

FRIDAY, APRIL 22, 2022

7:00 am-6:00 pm	AAHM Conference Registration	<i>Lower Lobby</i>
7:00-8:00 am	President's New Member Breakfast	<i>Highrock</i>
7:00-8:00 am	<i>Bulletin</i> Breakfast	<i>Broadway 1 & 2</i>
7:00-8:00 am	<i>Journal</i> Breakfast	<i>Broadway 3</i>
7:00-8:00 am	<i>Nursing History</i> Review	<i>Broadway 4</i>
7:00-8:00 am	Medical Heritage	<i>Whitney</i>
7:00-8:30 am	Continental Breakfast	<i>Gallery</i>
8:30-10:00 am	Welcome and President's Address Presiding: Barron Lerner, New York University <i>"Unnecessary Sleep": Opium, the Trial of Ann, and the Therapeutic Dilemma of Slavery</i> Keith Wailoo, Princeton University, AAHM President	<i>City Center M2 upper level</i>
10:00 am-5:00 pm	Book Exhibit	<i>Saratoga Ballroom 1</i>
10:00-10:30 am	Refreshment Break	<i>Saratoga Foyer</i>

10:30 am – 12:00 noon Concurrent Sessions A1 – A6

A1. Postpartum Histories: Race, Gender, and Disability in Postnatal Care

Saratoga Ballroom 2

Chair: Nicholas Bonneau, University of Maryland

1. [Udodiri Okwandu, Harvard University, *Defending Anne Bradley: White Racial Decline and the Medico-Legal Construction of Puerperal Insanity*](#)
2. [Miriam Rich, Dartmouth College, *Monstrous Affect: Touch, Caregiving, and Anomalous Newborn Bodies in 19th-Century U.S. Medicine*](#)
3. [Elizabeth O'Brien, Johns Hopkins University, *Temporary Sterilization During Postpartum in 1930s Mexico*](#)

A2. Ethics and Biology

Saratoga Ballroom 3

Chair: David Herzberg, University of Buffalo,

1. [Zoe Adams, Yale University, *Not in Our Medical Society: Methadone and the Unethical Doctor in Late 1960s New Orleans*](#)
2. [Gina Surita, Princeton University, *From Cancer to Carbohydrates: Metabolic Cycles, Collaboration, and Experimentation in 1920s Biochemical Physiology*](#)

3. [Alexis Bedolla, Universidad Nacional Autónoma de México, *The development of U.S. epidemic intelligence: from biological weapons to emergent diseases and bioterrorism* \(Pre-recorded video\)](#)

A3. Segregation, Race, and Space (in person and virtual)

Alabama/Travers

Chair: Adam Biggs, Johns Hopkins University

1. [Ashley Graham-Perel, Teachers College Columbia University, *"We've Integrated, Now What?" The Interrelationships between Nursing, Race, and Medicine at New York's Lincoln School for Nurses*](#)
2. [Kevin McQueeney, Nicholls State University, *"A Great and Manifest Destiny": Creating A White Medical District in New Orleans, 1900-1940* \(Pre-recorded video\)](#)

A4. Three Centuries of Mad Women

Highrock

Chair: Laura Hirshbein, University of Michigan

1. [R.E. Fulton, Independent scholar, *Unwritten Laws: The Gender of Insanity in the Nineteenth-Century American Courtroom*](#)
2. [Rachel Louise Moran, University of North Texas, *Self-Help, Psychiatric Help, and the Postpartum Revolution of the 1980s*](#)

A5. Medicine in the Margins: Expanding Our Perspective of Early Medieval Knowledge and Practice

Broadway 1 & 2

Chair: Arsenio Ferraces-Rodríguez, University of A Coruña

1. [Meg Leja, Binghamton University, *Pushing the Boundaries of a Binary: Medicine versus Religion before the year 1000*](#)
2. [Jeffrey Doolittle, Fordham University, *Hidden in Plain Sight: Assessing Marginal Therapeutic Recipes in Early Medieval Medical Encyclopedias*](#)
3. [Claire Burridge, University of Sheffield, *Here, there, and everywhere: A fresh perspective on the manuscript contexts of medical knowledge*](#)

A6. Pandemics, Public Health, and the Making of the Modern American State

Broadway 3 & 4

Chair: Stephen Pemberton, New Jersey Institute of Technology

1. [Beatrix Hoffman, Northern Illinois University, *Influenza 1918-19 and U.S. Health Care Exceptionalism*](#)
2. [Stephen Colbrook, PhD Candidate, *Why U.S. State Development Matters to the History of HIV/AIDS* \(Pre-recorded video\)](#)

12:00 noon-1:00 pm Lunch on your own

12:00-1:00 pm *Demystifying the Publication Process: A Chat with the Editors of BHM, JHMAS, & NHR*
Whitney

1:15-2:45 pm Workshops L1-L6

L1. *Historicizing Practitioners' Emotions in the History of Medicine* **Saratoga Ballroom 2**
Jacob Moses, Agnes Arnold-Forster, Kimberly Adams, Megann Liciskai

L2. *Carceral Psychiatry, Abolitionist Psychiatry* **Saratoga Ballroom 3**
Hannah Zeavin, Kylie M Smith, Udodiri Okwandu, Ayah Nuriddin, Jessica Adler

L3. *A Historiographic Challenge: Race and Racism in the History of Medicine* **Alabama/Travers**
Rana Hogarth, Barron Lerner, Ezelle Sanford III, Christopher Willoughby

L4. *Shaping our Future and Understanding the Past: Developing and Implementing an Antiracist Curriculum at a Medical School* **Highrock**
Katherine Schaub, Ameisha Tutwiler, Chisom Nwagbo, Elizabeth Shimoura

L5. *Race Relations at Academic Health Centers: Historical Scholarship to Enrich Teaching and Community Engagement* **Broadway 1 & 2**
Raúl Necochea López, Jeffrey Baker, Jason Glenn, Aimee Medeiros, Dominique Tobbell, Ren Capucao

L6. *Approaching the Intersections of Medicine and Anthropology: Insights from the Americas in the 20th Century* **Broadway 3 & 4**
Julia E Rodriguez, Rosanna Dent, Catherine Mas, Alberto Ortíz Díaz, Laura Stark, Adam Warren, Taylor Dysart

2:45-3:00 pm Break

3:00-4:30 pm Concurrent Sessions B1 – B6

B1. Power and Knowledge in Women's Bodies **Saratoga Ballroom 2**
Chair: Leslie Reagan, University of Illinois, Urbana-Champaign

1. [Andrea Ditkoff, Rutgers University, "Healthy Women, Healthy Lives": The Nurses' Health Study and American Women's Health Research, 1960s-1990s](#)
2. [Madeleine Ware, Yale University, Gynecological Gymnastics: Assuaging Victorian Anxieties with Pelvic Floor Strengthening](#)
3. [Andrew Simmons, University of Rhode Island, Working Around the Black Box: Women and Medical School Admission 1900-1970](#)

B2. Health and Incarceration in Historical Perspective **Saratoga Ballroom 3**
Chair: Miriam Rich, Dartmouth Society of Fellows

1. [Caroline Beit, Yale University, The Newgate Prison Trial: Lessons from England's First Vaccine Clinical Trial for the Covid-19 Era](#)
2. [Charlotte Kim, Yale University, The 1918 Influenza at Eastern State Penitentiary: Narratives of Ambivalence Among Incarcerated Men](#)
3. [Heather-Destiny Konan, Emory University, Heat, Health, and COVID-19 in Texas Prisons](#)

B3. Medicine and Slavery in the North (in person and virtual) **Alabama/Travers**
Roundtable Session

Chair: Jason Glenn, University of Kansas Medical Center

Introduction: Richard Mizelle, University of Houston

Panelists:

Christopher Willoughby, Schomburg Center For Research In Black Culture

Rana Hogarth, University of Illinois

B4. Regulating Safety in the American Medical Marketplace **Highrock**

Chair: Nancy Tomes, Stony Brook University

1. [Alexander Parry, Johns Hopkins University, *Federalizing Safety: Consumers, Regulation, and the U.S. National Commission on Product Safety, 1968–1970*](#)
2. [Jiemin Tina Wei, Harvard University, *Contraceptives and their Physician-Proselytizers: Hugh Davis, Howard Tatum, and the Market of Reproductive American Women, 1970-1985*](#)
3. [Brice Bowrey, University of Maryland, *The Pursuit of Safe Medical Devices: Manufacturers, Medical Experts and Changing Federal Regulation, 1960-2000*](#)

B5. Health and mobility in premodern northwestern Europe 1300-1500 **Broadway 1 & 2**

Chair: Dora Vargha, Humboldt-Universität zu Berlin

1. [Lola Digard, Universiteit van Amsterdam, *Expiatory pilgrimages and the health of mobility in the county of Flanders, 1300-1500*](#)
2. [Janna Coomans, Universiteit van Amsterdam, *Biopolitics, Health and the Itinerant Poor in the Late Medieval Netherlands*](#)
3. [Claire Weeda, Universiteit Leiden, *Regulating the mobility of the able-bodied poor and public health services in fifteenth-century cities in the Low Countries*](#)

B6. Placing the Microbe: Global Visions of Environment and Health in an Antibiotic Age
Broadway 3 & 4

Chair: Richard Keller, University of Wisconsin-Madison

1. [Elliott Bowen, Nazarbayev University, *Chasing Syphilis: Penicillin Therapy, Sex Research, and the Origins of VD Contact Tracing in Hot Springs, Arkansas, 1943-1953* \(Pre-recorded video\)](#)
2. [Johanna Conterio, Flinders University, *Microbes in the Steppe: Tuberculosis Treatment between Probiotics and Antibiotics, 1920s-1950s* \(Pre-recorded video\)](#)
3. [Emmanuelle Roth, University of Cambridge, *Controlling the Reservoirs of Ebola: Shifting Epistemologies of Epidemic ‘Latency’ across Scientific Disciplines in the early 21st century* \(Pre-recorded video\)](#)

4:30-5:00 Refreshment Break

Saratoga Foyer

5:00-5:45 pm Author Chats 1-4

Author Chat 1

Highrock

Chair: Jonathan Sadowsky, Case Western Reserve University

Peter Swenson, Yale University, *Disorder: A History of Reform, Reaction, and Money in American Medicine*

Kim Nielsen, University of Toledo, *Money, Marriage, and Madness: The Life of Anna Ott*

Author Chat 2

Broadway 1 & 2

Chair: Deborah Doroshow, Icahn School of Medicine at Mount Sinai

Lucy Lester, University of Chicago, retired, *Women and the Practice of Medicine: A New History (1950-2020)*

Katherine Carroll, Boston University, *Building Schools, Making Doctors: Architecture and the Modern American Physician*

Author Chat 3 (in person and virtual)

Alabama/Travers

Chair: Naomi Rogers, Yale University

Susan Reverby, Wellesley College, retired, *Co-Conspirator for Justice: The Revolutionary Life of Dr. Alan Berkman*

Sydney Halpern, University of Illinois, Chicago, *Dangerous Medicine: The Story behind Human Experiments with Hepatitis*

Author Chat 4

Broadway 3 & 4

Chair: Jessica Adler, Florida International University

Elena Conis, University of California, Berkeley, *How to Sell a Poison: The Rise, Fall, and Toxic Return of DDT*

Jeffrey Reznick, National Library of Medicine, *War and Peace in the Worlds of Rudolf H. Sauter: A Cultural History of a Creative Life*

5:45-6:00 pm Break

6:00-7:00 pm Fielding H. Garrison Lecture

City Center M2 upper

"Syphilis, 1880-1917: Patients, Disability, History"

Janet Golden, Rutgers University

7:00-9:00 pm Garrison Reception

Gallery

SATURDAY, APRIL 23, 2022

7:00 am-6:00 pm AAHM Conference Registration

Lower Lobby

7:00-8:00 am Women Historians Meeting

Saratoga Ballroom 3

7:00-8:00 am Clinician Historians Meeting

Saratoga Ballroom 2

8:00-9:30 am AAHM Awards and Breakfast

City Center M2 upper

8:00-2:30 pm Book Exhibit

Saratoga Ballroom 1

9:30-9:45 am Break

9:45-11:15 am Concurrent Sessions C1-C6

C1. Health and Dispossession in Native History, 1865–1918

Saratoga Ballroom 2

Chair: Jennifer Gunn, University of Minnesota

1. [Juliet Larkin-Gilmore, ACLS Oscar Handlin Fellow, *Health-Seeking as a Tool of Dispossession: The Cherokee Health Drive of 1917*](#)
2. [Macey Flood, University of Texas Medical Branch, “The condition of the Indians”: health and territoriality, 1865-1891](#)
3. [Frank Vitale IV, National Library of Medicine, *Charting Death: Visualizing Mortality Data from the Carlisle Indian Industrial School, 1879-1918* \(Pre-recorded video\)](#)

C2. Everyday Technologies of Mental Health: Mediation, Calibration, Datafication

Saratoga Ballroom 3

Chair: Susan Lamb, University of Ottawa

1. [Jeremy Greene, Johns Hopkins University, *Broadcasting Brain Waves: Wireless Technologies, DIY Electroencephalography, and the Mediation of Psychosis*](#)
2. [Hannah Zeavin, Berkeley, University of California, *Prediction as Prevention: The Datafication of the Suicide Hotline* \(Pre-recorded video\)](#)
3. [Jaipreet Viridi, University of Delaware, *Auditory Stresses: Miscalculation & Misfitting of Hearing Aids* \(Pre-recorded video\)](#)

C3. Health Politics and Activism (in person and virtual)

Alabama/Travers

Chair: Kimberly Adams, Stanford University

1. [Isobel Ashby, University of Wisconsin-Madison, *Recruiting Right-to-Lifers on Campus: Feminists for Life of America, ‘Pro-Life, Pro-Women’ Activism, and College Outreach Programs*](#)
2. [Karissa Patton and Whitney Wood, Vancouver Island University, “An Act of Independence and Self Love”: Self-Examination as Women’s Health Activism in Canada, 1970-1990](#)
3. [Eana Meng, Harvard Medical School, “The Promised Land”: The 1972 Black Panther Party Delegation to China and Its Impact on Three Healthcare Providers](#)

C4. Sexual Controversies

Highrock

Chair: Raul Necochea López, University of North Carolina

1. [Arnav Bhattacharya, University of Pennsylvania, *Negotiating between a Racialized and a Universal Sexual Subjectivity: Race, Sexology, and Medicine in Twentieth-Century India*](#)
2. [Andreas-Holger Maehle, Durham University, *The Sexual Psychology of Albert Moll: A Lost Alternative to Freud’s Theory of Sexuality?*](#)
3. [Queenie Ng, Nanyang Technological University, *Defending the Family: The Sanctioning of Sexual Knowledge in Singapore, 1980-1990* \(Pre-recorded video\)](#)

C5. Politics of Space

Broadway 1 & 2

Chair: Jennifer Thomas, Virginia Tech

1. [Gaëtan Thomas and Guillaume Lachenal, Médialab, *Erased histories of the early AIDS epidemic in Paris. Space, loss, and postcolonial connections at the Claude Bernard Hospital*](#)
2. [Cara Fallon, Yale University, *Therapeutic Deception? Dementia Villages, Institutional Care, and an Emerging Ethic of Alzheimer's Disease Care*](#)
3. [Kim Nielsen, University of Toledo, *Medical Cure, Moral Redemption: Dorothea Dix and the Making of Asylums and Prisons*](#)

C6. Racism in Training and the Profession

Broadway 3 & 4

Chair: Chris Crenner, University of Kansas

1. [Eleanor Shaw, The University of Manchester, *Old Boys' Network or Meritocracy? Recruitment at the British Journal of Anaesthesia 1970-2020*](#)
2. [David Johnson, Federation of State Medical Boards, *Diversity and Power Structures in Medical Licensing: Historical Context and Suggestive Trends*](#)
3. [Rimma Osipov, UNC School of Medicine, *Doctors as Strangers: International medical graduates and the "crises" of medicine and immigration in the 1960s and 70s \(Pre-recorded video\)*](#)

11:15-11:30 am Break

11:30 am-12:30 pm Poster Session and Refreshments

Gallery

1. Leigh Alon, Johns Hopkins University, *Tay Sachs Disease*
2. Zachary Blatchford, Clarkson University, *The Curiously Long History of Oxycodone's Addiction Liability*
3. Melissa Brown, Stephen Casper, Clarkson University, *"How dangerous is heading?": Soccer, Brain Injury, and History*
4. Arielle Coughlin, Clarkson University, *Trends in Obstetric Analgesia Practices*
5. Paul Cummins, Clarkson University, *Conscientious Objection in Military Service and Health Care: The Importance of Disanalogy*
6. Genevieve Dally-Watkins, The University of Sydney, *Cultures of Colonialism and Natural History: The Immunitary Logic of Charles Nicolle*
7. Janet H. Davis and Joseph Coates, Purdue University Northwest, *A Historical Analysis of the Indiana Center for Evidence-based Nursing Practice*
8. Kristen Ann Ehrenberger, University of Pittsburgh, *Teaching Medical Students History of Nutrition*
9. Joy-Louise Gape, SUNY Stony Brook University, *COVID related discrimination aimed at Asian Americans in historical perspective*
10. Luke Haqq, University of Minnesota, *Medical Malpractice*
11. Alan Hawk, National Museum of Health and Medicine, *Operation Warp Speed – Preserving the history of the Department of Defense response to COVID-19*
12. Mary Horton, University of Texas, *The Power of Stories: Teaching U.S. History of Psychiatry To Clinical Students Through Stories*

13. Steven Howe, University of California, San Diego, *Byzantium Xenones : Invention of the Modern Hospital*
14. Catarina Janeiro, University of Porto, *Wonder women, where were you one hundred years ago? - what a medical historian can do for gender equality*
15. Jonathan Kuo, University of California, Berkeley, *The Personal Belief Exemption to Vaccination in American History in Data*
16. Yating Li, University of Illinois, Urbana-Champaign, *Race for Three Shots: HPV vaccination, Women and Biopolitics in Mainland China (2010s-present)*
17. Walker Magrath, Johns Hopkins University, *The Fall of the Nation's First Gender-Affirming Surgery Clinic: Interrogating Scientific Evidence in the Realm of Institutions, Morality, and Bias*
18. Shannon Mattice, University of Rochester, *African American patients cannot and do not feel the same pain as white patients*
19. Cameron MacDonald, Regis University and University of Newcastle, *James Paget's 1867 bone-setting perspective still matters: The historical genesis, development and historical narrative of manual therapy across professions.*
20. Jay Natarajan, Matthew Kubina, Sanjay Jinka, Nancy Gantt, Northeast Ohio Medical University, *Silicone Valley: The Dark History of Breast Implants*
21. Dalena Ngo, Yale University, *Narrative Medicine workshops on anti-blackness, anti-black violence, professional development to promote black excellence and radical healing*
22. Aminata Niang, Laura Ettinger, Clarkson University, *"I won't be a Guinea pig for white people!"*
23. Naveed Nikpour, Stony Brook University, *Integration of Medicine and the Community: How the 1984 Family Doctor and Nurse Program in Cuba Transformed Health Care*
24. Jane Oppenlander and Eva Williford, Clarkson University, *Integrating History, Bioethics, and Technology into a Redesigned Epidemiology Course*
25. Xiaomei Pei, Federation of State Medical Boards, *The licensing and disciplining of physicians*
26. Jonathan Pham and Kathryn Martin, University of California, Berkeley, *STS-90 Neurolab Space Shuttle Mission and the First Animal Space Survival Surgery*
27. Codruța Alina Popescu, Armean Sebastian Mihai, Buzoianu Anca Dana Clarkson University and Iuliu Hațieganu University of Medicine and Pharmacy, *Ethical and Public Health Attitudes on Physical Distancing, Self-isolation, Quarantine, and Lockdown in the early stage of the Covid-19 pandemic in Romania*
28. Dillon Prus, Clark University, *"To Go Where the Medical Men Cannot Go": Advertising the Tuberculosis Campaign and Redefining Public Health in Michigan, 1920-1940*
29. Jesús M. Saavedra, Centro de Estudios Avanzados de Puerto Rico y el Caribe, *First Female Licensed Physician (1609) of the Caribbean (West Indies)*
30. Corey Schultz, University of Pittsburgh, *A Settlement House and a Hospital: Immigrant Healthcare Provided by Pittsburgh's Jewish Community*
31. Ida Sofie Rettedal Skjaeveland, University of Oslo, *Death and dying in medical practice in Norway in the 1980s and 1990s*
32. Anne Sigrud Lindblad Stokke, University of Oslo, *Youth narcomania as a criminal problem in 1960s Norwegian news media*
33. Nicole Topich, Oskar Diethelm Library, Weill Cornell Medicine, *The Rise and Decline of*

Psychiatric Hydrotherapy

34. John Witherspoon, Virginia Commonwealth University, *Adventure, Races and Retreats: Ulysses S. Grant's Visits to Saratoga Springs*
35. Emily Xiao, Johns Hopkins University, *Border Conceptions: A Cluster of Neural Tube Birth Defects in the Lower Rio Grande Valley*
36. Saul Zuniga, Southwestern University, *To Live and Birth On: Mexican Midwives' Prosperity Into Modernity*

12:30-1:30 pm **Lunch on your own**

12:30-1:30 pm **Meet the editors of *Social History of Alcohol and Drugs***
Whitney

12:30-1:30 pm **Global Histories of Medicine, Science, Race and Colonialism: Book Series**
Launch/meet the editors **Broadway 1 & 2**

1:30-3:00 pm **Concurrent Sessions D1-D6**

D1. Racism Across Borders

Saratoga Ballroom 2

Chair: Adam Warren, Washington University

1. [Steve Server, University of Chicago, *Encountering an "unknown Mexico": Race, eugenics, and medical education in Mexico, 1935-1940*](#)
2. [Pamela Maddock, University of Sydney, *Race, trust, and disease control in the US Army: Mandated prophylaxis for stevedores in St. Nazaire, 1917*](#)
3. [Carly Naismith, York University, *In the Minority: Anatomical Education in Canada and the Hidden Curriculum of Gender Roles and Race Relations*](#)

D2. Politics of the Body

Saratoga Ballroom 3

Chair: Lara Freidenfelds, Independent Scholar

1. [Sandra Eder, University of California, Berkeley *"A Happier Future." The Making of the 'Transsexual' Patient at the Gender Identity Clinic at the Johns Hopkins Hospital, 1966-1979*](#)
2. [Richard McKay, University of Cambridge, *"I told him that there had been no girl": Examining an allegation of same-sex gonorrhea transmission in 1930s British Columbia*](#)
3. [Olivia Weiss, Case Western Reserve University, *A Partner in the Ballroom: Testicular Prosthesis and Masculinity in Medical Journals and Patient Experiences*](#)

D3. The Power in Front of the Throne? (in person and virtual)

Alabama/Travers

Chair: Mical Raz, University of Rochester

1. [Kelly O'Donnell, Yale University, *Behind the Great Doctors: Locating the Physician's Wife in the History of American Medicine*](#)
2. [Sarah Naramore, Northwest Missouri State University, *Sense and Amiability: Julia Rush and the character of American medicine, 1776-1815*](#)
3. [Wendy Kline, Purdue University, *Nassar and the National Nightmare: gynecology, gymnastics, and the potential for abuse*](#)

D4. Patient Power and Eugenics

Highrock

Chair: Sarah Rodriguez, Northwestern University

1. [Heather Dron, University of Michigan, *Refusal and Resistance: Patients' and Relatives' Objections to Sterilization in California Institutions, 1922-1948*](#)
2. [Paul Lombardo, Georgia State University, "The Courage of their Convictions," *Nazi Sterilization Law in the US Press, 1933-1949*](#)
3. [Nali Gillespie, Duke University, *Postpartum Sterilizations and Reproductive \(In\)justice in the mid-twentieth Century at a North Carolina Teaching Hospital* \(Pre-recorded video\)](#)

D5. Medicine and Digital Humanities in Action

Broadway 3 & 4

Chair: Simone Caron, Wake Forest University

1. [Mary Fissell, Elaine Leong, Johns Hopkins University, *Print, Pills, and Promotion in Seventeenth-Century London*](#)
2. [Angela Potter, Purdue University, *Going to Therapy: Locating Outpatient Treatment Spaces in the Therapeutic Landscape, 1945-1975*](#)

3:15-4:15 pm AAHM Business Meeting and Refreshments

Saratoga Ballroom 3

4:15-4:30 pm Break

4:30-6:00 pm Concurrent Sessions E1-E6

E1. Epidemics, Chronicity, and Pandemicity

Saratoga Ballroom 2

Chair: Jacob Steere-Williams, College of Charleston

1. [Simone Caron, Wake Forest University, *The Expansion and Limits of Public Health during Epidemics in Winston Salem, NC, 1910-1930*](#)
2. [Emma Broder, Harvard University, *Epidemiology without Pathology: Nonspecific Disease Definition at Lake Tahoe, 1984-5*](#)
3. [Robert Frank, University of California, Los Angeles, *The Birth of a Monster: The Emergence of Lethal Smallpox in Early Stuart London*](#)

E2. Developing Expertise and Knowledge in the Body and Environment

Saratoga Ballroom 3

Chair: Jeremy Greene, Johns Hopkins University

1. [Lan Li, Rice University, "The Pain of Overthinking: Attitudes of the Spleen 脾 in Literary, Medical, and Culinary Cosmologies"](#)
2. [Joseph Leonardo Vignone, Harvard University, "But Do Not Overdo It and Sicken Your Patient!" *al-Rāzī, Enhancement Medicine, and the Structure of the Human Mind*](#)
3. [David Jones, Sunil Amrith, Harvard University, *Air Pollution, Health, and the Politics of Indigenous Knowledge in India*](#)

E3. When and Where Slavery Entered: New Directions in the Study of Race and Medicine (in person and virtual)

Alabama/Travers

Chair: Cassia Roth, University of Georgia

1. [Jim Downs, Gettysburg College, *The Phantom of Slavery in Epidemiology: \(In\)visible Knowledge Production in the Atlantic World*](#)
2. [Rana Hogarth, University of Illinois, *"For negroes do not prepare so much, nor so good blood as the whites...": Enduring Medical Knowledge in the Age...*](#)
3. [Diana Louis, University of Michigan, *The "Method in her Madness": Harriet Tubman and 19th-century Conceptions of Insanity* \(Pre-recorded video\)](#)

E4. Therapeutics and Creation of Knowledge

Highrock

Chair: Kristen Ann Ehrenberger, University of Pittsburgh

1. [Wankun Li, University of Strathclyde, Glasgow \(Wellcome Trust\), *'The Iron Man' and 'The Painless Hospitals' in Great Leap Forward China*](#)
2. [Natalie Shibley, Wesleyan University, *Peanut Panacea: The Medical Ideas of George Washington Carver*](#)
3. [Yijie Huang, University of Cambridge, *Pulse Remedies and the Topology of Healing in Early Modern England* \(Pre-recorded video\)](#)

E5. From Cradle to Older Adults

Broadway 1 & 2

Chair: Beatrix Hoffman, Northern Illinois University

1. [Johanna Schoen, Rutgers University, *Life and Death in the Nursery: Making decisions in the NICU*](#)
2. [Vivien Hamilton, Harvey Mudd College, *Race and the promise of the incubator in mid-20th century neonatal care*](#)
3. [Susan Grant, Liverpool John Moores University, *"Caring for Older People: Geriatric Consultation Offices in the Soviet Union, 1957-1982"*](#)

E6. Disability Rights and Technology

Broadway 3 & 4

Chair: Kim Nielsen, University of Toledo

1. [Sarah Rose, University of Texas at Arlington, *Too Defective to Hire: Safety Engineers, Industrial Surgeons, and Rendering Invisible Disabilities Visible*](#)
2. [Leah Samples, University of Pennsylvania, *"A Second New Deal for the Blind": Crippling Welfare Maintenance Care Regimes*](#)
3. [Christopher Rudeen, Ph.D. Candidate, *Self, Aid, and Company: Ernest Dichter's Study of Hearing Aids*](#)

6:00-7:00 pm Themed Happy Hours/Caucuses/Constituencies

Graduate Students

Johns Hopkins

Whitney

Saratoga Ballroom 1

SUNDAY, APRIL 24, 2022

7:00 am-12noon AAHM Conference Registration

Lower Lobby

7:00-8:30 am AAHM Post-Mortem Breakfast

Highrock

7:00-8:30 am Continental Breakfast

Gallery

8:30-10:00 am Concurrent Sessions F1-F5

F1. Disease, Surveillance, and the Carceral State (in person and virtual) *Alabama/Travers*

Chair: Samuel Kelton Roberts, Columbia University

1. [John Shepherd, Durham University, *Data, Diagnostics and Delinquency: Clinical Crime Prevention in Interwar Massachusetts*](#)
2. [Alexandra Halberstam, Yale University, *Incarceration of Tuberculosis Patients at the Turn of the 21st Century: Infectious Disease Control and Expansion of the Carceral State*](#)
3. [Lynne Gerber, Siri Colom, Independent Scholar, *Weed at the Altar: Religion and the Distribution of Medical Marijuana in 1990s San Francisco*](#)

F2. Technology and Health

Broadway 1

Chair: Beth Linker, University of Pennsylvania

1. [Lauren Ruhrold, University of Minnesota, *Meet the Makers: The Early Origins of the Medical Device Industry*](#)
2. [Maia Woolner, AMS Postdoctoral Scholar, *Speed as a Barometer of Mental Health: Chronometry in Late Nineteenth- and Early-Twentieth Century French Medicine*](#)
3. [Cinderella Ochu, University of Johannesburg, *"Depo" and Development in Sub-Saharan Africa: Investigating Women and Contraceptive Technologies in Nigeria 1960s-1990s \(Pre-recorded video\)*](#)

F3. Vaccine Trust and Mistrust

Broadway 2

Chair: Jacob Steere-Williams, College of Charleston

1. [Kirsten Moore-Sheeley, Cedars-Sinai, *Chasing the Magic Bullet: The Promises and Consequences of Vaccine Research*](#)
2. [Andrea Rusnock, University of Rhode Island, *Origin Stories of Inoculation and Vaccination*](#)

F4. Disease, Healing, and Rural Consciousness

Broadway 3

Chair: Judith Houck, University of Wisconsin-Madison

1. [Benjamin Folger, University of Oklahoma, *The Heartland in Trouble: A study of race, medicine, and social movements in early 20th century Oklahoma*](#)
2. [Rima Apple, University of Wisconsin-Madison, *The problem of maternal ignorance: Rural public health efforts during the Great Depression*](#)
3. [Stephen Hussman, University of Arizona, *The Beneficent Godfather: Dr. Augusto Ortiz and the Creation of Arizona's Mobile Rural Health Medicine Program \(Pre-recorded video\)*](#)

F5. Reforming Psychiatric Institutions

Broadway 4

Chair: Kylie Smith, Emory University

1. [Bradford Pelletier, Columbia University of New York, *Modjeska Simkins, the South Carolina Department of Mental Health, and Reluctant Desegregation \(1963-1966\)*](#)

2. [Jennifer Thomas, Virginia Polytechnic Institute and State University, *The Conolly and Kirkbride Treatises: A Nineteenth-Century Asylum Design Comparison*](#)
3. [Shir Bach, University of North Carolina, Chapel Hill, *Inside, Outside, Morningside: Alaska's Insane in Portland, Oregon*](#)

10:00-10:30 am Break

Gallery

10:30-12:00 noon Concurrent Sessions G1-G5

G1. Children as Historical Subjects (in person and virtual)

Alabama/Travers

Chair: Amy Hay, University of Texas Rio Grande Valley

1. [Elisabeth Yang, Rutgers University, *Home Nurseries: Medico-Moral Domains of American Infants in Late Nineteenth and Early Twentieth-Century Medical Advice Literature*](#)
2. [Ijeoma Kola, University of Notre Dame, *Asthma's Poster Children: Black Children at Residential Asthma Treatment Centers, 1960-1975*](#)
3. [Lisa Pruitt, Middle Tennessee State University, *Who in the World was Katie Beckett? Ventilator-Dependent Children and the Battle for Home-Based Care in the 1980s*](#)

G2. Constructing Race and Human Reproduction in Medicine (1700–1850)

Broadway 1

Chair: Kelly O'Donnell, Yale University

1. [Marcia Nichols, University of Minnesota Rochester, *Anatomical illustrations, obstetrical education, and the construction of the "ideal Woman"*](#)
2. [Margaret Carlyle, University of British Columbia, *Population Crisis and the Birth of Phantoms in the Eighteenth-Century French Atlantic World*](#)
3. [Mary Hague-Yearl, McGill University, *Humoral Medicine and the Invention of Racial Ideology*](#)

G3. Mediating Medicine: Genre, Society, and Medical Subjects

Broadway 2

Chair: Nancy Tomes, Stony Brook University

1. [Manuel Merkofer, Universität Zürich, *Looking for the neurosurgical patient: Walter Matthias Diggelmann's "Shadows, diary of an illness"*](#)
2. [Arsenio Ferraces-Rodríguez, Universidad de A Coruña, *Surgery, pain and compassion in ancient medicine according to medical recipe books of the 5th-11th centuries*](#)

G4. Occupational Medicine and Patient Debt

Broadway 3

Chair: Anne Marie-McAlister, Independent Scholar

1. [Andrew Hogan, Creighton University, *Recruiting Black Practitioners in Allied Health: Achievements, Barriers, and Lessons in the 1990s*](#)
2. [Lukas Engelmann, University of Edinburgh, *An "Epidemiology of Science." Epidemiological reasoning and the emergence of the information sciences*](#)

G5. Public Health, Genomics, and Biological Warfare

Broadway 4

Chair: Mindy Schwartz, University of Chicago

1. [Yemok Jeon, Woodrow Wilson International Center for Scholars, *War during the War: Public Health Campaigns Driven by "Biological Warfare" in North Korea during the Korean War*](#)
2. [Jim Harris, The Ohio State University, *House Flies and Health Visits: The Campaign to Curb Infant Mortality in Manchester, 1890-1914*](#)

Abstracts

FRIDAY, APRIL 22, 2022

A1. Postpartum Histories: Race, Gender, and Disability in Postnatal Care

A1.1 Udodiri Okwandu, Harvard University, *Defending Anne Bradley: White Racial Decline and the Medico-Legal Construction of Puerperal Insanity*

This talk will consider how the medico-legal construction of postpartum mental illness served to articulate the sociopolitical problem of race in the United States during the Progressive Era. Postpartum mental illness - initially called puerperal insanity (PI) - first emerged in American texts in the 1830s and was defined as a mental condition that developed during pregnancy, childbirth, and lactation. By the latter half of the 19th century, it was considered a common complication of childbirth as White American physicians participated in child delivery, served as general practitioners in middle class homes and treated more women in asylums. With these spaces disproportionately involving interactions between privileged White physicians and patients, the disorder became intimately associated with White, Anglo-Saxon women. Darwinian evolutionary theory further cemented this association as it was understood that civilization could be accompanied by nervous weakening and compromised White women's capacity to endure labor. However, at the turn of the twentieth century, the stability of the diagnosis began to collapse. In the backdrop of increased rates of crime among all racial and socioeconomic groups, medical and legal practitioners became fixated on mothers who committed, what I call, "crimes against domesticity", a spectrum of acts that include the neglect of self, children, and home or even murder. At the same time PI's symptoms became increasingly visible among non-white populations as a consequence of migration and urbanization, challenging the conventional belief that the disorder uniquely struck White women. At this time, sub-classifications of PI emerged, including puerperal mania, puerperal melancholia, and puerperal dementia praecox. In examining medical jurisprudences, case reports, and publications and manuscripts of scientists and physicians engaged in the racial sciences, psychiatry, and reproductive medicine, this paper demonstrates that the "breakdown" of puerperal insanity as a diagnostic category served to accommodate the shifting racial demographic of its sufferers all while maintaining the integrity and protection of white female sufferers under the law. As Okwandu demonstrates, non-white subjects who suffered from postpartum mental illness were disproportionately punished by the law, reinscribing the association between blackness and badness and, consequently, reinforcing the conflation of postpartum mental illness with white feminine normativity.

A1.2 Miriam Rich, Dartmouth College, *Monstrous Affect: Touch, Caregiving, and Anomalous Newborn Bodies in the 19th-Century U.S. Medicine*

This talk analyzes the significance of postnatal care in nineteenth-century U.S. case histories of “monstrous birth.” It argues that affective practices in the postpartum period—including embodied relations of touch, caregiving, and emotional response—served to locate and configure the monstrosity of anomalous newborn bodies. Drawing on theoretical frameworks from scholars such as Sarah Ahmed, this talk considers how affective interactions work to associate and demarcate different bodies, locating them as particular kinds of relational subjects. Specifically, the talk explores the affective positioning of newborns with severe congenital anomalies such as anencephaly—infants defined as “monstrosities” within nineteenth-century medical and scientific nomenclature. By examining the embodied actions, emotions, and ethical imperatives that such newborns evoked, this talk seeks to understand how they were positioned within broader networks of family, community, and human kin. Using an against-the-grain reading of case histories and images from nineteenth-century medical journals, monographs, and collection catalogues, the talk considers descriptions of embodied interactions between medical attendants, patients, and newborns in the period after birth. These included practices such as palpating, feeding, swaddling, bathing, comforting, concealing, and/or experimentally manipulating infant bodies. By considering modes and boundaries of interpersonal touch, the talk shows how monstrous newborn bodies occupied an ambivalent affective position—eliciting some, but not all, imperatives of caregiving typically associated with newborn children in these contexts. This affective positioning underscored the tensions that structured the historical category of monstrosity in medical practice, helping to configure both the alterity and the relational familiarity of monstrous bodies within the space of clinical encounter. In this way, the talk contributes to a broader exploration of how concepts of disability and bodily deviance were constituted within the practices of nineteenth-century medicine.

A1.3 Elizabeth O'Brien, Johns Hopkins University, *Temporary Sterilization During Postpartum in 1930s Mexico*

During the 1930s, Mexican authorities undertook an ambitious project to federalize the public health system and provide free medical services to people across the nation, especially those in impoverished and underserved communities. Access to healthcare would help realize the promises of Mexico’s 1910-1920 social revolution, which had sought to secure justice for workers and peasants through land distribution, unionization, secularization, and access to education. This era witnessed a surge of popular pleas for fertility control amongst all classes of women. Although some doctors were attentive to women’s concerns about the structural factors that limited their reproductive choices, their practices were still guided by a patriarchal emphasis on state management of reproduction. Such control was predicated on women’s unequal access to

citizenship and incorporation into the economy, the increasing bureaucratization of maternal and infant healthcare, and the persistence of racial and class prejudices despite revolutionaries' egalitarian rhetoric. Drawing on medical treatises, women's letters of complaint, and papal encyclicals, this presentation examines a form of temporary sterilization in which doctors bifurcated the vaginal canal to create a pocket of tissue that could be used for recreational sex without resulting in pregnancy. The paper shows that this procedure was explicitly classed and racialized: whereas indigenous and African-descendent women were more likely to undergo permanent sterilization, lighter-skinned women experiencing illness were more likely to be temporarily sterilized. Religion was also at stake for some doctors who saw temporary sterilizations as a revolutionary solution that halted childbearing while still reconciling sterilizing practices with Catholic mores. Women, for their part, voiced increasing demands for access to abortion and fertility control during the progressive era. Bringing these threads together, this paper argues that women's demands for fertility control altered the landscape of reproductive healthcare, even while their postpartum care was influenced by Catholic prohibitions of fertility control, on the one hand, and eugenic doctors' pursuit of racial regeneration, on the other.

A2. Ethics and Biology

A2.1 Zoe Adams, Yale University, *Not in Our Medical Society: Methadone and the Unethical Doctor in Late 1960s New Orleans*

In 1969, the Orleans Parish Medical Society (OPMS) ordered Dr. James T. Nix, director of the J.T. Nix Methadone Clinic—founded one year earlier—to close his clinic down. The Society—backed by the American Medical Association (AMA) and the Federal Bureau of Narcotics and Dangerous Drugs (BNDD)—charged Nix with unethical conduct, yet he kept his clinic's doors open. I use this case study of the first methadone clinic in the Deep South—contextualized by my research on community and governmental responses to the first clinics opened in Boston and New York City—to understand a transitional moment in the U.S. regulation of methadone and illuminate the carceral logic that continues to limit access to this lifesaving medication.

-Up until the mid-1960s, American physicians could prescribe methadone to patients struggling with heroin addiction with few requirements. Despite peer-reviewed studies demonstrating methadone's ability to treat heroin addiction since 1965, the Food and Drug Administration (FDA) viewed potential illegal methadone sales as more important than patient preferences and outcomes. Beginning with the 1966 Narcotic Addiction Rehabilitation Act (NARA) and the subsequent 1972 FDA regulations, physicians were required to establish "methadone treatment programs," which mandated patient participation in social services, counseling, and weekly urine screening. Nix, a white, Roman Catholic surgeon, defied the federal regulations and prescribed methadone in an accessible manner that reflected his deep commitment to patient autonomy.

Furthering a brand of health activism was both anti-government and radically patient-centered, Nix believed his patients—most of whom were Black by 1970—should be able to obtain methadone from any doctor’s office and not be required to participate in psychiatric treatment.

Drawing upon archival correspondence between Nix, the OPMS, the AMA, and the BNDD, as well as newspapers, medical journal articles, and oral histories, I trace Nix’s provocative responses to leaders at local and national organizations who succeeded in shutting down his clinic in 1971. Through a critical analysis of Nix’s story, I show how organized medicine and the federal government used methadone regulations to target physicians and further curtail the freedom of patients already marginalized by healthcare systems.

A2.2 Gina Surita, Princeton University, *From Cancer to Carbohydrates: Metabolic Cycles, Collaboration, and Experimentation in 1920s Biochemical Physiology*

This paper analyzes the research program of Prague-born, Nobel Prize-winning, husband-and-wife biochemist team Dr. Carl Cori and Dr. Gerty Cori during their tenure at the State Institute for the Study of Malignant Disease (now Roswell Park Comprehensive Cancer Center) in Buffalo, New York. After leaving post-World War I Europe for Buffalo in 1922, the Coris not only found themselves working in a new country, but also in a new kind of institution, one that prided itself on being the first laboratory dedicated exclusively to cancer studies. Utilizing newly uncovered archival sources, this paper analyzes the Coris’ marital scientific collaboration in the making, and argues that it was by navigating their way through the Buffalo institute’s expectations for cancer research that the Coris solidified their research partnership and were led to the field of investigation for which they would become best known: carbohydrate metabolism. Working in the immediate aftermath of the isolation of insulin in the nearby Canadian city of Toronto, the Coris’ research into how the animal body processes carbohydrates had implications not only for cancer, but also for diabetes. Despite encountering resistance to their collaboration and gender discrimination, the Coris published dozens of co-authored papers during their time in Buffalo, which culminated in their 1929 elucidation of the “Cori Cycle,” one of the earliest metabolic cycles to be explained. An analysis of the Coris’ work sheds light on issues of gender, scientific collaboration, and the laboratory-clinic relationship in 1920s American biomedical science.

A2.3 Alexis Bedolla, Universidad Nacional Autónoma de México, *The development of U.S. epidemic intelligence: from biological weapons to emergent diseases and bioterrorism*

The development of epidemic intelligence in the US has historical ties to its national security concerns. Initially, the idea of epidemic intelligence emerged during the Cold War to respond to the threat of a surprise Soviet attack with biological weapons. It took institutional form when Alexander

Langmuir created the concept and practice of disease surveillance and established the Epidemic Intelligence Service within the CDC in 1952. At the end of the Cold War when the threat of a Soviet biological attack subsided, however, epidemic intelligence evolved as an epidemiological conception to then become interested in addressing the problems of emergent infectious diseases and bioterrorism in a globalized world.

Considering this context, the focus of this paper centers in the historical continuity of the relationship between American epidemiology and national security. Most notably, through analyzing the notion of “preparedness,” this paper argues that, despite meaningful historical changes occurred during the second half of the twentieth century in epidemiological knowledge and US national security objectives, there has been a persistent influence of security concerns in the development of epidemiological practices of data gathering. In this particular area, the influence of US national security can be contemporary observed in the creation of novel practices of disease surveillance – like that of syndromic surveillance – that have evolved in close relationship with the American discourse of biosecurity. This is a significant route of historical exploration that expands the history of epidemiological thinking in that it can show how epidemiology as a discipline has been profoundly affected not only by colonialism and gender but also by geopolitics.

A3. Segregation, Race, and Space

A3.1 Ashley Graham-Perel, Teachers College Columbia University, *“We’ve Integrated, Now What?” The Interrelationships between Nursing, Race, and Medicine at New York’s Lincoln School for Nurses*

“Here we stand as a racially integrated healthcare system, now what?” To many, this may seem an odd or off-putting question, but it is pivotal to acknowledge the history of segregation in healthcare. The duality of racial segregation versus integration has directly correlated with the health of African American patients. The racial segregation of patients in healthcare not only resulted in poor health of the Black community, but also limited the medical/nursing professional advancements of people of color. African Americans historically have been medically destitute; this ranges from the unpardonable conditions of slavery; the justification of slavery through describing Blacks as “subhuman things, separate from white, Western evolution based on medical scientific fact” (Byrd & Clayton, 1992, p. 194); the use of Black bodies for experimentation and medical training, such as the forced “slave breeding” after the outlaw of the Atlantic slave trade to America in 1807 (p. 194) and the infamous Tuskegee experiments on 400 Black men that lasted 40 years under the tutelage and jurisdiction of American government (CDC, 2020; Reverby, 2009). It was apparent to medical professionals and organizations that in order to better the health of the Black community-at-large, the development of Black hospitals was critical. In my paper, I investigated the health of Blacks in

New York City and how the establishment of a Black nursing school benefited the community. Byrd and Clayton (1992) reported that the “death rates in 1870, 1880, and 1890 censuses were so staggering, the New York Life’s Equitable’s actuaries confidently predicted black extinction by 2000 AD” (p. 195). In New York City, the first school to admit and train Black women in the nursing arts, Lincoln School for Nurses (LSN) (1898-1961), was established with the mission of training Black women to care for Black patients. This paper will highlight the historical case study of LSN and its trailblazing nurse graduates such as Adah B. Thoms and Ivy Tinkler. These nurse leaders were quintessentially critical to the professionalization of Black nursing and the health of the Black community. From doubts and divide, to acceptance and accolades. Historians such as Darlene Clarke Hine, Adah Thoms, and Mary Elizabeth Carnegie, have presented the history of Black nursing. This paper will add to that cadre of archives with the investigation of the interrelationships between medicine, nursing, and society during LSN’s years of operation. Furthermore, the investigation explores the standards of the Black community’s health that warranted the development of Lincoln School for Nursing and how, despite integration, the health status of the community has remained unfalteringly destitute.

A3.2 Kevin McQueeney, Nicholls State University, *"A Great and Manifest Destiny": Creating A White Medical District in New Orleans, 1900-1940*

Between 1900-1940, New Orleans invested heavily in efforts to grow the city's increasing trade with Latin America and tourism through civic improvements, public health campaigns, and an expanding health care economy. As boosters promoted New Orleans as a healthy city, with a robust health care system, they also advocated for residential segregation and spatial concentration of Black residents in less-desirable areas, often using arguments of poor Black health as justification for removal. This works explores that history, with a particular focus on the push by white leaders to evict Black medical institutions like the Providence Sanitarium, Flint Goodridge Hospital, and Flint Medical College from the medical district, and the role of municipal powers and federal funding—through programs like the WPA—in supporting the efforts to create a white Medical District. Following the work of historians Samuel K. Roberts., Jr. and Nyan Shah, and others, I explore the intersection of the segregation of health care and urban space in the early decades of the twentieth century. The sources I use include the city's first comprehensive plan, Sanborn maps, Board of Health reports, hospital and medical school documents, newspaper articles, and speeches by public and health officials.

A4. Three Centuries of Mad Women

A4.1 R.E. Fulton, Independent scholar, *Unwritten Laws: The Gender of Insanity in the Nineteenth-Century American Courtroom*

In February 1859, New York politician Daniel Sickles discovered that his wife was sleeping with Phillip Barton Key II. Enraged, Sickles shot Key in broad daylight across the street from the White House. His lawyers argued that Sickles was temporarily insane at the time of the murder, and despite the publicity and violence of his actions, the jury agreed. Sickles was acquitted.

Legal historians including Lawrence Friedman term the defense Sickles employed “the unwritten law,” a legal construct which invoked insanity to allow middle- and upper-class white men to avoid punishment for violence in defense of family and honor. Although the “unwritten law” is generally considered the province of men alone, historian Carolyn Ramsey’s research on the history of intimate partner violence indicates that white middle- and upper-class women had access to a version of the “unwritten law” that preceded the late twentieth century’s construction of “battered woman syndrome.” This paper builds on Ramsey’s work by examining the case of Josephine McCarty, an Albany doctor who shot her lover, Milton Thomson, on a crowded streetcar in 1872. At trial, McCarty’s lawyers argued that she fired the shot in the grip of temporary insanity brought on by the combined effects of menopause and years of abuse from Thomson. Like Sickles, McCarty was acquitted.

Drawing on newspaper accounts of the McCarty trial and articles from the nineteenth-century *American Journal of Insanity*, this paper considers the differing construction and deployment of insanity defenses for middle-class white men and women whose public murders were motivated by interpersonal conflict. In doing so, it contributes to a richer understanding of the legal implications and public uses of medical discourses on mental illness in the nineteenth century.

A4.2 Rachel Louise Moran, University of North Texas, *Self-Help, Psychiatric Help, and the Postpartum Revolution of the 1980s*

In the mid-1980s, activists organized the first American groups specifically addressing postpartum mental illness. The groups had a range of purposes and goals, with some offering general help for new parents and some focused on recovery from severe postpartum mental illness. While the groups continued to have self-help aims, two of them emerged as larger, organized social movement organizations. Both Depression After Delivery (DAD, founded in 1985) and Postpartum Support International (PSI, founded in 1987) came to function as advocacy groups.

Their role as advocacy groups was shaped substantially by their relationships with psychiatrists. The founder of DAD partnered with a psychiatrist who became the group’s medical advisor. He became

a presence in the intimate meetings of the group, and helped shape the group's direction as it expanded to include psychologists and therapists as members alongside lay women. DAD adopted a medical language of postpartum illness, and some leaders expressed frustration with other postpartum groups that focused on women with subclinical depressions. Meanwhile the founder of PSI was encouraged to start the a postpartum-specific by a psychiatrist she had been partnering with for years in her activism around parenting. He became a central figure in her organization the first few years, working in a way that seemed fine to her at the time but that she now characterizes as him being a "puppeteer."

Still there were many limits to medicalization. When DAD faced an empty bank account the board was divided about whether they should accept the pharmaceutical money that had been offered. And when the psychiatrist working with PSI pressured the women to lobby for postpartum depression and postpartum psychoses as specific diagnostic categories in the Diagnostic and Statistical Manual of Mental Disorders, the women leading the organization chose not to prioritize his project. This paper examines the relationship between psychiatry and postpartum organizations of the 1980s, and how women's health activists of the era navigated between self-help roots and the psychiatric support.

A5. Medicine in the Margins: Expanding Our Perspective of Early Medieval Knowledge and Practice

A5.1 Meg Leja, Binghamton University, *Pushing the Boundaries of a Binary: Medicine versus Religion before the year 1000*

This paper explores the range of genres that can be found in early medieval collections that preserve different types of medical writings. Given the dearth of scholarship on premodern medical texts that do not fit within the classical canon of Hippocrates and Galen, the aim of the paper is to probe the boundaries between what was considered "medicine" and what was not. A handful of manuscripts from before the year 1000 contain writings on bodily therapeutics alongside writings of an overtly "spiritual" nature—primarily, saints' lives, prayers, and Christian conduct literature. At first, these appear to challenge long-standing historical stereotypes about the incompatibility of "medicine" and "religion." However, the new, comprehensive digital catalogue makes clear that such groupings of "mixed" texts remain relatively uncommon, representing only a small percentage of the total number of extant codices. The paper investigates the circumstances under which anonymous scribes compiled these assortments of texts, paying particular attention to the textual and thematic bridges between the medical and the spiritual, the pairing of discourses regarding the health of body and soul, and the potential uses for such codices in healing practices. Approaching bodily healing through the binary of human intervention versus Christian miracle plays to modern stereotypes of the medieval world. Yet it is equally inaccurate to assume that early medieval

scholars possessed no conception of the “medical,” as related to modern understandings of healing through scientific knowledge and learned human technique. The manuscript evidence points to the ubiquity of medical texts but also their tendency to appear in specific patterns and recognizable groups. The paper argues that we should think of a layered approach—not medicineorreligious cures, not medicinethenreligious cures, but a complementary reciprocity.

A5.2 Jeffrey Doolittle, Fordham University, *Hidden in Plain Sight: Assessing Marginal Therapeutic Recipes in Early Medieval Medical Encyclopedias*

Even within some of the best-known early medieval medical manuscripts, there are still many important textual and material features that have thus far escaped the attention of researchers. This paper explores such routinely overlooked features through an analysis of marginal additions found in several ninth- and tenth-century medical encyclopedias from Naples and Montecassino in southern Italy. Though the main contents of these medical manuscripts have long been studied, the marginal comments found in them, including many additional therapeutic recipes appended to the main texts, have tended to be minimized or ignored. Ranging from one-off preparations to substantial efforts at reorganizing and incorporating recipes from other sources, these marginal therapeutic texts provide a rich and as-yet largely untapped source of information for medieval interactions with the main medical texts as well as further evidence for the transmission and adaptation of classical medical knowledge in the early middle ages. Furthermore, such marginal therapeutic preparations provide compelling evidence for changes and continuities in what later readers thought medical recipes should look like and of what materials they should be composed. These subtle details can help demonstrate the activities of different southern Italian scriptoria such as Montecassino and Naples, the importance of these medical books to subsequent readers, and substantial new insights regarding the scholarly use of these materials.

A5.3 Claire Burridge, University of Sheffield, *Here, there, and everywhere: A fresh perspective on the manuscript contexts of medical knowledge*

Studies of early medieval medicine have traditionally concentrated on texts contained within “medical manuscripts”, that is, manuscripts that are composed predominantly, if not entirely, of writings that modern scholars consider to be “medical”. Such writings range from recipe collections to treatises on diagnosis and prognosis, bloodletting, dietetics, etc. Medical knowledge found beyond this manuscript category, such as marginal notes added to a codex that may otherwise appear to be unrelated to medicine, has been seen as exceptional and is often overlooked. Recent work, however, indicates that these seemingly exceptional appearances of medical texts outside of medical manuscripts are, in fact, highly typical within the full corpus of recorded medical knowledge that survives from the early Middle Ages. Crucially, the majority of the codices that have been

added to our project's new digital catalogue break the medical manuscript mold. In showcasing the varied textual environments in which medical writings appear, this paper reveals the need for de-centering medical manuscripts as the foundation for research in this field. In short, these findings offer new insights into the transmission, use, and users of medical texts, highlighting the importance of moving beyond the traditional focus on the classical canon alone and instead considering the full spectrum of medical writings in this period.

A6. Pandemics, Public Health, and the Making of the Modern American State

A6.1 Beatrix Hoffman, Northern Illinois University, *Influenza 1918-19 and U.S. Health Care Exceptionalism*

The COVID-19 pandemic has amplified calls for universal access to health care and an end to a system that ties insurance coverage to employment. A century ago, during the influenza pandemic that killed at least 50 million worldwide, Progressive reformers also made arguments about expanding state capacity to protect workers from the costs of sickness. But proposals for government-supported compulsory health insurance were defeated in 1919, and the U.S. set on a path toward developing its uniquely expensive, inefficient, and unequal health system. This paper examines how the 1918-19 pandemic affected the campaign for compulsory health insurance. My earlier book on the campaign, *The Wages of Sickness* (2001), took the silence in the primary sources as an indication that pandemic influenza had little or even nothing to do with welfare state development. This investigation will revisit those sources to locate references to the pandemic and to seek evidence about how influenza did, or did not, influence the fate of Progressive health legislation.

A6.2 Stephen Colbrook, PhD Candidate, *Why U.S. State Development Matters to the History of HIV/AIDS*

It is well-known that the federal government's response to HIV/AIDS was painstakingly slow, partly because the disease disproportionately affected stigmatized minorities – especially gay men and IV drug users. Rebuffed at the national level, AIDS activists and policy elites turned to state legislatures to address a host of concerns stemming from the pandemic, including the high cost of drug therapies, the rampant discrimination experienced by those suspected of infection, and the housing and healthcare needs of people living with HIV. State and local bureaucracies bore the brunt of the work during the epidemic's early years, as federal health agencies reeled under a series of budget cuts enacted by the Ronald Reagan administration. This paper argues that state governments adopted widely divergent strategies to stem the spread of the disease, creating a fractured and disjointed approach to a crisis that was national and global in scope. Through case studies of

California, Illinois, and Texas, it shows that the preventive playing field was wildly uneven as cases of HIV ignited in the 1980s.

B1. Power and Knowledge in Women's Bodies

B1.1 Andrea Ditkoff, Rutgers University, *“Healthy Women, Healthy Lives”: The Nurses’ Health Study and American Women’s Health Research, 1960s-1990s*

Launched by Harvard epidemiologists in 1976, the Nurses’ Health Study (NHS) is the largest and longest running study of women’s health in the world. Hundreds of thousands of nurse participants fill out biennial questionnaires covering almost all aspects of their health, from mental illness to diet. NHS findings helped shape public health policy, clinical practice, and individual behavior as the study—frequently discussed in the popular press—reached the medical community and general audiences. This paper uses the NHS to examine the evolution of women’s health research in the United States from the 1960s-1990s, reevaluating how researchers produced medical knowledge about women’s bodies and how female research subjects experienced their participation. Historians of women’s health research have largely overlooked observational studies like the NHS, instead focusing on clinical trials and female research subjects’ exploitation. Although this narrative accurately reflects many women’s experiences, examining nurses who participated in the NHS offers important insights into other modes of scientific knowledge production about women’s health. While clinical trials largely excluded women of reproductive age between the mid-1970s and mid-1990s, women of reproductive age could participate in observational studies in which researchers analyzed participants’ self-reported behavior and exposure. Since methodology shapes the dynamic between participants and researchers, looking beyond clinical trials allows historians to see a new group of female research subjects who frequently had more power and agency than those in clinical trials. The NHS’ reliance on self-reported data empowered participants in ways not possible in a clinical study. Nurses’ medical education made them particularly informed participants and created opportunities for them to influence the study and collaborate with investigators. This paper draws from oral histories, medical and popular publications, and nurse activists’ writings to raise new questions about the development of American women’s health research—a process that has shaped not only the field’s priorities, but also women’s everyday experiences and healthcare.

B1.2 Madeleine Ware, Yale University, *Gynecological Gymnastics: Assuaging Victorian Anxieties with Pelvic Floor Strengthening*

In the 1890s, renowned gynecologist Horace M. Stapfer held a clinic for women at the Hôpital Baudelocque in Paris where he offered a new system of non-surgical techniques known as gynecological gymnastics. This system was based on a wider nineteenth-century physical culture movement and involved a series of pelvic floor massages and strengthening exercises intended to

treat an array of ailments including irregular or painful menstruation, uterine prolapse, hemorrhages, and non-infectious inflammations.

In this paper I examine literature on gynecological gymnastics by obstetrics and gynecology specialists, especially the images in hundreds of medical publications on the practice in Europe and North America at the end of the nineteenth century. These overlooked images differ from other gynecological texts of the time as they are not only dramatically desexualized but are also deliberately designed to discourage general fitness or musculature for women beyond their pelvic floor. Indeed, men are sometimes featured performing maneuvers on each other. There are also hairless figures with emaciated rib cages which resemble twentieth-century extra-terrestrial cartoons more than nineteenth-century medical diagrams. Historians have argued that the desexualization in gynecological gymnastics was part of a strategy for practitioners to protect their credibility and reputations in 'prudish' Victorian-era society, but race and empire were also key components of late nineteenth-century culture and medical practice. I argue that the mechanical manipulation of women's bodies through gymnastics and massage was a tempting solution for gynecologists and social reformers who worried that white Europeans and white Americans were becoming weaker and less fertile. Placing imperial depictions of Black women in childbirth alongside these gynecological gymnastic images reveals a tension in Victorian-era medicine and popular culture around healthy white women's bodies. 'Healthy' white women were represented as reproductive but not hypersexual, fit but not strong, in order to avoid characteristics associated with moral, mental, and physical degeneracy in caricatured depictions of non-white women in imperial territories. This tension continued even after gynecological gymnastics fell out of practice in the 1920s and demonstrates how medical practitioners developed treatments through a racialized perception of women's sexuality and fitness.

B1.3 Andrew Simmons, University of Rhode Island, *Working Around the Black Box: Women and Medical School Admission 1900-1970*

The Flexner reforms greatly reduced the number of medical schools in the United States as scientific medical training became the norm. Schools that closed included those for women and African Americans. Because many of the remaining medical schools were nominally open to women, Abraham Flexner and others believed that women would have ample opportunities to pursue medical careers. This did not turn out to be the case. Before 1970, the percentage of women who applied and were admitted to medical school never exceeded ten percent. This was consistent with a larger pattern of exclusion from medical education of women, African Americans, and other groups.

Historians agree that after the Flexner reforms medical education became more expensive and admission more difficult, and their works hold clues about the role of the medical school admission process in reproducing a white male profession, but none directly address it. Understanding the historic exclusion of women and minorities starts with the selection process of future doctors. The medical school admission process, like all admission processes, is by necessity secretive. Researchers are not likely to find any notes from admission committee meetings nor student files. Sources from outside the black box of admission committees, however, provide valuable evidence about selection processes over time. These include personal narratives from oral histories as well as autobiographical writings from the students themselves. Personal accounts complement other sources from medical schools, the AMA, and reports generated by foundations and government.

In this paper, I will show how personal narratives, especially oral histories of women doctors, complemented by the other sources noted above, coalesce into a textured historical account of past discriminatory practices in medical school admission. Such an account shows, moreover, how the medical profession's priority of creating quality medical education and building professional prestige occurred at the expense of fairness and equity. These problems persist to this day despite efforts by the medical schools to address them since the early 1970s.

B2. Health and Incarceration in Historical Perspective

B2.1 Caroline Beit, Yale University, *The Newgate Prison Trial: Lessons from England's First Vaccine Clinical Trial for the Covid-19 Era*

Given COVID-19, more needs to be done to protect the health of those experiencing incarceration; COVID-19 has ravaged prisons--vaccination is a mitigation strategy. The Newgate Prison experiment (1721) often called the 'West's First Vaccine Clinical Trial' provides a historical example of incarcerated individuals' involvement in clinical trials (Boylston 2012). In this experiment, six incarcerated individuals at Newgate Prison in London were experimented on by Dr. Maitland and Dr. Sloane to test the safety and efficacy of smallpox variolation. The ethics of the trial are further complicated by the fact that the participants were offered release in exchange for participation. This research asks: What are elements of the 1721 Newgate trial that should serve as lessons for including incarcerated individuals in clinical trials during pandemics? The research methodology for this project relied primarily on archival research. A multitude of sources were used, including first hand reports of incarcerated individuals about the conditions of the prison, letters from the King, narratives written with input from the doctors who performed the trial, philosopher's opinions, secondary sources, and consultations with researchers who have subject matter expertise. These sources were then used to investigate the ethical implications of the trial, and elucidate bioethically sound recommendations based on the trial's history. Findings suggest that while incarcerated

individuals are a vulnerable population, they should not be categorically excluded from clinical trial participation because real benefits to both incarcerated persons and society exist; however, proper safeguards are still important. The current status quo in the U.S., wherein incarcerated individuals are effectively legally barred from joining any clinical trial for access to lifesaving medication or intervention by virtue of 45 CFR 46, causes disproportionate lack of access to healthcare, and the ease of disease spread in prisons makes this access all the more critical. Scholars like Wang, Zenilman, and Brinkley-Rubenstein (2020) have called for a reconsideration of this effective ban. While additional case studies should be examined, it provides a starting point for exploring how incarcerated individuals should be involved in clinical trials.

B2.2 Charlotte Kim, Yale University, *The 1918 Influenza at Eastern State Penitentiary: Narratives of Ambivalence Among Incarcerated Men*

Correctional settings may not have been invented with the purpose of spreading infections, but they have excelled at doing so long before they came to be identified as hotspots for COVID-19. They certainly fell victim to the influenza pandemic of 1918, an illness with a similarly devastating sociological toll, though relatively little has been published regarding the plight of prisons and jails during this era. Even less apparent are the lived experiences of incarcerated patients themselves, who traditionally have not been the ones to tell history.

To address this gap in the literature, this paper analyzes archives from the Eastern State Penitentiary in Philadelphia, a historic prison that is now operational as a museum. Recently, the museum published a blog article detailing the course of the flu pandemic at the prison: it began in September 1918, was followed immediately with quarantining and social distancing policies, and ultimately claimed only three lives among more than 1,300 people incarcerated at the facility. A central reference for this blog post was *The Umpire*, a newsletter circulated by the incarcerated male population at the time. On the surface, the newspaper seemed to praise and honor prison staff, in particular the physician, for protecting its incarcerated population from the flu.

More careful scrutiny of the archives, however, challenges this notion that the incarcerated men were content to be the doctor's patients. Despite a superficial benevolence, the men were not placidly deferential to their prison officials, who publicly espoused the eugenics movement of the time, in which criminals necessarily possessed hereditary psychological faults. (In fact, documents from 1919 suggest evidence of the poor conditions and social discord unraveling the institution, rife with whistleblowing, protests, even suicide). Painfully aware of their stigmas, the incarcerated men used *The Umpire* as a vessel for self-redemption. Even in the supposed absence of top-down censorship, the writers deliberately model cooperative behavior; only through covert ways do they reveal their distrust of the physician or challenge his clinical decisions. These accounts teach us the

complexity and strategy of the relationships forged between incarcerated patients and their health providers.

B2.3 Heather-Destiny Konan, Emory University, *Heat, Health, and COVID-19 in Texas Prisons*

As the COVID-19 pandemic ravaged U.S. communities these past two years, it also elucidated significant gaps in standardized healthcare and policy in many U.S. institutions. The increase in COVID-related lawsuits against prisons in Texas are calling attention to the critical issues of a lack of proper infrastructure, healthcare policy, or transparency within the Texas correctional healthcare system. This project considers the questions: 1) What can we learn from this history of heat stress within Texas prisons throughout the early 2000s, particularly for future policies addressing COVID-19 in correctional facilities and 2) How and why did the health interests of correctional officers and incarcerated people converge in response to exacerbated health stressors in carceral settings? Throughout the 20th century, numerous cases were brought against Texas prisons and jails citing medical negligence in correctional facilities. It was not until 1976 in the landmark case, *Estelle v. Gamble*, that the US Supreme Court finally addressed the constant concerns about healthcare within prisons by concluding that “deliberate indifference to serious medical needs of prisoners” is a violation of one's Eighth Amendment. Since the ruling, however, the Texas Department of Criminal Justice (TDCJ) has had a history of heat-related deaths and injuries that have placed a burden on the Texas correctional health services. Through a variety of primary, Texas prison policy documents and heat-related case law from the Texas Fifth Circuit Court of Appeals, the research aims to document a history of (or lack thereof) legislation regarding heat conditions in prisons, highlight organizations linked to advocacy efforts to address the issue, and identify any history of action taken by TDCJ and their affiliated healthcare system. Findings of the project highlight a significant deviation from the narrative about the historically oppositional role between incarcerated people and correctional officers. The lack of TDCJ and Texas correctional healthcare accountability, substandard heat-related policy, and long-term breakdown of Texas prison infrastructure negatively impacted the health of both incarcerated people and correctional officers. While challenging their assumed adversarial roles, these factors also provide important lessons on the joint health interests of incarcerated people and correctional officers, relevant to current COVID mitigation.

B4. Regulating Safety in the American Medical Marketplace

B4.1 Alexander Parry, Johns Hopkins University, *Federalizing Safety: Consumers, Regulation, and the U.S. National Commission on Product Safety, 1968–1970*

Responding to pressure from lawmakers, bureaucrats, medical professionals, consumer advocates, and the media, U.S. President Lyndon Johnson appointed the National Commission on Product

Safety (NCPS) to analyze the hazards of everyday consumer products and the extent to which existing laws and voluntary standards protected the American public from harm. From 1968 to 1970, the NCPS held twenty-two days of hearings, many of which revolved around the efforts of corporations and nonprofits to ensure the safety of consumer goods without federal intervention. Underwriters Laboratories, the United States of America Standards Institute, and several trade associations and retailers discussed their programs to test and to certify domestic appliances and testified to the advantages of industry self-regulation. The commissioners and many other participants at the hearings, however, questioned whether nonstate measures did or even could adequately prevent injuries. Consumer protection, they asserted, warranted at least some regulatory constraints on free enterprise.

This presentation uses the transcripts of the NCPS hearings to investigate the historical rationales for voluntary product standards and the drive for federal regulation culminating with the 1972 Consumer Product Safety Act. I show how the interests and political ideologies of the business community, experts from nonprofits like the National Safety Council, and the consumer movement influenced their perspectives on the effectiveness of voluntary safety programs and the need for state action. Each of these groups, moreover, professed to speak on behalf of their fellow Americans as consumers, taxpayers, patients, and citizens. Drawing on recent literature about the “ventriloquism” of political discourse related to consumers, I explore how the NCPS hearings incorporated different visions of safety and the public good. Safety thus came to define the sale, use, and perception of consumer products as much as their manufacture.

B4.2 Jiemin Tina Wei, Harvard University, *Contraceptives and their Physician-Proselytizers: Hugh Davis, Howard Tatum, and the Market of Reproductive American Women, 1970-1985*

Throughout the 1970s-80s, commercialized reproductive technologies experienced a reputational crisis. After the high-profile 1970 Nelson Senate hearings, a reported 18-30% of U.S. women stopped taking or receiving the Oral Contraceptive Pill (OCP). The intrauterine device (IUD), particularly the Dalkon Shield manufactured by A. H. Robins Company, was announced to the medical community and consuming public as the OCP’s ideal alternative. Displacing the defamed OCP from the market niche of contraceptives-seeking American women, Dalkon Shield became the most popular IUD. Yet, like its predecessor, it experienced its own media crisis. In 1974, information surfaced about Dalkon Shield’s serious side effects, including uterine wall perforation, ectopic pregnancy, and death. Robins filed for bankruptcy in 1985, when the product had been removed from market and 11,000 lawsuits filed.

In this presentation, using scientific publications, deposition records, and physicians’ personal papers, I trace the strategies of two physicians: Hugh Davis, co-inventor of Dalkon Shield, who

discredited the OCP and marketed his Shield as its logical successor; and Howard Tatum, inventor of the Tatum T IUD, who exposed Dalkon Shield's harms and unseated it with his own competing product. In unearthing the interpersonal networks underlying this litigious and regulatory drama, I argue that these commercial contraceptives were not natural heirs to one another but rather constructed as such by their influential physician-inventors. I join historians' debates about the usefulness and perils of using ecological metaphors, such as "niches," to describe social phenomena. Market desires are not natural phenomena, but rather, malleable to human construction, capable of being molded, captured, redirected, and produced. This succession of commercial products—from OCP to Dalkon Shield to Tatum T—reveals the strategies for mutual leveraging among commercial marketing, consumer safety regulations, and medical expertise in the 1970-80s U.S.

B4.3 Brice Bowrey, University of Maryland, *The Pursuit of Safe Medical Devices: Manufacturers, Medical Experts and Changing Federal Regulation, 1960-2000*

Although the Federal Food, Drug, and Cosmetic Act gave the U.S. Food and Drug Administration (FDA) significant authority to regulate pharmaceuticals in 1938, the FDA did not receive substantial authority to regulate medical devices until 1976. This disparity and the subsequent shift in policy were a result of the unique economic and technological history of the medical device industry. Specifically, new technologies brought to market by medical device firms in the 1960s forced the courts to reconsider their definition and conception of medical devices. These decisions presaged Congress' enactment of sweeping new medical device regulations in the 1970s in response to scandals and growing public calls for reform. However, the vast number of small firms involved in the production of devices and the intimate relationships between medical experts and manufacturers led the FDA to implement a regulatory regime quite different from that envisioned by Congress. This analysis highlights the importance of industry-specific dynamics and technological innovation in the formation of regulatory regimes. It also demonstrates the agency and influence regulators exercise when enforcing the laws that bind businesses, shape markets, and protect patients.

B5. Health and mobility in premodern northwestern Europe 1300-1500

B5.1 Lola Digard, Universiteit van Amsterdam, *Expiatory pilgrimages and the health of mobility in the county of Flanders, 1300-1500*

In late medieval cities of the county of Flanders, expiatory pilgrimages were often imposed on individuals as a punishment for various offences. Links have been drawn between the religious and legal implications of this practice. Yet it is arguable that expiatory pilgrimages could also be

considered in terms of health and prophylaxis. This paper first intends to demonstrate that imposing expiatory pilgrimages, in and of itself, could be interpreted as a health measure. It will next explore how health could be preserved in a mobile environment.

In the urban setting of Ghent, expiatory pilgrimages were imposed in two main situations, that both related to health. First, it could be imposed on individuals who infringed on health-related policies defined by the city, such as improper disposal of waste. Second, it could be imposed on individuals in conflict who disturbed the peace of the urban community. In both cases, expiatory pilgrimages had moral implications, and could be regarded as a way to re-establish a perceived moral and social equilibrium that had been transgressed. Imposing them was thus a way to promote spiritual health in urban communities. Pilgrimages imposed on individuals embroiled in conflict, prevented the further escalation of violence in the city.

Preserving the health of pilgrims was a serious concern. Both the pilgrims themselves were conscious of the danger that such a journey could represent. This is evinced by the fact that a lot of pilgrims redacted testaments before they embarked on their travels. Municipal governments also acknowledged the dangers when they imposed these pilgrimages. Pilgrims had to consider the site's distance, topography and climate, and take into account season and social conditions (such as wars, accessibility of hospices and labor opportunities). Municipal governments acknowledged and manipulated these aspects when imposing pilgrimages. The distance of the site often was adapted to the gravity of the offence, and the date of departure adapted to seasonality and potential military conflicts both in the city of origin and on route. They could also provide assistance in the form of letters of safe conduct or even subsidies.

B5.2 Janna Coomans, Universiteit van Amsterdam, *Biopolitics, Health and the Itinerant Poor in the Late Medieval Netherlands*

Due to their mobile existence, the itinerant poor roaming north-western Europe have been a notoriously difficult group to grasp for historians. Living in places for only a limited amount of time and in pursuit of short-term goals of subsistence, such people had little affinity with, or were excluded from, the civic duties and promotion of a greater common good that undergirded public health programs promoted by urban authorities. In the fifteenth and sixteenth centuries, the foreign poor were increasingly criminalized and perceived as a threat to local social stability and health – bringing both epidemic and moral illnesses. It is well known that the era's political and religious upheavals uprooted populations and transformed the organisation of poor relief. Yet scholars have rarely commented on the ensuing impact on public health policies and how these were shaped by Galenic ideas on communities' wellbeing. And even when they did,

observation/their perspective tended to adopt the perspective of urban elites rather than that of the itinerant populations themselves. Filling both lacunae, this article has two aims. First, it seeks to establish some of the complex strategies of subsistence employed by the itinerant poor to preserve their health. Secondly, adopting the concept of biopolitics, it investigates the policing of the foreign poor undertaken to protect urban public health interests and what effects the regulation and bans in the name of urban public health had on their status and mobility. Galenic ideas on flow, circulation, miasma and corruption shaped a strongly negative perception of this group in multiple ways and created a rejection of their strategies of subsistence. Thus, by tying these perspectives together, we see more clearly the shifting connections between public health interests, perceptions of community and social order.

B5.3 Claire Weeda, Universiteit Leiden, *Regulating the mobility of the able-bodied poor and public health services in fifteenth-century cities in the Low Countries*

From the fourteenth century, cities in the southern Low Countries regularly issued ordinances dealing with the presence of the able-bodied poor, or so-called ribalds. Often, particularly in times of health crises, they were ordered to leave the city and seek their livelihood elsewhere. On other occasions, they were employed in public works, both inside the city and in army and naval services. They laboured as porters and tent carriers, dug ditches and canals, built roads and bridges, cooked food, cleaned, and worked as hands on deck. Although frequently shunned as a public health threat, these men and women thus served as the bedrock of public health services. This paper explores how urban authorities, depending on situation, recruited these casual workers in public health services, sometimes offering them temporary residency, or moved them out of the city. How were the ribalds remunerated, and what were their working conditions? What temporary rights did they gain from labouring in public works? And how were these revoked? This paper addresses these questions through an analysis of the fifteenth-century financial accounts and bylaws of the city of Utrecht, Louvain, Ghent, Bruges and Antwerp.

B6. Placing the Microbe: Global Visions of Environment and Health in an Antibiotic Age

B6.1 Elliott Bowen, Nazarbayev University, *Chasing Syphilis: Penicillin Therapy, Sex Research, and the Origins of VD Contact Tracing in Hot Springs, Arkansas, 1943-1953*

In recent years, historians have begun to rethink the impact of antibiotics on post-1945 developments in American medicine. In contrast with earlier accounts that presented their invention as a major turning point in humanity's battle with infectious disease, more recent scholarship questions the extent to which antibiotic therapies revolutionized medical practice.

Though yielding more complex accounts of therapeutic change, this wave of revisionist scholarship has yet to consider how the advent of the antibiotic age affected one of early twentieth-century America's most popular medical institutions: the health resort. Most of the scholarship on this topic assumes that after World War Two, health resorts and the naturopathic cures they offered went into rapid decline, as the increasing availability of penicillin and other "miracle drugs" undercut the concept of "land health" that had sustained them for decades.

In this paper, I challenge the narrative of the American health resort's post-war demise. Focusing on Hot Springs, Arkansas, a city known as the "Mecca of the American Syphilitic" on account of the thousands of men and women who traveled to there to be treated for venereal disease (VD), I argue that antibiotic therapies did not so much supplant health resorts as they did invest them with new purpose. After the introduction of penicillin therapy in 1943, doctors at the Hot Springs Medical Center (a federal facility run by the United States Public Health Service) shifted the focus of their efforts from case-holding to case-finding. Through consultation with Alfred Kinsey, who traveled to Hot Springs shortly after the publication of *Sexual Behavior in the Human Male* in 1948, they developed a new form of VD contact tracing—one based on "down-to-earth discussions" of a completely unprejudiced sort. During the late 1940s and 1950s, medical professionals from all across the country journeyed to Hot Springs to master these new techniques, forming a vast "interviewing flying squadron" that played a key role in post-war VD eradication efforts. Their actions point to the persistence of place in post-war American medicine, while also offering insights into the origins of contact tracing in contemporary public health.

B6.2 Johanna Conterio, Flinders University, *Microbes in the Steppe: Tuberculosis Treatment between Probiotics and Antibiotics, 1920s-1950s*

A recent "probiotic" turn in science studies, geography, and anthropology has proposed a reassessment of the microbe, highlighting the dependence of all life, including human life, on microscopic life forms such as bacteria, viruses, and fungi, and the relative minority of microbes that harm human life. This paper places such a "probiotic" approach to the microbe in historical perspective. Using sources from the Russian archives of the Commissariat of Public Health and published medical sources, it focuses on the study of bacteria in the Soviet Union in 1920s and 1930s to develop probiotic therapies, which treated bacterial infections with other life forms. These included tuberculosis cures with fermented mare's milk, bacteria-rich mud, and sea water, administered in the vast network of Soviet health resorts.

Focusing on fermented mare's milk, the paper argues that medical researchers saw this probiotic preparation as inseparable from and deeply embedded into the ecological context in which it

developed, shaped by the climate, landscape, and geography of the steppe. Although in the 1920s, physicians and researchers developed and debated the relative merits of synthetic substitutes produced in a laboratory using the “bacterium orenburgii” as an agent of fermentation, and lamented the poor hygienic conditions of the steppe towns in which the cures were taken, medical officials and researchers came to an agreement in the 1930s that the probiotic therapies were most effective when the milk was produced, fermented, and taken in the climatic context of the steppe. Climate not only had direct therapeutic significance, but also influenced the quality of the mare’s milk, fermentation process, and resulting therapeutic preparation. When antibiotics were introduced in the late 1940s and 1950s, they were combined with climatic and probiotic treatments in tuberculosis therapy.

The ongoing significance of probiotic and climatic therapies in the treatment of tuberculosis patients in the Soviet Union illustrates a broader divergence in the Soviet approach to scientific biomedicine. The rise of bacteriology did not lead to a paradigm shift away from the environmental dimensions of disease in Soviet medicine, as occurred in other contexts within scientific medicine, particularly after the discovery of antibiotics. Climate, geography, and landscape had ongoing significance in Soviet approaches to biomedical research and practice, including bacteriology.

B6.3 Emmanuelle Roth, University of Cambridge, *Controlling the Reservoirs of Ebola: Shifting Epistemologies of Epidemic ‘Latency’ across Scientific Disciplines in the early 21st century*

In the 2010s, the scope of outbreaks of Ebola in humans shifted, becoming much greater. Two large epidemics, in 2013–2016 in West Africa, and 2018–2020 in the Democratic Republic of the Congo, left more than 30,000 victims, while the accelerated development of diagnosis tools and therapeutics enabled more than 10,000 to recover from the disease. This conjuncture deeply transformed the socio-ecological mechanisms that sustain the viral disease in a given place, and unsettled epistemologies of “disease reservoir”, which this paper maps and problematizes. Since the 2000s, disease ecologists have been pointing towards several species of fruit bats, threatened by bushmeat hunting and deforestation, as likely “reservoirs” of a disease described as “latent” in certain landscapes. Such framings of Ebola as an emerging zoonosis have been central, since the mid-2000s, in shaping environmental prevention policies at the crossroads of sanitation (through banning bushmeat markets) and sentinel surveillance (through wildlife sampling). Yet in the last couple of years, some virologists have come to consider the likelihood that Ebola survivors may act as disease “reservoirs” themselves and present a significant risk of epidemic resurgence. Recent genomic research suggests that the virus may persist in the bodily fluids of survivors and lead to relapse after a “period of latency.” This paradigm shift is reviving projects of using antivirals to cure people, and modernist dreams of disease eradication. Using ethnographic fieldwork with

researchers studying the ecology of Ebola, key scientific literature and their reception in international media, this paper examines shifts in the epistemic authority of virology over ecology in shaping the way that Ebola may be controlled. I argue that different ontologies of a “disease reservoir,” as an ecological interaction across scales of life, and as viral fluctuation within the bodies of former patients, underpin a burgeoning interdisciplinary controversy with public health fallouts. The paper contributes to emerging scholarly engagement with epidemiological frameworks of zoonosis, and challenges the idea that human-animal relations, and the complexity of notions of “place,” have overwritten a lab-centered focus on pathogens.

SATURDAY, APRIL 23, 2022

C1. Health and Dispossession in Native History, 1865–1918

C1.1 Juliet Larkin-Gilmore, ACLS Oscar Handlin Fellow, *Health-Seeking as a Tool of Dispossession: The Cherokee Health Drive of 1917*

The turn of the twentieth century marks the nadir of Native populations in the United States. For decades, federal Indian policies of removal, assimilation, and forced education attempted to accelerate what settler officials hoped would be the inevitable process of Native disappearance. These policies promoted the myth of the “vanishing Indian” because it made their lands available for settlement. Two consequences of these policies were dispossession and disease/mortality. This paper examines the previously unstudied connections between these two outcomes, specifically the process of Native dispossession via long-distance medical referrals. Using documents from the National Archives, it will argue that the health crises in Indian Country in the early twentieth century provided an opportunity for US Indian agents and physicians to accelerate the process of selling off Native lands to white settlers. It will focus on the 1917 Cherokee Health Drive during which federal physicians diagnosed and subsequently transferred many Cherokees (living in what is known as Eastern Oklahoma) to the Southwest. This health drive, run by physicians and nurses from the Office of Indian Affairs, sought to identify and remove sick Cherokees from their homelands under the guise of helping them. Many, indeed, did need and want medical help. However, as I will show, due to several factors including limited space in local sanatoria, many were shipped to sanatoria far from home. One of those hospitals was at the Fort Yuma Indian School. Using documents from the Fort Yuma Agency, this paper traces the outcomes of several patients who were sent there for treatment, the consequences of a long arduous journey, the financial implications for their families, the ways their referrals exposed their property to predation, and the overall decision-making process by which they and government employees decided on their removal.

C1.2 Macey Flood, University of Texas Medical Branch, *“The condition of the Indians”*: health and territoriality, 1865-1891

In the early spring of 1890, following a series of difficult winters and outbreaks of illness, Ojibwe tribal communities in present-day Wisconsin and Minnesota flatly refused a loan offer of \$75,000 from the United States government on the grounds that the money would mean putting their land and timber resources at risk for federal acquisition. Although these tribal nations by their own admission needed the food, goods, and medicine the offer included, and indeed had sent numerous requests for all three, they collectively determined that the terms of the \$75,000 outweighed pressing individual health and economic concerns.

This paper situates the 1890 federal offer and tribal refusal within a broader context of health provisions and federal dispossession in Ojibwe tribal communities through the closing decades of the 19th century. Throughout these decades, Ojibwe in Minnesota and Wisconsin navigated a host of federal and state initiatives designed to disrupt Ojibwe economies and land-ownership. These initiatives, figured as mechanisms of reform, included land allotment, the amplification of the timber industry, and an increase of state economic restrictions through timber and game laws. Towards health, Ojibwes mobilized resources, rented dams, cut timber, and, when pressed, sold land. This paper picks up health in relation to land and land-use, in particular allotment and the timber industry. Broadening health-seeking to include land- and community-centered decisions, this paper demonstrates the flexibility and foundations of Ojibwe health-seeking. This paper also demonstrates that underlying late-century federal reform initiatives were a standing commitment by the state to transform Indigenous peoples into healthy, working, Christian subjects and Indigenous land into productive, American territory. In other words, health as a settler rationale underlay federal policy that married religious assimilation, federal paternalism, land reform through industrialized logging and agriculture, and land displacement through allotment.

C1.3 Frank Vitale IV, National Library of Medicine, *Charting Death: Visualizing Mortality Data from the Carlisle Indian Industrial School, 1879-1918*

The history of mortality at Native American boarding schools is an often-referenced topic in both popular and academic discourses, especially with the recent discoveries of numerous unmarked cemeteries at schools in Canada and repatriations from the burial grounds of the Carlisle Indian Industrial School (CIIS) in Central Pennsylvania. However, these discussions rarely extend beyond a count of the total number of student deaths. Building on a recent mortality census of the CIIS, the largest and flagship federally run Native American boarding school at the turn of the 20th century, this paper explores how death can be examined beyond simple enumeration. Quantitative analysis of the circumstances, demographics, and causes of death at the CIIS provides rich data that

supplements our existing understanding of Indigenous youth mortality in the Boarding School Era. Placing this data in the broader context of the history of the CIIS further reinforces how healthcare at these schools was used to support the dispossession of Indigenous youths' land and identity. Methodologically, this paper also demonstrates how quantitative analyses of mortality can extend historians' understanding of colonial institutions and their impacts on health.

C2. Everyday Technologies of Mental Health: Mediation, Calibration, Datafication

C2.1 Jeremy Greene, Johns Hopkins University, *Broadcasting Brain Waves: Wireless Technologies, DIY Electroencephalography, and the Mediation of Psychosis*

Wearable technologies that transmit physiological information in real time are now commonplace items. Your smartphone or smartwatch can transmit your sedentary quotient, sleep duration and quality, and pulse rate to a central server for collection and data mining by a series of unknown parties. One out of every five U.S. employers who offered health insurance in 2018 collected wireless physiological information from the wearable devices of their employees to monitor not only the somatic but also the mental health of their workers. Yet as new as the present state of omnipresent wireless physiological surveillance may seem, more than a half century ago radio devices were generating similar hopes and fears for making mental processes trackable to the outside world. With the right transmitter and the right receiver, wireless technologies promised to detect the physiological basis of neurological activity, translate those functions into electronic form, and then broadcast them outside of the body to be legible to a host of interested parties.

This talk draws on new research in the archives of the Holter Foundation, which first developed and tested techniques for radio-electroencephalography in the 1940s and 1950s. The Holter radio-electroencephalograph (REEG) is one of many artifacts from an earlier era of wireless medicine we have learned not to see precisely because its impact has been so profound. While prototype "thought recorders" may have first appeared in the early 20th century as the stuff of science fiction, between the late 1940s and the early 1960s, emerging technologies in Holter's laboratory helped lay the foundation for the modern wearable medical electronics industry. Yet the REEG found a very different reception than its designers originally intended.

Originally designed as a tool for neurologists, the tool quickly became a flash point in the field of psychiatry, as persons living with psychosis and other forms of severe mental illness employed their own readings of REEGs (and tried to build their own REEG devices) to contest prevailing definitions of psychosis. Increasing preoccupations over secrecy, surveillance, and the broadcasting of hidden messages colored how both inventors and users interpreted and applied these new technologies. The Cold War may be over, but these anxieties—about where one's brain activity is broadcast, who has access to it, and how it might be used—remain.

C2.2 Hannah Zeavin, Berkeley, University of California, *Prediction as Prevention: The Datafication of the Suicide Hotline*

Across the 20th century and into our present, new modes of relating at a distance have given individuals in crisis an ever-expanding set of tools for accessing mental health care. From broadcasts to Instant Relay Chats, letter writing to e-therapy, psychiatrists, psychoanalysts, and peer-activists have attempted to send therapeutic care beyond the consulting room by harnessing quotidian, habitual media to connect would-be patients to the help that they need wherever they are, whenever they need it. The suicide hotline is one such form of teletherapy, premised on reaching users who otherwise couldn't access traditional therapy as well as those in extremis: it's nearly ubiquitously available, free, and comes in over a household utility or, now, a cellphone. It was designed to provide great flexibility and control to users, and to circumvent traditional modes for seeking care in while in crisis: namely, it has sought to create a space of care outside the jurisdiction of psychiatry and policing and the threats their forms of intervention carry.

This paper examines the turn to algorithmic care in the hotline and its effects: the introduction of datafication and tracking has relinked the hotline with policing. If hotlines were initially an experiment in what can happen when we don't call the police and instead perform mental health care in community, by community, without intervention, contemporary digital mental health has increasingly smuggled back in exactly what early champions of the hotline knew those in crisis needed to be able to avoid: interfacing with involuntary hospitalization and the carceral state. Algorithms can triage crisis calls, new platforms can remediate the hotline to make it more appealing to a broader user base, and digital efforts can bolster access to mental health—but digital mental health also turns care into a backdoor for surveillance and state violence in a moment where so many are, and have been, vulnerable.

C2.3 Jaipreet Viridi, University of Delaware, *Auditory Stresses: Misevaluation & Misfitting of Hearing Aids*

In 1974, an intradepartmental task force appointed by the U.S. Secretary of Health, Education, and Welfare was charged with examining issues relating to hearing health services and the sale of hearing aids. The task force was prompted by a report released the previous year by the Retired Professional Action Group, and the subsequent Senate Subcommittee on Consumer Interests of the Elderly that examined the arguments made in the report. Together, they acknowledged that the misrepresentation of sales in the hearing aid industry, the lack of standard licensing of hearing aid dealers, and the adequate evaluation and fitting of hearing aids, were all major issues that harmed the consumer—especially the elderly consumer. Yet for the consumer, the most pressing concern

for them was fitting: the process whereby the selected hearing aid is programmed to provide the correct amplification to maximize quality and benefit.

Historians have outlined how testing reinforces artificially privileged values and elevates culturally prescribed standards. Testing also, as outlined in Hui, Mills, and Tkaczyk's *Testing Hearing* (2020), calibrates and normalizes individuals, groups, and technologies. For hearing aids, the tests and process of fitting have been a point of contention since the early 1930s, as tests were regulated by hearing aid firms, and fitting implemented by their dealers. A correct fitting was one that set amplification to target an individual's speech hearing range; as dealers were aware, however, this was a complicated process. Misfitting meant a mismatch between the technical features of the hearing aids with the consumer's physiology, that is, misfitting, which resulted in auditory stresses: unwanted auditory stimuli, nervous disorders, mental and physical fatigue, and psychological reactions—including dejection, anger, pain, and disgust. Moreover, misfitting could even destroy a consumer's residual hearing and render them completely deaf.

This paper examines dealers' approach to hearing aid fittings during the mid-twentieth century and how they navigated worries about auditory stresses alongside technical advancements in hearing aids and audiometric testing. By positioning this history at the intersection of the history of medicine and history of technology, this paper presents a complicated story about biomedicalization and the difficulties of standardizing technology.

C3. Health Politics and Activism

C3.1 Isobel Ashby, University of Wisconsin-Madison, *Recruiting Right-to-Lifers on Campus: Feminists for Life of America, 'Pro-Life, Pro-Women' Activism, and College Outreach Programs*

In October 1997, 165 students at the University of Wisconsin-Madison attended an on-campus presentation about abortion by a feminist activist. The talk, entitled 'The Feminist Case Against Abortion', was delivered by the Executive Director of Feminists for Life of America (FFL), an organization that positioned abortion as antithetical to women's liberation. By the 1990s, self-proclaimed "pro-life feminists", like those in FFL, could be found on college campuses across the United States. Through their outreach programs, they sought to convince students that abortion constituted a physical and emotional assault on women, for it supposedly devalued motherhood, allowed misogynists to engage in consequence-free sex, and was an act of violence against women akin to rape. In short, they depicted pregnant women, as opposed to just the unborn, as victims of a purportedly coercive and abusive practice. Certainly, pro-life feminists' "women-centered" strategies were distinct from "fetal-centered" arguments vocalized in the immediate aftermath of *Roe v. Wade* (1973).

Beyond their rhetorical denunciation of abortion, FFL established on-campus daycares and healthcare services for student parents, thus demonstrating their material commitment to alleviating the burden of crisis pregnancies. Instead of dismissing right-to-life college recruitment campaigns as merely cynical ploys, this paper takes seriously the lack of support available to pregnant college students. So doing helps explain why pro-life feminists, similarly to their peers working in crisis pregnancy centers, appealed to some college-age women. It also recognizes that, in such constraining circumstances, just how free young women are to exercise reproductive choice may be called into question.

Inspired by Karissa Haugeberg's and Jennifer Holland's recent histories, this paper joins emerging literature that recognizes the right-to-life movement's diverse membership and varied tactics in the decades following Roe. Through an analysis of 1990s pro-life feminist literature, particularly FFL's publications, this paper will argue for the growing significance of "pro-women" strategies to the right-to-life cause. Indeed, despite FFL's awkward ideological positioning between conservatives in favor of "life" and feminists in support of "choice", depicting abortion as an affront to women as well as fetuses broadened the appeal of the right-to-life cause at the turn of the century.

C3.2 Karissa Patton and Whitney Wood, Vancouver Island University, *"An Act of Independence and Self Love": Self-Examination as Women's Health Activism in Canada, 1970-1990*

In the early 1970s, women's health activists argued that the act of self-examination liberated them from a reliance on a patriarchal medical system. Throughout the decades that followed, self-examination transformed from a niche feminist technique to a relatively commonplace preventative health practice, increasingly discussed within popular women's magazines across North America. Tracing this transformation, we discuss the impact of self-examination as an act of prevention, health education, and feminist resistance in late-twentieth century Canada.

Alongside the growth of "second-wave" feminism, women's health and birth control centres emerged across Canada and the United States to provide education and services designed by women, for women. The women running these centres actively encouraged their clients to take healthcare into their own hands, both figuratively and literally. In doing so, breast and pelvic self-exams became staples of the women's health movement. As a range of groups increasingly turned their liberationist critiques towards the structures of mainstream medicine, self-exam became a vehicle that allowed women to push back against what they cast as the systemic power imbalances involved with the traditional doctor-patient relationship. When self-examination techniques, and particularly pelvic self-exam, attracted growing attention in the popular press, they were

denounced by a small but vocal group of Canadian physicians, resentful of lay incursions into medical practice.

The history of self-examination programs has taken a backseat within broader histories of the women's health movement, often overshadowed by histories of contraception and abortion rights and services. Our research builds on the small body of work about the history of the self-exam and highlights the significance of self-examination programs within the Canadian women's health movement. Drawing on women's magazines and feminist newsletters, archival files from Canadian feminist health centres, and debates about self-examination in national newspapers, we reveal how shifting narratives about women's liberation, responsibility for preventative health practices, and medical authority intersected in the feminist practice of self-examination. Self-examination in the 1970s and 1980s eased climbing anxieties about breast and cervical cancer, fueled conversations about changing medical expectations and patient rights, and centred and fostered women's autonomy over their own bodies.

C3.3 Eana Meng, Harvard Medical School, *"The Promised Land": The 1972 Black Panther Party Delegation to China and Its Impact on Three Healthcare Providers*

Upon arriving in Beijing, China on March 8th, 1972, Tolbert Small wrote, "Free at last, home safe, unlike M.L.K, we didn't have to die to go to the promised land." Small was part of a twenty-person Black Panther Party (BPP) delegation to China from March to April 1972, arriving only days after President Richard Nixon's trip to China ended. There were a few healthcare-oriented delegates: Small, Marie Branch, and David Levinson. Small was the physician for the BPP headquarters in Oakland, California and directed its free clinic where Levinson worked as a medical volunteer, and Branch, a nurse, helped set up the Los Angeles chapter's free clinic. The BPP, which advocated for the self-determination of oppressed communities, was informed by Maoist politics in its healthcare pursuits, as noted by a small but growing number of scholars. The China trip exposed the American delegates to the perceived successes of China's sociopolitical and medical revolution – such as the barefoot doctor's movement in rural communities and advances in integrative medicine through modern developments such as acupuncture anesthesia – in order to engender and solidify the delegates' political commitment. Using personal papers and oral histories, this article provides a first-hand look at the medical encounters that took place and traces the significant impact the trip left on Small, Branch, and Levinson. To varying degrees, all three adopted the barefoot doctor approach to healthcare, incorporated Chinese medicine into their medical practice, and committed themselves to a life-long pursuit of correcting societal injustices. Whether it was helping publish one of the first English-translated acupuncture books (Small), implementing cultural competency in nursing curricula (Branch), or working in the Salvadorian Civil War (Levinson), these healthcare

practitioners saw medicine as a political orientation, even as they became less involved with the BPP and began to view Maoist politics in new light. They offer us a nuanced examination of the history of politics in medicine -- politics was not about party affiliations but instead about the concern of others, serving as an ethical guide for enacting creative, innovative, and accessible quotidian care for all in pursuit of “the promised land.”

C4. Sexual Controversies

C4.1 Arnav Bhattacharya, University of Pennsylvania, *Negotiating between a Racialized and a Universal Sexual Subjectivity: Race, Sexology, and Medicine in Twentieth-Century India*

Richard Francis Burton, British explorer, and Orientalist was one of the first translators of texts such as *The Kama Sutra* (1883) and *The Arabian Nights* (1885) in English. In his translation of the latter, he appended a “Terminal Essay” in which he devised a geographical sexual zone in the global South, the inhabitants of which, he argued, were biologically predisposed to homosexuality. Racially constituted sexual bodies undergirded the sexual imagination of Orientalists, colonists, and sexologists alike. India, for example, played a vital role in the racialized sexual imagination of German sexologist, Magnus Hirschfeld who traveled there in the 1930s with hopes to unearth a primeval sexual culture, that had been untouched by the modern sexual mores of the fin de siècle Europe. It was therefore not surprising that Indian sexologists in the 1950s reacted enthusiastically to Alfred Kinsey’s sex research with the hopes of conducting similar work to investigate the nature of “Oriental Sexuality.” There were however also critical responses to Kinsey’s methodology among Indian sexologists and psychiatrists who interrogated whether his research encompassed all of humanity or was restricted to Americans. Sexology together with other issues concerning reproduction such as contraception have not only attracted the attention of birth control advocates and sexologists, but the sexual management of the population was also of primary concern for the colonial as well as the post-colonial Indian state. Existing historiography on sexual medicine and reproductive politics in twentieth-century India has studied the intersections of the fields with diverse themes of class, colonialism, and gender. However, questions relating to racism and its impact on constituting sexual subjects have remained unexplored. In this paper, I argue that race remained foremost in the formulation of sexual science and medicine through twentieth-century India. Race was crucial in the initial phases of the emergence of the field as well as during the phase of institutionalization of sexual medicine during the mid to late 20th century. My paper will be based on the works of Indian as well as Western sexologists, Orientalists like Burton together with archival material obtained from the Kinsey Institute, Indiana, and Wellcome Library, London.

C4.2 Andreas-Holger Maehle, Durham University, *The Sexual Psychology of Albert Moll: A Lost Alternative to Freud's Theory of Sexuality?*

The Sexual Psychology of Albert Moll: A Lost Alternative to Freud's Theory of Sexuality?

Sigmund Freud's Three Essays on the Theory of Sexuality (1905) have found wide acclaim until the present time as the foundational work for a psychoanalytic understanding of the development of human sexuality (e.g. J. Lear 2015; J.-M. Quinodoz 2005; K. Sutton 2019). Much less known is the work of Freud's rival in Berlin, the neurologist Albert Moll (1862-1939), who conceptualised his own sexual theory (A.-H. Maehle and L. Sauerteig 2012; H. Oosterhuis 2019). In this paper, I elucidate how Moll arrived at a more specific interpretation of the sexual drive than Freud's libido theory, distinguishing two basic components: the 'detumescence drive', aiming at the release of tension through evacuation of sperm or secretions; and the 'contractation drive' urging towards physical and mental contact with the sexual partner or object. Taking inspiration from the psychopathological studies of Richard von Krafft-Ebing, Moll also analysed in detail deviations of sexual behaviour differentiating inborn and acquired causal factors.

As I demonstrate, Moll developed these ideas in two of his main works, *Die Konträre Sexualempfindung* (1891, second edition 1893) and *Untersuchungen über die Libido sexualis* (1897), by the use of numerous patient case histories from his private practice in Berlin. Many of these cases stemmed from homosexual men, who revealed details of their childhood memories, inner life, feelings, and sexual experiences to Moll as their therapist. Although Moll took the view that homosexuality often required no psychotherapeutic intervention, he treated homosexual patients on their request to address their mental and social suffering. He used for this his own form of 'association therapy' (not to be confused with Freudian free association), which encouraged the patients to focus on heterosexual mental images and phantasies and to suppress homosexual thoughts and feelings (Moll 1911). While Moll's utilisation of case histories to comprehend the patient's condition was not dissimilar to Freud's, he thus employed a therapeutic method that emphasised conscious self-control rather than making the unconscious conscious, which Moll later criticised as dangerous 'digging into the sexual' (Moll 1925). I aim to suggest explanations why Moll's form of psychotherapy eventually failed to receive the appeal that Freud's psychoanalysis won.

C4.3 Queenie Ng, Nanyang Technological University, *Defending the Family: The Sanctioning of Sexual Knowledges in Singapore, 1980-1990*

In *The History of Sexuality*, Foucault argued that the "future and fortune of societies were tied not to the number of uprightness of its citizens, their marriage rules and family organization, but to the manner in which each individual made use of his sex". As sexuality becomes increasingly wedded to the biopolitics of nation building, functioning both as a marker of its economic and biological

wellness of nation-states, individual sexual contact and conduct rendered regulation. More importantly, during times of crisis, it warranted instruction. In early twentieth century America, pioneering sex education educators like Maurice Bigelow and Prince A. Morrow advocated for sex education to combat commercialized vice, venereal diseases, and neutralize the ongoing population explosion. Decades later, during the 1980s, concerning global trends of soaring unplanned teenage pregnancy and abortion rates, alongside youth-on-youth sexual violent crimes sparked a renewed interest in sex education among developed nations, and garnered newfound support within the recently decolonized Southeast Asian region. Situating the discussion on Southeast Asia Singapore, this paper explores how sex education was introduced and conceived amidst the burgeoning issues posed by industrialization, which includes rising marital dissolution, and the weakening of parental authority. Analysing the cultural and scientific discourse on sex education from 1980-1990, this paper demonstrates how sex-educator-medical-professionals capitalized on the Asian Values Campaign, a governmental policy launched to correct the problems of industrialization, to introduce and disseminate “scientific” sex education literature, which turned out to be more obscene than the indecent publications that was sanctioned under the same campaign.

C5. Politics of Space

C5.1 Gaëtan Thomas and Guillaume Lachenal, Médialab, Erased histories of the early AIDS epidemic in Paris. Space, loss, and postcolonial connections at the Claude Bernard Hospital

Our paper is a contribution to a postcolonial history of AIDS in Paris. Focused on the unique trajectory of the Claude-Bernard hospital, the presentation connects the first decade of the epidemic to a broader history of postcolonial medicine and migrations. Combining oral history, digital approaches and an ethnographic exploration of memory and loss in a liminal zone of North Paris, it explores the possibility of writing medical history from the void left by the destruction of an institution.

Paris hospital Claude-Bernard was demolished in the early 1990s, during the most tragic years of the AIDS epidemic in France. In the previous years, it had become the clinical and epidemiological center of the epidemic in the country, where many AIDS patients were cared for – including the one whose lymph nodes samples led to the first isolation of HIV. The destruction of the hospital added to a sense of loss, at a time where friends and family were still mourning former patients.

Created in 1906, the hospital focused on contagion, a function that was reflected in its architecture and the shape of the campus - a very long and narrow strip of land located at the northern edge of the city. When the threat of infectious diseases seemed to wane in metropolitan France in the 1960 and 1970s, Claude-Bernard transformed into a postcolonial hospital. It did not only receive a

majority of patients from African diasporas living in Paris, but developed strong ties with newly independent countries from France's former empire.

Drawing from archival materials and interviews with former patients, their relatives, and staff, our presentation uses the exploration of the disappeared hospital as a strategy to situate the development of the AIDS epidemic in Paris within broader histories of urban epidemics, African migration and postcolonial medical collaborations in tropical medicine. We will highlight the potential of our research strategy, based on the use of visualizations - maps and 3D representations of the hospital - that intend to include its particular architecture (and its erasure from urban space) within the very production of oral histories.

Our project focuses on African diasporas, populations that have been overlooked in the rather abundant literature on the first decade of the AIDS epidemic in France.

A history of exchanges between France and its former African colonies can be approached through the hospital's involvement in networks of tropical medicine. Quite significantly, an entire pavillon at Claude-Bernard was reserved for patients arriving directly from Gabon.

Claude-Bernard's destruction confirmed the preference of France's medical elite for bigger, integrated "blocks" buildings, that have proven unadapted for emerging infectious diseases. Our research signals untimely shifts in the architecture of contagion in France.

C5.2 Cara Fallon, Yale University, *Therapeutic Deception? Dementia Villages, Institutional Care, and an Emerging Ethic of Alzheimer's Disease Care*

In the early 1990s, a Dutch nursing home redesigned its facility into a "village" for Alzheimer's disease patients. Rather than waxed floors and white coats, De Hogeweyk—a gated elder care facility in Weesp, Netherlands—mimicked the community outside its walls, with gardens and town centers, ocean views and buses to nowhere, and health professionals dressed in plain clothes. The founders of De Hogeweyk aimed to provide more "humane" memory care, even for persons whose diseases eroded their ability to recall the past or orient in the present.

In the following decades, dementia villages appeared across global communities from South Africa to India to the United States, re-envisioning institutional care for elderly with Alzheimer's disease. Dementia villages in the Chagrin Valley, Ohio, and Chula Vista, California, for example, targeted specific historic periods such as "the 1953-1961 time period" to "soothe" residents with design features evoking a seemingly familiar past. Others, such as dementia villages in Bangalore and Johannesburg were designed in dialogue with the Dutch facility, aiming to mirror contemporary communities outside its gates. As these facilities carefully designed institutionalized "community life" for persons with Alzheimer's disease, they foregrounded new questions on the relationships between history and memory; reality and deception; care and cure.

This paper analyzes the historical and ethical frameworks for the rise of “dementia villages” in the late twentieth and early twenty-first centuries. Drawing on archival collections, published medical literature, institutional paraphernalia, and digitized materials for four dementia villages (Nikisa Village in Bangalore, India; Chula Vista and Chagrin Valley in the USA; and De Hogeweyk in the Netherlands), this paper asks how and why the concept of dementia villages emerged along with how these facilities brought forward new questions surrounding cultural values for elder care, the boundaries of compassionate care and deception, and how, rather than pitting care against cure, villages resembling “normal” community life functioned as both care and cure, in the absence of either.

C5.3 Kim Nielsen, University of Toledo, *Medical Cure, Moral Redemption: Dorothea Dix and the Making of Asylums and Prisons*

Between 1830 and 1875, every state in the ever-expanding United States allocated land, money, and legislative attention to the creation of insane asylums. Public institutions grew from eight to seventy-one during these years, cementing the asylum’s economic, medical, and social power. Though white male physicians directed these institutions, their contemporaries and today’s scholars concede credit for the public fervor that enabled the movement to Dorothea Dix (1802-1887). Beginning with her 1843 Memorial to the Legislature of Massachusetts, Dix became a widely lauded reformer and lobbyist. Strengthened with female moral authority, her highly publicized texts emphasized the mistreatment and horrific conditions experienced by mad people. Within the history of medicine, Dix is accorded much credit in the development of asylums, “moral treatment” and a humane, medicalized understanding of insanity. In this paper, which analyzes Dix’s career from the 1830s to the 1850s, I argue that Dix conflated the medical cure of the insane and the moral redemption of prisoners. In Dix’s rhetoric and lobbying, as well as in her efforts to design asylums and prisons, cure and redemption became one cause treated via overlapping methods. By helping to create and professionalize medicalized insane asylums as well as carceral prisons, however, Dix separated the two populations that most early nineteenth-century communities institutionalized together. The sources on which this analysis builds are Dix’s writings about the building of prisons and asylums, her moralistic fiction, her legislative proposals, the work she relied on, and her guidance for asylum medical personnel and prison employees.

C6. Racism in Training and the Profession

C6.1 Eleanor Shaw, The University of Manchester, *Old Boys' Network or Meritocracy? Recruitment at the British Journal of Anaesthesia 1970-2020*

In 2021, the Journal of the American Medical Association drew widespread condemnation for releasing a podcast and a tweet that appeared to deny the existence of structural racism in the US. The fallout led to the eventual resignation of the Editor in Chief and a Deputy Editor. Several of the critiques blamed the 'old boy's network' at the journal for failing to include black contributors in the process of making and releasing the podcast. In the UK, recent research by Woodhams et al found black women surgeons are 42% less likely to be promoted to consultant level than white men and claimed that, until 'old boys' networks' are dismantled, the current exclusion of professionals along gender and racial lines from senior status will continue. But how are 'old boys networks' built and maintained? This paper will address this question through a case study of the British Journal of Anaesthesia (BJA), a high-impact specialist medical journal founded in 1923.

The recent rise of network analysis in historical research, such as Deborah Neill's work on tropical medicine and John Fagg et al's work on networks and 19th century American periodicals has fruitfully brought sociological tools and concepts into work on medical specialisms and publications. This paper discusses the results of a network analysis on the inter-personal relationships and values-based recruitment system at the BJA. Medical journals are elite institutions that play a significant role in shaping the leadership of the profession. They operate with limited oversight and use professional networks to recruit reviewers, board members and editors. Analysis of archive documents, oral histories and the journal itself finds this method of recruitment is legitimised through ideas of meritocratic assessments of intellectual ability, but actually results in mechanisms of exclusion being hard-wired into the organisational culture. Using Haas' theory of epistemic communities and McDonald's work on accessing social capital through gendered and racialized networks, this paper argues that within bonding exercises, away days and dinners, social capital is predicated on sameness, resulting in the exclusion of those who cannot replicate this sameness under the guise of intellectual inferiority.

C6.2 David Johnson, Federation of State Medical Boards, *Diversity and Power Structures in Medical Licensing: Historical Context and Suggestive Trends*

Systemic racism and structural inequities have long been pervasive in healthcare in the United States. This is evidenced by alarming disparities in access to health care and outcomes. And what of the system for medical licensing that brings physicians into healthcare? Have the same systemic biases and inequities been at work?

State medical boards arose in the last quarter of the 19th century as the legal entities statutorily empowered to oversee the licensing and discipline of physicians. To date, no studies have captured the historical composition of medical licensing boards or explored systemic biases embedded within these quasi-governmental agencies. Evidence suggests these boards skewed toward white males and only in the last 50 years have signs of diversity become evident.

This session gathers available information and data from the Federation of State Medical Boards to provide the framework for a collective portrait of state medical board composition. This portrait is derived through a series of “snapshots” that in aggregate present a portrait that includes the historical biases embedded in the licensing system.

These snapshots include North Carolina’s practice of annotating the record of black physicians and the scoring of their licensing exam; medical boards’ embrace of the AMA Council on Medical Education’s classification system of medical schools which disadvantages schools admitting larger number of women and historical black medical colleges; the use of citizenship requirements to limit the licensure of international medical graduates starting in the 1920s; photographic evidence of individual medical boards’ composition 1956-1984; and data on gender diversity on state medical boards more recently (1985-2020).

Collectively these “snapshots” provide the framework for a portrait supporting the hypothesis that medical licensing boards and the system for licensure reflected the same biases and power structures seen in the American medical profession and society at large.

C6.3 Rimma Osipov, UNC School of Medicine, *Doctors as Strangers: International medical graduates and the "crises" of medicine and immigration in the 1960s and 70s*

International medical graduates (IMGs), previously termed foreign medical graduates (FMGs) have had a significant presence in the United States since shortly after the Second World War. Despite representing up to 25% of American physicians over the course of the second half of the 20th century, the role of these physicians has been largely relegated to the margins of accepted historical narratives of the medical profession and US healthcare system during this period. Coming initially from Eastern Europe and then increasingly from Asia, the Middle East, and Africa, this group of physicians began to take on a disproportionate role in staffing critical urban and rural hospitals and serving vulnerable Americans. This project takes part in the process of writing this group back in to the professional, social, political history of American medicine. The mid-1960s through the end of the 1970s were a time of open vehemence towards IMGs in American medicine. Examining editorials in medical journals, position statements from organized medicine organizations, health services research reports, popular press accounts, and narratives from International physicians in the US at that time helps reveal the complex, sometimes contradictory ways that the debate about

restricting IMGs in the US interfaced with both the perceived “crisis” of authority in American Medicine and anxieties about immigration and assimilation after the Immigration and Nationality Act of 1965. The growing number of international medical graduates troubled accepted wisdom on professional regulation and exacerbated concerns over decreased trust in the doctors and institutions. Debates about their role in US healthcare reflected contested ideas about American hegemony, civil rights, and international obligations. Since the 1940s, IMGs have been most visible when debates about impending change in the US healthcare system and the role of immigration in American society intersect. This has resulted in periods of relative tolerance and quiet recruitment interspersed with bursts of controversy and regulation. Although glaringly apparent in the 1960s and 70s, such shifts continue to keep this group vulnerable, as they continue to be called upon to fill the demographic, financial, and moral gaps in an increasingly strained US healthcare system.

D1. Racism Across Borders

D1.1 Steve Server, University of Chicago, *Encountering an “unknown Mexico”: Race, eugenics, and medical education in Mexico, 1935-1940*

In 1935, Mexican government and the National Medical School collaborated to establish an educational and public health program called the *servicio medico-social* (SMS). The SMS would bring senior medical students into the rural countryside for a period of five months, serving as the town doctor for hamlets which may have never experienced biomedicine before. Part of these young students’ charge was to send regular reports back to Mexico City: for example, details of water quality, nutrition, hygiene, and plumbing in the region. Though medical students were not obligated to provide examiners with information of local culture and custom, nevertheless, across hundreds of these theses, medical students offered detailed ethnographic accounts of a town’s language, medical practices and beliefs, social structure, etc. Many also offered descriptions of their understandings of indigeneity, invoking various rhetorics—including the biological—to make sense of their encounter with a Mexico previously unknown to them.

While previous studies of the SMS have discussed the racist and colonizing impulses present in the SMS—seeing the program as a sort of Foucauldian biopowerful grab by the State—in this presentation, I hope to explore the ways that race structured the moment of encounter between doctor and patient on the ground. In the course of presenting clinical vignettes and personal reflections from medical student theses, I discuss how racial, racist, and eugenic ideas informed the ways that students understood the Mexican State’s modernization project, the role of the profession of Medicine in the lives of indigenous people, and indeed, their own position as budding physicians vis a vis their patients. I argue that racial and eugenic discourses gave medical students a mode of justifying a supraordinate social position over patients, under the rubric of paternalistic

care. In this way, this presentation is a case study which will permit us to understand how race may both explicitly and subtly inform the ways in which medical students come to understand their professional role, and consequently, may structure the underlying politics of the exam room.

D1.2 Pamela Maddock, University of Sydney, *Race, trust, and disease control in the US Army: Mandated prophylaxis for stevedores in St. Nazaire, 1917*

The history of controlling sexually transmitted diseases in the US Army in the twentieth century is a well-known public health-military medicine story. In the First World War, with the help of civilian reformers and a Presbyterian moralist as Commander in Chief, US officers approached the massive problem of VD rates with education about the manliness of self-restraint, alternative recreation, and chemical prophylactic stations for men after exposure. Less well-known, however, is the way particular military decisions about controlling sexually transmitted infections in France contributed to institutional racism in the military generally and more specifically, racist understandings about trusting patient narratives.

This paper argues that official responses to rates of infection in the army furthered a racism that perpetuated a mutual distrust in public health. General John Pershing issued orders that all members of the AEF report for chemical prophylaxis after purchasing sex, but for African-American stevedores at St Nazaire, he mandated each man undergo the prophylaxis regimen each time he returned from town, whether he admitted to exposure or not. Medical officers explained that they had to make this compulsory because Black service members viewed the regimen of prophylaxis, which involved not just washing genitals but also injecting a silver nitrate solution into the urethra, with “horrified suspicion,” and therefore would not report for the procedure unless orders made it compulsory. Because stevedores did not trust the procedure of prophylaxis, medical officers understood, it made sense to mandate that they undergo this ordeal rather than trust the men about their own conduct. These orders, along with others, did bring down the rates of infection at the port. At the same time, they silenced Black workers’ narratives and denied them a measure of bodily autonomy that their white counterparts in the army had. Ultimately, the project highlights an example of racial disparities in responding to the problem of distrust of medical authorities with mandates.

D1.3 Carly Naismith, York University, *In the Minority: Anatomical Education in Canada and the Hidden Curriculum of Gender Roles and Race Relations*

By 1900, cadavers for Canadian medical school dissections were being procured under the auspices of Provincial Anatomy Acts from hospitals, asylums, and other state-funded institutions. Majority of the bodies received between 1900-1950 were white males. When female and/or racial minority

cadavers were obtained, they often received treatment considerably different from that of the 'typical' white male subject. This could take the form of dissection for a special class, prosection for illustration, or preparation for the anatomical museum.

Assessing dissection room records from Dalhousie University, McGill University, the University of Toronto, the University of Western Ontario, the University of Manitoba, the University of Saskatchewan, and the University of Alberta, my presentation will look at the difference in treatment that these racialized and gendered bodies received. In assessing how they were utilized I will assess how social prejudices seeped into anatomy classes, exposing facets of the hidden curriculum and how that treatment affected future generations of doctors, their approach to medicine, and the many female and minority patients who would one day be under their care.

D2. Politics of the Body

D2.1 Sandra Eder, University of California, Berkeley *"A Happier Future." The Making of the 'Transsexual' Patient at the Gender Identity Clinic at the Johns Hopkins Hospital, 1966-1979*

The Gender Identity Clinic (GIC) at the Johns Hopkins Hospital was the first such clinic to offer what was then called "sex-change operations" at an American medical institution. While the Hopkins Clinic was the first of many to emerge in the late 1960s and 1970s, it was closed in the midst of controversy about the direction of transgender care and due to a lack of funding and administrative support in 1979. Using primary archival and published sources, this paper explores the ways in which the clinic created a particular kind of "transsexual patient" modeled on practitioners' earlier engagement with question of sex and gender at the clinic. I argue that already existing practices in intersex case management, particularly a focus on surgery as a main factor in sex assignment, a formulation of an eventually fixed gender identity, and a prognosis of future happiness as justification for medical intervention, shaped the formulation of new protocols at the GIC.

D2.2 Richard McKay, University of Cambridge, *"I told him that there had been no girl": Examining an allegation of same-sex gonorrhea transmission in 1930s British Columbia*

In British Columbia, as in other parts of North America, the late 1930s witnessed reinvigorated efforts to control venereal disease (VD). Beginning in 1936, provincial authorities expanded funding for free clinics in the largest cities of Vancouver and Victoria; empowered a centralized bureaucracy for VD control; and appointed a charismatic physician, with connections to influential figures in the American social hygiene movement, to lead this agency's efforts. Soon armed with persuasive local statistics, public health workers began waging a high-profile campaign to tackle an entrenched system of commercialized prostitution.

It is against this backdrop that a criminal investigation of buggery, involving several white working-class men in Victoria, stands out as highly unusual, moving against these contemporary currents and coming to authorities' attention, it appears, through the reporting of a venereal infection. This presentation will analyze verbatim preliminary hearing transcripts—to date only superficially described in the secondary literature and subject to restrictive privacy legislation—as well as public health reports and newspaper articles to investigate several questions. To what extent did VD control efforts encourage police and health workers to collaborate? Did one defendant, upon discovering that he had acquired a sexually transmitted infection, risk imprisonment by seeking police involvement? And how did these men understand the causes, risks, and symptoms of VD, especially in relation to same-sex contacts?

My presentation will explore this case's uniqueness and historical specificity—a rare documented instance implicating same-sex VD transmission at a time when concerns focused overwhelmingly on female prostitutes. I will also link it to an emerging trend that would draw attention across North America and Europe over the ensuing three decades: the increasingly prominent role attributed to “male homosexuals” in the spread of VD. Finally, I will reflect on the methodological issues of de-identification and data abstraction when working with historical records subject to privacy restrictions.

D2.3 Olivia Weiss, Case Western Reserve University, *A Partner in the Ballroom: Testicular Prosthesis and Masculinity in Medical Journals and Patient Experiences*

Testicular prostheses first began to be successfully used in 1939, and the process gained acceptance through the 1970s and 1980s as a routine treatment option for testicular loss. Loss of testicles often leads to emotional and mental distress; this distress has been noted yet under-examined in medical literature on testicular prostheses. This paper argues that while medical sources in the 1990s and into the 2000s began to include analysis of patient satisfaction with testicular prostheses, there has been a substantial lack of attention paid to the emotional effect of testicular prosthesis on masculine identity. To make this argument, this paper connects medical articles about the technicalities of testicular replacement, and patient-authored stories of losing a testicle and potentially replacing it with a prosthesis. The medical literature ranges from 1941 to 2020, presenting the technical and scientific background of orchiectomies, implant placement, and other surgeries for patients suffering the loss of a testicle. Patient-authored posts from online cancer support forums span from the 1990s to 2020 as patients found community through the veil of anonymity and the fraternity of shared experiences; their posts address different aspects of cancer and speak to the emotional and mental turmoil that accompanies disease attacking and taking away

body parts seen as intrinsic to masculine identity. This paper will demonstrate that medical sources fail to completely address the emotional impact of testicular loss and subsequent replacement on personal understandings of masculinity, and that the psychology of the expression of masculinity is overlooked in the medical literature on a psychologically-grounded and deeply gendered surgical process.

D3. The Power in Front of the Throne?

D3.1 Kelly O'Donnell, Yale University, *Behind the Great Doctors: Locating the Physician's Wife in the History of American Medicine*

The glossy magazine MD's Wifepromised relevant and engaging content to “the women behind the great men of medicine.” From most of the twentieth century, under various titles, it reported on AMA conferences, encouraged readers to lobby their elected officials, and offered advice for coping with the unique challenges of being married to a doctor. This long-running publication served as a central node for the Woman's Auxiliary to the American Medical Association and recorded the group's relentless organizing and socializing. But the well-documented Auxiliary, though large and active, represented only a small portion of the massive population of physicians' wives across the country, supporting the doctors—great or otherwise—of modern America.

Partners in practice, nurses (lay and trained), cultural messengers, political activists, financial backers, secretaries—these are only some of the roles frequently played by doctors' wives, comprising what amounts to a shadow labor force within the medical profession. This talk offers a preliminary argument for the need to consider marriage and romantic partners in our histories more closely, as they are essential to understanding the transformations of American medicine. A true integration of this social world in our histories of health care holds the potential to radically alter our understanding of labor dynamics and the transmission of knowledge and prestige about medicine within society and culture.

At the same time, this talk will also reflect on the major methodological difficulties in documenting this domestic realm. While this history is urgent, doctors' wives have evaded the scrutiny of medical historians for a number of reasons. Not only is much of the history of medicine cataloged in the heavily curated professional papers of physicians, but partners of physicians were often heavily invested in upholding a particular image of their husbands for the public and posterity. By expanding our archive and reading older sources creatively, we can begin to appreciate doctors' wives as a missing piece in the puzzle of our health care histories.

D3.2 Sarah Naramore, Northwest Missouri State University, *Sense and Amiability: Julia Rush and the character of American medicine, 1776-1815*

Benjamin Rush's (1745-1813) figure looms over the history of early American medicine. His prolific publication record and direct influence on thousands of medical students between 1769 and 1813 left a lasting impression. A recent revival in Rush scholarship has used his connections to link him – an in turn American physicians – into wider debates about the development of the medical profession, political and social debates of the new republic, and how his specific ideas evolved and were used by others throughout the nineteenth century. Focus on this networked and professional approach to Rush, however, runs the risk of missing the informal relationships that shaped American medical practice.

Rather than focus on Benjamin Rush, this paper considers the medical role of his wife Julia Stockton Rush (1759-1848). Historians have long recognized the lack of firm boundaries between home and business in the eighteenth-century and the medical field was no different. For Benjamin to function as a physician and professor, Julia needed to work to maintain social, professional, and financial relationships. The remarkable amount of documentary evidence about Julia makes her a valuable figure to study when considering the important role of “doctor’s wife” during this period. While historians have studied the letters written between Benjamin and Julia with an emphasis on what they tell us about Benjamin’s work, Julia typically appears as a passive recipient of information rather than a fleshed intellectual partner to her husband. Such assessments miss this key aspect of their relationship. By reframing the assessment of documents to consider Julia’s contributions it becomes clear that far from a supporting background character she was a substantial medical and business partner to her husband. From her early navigation of apprentice fees as a teenage bride to her discussion of medical theory during the 1793 yellow fever epidemic to her astute assessment of Benjamin’s final illness in 1813, Julia Rush had considerable influence on the day-to-day practice of medicine. Her contributions, questioning of Benjamin’s methods, and engagement in the intellectual world of Philadelphia were just as much a part of American medical practice as her husband’s formal lectures.

D3.3 Wendy Kline, Purdue University, *Nassar and the National Nightmare: gynecology, gymnastics, and the potential for abuse*

As a toddler with boundless energy, McKayla Maroney loved imitating the gorillas in the movie Tarzan, hopping around on her hands and knees. Desperate to tire her out, her mother signed up for local “mommy and me” gymnastics classes. “From my earliest memories, I always wanted to be a gymnast,” Maroney wrote in a prepared statement to the Senate Judiciary Committee in September of 2021. Her mother, who had served in the U.S. Navy, had “instilled the importance of patriotism and sacrifice” in her, and more than anything, Maroney “wanted to one day win medals

for Team USA.” Her dream came true in the 2012 London olympics, where she won a Gold and Silver medal.

But by then, the dream had already turned into a nightmare, one that she would be forced to recount over and over in the hopes that the problem would be stopped. On September 15, 2021, four olympic gymnasts, Simone Biles, McKayla Maroney, Maggie Nichols, and Aly Raisman, testified bravely, eloquently, and passionately for over an hour in front of the Senata Judiciay Committee. “As most of you are probably aware, I was molested by the US Gymnastics National Team and Olympic Team Doctor Larry Nassar,” Maroney began. “In actuality, he turned out to be more of a pedophile than he was a doctor,” she continued, her wide eyes squarely facing the room full of senators. They needed to hear that the cost, which continued to take its toll, was unbearable. “The scars of this horrific abuse continue to live with all of us,” Simone Biles declared minutes prior to Maroney’s statement, after breaking down in tears. “No accountability has occurred,” added gymnast Maggie Nichols, the first to come forward with abuse allegations back in 2015. Aly Raisman, the last of the four olympic gymnasts to testify that September morning, added, “it is naïve to assume the problem rests only with Nassar.” If this was a story of just one pedophile abusing his role as a medical practitioner, then the world could move on, believing it was an isolated incident that would never happen again.

After the story broke in 2016, and the number of survivors willing to speak out grew exponentially, the obvious question in many minds was simply, how did this happen? How could a pedophile rise up the ranks to become the national medical coordinator for USA Gymnastics? And how could he get away with sexually abusing hundreds of girls for nearly twenty years? The Nassar case, “the largest case of sexual abuse in the history of American sport,” as Biles put it in her 2021 testimony, exposed the incredible potential for abuse. The collective shock continues to this day, amongst a whirlwind of editorials, tweets, interviews, and even Senate hearings. This total lack of awareness, among USAG, coaches, parents, and the survivors themselves, about what was actually happening during Nassar’s “treatments” speaks volumes about our assumptions regarding pain, medicine, and healing. As one feminist practitioner put it, “what happens to a woman in the privacy of a medical exam room has always been a secret between that patient and her caregiver.” We would now add, in light of the Nassar case, that what happens to a girl in the privacy of a medical exam room remains a secret between her and her medical trainer. And it shouldn’t be.

Since the 1970s, we have experienced a collective faith (or blindness) that unethical medical treatment was a thing of the past. Scathing exposés about unethical medical treatment revealed in the media in the 1960s and early 1970s – such as the Tuskegee syphilis experiments -- resulted in watchdog organizations, new regulations and policies put in place, and an emphasis on informed consent. Patient rights, and patient advocacy, became a staple of modern medicine, thanks in part

to the women's health activists' demand that women (and really, all patients) had a right to know what choices their providers were making about their patients' bodies. This collective faith regarding safety and accountability, particularly for young female athletes, has been shattered. This paper places the Nassar nightmare in historical context, in order to understand how and why we allowed it to happen.

D4. Patient Power and Eugenics

D4.1 Heather Dron, University of Michigan, *Refusal and Resistance: Patients' and Relatives' Objections to Sterilization in California Institutions, 1922-1948*

California was on the vanguard of the eugenics movement, which encompassed a complex mix of political and progressive interests seeking to improve the quality of populations based on an agricultural model of "better breeding," encouraging reproduction in some families and discouraging or preventing reproduction in others. In 1909, the state was among the first to enact legislation that permitted the sterilization of institutionalized people with mental illness, epilepsy, or intellectual disability (and even venereal disease), ostensibly because these traits were inheritable. Of more than 60,000 such sterilizations documented in the United States in the first half of the twentieth century, about a third were in California.

Although the law did not require permission or consent from patients, their guardians, or families, nevertheless by the 1920s, a process for requesting permission for sterilization was set up. Families and guardians of institutionalized patients at psychiatric hospitals or homes for the intellectually disabled were asked to sign permission forms documenting their purported consent to the operation. Even though roughly 80% of cases have such signed documentation, it is widely acknowledged that these processes would not meet contemporary standards of informed consent, both because of lack of clear explanation and understanding, asymmetries in power between medical staff and patients or families, and because sterilization was often required as a condition of release. Indeed, when families explicitly refused to give their consent, Medical Superintendents might simply seek authorization to sterilize these patients directly from the Director of Institutions. This paper seeks to answer the following questions: 1) Why did medical staff, institutional and state administrators go to the trouble of obtaining signed permission forms from families when the law did not require it and when, in spite of explicit refusal from family members or the patient, they might nevertheless go ahead with the operation? What function did consent serve, under these circumstances? 2) What did families, patients, and guardians give as reasons for their refusal? What concerns did they raise? Who had standing to refuse sterilization? What can historic resistance to coercive sterilization tell us about informed consent?

Using microfilmed Department of Institutions records comprising more than 53,000 documents digitalized and indexed by the Sterilization and Social Justice Project, this study examined cases where there was an indication that consent was refused. A close qualitative analysis of 639 administrative files associated with 326 individuals for whom sterilization was explicitly refused provides a lens to better understand asymmetrical relationships of power and discriminatory processes of consent documentation, or in other words, the manufacturing of consent. This presentation also documents objections raised by patients, relatives, and guardians about sterilization. Refusers expressed considerable ambivalence and some estrangement, many were parents (~77%) or other relatives of young people confined at homes for the feebleminded. The themes that arose from this analysis were 1) reluctance to sign official paperwork documenting permission for sterilization; 2) a tendency for superintendents to invalidate refusals due to circumstances of would-be consenters (often intellectual or legal status); 3) religious objections (at times priests or other spiritual advisors would intercede); 4) deference to medical discretion (often with the assumption that the sterilization was intended for therapeutic benefit); 5) disagreement about giving permission for surgery among patients, relatives, and guardians; 6) rejection of the need for the operation accompanied by skepticism about utility, necessity, diagnosis and heritability; 7) estrangement, or denial of responsibility or legal status to sign forms; and lastly, 8) fear of blame or interpersonal repercussions. These diverse responses underscore the discrepancy between the purported intent of consent documentation to uphold the desires and wishes of relatives, guardians, and patients about reproductive surgery and the ways in which bureaucratic “consent” processes were enacted, likely to the detriment of impoverished people of color.

D4.2 Paul Lombardo, Georgia State University, *“The Courage of their Convictions,” Nazi Sterilization Law in the US Press, 1933-1949*

Accounts of the impact of American eugenics often contain a linear argument, tracing legal developments in the US to the horrors of the Holocaust. It is similarly common to see a bright line drawn at the end of WWII, using the fall of the Nazis as a benchmark for the demise of eugenic thinking. Neither of these generalities is accurate.

Newspapers in the US regularly reported details of laws sanctioning eugenic sterilization in both Germany and the US. Those news reports provide a barometer for examining the popular acceptance of eugenic policies in the US, and also reveal how much attitudes about eugenics may have been affected by reports of the wide-ranging and dramatic legal regime of sterilization launched in Germany in the 1930s.

This paper uses newspaper coverage as a measure of what Americans thought about eugenics, with a particular focus on coverage of the 1933 Nazi Law for the Prevention of Hereditary Disease, eventually used to justify more than 400,000 eugenic sterilization operations on German citizens from 1934-1945. American newspaper readers, from urban dwellers who read their news in daily papers, to inhabitants of the smallest hamlets in the rural countryside, reading dispatches that may have arrived only once a week, all consumed a regular diet of news about eugenics. Even the least informed would easily have been able to track the rise of Nazi eugenics, and view that news alongside parallel coverage of several new sterilization laws in the U.S., enacted after the Nazi law, while simultaneously reading reports of ongoing sterilization programs in most states.

A survey of newspapers reveals that while some US critics spoke out against Hitler's excesses, there was no widespread popular disgust or revulsion at the Nazi sterilization laws. In fact, those laws were often applauded in the press, and used by some as a goad to further eugenic enactment in the states.

D4.3 Nali Gillespie, Duke University, *Postpartum Sterilizations and Reproductive (In)justice in the mid-twentieth Century at a North Carolina Teaching Hospital*

This paper explores the landscape of postpartum sterilizations within North Carolina during the mid-twentieth century through a case study of Duke University Hospital, a prominent academic teaching hospital. North Carolina was well known for its Eugenics Program which sterilized over 7000 North Carolinians, many involuntarily. It is less known how many sterilizations were being performed on obstetrical services in teaching hospitals during this same time period. While the Eugenics Board focused on sterilizing people it deemed to be intellectually disabled or epileptic, obstetricians were also navigating the legal and ethical waters of voluntary and medically indicated postpartum sterilizations. At the same time, North Carolina was facing challenges related to a high maternal mortality rate, a large rural population and segregated healthcare systems by race and social class. We analyzed records from the NC Eugenics Program Board to determine the degree to which Duke University Hospital was involved in these sterilizations and then analyzed postpartum sterilizations from Duke's labor and delivery records from 1930-1965 to assess the indications for such sterilizations. We also conducted oral history interviews with former obstetrics residents from the 1960s-1970s. Our analysis confirms that not only were Eugenics Board sponsored sterilizations being performed at teaching hospitals in North Carolina (and supported by the obstetrics department), but that an even larger proportion of sterilizations were being performed on patients with medical indications indicative of high-risk pregnancy, such as toxemia. Furthermore, our analysis suggests that there may have been overlap between eugenic and medical indications for postpartum sterilization, at the discretion of obstetricians and with varying degrees of patient

consent. Our analysis also indicates that the social class of the patient played an important role in women's access to voluntary sterilization, in that women from higher socio-economic classes could more easily access voluntary sterilizations during a time when it was restricted. These findings help shed light on how academic obstetrics today carries fraught legacies of reproductive injustices.

D5. Medicine and Digital Humanities in Action

D5.1 Mary Fissell, Elaine Leong, Johns Hopkins University, *Print, Pills, and Promotion in Seventeenth-Century London*

Historians of medicine have employed three volumes of late seventeenth-century advertisements (mostly handbills) in the British Library to analyze the workings of London's medical marketplace. Drawing upon methods from media studies and the digital humanities, and analyzing all surviving medical works produced in English over the century (over 2000 works) we show that that handbill advertisements were just the tip of the iceberg. Many a book that looks purely informational proves, upon closer reading, to be a form of promotion; often the introduction or the very last page provides an address and even the times of day a healer was available. Interpretations of seventeenth-century popular medical writing have been shaped by Nicholas Culpeper's writings, advocating for medical knowledge open to all. However, much as today, what appears to be disinterested medical information offered to the public was often selling a practitioner or product. Such promotion was deeply woven into the fabric of medical writing in seventeenth-century London.

This broad array of promotional texts began well before a boom in the late seventeenth century and included not just the colorful "quacks" who have often been the focus of secondary literature. From John Archer, physician to Charles II (available 12-4 at his Knightsbridge home), to the un-named doctor's wife in Dean Court who treated female patients, medical writing was often self-promotion. Such medical work was deeply rooted in London; in some cases, we can trace how moving from one neighborhood to another altered the way a practitioner framed the medical information presented.

These promotional texts were generated by the realities of the medical marketplace. Venereal disease was deeply stigmatizing yet commonplace; many texts were directed to such sufferers who might not want to ask friends or neighbors. By contrast, almost no promotional works survive for midwives, whose neighborhood practices were built almost entirely by word of mouth. Thus, our revisionist account of medical "advertising" allow us to further understand complex and overlapping medical economies, and revisit key narratives about the rise of medical consumerism and the commercialization of healthcare.

D5.2 Angela Potter, Purdue University, *Going to Therapy: Locating Outpatient Treatment Spaces in the Therapeutic Landscape, 1945-1975*

Today, the CDC reports that roughly one in four Americans will receive outpatient treatment for mental illness each year, with approximately one in ten receiving counseling or therapy from a mental health professional. Medical offices seem “natural” in our modern therapeutic landscape, though not long ago they were the sites of a dramatic therapeutic revolution.

At the end of World War II, families seeking treatment for loved ones diagnosed with mental illness had few options outside of hospitalization. The growing financial and humanitarian burden of mental illness triggered a crisis of care, as the nation looked for new strategies to combat its greatest public health challenge. A new sense of scientific optimism unleashed the forces needed to remake the therapeutic landscape of mental illness treatment and usher in a period of growth and change in the provision of both custodial care in state funded asylums and outpatient treatment. In just two decades, the office supplanted the asylum as the primary site for mental illness treatment. Despite this, there has been little historical scholarship on how this change unfolded at the local level.

Across the period from 1945 to 1965, outpatient treatment, including psychotherapy, occupational and activity therapy, clinical social work, family guidance, psychotropic pharmaceuticals, fundamentally altered the way mental illness was conceived and treated. This paper presents a narrative and spatial analysis of the development of outpatient treatment in Indianapolis, Indiana. The study draws from a geocoded relational database of clinicians, and treatment facilities built from a wide range of primary source documents providing data on patient demographics, treatment statistics, and therapeutic modalities.

Indianapolis was both emblematic of the broader therapeutic revolution and specifically significant in the development of modern biopsychiatry. There were more than seventy treatment sites and two hundred clinicians provide a range of mental health services-- from marriage counseling to music therapy, and from psychopharmacology to prayer. Early public mental hygiene and health clinics were joined by private practice offices and religious and social service counseling centers. Outpatient treatment spread along established clinical and social service pathways reinforcing a polycentric health care system.

E1. Epidemics, Chronicity, and Pandemicity

E1.1 Simone Caron, Wake Forest University, *The Expansion and Limits of Public Health during Epidemics in Winston Salem, NC, 1910-1930*

The city of Winston, North Carolina, grew rapidly from a population of 443 in 1870, to 10,008 in 1900, to 17,167 in 1910. Much of this increase came from Winston becoming a center of the tobacco industry; by 1897 Winston was the third largest tobacco-manufacturing town in the nation. In 1913, it merged with the town of Salem; this merger and continued in-migration for tobacco jobs led the city to become the largest in the state by 1920 with a population of 48,395. This near tripling of the population in one decade exacerbated health conditions in the city. With African Americans as the overwhelming majority of tobacco workers, living in cramped conditions conducive to the spread of epidemics, racial tensions over access to health care exploded. Reformers and activists formed the Forsyth County Public Health Department (FCPHD) in 1913 to protect the general health of city residents, and to stop the spread of communicable diseases, especially among the city's economically essential tobacco workers. Soon after its founding, the FCPHD faced its first major health crisis in 1916 when a scarlet fever epidemic broke out among adults. Two years later, the Influenza pandemic hit the city with force. Based on the records of the NC Board of Health and FCPHD as well as on local newspaper accounts, this paper looks at the cooperation among federal, state, and local officials to contain these back-to-back epidemics, and the impact they had on the growth of the FCPHD. This paper also engages with recent studies on the resultant physical and mental health disabilities that survivors of epidemics endured to show the FCPHD's lack of public health preparedness to support them once the immediate threat of contagious disease waned.

E1.2 Emma Broder, Harvard University, *Epidemiology without Pathology: Nonspecific Disease Definition at Lake Tahoe, 1984-5*

In this paper, I describe the 1984-5 outbreak of a strange, mononucleosis-like disease in Lake Tahoe, Nevada, a subsequent CDC investigation of which helped create the label chronic fatigue syndrome. The CDC, using the epidemic intelligence model promoted by the agency's Cold War director, Alexander Langmuir, created a case definition and used laboratory techniques to search for an infectious, microbial cause of the disease. Their efforts were unsuccessful as symptoms were common, protean, and vague, including fatigue, muscle and joint pain, low grade fevers, and headaches. While laboratory tests initially suggested infection with Epstein-Barr Virus, these weren't universal or reproducible. In this respect, the outbreak failed to conform to the biomedically-based model that the CDC's Epidemic Intelligence Service was famous and celebrated for, but I will argue that the outbreak's failure to conform to a specific etiological framework opens up numerous questions about the role of epidemiology in understanding contested illness in the late 20th century.

Other scholars writing on this outbreak and the subsequent social construction of chronic fatigue syndrome have argued that the lack of a specific etiology and ensuing media attention set patients and sympathetic doctors up for inevitable controversy, effectively demonstrating how the disease fails a test of biomedical validity. I show instead that the earlier history of nonspecific disease outbreaks parallels the rise of epidemiological frameworks contingent upon biomedical knowledge, leaving feeble or unarticulated psychological assumptions to fill in the epistemic gaps around the disease entity. Skeptical local physicians diagnosed a confirmation bias in the doctors seeing the CFS patients, for example. And as the condition became a diagnosis of exclusion, defined by subjective symptoms when no organic pathology could be discerned, researchers became increasingly uncomfortable with this supposed epistemic uncertainty, relegating serious patient engagement to a minority of internists—and psychoanalytic analyses. Drawing on case reports of local physicians, CDC epidemic aid memoranda, and popular and news media coverage of these events, I will contribute to histories of epidemiology and public health that explore the role of failure and persistent uncertainty around infectious disease at the end of the 20th century.

E1.3 Robert Frank, University of California, Los Angeles, *The Birth of a Monster: The Emergence of Lethal Smallpox in Early Stuart London*

HIV/AIDS, SARS, and now Covid-19 remind us forcefully that “new” diseases can arise by a variety of mechanisms. Building on the work of Carmichael and Silverstein, I present here new evidence that smallpox, the most feared and lethal disease of the long eighteenth century, especially in Britain, arose from a more benign ancestor.

More specifically, I argue that killer smallpox—at the very least in England—emerged locally in rapidly-growing London over a relatively short period c. 1595-1640. From a uniformly benign childhood disease—little feared and killing few—it changed to include more lethal forms, especially the confluent and “flat” types. This new spectrum killed 15-35% of those who contracted it.

Using the rare parish registers that recorded cause of death, and equally rare weekly and annual London Bills of Mortality (1627+), we can trace how smallpox changed from constituting 0.4-2.9% of burials in the 1580s, to peaks like the epidemic of 1634, when it caused 1354 deaths—13% of all burials.

Literary and qualitative evidence parallels the statistical. In a flurry beginning about 1600, networks of correspondence—in the State Papers, in the Cecil family archives, in John Chamberlain’s London newsletters, and in numerous private collections—report the growing fear of smallpox, as well as

the named adults dying of it. From about 1610, poetry lamented premature deaths of prominent nobles, and the scarring of aristocratic female faces. Funeral sermons comforted the living, and drew life lessons from untimely deaths. Diaries, such as Ralph Josselin's, reflected the fear in the home counties that this new smallpox would spread to the countryside, and the dread of contracting it on a trip to London. A new disease even demanded a new name. Books, letters, and Bills of Mortality dubbed this lethal variant "flocks," or "flox," a name that originally denominated a lumpy, brown dressing used on horses.

Finally, I underpin the statistical and literary with very recent evidence from molecular biology, that all known samples of the smallpox virus derive from a common ancestor in the early seventeenth century—an evolutionary ground zero for a new spectrum of disease.

E2. Developing Expertise and Knowledge in the Body and Environment

E2.1 Lan Li, Rice University, *"The Pain of Overthinking: Attitudes of the Spleen 脾 in Literary, Medical, and Culinary Cosmologies"*

This essay offers a cultural history of spleen conditions from medical texts composed in classical Chinese. Known as one of the most "interior" of the Yin organs, the spleen (pi 脾) manifested diseases related to the emotions that were often deadly. Among the emotions, overthinking was particularly dangerous to the spleen. Here, I argue that thinking was not only an element of cognition but also a category of feeling. The spleen defined temperaments and was affected by temperaments and shaped one's tastes, preferences for flavors, and sensitivity to flavors. Specific sounds, colors, and emotions could orient and harm the organs. In considering the broad functions of the spleen, this paper thus interrogates the ontological category of emotions, where rather than functioning as an object against reason, emotions included forms of cognition and thinking.

This paper furthermore contributes to scholarship on cognition and imagination that conflict with legacies of the mind sciences. In particular, it builds on existing scholarship on histories of the mind in the absence of the brain to diminish and decenter the contemporary organ for thinking and contemplation. In doing so, engage postcolonial histories of science and medicine through what is increasingly called "negative ontology." Through presenting a history of thinking as a kind of emotion through the spleen, I highlight anatomical cosmologies without the brain and categories of cognition without rationality. Rather than fixating on historical ontology, which determines objects and paradigms of the past, negative ontology instead captures the imperfections of decolonial aspirations and anti-colonial imperatives.

E2.2 Joseph Leonardo Vignone, Harvard University, *“But Do Not Overdo It and Sicken Your Patient!” al-Rāzī, Enhancement Medicine, and the Structure of the Human Mind*

The education of medieval Islamic scholars required that they memorize countless texts across multiple fields of knowledge to acquire both pietistic and professional status. In order to excel in these challenging academic circumstances, scholars perused medical texts for information about how to manipulate the humoral complexions of their brains and achieve greater, more prestigious feats of memorization. In response to heightened demand for such strategies, physicians of the medieval period discussed methods of memory enhancement at length in treatises of medicine directed toward these scholarly audiences. They described memory as a physical process occurring in regions of the brain responsible for the reception and deposit of images acquired through sense experience, with the strength of recollection depending on the health and congenital structure of these regions. Physicians generally conceded that no interventions could be safely recommended for improving the brain’s recollection beyond the treatment of recognized pathologies by experienced practitioners. This paper will investigate a shift in attitude that occurred by the tenth century toward advocating these treatments for enhancing the memory of otherwise healthy individuals. It will argue that this shift was heralded by the influential physician Abū Bakr al-Rāzī (d. 925), who provided an aggressive regimen for enhancing the memory in his monumental work of medicine, *al-Ḥāwī*. Disagreeing with previous physicians on the safety of this regimen, al-Rāzī argued that those seeking memory enhancement could do so in calibrated stages of treatment that would incline the humoral constitutions of their brains toward a complexion optimal for memorization. Situating al-Rāzī’s text within an arc of medical writing on the human brain and the substances that could be used to increase its efficiency dating to the Antique era, this paper will provide a greater understanding of the importance Muslim scholarly circles laid by longstanding medical theories of mind and memory. Moreover, it will probe a significant point of tension in the medieval Islamic world between models of care advocated by physician-practitioners and the demands of a learned society whose members wished to use these models for their own, often ethically and medically controversial purposes.

E2.3 David Jones, Sunil Amrith, Harvard University, *Air Pollution, Health, and the Politics of Indigenous Knowledge in India*

In January 2019 India’s Minister of Environment, Forests, and Climate Change sidestepped demands from Parliament to take air pollution more seriously. He argued that no data in India had shown a relationship between air pollution and health. This rhetorical gambit involved two claims: first, that knowledge of the health effects of air pollution produced in other countries had no relevance for India, and second, that no such knowledge had been produced in India. While both claims can be disputed, this paper focuses on the second. Drawing on archives in Delhi, Mumbai, Geneva, and Washington, it demonstrates the long history of air pollution anxiety and research in India. British

imperialism brought coal-fired industrialization to India in the mid-19th century. Concern about the health effects of coal smoke emerged immediately. In the early 20th century, Smoke Nuisance Commissions in Calcutta and Bombay published annual reports about air pollution control, including data that linked air pollution to mortality. After independence in 1947, researchers in many fields (e.g., occupational hygiene, urban public health, respiratory medicine, and meteorology) in several cities scrutinized air pollution. Their concerns spanned problems old (e.g., textile mills, coal) and new (e.g., atomic power, chemical industries). These researchers also engaged with the WHO and international networks of air pollution research. Concerns about indigeneity figured prominently. Because of strict import controls and limited financial resources, Indian researchers had to develop their own air pollution monitoring technology. They came to take pride in their indigenous devices which were designed for Indian conditions. They also argued that research needed to be done in India for environmental and physiological reasons, for instance because India's tropical heat and humidity altered the nature of air pollution and its effects. They scrutinized and debated the relevance of foreign expertise, even as their own research consistently confirmed foreign findings about the toxicity of urban air. This history raises a puzzling question: why would a nationalist Minister not applaud the work of Indian scientists who had used indigenous equipment to make contributions to global knowledge of the health effects of air pollution? Other interests were evidently in play.

E3. When and Where Slavery Entered: New Directions in the Study of Race and Medicine

E3.1 Jim Downs, Gettysburg College, *The Phantom of Slavery in Epidemiology: (In)visible Knowledge Production in the Atlantic World*

The history of epidemiology has been popularly told as a story that originated in mid- nineteenth-century London when Dr. John Snow first tracked the origins of cholera to a water pump. Snow mapped how cholera moved across a neighborhood in London and in so doing developed a theory of disease transmission. While the medical community eventually embraced Snow's argument, in order for his theory also to be widely adopted by the medical and scientific community, it needed more proof.

Beginning in the late 18th century, physicians and intellectuals gathered in Saint Domingue and founded the Cercle des Philadelphes. Boasting a membership that included Benjamin Franklin among other authoritative thinkers of the Early Republic, the Cercle des Philadelphes was one of the leading intellectual societies during the 1780s. Drawing on the natural environment, physicians advanced scientific ideas that had long been theorized in the British and French metropole but lacked the place and population to apply these ideas. Santa Domingue's large plantations and sizable enslaved population enabled the Cercle des Philadelphes to learn more about botany, agriculture, meteorology, climate, and the spread of epidemic disease.

While historian James E. McClellan meticulously charts how the Cercle des Philadelphes produced a three-volume study of scientific ideas, scholars have paid very little attention to the ways in which enslaved people contributed to this form of knowledge production. Drawing on Ira Berlin's formulation of the "slave society" rather than a "society with slaves," my paper argues how the advancement of scientific principles was aligned with the institution of slavery. I highlight examples of how Cercle des Philadelphes depended upon enslaved people to understand the spread of infectious disease, often using enslaved people's bodies in experiments as well as drawing on information of their health to map the presence of infectious disease. Slavery created social arrangements that transformed plantations into laboratories, allowing doctors to study the spread of infectious disease across an incarcerated population.

While the Cercle des Philadelphes' volumes are replete with new theories and ideas, the enslaved people who helped to carry out the experiments, served as unmasked subjects of study, and created the conditions in which knowledge could be produced have been summarily erased from the history of science. My paper seeks to reanimate the activities of the Cercle des Philadelphes in an effort to understand and to learn more about the ways in which enslaved people and the institution of slavery advanced scientific knowledge in the 1780s.

My paper concludes by explaining how Black Feminist theory can be used as an interpretive strategy to excavate the lives of enslaved people often buried in medical treatises.

E3.2 Rana Hogarth, University of Illinois, *"For negroes do not prepare so much, nor so good blood as the whites...": Enduring Medical Knowledge in the Age...*

The imagined peculiarities of enslaved African bodies and the specific practices one had to undertake to manage those bodies appeared in eighteenth-century and nineteenth-century medical manuals on slave management in the British West Indies. These medical texts were a formative medium in which white physicians traded the latest methods for treating enslaved patients, justified their own existence as experts on Black health in slave societies, and engaged in a kind of indirect self-promotion. However, these texts do more than show the ways in which physicians exploited the slave system for professional gain. They provide us with insights into what medical knowledge about Black people's bodies was transmitted, what was agreed upon, and what endured in the era of slavery. In other words, this paper seeks to understand the calculus and rationale behind the kinds of knowledge about Black people's bodies that became unquestioned medical truth, and the kind of knowledge that did not. The so-called "truths" about Black people's bodies this paper explores include assumptions about easier childbirth than whites, higher pain tolerance, and a propensity to gastrointestinal disorders. Many of these erroneous claims about Black people's bodies have been the subject of research by a growing number of historians of medicine; however,

these claims are seldom investigated alongside assumptions about Blackness that failed to take hold in slavery era medical texts—such as restraint in bleeding slaves.

E3.3 Diana Louis, University of Michigan, *The “Method in her Madness”: Harriet Tubman and 19th-century Conceptions of Insanity*

Every historical account of Harriet Tubman’s life includes her harrowing head injury and the resulting religious visions and spells of unconsciousness. Scholars have shed light on the illness through the lens of contemporary medical taxonomies, however this talk aims to explain the meaning of Tubman’s condition in the context of the medical world of the nineteenth century. In the nineteenth century, her condition fit squarely in the realm of what lay people and psychiatrists alike considered epilepsy -- a form of “insanity.” In response to would-be conclusions that Tubman was “insane,” reformer Sarah Bradford wrote, “There was a wild poetry in these descriptions which seemed to border almost on inspiration, but by many they might be characterized as the ravings of insanity. All that can be said is, however, if this woman is insane, there has been a wonderful method in her madness.” Using a black feminist theoretical stance that privileges the empirical experiences and knowledge production of marginalized people, this paper tells a history of insanity centered around Harriet Tubman’s life. An analysis of the “method in [Tubman’s] madness,” reveals that African Americans had distinct ideas on “insanity.” I argue that for Tubman mental disability is multifactorial. It is dependent on biological and physiological processes, environmental context, and social position, all of which work in tandem to impact health, for better or for worse. Further, I contend that her story reveals how nineteenth-century medical perspectives and practices concerning black peoples’ mental health were rooted in racially biased cultural narratives and culturally-shaped diagnostic criteria. Rendering a history of “insanity” outside the prowess of the white men of psychiatry provides a broader view of the history of medicine and new possibilities for understanding sickness and health.

E4. Therapeutics and Creation of Knowledge

E4.1 Wankun Li, University of Strathclyde, Glasgow (Wellcome Trust), *'The Iron Man' and 'The Painless Hospitals' in Great Leap Forward China*

In the years of the Great Leap Forward (1958-1962), workers bore the cost of high industrial output in the form of injuries caused by overwork in unsafe workplaces, and the suffering was all the worse for those who fell through the gaps of China’s uneven welfare system. On 26 May 1958, Qiu Caikang, an iron worker from Shanghai Third Steel Factory, was burned by the molten steel, and as a result, 89 per cent of his total body surface area was destroyed. After a successful operation performed by the doctors at Shanghai Guangci Hospital, Qiu became a national labour model known

as the “Iron Soldier” and the Hospital was praised as the “Painless Hospital” and a “Happy Home” for workers. In the next years, the CCP made Qiu’s surgery a centrepiece of a political campaign among doctors and nurses, with the goal of establishing “Painless Hospitals” for workers throughout the country.

Using published materials and archives from the Shanghai Health Bureau and hospitals, this paper analyses the ideological debates in Qiu’s operation records and the medical care movement during the Great Leap Forward. I argue that the story of Qiu’s operation shaped the image of both working-class patients and medical practitioners trained in Western medicine a critical juncture in the history of China’s public health system and medical technology. In Mao-era China, the operation theatres became the theatres of class education for doctors and nurses as well.

E4.2 Natalie Shibley, Wesleyan University, *Peanut Panacea: The Medical Ideas of George Washington Carver*

This paper focuses on George Washington Carver’s beliefs about health, encompassing his interest in diet and nutrition, as well as his work on medical innovations, including a peanut-based elixir intended to treat colds and a method of peanut oil massage meant to treat polio. Although Carver’s peanut oil massage therapy was publicized during the 1930s and he received hundreds of letters on the subject, it has not been a widely remembered aspect of his work. He saw himself as a research scientist not only of agriculture but also of medicine. I present a view of Carver as a researcher and practitioner of health care and situate his work and thoughts within the larger context of medical research and health care in Tuskegee, Alabama. His intellectual contributions in the field of health linked the well-being of human bodies to innovative understandings of nature and agriculture. This paper argues for the importance of Carver and his scientific research to black intellectualism and to health politics in the early twentieth century. The sources are drawn primarily from Carver’s correspondence, as well as newspapers and magazines, medical and trade journals, and other documents.

E4.3 Yijie Huang, University of Cambridge, *Pulse Remedies and the Topology of Healing in Early Modern England*

In his *Essays of Effluvioms* (1673), Robert Boyle, one of the most influential natural philosophers in Restoration England, cited from several ancient and early Renaissance physicians an interesting, somewhat bizarre remedy. Sealing a living spider in a nutshell and attaching it to the wrist, where physicians normally took the pulse of their patients, this remedy was believed to cure agues effectively. Whereas Boyle doubted the validity of such narratives, he revealed great interest in the pulse, the very location of the spider, not just as a site of diagnosis, but one of therapy. A wider look at early modern medical recipes shows that Boyle was far from alone in investigating the pulse’s

therapeutic significance. This paper will examine pulse remedies – medicinal substances applied particularly to people’s wrists – in a range of seventeenth-century English medical treatises, casebooks and recipe collections. It will first identify as many disease-therapy correlations as possible in these pulse remedies and chart what sorts of materials and methods were often arranged to treat what types of diseases. It will then ask how and why these correlations were operated specifically at the pulse. This will open up two further enquiries. On the one hand, it will trace the history of these pulse remedies and the cumulative conceptions of the body in which they were embedded. On the other, it will look at how they were received in and after late seventeenth-century medical and natural philosophical discourses. In so doing, this paper addresses the historical topology of healing and its striking resilience. Analysing how pulse remedies survived radical changes of physiological theories through a *longue durée*, I will finally chart the curious continuity of medical practice facilitated by experience, customs, and imaginations.

E5. From Cradle to Older Adults

E5.1 Johanna Schoen, Rutgers University, *Life and Death in the Nursery: Making decisions in the NICU*

In December 1976, Andrew Stinson was born at a Community Hospital at 800 grams and a gestational age of 24 ½ weeks. No one expected Andrew to survive and both parents asked that no heroic efforts be made to extend his life. Despite their wishes, Andrew was transferred to the Pediatric Hospital Center where he was placed on a respirator. Over the following months, he became entrapped in an intensive care unit where doctors employed the latest therapies to try to save his life. As a result of the treatments, he contracted a chronic lung disease, grueling blood and urinary infections, a gangrenous leg, fractured bones, and seizures. When his parents objected, doctors threatened to get a court order to enforce their right to save him. In June, Andrew dislodged the tube connecting him to the respirator. PHC physicians decided not to reconnect him. He finally died four days later.

Pediatricians began to aggressively treat premature infants with new technologies developed in the 1960s. At the borderline between fetal research and the new sub-specialty of neonatology, physicians who sought to keep younger and younger infants alive confronted both the promises and limits of neonatology. Improvements in neonatal care meant that the infant death rate in the first month of life was almost cut in half. But for many infants treatment led to a prolonged period of dying while others survived with severely compromised health. Drawing on the medical literature, oral history interviews, and journalistic accounts, this paper analyzes how clinicians sought to ascertain certainty as they made prognostic evaluations to forge a path between life and death. They debated the ethical questions surrounding when to provide and when to withdraw care and argued about the involvement of parents in these decisions. While several journalistic accounts

chronicle the ethical issues that emerged with the development of neonatology and several works trace the history of incubators, there is to date no comprehensive history of neonatology. This work will shed light on clinicians' attempt to straddle the boundary between research and therapy, when to provide and when to withdraw care, and whom to involve in the decision-making process.

E5.2 Vivien Hamilton, Harvey Mudd College, *Race and the promise of the incubator in mid-20th century neonatal care*

Invented in France in 1880, incubators for premature infants arrived in American hospitals and at exhibitions by 1900. Early models kept the babies isolated from the environment, allowing these infants to continue developing as they would have in utero. Portrayed as both mechanical wombs and artificial mothers, these devices promised to replace or even improve upon mothers' bodies and care. This paper examines the clinical use of incubators in US hospitals in the mid-20th century, evaluating that promise within a medical system shaped by racial injustice and ignorance of women's bodies.

Incubators arrived as eugenics was flourishing in the United States, and in some ways, these were anti-eugenic devices, allowing so-called "weak" infants to survive. But, as Dána-Ain Davis has noted in her analysis of current neonatal care, "the technologies of saving ... gesture that the child or infant worth saving is white" (Davis 141, 2019). My historical research corroborates this. Babies and mothers of color are almost entirely invisible in medical texts and popular accounts of premature births. The 1906 novella, *The Incubator Baby* begins with the image of storks in the garden of paradise, looking for "a sweet pink and white baby ready to be carried away" (Butler 1906, 2). Where I do see evidence of doctors noting the higher rates of premature births in Black communities, beginning in the 1940s, I also see those same doctors attempting to erase the existence of these babies by changing the criteria for prematurity. A medical group in Cincinnati in 1945 argued that the weight cut off for a full term baby should be lowered to 5lb 3oz from 5 ½ lbs for Black infants, a move that would erase the racial disparity in pre-term birth rates and also deny crucial life-saving medical care to Black babies (Brown, Lyon and Anderson 1945). This paper traces the appearance and impact of these kinds of arguments through published medical literature, investigating the way medical racism and assumptions of racial difference shaped access to and use of this technology.

E5.3 Susan Grant, Liverpool John Moores University, *"Caring for Older People: Geriatric Consultation Offices in the Soviet Union, 1957-1982"*

This paper assesses geriatric consultation offices in the Soviet Union and their expression as centres of care for older people. Doctors and scientists from across the Soviet Union gathered at the

Institute of Gerontology, Academy of Medical Sciences USSR, in Kiev, to discuss the best ways of providing geriatric care through these kabinetyor consultation offices. After the first consultation office was established in 1957, interest expanded, and they mushroomed throughout the 1960s and 1970s. This paper examines the purpose and reach of these offices and the scientific and medical discussions around them to reveal several salient issues: the type of medical service provided to older people; the relationship between local and central actors; and the development of geriatrics in the Soviet Union.

These issues will be discussed within a broader historiographical framework that will analyse change and continuity across the Khrushchev and Brezhnev periods (1955-1982) and shed light on attitudes to older people during late socialism, as well as the historiographical debate around late Soviet values. Research is based on a range of sources, primarily the central state archive in Kyiv, Ukraine, which holds material on the Institute of Gerontology. The archive provides detailed files on geriatric consultation offices in the 1950s and 1960s. I also draw on dissertations from the Soviet period, as well as the press and periodicals to assess the impact of the consultation offices. This material will be framed within the broader Soviet healthcare context.

E6. Disability Rights and Technology

E6.1 Sarah Rose, University of Texas at Arlington, *Too Defective to Hire: Safety Engineers, Industrial Surgeons, and Rendering Invisible Disabilities Visible*

During the 1910s and 1920s, within just a generation, disability went from being widely viewed as simply part of working life to an inevitable disqualification to paid work. The passage of workmen's compensation laws explains part of the shift, since insurance companies interpreted compensation statutes in ways that discouraged American and British employers from hiring workers with disabilities or retaining current employees. By 1926, half of the nation's 600 largest companies reported that they were unwilling to hire any disabled workers at all, largely due to concerns about workmen's compensation. But how did the burgeoning safety and industrial surgery movement factor in, along with the newfound prominence of "invisible disabilities" such as those wrought by poison gas, shrapnel, and other World War I technologies and reshaped by industrial and agricultural racism?

I argue that, in the United States in the immediate postwar years, safety engineers, industrial surgeons, and efficiency experts redefined disability as a slippery, hard-to-detect bodily characteristic, more likely to be invisible than apparent to the naked eye. Spotting such disabilities required considerable expertise and bodily knowledge, in theory, thereby justifying the economic value of these new experts' scientific and medical approaches to classifying workers' diverse bodies.

The Knights of Labor Journal argued that compensation acts had imposed a “new status for the workman...the duty of maintaining a condition of health, alertness and strength not before demanded of him from the employer.”

Safety engineers and industrial surgeons also cast disabled workers as inherently unsafe and, therefore, unemployable in “modern,” efficient workplaces, even department stores. As the personnel superintendent for Brooklyn’s Sperry Gyroscope Company noted to the Veterans’ Bureau, many others assumed that even rehabilitated Great War veterans were “all physically unfit.”

E6.2 Leah Samples, University of Pennsylvania, *“A Second New Deal for the Blind”: Crippling Welfare Maintenance Care Regimes*

In this presentation, I examine how the on-the-ground implementation of mid-twentieth century federal and state welfare programs designed to provide income security relied on the maintenance practices and labor of the aid recipients themselves. Using the case study of Title X: Grants to States for Aid to the Blind of the Social Security Act, I look at the complex and frequent maintenance routines blind Americans were expected to perform such as regularly paying a visit to a state-approved ophthalmologist to confirm their blindness, continuously tracking and recording any gifts received from friends and family members, and even maintaining a weekly, state-approved budget for their entire household expenses. Failing to perform even one of these routines could cost them their welfare benefits. While these state-approved maintenance regimes were designed to standardize the process of efficiently and effectively administering and managing federal funds, we see that in practice blind Americans used the knowledge they gained from these practices for political action to disrupt not maintain the welfare system. By crippling maintenance practices designed to standardize and force likeness, sightless Americans instead used these very maintenance practices like the eye exam or the household budget to bring attention to the dynamic nature of vision, the messiness of kin relations, and the inadequacy of their current aid amounts.

E6.3 Christopher Rudeen, Ph.D. Candidate, *Self, Aid, and Company: Ernest Dichter’s Study of Hearing Aids*

Ernest Dichter, the “father of motivational research,” made his name promising to uncover what the customer really wanted. “As psychologists,” Dichter wrote, “we are equipped to discover subtle, unconscious and irrational motivations in people’s actions which are often more important and decisive than intelligent and reasonable arguments.” This quote comes from a 1950 proposal sent to Paravox, a hearing aid manufacturer that had consulted Dichter to help sales. The suggested study adopted a medical model of deafness, portraying it as a problem to be solved. Namely,

Dichter proposed a series of interviews with hard-of-hearing consumers to understand why some would choose not to do the “rational” thing and “fix” their hearing—unconscious motivations were “especially important,” Dichter wrote, “when there is a strong likelihood that neurotic personality traits are involved, as in the case of hard-of-hearing people.” This talk explores the study produced by Dichter as well as the resulting marketing from Paravox to locate the ways in which psychologists extended the attribution of corporeal deviance (in Rosemarie Garland-Thomson’s words) to psychological deviance. Building on the work of Jaipreet Viridi, who focuses on “the question of ethical advertising” of hearing aids as part of the longer history of deafness cures, I argue that advertisers constructed a hard-of-hearing subject also suffering from loss of self. Dichter’s report frames informants as having an “affliction [that] leads to increased sensitivity and over-expectations which can seldom be fulfilled.” These individuals were thereby given psychological symptoms that advertising could cure. The new, hybrid subject of self-and-aid would not only have improved hearing but would be free of the supposedly more harmful self-blame characteristic of the condition: the final report stated that “Buying an aid actually relieves guilt feelings and self accusation which are not uncomfortable feelings but often even more dangerous and harmful than the hearing impairment itself.” Companies such as Paravox created a market for their products that went beyond claims (often unfulfilled) of restoring consumers’ hearing. This case study thus provides a deeper look into the ways in which perceptions of D/deaf people as impaired were used to sell self, aid, and company.

SUNDAY, APRIL 24, 2022

F1. Disease, Surveillance, and the Carceral State

F1.1 John Shepherd, Durham University, *Data, Diagnostics and Delinquency: Clinical Crime Prevention in Interwar Massachusetts*

On what basis do we judge the risk of a given offender to society? Through the 1920s American psychiatrists argued that behaviors and emotions of childhood were key to diagnosing and intercepting developing patterns of criminality. The Judge Baker Foundation (JBF), first of many new child guidance clinics, was established in 1917 to serve the Boston Juvenile Court. JBF psychiatrists William Healy and Augusta Bronner promised to identify incipient psychoses and ‘maladjustments’ in Boston’s delinquents and advise on proper sentencing and ‘treatment’. But was this clinical crime prevention effective? By 1934 social scientists Sheldon and Eleanor Glueck claimed that JBF psychiatrists had failed and instead offered their own scoring system, utilizing statistical correlates of risk to identify dangerous juveniles. Faced with the causal complexity of crime revealed in JBF case records, the Gluecks increasingly doubted the accuracy of psychiatric diagnoses and proposed that subjective judgements be augmented with more objective quantitative assessments of

background factors and future risk. Kathleen W. Jones has pointed to a ‘problem of authority’ in the history of child guidance, specifically the extension of psychiatric authority during this period to judge social ills and ‘problem behaviours’ (Jones, 1999). In turn, we examine how psychiatrists’ new authority to anticipate criminality was challenged by statistical methods of prediction. Drawing on Theodore Porter we locate this episode within the broader history of medicine’s ‘trust in numbers’ (Porter, 1995). Using archival records of the Gluecks’ JBF study we trace how these numbers were assembled from wide networks of surveillance and reporting to construct new predictive instruments, the collaboration of psychiatrists and social scientists in crime prevention and the construction and contestation of diagnostic and statistical categories of delinquency. Today criminal justice and law enforcement are replete with pre-trial risk assessment tools, predictive policing technologies and psychiatric ‘threat assessments’ of juveniles. Through the work of the JBF and the Gluecks we can see the early development of such instruments in a context of clinical crime prevention. Moreover, this history points to hidden value judgements which have informed supposedly objective psychiatric and statistical measures of preemptive suspicion.

F1.2 Alexandra Halberstam, Yale University, *Incarceration of Tuberculosis Patients at the Turn of the 21st Century: Infectious Disease Control and Expansion of the Carceral State*

The relationship between the spread of infectious disease and incarceration has long been bidirectional. Infectious diseases, including influenza, hepatitis C, typhus, HIV/AIDS, and tuberculosis, have spread through carceral settings largely unchecked. So, too, has incarceration—in the form of prisons, jails, and informal quarantines resembling conditions of confinement—been used as a public health strategy to control the spread of disease. In the early 1990s, the rise of mass incarceration, HIV/AIDS, slashed social services, and the War on Drugs laid the foundation for the rise of antibiotic-resistant tuberculosis. Fear—and poorly designed public health policy—spread. Some individuals, most often low-income People of Color experiencing homelessness, were civilly committed to prisons and jails for refusing or failing to complete a course of antibiotics. This practice became formalized through court cases.

In this paper, I examine court cases, legislation, testimony, newspaper archives, and grant descriptions about tuberculosis medication adherence and incarceration in the US between 1990-2010. Situating this discussion within a longer history of incarceration as infectious disease control, I draw on frameworks about investment in the carceral state and surveillance of low-income Communities of Color proposed by prison abolitionists and scholars such as Naomi Murakawa, Elizabeth Hinton, and Ruth Wilson Gilmore. This analysis expands the literature about the use of incarceration as a public health disease control strategy by documenting previously-unexplored cases of involuntary commitment of those with tuberculosis to prisons and jails. I argue this practice of incarcerating individuals with tuberculosis contributed to the expansion of the carceral state,

surveillance of low-income Communities of Color, and further entrenched the misuse of incarceration as a public health strategy to control infectious disease and of carceral settings as healthcare facilities.

This exploration will caution healthcare professionals against relying on incarceration, surveillance, and punishment as a public health strategy, a lesson that remains critical during pandemics such as COVID-19.

F1.3 Lynne Gerber, Siri Colom, Independent Scholar, *Weed at the Altar: Religion and the Distribution of Medical Marijuana in 1990s San Francisco*

In August of 1996 California police officers raided San Francisco's Cannabis Buyer's Club. The raid was part of a showdown between supporters and opponents of Prop 215, a state-wide bill that proposed legalizing medical marijuana. Between the raid in August and the election in November, San Francisco officials and AIDS activists sought other ways to get pot to those with urgent medical needs. They found an unlikely partner in a group of churches organized by the Metropolitan Community Church of San Francisco (MCCSF), a gay-identified congregation in the city's Castro district. These churches publicly distributed medical marijuana in their church buildings with their congregations' blessings and their city's forbearance.

This paper will tell the story of this unusual partnership and how it developed in the context of the AIDS epidemic and San Francisco's particular history in supporting treatment options that spanned the spectrum of legality. It will attend to the larger dynamics of AIDS, drugs, and race in the city, dynamics which made it possible for largely white congregations such as MCCSF to risk providing illegal substances while other religious groups, notably African American churches, were vocally opposing needle exchanges which also eased access to illegal substances in the name of easing the burden of AIDS. Within those contexts, the paper will analyze the cultural work which allowed these churches to suspend the moral charge surrounding marijuana use and risk legal prosecution. We will argue that the distinction they made between "healing" and "cure," with the later being the purview of medicine and the former the purview of religion, is a significant piece of that cultural work.

F2. Technology and Health

F2.1 Lauren Ruhrold, University of Minnesota, *Meet the Makers: The Early Origins of the Medical Device Industry*

At the turn of the twentieth century, sixty-five American surgical instrument makers of various stripes gathered in Detroit to discuss the dynamics and future of their trade. The meeting was

precipitated by a growing sense among individual makers that their lack of association subjected them to vulnerability, especially amidst an increasingly powerful medical profession. Many anxieties were discussed, among them being heightening tensions with physicians, the growth of commercial fraud, and worsening working conditions. This first meeting of the American Surgical Trade Association, which finally put tradesmen “on speaking terms with...fellow tradesmen,” helped forge a shared sense of identity among makers in industry terms.

This paper interprets this and related cooperative episodes as a critical installment in the early history of the medical device industry. While instrument makers were not yet attached to the term “device,” they did forge clear networks on which the growth of the industry depended. This paper explores the factors that brought makers together, the fragility of their association, and the foundation laid by their bond. It reinterprets familiar surgical texts and instrument catalogues, as well as draws on neglected trade literature and medical journals. This paper ultimately places the origins of the medical device industry at the feet of craftsmen, examining how they collectively shaped the structure and dynamics of a nascent industry.

Historiographically, this paper is nested in conversation with literature that discusses the history of the medical device industry specifically and scholarship concerned with the history of medical technology more broadly. The former tends to focus on the post-WWII era, centering the actions of regulators in the 1970s or tinkering engineers and physicians in the 1950s. The latter tends to historicize specific devices, devoting less attention to the broader industry within which individual products were entrenched. This paper adopts a longer perspective to draw an older and more inclusive boundary around who and what counts as relevant to the history of the medical device industry.

F2.2 Maia Woolner, AMS Postdoctoral Scholar, *Speed as a Barometer of Mental Health: Chronometry in Late Nineteenth- and Early-Twentieth Century French Medicine*

This paper explores the material history of timekeeping devices and the rise of medicalized mental chronometry in France between the 1880s-1920s. More specifically, it traces the history of d’Arsonval’s chronometer, a small portable time-measurement device invented at the end of the nineteenth century that changed the face of French mental medicine in the twentieth century. This instrument, designed to measure “psychic time”--or the speed of one's reaction to an external stimuli--was imported by its proponents into insane asylums, elementary schools, and the military. Over time d’Arsonval’s chronometer became the instrument of choice for French doctors and researchers who believed that “the speed and regularity of thought” was a signifier of psychological and emotional health.

By tracing the story of this object's history in various contexts from the classroom to the trenches, this paper demonstrates how medicalized mental chronometry became mixed up in the new sciences of "productivity." With repercussions for school children, traumatized combatants, and the new women's workforce, mental chronometry helped entrench our obsession with speed and the pathologization of "slowness," all while clocks and chronometers became the objects of patients' mental delusions.

F2.3 Cinderella Ochu, University of Johannesburg, *"Depo" and Development in Sub-Saharan Africa: Investigating Women and Contraceptive Technologies in Nigeria 1960s-1990s*

The threat of global population explosion after World War II and the need to deal with poverty and overpopulation in the third world became a major concern of the developed nations in the 20thc. Consequently, hormonal contraceptives, such as Depo-Provera, were exported as aid to developing countries. This initiative was received with suspicion by African nations who saw the exportation as a new form of colonialism, and an encroachment on the African culture which values large family. More so, an alien medicine for fertility control, as opposed to the traditional approach utilized by the people, was perceived as a scheme by the West to numerically dispose Africans. This rhetoric was drawn by the Western fear of being "swamped" in the future if black population was not controlled. Research on Depo further justifies this claim. The injectable was originally used in the treatment of other health conditions and women experienced infertility as a side effect. This discovery led to its repurposing as a contraceptive, and on humanitarian grounds, sent to recently decolonized nations in Africa and Asia, with Nigeria becoming one of the major markets due to its high population. Women who used the drug experienced contraindications ranging from mild to severe. Despite the pitfalls, Nigerian women sought the drug in large numbers. The device was used by the acceptors as a 'hybrid' form of birth control; socially designed to sponsor their own agenda-space births, curb neonatal/maternal mortalities, and gain sexual autonomy. Investigating through gender lens, the paper historicizes the antecedent of the technology in Africa, exploring specifically, socio-cultural norms and systems influencing contraceptive behavior in Nigeria. These dynamics were explored within the context of western medicine, acceptance, and resistance. The originality of this work rests on the oral interviews I garnered from women in the field. Women aged 40 years and above were selected as participants of the study. I also relied on post-colonial medical reports reposed in the National Archives Ibadan.

F3. Vaccine Trust and Mistrust

F3.1 Kirsten Moore-Sheeley, Cedars-Sinai, *Chasing the Magic Bullet: The Promises and Consequences of Vaccine Research*

Vaccines have long been held as the end goal for infectious disease control, a magic bullet for pathogenic organisms. Developments in immunology and vaccine research, along with successful disease eradication efforts, in the decades after WWII engendered confidence that scientists could create vaccines for any infectious disease given the time and resources. However, this confidence has not translated into the magic bullets scientists imagined in every case, as effective vaccines for HIV/AIDS, tuberculosis, and other diseases remain elusive. This talk draws on the history of scientific and technological failure to examine the spillover of this yet-to-succeed chase for the magic bullet—an activity that takes place largely in laboratories and controlled trials, but which has tremendous social, economic, and political effects. Using malaria vaccine research as an example, the talk explores how the search for vaccines can have unintended beneficial and negative effects, including drawing attention to neglected health problems in marginalized populations and breeding mistrust among research subjects. Historicizing the search for a malaria vaccine, it also shows how initial motivations for vaccine research—in this case, protecting American soldiers overseas—can transmute into new motivations with different moral valence, such as the humanitarian effort to save African children. In doing so, this talk argues that histories of unfulfilled promises in medical research should not simply be seen as histories of failure; rather, they should be examined as equally generative as histories of so-called medical success.

F3.2 Andrea Rusnock, University of Rhode Island, *Origin Stories of Inoculation and Vaccination*

April 2022 will mark the 300th anniversary of the smallpox inoculations of two English princesses, Amelia (age 11) and Caroline (age 9), carried out with King George I's approval and under the supervision of two royal physicians. Most eighteenth-century writers, including Voltaire, praised the royal inoculations and recognized the power of royal and aristocratic patrons, such as Lady Mary Wortley Montagu, in promoting the benefits of inoculation and in launching its public acceptance. These early histories focused on elite endorsement -- those who took the jabs effectively authorized its use. In the nineteenth century, historians found a new hero in Edward Jenner and in hagiographic accounts the triumph of vaccination revealed the power of physicians -- those who gave the jabs in place of those who took it. In the twentieth century, with the development of vaccinology, historians rediscovered inoculation and the role of medical scientists -- those who developed and tested the vaccines, not the patients or physicians, authorized their use. More recently, however, histories of inoculation and vaccination have downplayed the significance of the royal patrons, royal physicians, and more generally the role of medical and scientific elite. Social studies of science, feminist and decolonial studies have redirected our attention toward the deeper

and more widespread roots of inoculation by uncovering the vernacular knowledge and contributions of lay practitioners – both women and men – excluded, for various reasons, from the European social-scientific-medical elite. Today, as we witness both the unprecedented rapid development of several COVID-19 vaccines in laboratories around the world and, simultaneously a significant public resistance to vaccination, we seem, once again, to be returning to a familiar narrative emphasizing the significant role political leaders, doctors, scientists, and social media influencers can and do play in authorizing vaccines. This talk will explore the origin stories of inoculation and vaccination and focus on how contemporary cultural, social, and scientific concerns have shaped these histories and suggest that the current COVID-19 pandemic challenges us once again to rethink how we understand this critical medical practice.

F4. Disease, Healing, and Rural Consciousness

F4.1 Benjamin Folger, University of Oklahoma, *The Heartland in Trouble: A study of race, medicine, and social movements in early 20th century Oklahoma*

As reported by President Virgil Berry in 1906 at the joint meeting of the Oklahoma Territory Medical Association and the Indian Territory Medical Association, Indian Territory was home to twice as many doctors as England, quadruple the amount in France, and six times the amount of Italy, where medical education was fostered by the state. Physicians in Oklahoma knew the lack of regulation over who could practice medicine was already a problem, and with statehood looming, doctors at this meeting took the three days in May to envision what their field would look like once the two associations joined, and Oklahoma became the 46th state to enter the Union. Just eight years later, Oklahoma would become one of the three largest hotspots of socialism in the United States. Disgruntled farmers read Appeal to Reason in waves and the votes reflected that. The state's relatively successful socialist movement was also the result of organization and appeal to their Christian values.

This paper seeks to bridge the gap between politics and medicine in early 20th century Oklahoma. While much of the nature of agrarian socialism has been explored, my paper notes the similarities in the organization of frustrated farmers and aggravated physicians fatigued by territorial disorder and inequality. The same doctors that were fighting for certification to practice medicine were treating a large population of Native Americans and African Americans. Some physicians embraced working alongside Native medicine while others discredited their methods and lack of education surrounding Western medicine. Much like other Southern states, stereotypical perceptions of African Americans' reliance on superstition and lack of trust in hospitals affected their treatment. Some physicians carried their philanthropic attitude in times of racial violence as well, making this newly admitted state a complex mix of racial tension, benevolence, and progress. Utilizing oral

histories from pioneer doctors and public health reports, this paper demonstrates the ways physicians viewed Native medicine. Both forms of organization in Oklahoma reflect a larger theme of the Progressive Era that ideologies of discontent drove activism and change.

F4.2 Rima Apple, University of Wisconsin-Madison, *The problem of maternal ignorance: Rural public health efforts during the Great Depression*

High rates of maternal and infant mortality and morbidity in the early 20th century; many men found to be unfit for military service during World War I: for health reformers, politicians, and medical practitioners the most oft-cited reason for these disastrous statistics was “maternal ignorance.” If mothers would only utilize the knowledge and benefits of modern medicine, they claimed, then such horrible situations would be avoided. Convinced that education would solve the problems, private agencies and local, state, and later federal governments designed initiatives to instruct mothers, including visiting nurse programs.

This paper evaluates the strength of this hypothesis through an examination of the experiences of federally-funded nurses in the Wisconsin county of Marathon. The narrative reports of the nurses, archived at the Wisconsin State Historical Society, detail the efforts of mothers coping with the realities of rural life and its social, cultural, and financial pressures during the Great Depression. As the nurses brought contemporary medicine into Marathon’s communities and homes, they discovered that ignorance was only one of many obstacles to mothers obtaining medical care, and certainly not the most significant one. Many women welcomed and appreciated the nurses as representatives of modern medicine, but were unwilling and, more likely unable, to benefit because of a myriad of other factors, such as family relationships, ethnic practices, material concerns and, most crucially, financial pressures.

An analysis of the narrative reports of the Marathon nurses discloses important factors that were generally ignored in developing public health programs to reach an under-served population in the first part of the 20th century. As such it could alert today’s rural public health efforts of potential obstacles.

F4.3 Stephen Hussman, University of Arizona, *The Beneficent Godfather: Dr. Augusto Ortiz and the Creation of Arizona's Mobile Rural Health Medicine Program*

Dr. Augusto Ortiz lived and worked in Arizona most of his professional life from 1953 until his death in 2006. Throughout his career as a family practitioner and educator he worked to bring health care to the poor and underserved. In his earlier years he worked in private practice in the Phoenix area primarily serving a needy Hispanic population. In 1972 Dr. Ortiz moved to Tucson and established a mobile health program based out of the University of Arizona’s Rural Health Office which provided

health care to many rural and underserved areas in southeastern Arizona. Areas of particular interest to him included community oriented primary care, migrant laborer health care, health education and folk medicine including herbal folk remedies and curanderismo. Shortly before he passed away in 2006, he was awarded a medal by the Surgeon General of the United States for his dedication to providing rural health to the needy and poor of Arizona.

My paper will discuss his (50 year) career and dedication to creating equity and equality in providing health care to the Hispanic community in and around the U.S./Mexico Border. Dr. Ortiz also lobbied in Congress on behalf of rural workers in order eliminate the use of pesticides and other agricultural labor practices that caused harm to many of his rural patients. His creation of the mobile rural health care program became a model for many other states, and has evolved into a nationally recognized program.

F5. Reforming Psychiatric Institutions

F5.1 Bradford Pelletier, Columbia University of New York, Modjeska Simkins, the South Carolina Department of Mental Health, and Reluctant Desegregation (1963-1966)

“Unless you put a stop to it NOW,” Modjeska Simkins fumed in a letter to the Secretary of Health Education and Welfare (HEW) in 1965, “[conditions at the South Carolina Department of Mental Health (SCDMH) will] always be SEPARATE but NEVER equal.” Simkins appeal illustrates the indignation of activists across the South during the struggle for medical civil rights, as they exposed the deplorable conditions in which African American patients languished while coping with the intersecting adversities of pernicious institutional racism, poverty, and mental illness. “The ominous howl that [SCDMH administrators] sent up avowing deep concern for Negro patients,” Simkins further warned the HEW in 1965, “is belied by their endemic neglect.” These two excerpts represent a small sample of the dramatic interactions in which Simkins, a Black woman, assaulted the racial and psychiatric status-quo using the tactics of the male-dominated world of the black freedom movement to forever alter the white-supremacist-male-dominated world of psychiatric care.

While Simkins solidified a central legacy within the Long Civil Rights Movement through *Briggs v. Elliott* and *Brown v. Board of Education*, this paper illuminates another aspect of her activism – a dedication to medical equality. Inspired by years working for the South Carolina Tuberculosis Association, Simkins’ career in medical activism culminated in the fight for equality at the SCDMH. Using Simkins’ extant papers preserved by the University of South Carolina and archival sources from the SCDMH (including administrative rhetoric and patient records), this study illuminates the process by which southern psychiatry was desegregated between 1963-1966. For decades,

psychiatric administrators in the South leveraged science in the service of racist colonial regimes that exploited Black patients. This study will show how a non-medical actor instigated changes to American medicine.

Connecting to scholarship concerning colonial psychiatry and global histories of medical decolonization, the story of the desegregation of the SCDMH adds to the burgeoning study of medical civil rights and complicates Derrick Bell's concept of "interest-convergence." Since portions of the formerly all-Black section of the SCDMH were converted into prison facilities after 1966, this study also contributes to Carceral Studies and Foucauldian debates concerning confinement and control.

F5.2 Jennifer Thomas, Virginia Polytechnic Institute and State University, The Conolly and Kirkbride Treatises: A Nineteenth-Century Asylum Design Comparison

During the 1840s and 1850s, construction of British and American insane asylum buildings and landscapes was steadily increasing. Two key physicians—John Conolly (1794-1866) of the Middlesex County Asylum at Hanwell in England and Thomas Story Kirkbride (1809-1883) of the Pennsylvania Hospital for the Insane in the United States—treated patients, served as institution administrators, and wrote strikingly similar mid-nineteenth century treatises about suggested asylum design and management best practices. The *Construction and Government of Lunatic Asylums and Hospitals for the Insane* by Conolly was published in 1847, followed by Kirkbride's *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* in 1854. Each author advocated for "linear" asylum building designs and structured verdant landscapes for patient treatment and each became an influential figure of nineteenth-century psychiatry in their respective countries. Kirkbridian ideals became synonymous with nineteenth-century American asylum design yet the similarities with Conolly's slightly earlier published principles remain unacknowledged in the historiography of psychiatry and design thus several key questions remain. Was Kirkbride influenced and inspired by Conolly's earlier treatise? How might that alter the interpretation of the importance of Kirkbride's influence in the U.S.? How did their design guidelines define interior and exterior patient spaces, enforce social norms, and reflect conventional and controversial power structures? Comparing key similarities and differences from the two treatises while highlighting specific institutional examples, this paper argues that it was likely that Kirkbride's writing was significantly influenced by Conolly's work and that both ideologies ultimately served to promote a gendered and racialized social control of select people across a wide range of territories within the American and British Empires of the era.

F5.3 Shir Bach, Chapel Hill and Reed College, University of North Carolina, *Inside, Outside, Morningside: Alaska's Insane in Portland, Oregon*

From 1904-1960, every Alaskan deemed insane by a jury of six men was sent to Morningside Hospital, a privately-owned and federally-funded psychiatric institution in Portland, Oregon. A common joke in the twentieth century Alaskan territory was that Alaska had three sides: inside, outside, and Morningside. This paper takes that joke seriously, focusing on the interplay of these three locations at moments of tension in Morningside's history. I use abbreviated patient records, congressional hearings, popular press coverage, and other archival sources to explore how doctors, hospital administrators, patients and their families, federal bureaucrats, and elected officials all worked to (de)legitimize the institution. Particular attention is given to events leading up to and following the passage of the Alaska Mental Health Act (AMHA) in 1956, which made Morningside obsolete through the funding of a psychiatric institution within the borders of Alaska. I argue that the downfall of Morningside was made possible through the successful integration of critiques emanating from both inside and outside of Alaska. Specifically, opponents of Morningside combined Alaskan critiques of the contract system on the basis of self-determination with longstanding critiques by patients and federal bureaucrats of the type of care provided at Morningside, especially the use of insulin coma therapy. In light of the unique opportunities presented by the extent and form of Morningside's archival record, this thesis synthesizes political, social, and medical history in service of a more robust history of Morningside and its patients.

G1. Children as Historical Subjects

G1.1 Elisabeth Yang, Rutgers University, *Home Nurseries: Medico-Moral Domains of American Infants in Late Nineteenth and Early Twentieth-Century Medical Advice Literature*

Directions for constructing and setting up home nurseries were a common feature of child-rearing and domestic medicine manuals, during the mid-to-late 19th and early 20th centuries. Physicians and other child-rearing authorities offered detailed directions on location, design, decoration, materials, and management of nurseries. The notion that the house had both a physiological and psychological impact on the child urged mothers to design the nursery in appropriate ways under the aegis of medical experts. For the medical community and middle-class mothers and mothers-to-be in Victorian and early Progressive America, domestic architecture had a prescriptive power; the configurations of the home nursery would lead to the configurations of the infant, and in turn, the "civilized" race, and nation.

This paper addresses how the home nursery itself was medicalized and transformed into a sanctified space of science, technology, religion, and politics, as physicians and child-rearing authorities proscribed objects as implements of "moralizing" and "normalizing" the infant. I explore

what the material world of babies—the nursery and its objects—reveals to us about their moral nature and agency, suggesting an intimate link between the physical topology of babyhood and the moral ontology of babies. Drawing from archival research and the material culture of babies, I consider that the ways in which infants’ engagement with the material world—the nursery, its furniture, and other objects or things of infancy—presumably, awakened or actualized their innate moral and spiritual capacities. I discuss how medical advice on home nurseries and infants’ objects connected the material with the immaterial, the clean with godliness, the beautiful with beauty, the simple with simplicity, and the dark with vice—signifiers of one’s race and class. The exigency to train the infant to be “moral” under the auspices of the superintending physician and scientific experts stemmed from this endemic fear of the regress and dissolution of the “superior” white race and in turn, “civilization.” Demonstrating how child health and medicine treaded beyond its ambit to the realm of metaphysics and theology, I point to the theoretical entanglements between the material and moral in the making of the idealized American healthy and happy infant in the home nursery which emerged as an ideological concourse of various infancies—mechanistic, plant-like, savage, tyrannical, impressionable, innocent, individualistic, and patriotic.

G1.2 Ijeoma Kola, University of Notre Dame, *Asthma's Poster Children: Black Children at Residential Asthma Treatment Centers, 1960-1975*

In the mid-twentieth century, the rise of psychosomatic approaches to asthma care led to the creation of residential asthma treatment centers for children. By 1975, nearly 15 of these institutions existed in different American cities, all organized around the belief that severely asthmatic children needed to be removed from the physical and emotional environment of their home in order to breathe more easily. Prominent American allergist Dr. M. Murray Peshkin not only helped establish numerous childhood asthma treatment centers, including the Children’s Asthma Research Institute and Hospital (CARIH) in Denver, Colorado but was also key in popularizing the idea of parentectomy. Despite the acceptance of parentectomy by many asthma specialists in the 1940s and 1950s, Black doctors did not advocate for parentectomy as an asthma treatment plan until the mid-1960s, after which Black enrollment at institutions like CARIH substantially increased. In this paper, I argue that the increased representation of Black children at residential asthma treatment centers was both a function of the growing asthma crisis in Black urban neighborhoods as well as an unintentional consequence of efforts to recruit more Jewish children, whom the centers were initially created to serve. I also posit that publicly funded residential asthma treatment centers capitalized on the few Black asthmatic children in their care to appeal to Black celebrities and businessmen to support their fundraising efforts. Despite receiving equal medical care and treatment as other children, Black children at CARIH and other asthma treatment centers became

poster children for parentectomy and institutionalized asthma care, which had lasting effects on public perception of Black individual and parental responsibility for asthma. Building on the historiography of Jewish philanthropic investment in Black community health institutions, this paper brings to the fore the lived experience of Black children at residential asthma treatment centers during the civil rights movement.

G1.3 Lisa Pruitt, Middle Tennessee State University, *Who in the World was Katie Beckett? Ventilator-Dependent Children and the Battle for Home-Based Care in the 1980s*

This paper explores the role of Katie Beckett in advancing the right of children with complex healthcare needs and disabilities to live with their families and integrate into their communities rather than living out their lives segregated and isolated in hospitals or nursing homes. Katie Beckett, born prematurely in 1978, contracted viral encephalitis as an infant. The disease left her medically fragile and ventilator dependent while she slept. It left her parents in an agonizing position – as long as Katie remained in the hospital, Medicaid would ignore their income and cover Katie’s expenses. If she went home to live with her parents, their income would cause her to lose Medicaid eligibility, even though it would cost the federal program considerably less to support her care at home than in a hospital or nursing home. Although they were both professionals, the Becketts could not afford the nursing care that would allow their daughter to live with them and they had already hit the lifetime cap on their personal health insurance. Katie’s mother doggedly pursued the issue and just before Christmas in 1981, the Reagan administration lobbied for a change in Medicaid policy that would allow Katie’s parents to care for her at home, after having spent the first three years of her life in a hospital. That Medicaid policy—spelled out in Part III, Subtitle B, Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (PL 97-248)—is still commonly referred to as the Katie Beckett Waiver. Using documentation from the papers of C. Everett Koop, Ronald Reagan, and George H. W. Bush, along with media coverage and personal accounts from Katie Beckett and her mother Julie Beckett, I demonstrate the power of a personal story to shape law and public policy for decades to come.

G2. Constructing Race and Human Reproduction in Medicine (1700–1850)

G2.1 Marcia Nichols, University of Minnesota Rochester, *Anatomical illustrations, obstetrical education, and the construction of the “ideal Woman”*

In eighteenth- and nineteenth-century midwifery atlases, man-midwives sought to justify their intrusion in the female profession of midwifery on the basis of their clinical utility in assisting in difficult births. By the nineteenth century, the man-midwife was on more sure footing in most European and American jurisdictions. These illustrated textbooks and lavish folios advertised male

mastery over the secrets of reproduction, the female body itself, and, increasingly a practitioner's particular brand of obstetrical training and delivery services to would-be students and clients in the competitive marketplaces of Europe and the United States. While eighteenth-century images tended to depict disembodied female parts-- the gravid uterus and the bony pelvis, in the nineteenth-century, many works began to also include images of fully-embodied pregnant women. In turn, many of these images included intricate flaps that allowed readers to virtually "dissect" the female body from the comfort of their homes. As showcases of obstetrical knowledge, flap anatomies were objects of curiosity whose novel graphic art appealed to wider audiences. Lifting flaps that unveiled the female reproductive body for medical purposes could just as easily be interpreted as a pornographic act imbued with elements of sexual titillation and voyeurism.

Both flat-faced and flap anatomies were produced and consumed in trans-Atlantic cultures anxious about female sexuality and "proper" feminine gender roles. This paper will examine both flat-faced and flap anatomical images to explore how images were used in obstetrical education that was still fraught with moral anxiety around male intrusions into a once-female vocation. By training the would-be obstetrician to view the female body as a medical, rather than a sexual, one, these images aided aspiring obstetricians in achieving a fully professional and gentlemanly engagement with the birthing female body by the end of their training. Moreover, these images—especially the fully-embodied women in flap anatomies—thoroughly constructed the ideal midwifery patient, and therefore the ideal woman, as white, bourgeois, and domesticated, an ideal that is only just now being challenged. Thus, it is crucial to examine midwifery illustrations to understand the development of obstetrics as a medical profession that still has implications for its practice today.

G2.2 Margaret Carlyle, University of British Columbia, *Population Crisis and the Birth of Phantoms in the Eighteenth-Century French Atlantic World*

In the eighteenth century, there was a widely held perception that France was facing a population crisis. Royal and civilian officials believed that its population was dwindling, especially when compared to powerful neighbors like Great Britain and the German lands. Although demographers have since ascertained that the French population was not, in fact, in free fall—rather, it was simply not increasing at the same rate as its neighbors—the fact remains that the French state perceived that it was facing such a crisis. In response to such fears, a multifaceted national discourse emerged around how to regenerate the nation's numbers. It was in the domain of human reproduction writ large that pro-natalist campaigners took up the cause of repopulating France. While many of the era's intellectuals focused on clerical celibacy and rigid Church morality around pre-marital sex as leading factors in France's anti-procreative tendencies, state and medical officials focused their

attention on the role of childbirth practices in both mainland France and its resource-rich Caribbean colonies.

Reproductive practices throughout the French Atlantic world were thus viewed by the French state as a key terrain for solving the population problem. In response, the French state undertook measures to streamline childbirth practices in the name of maternal and infant survival and health. In this paper, I argue that medical innovation in the domain of childbirth attests to state scrutiny of both national and colonial reproduction practices. I focus on one particular invention of the mid-eighteenth century known as the obstetrical “phantom,” a 3D model built by midwives and man-midwives (using such materials as textiles, wood, and wax) that functioned as a teaching tool in various medical contexts in the French Atlantic. I suggest that the obstetrical “phantom” served as an ideological tool aimed at population renewal that would streamline birthing practices and stamp out maternal and infant mortality. Indeed, the design, construction, and deployment of such “phantoms” ultimately signaled the French state’s commitment to rationalizing and controlling childbirth—a practice long deemed irrational and mysterious—with the direct aim of renewing France’s population.

G2.3 Mary Hague-Yearl, McGill University, *Humoral Medicine and the Invention of Racial Ideology*

In his 1812 elephant folio production, *Anatomie du gladiateur combattant*, Jean-Galbert Salvage included a curious two-page chapter on the characteristics of the human races. Present within his commentary was a strong, if implicit, link between humoral theory and racial temperament. This observation will be the starting point for a retrospective examination of how humoral theory was called upon in comparative discussions of race.

Salvage’s work makes for a compelling example because he was writing at a time when the presence of humoral theory was diminishing within the European academic medical framework after having been central for the preceding two millennia. Moreover, Salvage used humoral language selectively. In his discussion of the “white race or species,” he highlighted the French as sanguine, English as choleric, and Germans as phlegmatic. However, he limited his use of humoral terminology when discussing those from North Africa, the Middle East, and South Asia. He opened his discussion of the “black race or species” with racist physical stereotypes of African bodies, wherein he made no references to humoral language; that he reserved, in limited terms, for remarks about the Chinese, Japanese, and Koreans and, separately, Indigenous North Americans. A dissection of Salvage’s text provides a starting point for a discussion about medical writings on race and the humours in the context of European colonialism.

In other examples I will consider, such as William Falconer's *Remarks on the influence of climate...on...mankind* (1781), humoral theory also plays a central role. The crucial additions offered by Falconer are details relating to colonialism. For instance, Falconer writes that inhabitants of a hot climate should be "indolent and slothful" but also "cruel and vengeful," yet he argues that local dietary habits can mitigate the impact of the heat, such as a vegetarian diet rendering a population "mild, tender, and forgiving."

I argue that humoral explanations in the texts I examine should be seen as part of a racist medical framework that supported a colonialist agenda. I will also demonstrate that the language of humoral theory continued to support racist conclusions even after humoral medicine itself had largely left the academy.

G3. Mediating Medicine: Genre, Society, and Medical Subjects

G3.1 Manuel Merkofer, Universität Zürich, *Looking for the neurosurgical patient: Walter Matthias Diggelmann's "Shadows, diary of an illness"*

This presentation describes the view of the neurosurgical patient at the end of the 1970s through the records of the leftist Swiss writer Walter Matthias Diggelmann (1927-1979), as well as related testimonials and interviews. Diggelmann underwent surgery of brain metastases, spending several months at the University Hospital of Zurich; he kept a diary using a dictaphone, later published under the title: "Shadows, diary of an illness". Moreover, he wrote two short stories, also describing his outpatient experiences before succumbing to the disease.

Since Roy Porter's resounding call for a sufferer's view, multiple patients' narratives have unearthed a medical history from below. Unfortunately, however, the history of neurosurgery still lacks this perspective. Echoing Porter's call, this presentation makes three arguments. First, the case of Diggelmann reveals the potentials and limits of the neurosurgical patient's agency in the late 1970s. Existing neurosurgical historiography has largely been based on doctors' own accounts, which envisioned a passive patient relying on surgical art, high technology medicine, or fate. In contrast, Diggelmann sought to engage in the process actively, developing his own way of dealing with a potentially fatal disease through writing, challenging doctors' autonomous decision-making, critically assessing a "complete reliance" of patients on their doctors, giving suggestions on how to improve doctors' communication with patients, and eventually insisting on outpatient care *avant la lettre*.

Second, the presentation argues that a strive for technological innovation and advanced specialization in neurosurgery throughout the 1970s sustained a troubled doctor-patient relationship. Neurosurgery's technicality diverted clinicians from dealing with patients' emotions and actual needs. Instead, they focused on medico-technical problems. In its contemporary form, neurosurgery also proved inaccessible for patients' trying to make sense of their disease or medical outcomes.

Finally, in "Shadows, diary of an illness", Diggelmann did not shy away from disclosing most existential fears, namely the fear of alienation from oneself or others, therefore providing a vivid case to study the social and emotional challenges neurosurgical patients face. The case also shows how patients' views on rehabilitation and the nature of brain disease were informed by contemporary medical theory, such as the disbelief in cerebral plasticity.

G3.2 Arsenio Ferraces-Rodríguez, Universidad de A Coruña, *Surgery, pain and compassion in ancient medicine according to medical recipe books of the 5th-11th centuries*

The collections of medical recipes written in Latin between the 5th and 11th centuries constitute a valuable document for the study of ancient practical medicine, not only because they describe a great variety of simple remedies and magistral formulas for the cure of diseases, but also because they offer information on social aspects, such as the medical profession, the doctor-patient relationship or the emotions derived from the medical act itself. Some prescriptions mention in their title their efficacy to cure a disease sine ferro, that is, without surgery. This detail, apparently unnecessary, implicitly opposes non-invasive pharmaceutical medicine to the invasive surgical technique, of great cruelty to the patient. Two explicit descriptions of a surgical operation, one concerning the removal of hemorrhoids and the other the removal of a cataract, demonstrate that in antiquity there was a clear awareness of the extreme suffering of the patient undergoing such surgeries as well as the risk of the operation. On the other hand, pharmaceutical recipes for the cure of the same ailments do not mention the suffering or the harshness of the treatment. When surgery was unavoidable, pain inhibitors were used. These included opium, mandrake or henbane, and especially somniferous sponges to anesthetize the patient. The only example of a somniferous sponge cited so far is the hypnoticum adiutorium, first published by Karl Sudhoff and erroneously attributed to the Salernitan Medical School. However, medieval manuscripts describe other sponges, dating from the 5th to the 11th century. All of them mention the purpose of avoiding the patient's pain while undergoing surgery. This should be related to the notion of compassion or mercy towards the patient, which has been recognized as a distinctive feature of Roman medicine.

G4. Occupational Medicine and Patient Debt

G4.1 Andrew Hogan, Creighton University, *Recruiting Black Practitioners in Allied Health: Achievements, Barriers, and Lessons in the 1990s*

In recent years, enhanced societal awareness of racial discrimination and oppression has led many clinical disciplines to foreground diversity, equity, and inclusion (DEI). Today's DEI initiatives have precursors dating back to the 1960s. Though characterized by differing terms, these efforts shared a common goal of increasing the representation of Black and other minority practitioners in clinical professions. Historians of medicine, including Kenneth Ludmerer and Naomi Rogers, have primarily focused on a brief period around 1968 when (mostly white male middle-class) medical student activists pushed for medical schools to admit more Black students. Subsequent efforts in the 1990s to reinvigorate minority recruitment have been largely overlooked. Attention to this later iteration offers unique stories, strategies, and lessons in considering how to make the most of the post-2015 wave of DEI initiatives.

My talk focuses on minority recruitment efforts during the 1990s in the female dominated (though not always women-led) allied health fields of occupational therapy (OT) and physical therapy (PT). Shaped in part by anti-affirmative action backlash in the 1970s, this era had new language and orientations, with a greater focus on diversity and multicultural awareness. During this period, more (but still representatively few) Black practitioners were active in OT and PT. They were often prominent instigators and leaders of minority recruitment programs. Importantly, Black women OTs and PTs played prominent roles in 1990s era recruitment efforts, often leading Offices of Minority Affairs within clinical professional organizations.

Minority recruitment efforts in OT and PT declined in the late 1990s. My research draws on archival documents, professional newsletters, published sources, and oral history interviews to examine various factors that influenced the rise, success, and limitations of these efforts. I argue that manpower considerations played a significant role in allied health professional organizations' investment in minority recruitment efforts. When demand for practitioners was high, organizations sought to recruit among underrepresented populations, including minority groups. As the job market grew tighter, interest declined. As I show, along with manpower concerns, changing economic conditions, health care system reconfiguration, and new expectations about evidence-based practice were all contributors to clinical professions' evolving commitment to minority recruitment.

G4.2 Lukas Engelmann, University of Edinburgh, *An "Epidemiology of Science." Epidemiological reasoning and the emergence of the information sciences*

In the history of epidemiology, the post-war period is commonly perceived as one structured by the wholesale transformation of the field's focus. As the burden of infectious disease retreated over the first half of the twentieth century, concerns about chronic conditions could now take centre stage. Many epidemiologists who had worked on the dynamics of pathogens, hosts and their environment, adapted their tools and theories to understand causes, spread and potential containment of non-communicable diseases. This transition supported the formation of social epidemiology in Anglo-American countries and moved social determinants of health into the focus of public health and policy.

Within the same period, epidemiological reasoning did not only extend to heart diseases and psychiatric conditions, but also assumed a new role in theorizing the distribution of knowledge. In this paper I argue that the expansion of epidemiology's tools, data practices and theories to non-communicable conditions opened an epistemic space to theorise the spread of information as epidemiological phenomena. Mathematical models built to simulate the spread of pathogens were used to theorize the "transmission of ideas" (Goffman & Newill 1964) and the information science pioneer Eugene Garfield wondered about an "epidemiology of science," (1955) while constructing the impact factor for the budding field of scientometrics.

With this paper I seek to demonstrate the influence and significant impact of epidemiological reasoning in the emerging information science. This will move historiography beyond often shallow accounts of the metaphorical and ubiquitous usage of "social contagion" across disciplines. Instead, I will show that this is a history of systematically adopting and expanding the epistemology of epidemiological reasoning to rethink and to theorize the foundations and infrastructures of scientific knowledge production.

G5. Public Health, Genomics, and Biological Warfare

G5.1 Yemok Jeon, Woodrow Wilson International Center for Scholars, *War during the War: Public Health Campaigns Driven by "Biological Warfare" in North Korea during the Korean War*

The early situation of the Korean War was dramatic. Although the UN forces occupied only 10% of the Korean Peninsular in September 1950, they seized most of Korea in October, losing the northern part of it not long after. From the middle of 1951, however, there was a lull in the fighting and the armistice negotiation. At this time when both a pen and a sword turned out to be a vain bid, the allegation of "novel weapons," or biological weapons, appeared on the battlefield. The communist bloc raised charges of "biological warfare" against the US. Many researchers have examined

whether the US military used biological weapons, but reached no clear conclusion. The previous studies on the allegations of "biological warfare" during the Korean War have developed into two branches. One is a study revolving around the authenticity of the allegations. The other is a study investigating strategic use of the allegation by the communist bloc, including China and the Soviet Union, partly due to limited access to communist documents, and for the same reason, this paper also follows the latter. Moreover, even though the alleged "biological warfare" occurred mainly in North Korea and the North Korean government waged various public health campaigns combined with the allegations, scholars have paid little attention to North Korea. Thus, this study attempts to find out how North Korea employed "biological warfare" to overcome the challenges such as dealing with infectious diseases and the low morale of North Koreans. By analyzing the memoirs of soldiers and captives, documents, and newspapers in North Korea in the 1950s, this paper reveals three characteristics of public health campaigns driven by the allegations. First, previous mass movements coalesced into the large-scale public health campaigns under the banner of fighting against "biological warfare" although some movements did not fit into the public health campaign; second, the immorality of "biological warfare" promoted the involvement of soldiers and civilians in the public health campaign by inciting hatred among them; third, complicated scientific knowledge on which campaign was based assisted North Koreans to accept the allegation unquestioningly.

G5.2 Jim Harris, The Ohio State University, *House Flies and Health Visits: The Campaign to Curb Infant Mortality in Manchester, 1890-1914*

As nearly 78 percent of the population of England and Wales lived in cities or towns by 1901, it had become abundantly clear to public health officials that the ecological conditions of English cities had detrimental effects on the public's health. Over the previous half century, the rise of a sanitary state and enactment of a series of Public Health Acts empowered local public health administrators, the Medical Officers of Health (MOsH) to take action to improve the health of cities through broad sanitary campaigns. The results of these efforts reduced mortality rates at large, but infant mortality rates remained alarmingly high (19.84% in the case of Manchester in 1901).

Annual reports by Manchester's MOH, James Niven, and his fellow MOsH show that they understood that the third leading cause of infant mortality (summer diarrhea) could be significantly reduced through public health mitigations. Through a qualitative and quantitative study of these reports, this paper will examine how Niven understood the etiology of diarrhea (as a function of climatic conditions favorable for the breeding of flies) and how he believed mitigations must include not only the cleansing of urban environs favorable for the flies, but also educational campaigns, especially for nursing mothers, about how to keep the infants' foodstuff safer from contamination. This educational work, conducted by female Health Visitors in the employment of the Medical

Officer of Health, quite literally brought public health efforts directly into the British home, thereby expanding the purview of public health well-beyond the 19th century sanitary regime.

Marjaana Niemi has argued public health policy often manifests in one of two forms: sanitary (combatting environmental hazards) or social (changing the social and economic systems that resulted in this stratification of public health). Ultimately, the campaign to curb infant mortality in Manchester required both sanitary and social interventions by non-family members to reduce infant mortality rates. While bridging the environmental history, the history of public health, and urban history, this paper will examine how this case study is exemplary of a widening scope of public health efforts in Britain at the turn of the twentieth century.