisibility. Reading these sources against the grain, contextualizing them within the larger medical and political histories, and triangulating them with non-institutional sources, allows us to breathe life into characters who otherwise would remain firmly in the shadowy margins of our histories.

Although contemporary experts argued that feeble-mindedness was an intellectual deficit, records show that children were admitted to such institutions for a dazzling array of perceived incapacities. Moreover, it was parents—not physicians—who largely determined the timing of admission and discharge, according to their private judgments of the institutions' therapeutic and economic efficacies.

Finally, institutional sources can identify historiographic oversights. Comparing the rhetoric and practice of feeble-minded institutions suggests that feeble-mindedness—not insanity—was the broad, catchall diagnosis of disability in the nineteenth century. Although historians have largely focused their attention on psychiatry and its institutions, feeble-mindedness closely reflected—and shaped—cultural anxieties about dependency, unemployment, and degeneration in the contemporary American psyche.

- Understand disability as a socio-culturally constructed identity
- Identify successes and failures in the history of medical professionalism
- Critically appraise clinical management from a historical perspective

E2. Rediscovering the Asylum: New Institutional Histories

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Asylum Politics: Fatigue, Flight, and Unresolved Questions

Everyone has tired, it seems, of asylum politics. From anti-psychiatry and anti-anti-psychiatry to revisionism and post-revisionism, historians of psychiatry now find themselves running away from the partisan battles of historiographies past. Admittedly, in a post-dehospitalization age, it is hard to muster the outrage that once attended revelations of asylum abuses, from involuntary commitment to snake pits and perennial neglect. Instead, it feels more proper to locate oneself in a dutifully contextualist intermediate zone, occasionally tinged by nostalgia for a time when institutions “still mattered”—or, more earnestly, existed to serve the patients who needed them.

But how representative are such sentiments, both within and beyond the scholarly community? To what degree are they symptomatic of a broader geographical imbalance in asylum scholarship? This paper poses those questions from the unique but suggestive case of Mazorra, Cuba's first, and until 1959, its only public psychiatric facility. Speaking from a context in which that institution has long been—and still remains—deeply politicized, I examine the relationship between institutional micropolitics as they have structured past historiographical debates and Cuban macropolitics (slavery, imperialism, Revolution) in their relationship to

Mazorra. In dialogue with a robust scholarship on psychiatry, colonialism, and postcoloniality, this paper seeks to establish a dialogue between the “old” institutional history and the “new” studies that have recently flourished outside of Western European and U.S. contexts. When we speak of asylum politics, are we even talking about the same thing? What do the old asylum politics stand to learn from the new—and vice versa? What kinds of sources, institutional and not, can help us elaborate conversations and even comparisons across the divide? Overall, this paper argues that new scholarship on the institution must reckon with those contexts in which asylums, precisely because of their political setting, always matter(ed) more than psychiatry as such.

- Appreciate the interplay between psychiatry and the State in Cuba
- 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

E2. Rediscovering the Asylum: New Institutional Histories

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The Master’s Tools: Integrating the Crownsville State Hospital, 1945-1970

For much of the first half of the twentieth century, the Crownsville State Hospital—originally the Maryland Hospital for the Negro Insane—was the only public psychiatric institution available to African Americans in Maryland. Founded in 1911, Crownsville was notorious for its overcrowding, lack of qualified staff, and mistreatment of patients. Accordingly, it became a focus of local efforts for racial integration.

In the 1930s and 1940s, African American community leaders and organizations such as the NAACP pushed for the desegregation of the care staff of Crownsville as a way to address the deplorable conditions of the hospital. As a result of these efforts, Crownsville superintendent Dr. Jacob Morgenstern hired the first African American clinical staff member in 1948. In 1963, Health Commissioner Dr. Isadore Tuerk desegregated the patient populations of Maryland state hospitals.

In this paper, I use institutional reports, patient records, and oral histories, to reconstruct and analyze the clinical and political ramifications of integration. For African American community leaders and organizations, integration offered a much-needed solution to Crownsville’s problems. It improved quality and access to psychiatric care for African American patients, and prompted a reorganization of diagnostic categories that had previously been built around race. Integration also gave African Americans access to educational and employment opportunities, which helped to transition Crownsville from a carceral to a therapeutic space.

However, the gains of integration at the Crownsville State Hospital were incomplete. With deinstitutionalization and the rise of the carceral state in the late 1960s and early 1970s, integration was no longer enough to address problems at Crownsville.

- Appreciate healthcare as an arena for social justice work
- 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)

E3. Disinfection Practices at the Turn of the 20th Century

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'Coolie' Control: Bodies and Labor in Late Victorian Colonial Disinfection Practices

In late nineteenth century British controlled India and South Africa medical officers forcibly 'dipped' naked indigenous Indians and Africans in carbolic acid mixtures in an effort to identify, isolate, and control the spread of typhoid fever, rinderpest, and bubonic plague. As a co-option of a veterinary public health measure on humans, this historically unexplored practice is a critical lens into the ways in which bodies—gendered, classed, and racialized—were the foci of epidemic control in the period of debates on the relative merits of field-based epidemiology and laboratory-based bacteriology.

Moving beyond the rhetoric of disinfection, and past what late Victorian sanitarians said about disinfection—of things, environments, and peoples—this paper focuses on the actual practices of disinfection. Narrowing in on examples of disinfection technologies and the material and labored reality of disinfection from British cantonments in India and field hospitals in South Africa, I unpack the dually constructed identities of the “coolie” and the “kaffir” as bodily terms, not just political ones. What I demonstrate is a unique and complex irony of colonial public health; indigenous Africans and Indians were both feared for spreading epidemics, necessitating heavy-handed and full-bodily measures like dipping, and at the same time put in charge as experts in disinfecting the dangerous things that white British bodies produced, particularly their excrement.

This analysis substantiates what many scholars have said about the way in epidemic disease was mapped onto colonial bodies unevenly in this period. Yet, instructively, by examining the level of practice, rather than rhetoric, this paper complicates what we know about state surveillance and state racism during the so-called “Bacteriological Revolution.”

- To understand the ways that public health practices were shaped and shaped by contemporary racial theories.
- To explore the complex process by which the laboratory and the field produced the practice of disinfection.
- To uncover the material technologies and labor of public health practice in colonial locations.

E3. Disinfection Practices at the Turn of the 20th Century

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Disinfecting the Nation: Fumigation in Early 20th-Century Argentina

After the end of the civil war in 1880, Argentina experienced a period of postcolonial revival, marked by prosperity and cosmopolitical liberalism. The country was set to become a model state of Latin America in the early 20th century and its outstanding sanitary program was supposed to demonstrate the nation's achieved modernity. But the extensive programs, designed to secure mostly the capital's hygienic status against the 'barbarism' of the rural Hinterland, also exposed the rigid and authoritative nature of hygienic policing. Since 1893, restrictive laws and strong legislative capacities gave sanitary forces an intrusive access into the fabrics of Argentine's society. Various sanitary police corps secured the city at the turn of the century in its port, its production facilities, its graveyards and food facilities, as Buenos Aires was officially considered to be in a 'perpetual epidemic state.' Hygiene, cleanliness and the prevention against epidemics were, as Julia Rodriguez (2006) has show, instruments of engineering social change, which established racial divides and installed a hidden authoritative regime within the supposedly 'golden era' of pro-democratic liberalism.

The extensive introduction and application of fumigation, my paper will argue, is grounded in the "secular hygienic catechism" (Armus 2011) of turn-of-the-century Buenos Aires. The technological solution promised prevention of yellow fever, tuberculosis, typhoid fever and bubonic plague, while the filling of private and public spaces with gaseous pesticides also pledged a novel level of supposed security. As the city invested largely in fumigation stations and mobile fumigation brigades and as neither private nor commercial spaces were spared, the technology became eventually a symbolic cornerstone of the hygienic regime of the new nation. And as a trail of Argentinian manuals, reports, records, photographs and caricatures show, fumigation acquired a meaning that exceeded the mere extermination of germs and vectors. The technology became a successful and pervasive technology within the Argentinian school of hygiene. Fumigation translated and maintained an outmoded notion of contagion into the 20th century, in which the protection against epidemics was also the authoritative and intrusive assertion of an all-encompassing cleanliness, which was supposed to protect against racial inferiority and social degeneration.

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

E3. Disinfection Practices at the Turn of the 20th Century

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Clayton Machine: Experimentation, Fumigation, and Empire

Hankering back to an apparatus invented and deployed by Dr Olliphant in Louisiana, the Clayton machine was patented in the UK in 1901 and quickly became a popular if contested system of ship fumigation. Claytonization comprised in the fumigation of vessels with sulfuric acid, aimed at destroying simultaneously vermin and insects as well as bacteria in the holds of the ship. Of prime concern, given the ongoing plague pandemic across the globe, were rats and their fleas. Launching an aggressive promotion and lobbying campaign, the London-based Clayton Company promised effective disinfection and no damage to ship or cargo, allowing for fumigation to be undertaken in loaded holds. Rather than however providing the ground for a consensus on maritime epidemic control, the Clayton divided medical and sanitary opinion. Whilst the French, led by Albert Calmette, conducted experiments leading them to adopt the apparatus not only in mainland France but also in Indochina, the British were rather less ready to accept the method, which was after all marketed under an English brand.

This paper examines the “Clayton fever” of the first decade of the twentieth century, assuming the particular fumigation apparatus as a window into examining conflicting and often self-conflicting ideas about disinfection in Britain and France at the time. Key to these developments, it will be argued, was the often neglected conflict between Western European powers and the Ottoman Empire as regards the necessity of maritime quarantine. The struggle concerned the efforts of the former to restrain and revert the Sublime Porte’s maximalist approach, which decreed that all vessels arriving to Istanbul from an infected harbor needed to come under quarantine. Could the new Clayton method provide a solution to the stalemate at the internationally composed Constantinople Board of Health? Or did it in fact further complicate already acrimonious inter-imperial relations over trade and epidemic control? Investigating the entanglement between laboratory science, engineering, and medical diplomacy in the shadow of the third plague pandemic, this paper will unravel the role of the Clayton machine as a forgotten but crucial technology in the modern history of disinfection and epidemic control.

- Appreciate the importance of international politics in the development of epidemic control technologies
- Recognize the role of emerging technologies in experimental science
- Expand their understandings of the development of modern medicine beyond the confines of the Western world, and the role played by non-Western actors in this process

E4. Persisting Plague

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Discussions of Plague in the Arabic Medical Commentaries Composed During the Second Pandemic

The study of plague in the Islamic world, especially the second pandemic, has borne great fruit over the past few decades. The seminal works of Michael Dols, followed by the more recent works of Stuart Borsch, Justin Stearns and Nükhet Varlik, have greatly enriched our understanding of the social, economic, religious and political impact of this disease on Islamic societies of the Mediterranean, stretching from Andalus to Cairo and Istanbul. These studies have made extensive use of a wide variety of sources, ranging from specific plague treatises, to theological tracts, archival documents and even commentaries on prophetic traditions. However, one type of source has not been examined thus far: commentaries on medical compendia, such as Avicenna's (d. 1037) "Canon of Medicine" and Ibn al-Nafis's (d. 1288) "Epitome". This is despite the fact that historians have long known that Avicenna discusses the disease in his "Canon." The main reason for this neglect has been the widespread dismissal of the entire commentary tradition as uncritical and intellectually stultifying. Yet, recent work has shown that philosophical and medical commentaries from the post-1200 period critically engaged with the source text and often contained innovative material. In this presentation, I shall introduce the audience to the plague sections from two medical commentaries on the "Epitome" composed by the Timurid court physician of Samarqand, Nafis ibn 'Iwaḍ al-Kirmānī (d. after 1439), and the Ottoman court physician of Istanbul, Ḥakīm Shāh al-Qazwīnī (d. 1521). Their discussions of plague will be compared to those found in earlier commentaries, particularly that of Ibn al-Nafis whose new understanding of physiology and humoral theory informed the work of these two commentators. Close attention will also be paid to how al-Kirmānī's and al-Qazwīnī's discussions respond to their own experience (if any) with the disease and the contemporaneous societal responses to the second pandemic.

- Recognize the dynamic interrelationship between medicine and society through history
- Understand the dynamic history of medical ideas and practices
- Deepen understanding of illness

E4. Persisting Plague

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The Myth of the 'Disappearance of Plague': Re-writing the History of the Second Pandemic

The question of plague's "disappearance" from Europe at the end of the Second Pandemic has been the subject of long historical debates, yielding a substantial scholarship. While some scholars argued that it resulted from administrative actions, such as the implementation of quarantine, others have emphasized the role of changes in urban planning, housing structures, and hygiene practices in European societies. In an attempt to go beyond an

anthropocentric perspective, still others have suggested that the increased use of arsenic to eradicate rats and the replacement of black rats by brown rats caused the plague to disappear from Europe. Currently, there is no consensus on this question.

Recent historical and scientific discussions stirred by Ann Carmichael's pioneering work on the persistence of plague in Western Europe makes it possible to question larger historiographical assumptions about the "disappearance" of plague. According to the persistence hypothesis, plague was sustained in the European Alps, spilling over to cause rural outbreaks, which were then carried toward major urban centers. Recent ancient DNA studies also support this hypothesis and suggest the possibility of a (now extinct) plague reservoir in Europe. Grounded in these cutting-edge discussions of plague persistence, this presentation will re-open a "can of worms," by shifting the emphasis from contagion narratives—deeply rooted in Eurocentric urban perspectives—to a persistence model that is closely associated with the rise and fall of historical plague reservoirs. To this end, this presentation will tackle misconceptions in the Europeanist plague historiography. In particular, it will problematize prevailing ideas of European exceptionalism, through which environmental imaginaries of the European past were conceived to be essentially different from other parts of Afro-Eurasia that were also affected by the Second Pandemic. Moreover, it will take the discussion beyond human-centered efforts, such as quarantines and disease control, in order to explore disease ecologies in the context of social, climatic, and environmental changes. In doing so, this presentation hopes to offer new insights into historical questions about plague's etiological and epidemiological behavior (especially persistence and extinction), while correcting glaring misconceptions in the historiography of the Second Pandemic.

- To understand the historical context in which past perception of plague (and plague control) developed.
- To recognize the development of European notions of plague (and plague control) in relationship to the epidemiological experience of non-western societies.
- To acquire a historically nuanced understanding of the persistence and extinction of plague and to explore its implications in re-writing historical narratives of pandemics.

E4. Persisting Plague

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The Making of 'Peculiarly English' and 'Peculiarly French' Plague Tracts

In 1348, as the Black Death moved into the Mediterranean, university-trained physicians began to document their responses to this 'previously unheard of' and 'universal' pestilence. In specialised treatises collectively known as plague tracts, these writers recorded their ideas about the disease's causes and suggested appropriate precautions and treatments. Subsequent writers copied, adapted, translated, and circulated the tracts throughout Europe and the Middle East for hundreds of years. Plague tract historiography acknowledges that these texts

demonstrate continuity in professional and popular treatments for the disease from the mid-fourteenth century until well into the sixteenth. As such, many historians claim that the tracts' ubiquity, formulaic structure, and repetitive contents give them little significant historical value. A closer reading and comparison of English and French tracts over a longer *durée*, however, demonstrates that this historiographical attitude is misinformed. As the plague became a more familiar experience after the initial shock of the Black Death, tract writers quickly moved away from discussing the disease's 'universal' aspects, and focused instead on its particularly local characteristics. At the same time, these authors increasingly began to incorporate commentary about locally specific concerns that were, they argued, directly related to their local plague outbreaks. While the Wars of Religion spurred accusations that 'shifty Jesuits from Paris' and 'Calvinist greasers from Germany' had caused plague outbreaks in France, for example, English tract writers placed greater emphasis on the likelihood that poor parishes in London had generated the disease. Taken together, local 'characteristics' and commentaries open the door to a much deeper understanding of how contemporaries perceived, conceptualised, and catalogued the recurrent plague outbreaks that they faced into the early eighteenth century. When plague tracts are reread in light of Ann Carmichael's ground breaking work on the existence of local, persisting reservoirs of plague – and in light of recent genetic evidence that there were at least two distinct strains of the plague circulating in Europe after the Black Death – it becomes possible to consider that there might be some validity to the variety of contemporary cultural perceptions of the disease that is evident in plague tracts.

- Better recognize the dynamic interrelationship that existed between historical cultures, their unique experiences with epidemic outbreaks, and the divergent ways in which they discussed and portrayed their experiences.
- Have a deeper understanding of the effect that the experience of repeated epidemic outbreaks has on societal beliefs about disease.
- Better understand that contemporary medical texts must be examined and interpreted in light of their specific local contexts, even if they constitute part of a much larger, formulaic 'genre.'

E5. Children's Health Policymaking: Negotiating the Balance between Evidence and Advocacy

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Challenging Medical Expertise: Immigration, Intellectual Disability, and Politics in the Early 20th Century

The 1924 Immigration Act (sometimes termed the Reed-Johnson Act) imposed severe limits on both the number of immigrants permitted to enter the United States and on those from Southern and Eastern Europe and Africa, while halting admission of Asians and Arabs. While the law erected steeper barriers to entry, it contained a new and narrow means of entry for a small group. Section 14 of the Act permitted the Secretary of Labor to allow children who

arrived after 1914 and were denied entry, but remained because of wartime exigencies, to stay if they had a parent who was a citizen. This exceptional measure was the product of political maneuvering on behalf of intellectually disabled children. Legislative hearings and federal court filings challenged the findings of Public Health Service Officers who made repeated findings that the children they sought to deport failed all the test they administered and were indeed intellectually disabled.

I examine the history of this legislation and the history of the individual children and families fighting to remain in the United States to make three arguments. First, I describe the challenge to medical authority by community members and their allies. While standards for assessing intellectual ability hardened within the medical profession, in the larger community their judgments of individuals' worthiness and intellect would be challenged. Second, I note the role of eugenics within the political debate over immigration and how it led to the sterilization of at least one child hoping to remain with her family and questions about the sterilization of others. Third, I argue that the historiography of intellectual disability and activism on behalf of the disabled has overlooked this early effort to secure legal rights because of an emphasis on institutionalization and post World War II fights for classroom inclusion. My paper unites the history of medicine, disability, and public policy, and signals that our current debates over immigration and over disability, have important precedents.

Primary sources include congressional hearings, legal cases, the papers of Presidents Coolidge and Harding, reports from the Commissioner General of Immigration, and newspaper accounts describing the activities of families fighting for their disabled children to be allowed to stay in the United States. The interpretation draws from the rich literature on the history of immigration, medical inspection, and disability.

- Develop an understanding of the history of medical assessments of intellectual disabilities.
- Reflect on the differences between medical and popular understandings of disability.
- Understand the interrelationship of legislation, law, medical judgments and social activism.

E5. Children's Health Policymaking: Negotiating the Balance between Evidence and Advocacy

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Newborn Screening Policy in Latin America: The Role of Special Interest Groups in Shaping National Health Policies

Screening newborns for metabolic conditions is one of the most successful international public health advances of the 20th century. As countries adopt national policies for newborn screening policies, they engage in a process of social negotiation among scientists and clinicians, families and advocacy groups, and other interested parties such as pharmaceutical companies and scientific instrument manufacturers. How and when newborns are screened for

different conditions in different countries thus reflects each nation's process for judging scientific evidence and competing claims by special interest groups.

Historical accounts of newborn screening (NBS) in the United States, for example, have shown how the role of special interest groups evolved over time. What began as a movement to expand screening led by families and disease advocacy groups later moved through a period marked by rising industry influence, eventually morphing into today's NBS process, in which scientific expertise dominates and the participation of special interest groups takes place within the boundaries of relatively tightly constrained roles.

In this presentation, we trace the development of NBS policies and policymaking processes in several key Latin American countries, such as Mexico, Brazil and Chile. In studying these nations with relatively robust NBS programs, we explore how politics and health policy intersect: How have NBS groups in these countries generated political will and marshaled resources for their preferred policy outcome? How have these groups framed the societal need for newborn screening? What processes are in place to adjudicate their claims? What has been the effect of international agencies in domestic policy?

As they have democratized in the latter half of the 20th century, many Latin American countries have been laboratories for developing innovative political processes for citizen participation. If we believe that the best health policy reflects scientific evidence as well as the needs and the values of the population, then the development of NBS in Latin America merits sustained attention. Our comparative history illuminates how NBS policy debates reflect deeper values, such as the appropriate role for citizen participation in policymaking.

- Comprehend the social and political processes that shapes public policies for newborn screening across the Americas
- Recognize the dynamic relationship between various stakeholders in shaping how medical expertise, scientific evidence and advocacy influence the evolution of newborn screening policies over time.
- Compare the evolution of newborn screening policies in several Latin American countries by tracing the distinct roles of public policymaking, scientific evidence, technology and family advocates.

E5. Children's Health Policymaking: Negotiating the Balance between Evidence and Advocacy

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Agent Orange and Disabilities

Decades since the American-Vietnam War and the "defoliation" program ended in Vietnam, Agent Orange persists not only in the environment but also in human bodies, in the form of cancer or birth defects. From the outset, the people on the ground who were exposed to this herbicide pointed to their bodies—to blisters, cancers, miscarriages, and infertility – and to their children's malformed bodies. They drew attention to this as incontrovertible evidence

of Agent Orange's health consequences. Understanding the impact and legacies of Agent Orange on the citizens, politics, and cultures of the United States and Vietnam requires the analytical lens of disabilities studies and attention to what are typically regarded as the most private and personal of bodily experiences and family events. Disabilities are at the core of Agent Orange's human health effects, and are intrinsic to the political and cultural activism that those effects continue to generate: by veterans exposed to the herbicide during war who have sought "disabilities benefits" and by parents devastated by newborns with unusual birth defects.

Since the 1970s, children with disabilities and "deformed" fetuses have been the predominant representations of the herbicide's effects—in lawsuits, congressional hearings, news photography, and documentary film. This visual repertoire has been vital to gaining attention and concrete benefits for those harmed by Agent Orange (in both the US and Vietnam), even as much of it reproduced a western tradition of viewing people with disabilities as isolated and pitiful curiosities. Frankly, Agent Orange has provided an avenue for voyeuristic viewing and filming of disabled bodies, particularly as the Vietnam government has granted foreigners relative freedom to film. (There is nothing comparable to HIPPA in Vietnam.) This paper investigates how people have used the display of their own sick and disabled bodies in order to secure medical services and how that visual material has served other political and cultural purposes as well. Sources include US government documents, environmental, peace, and veteran organization records, and documentary film; Vietnamese periodicals; and ethnographic research in museums and memorial sites in both countries.

Key words: Disability, Public Health; Toxic exposure, veterans.

- Develop an understanding of the history of Western assumptions about people with disabilities.
- Reflect on the differences between medical and popular understandings of disability.
- Develop understanding of the relationship between American and Vietnamese movements for health care related to herbicide (dioxin) exposure.

E6. War and the Mind in Twentieth-Century Medicine

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Tension Control on the Homefront and Warfront: Neuromuscular Relaxation and the G.I. Generation

In 1943, fitness instructors at the U.S. Navy's pre-flight training schools reported that, "many cadets seemed fatigued, restless, sleepless, and apprehensive." Reports from combat zones also indicated that "failure to relax" was a "menace" and "seemed responsible for loss of pilots and planes." Citing these concerns, instructors acknowledged that their physical training regimens were good at strengthening pilot's bodies but were less effective at "steeling their

nerves.” To this end, instructor’s initiated an experiment with Progressive Relaxation, a neuromuscular technique that aimed to ease the mind by releasing tension in the muscles. Instructors liked that the technique emphasized self-reliance, lessened the need for sedatives, and did not require any special apparatus or the presence of a psychiatric expert. Emboldened by clinical evidence about the technique’s effectiveness, they believed neuromuscular relaxation could fortify soldiers to withstand the intense pressures of war.

Clinical studies helped military trainers feel confident about implementing the technique, but this paper shows that such evidence also helped distance relaxation from its widespread association with women. Since the 1880s, female physical educators had often promoted similar mind-body techniques to help women alleviate nervousness. During political and economic upheavals of the early twentieth century, they organized special campaigns for expanding women’s access to relaxation exercises, believing that support for women’s emotional resiliency also improved the health of homes and communities. By the time WWII began, neuromuscular relaxation was a common feature of women’s physical education curriculum, but it was entirely absent from men’s physical training programs.

To examine the gendered history of WWII-era campaigns for relaxation, this paper analyzes records from physical education leaders in universities, the YWCA and YMCA, and the U.S. military. Scholars have documented that WWII generated new opportunities for women to engage in traditionally male activities, but the opposite process has been less discussed. I thus explore why clinical investigations of neuromuscular relaxation helped physical educators repackage and implement feminized practices for tension control, a shift that provided military men with less stigmatized ways to admit their anxiety without calling into question their intelligence, masculinity, or commitment to the projects of war.

- Develop historical understanding about the role of mind-body medicine during an era of biomedical expansion.
- Recognize the interrelationship between the nature of evidence, gender, and the production of health practices.
- Recognize cultural dynamics that influenced therapeutic options for war-related trauma.

E6. War and the Mind in Twentieth-Century Medicine

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Fighting Emotions: Instincts and the War Impulse in Early 20th-Century America

“The impulse to war is stronger than the desire to live; it is stronger than the fear of death,” wrote US surgeon George W. Crile 1915 in “A Mechanistic View of War and Peace” (p. 4), reflecting on what he saw as the biological inevitability of war based on his experiences as a medical officer in France during World War I. Crile’s reflections on the “impulse to war” were part of a broader set of conversations during the 1910s and 1920s about the relationship between emotion, psyche and body. Pre-war psychological and physiological theories of

emotion and instinct became part of wartime explanations for the causes of war, but the horrors of war also led psychologists, physicians, and others to search for alternative outlets for the fighting emotions.

This paper examines early twentieth-century debates among physiologists and psychologists about the relationship between instinct, emotion, and war. It focuses on the work of American physiologist Walter B. Cannon and British psychologist William McDougall, who moved to the United States after World War I, based on their published books and articles, materials in Cannon's archival papers, and newspaper and periodical publications. Cannon's pre-war research on the sympathetic nervous system, the flight or fight response, and the physiology of fear and anger drew on McDougall's work on the so-called pugnacious instinct. Echoing William James's call for a "moral equivalent of war," Cannon concluded his 1915 book, "Bodily Changes in Pain, Hunger, Fear and Rage" with a call for a physiological equivalent for war that could provide an outlet for fighting emotions and maintain martial hardiness without the carnage of modern warfare. Following the Great War, McDougall similarly advocated for consideration of the physiology and psychology of emotions in efforts to prevent future wars, but in terms that marshaled eugenic debates about war's consequences for military men. Infused with contemporary idioms of masculinity, Cannon and McDougall's work illuminates how research on emotions at the interface of mind and body, physiology and psychology, contributed to broader dialogues about the nature of war and the possibilities for peace in the early twentieth century.

- Recognize the dynamic interplay between medicine and society through history
- Develop the capacity for critical thinking about the nature, ends and limits of medicine
- Deepen understanding of illness and suffering

E6. War and the Mind in Twentieth-Century Medicine

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"In the Next War, Psychiatric Casualties Will Be Inevitable:" The Implications of the Army's Post-Vietnam Approach to Mental Health For The Iraq War

During the Iraq and Afghanistan wars, concerns over U.S. troops' mental health, and with them claims that the military medicine is unprepared to address these issues – or is even apathetic – have reverberated throughout U.S. culture. These debates, however, have lacked historical context; despite significant scholarly attention to the history of military medicine, scant attention has been paid to the Army's approach to mental health issues between the Vietnam War and the War on Terror. This paper provides that context. Drawing on archival material from the United States Army and interviews with research psychologists at the Walter Reed Institute for Army Medicine, I argue that the Army's efforts regarding mental health in the 1980s and 1990s defined both the limitations and possibilities for addressing military mental health issues in the twenty-first century.

In the 1980s, Army psychiatrists and psychologists anticipated that the next war would be fought against the Soviet Union and that it would be brutal but short, and their doctrine emphasized battle fatigue, a reaction that they understood as normal and temporary. The failure to imagine other types of conflicts – particularly lengthy, irregular conflicts like those in Iraq and Afghanistan – and the struggle to adequately train soldiers and leaders to address mental health issues set the stage for the issues that the Army confronted after 2001: numerous, complex mental health issues; pervasive stigma; and lack of resources.

In the 1990s, however, Army began deploying Human Dimension Research Teams to conduct real-time research on deployed soldiers' well-being. As researchers surveyed soldiers in Bosnia, Haiti, and elsewhere, they not only determined that factors beyond combat shaped troops' mental health but developed a set of research protocols that yielded real-time data on soldiers' mental health. As mental health issues emerged as a primary concern in Iraq, this capacity played an increasingly prominent role in structuring the Army' response.

This twinned story of success and failure, of the lack and presence of foresight, helps contextualize the Army's twenty-first century struggles. As it does so, it also suggests lessons for mental health and epidemiology in the military and beyond.

- Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.
- Acquire a historically nuanced understanding of the U.S. Army's approach to mental health treatment and surveillance between the end of the Vietnam War and the beginning of the Iraq and Afghanistan Wars.
- Critically appraise how those approaches created both capacities and limitations during the United States' twenty-first century conflicts.

Key Words: Mental health and war; epidemiological research; military medicine

F1. The Community and Public Health

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Plain Talk: The History of Appropriate Technology for Health Communications in "Low-Literate" Communities

In 1988, the Program for Appropriate Technology in Health (PATH), an international health consultancy, won a \$200,000 grant from the Ford Foundation to design health communications materials for "low-literate" communities in the United States. The program, dubbed "Plain Talk," tested their pamphlets, posters, and novel health media like comic books on communities thought to have below average literacy rates: "inner city" foster children in Washington, DC and Baltimore, MD, Alaska Native youth in Juneau, AK, and Spanish-speaking immigrants in Austin, TX. The primary publication of the program, a manual on creating "culturally appropriate" health communications materials for low-literate communities,

informed not only policy initiatives in the United States—where it still forms the basis for the National Institute for Health’s “Clear & Simple” program, the Centers for Disease Control’s “Simply Put” program, and Health.gov’s “Plain Language” strategy—but also American bilateral foreign aid programs in the developing world.

Drawing on archival and oral historical material, this paper considers the ways that certain modes of public health communication were considered more appropriate—both culturally and technically—for an imagined community of “low-literate” people who were, by all other measures, extraordinarily diverse. It also reflects on how this community was projected outward into the developing world. In doing so, this paper shows how ideas about what was or was not appropriate were negotiated by the communities enrolled in the study’s focus groups. Every aspect of the health communications materials developed through Plain Talk was debated for its fit with the community, from adjusting reading levels downward even after certain pamphlets had passed focus group comprehension tests, to selecting which information on health interventions to include, to adapting images to reflect local customs, to the format of the media technology itself—comic books were believed to be good for “inner city” youth, while pamphlets aimed at Spanish-speaking women were criticized by outside evaluators who believed the target community would prefer novellas. In examining the assumptions underpinning the Plain Talk program, this paper seeks to interrogate the historical basis of contemporary programs aimed at the same communities.

- Critically appraise the way “communities” are conceptualized in public health studies.
- Recognize the importance of the dynamic relationships between researchers and the communities where they work for public health practice.
- Identify successes and failures in the history of public health research.

F1. The Community and Public Health

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Alcohol, Oil, and “Eskimo Capitalists”: Contesting the Barrow Alcoholism Study, 1979-1984

In April 1979, a University of Pennsylvania (UPenn) research team, consisting of psychiatrists and sociologists specializing in studies of alcoholism, arrived in Barrow, a remote village on Alaska’s Arctic coast. The North Slope Borough, the regional government responsible for Barrow, had commissioned the team to do a community study, because the Borough had identified alcoholism as their most pressing public health concern. The following January, before the Borough or the residents of Barrow had been advised of the study’s results, an article appeared on the front page of the New York Times titled “Alcohol Plagues Eskimos.” The piece claimed that seventy-two percent of the Inupiat population of Barrow were alcoholics. The researchers attributed this shocking statistic to the development of the Alaskan oil industry, which was driving rapid economic and cultural change in the village. Because of these

processes, the researchers predicted that alcoholism would cause the “extinction” of Barrow’s Inupiat community within thirty years.

Barrow’s residents were outraged. In a series of lengthy public meetings, they condemned the research team’s conduct and disputed their conclusions. Alaska-based alcoholism researchers also issued critiques of the study and presented themselves as allies of the Inupiat. Because of their familiarity with Inupiat culture, they argued, Alaskan researchers were well-equipped to show that the UPenn team had used culturally-inappropriate methods, which rendered their conclusions invalid.

Relying on oral histories and archival material, this paper focuses on the Barrow Alcoholism Study and its consequences, both for the residents of Barrow and for the politics of health research in Alaska more generally. For the UPenn team, Barrow looked like a valuable epistemic resource for exploring the health impacts of transitions to capitalism in isolated indigenous communities. But, Barrow’s residents insisted that they would not be used as “so many laboratory specimens,” contested the capacity of the UPenn team to legitimately know or speak about their community’s health problems, and pushed to reform the 1984 Arctic Health Science Policy to include robust community protection measures. The Barrow Alcoholism Study, then, can give us insight into how communities participate in shaping notions of ethical research conduct.

- Gain a deeper understanding of how notions of community participation in research have developed historically.
- Acquire a greater sensitivity to the challenges and complexities of performing public health research in cross-cultural environments.
- Understand why public health research that fails to dynamically involve community members in research design might result in conflict between researchers and local communities.

F1. The Community and Public Health

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Culture Bound: Anthropology and Health Care in Cold War Miami

“Ethnocentrism has got to go!” exclaimed Hazel Weidman, a social anthropologist at the University of Miami School of Medicine. The Miami Herald quoted her saying this in a 1973 article that publicized a major research effort beginning in Miami, known as the Health Ecology Project (HEP). Its stated goal was to improve the provision of health care to members of a multicultural community. Directed by Weidman, the HEP was a five-year study on the health cultures of five different ethnic groups: Bahamians, Cubans, Haitians, Puerto Ricans, and Southern Blacks. HEP researchers found a range of illnesses, beliefs about illnesses, and alternative health practices in the area immediately surrounding Jackson Memorial Hospital, whose residents were seen as under-utilizing services at South Florida’s only public hospital.

My research traces the implementation of the HEP and its reverberations in health care and medical education. Using archival materials and published literature from the 1970s and 80s, I hope to uncover the aspirations of medical anthropologists at the forefront of their field, as well as the social tensions that shaped the limitations of cross-cultural research and culturally appropriate health care. I argue that this ecological perspective on health in Miami allowed American medical anthropologists to redefine health as a universal human problem for which there were different culture-bound responses. When they convinced patients and health providers in Miami of the relevance of the health culture concept, some of the authority of biomedically oriented physicians shifted to cultural experts who could serve as mediators between the community and public health services.

In order to illustrate how Miami anthropologists created a new professional role, I turn to the community mental health clinics established in each of the five ethnic communities. For each clinic, Weidman appointed a “culture broker” to direct services and apply the knowledge and methods that the HEP produced. The activities of Weidman’s team demonstrate a key moment in the intersection of medicine and anthropological research, which contributes to our understanding of the formation of academic medical anthropology as well as shifting notions of health expertise in the late twentieth century.

- Deepen understanding of the ways in which "culture" became relevant to medical practice in the U.S.
- Develop greater sensitivity to the ways in which multicultural communities interact with a largely monocultural health care system.
- Assess the promises and limitations of cross-cultural research for public health applications.

F1. The Community and Public Health

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Iterative Interactions: Public Health Research in Central Brazilian Xavante Communities, 1990-2015

Since the earliest anthropological and genetic studies in the late 1950s and early 1960s, Xavante Indigenous villages in Central Brazil have received a near constant stream of human sciences researchers. This paper examines the implications of iterative experiences of research for a community that has sustained biomedical interest for almost six decades. It focuses on villages from one Xavante territory and their relationships with a team of researchers from the preeminent Brazilian public health research center, the Escola Nacional de Saúde Pública – Fundação Oswaldo Cruz (ENSP). Since the 1990s, ENSP researchers have developed myriad research projects in this territory, ranging from studies of nutrition and food production to critical analysis of demographic methodology and state census practices. In the process, the researchers have trained a generation of scholars of Indigenous health, conducting extensive

fieldwork in Central Brazil. Tracing the evolution of interactions between this research team and community members over a twenty-five year period from 1990 to the present, this paper uncovers the creative systems that community members have developed to manage the presence of researchers. Drawing on published papers, archival field notes, and oral histories with researchers and research subjects, it examines how Xavante subjects have influenced the direction and shape of research agendas, attained political goals, and molded researcher-community engagement to be a resource for their villages.

This paper contributes to contemporary debates about the ethics of biomedical research in Indigenous communities by highlighting the role of deep histories of researcher presence in shaping the experience of both researchers and research subjects. Groups seen as offering special interest for biomedical research, whether Indigenous communities, patient populations suffering from uncommon ailments, or communities local to large research institutes, often have previous experience with researchers that can dramatically affect new research efforts. This paper draws attention to the ways prior experiences shape community reception of new projects, as well as accentuating, tempering, or ameliorating conflict with researchers.

- Develop a historically informed sensitivity to the role of prior experiences in shaping receptivity or resistance to research, especially in marginalized populations
- Critically assess the possibilities and limits of community-engagement models for public health research
- Deepen understandings of the role of political and historical context in shaping communities' willingness to participate in research

F2. Conceptualizing Biocommunism from East and Southeast Asia

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BioCommunist Diplomacy: Winning Hearts and Minds through Medicine, Vietnam 1942-1972

The two periods of armed conflict usually referred to as the Franco-Vietminh War and the Vietnam War were multi-lateral conflicts in which nations showed their support for one or another "side" of the conflict in multiple ways. Medicine is one of the most understudied of these shows of support. Medical care, for both combatants and civilians, and medical education initiatives were some of the principal ways the nations directly involved in combat and those nations which wished to show support for one side or the other sought to win hearts and minds of the civilian population and among the combatants and their governments. Virtually all Vietnamese medical units during the time under examination held "winning hearts and minds" clinics and offered medical services for civilians. Likewise they collaborated with medical units sent to Vietnam by their allies, the Communist Block countries for the North and the United States and its allies for the South. Further, many Vietnamese military medical personnel, from North and South, were sent abroad as diplomatic gestures of goodwill. The activities of North

Vietnamese and South Vietnamese medical personnel in these winning hearts and minds programs offers an intriguing angle on the diplomatic and military agendas of various forces in a country that was a colonial possession prior to and during World War II and then during the wars of decolonization which followed World War II was divided by international fiat. Vietnamese medical personnel played both medical and diplomatic roles in events that dominated the world news for nearly twenty years and shaped the final decades of the twentieth century. This essay will be based on archival records from the Centre for Heritage of Vietnamese Scientists, published diaries and memoirs of Vietnamese medical personnel from north and south, and on personally conducted interviews with Vietnamese from north and south who either participated in or utilized the services of these international medical initiatives during the Franco-Vietminh War and the American War in Vietnam.

- Will aid recognition of the dynamic interrelationship between medicine and government world wide.
- Will contribute to a historically nuanced understanding of the factors shaping third world health care systems.
- Will contribute to an historically informed understanding of the uses of medicine and physicians in diplomatic initiatives.

F2. Conceptualizing Biocommunity from East and Southeast Asia

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Communism and Transnationalism in Wartime Chinese Medicine, 1937-1945

This paper examines the history of medicine in Communist-held areas in China during World War II from 1937-1945 through the lens of the Americans and Overseas Chinese who assisted in the development of Chinese biomedicine. I argue that their understudied endeavors instituted a viable health care system, which saved lives and sustained the Chinese war effort. This paper thus augments two arguments in the historiography of Communist medicine, and global health. First, contrary to existing nation and ideologically based narratives that primarily attribute health care in Communist-held areas to a Canadian Communist doctor and his Chinese collaborators, this paper highlights a larger transnational and nonpartisan history of medicine. The non-partisan Chinese Red Cross Medical Relief Corps (CRCMRC) and the left-wing New York-based China Defense League (CDL) was central in developing state medicine, adapting imported technology to local circumstances, and creating mobile medical units in Communist-held China. Second, the tremendous effort by the Chinese diaspora and American aid organizations in donating time, money, and expertise in supporting wartime medicine revealed the possibility of developing biomedicine in China even in an era of high economic scarcity. Their efforts challenge existing writings on the inevitable growth of money and markets in modern Chinese medicine.

Drawing from correspondences, reports, and pamphlets in the CRCMRC and CDL archives, and from newspapers reports, I show the ways in which the Chinese diaspora created new forms of biomedicine that sought to overcome wartime scarcity. Diasporic medical personnel manufactured pills on a large scale from traditional Chinese medicine (TCM) to overcome the bulky nature of herbal medicine. They created mobile medical units to inoculate, delouse and operate on soldiers and civilians. Furthermore, they introduced pharmaceuticals, medical instruments, and medical textbooks to the base areas. They also constructed and led hospitals which staffed surgeons and medical technicians who operated on and provided first-aid to civilians and soldiers. Mobility, adaptability, and transnationality became emblematic of Communist medicine. Such wartime efforts left post-war legacies, where the Chinese supported state medicine, developed new biomedical forms of TCM and kept with ideas of mobility and portability in Chinese health care.

- Illustrate how the Chinese diaspora's financial and medical support for wartime health care in Communist-held areas of China challenge current academic works on the inevitable growth of money and markets in modern Chinese medicine
- Broaden ideas of state medicine to include initiatives by the diaspora, military personnel, and traditional medicine practitioners.
- Understand how the contingencies of war and transnational support led to the development of military medicine that exhibited medical characteristics of mobility, adaptability, and portability, augmenting the conventional narrative of the association of biomedicine with stationary and large-scale hospitals, clinics, and laboratories.

F2. Conceptualizing Biocommunity from East and Southeast Asia

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Bounding the Tropical: Migratory Mosquitoes, Malaria, and the Korean Peninsula, 1964-present

When South Korea volunteered to participate in the Vietnam War (1964-1973), among its major concerns was the role of public health and military medicine, especially in the context of the unfamiliar, jungle environment of Vietnam, where it would be sending its combat troops, along with civilian contractors and a number of outreach teams. In particular, the Koreans were concerned with tropical disease and the possibility of encountering parasites.

As part of the effort to control for this cluster of disease issues, KOPREM (Korea Preventive Medicine) teams were formed with the assistance of USAID, and these medical teams targeted malaria specifically in the field context of Vietnam from the late 1960s. This field experience thus served as a trial for knowledge production in Southeast Asia, with the results soon returning to the Korean domestic context, as these doctors and medics rotated out of their Vietnam service by the early 1970s. In fact, much of South Korea's knowledge of the field of tropical medicine derives from this kind of overseas experience (Thailand, Vietnam), and carries with it the ideological edge of embedded developmental assumptions (prioritizing East

Asia over Southeast) and the charged ideological context in which malaria was encountered (mosquitoes = nomadic, migratory, suspect).

In the most recent two decades (1994-present), malaria has made a resurgence in South Korea, in part due to the circumstances of global warming, and also due in part to the shared border with North Korea. If malaria in Vietnam held strong ideological connotations (1964-1973), it once again raises the possibility of raising concern through blurry borders, as cases of malaria in the south are often blamed on these mosquitoes. Drawing from sources including Korean materials, KOPREM documents, and American archives (NARA), this paper shows how cooperation between South and North Korea on some public health issues (tuberculosis) remains possible, given the shared Vietnamese experience on both sides. But the border remains a sensitive place, even as the mosquitoes evade control.

- To reframe “Tropical Medicine” in the context of an Asian medical system
- To examine Asian – Asian medical interactions in a developing context
- To understand malaria and its ideological implications both in the Cold War and the Vietnam War

F2. Conceptualizing Biocommunity from East and Southeast Asia

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Building People’s Nutrition: Nutrition Science and Food Politics in 1950s Communist China

In few countries were hunger and malnutrition politicized more than they were in twentieth-century China. The KMT Nationalist regime’s failure in the management of overall food supply paved the way for the Chinese Communist Party’s (CCP) eventual triumph in 1949. When the CCP seized power, however, the Communists had to face the same dilemma that had long haunted its political opponent, because food scarcity could not be improved overnight. Malnourished population, once a strategic target for political mobilization against the KMT regime, turned into a potential political threat to the new regime’s stability. Furthermore, food calories arguably remained as the prime source of energy in China’s national economy, predominantly agricultural. In order to build strong socialist economy – industrially mighty and yet egalitarian, the Chinese working population should eat better and more food than at any other time.

Against this backdrop, the Communist authorities made unsparing efforts to promote nutrition science to optimize the working population’s food consumption, or at the very least to minimize food waste, while improving nutritional intake for the potential workforce in various institutions and organizations. Drawing from archival work on the research of Chinese physiologists, the People’s Daily, and writings on nutrition, I show that the Chinese Communists promoted these efforts in institutions ranging from military barracks and factories, to schools and hospitals, to welfare institutions and politically punitive labor camps. Rather than following

soviet model, this paper argues, the Communists emulated the state-led nutrition improve movement that the previous regime practiced.

- Acquire a historically nuanced understanding of medical knowledge and practice in non-Western society
- Understanding the politicization of medical knowledge and practice under the circumstances of Cold War confrontation
- Understanding unique significance of nutrition science in medical practice

F3. Beyond Psychedelics: Rethinking Boundaries in Psychiatric Medicine

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Making the Invisible Visible: The Unexpected Entanglements of Psychiatry, Midwifery, and Psychedelics

On November 13, 1956, recently certified Czech psychiatrist Stan Grof swallowed 150 micrograms of LSD as one of the earliest Czech volunteers for a research study. Within a few hours, his entire conception about the human psyche and the role of psychoanalysis was turned upside down. He described being hit by a radiance comparable to a “nuclear explosion” which catapulted him out of his body, expanding his consciousness to “cosmic dimensions.” The timing was fortuitous, for Grof was in the midst of an existential crisis. Like many psychiatrists in Europe and the U.S. in the 1950s, he was inspired by Freudian analysis. Psychoanalysis was brilliant in theory, he believed, but abysmal in practice. It lacked visible proof of efficacy, a reminder of the profession’s struggle for legitimacy. Over the next fifteen years, Grof set out to provide that proof. He established himself as the world’s foremost researcher of psychedelics, conducting over 2000 psychedelic sessions first at the Maryland Psychiatric Research Institute and then at the Esalen Institute in CA.

This paper draws on the records of the Maryland Psychiatric Research Center LSD Training Program Study and the papers of Grof to explore the “unexpected entanglements” between psychiatry, midwifery, and psychedelics. Grof observed “astounding parallels” between psychedelic experiences and the clinical stages of delivery, believing that the common denominator between the two was the trauma of birth. He proposed a “new cartography of the human psyche” grounded in this observation, calling it the Basic Perinatal Matrices (BPM.) Despite the fact that Psychologist Abraham Maslow declared Grof’s framework “the most important contribution to personality theory in several decades,” its influence has been largely ignored by medical historians.

While developing his theory, Grof worked closely with midwives in the Bay Area of California, and in turn, the midwives applied his theory to the structure of birth. In this way, the two seemingly disparate groups – midwives and psychedelic researchers – further legitimized the scientific and spiritual components of altered states of consciousness – whether through psychedelics or giving birth.

Key Words: Psychiatry, Birth, LSD

- Develop an understanding of the interdisciplinary connections between Psychiatry and Midwifery
- 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

F3. Beyond Psychedelics: Rethinking Boundaries in Psychiatric Medicine

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Stars, Saints, and Sex: Hollywood Hospital and LSD Experiences in the 1960s -70s

In 1962 Hollywood heartthrob Cary Grant admitted that he was struggling with alcoholism as he filed for his third divorce. That year he allegedly took LSD for the first time, which was then a legal, if unusual, form of treatment for addiction. He did so after traveling to Canada for this experience that promised to cure him from his problem drinking. Newspaper reports later confirmed that Grant took LSD as part of therapy regimen designed by Canadian psychiatrists. He subsequently embraced mysticism and yoga, praising the LSD session for triggering a positive set of changes in his life. Cary Grant's story became a spotlight for rumours about the elite treatment facility in Vancouver, known as Hollywood Hospital, but until recently those stories have remained in the historical shadows, fuelled by half-truths, salacious tabloid reports, and a lack of clear historical evidence.

In 2013 remnants of the Hollywood Hospital patient records were deposited at the British Columbia Archives from a private collection. Those files indicate that unlike Grof, who used psychedelics to interrogate trauma, Hollywood superintendent Ross MacLean, along with others, including psychedelic enthusiast Al Hubbard, futurist Frank Ogden, and psychedelic guide John Holloway, explored themes of spirituality, sexuality, death, and creativity as they attempted to probe the edges of psychiatry as a bio-medically oriented healing profession. Teasing apart the 500 individual experiences, including nursing and subject transcripts, illustrates how contemporary psychedelic researchers attempted to redefine addiction while expanding a scientific framework for psychiatry that included elements of spirituality and creativity.

These advocates for psychedelic therapy borrowed liberally from eastern spirituality and meditation, indigenous rituals with peyote and ayahuasca – which they viewed as proximate substances, and non-western approaches to healing that applied a more holistic understanding of the mind, body, and the role of consciousness in navigating one's place in the world. Although orthodox biomedical researchers by the 1960s and 1970s grew critical of these non-western approaches in modern medicine, the psychedelic research gained traction in a field that had made limited gains in treating addiction. This paper examines some of these

intersections by closely analyzing the 500 subjective reports of patients who described how the experience affected them.

- Consider how historical subjects described their LSD experiences in their own words
- Understand how 1960s psychiatrists experimenting with LSD drew from Indigenous practices and eastern philosophies to interpret the healing mechanisms of psychedelic substances
- Appreciate the experimental medical context as a dynamic encounter between subjects and observers.

F3. Beyond Psychedelics: Rethinking Boundaries in Psychiatric Medicine

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Psychiatric and Political Paradigms in Psychiatrist William Sargant's Cold War Science of Brainwashing

Anxieties in postwar Britain and the United States about the vulnerability of its citizens to the influence of enemy ideology came to a head with the coinage and adoption of the term 'brainwashing' in the early 1950s. Some efforts were made within the human sciences to investigate whether fears of brainwashing had any legitimate scientific bases. Focusing on one such effort, this paper provides an account of the development of controversial London psychiatrist William Sargant's 1950s Pavlovian theory of brainwashing.

Since the early 1940s Sargant had insisted on a physiological paradigm of psychiatry. Drawing from published professional papers, interviews, popular publications, biographical accounts of Sargant's life, and unpublished, newly-catalogued archival material held at the Wellcome Archive in London, I argue that Sargant's influential theory of brainwashing and conversion extended his earlier advocacy of a physiological paradigm of psychiatry into the Cold War context.

Looking at Sargant's career as a self-described "physician in psychological medicine," I historicize his somatic approach to psychiatry, showing that the problems to which he directed his psychiatric thinking changed over time while his clinical approach and theoretical framework in fact remained constant from the Second World War onwards. During World War Two, Sargant had turned his attention to the development of aggressive somatic interventions aimed at the speedy return of war neurotic troops to the front-lines. During the Cold War, Sargant argued that his past and continuing work established a positive scientific basis of brainwashing. Sargant's polemical attempts in the professional and public spheres to keep his controversial psychiatric interventions relevant, and to promote a physiological paradigm of psychiatry, thus changed over time in stride with shifting political priorities.

Keywords: Brainwashing, Cold War, William Sargant

F3. Beyond Psychedelics: Rethinking Boundaries in Psychiatric Medicine

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“We must counter this most unfortunate development.” LSD, Medical Activism, and the Spring Grove Studies

In October 1965, Drs. Albert Kurland and Charles Savage, Director and Associate Director of LSD research at the Spring Grove State Hospital in Catonsville, Maryland, opened the doors of their treatment facility to CBS news correspondent Charles Kuralt and his film crew. Though the two often declined inquiries from the press in an effort to thwart the sensationalism surrounding LSD, Kurland and Savage thought the network’s interest in depicting the compound as an effective treatment tool valuable. Recent controversies over the recreational use of LSD had become a guiding concern for the Spring Grove team. Years prior, Kurland and Savage had deemed the social rehabilitation of LSD as of “critical salience” to their future or “to if there would be any future for LSD research” at all. Their choice to allow CBS to broadcast two inpatients’ transformative yet mundane experiences with LSD was but one installment in the Spring Grove team’s campaign to create a more favorable view of LSD and psychedelic therapy.

As skillfully chronicled by various historians, by the mid-1960s, LSD had engendered impassioned and polarizing debates about the potential hazards and benefits of integrating psychedelics into modern society. Most accounts frame this discord as a contest primarily waged between government officials, those who scorned LSD as a menacing black market commodity, and countercultural gurus, those who exalted this drug as a hallowed sacrament. These narratives frequently cast researchers in a passive role within that exchange, arguing that organized psychiatry’s close financial relationship with the government made researchers susceptible to political pressure, thereby prompting them to condemn LSD alongside their grantmakers. A close examination of Spring Grove and its illustrious drug researchers, however, tells a different story. Drawing on Charles Savage’s personal papers and institutional documents from the Spring Grove State Hospital, this paper explores the Spring Grove team’s larger, calculated effort to midwife a more favorable view of this curative yet controversial drug.

Keywords: LSD, Psychiatry, Psychotherapy

- Develop a deeper knowledge of the history of psychedelic research and its applications for medicine and healing.
- 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.

F4. Designing Disability: User Modifications of Prosthetics and Assistive Technology

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Designing through the Material: Object Lessons of Disability and User Modification

On both sides of the bag, several rows of beads, carefully handstitched in clumps of three, form an ornate pattern. A loop of black cotton tape makes its closure, or perhaps even its handle. For Amelia Woods of Hazeldan County near Ottawa, this black silk purse contained what was probably her most dependent possession: a Bakelite conversation tube, used for amplifying her hearing. The tube remains in near pristine condition, with minor wear and tear near the ear-tube and the horn. Its materiality suggests Amelia valued her device, crafting an adaptation for its use—a notable thing, as rarely were nineteenth-century hearing devices sold or purchased with bags.

In "Branding and Designing Disability" (2014), Elizabeth DePoy and Stephen Gilson question why there has been a failure to recognize assistive devices as part of one's outfitted, visible identity, especially given the range of styles and prices available to users. The limitations of environment and social surroundings, as well as available prosthetics, often inspired people to construct their own devices to better align themselves with their disability. This paper focuses on the disability experience through material culture: what narratives surround artefacts crafted by design? What can the history of these artefacts reveal about constructions of user identity through object permanence? The elucidation of these objects can allow us to trace the different interpretive frameworks by which users addressed their physical/mental impairments, including how social, cultural, and medical factors shaped their identities, or signified an individual's position in society. Using examples from museum collections across Ontario, this paper looks at how users modified or adjusted technologies to bring them into better alignment with their bodies and the identities they wish to represent. Objects such as special crutches for a one-legged Inuit man to navigate through snow, an iron claw prosthetic arm for a country bicycle repairman, or a crocheted blanket for an elderly wheelchair user signify aspects of personal adaptation. In particular, this paper focuses on how users drew attention to their technologies rather than camouflaging them, in order to better contextualize the material lives of disabled persons in Canadian history.

- Examine how material culture can be used to analyse disability experiences in history.
- Develop an understanding of how 'users matter' (or 'don't matter') and concepts of personal adaptation and identity.
- Identify uniquely Canadian heritage within environmental and social interactions between disabled persons and their technologies.

F4. Designing Disability: User Modifications of Prosthetics and Assistive Technology

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From Status to Stigma: The Walking Cane in the Twentieth Century

"Every well-dressed man without exception, carries a cane," wrote the "Chicago Daily Tribune" on May 11, 1890. In the late nineteenth century, walking canes represented the height

of fashion and the pinnacle of refinement. Canes were purchased as gifts, passed down through families, carved by craftsmen, and sold by fashion houses of Tiffany and Faberge. Yet, by the end of the twentieth century, canes had become stigmatized—and standardized—aluminium devices sold by medical supply shops and physical therapy offices. Many elderly disabled, the “primary users,” rejected these devices as symbols of decline.

Drawing on medical journals, newspapers, popular periodicals, and historical cane collections, this paper investigates the walking cane’s fall from fashion, standardization, and resistance from its primary users that prompted a series of new forms and functions of the cane. While canes in the early twentieth century were closely connected with the elderly, they also carried many other meanings, particularly wealth, style, and professional identity. In the mid-twentieth century, the growing professions of orthopedics and rehabilitation sought to standardize the treatment of age-related disabilities and the mobility devices associated with them. Emphasizing the danger of improperly fitted canes, physicians and physical therapists took over the design, function, and distribution of canes, and in doing so, inadvertently removed the multitude of meanings from these once multifaceted devices. While some users have begun personalizing their canes once again, many resist and reject the devices, resulting in a different set of modifications by supply companies based on concealment.

The history of the cane provides an alternative perspective for user modification of prosthetic devices. This history demonstrates how the standardization of mid-century canes touted by physicians and physical therapists stripped the devices of a diversity of meanings and removed an important avenue for the agency and identity of its users. It highlights the ways stigma has interacted with technologies and resulted in different kinds of device modification. Finally, the history of the cane opens up new questions concerning the role of age in shaping responses to disability and identity over the life course.

- Examine the relationships between aging, disability, and user modification of devices
- Provide historical context for the stigmatization of devices used by the elderly, the disabled, and the elderly disabled
- Develop a deeper understanding of the role of technology in altering experiences of everyday life.

F4. Designing Disability: User Modifications of Prosthetics and Assistive Technology

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Designing Disability, Designing the Nation: Artificial Limb Technologies and American Expansion

In 1895, Z.T. Daniel, a physician with the United States Indian Service in South Dakota, wrote a letter to the New York artificial limb manufacturer A.A. Marks. In it, he detailed a leg amputation that he had performed on a Sioux chief in his district. “I did not succeed in getting his consent to operate until I told him about your excellent limbs,” Daniel enthused. He enclosed a photograph of the chief, outfitted in full regalia and seemingly showing off his new

prosthesis. Daniel expressed his hope that the photograph would “be interesting to his race, and an example of what the ‘White Medicine Men’ can do for his people.”

This presentation examines disability as a site for American nation-making in the late nineteenth and early twentieth centuries and interrogates the often dramatic divergences between the experiences of artificial limb manufacturers, physicians, and users. In the minds of settler physicians and East Coast manufacturers—some of whom wore artificial limbs themselves—prostheses were tools of bodily wholeness and productivity, operating in parallel with efforts to civilize foreign peoples, tame frontier landscapes, and open distant markets. For users from different cultures, however, artificial limbs could bear very different meanings, and adapting to or refusing these limbs could also be a way of adapting to or refusing imperial power. Building on extant work in the history of prostheses, colonial medicine, and indigenous health, this presentation begins by examining artificial limbs worn by Omaha and Sioux peoples, putting their engagement with disability technologies in the context of American expansionism. It then moves to the history of the Panama Canal project, considering how workers of different ethnicities who were “hurt on the P.C.,” as one labourer put it, made individualized claims for compensation and prostheses, aiming to design their own technological futures when full American citizenship was not forthcoming. Prostheses, this presentation concludes, were rhetorically and culturally designed and negotiated by their different users, often in contentious circumstances. In order to understand both bodily technology and the imperial project, disability’s meanings must be read in and through cultural differences, changing landscapes, and citizenship ideals.

- Develop the capacity for critical thinking about users’ experiences with disabilities, prostheses, and assistive technologies.
- Acquire a historically nuanced understanding of successes, failures, and complications of cultural awareness and American citizenship in the history of medicine.
- Recognize the dynamic interrelationship between medicine, culture, and politics through history.

F4. Designing Disability: User Modifications of Prosthetics and Assistive Technology

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Designing Self-Help: Rehabilitation Gadgets of the 1950s

This paper considers the boundaries and convergences between design and rehabilitation in the mid to late twentieth century U.S. In the post-World War II era, rehabilitation specialists focused on the goal of moving people with disabilities out of the hospital and toward the mainstream. Much of this work consisted of developing assistive and adaptive tools to enable disabled people to live in the inaccessible worlds of home, work, and city. The specialties of occupational therapy and rehabilitation science opened new areas of

research on the interaction of disabled people with the designed environment, and ultimately influenced the development of accessible design that acknowledged a range of user abilities. This paper focuses on the technological work that was performed at the Institute of Physical Medicine and Rehabilitation at Bellevue Hospital, one of the leading sites of rehabilitation practice in the post-World War II era. With an unrelenting focus on his patients becoming “independent,” the Institute’s founder Dr. Howard Rusk highlighted the use of “Self-Help Aids,” or a range of devices for use in daily activities including eating, dressing, writing, and walking. These gadgets, many of them made by patients themselves in a small workshop within the Institute, both mimicked and built upon standard designs of the time, from the automobile to the telephone to pieces of furniture. Preserved only in photographs and drawings, these objects provide a rare early version of “accessible” design developed in an era with few to no accommodations for disabled people.

The devices that the Institute staff and their patients developed point to little-studied areas of medical practice, including those which closely resemble the work of design. When orthopedists, prosthetists, occupational therapists, and other specialists work with their patients to select, shape, and fit specialized tools, their work interacts with the broader material world that we know as “design” – and yet the material products of these practices are rarely discussed together. Looking at the output of Rusk’s “Self-Help” workshop, as well as some of the mainstream design informed by this work, we can consider how the fields of rehabilitation and design intersect and diverge.

- Recognize the dynamic interrelationship between medical practice and technological design.
- Critically appraise rehabilitation practices from a historical perspective.
- Develop an historically informed awareness of the relationship between disability and design barriers in society.

F5. Alternative Medicine, Alternative Politics

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Figs, Nuts, and a “car-load of sweet corn:” Scientific Claims and Forms of Expertise in the Battle Creek Sanitarium Health Food Experiments

This paper considers the constitution of scientific claims in the development of health foods at Battle Creek Sanitarium laboratory run by members of the Kellogg family between 1898 and 1909. Historians of medicine have recently revived a standing interest in the relationship between science and consumer culture in the twentieth and twenty-first centuries. They have extended existing accounts of the role of consumer products in transmitting and popularizing scientific knowledge into the realm of healthcare interactions, providing a compelling reexamination of the trajectory of 20th and 21st century biomedicine through the development of the “consumer patient.” Their work has not exhausted, but rather invites, a

detailed reexamination of the relationship between scientific knowledge, consumer culture, and lay expertise. In this paper, I analyze the in-house correspondence of food experiments conducted at the Battle Creek Sanatorium laboratory for the purpose of developing health food products. I place the food experiments within the context of digestive physiology research and provide a close reading of the ways in which this research was navigated in the food experiments. I argue that health foods and their scientific claims were neither straightforward translations of digestive physiology research, or profit-driven fabrications, nor were they simply metaphors for spiritual notions of purity, nature, and health. Rather, products and claims were significantly shaped by the pragmatic realities of managing the supplies and demands of a food laboratory, by consumer and market pressures, and by the materiality of food itself. I show how lay modes of evaluation based on sensory perception were built into the ways in which products were developed. By doing so, I propose that we shift our focus from charting the influence of consumer culture on scientific expertise, and vice versa, and instead explore how forms of scientific expertise and local cultures of consumer product development evolved together at particular times, creating new groups of ‘consumer patients’ disposed to evaluate new forms of scientific claims.

Keywords: Scientific expertise, Consumer culture, Food, Materiality

- Develop the capacity for critical thinking about the nature and limits of scientific forms of evaluation, in particular as they pertain to the difference between ‘health claims’ made in the context of nutraceuticals, and outcome-based systems of evaluation
- Acquire a historically nuanced understanding of the development of patient cultures in the 20th and 21st centuries, and their roles in shaping healthcare encounters
- Understand the dynamic interplay of medical ideas and practices, in particular the relationship between scientific knowledge of digestion, the practicalities of health food development, and the materiality of food substances

F5. Alternative Medicine, Alternative Politics

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Practicing Pilates: German Life Reform, Physical Culture, and American Modernity

Beginning in the 1990’s, the practice of Pilates resurfaced in American popular culture after spending several decades in specialized niches, mostly in New York and California among dance communities. This renewal was in keeping with earlier trends towards other environmentally conscious options including vegetarianism, organic farming, yoga, the Feldenkrais method, and other physical cultures. What these various groups held in common was their claim to offer an “alternative” therapy or way of life in opposition to that proposed by traditional or orthodox medicine. A century earlier, many German groups, known collectively as the Life reform movement (Lebensreformbewegung), coalesced around a similar theme of

“returning to nature” in order to regain health. It is within this historical context that the man behind the method, Joseph Hubertus Pilates, was born. His intellectual development was shaped not only by the German Life reform mentalities of his parents but also by his internment during World War I at the English POW camp, Knockaloe, in which he encountered and rehabilitated Germany’s wounded soldiers. It was there that he began to develop his own system and techniques which he later applied to professional boxers and policemen in Hamburg and after 1926, to professional dancers of the New York City Ballet and the American public more generally.

The name Pilates is common enough but little attention has been paid to the ways in which the contours of Pilates’ intellectual development affected his techniques, his inventions, and his medical philosophy. By situating Pilates in his historical context, I intend to shed light on the ways in which Pilates successfully imported his method to the United States in the 1920’s as well as the reasons for its rise in popularity as an “alternative” therapy and fitness model. I make use of his published guides, publicity materials, and interviews given to various newspapers by both Pilates and his students. I also approach the topic transnationally. While historians have often described the German Life reform postures as “anti-modern,” this paper will demonstrate the ways in which the mentalities that underpinned the German movement also resonated with modern American culture.

- Provide historical understanding of modern alternative therapies and their relationship to traditional medicine.
- Recognize the dynamic relationship between medicine and society through history.
- Recognize the interrelationship between medical thought and material culture.

F5. Alternative Medicine, Alternative Politics

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“Embracing the Good in Every Cult and System”: Naturopathic Healers’ Populism in Early Twentieth Century America

The history of naturopathy is one of collective action; it’s a story of how disparate nineteenth-century alternative healing practitioners came together beginning in 1896. During it’s early heyday-through 1950, the result was an eclectic blend of therapeutics that demanded a way of life—that individuals link body, mind, and daily purpose to prevent disease and aid the body’s innate healing abilities. There were multiple definitions of “naturopathy”—disagreement about distinct philosophies, methods, and credentials (or lack thereof). Benedict Lust and Louisa Stroebele Lust nationally championed naturopaths’ professionalization and their right to practice the many methods that fell under the terms “naturopathy” and “natural healing:” chiropractors, some osteopaths, botanics, hydrotherapists, hygienics (food, exercise, sleep, clothing, air/breathing mindfulness) electromagnetic healers, anti-vaccinationists and anti-divisionists, iridologists, massage therapists and self-defined “true” naturopaths. As the

American Medical Association had gained an increasing monopoly over public health policies, the military and hospital systems, and pharmaceuticals, naturopaths fought the dominance of regular medicine and industrialization.

This paper argues that naturopathy was a political hub of resistance for all alternative healers. This research is from *Nature's Path: Naturopathic Healing in America* (Johns Hopkins 2016), the first book-length history of naturopathy's philosophies and therapeutics and efforts to professionalize, and that details women and men who promoted a radical cultural and medical critique. I draw on a century of journals and texts of American naturopaths, proceedings of naturopathic associations, naturopathic schools' archives, and documents from alternative healing movements. Social and medical history and analyses of gender, class and ethnicity reveal the "medical populism" of the collaborative work of these anti-regular practitioners—a desire for people to have control over their own health and choose their practitioner, rather than being dictated to by AMA physicians.

As a result of their activism, naturopaths secured for disparate alternative healers significant legislative, institutional and cultural changes favoring their ability to treat the sick. They continued to critique medical science, created alternative health schools, and paved the way for the better-known watershed of the 1960s-'70s alternative health movements. What were once distinct groups of practitioners became honed into a professionalized, educationally sound, and politically organized Naturopathic healing profession, predating and ushering in complementary and alternative healing practices currently in use.

Continuing Medical Education Learning Objectives:

- Recognize the dynamic interrelationship between medicine and society over time.
- 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 and limits of medicine and how it has been, and continues to be, influenced by alternative systems of healing.

F5. Alternative Medicine, Alternative Politics

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Nazis, Jews, and the Politics of Homeopathy in the mid 20th century

This paper examines a little-known chapter in the history of homeopathy and its migration from German-speaking Europe to Britain and the United States in the 19th and 20th centuries. At the center of this story is the simultaneous, paradoxical embrace of homeopathy by the Nazis and the beginnings of a new chapter in its spread outside of Central Europe through the work of Jewish homeopathic physicians who fled. These Jewish refugees brought with them approaches to health, ecology, and education that undergird some of the most established branches of alternative medicine, organic agriculture, and alternative education

practiced in Britain and the US today. At the center of this story is the Viennese Jewish pediatrician, Karl König. König belonged to a circle of Jewish physicians, educators, and ecologists around the philosopher Rudolf Steiner, founder of anthroposophy, a spiritual system that structures anthroposophic medicine (modified homeopathy), biodynamics (the oldest form of organic agriculture), and Waldorf education (an alternative school system). König established the network of intentional communities known as the Camphill movement, which blend homeopathic medical care, biodynamic agriculture, special education in residential care villages for people with disabilities. These communities embody the cultural and ideological tensions at the heart of homeopathy—their founding members came from the 1960s and '70s counter-culture, yet they embrace a conservative, ascetic lifestyle.

Recent literature on ecofascism and, more specifically, on the Nazi embrace of homeopathy and organic agriculture, has challenged the widespread tendency to see alternative medicine and ecology as litmus tests for the counter-culture and the political left in 20th century North America and Western Europe. Homeopathy, it is now clear, draws on a complicated blend of ideological influences. This paper uses the writings and personal correspondence of König and his close associates to show how Jewish homeopaths navigated this ideological landscape, how they situated homeopathy in Central European and Jewish holistic, mystical, and medical traditions, and how they breathed new life into movements for alternative medicine and ecology in the English-speaking world. This story both underscores the ideological complexity of these movements and helps to map their intellectual and cultural underpinnings.

- Recognize the historical context for contemporary debates about alternative medicine and integrative care.
- Understand how alternative medicine connects to other fields, such as special education and organic agriculture.
- Describe how race, ethnicity, religion and class have factored in the appeal and use of alternative medicine (and continue to do so).

F6. Babies or No Babies: Reproductive Health

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Failing Mothers and Babies: Antenatal Care in Glasgow, 1918-1974

Recent historical debates about maternal health have focused on maternal and infant mortality, the introduction of state-sponsored maternal and infant welfare reforms, morality and voluntary agencies. The emphasis has been providers and provision, obscuring patient agency and experience in understanding women's maternity choices and broader healthcare decision-making. Using Glasgow, Scotland for a case study, a city reputed for its health problems and historic socio-economic polarity, this paper explores the complex decisions poor pregnant women faced. These are contextualized within the networks of people, skills and

services which sought to engage them in healthcare. It is these women from areas of high socio-economic deprivation who consistently have been the least likely to engage with antenatal services and, consequently, who, along with their babies, have had the highest risk of poor pregnancy outcomes.

Glasgow Corporation sought to tackle the city's high rates of maternal and infant mortality after the Great War. Core to their agenda was increasing antenatal provision. However, their antenatal clinics quickly closed due to non-attendance. Instead, district nurses and midwives experienced greater success in securing poor women's confidence than state providers and continued to do so even after the 1948 introduction of the National Health Service (NHS). These nurses were known to all in the community. Yet despite providing non-judgemental care, they too struggled to engage many pregnant patients with antenatal care. Utilizing a combination of training manuals, nursing journals, corporation papers, and oral histories from district nurses and midwives, this paper analyses their work with poor pregnant women. Moreover, because the historical patient's voice is limited, this paper pilots using oral interviews about healthcare decision-making with women from some of Glasgow's current poor communities and who had their babies in the 1970s-1990s to shed light on gaps in the patient's historical record.

Key words: antenatal care; home health care; district nurses

By the end of this activity, the learner will:

- Identify the contributors to the success of district nurses and midwives in engaging pregnant women with antenatal provision
- Describe the changes in antenatal provision within the changing administrative and political health care structures
- Understand the importance of personal relations in achieving public health objectives

F6. Babies or No Babies: Reproductive Health

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Advertising Eugenics: Selling America on Health, Heredity, and Happy Babies, 1905-1953

From about 1905 until well after World War II, literate Americans regularly referred to eugenics as the science of health, heredity and prosperity. Scholars have explored how eugenic references were commonplace in settings as varied as university courses, scientific texts and religious sermons. Less attention has been paid to pervasive references to eugenics in American advertising during a period when the U.S. became the world's greenhouse for consumer culture.

A review of newspapers and magazines during the first half of the 20th Century reveals that "eugenics" was a favored term for touting a wide range of products. After experts

complained about dysgenic trends such as the fashionably thin female form at the 1914 Human Betterment Conference, ads appeared urging women to buy eugenic hats, eugenic shoes and eugenic gloves to go with the more desirable full figure of the eugenic woman. In an era when the press reported regularly on eugenic marriages and eugenic babies, vendors advertised eugenic dolls, eugenic toys and eugenic child rearing aids. Druggists sold patent medicines under the banner of eugenics, so too “women’s products” such as the famous herbal medicines of Lydia Pinkham. Cosmetologists and dry cleaners launched eugenic promotions, and merchants sold an entire brand line of personal hygiene products carrying the trademark “Eugenicol.” There were eugenic beauty aids, eugenic motor cars, eugenic soft drinks, even eugenic diamonds. Perhaps most telling was eugenic branding by would-be politicians, wishing to associate themselves with health, efficiency and progress.

This presentation will include examples of a wide range of advertisements appearing in newspapers and magazines published and distributed across the country. These ads demonstrate that America absorbed not only the political and ideological messages of the eugenics movement; they also show that the eugenic label was used pervasively in attempts to fuel consumer demand.

- Participants will appreciate the pervasiveness of eugenic language and imagery in advertisements from the US during the first half of the 20th Century.
- Participants will understand the popularity of eugenics as a positive term of association during the period in question.
- Participants will appreciate the variety of products that were sold as "eugenically" valuable to health and hygiene.

F6. Babies or No Babies: Reproductive Health

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‘Arrest me, I’m on the pill’: Birth Control Activism in Ireland, c.1970-79

In 1971 members of the Irish Women’s Liberation Movement (IWLM) were part of a dramatic spectacle. Taking a train from Dublin (where contraceptives were illegal), they travelled to Belfast (where contraceptives were freely available under UK law) in order to purchase condoms and other contraceptives in an act of defiance against Ireland’s restrictive Criminal Law Amendment Act which had banned contraception in 1935. After buying spermicidal jelly and condoms at a chemist’s shop, the group of women returned to Connolly Station, Dublin waving their purchases at customs officials. Although the women were not arrested, the incident nonetheless attracted widespread media attention and publicity. It was not until 1979 that Ireland’s Family Planning Act was passed, legalizing contraception if obtained from a doctor. The efforts of the IWLM to change Ireland’s stringent laws on contraception were part of those of a wider group of activists, which included the Irish Family Planning Association, founded in 1969, and later Irish Women United, a radical feminist group

founded in 1975. Irish Women United, who were critical of the fact that the IFPA's activism mainly targeted the middle-classes, initiated the Contraceptive Action Programme (CAP) in 1976. CAP shops were established which sold non-hormonal contraceptives illegally while activists campaigned for an end to Ireland's ban on contraception, the provision of contraceptives through health clinics, and the introduction of sex education programmes in schools and colleges. These were radical ideas for 1970s Ireland and were inspired by the American and British women's movements.

Recent Irish studies have explored the role of the Catholic Church, government and medical profession in the implementation of the Criminal Law Amendment Act in 1935. But we know little about late twentieth-century activism against this ban. Drawing on the Roisin Conroy collection, feminist magazines, activists' memoirs, newspapers, and interviews, this paper will examine the strategies utilised by Irish feminist activists from 1970 to 1979. The activities of feminist campaigners in the 1970s may be viewed as acts of rebellion against the Catholic Church, state and traditional medical structures in Ireland; they also played a crucial role in popular consciousness-raising around sexuality and contraception.

- Consider the strategies utilised by Irish birth control activists and how these were shaped and influenced by both the international women's movement and by local and national circumstances.
- Analyse the role of feminist groups in consciousness-raising in debates on contraception in 1970s Ireland.
- Understand the complex history of reproductive rights in Ireland.

F6. Babies or No Babies: Reproductive Health

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Psychosomatic Gynecology in the American Fertility Clinic, 1940-1960

This paper will explore how psychiatric theories and psychiatrists entered the modern American fertility clinic in the 1940s and 1950s. Amidst a culture of conformity and pronatalism, the stakes of achieving parenthood were high for potential patients who arrived at the doors of post-war fertility clinics in greater numbers than ever before. As they did so, the idea that emotions played a causal factor of impaired fertility was increasingly embraced by both psychiatrists and gynecologists. Clinics, like the one at Mount Sinai Hospital in Chicago Illinois, opened to treat and investigate the new field of Psychosomatic Gynecology. In this emerging field, however, the responsibility for the psychological treatment of patients was unclear. Was it the role of physicians in gynecology and urology to seek training in psychoanalysis? Was empathy and life experience enough to understand the emotional aspects of infertility? Or, did psychiatrists need to be more fully integrated into the diagnostic team at sterility centers? Psychosomatic gynecology practitioners bemoaned the fact that when a "sterile" woman is attempting to conceive "it is surprising how often personality problems are neglected or

ignored as causative factors.” To meet this perceived need physicians became either “psychiatrically-oriented physicians” or sought consults with psychiatrists before pursuing some treatments for infertility.

There is a rich historiography in the history of gender and sexuality, psychiatry, and medicine that has explored how gender and sexuality became sites of interest and anxiety in American culture and in practices ranging from family therapy and psychoanalysis to research on intersexuality. Yet, little scholarship has focused on how psychiatry changed ideas and practices within reproductive medicine. Using multi-specialty journals like *Fertility & Sterility* and archival material from fertility clinics and publications in the emergent field of psychosomatic Gynecology this paper argues that gendered understandings of behavior and personality development became a key means by which to screen and ultimately, deny access to therapies for infertility. Furthermore, the paper shows the formation of a specialty that crossed the mind/body divide in novel ways and in so doing, brought psychiatry as a diagnostic tool to the modern multi-specialty fertility clinic.

- Deepen understanding of how gender and sexuality impacted psychiatric theories about the causes of sterility.
- Acquire historically informed appreciation of the organization and development of fertility clinics in America.
- Learn how involuntary childlessness was experienced by both men and women during the 1940s and 1950s.

G1. Subjectivity and Epistemology in Clinical Settings

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British Perceptions of Hendon Cow Disease in the 1880s

In regards to scarlet fever, an April 24, 1886 *Lancet* article proclaimed, "We appear, indeed to be on the threshold of a discovery which maybe only second to that of Jenner in its ultimate results." Such optimism reflected the perception that the study of microbiology had the potential to determine the organisms responsible for infectious diseases that claimed the lives of thousands each year and could even lead to methods like pasteurization and vaccination that could reduce the annual death toll. The notion of scarlet fever being transmitted by germs in the milk supply was widely discussed in this era of preventative medicine. W. H. Power's report in 1882 concerning an outbreak of the disease in certain districts of London suggested that the circumstances surrounding the scarlet fever incidents could be due to the cow's condition rather than human sickness that had always been believed to be the root of the infection. Power's investigation of an occurrence of the malady at Hendon in 1885 would put his personal theory under public scrutiny.

Both the revolutionary conjecture concerning the transmission of scarlet fever through diseased cattle and the scientific controversy regarding the microbe that ensued were

frequently mentioned in the literature printed between 1885 and 1889. Through analyzing articles in nineteenth-century medical journals, veterinary publications, and British newspapers and periodicals, it is apparent that there were many actors in this saga from medical officers of health, to physicians, to bacteriologists that all had a role to play in the unfolding of events. Despite the fact that these individuals employed the novel and most rigorous tools of their times to establish objective truths, many entered the investigations with external motivations and preconceived ideas. This inquiry into the cause of Hendon Cow Disease remained unresolved. However, it did raise awareness amongst the British people about the importance of public health initiatives like boiling milk and maintaining cleaner environments and ignite a renewed effort to amend the "The Contagious Diseases (Animals) Bills." In subsequent decades, Hendon Cow Disease was referenced in treatises about other milk-borne illnesses, showing the importance of a few isolate cases.

- To understand how milk scaraltina also called Hendon Cow Disease was viewed by physicians, veterinarians, medical officers of health, and the British public and how that impacted the etiology of the malady.
- To show how the investigation of this mysterious illness was a product of its time in history, a time that was at the beginning stages of microbiology research but still held on to the environmental interpretations of disease.
- To illustrate how the people and government chose to respond to the alleged crises.

G1. Subjectivity and Epistemology in Clinical Settings

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Thyroids, Lymph, Blood, and Brains: Organs and Psychiatry in the Early Nineteenth Century

The history of psychiatry swings on a pendulum between views of mental disorders as physical illness and mental disorders as the domain of an immaterial or inaccessible mind. Current understanding emphasizes a complex world of neurotransmitters and emotional experiences. This paper explores the similarly complex world of the late eighteenth and early nineteenth century, beyond ancient wandering wombs and nineteenth-century phrenology. Relying primarily on American psychiatry and the Pennsylvania Hospital as a prime example, I examine the theoretical role played by more distant organs and organ systems. Theorists connected the actions of external stimuli, minds, brains, and organs as diverse as the lymph nodes and thyroid. I will also view the period as more than the birthplace of the asylum and shift the focus onto a psychological physiology.

In an 1807 essay, American physician Benjamin Rush, addressed a connection between thyroids and "mania." He hypothesized that the duct-less gland must exist to help abstract "excitement" (a stimulating entity) from the blood vessels and the brain. The thyroid serves as one example of many that juxtapose otherwise distinct physiologies. Rush, like his contemporaries, thought that the brain served as a vital connection between body and mind.

Nevertheless, the brain was far from the end of the story. In Rush's general physiology, he described the body as a system in which one organ could be in sympathy with any number of others, typically through the medium of a widespread system like the blood vessels or nerves. I will use Rush's published and manuscript work as a springboard to broader thinking about bodies and minds. This view helps explain the theoretical grounding for the diverse therapeutic approaches practiced at the Pennsylvania Hospital. A whole-body conception of illness, including mental disorders, legitimized isolation of patients in hospitals and asylums, therapeutic bleeding, moral treatment, and strict regimen.

- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education.
- Acquire a historically nuanced understanding of the organization of the U.S. healthcare system.
- Develop the capacity for critical thinking about the nature, ends and limits of medicine.

G1. Subjectivity and Epistemology in Clinical Settings

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The Calculus of Suffering in Nineteenth-Century Cancer Care

Dr. James Fell was an American physician, who arrived in London in the 1850s claiming to possess a new cure for cancer. In 1856 he applied to the board of the Middlesex Hospital to trial his treatment on the patients held within. The board, 'ever alive to the importance of doing all in its power to advance the treatment of this intractable complaint', agreed and wrote up their assessment of his 'plan' in their minutes.

Containing both highly textured accounts of the cancer patient's bodies, and incorporating their own descriptions of suffering, these minutes provide us with invaluable insight to the sensory and emotional experience of women whose voices often go unheard in the history of medicine. Moreover, as this paper will demonstrate, the minutes allow us to interrogate the various criteria medical men used to assess the effectiveness of treatment for a disease that most agreed was incurable. I argue that in a context where a complete cure was believed to still elude the medical profession, surgeons and physicians had to make use of a complex calculus of suffering, and consider an expansive and holistic interpretation of health and wellbeing, in order to decide whether to incorporate Fell's treatment into their clinical arsenal.

The history of cancer in the nineteenth century remains understudied, and we still lack a full and nuanced appreciation of hospital-based care for any disease in that same period. This paper will thus provide three crucial interventions into the historiography: first, it will make use of this case study to explore cancer knowledge as well as the lived experience of the disease in nineteenth-century Britain. Second, it will argue that surgeons and physicians were attuned to the multidimensional needs of their patients, and understood themselves to be offering

palliative and social care alongside, or instead of, curative treatments. And finally, I will suggest that historians of medicine need to encounter the emotions and senses of their subject matter in order to fully grasp the materiality of disease, the doctor-patient relationship, and the clinical experience more generally.

- 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

G1. Subjectivity and Epistemology in Clinical Settings

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An 1869 Séance in Salem: Public Experiments Using a Medical Curiosity and Telegraphic Communication for Precision, Objectivity and Dramatic Effect

At the 1869 meeting of the American Assoc. for the Advancement of Science in Salem, Mass, a prominent Boston physician, Dr Jabez Baxter Upham, conducted experiments before a large audience, where he claimed to be transmitting heart pulsations by telegraph to the Cambridge Observatory. The demonstrations took place at Lyceum Hall before 240 members of the AAAS, including an array of professors, young scientists, inventors, naturalists/explorers, curators, journalists and educators (such as Harvard's new president, Charles W Eliot) who wanted more useful knowledge in the college curriculum. Their eyes were fixed on the same stage where Alexander Graham Bell would demonstrate his telephone 9 years later. What they saw was an equally remarkable vision of technology.

On stage Dr. Upham presented a young man named M. Groux from Hamburg, Germany, who had a congenital absence of his sternum. His heart could be seen beneath a thin layer of skin. Groux was more than willing to participate, had travelled around the country and Europe appearing before medical societies and royalty, and prepared a monograph for his audiences with drawings of himself and the apparatus needed to record his heartbeat and the wonders of human physiology.

Upham adapted Groux's cardiographic machine to connect it to pulsating columns of fluid, visible to the audience, that also triggered signals sent by telegraph to a Western Union office in Boston and then to Cambridge over Harvard's dedicated line. There at the observatory the signals were recorded on the Bond chronograph, using equipment designed for precise measurement of celestial events. Upham may have been the first and most unheralded person to make such an elaborate and public attempt to show, like Bell, the convincing nature of remote sensing. However, Upham's efforts served no useful purpose at the time, and attracted no benefactors and little academic recognition.

Source materials include handwritten accounts, other archival collections, contemporary medical journal reports and newspaper stories which describe the audience, the demonstration (described by one observer as a séance) and the nature of scientific experimentation in post-Civil War America

Key words: cardiac physiology, human experimentation, history of medical technology.

- to understand the use of congenital anomalies in medical science
- to understand the modern origins of medical technology and useful knowledge
- to understand the relationship of remote sensing and the objectivity of medical evidence
- or critical thinking about the nature, ends and limits of medicine.

G2. "The Substances of Healing": Material Culture in Chinese Medicine

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Making Qi Real: Meridian Machines and "Putative Energy" in Chinese Medicine

In the spring of 1958, officials in the PRC Ministry of Health witnessed the demonstration of a "Nakatani electrodermometer." Built according to a Japanese prototype, this machine (allegedly) detected electromagnetic patterns on the surface of the human body that were identical to the meridians (or channels) of Chinese medicine. After its debut, the machine prompted a flurry of writing in Chinese medical journals about the relationship between science and Chinese medicine. My paper uses this episode to explore the role of machines in attempts at establishing the ontological basis for Chinese medicine, particularly the role of apparatus in "proving" the real nature of qi.

Sean Lei has demonstrated how twentieth century critics of Chinese medicine called for the abandonment of traditional concepts such as yin/yang, qi, and Five Phases, and lobbied for biomedical science to become the basis for defining the material reality underlying Chinese medicine's therapeutic effects. According to Lei, the process of "scientization" of Chinese medicine has been an on-going process/debate, producing a "mongrel medicine" that exists in an unstable relationship with science. Indeed, even today, the NIH (NCCIH) defines Chinese medicine as a system that is based on "putative energy," a form of energy that has not been affirmed to exist through scientific apparatus, thus placing Chinese medicine in the same category as Reiki and healing with crystals.

Through an examination of Chinese and Japanese medical journals, this paper probes the genealogy of the Nakatani meridian machine as an apparatus that attempted to bring qi into the realm of scientific reality. Developed in post-war Japan, its origins can be traced to the physiology labs of Europe and Russia in the late nineteenth centuries. From the 1930s through the 1950s, the Chinese acupuncture modernizer Cheng Dan'an translated Japanese research into influential work about the "real" nature of meridians. The arrival of the Nakatani machine

in 1958 highlighted schisms among Chinese physicians regarding the role of science and classical theories in modernizing Chinese medicine. In conclusion, I examine an actual meridian machine used in acupuncture practice today to consider the century-long desire to visualize the invisible in Chinese medicine.

- Promote tolerance for the ambiguity of theories and the nature of evidence
- Appreciate the interaction between biomedical sciences and unconventional therapies
- Become cognizant of the ways global circulations and new technologies impact contemporary healing practices

G2: “The Substances of Healing”: Material Culture in Chinese Medicine

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Milk in Chinese Medicine

Milk has potent symbolic resonance, having borne in different times and places associations with maternal love (or duty), the uncivilized other, and national vigor. It is also, of course, a material substance that is wrung out of living bodies, preserved in diverse ways, and transformed into shapes and textures much different from its original liquid form. In China, on the rare occasions when historians have addressed the use of dairy, the question they have almost invariably sought to answer is “Why didn’t the Chinese consume more milk?” Explanations of the Chinese “failure” to make more use of dairy have ranged from the cultural (they associated it with the peoples living on the northern and western frontiers, whom they considered uncivilized) to the physiological (they were lactose intolerant).

The idea that the Chinese eschewed dairy is mistaken, however. It ignores the place in imperial Chinese culture where dairy was most visible: medicine. Doctors prescribed, and patients consumed, human milk, cow milk, sheep or goat milk, even pig and donkey milk. These milks were generally processed in some way, whether heated, dried, fermented or turned into various forms of butter or cheese. This paper examines sixteenth through nineteenth-century pharmacy and dietetic literature to better understand the therapeutic uses of dairy in early modern China. It explores not only the symbolic associations of milk in this period but also its everyday uses, the ways in which the physical characteristics of different milks both constrained and inspired their applications in human bodies. The paper thus highlights an aspect of traditional therapy that is generally neglected in versions of Chinese medicine practiced today.

- Recognize diversity and change over time in a “traditional” form of medicine
- Promote tolerance for ambiguity of theories by considering a familiar substance in a different paradigm
- Develop a historically informed sensitivity to non-biomedical ideas about nutrition and medicine.

G2: “The Substances of Healing”: Material Culture in Chinese Medicine

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Medical Things and the Body-as-Technology in the Qing Court’s Golden Mirror, 1742

In the last month of 1739, the Qianlong Emperor (r. 1736-1795) ordered the compilation of a treatise on medicine “to rectify medical knowledge” throughout the empire. By the end of 1742, eighty participants chosen from several offices within the palace bureaucracy in Beijing completed the Golden Mirror of the Orthodox Lineage of Medicine (Yizong jinjian 醫宗金鑑). In addition to integrating literati trends in evidential scholarship from the Jiangnan region into the imperial medicine of the Manchu court, as has already been demonstrated in Qing medical history, the Golden Mirror also coalesced publishing trends that made medicine more accessible to a wider audience through rhymes, annotations, illustrations, and instructions to use both material things and one’s own body therapeutically. Readers could learn about not only a range of medical tools - acupuncture needles, moxibustion sticks, devices for smallpox inoculation, braces for securing broken bones – but also multiple ways to use their body-as-technology through self-cultivation, ritual, and corporeal mnemonics. These bodily methods were intended to improve the accuracy of pulse reading, the efficacy of drug treatments, and the predictability of disorders. Hand mnemonics, for instance, were a form of embodied medical technology that enabled the reader to memorize multiple temporal orders of the cosmos in relationship to the pulse readings and conditions of individual sufferers. In addition to mastering how to read the patient’s body accurately according to the four examinations (sizhen 四診) and how to use the various material tools of the medical trade, the ideal physician was also expected to master his own body. This paper provides examples of the three corporeal distinctions of 1) the patient’s body, 2) the physician’s body-as-technology, and 3) the physician’s hand-as-medical-technology. These analytical distinctions of the patients’ and physicians’ bodies give better purchase on the connection between bodies and “the substances of healing” that were embedded within the norms of medical practice that the Qing court’s imperial physicians established in the Golden Mirror and may also have implications for studies of how the physician’s body-as-technology mediated corporeal realities with therapeutic strategies elsewhere.

- Learn to apply analytical distinctions related to the “body” from the patient’s body to that of the physician’s body-as-technology and hand-as-medical-technology
- Develop understanding of why focusing on “material culture” opens up illuminating ways to approach the history of medical practices and embodiments
- Understand some ways that material culture and body-as-technology intersected in Chinese medicine circa 1742 that could be applied in other cases

G2: “The Substances of Healing”: Material Culture in Chinese Medicine

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Eating Exotica: Novel Remedies and Plebeian Desire in Eighteenth-Century China

Medieval imports of exotic cures through foreign trade had permanently changed the repertoire of medication in China. At that time, consumption of such luxuries was likely to have been restricted within the upper echelon of society, and few other than expert practitioners knew how to use them properly. From the sixteenth century onward, however, the quantity and variety of materia medica available to Chinese urban consumers grew substantially, due in part to stimulus provided by an increasingly monetized and globally integrated economy. As a result, many formerly imported medicines and spices came to be cultivated in domestic localities, and knowledge about these drugs also circulated more widely with the advent of cheap printed books. By the eighteenth century, many formerly exotic ingredients had been rendered familiar, and as the Qing Empire's frontier expanded, a new batch of novel cures arrived on the scene from Southeast Asia, Tibet, and Inner Asia.

Although exoticism in Qing imperial ideology and popular literature has been well documented in recent historiography, we still lack concrete knowledge of how these broader cultural shifts may have shaped the "material abode" of everyday life. Furthermore, medicine is frequently absent from discussions of Chinese material culture, an unfortunate omission that I seek to remedy in my work. In this paper, I survey early modern Chinese pharmacy texts for evidence of how people obtained such cures, who were consuming them, and how they sought to tame these unfamiliar substances with resources at hand. My findings suggest that unlike earlier imports that catered to aristocrats and high officials, early modern exotica circulated widely through both commercial and gift exchanges, generating a whole repertoire of recipes that were primarily intended to work in the household kitchen, rather than a pharmacist's workshop. Culinary preparation constitutes a key node in which first-hand, sensory experience mingled with curious desire kindled by tall tales about distant places and peoples. As a result, this newly-acquired taste and set of material practices came to be fixed later as a quintessential part of modern-day Traditional Chinese Medicine.

- To understand that the early modern addition of many exotic ingredients in Chinese pharmacy took place not as a result of learned deliberation, but fueled by popular consumption;
- To consider what constituted "exotica" for a Chinese consumer in the 18th century - and compare that with the more familiar history of European exoticism;
- To recognize the richness of dietetic and culinary manuals as a primary source to study the material culture and social history of consumption, and to consider the methodology of doing history with recipes.

G3: Medical Economics "From the Ground Up": Physician Organization and group Practices from Local, National and Transnational Perspectives

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Medicine in the 'Muskeg Metropolis': Physician Practices in Canadian Resource Towns, 1960-1980

This paper examines the history of doctors' group practice in Canada's northern "resource towns" during a key period of medical system expansion. Using the case study of nickel town, Thompson, Manitoba, it situates this history within in the broader evolution of group practices in Canada, a history that was intertwined with regional economic development in the mid to later decades of the 20th century.

Thompson was among most successful planned resource city in the nation. Health care was a part of the plan, and the mining company partnered with the provincial government to build a new medical centre as a keystone service for the new city. But planners underestimated the challenges of medical economics in 1960s and 70s Canada. Physicians brought in to staff the medical center and attached hospital quickly organized into stratified private group practices that operated outside of the universal public health care system, Medicare (implemented by the late 1960s). Challenged by recruitment and retention, senior physicians increasingly targeted junior doctors from abroad. Thompson quickly became one of the most international communities of physicians in western Canada, a result of the transient population of junior doctors from Scotland and Ireland, and later from India and Pakistan.

Historians interested in physician organizations in Canada have largely focused how medical societies influencing health policy (Naylor 1986, Marchildon 2012) while others have investigated the organization of cooperative community clinics (Lomas 1985, Feather 1991). This paper fills a gap in the history of group practice in Canada by examining private group practice formation, and the impact this had on physician experiences and local medical economics in resource towns. Drawing from newspaper articles, provincial government documents and reports relating to the planning and marketing of Thompson as a northern town transformed from "muskeg to metropolis," this paper examines the goals and aspirations of Thompson planners against the testimony drawn from five (5) oral interviews with physicians who were recruited to practice in Thompson over these decades. This enables a discussion of how group practices functioned in resource towns, and the role foreign-trained physicians played in the development of Canada's northern communities.

- To understand the complex history of medical economics in group practices in three national contexts.
- To deepen our understanding of how physicians responded to local challenges and opportunities in shaping the terms of their private practices at mid century.
- To assess the impact of physician practice choices on access to rural and remote health care.

G3: Medical Economics "From the Ground Up": Physician Organization and group Practices from Local, National and Transnational Perspectives

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On the Threshold of the Welfare State: Improving Access to Healthcare in Rural and Remote Areas in Sweden 1915-1923

Equal access to health care has been an overarching goal in the development of public funded health care services such as the NHS in the United Kingdom and the universal systems of the Nordic welfare states in the 20th century. Although more than half a century has passed since their introduction, this goal still remains to be reached. It is usually not as a result of financial constraints, but of a long-lasting difficulty to recruit and attract qualified medical personnel to rural and remote areas. In other words, there is a discrepancy between society's needs, and the priorities and choices of the medical professionals themselves. This paper examines the Swedish debate 1915-1923, analysing official and professional reports, inquires, proposals and resolutions in period when access to healthcare became a political issue of national concern. Serving in the north was by both physicians and policymakers considered as a professional and personal sacrifice. Remote districts were portrayed as unattractive and unpleasant, practice as difficult and demanding and the population as poor and uncultured. In addition, higher costs of living and a poor income from private practice frequently resulted in economic loss. Consequently, the majority of measures proposed to improve recruitment were for a long time financial incentives: wage increments, allowances and subsidies, measures whose effectiveness today are disputed [WHO, Increasing access, Global Policy Recommendations, 2010]. In Sweden, a severe bout of influenza in 1920, along with public debate and parliamentary activism in its wake became a catalyst for new incentives. On the threshold of the welfare state a new social program for the north was introduced, changing perspectives from physicians and their demands, to the needs of the population. This involved state subsidies for establishing cottage hospitals in remote districts and employment of district nurses and trained helpers. In the end the new program did not only improve access to health care, it also benefited medical professionals themselves, resulting in better working conditions, a widened scope of practice, along with improved recruitment and retention. The result emphasises the importance of including also infrastructural and organizational aspects in discussions of durable health economics.

The objective of this presentation is to:

- Address the persisting problem of recruitment and retention of physicians to rural and remote areas by introducing a historical perspective to this topical issue.
- Deepen our understanding of how physicians responded to local challenges and opportunities in shaping the terms of their private practices over the 20th century.
- Assess the impact of physician practice choices on access to rural and remote health care.

G3: Medical Economics “From the Ground Up”: Physician Organization and group Practices from Local, National and Transnational Perspectives

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The Battle over Group Practice in the Founding of Universal Medical Care Coverage in Canada in the Early 1960s

First implemented in 1962 in the province of Saskatchewan after a lengthy struggle with the medical profession, universal coverage for physician services was eventually adopted throughout Canada by the early 1970s. However, the lengthy struggle over medicare’s introduction in Saskatchewan led to a province-wide physician’s strike and a compromise known as the Saskatoon Agreement that privileged traditional physician-based practices and fee-for-service remuneration (Marchildon and Schrijvers 2011; Marchildon 2016). This paper focuses on the community clinic movement, which promoted major change in the delivery of medical care services through group practices (Rands 2012).

A key ingredient in sustaining family physician opposition to universal medical care was the support of the traditional medical practice model relative to emerging group practice models of primary care. The few doctors who supported universal coverage of medical services were influenced by newly emerging group practices in the United States and Canada. Some would join the community clinics, a consumer-driven group health co-operative initiated by activists identified with the left wing of the governing political party. Although the government initially supported the community clinics, the Saskatoon Agreement reinforced a physician funding model that worked against the future sustainability of community clinics adopting a group practice approach.

This paper relies on the archival records of the Saskatchewan government and a private citizen (Stand Rands) who was one of the key organizers of the community clinic movement. This evidence reveals the tension within the pro-medicare faction: those supporting the community clinics and their desire to see the delivery of medical care transformed; and a provincial government which was only prepared to reform financing in the face of the overwhelming opposition of organized medicine.

The legacy of the Saskatoon Agreement made primary care reform – which has attempted to introduce the basic elements of group practice – extremely challenging since the 1960s. As a consequence, primary care reform has been both extremely incremental and limited in its impact, and is one of the important causes of deteriorating health system performance.

Keywords: group practices; primary care; universal coverage; doctors’ strike

- To understand the history of economics of group practice from both governmental and physician standpoints

- To understand the non-economic motives behind physicians either accepting or rejecting group practice as an alternative to traditional primary care practice
- To assess the impact of a universal health coverage policy that limited the expansion of the group practice model

G3: Medical Economics “From the Ground Up”: Physician Organization and group Practices from Local, National and Transnational Perspectives

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Group Practice in the American Heartland, Cooperative and Regional, 1910-1957

The day the stock market crashed in 1929, an immigrant physician in Elk City, Oklahoma assembled his patients in the town’s library to discuss why the richest nation in the world could not provide medical care for all its citizens. Michael Shadid proposed the principle of cooperative organization—a form familiar to his farmer patients—be applied to the delivery of medical care. Shadid established a member-owned health cooperative, a “miniature Mayo Clinic” serving rural southwestern Oklahoma. It was influenced by rural health needs, Mayo’s model of multi-specialty group practice that pooled and redistributed income, and socialist beliefs in health care as a basic human right.

Group practice, like health cooperative, meant different things to different people. It was promoted by health reformers like the Committee on the Costs of Medical Care (1932) as a solution to a wide range of problems, primarily economic. Its prominence in prepayment medical plans and cooperative health organizations like the one in Elk City linked it in the public mind with alternatives to solo, private fee-for-service medical care. The appeal was strongest in rural and semi-rural areas where group practice addressed rural doctors’ concerns with professional isolation, equipment costs, and time and income for vacations and continuing medical education. A cooperative or capitated payment arrangement provided cash-strapped rural residents affordable care. In 1946, the Public Health Service found the majority of group practices were located in isolated, semi-rural counties in the Midwest, Pacific, and West South Central states.

Organized medicine worried that group practice was the wave of the future, unsure whether it was a solution to longstanding geographic inequities in medical service, or the entering wedge of socialized medicine. Its employment by the growing health cooperative movement heightened their fears. By the time Michael Shadid was elected founding president of the Cooperative Health Federation of America in 1946, group health cooperatives—precursors to the co-ops of the Affordable Care Act—provided care for about two percent of the American population. This paper traces the development and influence of group health cooperatives and regional group practices in shaping rural U.S. health care through the mid-twentieth century.

- To understand the historical alternatives to private fee-for-service medical care represented by health cooperatives and regional group practices in the U.S. from the early to mid-20th century.
- To deepen our understanding of how rural physicians and consumers responded to local challenges and needs in shaping the economic forms of health care delivery.
- To assess the impact of the organization of medical practice on access to rural and remote health care.

G4: Challenging Boundaries in Medieval Medicine

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'Salvation is Medicine': Rethinking Medieval Medicine from the Perspective of the Devotional Miscellany

Sources from throughout late medieval western Europe assert a conception of medicine as a definitively soul-directed therapy. William of St. Thierry considered medicine as integral to divine contemplation, for example, as he understood the proper balance of the humors to affect the higher powers of the soul, and Caesarius of Heisterbach, insisted that Christian prayer rivaled any remedy offered at the University of Montpellier because, "Jesus by interpretation is healing, for savior is doctor, salvation is medicine." Our historical reckoning of medieval medicine, however, has been premised on a conceptual hierarchy that privileges academic medical texts and occupational markers. This paper offers an avenue for rethinking the history of medieval medicine from the perspective of Salus, which simultaneously connoted health and salvation. Doing so, it argues, provides a broader picture of the medical marketplace, one that in fact will allow us to re-embed women into the history of medieval medicine.

As an example of the inclusive potential that such a perspective offers, I discuss a set of manuscripts from thirteenth-century Liège. The manuscripts, all created for use in women's religious communities, demonstrate that the Cistercian nuns and beguines who staffed the region's hospitals and infirmaries were reading Christian devotional literature alongside of medical charms, recipes, and healing prayers. These manuscripts have been known to scholars for centuries, and are much discussed among historians of Christian hagiography and female spirituality. However, no one has yet recognized the critical insights they offer into female healthcare education and practice. The implications of this research are manifold: not only do we gain a better understanding of how women operated as healers in later medieval Europe, we also come to a more comprehensive picture of healthcare distribution and medieval theories of healing. The paper argues that scholars of medieval medicine must expand their range of sources in order to reflect a comprehensive picture of Salus.

- CME Objective 1: Deepen understanding of illness and suffering
- CME Objective 2: Recognize the dynamic interrelationship between medicine and society through history

- CME Objective 3: Develop the capacity for critical thinking about the nature, ends and limits of medicine

G4: Challenging Boundaries in Medieval Medicine

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The Sufferer's Experience of Plague as Political "Sickness"

Ann Carmichael has explored how the language used to describe plague shaped the illness and its treatment for those experiencing it. Her work with the universality of the language of medieval plague and with the localized language of 'the last past plague' helps researchers understand plague as not just a biological event, but a social and cultural event. In the spirit of Carmichael's work, my contribution will push the boundaries of the debate about how language shapes the experience of illness by looking not at words, but a silence. I explore a historical source that should have had a lot to say about the first wave of plague, but didn't: the witness testimonies from the canonization inquest for Delphine de Puimichel. This inquest, held in Provence in 1363, is a good candidate for testimony about the first wave of plague. All 68 witnesses had lived through the first wave. The inquest format gave them room to talk. But in hundreds of folios of testimony, only one person described a healing of the first wave of plague. At first I assumed that no one spoke of the first wave of plague because Delphine didn't heal many people until the second wave. But I came to understand there was more to this silence. For these witnesses, the first wave of plague was inseparable from a moment of shocking political upheaval when their queen assassinated her first husband and went to war with his brother. These witnesses did not speak of Delphine healing plague because that was not the disease; it was only a symptom. Instead they spoke of her healing political violence. The language of the text suggests these sufferers sought a remedy that went to the root of the perceived problem - the health of men's souls. By considering the first wave of plague from the perspective of these witnesses - as political violence expressed as epidemic - we can better understand sufferers' construction of illness and healing.

- CME Objective 1: Discuss the impact of political events on the perception of illness
- CME Objective 2: Recognize the importance of pre-modern evidence in the history of epidemic illness
- CME Objective 3: Develop a historically nuanced understanding of the language used to describe epidemic illness

G4: Challenging Boundaries in Medieval Medicine

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The Divinely Sick Hippocrates: Making a Place for Learned Medicine in High Medieval Religion

During the European Middle Ages medicine and physicians were frequently criticized for directing the attention of good Christians away from proper contemplation of Christ and a focus on spiritual welfare. Nonetheless, almost everyone in the Middle Ages availed themselves at some point of earthly medicines for physical complaints. This tension between physical healing and spiritual healing existed throughout the Middle Ages, but was especially apparent in the high medieval period (ca. 1100-1300 AD), after the reintroduction, translation, and discovery of a great mass of learned medicine from Hippocrates, Galen, and their Arabic commentators. Learned clergy were faced with the choice of either incorporating this mostly pagan or non-Christian medicine or rejecting it wholesale. Most religious authors opted for the former choice, allowing and even encouraging Christians to avail themselves of the healing knowledge of ancient and foreign physicians, so long as it didn't divert them from proper Christian behavior. One method that both literate physicians and clergy used to render non-Christian medicine more palatable was to translate figures and elements of that medicine into a more explicitly Christian framework. As examples of this method, I will draw on writings, both medical and religious, of the twelfth and thirteenth centuries, including the herbal of Henry of Huntingdon, the pastoral writing of Parisian theologians like Peter the Chanter and Alan of Lille, and sermons of William of Auvergne, Stephen of Bourbon, and Jacques de Vitry. In their works, Hippocrates becomes divinely inspired, Christ becomes a learned physician, Adam suffered imbalanced humors after the Fall, and pharmaceutical compounds like theriac served as metaphors for the complexity of spiritual healing. Through analysis of these works I will demonstrate that medieval medicine and medieval religion were not wholly separate fields, but drew on each other's language, imagery, and authorities.

- CME Objective 1: Demonstrate the fruitful intersection of medicine and religion during the European Middle Ages
- CME Objective 2: Recognize attempts to Christianize ancient, pagan medical authorities like Hippocrates
- CME Objective 3: Understand the application of technical medical language in medieval religious contexts

G4: Challenging Boundaries in Medieval Medicine

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Still On Top? Dissonances in Holy Healing Practiced by Male and Female Saints

The medieval cult of the saints wrestled with its relationship to the medical profession. Collectors of miracle tales were sometimes hostile to pilgrims who sought medical assistance from physicians described as "useless" (inaniter); Thomas Becket even appeared to one pilgrim in a dream and ordered him not to seek medical care. Yet, the thirteenth-century compiler of

the Golden Legend's holy biographies, Jacobus of Voragine, carefully portrayed medical workers as experts competent in their field. Jacobus suggested that the patients' illness, pain, or disfigurement was simply beyond the possible care of human science and thus required divine assistance; the high quality of medical care could not accomplish what God's saints could. Jacobus's position has an exciting consequence: while female medical practitioners did not achieve the exalted positions or the respect accorded men in the field, male and female saints had equal access to miraculous power. Historians have mostly treated medicine and miracles separately, but granting saints esteem in the medical field acknowledges women's important role in healing the sick during the Middle Ages.

Even so there is a peculiar glass ceiling for female saints' healing abilities. In the case of leprosy, a widespread and important illness in the high medieval period, female saints are well recorded offering palliative care: they washed, fed, clothed, and sheltered patients in high numbers. Such care is actually crucial for leprosy patients, as it can slow the progress of the disease, even stopping it from reaching its most devastating development. These saints did not, however, cure leprosy. Male saints, such as Thomas Becket and William of York—two contemporary English archbishops whose cults competed fiercely in the twelfth and thirteenth centuries—easily offered lepers the miraculous cures that eluded their female counterparts. This paper will investigate, through biographies of saints' lives, the dissonances in holy healing as practiced by male and female saints and ponder whether female saints remained in subordinate positions, in what we might consider today nursing fields, while cults of male saints asserted dominant, superior positions as healing experts.

Keywords: leprosy, saints, medieval

- CME Objective 1: Understand the dynamic history of medical ideas and practices and how they intersect with ideas about religion and faith.
- CME Objective 2: Improve understanding of illness and care in deep historical perspective.
- CME Objective 3: Recognize the dynamic interrelationship between medicine, religion, and society through history.

G5: Mental Hygiene and Psychological Health in Early Twentieth-Century East Asia

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Hysteria, Gender, and Mental Hygiene in Japan, 1900s–1920s

Decades before Japanese psychiatrists launched the mental hygiene movement in the 1920s, medical and social reformers expressed concern about the psychological health of Japanese citizen-subjects during a time of modernizing change. In the wake of social dislocations and shifting gender roles, they focused especially on women and their “deviant” behaviors, which ranged from crime to reading too many novels. In this paper, I show how

reformers drew on a new discourse of gendered mental diseases such as “hysteria” (hisuterii) to explain women’s various transgressive behaviors. Using medical handbooks and patent drug advertisements that flooded a burgeoning medical marketplace from the 1900s to 1920s, I argue that medical experts and drug manufacturers alike defined hysteria less as a disease and more as an explanation for deviant behaviors that violated the norms of gender hierarchy and family expectations. The handbooks and advertisements often turned out to be conservative social critique dressed as medical claims to knowledge, expressing a cultural narrative about the dangers of social change and the role of gender as a politicized category for interpreting new social relationships and identities.

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

G5: Mental Hygiene and Psychological Health in Early Twentieth-Century East Asia

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Taming the Mind: The Politics of Mental Hygiene in 1930s China

Beginning in the early 1930s, Chinese intellectuals became increasingly concerned about the poor psychological health of their fellow countrymen. As the psychologist Zhang Yinian noted in a 1936 tract, the Chinese people were already aware of the importance of public health, but had overlooked the equally important need to monitor the health of their own minds. Consequently, mental illness, feeble-mindedness, and all types of social and behavioral deviance were continually on the rise. To combat the problem, the Chinese Mental Hygiene Association was formed in 1936. Advocating such methods as eugenics, euthenics, and early childhood education, the Association aimed to stymie the advance of psychological and psychiatric disorders.

Although previous research on early twentieth-century China has examined the increasing attention that political regimes paid to public health, little research has been conducted on the psychological aspects of this project. In China, the discourse of mental hygiene – like that of public health – was consistently linked to broader concerns about the health of the Chinese nation and race. Particularly at a time when China was experiencing warlordism, civil war, and foreign imperialism, intellectuals believed that the principles of mental hygiene could be implemented toward the end of forging a unified and nationalistic populace.

Using Chinese-language tracts written by psychologists and statesmen, this talk will show how the discourse of mental hygiene in early twentieth-century China was ultimately utilized for political, rather than therapeutic, ends. Specifically, mental hygienists aimed to

ensure the ideological conformity of the Chinese people and their unquestioning obedience to political authority.

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

G5: Mental Hygiene and Psychological Health in Early Twentieth-Century East Asia

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Edged out of Centre Stage?: Psychiatrists and Mental Hygiene in Wartime Japan

Contemporary definitions of mental hygiene tend to stress the primary role that psychiatrists play in the maintenance of mental health and prevention of mental illness. In early twentieth-century Japan, however, psychiatrists were not necessarily at the forefront of the mental hygiene movement. Due to mental hygiene's dual thrust -- the treatment of hospitalized patients and the preservation of psychological health among the general population -- psychiatrists found themselves in greater competition with other professionals, such as psychologists and social workers, who also offered their advice and services to governments. In 1940, the Japanese Diet passed the National Eugenics Law, which mandated the sterilization of those diagnosed with hereditary mental and physical disorders. The psychiatrist Kaneko Junji (1890-1979), among others, declared that the establishment of such legislation would, as it already had in Nazi Germany, bankrupt the psychiatric profession and jeopardize mental hygiene. In promoting the notion that mental illnesses and behavioural deviance were symptomatic of "bad genes" and were best remedied through sterilization, Kaneko explained, the law would make psychiatry and more effective preventative measures seem pointless and unworthy of official support and public respect.

This paper assesses Kaneko's prediction, examining indications that psychiatrists in wartime Japan became eclipsed by experts in psychology, law, juvenile corrections, social work, and labour management in public discussions of mental hygiene. While expressing the same warnings as non-medical experts about wartime society's corrupting influence on women and youth, Kaneko and other psychiatrists appear to have run a greater risk of being officially censored. The paper's claim will be tested through an examination of articles and comments published in wartime psychiatric and medical journals that are demonstrative of both official and self-censorship.

- Recognize the dynamic interrelationship between medicine and society through history
- Develop knowledge and understanding of professional behaviours and values
- Develop the capacity for critical thinking about the nature, ends and limits of medicine

G5: Mental Hygiene and Psychological Health in Early Twentieth-Century East Asia

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Playing with Parental Education: The Mental Hygiene Movement in Parenting Primers, 1932-1938

Mental hygiene entered China at a time when intellectuals were rethinking traditional family roles and relationships. In contrast to the more radical and anarchistic thinking of the previous generation, by the 1930s, psychologists and mental hygienists promoted a stable, monogamist, nuclear family. This focus dovetailed with the Nationalist regime's traditionalistic New Life Movement (starting in 1934), which sought to promote social harmony and compliance with the new regime through an emphasis on discipline, obedience, and traditional values. Capitalizing on government interest, mental hygienists promoted their subject by developing primers and textbooks, which they sought to integrate into educational curricula. Mental hygienists penned new parenting primers not only for professional experts and university students, but also for middle-school children. This paper examines and compares parenting primers to show how proponents of the Mental Hygiene Movement depicted certain neuroses and behavioral disorders as potentially threatening to social stability, family harmony, and individual health. Many of these textbooks offered women and children access to scientific information that reframed family relationships in terms of psychological principles. Such information potentially offered a new basis for the legitimacy of parental control over children. Proponents adapted the principles of mental hygiene to promote social cohesion among the Chinese people, but did so with enough flexibility and latitude that textbooks could take on very different concerns, especially when addressed to older or younger readers.

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

H1: Politics, Power and Political Economy in World Health

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"Salvation is Medicine": Rethinking Medieval Medicine from the Perspective of the Devotional Miscellany

Debility was everywhere in the antebellum Gulf South. For white, upper-class citizens, the debilitating effects of the semi-tropical climate haunted their daily lives. At the same time, abolitionists and ex-slaves argued that enslaved men and women were continually debilitated by the very fact of their condition. Debility also attained a metaphorical meaning in debates

about the political question the region posed for the nation's identity. The meanings of debility were both deeply subjective and politically charged, moving fluidly between individual and collective bodies. At the same time, they influenced and were influenced by prevailing ideas about climate, race, and suffering. This paper will demonstrate that the antebellum Gulf South is a uniquely important context for exploring these tensions. It possessed a climate that both beckoned and repulsed, known as much for sickness as health, and debility was at the heart of this understanding. At a time when boosters sought to persuade increasing numbers of white settlers to migrate into the region, especially the southeastern borderlands of Florida, questions of debility—bodily and otherwise—were especially stark.

Studying debility in this context calls attention to the intersections of bodies, environments, and labor in everyday life, foregrounding bodily experiences that do not fit cleanly in diagnostic frameworks. Debility was a ubiquitous, yet capricious term that could encompass a constellation of maladies (including, but not limited to, chronic pain, fatigue, diseases like consumption and yellow fever, and general weakness and impairment.) In situating the experiences and understandings of debility within historical contexts of power, privilege, and the body, I build on the work of historians of medicine and disability such as Julie Livingston. Other scholars have explored acclimation in this regard, but the idea of debility has been largely taken for granted or they have not considered its historically specific nature. Using archival records of people living, traveling, and laboring in the antebellum Gulf South as well as published primary literature on the subject, this paper asks where debility appeared, in what populations, and what could be gained and lost by its designation.

Keywords: debility, climate, U.S. South

- Understand the historical context of debility in the 19th century
- Understand the role of race and environment in meanings of debility over time
- Recognize the dynamic relationship between medicine and society through history.

H1: Politics, Power and Political Economy in World Health

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Shifting Tactics: DDT, the Philippine Postcolony, and the United States Health Technocracy in the Far East

The official WHO narrative celebrates the organization's role in providing much needed technical expertise to newly-independent states, that in turn, led to their adoption of new health technologies for disease control. One crucial element in the narrative was Asia's shift to DDT use to battle malaria. The 1954 Asian Malaria Conference in Baguio, Philippines dispelled doubts over DDT use by providing hard empirical evidence of the insecticide's effectiveness despite varying mosquito behaviors and other variables attendant to Asia like house materials and torrential rains. My paper presentation considers that prior to 1954, there was very little consensus to DDT and a confluence of reasons must be considered to understand a country's

shift to use insecticides in their long campaign against malaria. These reasons range from the role of international organizations like the WHO to the attractiveness of new technocentric approaches to public health. I also bring a crucial element that the current literature on the politics of international health has glossed over. I refer here to the role of the United States Operations Mission (USOM) in providing expert knowledge to host countries, and more important its use of various forms of diplomacy as well as its role in setting up drug control regimes. The USOM acted to promote U.S. postwar foreign policy goals while contributing to the global pursuit for a zero-malaria world. The Philippines, which was a U.S. colony until 1945, became an important focal point to what I call the United States "health technocracy" —a network of foreign aid officials and medical personnel who shaped their recipient countries' health policies by determining the flow and distribution of public health technologies, where to get them, and who should receive them. My paper ultimately argues that DDT, together with antibiotics and vaccines, were not only novel postwar technologies but were also instrumental in the expansion of U.S. postwar biopower in the region and the Global South.

The paper seeks to achieve three objectives. First, it explores the early history of United States foreign assistance agencies in promoting public health technologies in Asia after the Second World War. Second, it brings attention to the notion of "health technocracy" as a function of U.S. imperial power, serving as undercurrent to the technocentric approaches by U.N. agencies like the WHO, UNICEF, etc. Finally, it looks at the notion of disease eradication as an ideological phenomenon attendant to postcolonial development and modernization.

H1: Politics, Power and Political Economy in World Health

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Harvesting Pharmaceuticals: Plants as Manufacturing Sites for Modern Medicine

During the 2014 Ebola outbreak, news reports pointed to a possible Ebola vaccine that researchers had manufactured in the leaves of tobacco plants. This new source for a human vaccine signified two pivotal shifts for the history of medicine. First, plants have a long and multifaceted history in many medical paradigms, but never before have plants been utilized as the manufacturing site of pharmaceutical products introduced to their structure. And second, the possibility of researchers to develop plant-made pharmaceuticals (PMPs) hinged upon research generated by an entirely non-medical discipline: agriculture. This paper expands the narrative of plants in medicine by considering the innovative use of plants as tools for pharmaceutical production, and it also contextualizes plant-made pharmaceuticals within the reductionist concepts that made them possible.

When PMP research emerged in 1989, the biochemists who forged the field chose their research subjects based on the cultural use of particular plants as commodities. Equipped with a plethora of genetic knowledge on crop plants, biochemists were able to adapt reductionist concepts that traversed plant biology and immunology to forge a new pathway for human and animal vaccine production. Couched within ethnobotanical theories on domesticated plants,

this paper contextualizes the ongoing development of plant-made pharmaceuticals within centuries of agricultural research to combat plant disease and to genetically modify and develop specific plants for human use. By examining how reductionism facilitated a plant discipline's contribution to pharmaceutical knowledge, this paper contributes to ongoing discourse surrounding the implications of and possibilities for reductionism in biological, as well as medical, sciences.

- Examine the implications of reductionism within the context of medicine and pharmaceuticals.
- Expand upon the narrative of plants as they are used in modern Western medicine.
- Develop an analytical understanding of how agriculture has influenced the experimental design of PMP research.

Key words: Plant-derived pharmaceuticals, reductionism, ethnobotany

H2: Representing the Fetus and Infant

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Seeing the Infant: Audiovisual Technologies and the Emergence of Infant Psychiatry, 1950s-1980s

Over the last fifty years in child psychiatric practice, video has become an almost ubiquitous tool for clinical care, scientific study, and educational training. Especially in the recent sub-field of early childhood psychiatry, audiovisual images play a prominent role, guiding diagnostic assessment and therapeutic intervention, and structuring research projects and daily routines. This paper engages with the historical origins of these practices, arguing that a new way of thinking about, looking at, and caring for infants emerged in the USA and Western Europe in the 1950s to 1980s, intimately bound to both epistemic and clinical possibilities offered by audiovisual technologies.

Drawing on a wide range of published and archival sources, the paper first investigates how American and British health practitioners (notably René Spitz, James and Joyce Robertson, and John Bowlby) used research and documentary films to direct attention to and criticize the institutional conditions of infant care during and immediately after the Second World War. I argue that this critique not only contributed to the development of attachment theory and an unprecedented public visibility of infants in the 1950s and 60s, but also spurred a new generation of psychiatrists and pediatricians (including Louis W. Sander, T. Berry Brazelton, Selma Fraiberg, and Daniel Stern) to investigate psyche and behavior of infants through technologically mediated observation. In the second part of the paper, I show how these practitioners increasingly relied on a micro-analytic study of videos to both theoretically and therapeutically approach the infant, now considered a primordially interactive being. These

approaches, I suggest, also laid the foundations for the emergence of infant psychiatry as a special field of medical expertise.

The paper engages with scholarship at the intersections of medicine, technology, and audiovisual media, and provides one of the first historical studies of the emergence of early childhood psychiatry and the role of video technologies in shaping both the field of knowledge and the organization and delivery of care.

Key Words: Child Psychiatry, Technology, Film and Media Studies

- Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
- Identify successes and failures in the history of medical professionalism
- Critically appraise clinical management from a historical perspective

H2: Representing the Fetus and Infant

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The Rise and Fall of the Fetoplacental Empire: Human Fetal Research in Sweden, ca 1960–1971

Between 1960 and 1971 the Swedish endocrinologist Egon Diczfalusy and his research team at Karolinska Institutet in Stockholm performed “perfusion studies” on aborted human fetuses. A “fetus chamber” that kept the fetuses “alive” outside the uterus enabled the researchers to examine the hormonal regulation of fetal physiology and development. Diczfalusy coined the term “the fetoplacental unit” to describe the close interaction between the fetus, the placenta and the mother. In the wake of the population “crisis” the fetal research at Karolinska Institutet was increasingly oriented towards developing new contraceptives and methods for termination of pregnancy. By the early 1970s, however, the “fetoplacental empire” (Diczfalusy) came to a sudden end.

This paper investigates some of the circumstances and conditions that were decisive in promoting Diczfalusy’s perfusion studies, and also discusses why it eventually became restricted. Using medical publications, policy documents and grant applications it will demonstrate the active part of Swedish and American funding agencies in supporting biomedical uses of fetuses taken from women who underwent legal abortions in Sweden during the postwar period and after. Drawing on hospital and patient records the issue of informed consent will be addressed. Newspaper reports and television programs are examined to highlight the role of the media in making fetal research public, how Diczfalusy’s studies were framed as controversial, and the consequences for developing national and international ethical guidelines and legislation.

Human fetal research in Sweden has hardly been addressed in previous historical scholarship. My paper elucidates not only the development of Diczfalusy’s perfusion studies at Karolinska Institutet but also more broadly shed light on how a complex set of factors

intersected to the establishment and ending of a controversial strand of human fetal research in Sweden.

Keywords: fetal research, biomedical ethics, abortion.

- Develop knowledge and understanding of professional behaviors and values.
- Contribute to the improvement of patient care through an analysis of the historical intersection of science and ethics.
- Recognize the dynamic interrelationship between medicine and society through history.

H2: Representing the Fetus and Infant

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Nuchal Translucency: Emergence of Quantified Vision in the Late Twentieth Century Obstetrics

A thin translucent space observed at the back of fetal neck on sonographic image, now called “nuchal translucency” (NT), was introduced in 1992 on the medical journal, and became a key visual marker for chromosome aneuploidy in countries with advanced medical technology in the late 1990’s. NT is recognizable only by measuring the translucent space at the back of neck of fetus in the first trimester. Measurement is necessary, because only the widest space in translucent membrane covering the region is called NT. Postmortem examination of an aborted fetus at this stage cannot verify its physical existence, due to abortion procedure. In this sense, NT is a unique entity that only appears on the sonographic image of fetus through the quantification of the image. This paper examines the way in which this new medical existence was enabled by the interaction of sonographic vision and obstetric ultrasound technology in the context of late twentieth century medical practice in global society, where Evidence Based Medicine was on the rise.

Obstetric ultrasound has been speculated as a producer of new visual practice on fetus. (Dudden 1992, Mitchell 2001, Dubow 2011, Boltanski 2011) Those studies can be situated in the larger strand of studies on representation in medical science. (Cartwright 1995, Stafford 1996) This paper aims to contribute to these strands by examining the structure of sonographic vision that enables the new medial entity called NT, which was formed in the interaction of practitioners, technology, and society, focusing on the process of the quantification of vision, through tracking the discussions in papers on NT published in medical journals in the 1990’s. This paper provides a case study of the emergence of quantified vision in the late twentieth century medicine.

obstetrics, vision, quantification

H3: Microbe Hunters Revisited

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Negotiating Local and International Practices: Yellow Fever Research in Late-Nineteenth Century Veracruz

In the early twentieth century Mexican governor Teodoro Dehesa implemented environmental policies in the port city of Veracruz to improve health conditions in working class housing communities. His policies were an extension of local conditions and international health concerns of physicians, such as U.S. Army physician George Miller Sternberg, who engaged in disease eradication efforts from public policy to conducting experiments in Veracruz in the late nineteenth century. This project shows how, despite its marginal treatment in scholarly literature, Veracruz was deeply embedded in political and medical discourse about tropical disease eradication in the late nineteenth century as a key site in international Yellow Fever research.

This paper explores the roles of a variety of political actors--urban residents, the national government and international researchers-- in attempts to prevent the spread of Yellow Fever among various groupings of Mexican visitors and residents. These actors took pains to disseminate knowledge about the role of environment in disease prevention via a complex constellation of factors in the port city of Veracruz. In doing so, this paper provides a window into policy and politics in Mexico; the influence of the international world on Latin America; the adoption and adaption of new ideas about hygiene; and reveals how local and national rhetoric around environment in Veracruz placed the city as a crucial nexus within international attempts to engage public health concerns in reference to Yellow Fever eradication.

- Understand the contributions of local research to international endeavors
- Develop an appreciation for the role of national policy and politics that both limited and provided spaces for conducting experiments
- Reflect on the wide web of knowledge production around Yellow Fever eradication that encompassed a variety of local and international participants

H3: Microbe Hunters Revisited

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Diagnosis Unknown: The Sentinel Case Report and Medical Detection in the Interwar Period, 1918-1939

The Spanish Flu pandemic of 1918-19 is thought to have begun when a U.S. soldier presented to camp with fever, headache, and a sore throat. The devastating outbreak would transform the way we approach disease transmission and public health. In the history of

medicine there are many such milestones or sentinel reports, when the epistemology of the field shifts due to being confronted with a “hitherto unrecorded”^{*} phenomenon. Unlike the more inductive or pattern-recognition approaches that govern solving a problem one has seen before—frequently the case in daily medical practice—these diagnoses of uncertainty require experimentation, imagination or prognostication, deduction, and in fact even detection. In this way, the unknown medical case is akin to the unsolved mystery.

The period between World War I and II (1918-1939) witnessed not only societal and economic upheaval and scientific discovery, but also the so-called “Golden Age of Detective Fiction,” classic mysteries wherein sleuths such as Agatha Christie’s Marple and Poirot and Dorothy Sayers’ Lord Wimsey solve murders employing a range of processes reflecting historical situation and scientific vogue: from the vestiges of Edwardian inductive wisdom to post-Freudian psychological speculation and forensic evidence gathering. The interwar period also marked physicians’ growing introversion and interest in the mechanisms of medicine such as diagnostic method and deduction. Both detective fiction and medical case reports were also beset by the anxieties of a modernizing, post-conflict society—the first accused of snobbery and insularity, the second of “Ivory Tower” erudition.

This paper compares different paradigms of diagnosis and reasoning in medical and fictional mysteries in the interwar period. By examining primary sources such as medical case reports, clinicopathologic conferences, journals, and short stories, it provides an intellectual history of diagnosis through cases of medical uncertainty which unsettled the field. Contextualized within the sociocultural and scientific momentum of the interwar years, this paper thus focuses attention on a period essential not just for the history of medicine and diagnosis, but also for the history of knowledge, to elucidate what historian Carlo Ginzburg has called the “leap from the known to the unknown.”

^{*}G.W.A Dick, who first reported Zika virus in 1952.

- Understand the history of sentinel or index cases in medicine during the interwar period and the scientific shifts that they created.
- Further the intellectual history of diagnosis and diagnostic reasoning, with an attention to diagnostic dilemmas and uncertainty and their ramifications for the diagnostic process and diagnostic error
- Explore the interaction between interwar literary and sensational mystery and the parallel development of medical knowledge, cognitive processes, and diagnostics

H3: Microbe Hunters Revisited

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High Politics and Pandemic Predictions: Predictive Theories for Influenza Pandemics, Their Historical Contexts, and Consequences

The history of responses to influenza provides a frame of reference for assessing the broader sociopolitical context of how we acquire knowledge of influenza pandemics. Since the first isolation of the influenza virus in the 1930s, experts have attempted to predict pandemics based on virus characteristics, natural cycles, or both. As early as 1952, the World Health Organization charged its researchers to watch for any changes in circulating flu viruses in order to forecast the next pandemic. I argue that by the 1970s predictive theories of influenza became entrenched in dialog among scientists and from them to politicians and the public. Confident in their ability to forecast the next pandemic, in 1976 U.S. public health officials warned that a global flu pandemic was looming. Vaccine production was rushed with forty million people vaccinated in ten weeks. The 1976 pandemic never materialized, the government spent vast sums of money, and there were serious adverse reactions to the vaccine. Decades later during the 2009 Swine Flu pandemic, President Obama used “lessons learned” from 1976 to avoid strategic and tactical mistakes. In this way, the history of responses to pandemic flu is circular, drawing on reports of itself. I contend that some of these lessons from history are misconstrued and misapplied.

Using a close analysis of primary source material, I summarize conclusions from the history of pandemic predictions. One enduring lesson is that predictive theories of influenza pandemics are unreliable. Another striking trend is that once politicized, the pandemic language shifts from possible, to probable, to certainty. But the language used to gain political attention is not the same language needed to communicate with the public. We are in a feedback loop with public media that often tout a worst-case scenario without adding clarity to the complexities of emerging viruses. This complicates the challenge to communicate pandemic risks among scientists and politicians in ways that the broader public can also understand. With the continual evolution of emerging viruses (e.g., influenza, Ebola, Zika) and the great potential for pandemics, it remains important to maintain vigilance and preparedness.

By the end of this activity, the learner will:

- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate research and education.
- 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: Cultures of Dissection

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Analysis, Evidence, and Passion: Discovering a Corpse in 1800

This paper examines the medical inquiry into a corpse mutilation case that took place in Guatemala in 1800. Throughout the course of a single month, several severed body parts – a pair of breasts, a pair of ears, and a pair of hands – were left in windowsills throughout

Guatemala City. Dr. Narciso Esparragosa, a leading figure of enlightened medicine and the chief of surgery at San Juan de Dios Hospital, examined evidence in the case and formed a key part of the ongoing investigation. This paper examines Esparragosa himself and the methods he employed in his inquiry. While on the one hand Esparragosa saw himself as a cutting edge, pushing for the use of cadavers rather than wax models in the teaching of anatomy, he was also influenced by more traditional ideas when it came to diagnosing matters of the heart.

Informed by recent work on enlightenment medicine in Guatemala, such as the closely related work by Martha Few, this research is also influenced by the study of emotions in early modern medicine, such as the work by Fay Bound Alberti. My research aims to situate Esparragosa's analysis in a way that both illuminates his medical moment and illuminates the possible interpretations of the case. Based primarily on criminal court records and hospital records from Guatemala (found at the Archivo General de Centroamérica, Guatemala City), the larger project upon which this paper is based presents the events of this sensational criminal case in several related contexts. It relies on social and cultural analysis to offer a narrative history.

The paper finds that Esparragosa's introduction of cadavers in the dissection room was almost certainly related, albeit indirectly, to the corpse mutilations. It also finds, at the intersection of dissection, medical analysis, and death, a great deal of human passion. This case complicates our understanding of what "enlightened" medicine looked like in Spanish America at the start of the nineteenth century.

Key words: Mutilation, Dissection, Enlightenment

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

H4: Cultures of Dissection

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Fetal Dissection in the Anatomical Renaissance

In her groundbreaking book "The Secrets of Women," Katherine Park argues that interest in reproduction was central to the emergence of human dissection in late medieval and early modern Europe. Anatomists, contends Park, were fascinated by the female body, especially the uterus, because this was where human life began. "The female body," Park writes, "emerged ... as the ideal type of body, with a hidden and secret interior, the paradigmatic object of dissection." My research shows that anatomists in the sixteenth and seventeenth centuries were equally interested in examining and dissecting embryos and fetuses. Late medieval and early modern physicians inherited an account of conception and

generation from ancient writers, primarily Aristotle, Hippocrates and Galen, but also medieval Arabic authors including Avicenna, Rhazes and Haly Abbas. Although these earlier writers were widely respected, many physicians were highly motivated to test and challenge these traditional authorities. The most famous anatomist of the period, Andreas Vesalius, actually did very little work on fetal development, and what he did was based on dissections of animals. He claimed that his contemporaries “all set dissection aside and base their views on frivolous arguments and a piling up of authorities.” Yet an examination of the writings of many early modern anatomists, including Gabriele Zerbi, Realdo Columbo, Charles Estienne, Hieronymus Fabricius ab Aquapendente, Felix Platter and Caspar Bauhin, demonstrates the utter falsity of Vesalius’ claim. All of these anatomists sought to see the earliest phases of human life with their own eyes, to verify or to correct what they learned from texts. And while these anatomists were often forced to rely on dissections of animals rather than humans, because, as Zerbi put it, “to open a pregnant woman is to destroy the fetus, and killing the mother is cruel and inhuman,” they all reported dissecting or witnessing dissections of miscarried or stillborn human fetuses, and addressed questions about the order of formation of the organs of the fetus, the connections to the mother through the umbilical cord, and the point at which the embryo became ensouled.

Key words: anatomy, reproduction, fetus

- 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.

H4: Cultures of Dissection

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A Dangerous Precedent: Race, Dissection, and Medical Schools in the U.S. North, 1762-1860

Keywords: Race, Medical Schools, Dissection

In his new novel “The Underground Railroad,” Colson Whitehead depicts the problematic relationship between antebellum medical schools and slavery through Dr. Stephens, a Boston trained physician who as a student stole exclusively black bodies. Like many real students, the fictitious Stephens shaped his beliefs about race through his medical training. The character Stephens draws attention to the understudied story of how northern medical schools exploited black bodies, a feature of medical education that transcended regional and political boundaries.

Utilizing medical student theses, medical journals, and newspapers, this presentation explores the use of black cadavers for anatomical instruction in the U.S. North from the late colonial period up to the U.S. Civil War. Historians of slavery and medicine often overlook northern medical schools, when discussing the history of black body snatching and American medical education, in spite of the fact that many “free states” still had slaves well into the nineteenth century. Following the blueprint established in Philadelphia and New York City during the colonial period, early southern medical professors in the 1810s and 1820s—often educated in Philadelphia, Boston, or New York—already had a model for the systematic exploitation of black bodies, when they began founding medical schools in the antebellum South.

Through a focus on the development of black body snatching in northern schools, I show that dissection of black bodies was central to the growth of a unified medical profession in the United States. Through dissection, physicians across regional boundaries possessed a shared intimacy with the black body, further solidifying medical practice as a white, male endeavor. Body theft and dissection positioned medical professionals as superior to the bodies that they stole. As with many antebellum slave owners, physicians in the North and the South understood black bodies as simultaneously valuable and degraded. Physicians across the country could steal black corpses with relative impunity due to their inferior status. Finally, through a common approach to African Americans, antebellum physicians largely remained unified even as the politics of the nation became fractured over the expansion of slavery.

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

H5: Historians’ Sources and Ethics

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Stilled Lives: Beyond the Human Anatomical and Pathological Specimen

The history of human anatomical and pathological specimen collections is intimately connected to the museum. Curators, anatomists, surgeons and pathologists carefully documented details of the patient, their external appearance, from gross to micro. During surgery or after death the expert eye would select a body part, organ or tissue to be processed (preserved, labelled and displayed). The practice of processing aids the viewer in a philosophical shift (i.e. distancing) from person/patient to specimen/artifact.

From the late Nineteenth-Century onwards, anatomists, surgeons and pathologists at the University of Texas Medical Branch, Galveston (UTMB) curated several museums. The museums of anatomy, pathology and surgical pathology played a pivotal role in what Jonathan Reinartz described as the “Age of Museum Medicine.” By the mid Twentieth Century, the

museums had been dismantled; many specimens were destroyed and the survivors were put in storage. This practice was employed in museums throughout the United States and Europe, largely due to shifts in curricula and the advances in imaging technologies.

An ongoing study of UTMB's two thousand surviving specimens has gone beyond the anatomical and pathological. Employing surviving contextual sources it is possible to explore and relate the medical and social histories of individuals who ended up in Galveston. These sources offer a new perspective on old data, providing us insights on race, immigration and ethics. This paper outlines several specimen narratives and how these types of data this can be used to develop an interdisciplinary curriculum that in turn will help secure the future of the specimen collections themselves.

Keywords: anatomical, pathological, specimen

- Expand the understanding of historical human anatomical and pathological specimen collections.
- Inspire the capacity for critical thinking about curatorship, procurement and the significance of medical museum collections.
- Recognize the dynamic relationship between medicine, history and society.

H5: Historians' Sources and Ethics

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"... apparently more frequent in the negro": black patients in Rudolph Matas' visual archive

In 1896, the eminent New Orleans surgeon Rudolph Matas published 'The Surgical Peculiarities of the Negro'. This research was primarily based on ten years of clinical observations at the city's Charity Hospital. As historian David McBride noted, this text became a standard reference for racialized medical researchers for decades after its first appearance.

This paper examines the visual materials generated and assembled in parallel with the making and circulation of Matas' 'Surgical Peculiarities'. These documents include a collection of photographs that capture chronic conditions among patients admitted to Charity's 'colored wards', photographs of patients exchanged between Matas and his professional colleagues, and photographs used for educational displays and presentations. Placed in these contexts, the photographs betray a range of uses and meanings for medical practitioners, researchers and teachers. The images provide valuable evidence of the framing of racialized diseases, but they are also a special category of patient record and raise important questions concerning their appropriate use and display by historians of medicine. Furthermore, changing archival practices have complicated use of these sources: some functions served by the images remain obscure, such as those contained in a scrapbook supplemented with Matas' handwritten captions.

The paper argues that these visual documents were essential to the production of Matas' racialized medical research and embodied a number of his key arguments for

fundamental racial differences. Through the publication, display and presentation of the photographs in a variety of professional contexts, Matas manufactured racialized diseases and reinforced the dominant white image of a pathological blackness. The paper argues that these images should, however, also be read against the grain of their intended purpose and used to reconstruct a fuller portrait of black health and the black patient experience. In working towards that more holistic account of the patients, the paper highlights not only the need for a social biography of the photographs as medical objects, but also for a micro-history of their archival afterlives.

Objectives:

- To examine, through analysis of an extensive collection of visual evidence, how photographs helped to frame and disseminate notions of racialized diseases in early twentieth-century American medicine.
- To explore how medical professionals have used and made meaning from patient photographs and how historians might approach the use of these documents.
- To consider the role of medical archives in producing uneven and sometimes unequal histories of medicine.

H5: Historians' Sources and Ethics

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"I Didn't Think You Were Hysterical": Hysterectomy and Health Activism, 1982-2016

Since 1982, after experiencing she describes as a wholly unnecessary hysterectomy performed without her truly informed consent, health activist Nora Coffey has been educating and telephone counseling women about how to live with the procedure's multitudinous health consequences or to avoid it altogether in favor of more conservative surgeries and alternative therapies. The Hysterectomy Educational Resources and Services (HERS) Foundation, a women's health education and advocacy non-profit organization, has served over a million women to date. Their individual experiences have been recorded in approximately one thousand post-hysterectomy questionnaires and in an extensive counseling records database. In this talk I examine the history of the HERS Foundation, analyze these records of women's experiences, and place the organization's efforts in the broader historical context of consumer health advocacy, gynecological surgery, and women's political organizing.

While medical historians have investigated the removal or modification of female reproductive organs in the form of contraceptive sterilization (both chosen and coerced), less attention has been paid to the more common and normalized hysterectomy that is typically performed for the alleviation of severe menstrual pain or the prevention of cancer. By the age of 60, an estimated 1 in 3 American women will have undergone this procedure. I argue that the efforts of the HERS Foundation, in addition to legitimizing its clients experiences, provides a

unique perspective on late twentieth century women's healthcare for medical historians. What can the information HERS has collected tell us about women's experiences of their bodies? How have these women conceptualized, and through contact with this organization rethought, their roles as patients and savvy consumers of gynecological practice? What role does trust—of physicians and of Coffey as a health counselor—play in their clinical encounters, and how is medical expertise weighted in these assessments? In this talk I seek to answer these questions and give voice to a population often explicitly objecting to common assumptions that they are merely “hysterical” women.

- Deepen understanding of women's experiences of menopause, hysterectomy, and gynecological surgery
- Understand the dynamics between patients, doctors, and health advocacy organizations
- Critically appraise health activism from a historical perspective

Posters

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Communistically-minded Health Care for U.S. Veterans: When State Medicine Prevailed

Most studies of attempts at health care reform in the twentieth century United States note that powerful interest groups have consistently – and successfully – opposed so-called state medicine. This paper explores an aberrant case study – a moment when those who lobbied for limits in federal power lost. At the height of the Great Depression, the government sponsored veterans' health system was almost a decade old. As economic conditions worsened and veterans increasingly demanded services and treatment, doctors and prominent politicians questioned whether veterans who claimed to be injured and ill were worthy of entitlements and worried about dangerous precedents; because of the existence of an expansive veterans' health system, the Journal of the American Medical Association maintained, “Socialistically and communistically minded demagogues will demand that the state administer care to all individuals.” President Franklin Roosevelt, known for supporting generous federal assistance to citizens, favored more strenuous restrictions on veterans' access to care since, he said, the government should “yield not to the sympathy which we would extend to a single group or class by special legislation... but ... extend assistance to all groups and all classes.” Veterans and their advocates effectively fought against arguments that they were no different from fellow financially devastated Americans – and ensured that Roosevelt's limits were ultimately overturned. As such, they helped guarantee that the veterans' health system emerged in the mid-1930s intact and primed for further expansion.

The poster focuses on the nature of political attacks against veterans' health care, and how the system endured them, highlighting the roles of the (occasionally joint) advocacy efforts

of public health professionals and organizations like the American Legion, and the dynamics of disease etymology. Physicians, bureaucrats, and United States President Franklin D. Roosevelt argued that veterans' access to publicly sponsored care should be limited to those with so-called service-connected disabilities. But the definition of that term was slippery and, in many cases, subjective. The political battles of the 1930s hinted at controversies that would surface surrounding the veterans' health system in the decades – and century – to come.

- Recognize the dynamic interrelationship between medicine and society through history
- Acquire a historically nuanced understanding of the organization of the U.S. healthcare system.
- Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.

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The Kiss of Life: William Tossach, John Fothergill, and Mouth-to-Mouth Rescue Breathing in 18th-Century Britain

During the 18th century, drowning became a major public and medical issue in Britain. In this period, asphyxiation, and especially drowning, was a common cause of death from accidents. Concerned medical practitioners and lay people formed rescue societies that investigated innovative ways of resuscitation, and taught these methods to the public. One such resuscitative method was mouth-to-mouth rescue breathing. Promoted as a method that could be attempted by any rescuer, this kiss of life required a rescuer to exhale as much as they could, fully inflating a patient's lungs.

There were two key British medical practitioners behind the promotion of the mouth-to-mouth resuscitative method: Scottish surgeon William Tossach and London physician John Fothergill. To better understand their promotion of this novel approach, this study examines Tossach's 1744 account of his successful case using mouth-to-mouth resuscitation as well as Fothergill's 1745 lecture to the Royal Society supporting mouth-to-mouth resuscitation. This is set against the broader context of competing methods, such as manual artificial ventilation using inflating bellows, at this time. Tossach supported mouth-to-mouth resuscitation because he had success using it to resuscitate a man, and Fothergill expected that Tossach's successful method could be used by other rescuers.

In the 21st century, mouth-to-mouth resuscitation has become less popular in CPR protocols aimed at the public. This presentation will conclude by finding parallels in the ways that rescuers' discomfort about mouth-to-mouth resuscitation made it unpopular in the 18th century, and makes it a less-than-effective part of layperson CPR in the 21st century.

- Deconstruct Fothergill's agenda in his use of Tossach's text.
- Analyse Tossach and Fothergill's enthusiasm for mouth-to-mouth resuscitation using a close reading.
- Contextualize the rise and fall in popularity of mouth-to-mouth rescue breathing by examining its origins.

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The Long History of Evidence-Based Healthcare Design

If evidence-based design is a catchword of 21st century healthcare design, the common assumption is that it is a new phenomenon. On the contrary, it has a long history. Nineteenth and early twentieth-century American healthcare designers also actively sought to find a neutral, scientific basis upon which to rest their design decisions.

This poster briefly outlines several historical examples of evidence-based design research from the 1870s to the 1930s. It then focuses in more detail on a 1940s renovation of The Cradle (an infant placement society in Chicago). Prominent pediatrician Dr. Louis W. Sauer and prominent hospital architect Carl A. Erikson collaborated in the redesign of three adjacent infant wards which had been suffering incidence of colds and pneumonia. Each ward was provided with a different design strategy --air conditioning, u/v radiation barriers, and natural ventilation--for eliminating air-borne germs. The design was a full-scale, real-time architectural experiment, which controlled for variables and which provided data that was expected to directly correlate design details to disease incidence. How the data was then interpreted proved crucial to the success of the experiment and the conclusions drawn from it.

This poster concludes that the long history of evidence-based design provides a crucial historical context which should inform current interests and illuminate the critical, but hidden process of transforming data into active policy.

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

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Apricots, Cancer, and the Politics of Choice: The Laetrile Controversy

A purported cancer treatment derived from apricot pits, supported by anecdotal patient testimony but unsubstantiated by objective scientific evidence, Laetrile became a symbol of the freedom of choice and patient empowerment in the 1970s in the United States. Groups who supported Laetrile fueled its national popularity through an anti-establishment political rhetoric that challenged orthodox medical authority. The ensuing political and scientific controversy over Laetrile's legitimacy as a cancer treatment forced medical professionals and regulatory authorities to reevaluate their roles in the medical world order.

Though this controversy was clothed as a scientific debate about a new drug's safety and efficacy, I argue that it was less about the merits of the science underlying the substance than it was about individual rights and challenging institutional power. Building upon the scholarship of other authors who have studied the bases of social movements, I demonstrate how Laetrile-promoting groups successfully created a unique collective identity for their members that bridged shared experiences of cancer patients with the themes of a grassroots conservative movement whose mission fostered an increased sense of individual autonomy.

By examining correspondence with the AMA, Laetrile-promotion paraphernalia, scientific reports, and media publications, this paper traces the Laetrile controversy from its conception in 1952 to its culmination in 1977, when individual physicians and patients, professional medical organizations, and governmental regulatory bodies were forced to equilibrate their power with respect to one another, and when the questions concerning Laetrile's legitimacy were deferred to the realm of Congress and the Courts.

Keywords: alternative medicine; patient autonomy; FDA

- Understand the historical, legal, and political elements that couched a biopolitical movement to advance patient autonomy throughout the course of the Laetrile controversy.
- Appreciate the role of the FDA and the Courts in shaping the practice of care for patients with terminal illness.
- Appreciate the role of the physician-patient relationship in shaping attitudes of trust and mistrust of traditional medicine, and consider ways in which alternative treatments have been addressed by medical orthodoxy.

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V.P. Demikhov and the Contradictions of Formation of Soviet Transplantology

In 1920-1960 Soviet experimental medicine presented the world a number of significant discoveries, that aided the development of such clinical areas as cardiac surgery and transplantology. In 1925 soviet surgeon I.P. Dmitriev presented his own method of interatrial septum perforation, based on his experiments on animals and corpses. In the same year

another Russian scientist physiologist Briukhonenko became the first in the world who constructed and introduced cardiopulmonary bypass. The research of surgeon N.N. Terebinsky in 1938-1940 gave the bases of experimental open-heart surgery.

Speaking about the outstanding scientists, we are to mention outstanding Russian physiologist V.P. Demikhov, who was a teacher of such prominent persons as Christian Bernard and Michael Ellis DeBakey. But despite the fact that his reputation was generally recognized by the foreign colleagues, Demikhov's achievements in the field of transplantology were not appreciated in the USSR for a long time. All his activities, researches and even his person were condemned by the Soviet medical community.

In 1937 being a third-year student of the biological faculty (physiology section) of Moscow State University Demikhov constructed the first artificial heart in the world. He implanted it to a dog and the dog even lived 2 hours after the surgery. In the same year Demikhov became the first who conducted the heart and heart-lung transplantation from one dog to another. In 1954 the scientist made his most famous experiment: transplanted the head of one dog on the trunk of another. There was made a section in the middle of anesthetized puppy's thorax and then the forepart of his trunk (including the paws) without heart and lungs was transplanted on the dog's neck. Through this experiment Demikhov approved the ability of complex transplantation and complete recovery of transplanted organs' functions.

Despite the fact that the book "Experimental transplantation of vital organs" written by Vladimir Demikhov became the first study about the experimental transplantology, the scientist hadn't got an academic degree till 1963. Only in that year the degree of Doctor was conferred to him. That was the official mark of respect and recognition of his achievements in the USSR.

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"Ganka shinsho" ("A New Treatise on Ophthalmology") and the Rediscovery of the Eyes in Early Modern Japan

How does one study the human body? This question acquired special significance in the social and medical contexts of early modern Japan during the Tokugawa period (1603-1868). For much of this period, the Tokugawa government tightly regulated Japan's foreign relations, and the Dutch—through the Dutch East India Company—were the only Europeans allowed to engage in official trade with Japan. From the eighteenth century, the Tokugawa government eased restrictions on the import of foreign books to promote learning for practical uses. The influx of European-language sources via the Dutch intermediaries stimulated intense interest in European science and medicine among Japanese intellectuals. This led to the rise of rangaku (or Dutch studies) in Japan.

In this poster, I focus on "Ganka shinsho" ("A New Treatise on Ophthalmology"), a Japanese translation and annotation by the nineteenth-century rangaku scholar Sugita Ryoukei, which was based on Joseph Jacob von Plenck's Latin treatise "Doctrina de morbis oculorum"

("The Instruction of Eye Diseases"). By comparing "Ganka shinsho" with earlier and contemporary Japanese works on the human anatomy, I explore how "Ganka shinsho" drew upon the rangaku tradition to introduce a new look at the physiology of the eyes and the pathologies and etiologies of eye diseases. First, the illustrations in "Ganka shinsho" rendered the eyes according to the medical and artistic impressions of rangaku-inspired visions of the corporeal self. These illustrations enlarged the sense of the material reality of the eyes as knowable objects. Second, the innovative linguistic choices in the translated text, characteristic of rangaku scholarship, were central to transforming discourses of eye diseases. These choices expanded the semantic range of traditional medical terms in Japanese intellectual thought, while reflecting a nuanced understanding of foreign concepts in explaining cause and remedy. Through this careful re-reading of "Ganka shinsho", I argue that medical knowledge in early modern Japan was reconfigured in the vibrant intellectual environment of rangaku studies. For the first time, the eyes were dissected in text and in image—they were worthy of investigation in their own right and as part of a coherent body of knowledge about the human anatomy.

- Develop a well-informed perspective on the dynamic relationship between medicine and society through a focus on the cross-cultural exchanges of medical ideas between Europe and East Asia.
- Develop the capacity to think critically about medical texts and illustrations for interpreting medical history.
- Acquire an understanding of the interactions of indigenous and foreign medical traditions in responses to diseases across geographical and cultural regions.

Keywords: Ophthalmology, Anatomy, Japan

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Labor, Race, and Comparative Disease Susceptibility in the Urban Old South

Recent studies have identified health and treatment disparities between white and black Americans. One study of white medical students, for instance, posited that “racial bias in pain perception is associated with racial bias in pain treatment recommendations” for black patients. False and at times fantastical beliefs about racial differences, we now know, led the U.S. military to conduct secret experiments during World War II to determine what effect chemicals like mustard gas had on black skin. Seeking “ideal chemical soldiers” resistant to attack and hoping to shield white troops, investigators classified black bodies as inferior, “other,” and therefore experimental, whereas white bodies were assumed superior, “normal,” and thus the control group. Whether past or present, racialized misconceptions and biases result in consequential decisions, policies, and actions.

My project examines how racialized (mis)perceptions of disease (in)susceptibility affected employment policies and hiring decisions in antebellum southern cities. Sources ranging from medical journals and reports to city council minutes and job advertisements

reveal that (aside from factors like race, skin color, gender, and skill) authorities and employers in the urban Old South appraised the disease “acclimation” status of potential workers when making hiring decisions, whether for a soldier, stevedore, washerwoman, or watchman. With the etiologies and epidemiologies of many diseases yet undiscovered, southern medical and municipal authorities preferred or required free black and enslaved workers during yellow fever epidemics that overwhelmingly targeted recently arrived and “unacclimated” white immigrants. These same white laborers, however, were favored during bouts with cholera, given that malady’s disproportionate impact upon black workers and contemporary reputation as a “Negro disease.”

Despite an expanding historical literature on illness, medicine, health, and death in the antebellum South, unexplored is how race and disease intersected with matters of labor, especially in urban environments. Medical researchers today are investigating the confluence of race, disease risk, and genetics among black Americans. Some have even hypothesized that the harshness of slavery triggered natural selection for genes with significant health and disease implications for African Americans. Scientists accordingly are turning to historians for context and expertise, and my work will contribute to such knowledge and collaboration.

- Develop a historically informed sensitivity to the diversity of patients (including appreciation of race, ethnicity, gender, class, and socio-economic status), and recognize the dynamic interrelationship between medicine and society through history.
- Understand the dynamic history of medical ideas and practices (including those proven false or ineffective), their implications for patients, health care providers, and other authorities, and the need for lifelong learning and scientific exploration.
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education.

Key Words: Disease, Race, Labor

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Paul de Kruif, Guerilla Fighter for Public Health

Public Health (PH) was not a major item in the thirties. Doctors had limited ideas on PH and officials were not necessarily MDs; trespassing, as physicians saw it, on medical turf created friction. Medical hierarchy (AMA) being against reform (governmental mingling in medical matters; “socialized medicine”) obstructed PH initiatives. In this setting Paul de Kruif (Microbe Hunters) popularized PH, medical problems and developments, as became clear from unpublished correspondences with writer Ezra Pound, Surgeon General PH Thomas Parran, many other doctors, among whom Henri Sigerist, champion of socialized medicine.

De Kruif discovered deficient health, mainly among the indigent, and exposed sore spots in American health care in popular magazines, heralding everyone's right to health. Many physicians got irritated (leftist De Kruif only had a PhD in bacteriology) and attacked him. But he also described how doctors, scientists and public health men contributed to better health for all after the Depression. He became a driving force in health rallies (against pellagra, mother and child mortality, tuberculosis, syphilis, polio, malnutrition). The American Journal of Public Health praised him for his "contribution to public understanding and appreciation of health work" (1934). He closely collaborated with his friend Parran, but many years on his own in the medical arena would follow.

Sigerist told De Kruif: "We shall never get a national health program unless the people ask for it" (1938). But motivating the people to stand up collectively for their right on health was difficult. Parran and De Kruif were convinced that government was indispensable for new PH activities during threat of war. They had to manoeuvre carefully in this minefield of contrasting opinions; De Kruif managed to present a National Health Plan to the President in person (1939). Sigerist did not appreciate this diplomatic move. Anyway, Roosevelt choose to invest in armaments. The friends then pointed to the appalling state of health of draftees and De Kruif promoted newly discovered vitamins and healthier food. In 1950 AMA leadership and De Kruif joined forces. Medical science and the attitude of younger doctors toward their patients had changed, favoring the awareness of PH and disease-prevention.

- recognizing the dynamic interrelationship between public health and medical politics during the thirties and forties;
- discovering that Paul de Kruif was an important actor between the public and the doctors;
- realizing the influence of popularization of medical science, including public health.