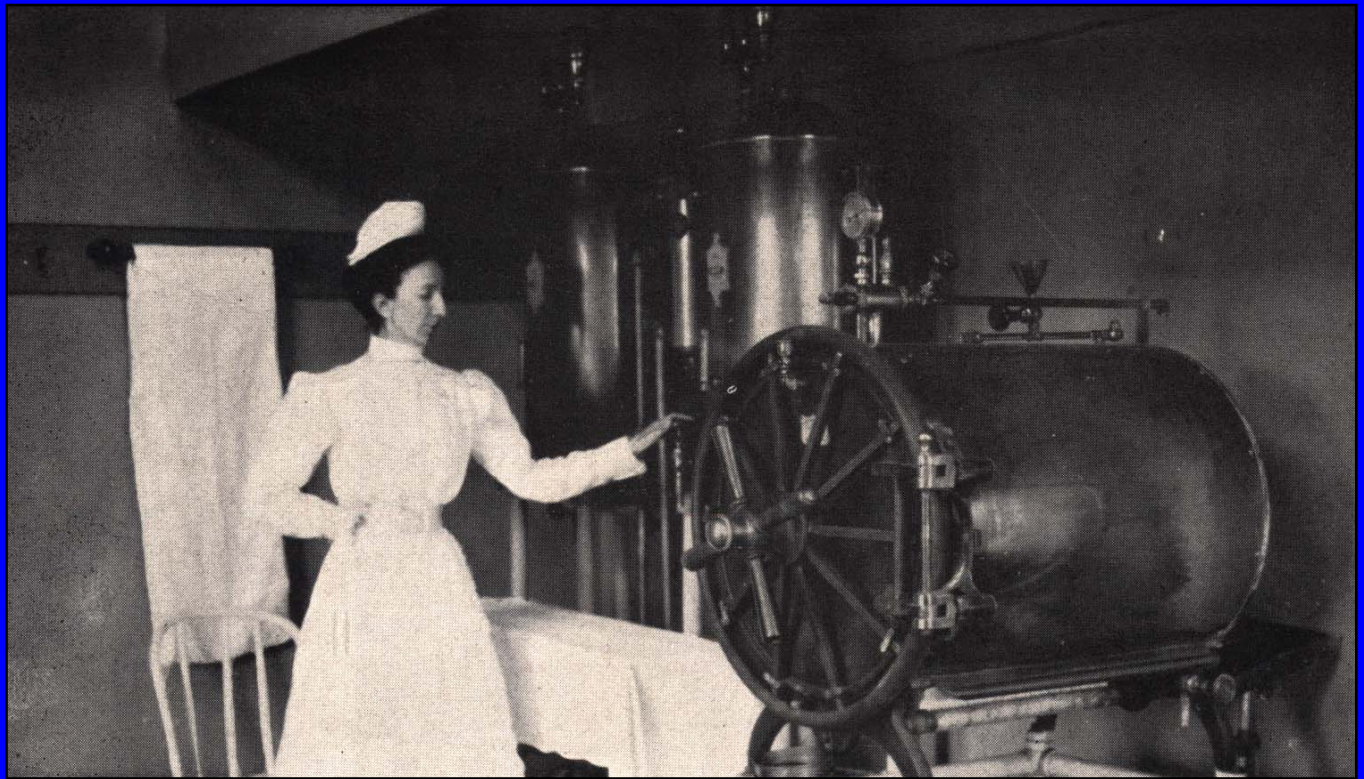


AMERICAN ASSOCIATION FOR THE HISTORY OF MEDICINE



AAHM 2013
ANNUAL MEETING

MAY 16-19, 2013
ATLANTA, GA



Meeting Overview

	Time	Activity	Location
W	4:00pm-6:00pm	ALHHS Board Meeting	Emory School of Public Health Claudia Nance Rollins (CNR), Room 1034.
THURSDAY, MAY 16	12:00pm-9:00pm	Registration	Emory Conference Center (ECC), Hearth
	8:00am-3:00pm	ALHHS Annual Meeting	CNR, Room 3001
	8:00am-3:00pm	MeMA Annual Meeting	CNR, Room 6001
	12:30pm	CDC Guided Museum Tour* & †	Conference Center Lobby
	1:00pm-6:00pm	AAHM Council Meeting (lunch provided)	Hickory Meeting Room
	2:00pm-6:00pm	Sigerist Circle Meeting	Oak Amphitheatre
	3:00pm	CDC Guided Museum Tour* & †	Conference Center Lobby
	5:30pm-7:00pm	Global Health Film Soirée	Silverbell Pavilion
	7:00pm-9:00pm	Opening Reception	Garden Overlook/Courtyard Rain Venue: Lullwater Ball Room
FRIDAY, MAY 17	7:00am-8:00am	Continental Breakfast Available	Conference Breakout Area
	7:00am-5:00pm	Registration	Lullwater Foyer
	7:00am-8:00am	New Member Breakfast	Hickory
	7:00am-8:00am	Oxford University Press Breakfast (private)	Basswood
	7:00am-8:00am	Bulletin of History of Medicine Breakfast (private)	ECCH Drawing Room
	7:00am-10:00am	Book Exhibit Set-up (closed to the public)	Azalea & Mountain Laurel Rooms
	8:15am-8:30am	Welcome	Lullwater Ballroom
	8:30-10:00am	Keynote Session	Lullwater Ballroom
	10:00am-5:00pm	Book Exhibit	Azalea & Mountain Laurel Rooms
	10:00-10:15am	Break	Conference Breakout Area
	10:15-11:45am	Concurrent Sessions A1-A5	Basswood, Dogwood, Oak Amphitheatre, Emory Amphitheatre, Hickory
	12:00-1:00pm	Lunch Sessions L1-L3	Starvine I, Starvine II, Silverbell Pavilion
	12:00-1:00pm	Graduate Student Luncheon	School of Public Health, Rita Anne Rollins Room, 8 th Floor
	12:00-1:00pm	Lunch on your own	Conference Center Dining Room, Area Restaurants
	1:15pm-2:45pm	Concurrent Sessions B1-B5	Basswood, Dogwood, Oak Amphitheatre, Emory Amphitheatre, Hickory
	2:45pm-3:00pm	Break	Conference Breakout Area
	3:00pm-4:30pm	Concurrent Sessions C1-C5	Basswood, Dogwood, Oak Amphitheatre, Emory Amphitheatre, Hickory
	4:45pm-6:00pm	Shuttles to Emory Campus or Walking Tour	Conference Center Lobby, Concierge Desk
	5:00pm-6:30pm	Exhibit and Reception: Medical Treasures at Emory, A Display of Rare Medical Books and Artifacts	Health Sciences Center Library, Emory University
	6:30pm-7:30pm	Garrison Lecture	Woodruff Health Sciences Center, Admin. Bldg., Auditorium
7:30pm-9:30pm	Reception	Woodruff Health Sciences Center, Administration Bldg. Plaza	
9:00pm-9:30pm	Shuttles available for return to Conference Center Hotel	Means Drive	

	Time	Activity	Location
SATURDAY, MAY 18	7:00am-8:00am	Continental Breakfast Available	Conference Breakout Area
	7:00am-5:00pm	Registration	Lullwater Foyer
	7:00am-8:00am	Clinician Historians' Breakfast Meeting	Salon I
	7:00am-8:00am	Women Historians' Breakfast Meeting	Salon II
	9:00am-12:00pm	Book Exhibit	Azalea & Mountain Laurel Rooms
	8:00am-9:30am	Concurrent Sessions D1-D5	Basswood, Dogwood, Oak Amphitheatre, Emory Amphitheatre, Hickory
	9:30am-9:45am	Break	Conference Breakout Area
	9:45am- 11:45am	Concurrent Sessions E1-E5	Basswood, Dogwood, Oak Amphitheatre, Emory Amphitheatre, Hickory
	12:00pm-1:15pm	Lunch Sessions L4-L6	Salons I, II, III
	12:00pm-1:15pm	Lunch on your own	Conference Center Dining Room, Area Restaurants
	1:15pm-3:15 pm	Civil War Bus Tour* ^{\$}	Conference Center Lobby
	1:30pm-3:00pm	Concurrent Sessions F1-F5	Basswood, Dogwood, Oak Amphitheatre, Emory Amphitheatre, Hickory
	3:00pm-3:15pm	Break	Conference Breakout Area
	3:15pm-4:45pm	Concurrent Sessions G1-G5	Basswood, Dogwood, Oak Amphitheatre, Emory Amphitheatre, Hickory
	5:00pm-6:30pm	Business Meeting	Silverbell Pavilion
	7:00pm-7:30pm	Reception (cash bar available to all)	Lullwater Ballroom
	7:30pm-9:30pm	Dinner & Awards Ceremony (must present ticket for admission)	Lullwater Ballroom
9:30pm-10:30pm	The Gary Motley Trio	Lullwater Ballroom	
SUNDAY, MAY 19	7:00am-8:00am	Continental Breakfast Available	Conference Breakout Area
	7:00am-8:00am	Postmortem Breakfast Meeting	Basswood
	7:00am-8:30am	History of Human Subjects Breakfast Meeting	Dogwood
	9:00am-12:00pm	Book Exhibit	Azalea & Mountain Laurel Rooms
	8:30am-10:00am	Concurrent Sessions H1-H5	Oak Amphitheatre, Hickory, Salons III, IV, V
	10:00am-10:15am	Break	Conference Breakout Area
	10:15am-11:45am	Concurrent Sessions I1-I5	Oak Amphitheatre, Hickory, Salons III, IV, V

& Registration required | * ID required | \$ Fee | ! AAHM attendees can visit the CDC museum at any time on Thursday or Friday on their own (Thursday 12am-5pm, Friday 9am-5pm). ID required.

For those participating in the President's, Clinicians, Women Historians', and Postmortem breakfasts, please first pick up food off of the general meeting continental breakfast buffet and then proceed to the assigned meeting room.

COVER IMAGE

Female Pharmacist with Autoclave: Aesculapian | Atlanta College of Physicians and Surgeons, 1911 Manuscript, Archives, and Rare Book Library, Emory University.

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Acknowledgments

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EMORY COLLEGE, PROGRAM IN SCIENCE AND SOCIETY

EMORY COLLEGE, THE STUDY OF HUMAN HEALTH

EMORY HEALTHCARE, ROBERT W. WOODRUFF HEALTH SCIENCES CENTER, EMORY UNIVERSITY

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Book Design and Production

Melissa Boone, Aria Ritz Finkelstein, Shlomit Ritz Finkelstein, and Anna Rogers

Website Design and Development

Michelle DiMeo and Megan Friddle

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MEETING SCHEDULE

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PARTICIPANT INDEX

Next Year's Meeting



AAHM 2014
Chicago Illinois
May 8-11, 2014

MEETING SCHEDULE

MEETING SCHEDULE

WEDNESDAY, MAY 15

4:00-6:00pm ALHHS Board Meeting | *Emory School of Public Health Claudia Nance Rollins (CNR) Bldg, Room 1034*

THURSDAY, MAY 16

12:00-9:00pm Registration | *Emory Conference Center, Hearth*

8:00-3:00pm ALHHS Annual Meeting | *School of Public Health Claudia Nance Rollins (CNR) Bldg., Room 3001*

8:00-3:00pm MeMA Annual Meeting | *School of Public Health Claudia Nance Rollins (CNR) Bldg., Room 6001*

12:00-5:00pm CDC Self-Guided Museum Tour (ID required)

12:30pm CDC Guided Museum Tour (registration and ID required) | *Conference Center Lobby*

1:00-6:00pm AAHM Council Meeting, (lunch provided) | *Hickory Meeting Room*

2:00-6:00pm Sigerist Circle Meeting | *Oak Amphitheatre*

3:00pm CDC Guided Museum Tour (registration and ID required) | *Conference Center Lobby*

5:30-7:00pm Film Soirée | *Silverbell Pavilion*

Global Health Film Soirée

Conveners: Anne-Emanuelle Bim, University of Toronto and Michael Sappol, History of Medicine Division of the National Library of Medicine

Film clip: “The Silent War: Colombia’s Fight against Yellow Fever” (Documentary Film Productions, 1943)

Commentary: Mariola Espinosa, Yale University

Film clip: “Medicine in the Tropics” (Firestone Tire and Rubber Company, 1948)

Commentary: Gregg Mitman, University of Wisconsin-Madison

Film Clip: “MD International” (AMA, Smith Kline, and French, 1958)

Commentary: Jane Kim, University of California at Los Angeles

7:00-9:00pm Opening Reception | *Garden Overlook/Courtyard Rain Venue: Lullwater Ball Room*

FRIDAY, MAY 17

- 7:00-8:00am Continental Breakfast Available | *Conference Breakout Area*
- 7:00-5:00pm Registration | *Lullwater Foyer*
- 7:00-8:00am New Member Breakfast | *Hickory*
- 7:00-8:00am Oxford University Press Breakfast (private)| *Basswood*
- 7:00-8:00am Bulletin of History of Medicine Breakfast (private)| *ECCH Drawing Room*
- 7:00-10:00am Book Exhibit Set-up | *Azalea & Mountain Laurel Rooms* (closed to public)
- 8:15-10:00am Welcome and Keynote Session, PUBLIC HEALTH GAME CHANGERS | *Lullwater Ballroom*

Welcome

Dean Robin Forman

Introductions

W. Clyde Partin and Howard Kushner, Emory University

History of Small Pox Eradication

William Foege, Center for Disease Control

Early History of AIDS

James Curran, Emory University

9:00am-5:00pm CDC Self-Guided Museum Tour (ID required)

10:00am-5:00pm Boo Exhibit | *Azalea & Mountain Laurel Rooms*

10:00-10:15am Break | *Conference Breakout Area*

10:15-11:45am Concurrent Sessions A1-A5

A1. THE ART OF MEDICINE AND THE ARTS | *Oak Amphitheatre*

Chair: Lisa Pruitt, Middle Tennessee State University

Plato's Portrait of the Physician and the Art of Medicine

Cynthia Patterson, Emory University

Illustrating Pregnancy and the Fetus in Early Modern Anatomical Atlases

Elisabeth Brander, Washington University School of Medicine, St. Louis

The Unnoticed Place of Art and Artists in Pasteur's Scientific Biography

Bert Hansen, CUNY- Baruch College

FRIDAY, MAY 17 10:15-11:45 (CONT.)

A2. "EMPIRES" AND AILMENTS | *Basswood*

Chair: Mariola Espinosa, Yale University

Establishing Medical Authority in the Lusophone Colonial Empire in Africa: 1850s-1950s

Dalila de Sousa Sheppard, Spelman College

In Bed with the Enemy: Sleeping Sickness and the Rise of International Cooperation, 1900-1940

Megan Valentine, College of Charleston

'From Deaths to Dollars': Cost, Price, and the World Health Organization's Effort to Calculate the Value of Malaria Eradication, 1955-1980

Kevin Moos, University of California-San Francisco

A3. MEDICINE, MEDICAL CELEBRITY, AND THE MEDIA | *Dogwood*

Chair: Barron Lerner, New York University

Polio Heroes, Flu Spokesmen and Public Rivals: A Look at Salk and Sabin and their Role in the 1976 Swine Flu Program

Caitlin Hawke, Independent Scholar, New York City

"This is Doctor X": Intern and the Road to (Dr.) Oz

Heather Varughese John, Yale University

From Bête Noire to Bulldog: The Making of a Public Medical Debate in Third Republic France

Courtney Thompson, Yale University

A4. FORTY YEARS AFTER ROE V. WADE | *Emory Amphitheatre*

Chair: Arlene Tuchman, Vanderbilt University

Shaping the Abortion Marketplace: Medical Authority, Self-help Gynecology, and Reproductive Politics, 1969-1976

Judith Houck, University of Wisconsin-Madison

From Conscience Clauses to Conscience Wars: The History and Politics of Refusal, 1973-2012

Sara Dubow, Williams College

A Matter for Scientific Study and Medical Judgment: Abortion Providers, Anti-Abortion Activists, and the Debate over Abortion Procedures

Johanna Schoen, Rutgers University

FRIDAY, MAY 17 10:15-11:45AM (CONT.)

A5. AGENCIES AND AGENCY | *Hickory*

Chair: Suzanne Junod, U.S Food and Drug Administration History Office

Disease Categories and Disciplinary Boundaries: Extramural Funding Programs for Gerontology in the National Institutes of Health, 1945-1965

Hyung Wook Park, Nanyang Technological University, Singapore

**The FDA vs. the NCI – Roots of Rivalry between Two Health Giants
Itai Bavli, University of British Columbia and**

Shifra Shvarts, Ben-Gurion University of the Negev

**Traversing the Orthodox-Unorthodox Divide: The Early History of Alternative
Medicine at the National Institutes of Health**

Eric Boyle, National Museum of Health and Medicine

12:00-1:00pm Lunch sessions L1-L3

**L1. SOURCES OF GLOBAL HEALTH HISTORY: CHINA, THE CARIBBEAN AND WEST AFRICA |
*Silverbell Pavilion***

Organizer and Chair: William H. Schneider, Indiana University

Archival sources on the History of Western Medicine in China, 1800-1950

William H. Schneider, Indiana University

Sources on Tuberculosis in the Colonial and Independent British Caribbean

Henrice Altink, University of York

L2. OPEN ACCESS AND THE FUTURES OF SCHOLARLY JOURNALS | *Starvine I*

Organizer and Chair: Graham Mooney, Johns Hopkins University, Social History of
Medicine

Pratik Chakrabarti, University of Kent, Social History of Medicine

Stephen Casper, Clarkson University, Medical History

Randall Packard, Johns Hopkins University, Bulletin of the History of Medicine

Judith Houck, University of Wisconsin-Madison, Journal of the History of Medicine and
Allied Sciences

L3. WORKING OUTSIDE THE ACADEMY | *Starvine II*

Organizer and Chair: Jessica Nickrand, University of Minnesota-Twin Cities

Lori Jones, University of Ottawa

Michael Sappol, History of Medicine Division of the National Library of Medicine

Eric Boyle, National Museum of Health and Medicine

12:00-1:00pm Graduate Student Luncheon | *School of Public Health, Rita Anne Rollins Room, 8th Floor*

12:00-1:00pm Lunch on your own | *Conference Center Dining Room, Area Restaurants*

FRIDAY, MAY 17 (CONT.)

1:15-2:45pm Concurrent Sessions BI-B5

BI. INFECTION CONTROL AND THE PROFESSIONAL | *Oak Amphitheatre*

Chair: Carlos Abramowsky, Emory University

Fatal to a Slight Scratch: Dissection Wounds and Professional Identity, 1810- 1860

Elaine LaFay, University of Pennsylvania

The 19th Century British Army Uniform as Prophylactic

Brenda Kellar, Oregon State University

“Overdoing” and “Failure to Do”: The Role of the Nurse in the Control of Staphylococcal Infections in American Hospital Nurseries, 1950s-1970s

Martha N. Gardner, Massachusetts College of Pharmacy and Health Sciences

B2. FROM ETHNO-PHARMACOLOGY TO CONTEMPORARY DRUG SHORTAGES | *Basswood*

Chair: Scott Podolsky, Harvard University

Planting for Empire: The Establishment of Cinchona Plantations in India

Rodion Kosovsky, Yale University

Raw Materials of Empire or ‘Treasures of the People’? The Value and Place of Medicinal Plants According to Franck Guichard and Joseph Kerharo, (Ex) Colonial Pharmacists

Noemi Tousignant, London School of Hygiene and Tropical Medicine and Laurence Monnais, Université de Montréal

Drug Shortages in the 21st Century: Recent History of a Mystery

Jacalyn Duffin, Queen’s University

B3. THE HEALTH POLITICS OF DISASTERS | *Dogwood*

Chair: Andrew Morris, Union College

The Spread of U.S. Medical Influence in the Wake of Foreign Natural Disasters

Julia F. Irwin, University of South Florida

Disaster, Vulnerability, and Public Health: Writing a History of the Present

Richard Keller, University of Wisconsin-Madison

Red Cross Nurses in the 1935 Dust Bowl: A Case Study of Drought, Doubt, and the Political Uses of Medical Neutrality

Marian Moser Jones, University of Maryland School of Public Health

FRIDAY, MAY 17 1:15-2:45PM (CONT.)

B4. WOMEN'S HEALTH ACTIVISM: ANOTHER TAKE | *Emory Amphitheatre*

Chair: Naomi Rogers, Yale University

Accessing Connections: Race, Women and Health Care in Cleveland
Jimmy Elaine Wilkinson Meyer, Independent Scholar, Lancaster, Ohio and
Kimberly Lenahan, Cuyahoga Community College

A New Middle Ground: The Women's Congressional Caucus and Reproductive Health Activism in the 1980s and 1990s

Heather M. Prescott, Central Connecticut State University

"Militant Fats": NAAFA's Struggle Against the Medicalization of Fatness

Kathleen Robinson, University of Wisconsin-Madison

B5. A NEW HISTORY OF LEPROSY: THE GLOBAL HEALTH IMPLICATIONS OF THE DISCOVERY OF MYCOBACTERIUM LEPROMATOSIS | *Hickory*

Chair: Monica Green, Arizona State University

Old Disease, New Insight: The Discovery of the Second Leprosy Agent Mycobacterium Lepromatosis

Xiang Yang Han, University of Texas, M. D. Anderson Cancer Center

Impacts of a Medical 'Discovery': Introducing the Leprosy Bacillus, 1870s-1920s

Magnus Vollset, University of Bergen

Pre-Modern Leprosy: An Imperial History of Calculated Imprecision

Hugh Cagle, University of Utah

2:45-3:00pm **Break | *Conference Breakout Area***

3:00-4:30pm **Concurrent Sessions C1-C5**

C1. BIRTHING AND MEDICAL PRACTICE | *Oak Amphitheatre*

Chair: Wanda Ronner, University of Pennsylvania

Writing the Gospel of Good Obstetrics: Joseph B. DeLee and the Chicago Lying-in Hospital and Dispensary, 1895-1931

Carolyn Herbst Lewis, Louisiana State University

The "Smooth Flow" of Birth: Streamlining and the Obstetrical Oeuvre of Joseph B. DeLee, 1930-1940

Caitjan Gainty, University of Wisconsin-Milwaukee

A Man's Place is in the Kitchen: Medical Experts, Pregnant Wives, and the Reconfiguration of Expectant Fatherhood in the United States, 1930s-1950s

Ziv Eisenberg, Yale University

FRIDAY, MAY 17 3:00-4:30PM (CONT.)

C2. SHOTS, SERUMS, AND VACCINES | *Basswood*

Chair: Michael Yudell, Drexel University

Curative Action: Joseph J. Kinyoun and the Diphtheria Antitoxin
Eva Åhren, National Institutes of Health

"Like Magic": The Development of the Anti-meningitis Serum and the Making of Scientific Medicine, 1907-1913

Karen Ross, Troy University

Fighting Epidemics in Wartime China: The Rise of Comprehensive Vaccination Strategies in Southwest China during the War with Japan, 1937 - 1945

Mary Augusta Brazelton, Yale University

C3. RACE AND MEDICINE ACROSS TIME AND SPACE | *Dogwood*

Chair: Lundy Braun, Brown University

Before Sickle Cell was "Sickle Cell": Jose Martins da Cruz Jobim's Hypoemia Intertropical and the Persistence of the Racialized Body, 1835

Melissa Creary, Emory University

Eat Wisely, Feel Lively: Images, Ethnicity & Assimilation in British Health Education, 1970-85

Roberta Bivins, University of Warwick

Dementia Americana: Black Doctors and the Problem of Racial Science in the Early Twentieth Century

Adam Biggs, University of South Carolina-Lancaster

C4. CONFRONTING HEALTH CHALLENGES ON THE POSTWAR GLOBAL SCENE | *Emory Amphitheatre*

Chair: Adam Warren, University of Washington

Exporting Health: Infant Mortality and Medical Exchange in Ecuador 1949-1965

Emily Harrison, Harvard University

Carving a Space for Cardiac Surgery in a World of Tropical Infections: Medical Missions and Modern Nation Builders in India, 1947-1962

Kavita Sivaramakrishnan, Columbia University

David Jones, Harvard University

Gambling on the Protestants: The Pathfinder Fund and Birth Control in Peru, 1958-1965

Raúl Necochea, University of North Carolina-Chapel Hill

FRIDAY, MAY 17 3:00-4:30PM (CONT.)

C5. CHILDREN AS A “USEFUL CATEGORY OF ANALYSIS” | *Hickory*

Chair: Janet Golden, Rutgers University-Camden

“Mother: Here’s the Aspirin Tablet that ‘Fits’ Your Child’s Needs:” Children and Aspirin Therapy in the Postwar Era

Cynthia Connolly, University of Pennsylvania School of Nursing

Redefining Cancer as an Infectious Disease: The Special Leukemia Virus Program and Mobilization against Childhood Illness, 1948-1968

Robin Scheffler, Yale University

Vulnerable Subjects, Vulnerable Knowledge: Linking Children’s Chemical Exposure to Health Outcomes in the United States and European Union

Arthur Daemmrich, Harvard Business School

4:45-6:00pm Shuttles to Emory Campus or Walking Tour | *Conference Center Lobby*

5:00-6:30pm Exhibit & Reception: Medical Treasures at Emory, A Display of Rare Medical Books and Artifacts | *Health Sciences Center Library, Emory University*

6:30-7:30pm Garrison Lecture: Break-bone Fever in Philadelphia, 1780: Reflections on the History of Disease | *Woodruff Health Sciences Center Administration Bldg., Auditorium, Emory University*
Randall Packard, Ph.D.

7:30-9:30pm Reception | *Woodruff Health Sciences Center Administration Bldg. Plaza*

9:00-9:30pm Shuttles available for return to Conference Center Hotel | *Means Drive*

SATURDAY, MAY 18

7:00-8:00am Continental Breakfast Available | *Conference Breakout Area*

7:00am-5:00pm Registration | *Lullwater Foyer*

7:00-8:00am Clinician Historian's Breakfast Meeting | *Salon I*

7:00-8:00am Women Historian's Breakfast Meeting | *Salon II*

9:00-12:00pm Book Exhibit | *Azalea & Mountain Laurel Rooms*

8:00-9:30am Concurrent Sessions D1-D5

D1. MEDICINE SPEAKING TO THE POOR IN EARLY MODERN EUROPE | *Oak Amphitheatre*

Chair: F. Eliza Glaze, Coastal Carolina University

Popularizing Medicine in Thirteenth-Century Europe: The Evidence from Sermons
Winston Black, University of Tennessee

Reaching the Poor? Intended Versus Potential Audiences for Contagious Disease Tracts in Late Medieval and Early Modern England
Lori Jones, University of Ottawa

Philanthropy and Medicine in 17th Century France: Paul Dubé, "Physician of the Poor"
Leigh Whaley, Acadia University

D2. FORMING ALTERNATIVE FAMILIES: MEDICAL IDEAS, DISCUSSIONS, AND PRACTICE | *Basswood*

Chair: Carla Bittel, Loyola Marymount University

Placing the Less than Perfect Child: Medical Views on Risk and Disclosure in American Adoption, 1945-1980
Sandy Sufian, University of Illinois-Chicago

Doctors, Nurses and Unwed Mothers: A Case Study of the Sophia Little Home in Rhode Island
Simone Caron, Wake Forest University

Alternative Insemination: When Medical Gatekeeping Ended
Kara Swanson, Northeastern University

SATURDAY, MAY 18 8:00-9:30AM (CONT.)

D3. MEDICINE AND CRIME | *Dogwood*

Chair: Nathaniel Comfort, Johns Hopkins University

Teaching Morality with a Surgeon's Scalpel: Brain Surgery for Criminals during the Progressive Era

Delia Gavrus, McGill University

A Rural Practice of Abortion and the Criminal Justice System: The Loss of Community Control

Mazie Hough, University of Maine

Eugenics and Crime: The Hillbilly Homicide of 1936

Paul Lombardo, Georgia State University

D4. THE EPIDEMIOLOGY OF CORONARY HEART DISEASE | *Emory Amphitheatre*

Chair: Joel Howell, University of Michigan

What Constitutes the Epidemiological Group of Interest: An Aggregation of Individuals or a Community? Strategies for the Study and Prevention of Coronary Heart Disease in Post-World War II Epidemiology

Gerald Oppenheimer, CUNY-Brooklyn College

The Decline in Coronary Artery Disease Mortality: Tracing its Origins, Contributing Factors and Unraveling the Mystery

Leslie Leighton, Emory University

The Epidemiologic Transition in Cardiovascular Disease: The Curious Course of a Captivating Concept, 1971-2012

Darwin Labarthe, Northwestern University

D5. SCHOOLING, PLAY, AND DISABILITIES | *Hickory*

Chair: Beth Linker, University of Pennsylvania

Pin the tail on the ...: Disability, Medicine and Children's Play in the West Over the Last Millennium

Walton O. Schalick, III, University of Wisconsin – Central Wisconsin Center

The Commodification of Disability: Idiot Schools and Custodial Care in Nineteenth-Century America

Kathryn Irving, Yale University

Making Seizures Safe: Accident, Impairment, and the Schoolyard Invention of Epileptic Stoicism in Postwar Detroit, 1945-1956

Rachel Elder, University of Pennsylvania

9:30-9:45am Break | *Conference Breakout Area*

SATURDAY, MAY 18 (CONT.)

9:45-11:45am Concurrent Sessions E1-E5

E1. COMMUNITY HEALTH CARE AND DOMESTIC MEDICINE | *Oak Amphitheatre*

Chair: Emily Abel, University of California-Los Angeles

Community Health Care: Struggles and Conflicts of an Emerging Public Health System in the United States in the First Half of the Twentieth Century

Rima D. Apple, University of Wisconsin-Madison

“Young Children Here March Happily Back to School”: Germ Theory, Scarlet Fever, and Domestic Medicine in Depression-Era America

Bridget Collins, University of Wisconsin-Madison

Nurse as Needed: The Doctor’s Wife Pressed into Service

Constance Putnam, Independent Scholar, Concord, MA

Charity, Care, and the Convalescent Movement in 19th Century Britain

Gabrielle Barr, Johns Hopkins University

E2. WHO’S IN CHARGE? CHANGING DEBATES OVER SCIENTIFIC KNOWLEDGE AND PREGNANCY | *Basswood*

Chair: Judith Leavitt, University of Wisconsin-Madison

Domestic Thermometry and Patient Labor, 1873–2013

Deanna Day, University of Pennsylvania

The Impacts of Medicalized Maternity in the Jewish Community of Tunisia, 1890-1940

Richard Parks, Brown University

Communicating a New Consciousness: Home Birth in Modern America

Wendy Kline, University of Cincinnati

Clinical Chronobiology and the Pursuit of the Biological Clock

Jole Shackelford, University of Minnesota

SATURDAY, MAY 18 9:45-11:45AM (CONT.)

E3. HEALTH, MEDICINE, AND THE COLD WAR | *Dogwood*

Chair: Joanna Radin, Yale University

Leprosy Control as Cold War Project: U.S. Public Health and Anti – Communist Policies in Post–Korean War South Korea

Jane Kim, University of California-Los Angeles

Preventative Medicine and Political Milieu: The Ascendancy of Public Health Structuralism in 1950s Czechoslovakia

Bradley Moore, University of Wisconsin-Madison

Cold War Cardiology: Paul Dudley White, Ancel Keys, Medicine, and US-USSR Diplomacy, 1955-65

Sarah Tracy, University of Oklahoma

Mobilizing the (Korean) Body: Re-Evaluating the Korean War and the Emerging Historiography of Rehabilitative Medicine, 1954-1977

John P. DiMoia, National University of Singapore

E4. PSYCHOACTIVE DRUGS, ADDICTION AND HISTORY: THE STATE OF THE FIELD |

Emory Amphitheatre

Chair: Elizabeth Watkins, University of California-San Francisco

The New Pharmaceutical History and the Drug War: A Match Made in History

David Herzberg, SUNY-Buffalo

Addiction Neuroscience and History

David Courtwright, University of North Florida

Historicizing Public Health Ethics and Addiction Policy: The Peter Bourne Controversy

Claire Clark, Emory University

Drug Policy, Drug Use, and Politics in Communities of Color

Samuel Roberts, Columbia University

E5. (FIRST HOUR) DIET AND MEDICINE | *Hickory*

Chair: Andrew Ruis, University of Wisconsin-Madison

Food or Drug?: The 1960s ‘Cholesterol Controversy’ and Professional Debates Over Responsibility for Eating Versus Treating

Xaq Frohlich, Northeastern University

The Salt Hypothesis: Evidence, Skepticism, and the Politics of Public Health

David Johns, Columbia University Mailman School of Public Health

SATURDAY, MAY 18 9:45-11:45AM (CONT.)

E5. (SECOND HOUR) SMOKING GUNS | *Hickory*

Chair: Jacob Steere-Williams, College of Charleston

Stories from the Origins of "Hill's Criteria," Guidelines for Causal Inference from Statistical Associations

Henry Blackburn, University of Minnesota School of Public Health and
Darwin Labarthe, Northwestern University

Historical Perspectives on Smoking Cessation among the Mentally Ill

Laura Hirshbein, University of Michigan

12:00-1:15pm Lunch sessions L4-L6

L4. MAXIMIZING THE MEDICAL HERITAGE LIBRARY'S USEFULNESS FOR RESEARCH: NEW CONTENT, NEW TOOLS | *Salon I*

Organizer and Chair: Michelle DiMeo, The College of Physicians of Philadelphia

Truth, Doubt, & Objectivity: Silas Weir Mitchell, John Kearsley Mitchell, and Concerns Regarding Phantom Limb Pain in Mid-to-Late 19th c. U.S. Neurology

Daniel Goldberg, East Carolina University

Lori M. Jahnke, Emory University

David Jones, Harvard University, Boston, MA, USA

Melissa Grafe, Yale University

L5. PUBLIC HISTORY IN A DIGITAL AGE: POSSIBILITIES AND IMPLICATIONS FOR MEDICAL HISTORIANS | *Salon II*

Organizers: Heidi Knoblauch, Yale University and Nancy Tomes, Stony Brook University

L6. WHEN SPECIALIZATION DID AND DID NOT TAKE PLACE: THE POWER OF GENERALIST VALUES IN MODERN MEDICINE | *Salon III*

(Special note: This session is based upon pre-circulated papers that will be made available to each person who signs up for the luncheon.)

Organizer and Chair: John C. Burnham, Ohio State University

The Spirit of Generalism in British Neurology: Specialization, State Medicine, and the Making of an Integrative Specialty, 1860-1990

Stephen T. Casper, Clarkson University

When Generalist Values Meant General Practice: Family Medicine in Post-WWII America

Paul E. Stepansky, Montclair NJ

Commentator: Rosemary A. Stevens, Weill Medical College, Cornell University

12:00-1:00pm Lunch on your own | *Conference Center Dining Room, Area Restaurants*

1:15-3:15pm Civil War Bus Tour | *Conference Center Lobby*

SATURDAY, MAY 18 (CONT.)

1:30-3:00pm **Concurrent Sessions F1-F5**

F1. DISPARITIES AND THEIR DISCONTENTS | *Oak Amphitheatre*

Chair: Merlin Chowkwanyun, University of Pennsylvania

**“That the Asylum for deserted Negroes is now complete for their reception...”:
Surveillance and Sickness in Eighteenth-Century Jamaica**

Rana Hogarth, University of Illinois

The Ultimate Solving of the Problem Will Be in Rural Areas

Jennifer Gunn, University of Minnesota

**The Emergence of the General Adaptation Syndrome in Contemporary Health
Disparities Discourse**

Deanne Dunbar, Emory University

F2. NEW MEANINGS OF THE PREGNANT/NOT PREGNANT BODY | *Basswood*

Chair: James C. Mohr, University of Oregon

Start Your Child Right: Prenatal Health Care in Early Twentieth-Century America

Shannon Withycombe, Duke University

**The Entangled Politics of Artificial Insemination, the Pill, and Abortion in America,
1960-1980.**

Bridgett Gurtler, Rutgers University

Abortion Debates and Early Pregnancy Loss: “Life,” “Choice,” and Lost Babies

Lara Freidenfelds, Princeton Research Forum

F3. EUGENICS AND THE HEALTH PROFESSIONS | *Dogwood*

Chair: Alexandra Stern, University of Michigan

Medicine and Eugenics in Imperial Russia, 1900-1917

Nikolai Kremmentsov, University of Toronto

Not in Your Genes: Andrija Štampar's Rejection of Eugenics,

Martin Kuhar, Croatian Academy of Sciences and Arts

**Measuring the ‘Fitness’ of the American Citizenry: Eugenics Field Workers and
Public Health Nurses in the United States, 1910-1925**

Tina M. Kibbe, University of Buffalo

SATURDAY, MAY 18 1:30-3:00PM (CONT.)

F4. ENVIRONMENTAL AND WORKPLACE EXPOSURES AS ETIOLOGY | *Emory Amphitheatre*

Chair: *Christian Warren, CUNY-Brooklyn College*

Industrial Hygiene and Toxic Chemicals Policy: The Interwar Years as a Formative Period

Ellen Spears, University of Alabama

Pollution and Politics Around Post-WWII Atlanta: The Long Shadow of Underdevelopment

Christopher Sellers, SUNY-Stony Brook

Reinterpreting the Risk of Congenital Malformation: New Directions in Research on Environmental Etiology and Chemical Exposure (1940-1971)

Heather Dron, University of California-San Francisco

F5. MEDICAL THEORY/MEDICAL PRACTICE | *Hickory*

Chair: *John Harley Warner, Yale University*

“The Operation is Very Trifling”: Percivall Pott on how to practice surgery in Georgian London

Lynda Payne, University of Missouri-Kansas City

The Medical Libertarianism of Alfred Russel Wallace: An Alternative Biological Narrative for the Victorian and Edwardian Eras

Michael Flannery, University of Alabama-Birmingham

The Making of a Medical Hypnotist: Albert Moll (1862-1939)

Andreas-Holger Maehle, Durham University

3:00-3:15pm Break | *Conference Breakout Area*

3:15-4:45pm Concurrent Sessions G1-G5

G1. PLAGUES AND PLACES | *Oak Amphitheatre*

Chair: *Ann Carmichael, Indiana University*

Plague in the Port City: The Marseille Plague of 1720 in Transnational Perspective

Cindy Ermus, Florida State University

Fellows of the Royal Society and Their Ideas about Contagion in the Late Seventeenth Century

Margaret Delacy, Northwest Independent Scholars Association

Richard Pearson Strong and the International Plague Conference in Muken, 1911

Jeong Se-Kwon, Seoul National University

SATURDAY, MAY 18 3:15-4:45PM (CONT.)

G2. NO PAIN, NO GAIN | *Basswood*

Chair: Keith Wailoo, Princeton University

Opinions on Comfort-Care in Ancient Greek Medicine

Louisa Wall, Emory University

Truth, Doubt, & Objectivity: Silas Weir Mitchell, John Kearsley Mitchell, and Concerns Regarding Phantom Limb Pain in Mid-to-Late 19th c. U.S. Neurology

Daniel Goldberg, Brody School of Medicine, East Carolina University

From Sensation to Experience: Changing Notions of Pain after 1945

Stephen Beitler, University of California-San Francisco

G3. CHILDREN ARE THE FUTURE | *Dogwood*

Chair: Lewis Leavitt, University of Wisconsin-Madison

Nurturing the citizens of the future: The milk stations program in Puerto Rico, 1926-1960

Elisa Gonzalez, Columbia University

Publicizing Prevention: The Health League of Canada and Immunization, 1933-1977

Heather MacDougall, University of Waterloo

Expecting "Normal" Babies: Genetic Counseling, Reproduction, and Disability in the Mid-Twentieth Century

Adam Turner, University of Oregon

G4. COLONIZING THE ASYLUM | *Emory Amphitheatre*

Chair: Dayle B. DeLancey, University of Wisconsin School of Medicine and Public Health

Bedlam in the New World: Colonial Politics and Origins of New Spain's First Mental Hospital

Christina Ramos, Harvard University

Bodily Concerns: Disease and Public Health in British Pauper Lunatic Asylums, c. 1830-1930

Claire Jones, University of Leeds

The Technocrat and the Patriot: The Mazorra Mental Asylum in U.S. Occupied Cuba, 1906-1909

Jennifer Lambe, Yale University

SATURDAY, MAY 18 3:15-4:45PM (CONT.)

G5. MEDICAL EXPERIMENTATION REVISITED | *Hickory*

Chair: Susan Lederer, University of Wisconsin-Madison

William Harvey's Examination of Viscount Montgomery: The Forbidden Experiment
Randy Kidd, Bradley University

Mysteries at Lynchburg: The World War II Origins of Human Hepatitis Experiments
Sydney Halpern, University of Illinois-Chicago

**Administering Colonial Science: Nutrition Research and Human Experimentation in
Aboriginal Communities and Residential Schools, 1942-1952**
Ian Mosby, University of Guelph

5:00-6:30pm Business Meeting | *Silverbell Pavilion*

7:00-7:30pm Reception (cash bar available to all) | *Lullwater Pavilion*

7:30pm-9:30pm Dinner & Awards Ceremony (must present ticket for admission) | *Lullwater Ballroom*

9:30-10:30pm The Gary Motley Trio | *Lullwater Ballroom*

SUNDAY, MAY 19

7:00-8:00am Continental Breakfast Available | *Conference Breakout Area*

7:00-8:00am Postmortem Breakfast Meeting | *Basswood*

7:00-8:30am History of Human Subject's Meeting | *Dogwood*

9:00-12:00pm Book Exhibit | *Azalea & Mountain Laurel Rooms*

8:30-10:00am Concurrent Sessions H1-H5

H1. EDUCATION BY DESIGN | *Oak Amphitheater*

Chair: Rosemary Stevens, Weill Cornell Medical College, Cornell University

Abstinence, Sex Education, and Sublimation in the United States, 1900-1930

Julien Comte, University of Pittsburgh

Letters Home from the Wards: Martha May Eliot and Changes to American Medical Education, 1918-1925

Deborah Levine, Providence College

Group Practice and Early Twentieth-Century American Hospital Design

Jeanne Kisacky, Independent Scholar, Ithaca, NY

H2. BEHAVIORAL AND "MIND" THERAPIES | *Basswood*

Chair: Susan Lamb, McGill University

The 'Chicago School of Psychology' and Hypnotic Magazine: Suggestive Therapeutics as Public Psychology in Fin-de-Siècle America

John Andrick, University of Illinois

Video Therapy: Self-Confrontation and the Development of a Psychiatric Technology

Peter Collopy, University of Pennsylvania

H3. MEDICINE, SEXUALITY, AND THE MALE BODY | *Dogwood*

Chair: Alice Dreger, Northwestern University

"How Intimately are Connected the Medical and Social Aspects": Oliver C. Wenger, the United States Public Health Service, and the Evolution of VD Control Strategies in Hot Springs, Arkansas, 1921-1936"

Elliott Bowen, Binghamton University

The Mainstreaming of Circumcision in the 1950s: Good for the Jews?

Elizabeth Reis, University of Oregon

Indigenous Health Promotion and Sexual Behavior Change among Gay Men in San Francisco 1982-1987

Colin Talley, Emory University- Rollins School of Public Health

SUNDAY, MAY 19 8:30-10:00AM (CONT.)

H4 THE WORLD OF TUBERCULOSIS | *Salon I*

Chair: Diego Armus, Swarthmore College

'Esta Obra De Reparación Social': Tuberculosis and the Politics of Modernity in Cuba, 1901-1906

John Gutierrez, CUNY-John Jay College

From a Clinical to a Public Health Problem?: The Prevention, Control and Treatment of Tuberculosis in Jamaica, c. 1918-1982

Henrice Altink, University of York

Why Hygiene (Weisheng) Is Not about Guarding Life: The Invisible Struggle between Tuberculosis and Wasting Disorders (Laobing) in Republican China

Sean Hsiang-Lin Lei, Institute of Modern History, Academia Sinica, Taiwan

H5. MEDICAL TECHNOLOGIES IN/SINCE THE 19TH CENTURY | *Hickory*

Chair: Jacqueline Wolf, Ohio University

The History of Prenatal Diagnosis in France from 1821 to 1970

Hélène Richard, Université Paris I Panthéon-Sorbonne, IHPST

"A Plea for the Lancet": Bloodletting and Scientific Medicine in Late Nineteenth-Century America

Eli Anders, Johns Hopkins University

Records as Agents: The Role of Materiality on the Lives of African American Patients in a State Mental Institution

Lorraine Dong, University of Texas-Austin

10:15-11:45am Concurrent Sessions II-IV

II. EXPERIENCING AND MANAGING ILLNESS AND DEATH IN THE HOME | *Oak Amphitheatre*

Chair: Jason Szabo, McGill University

At the Grave's Brink: Patients and Pity in Early Modern England

Olivia Weisser, University of Massachusetts, Boston

Experiencing and Managing Illness and Death in the Home

Hilary Marland, University of Warwick

Death Isn't What It Used to be: From Hospice as Aspiration to Imperative

Carla Keims, SUNY-Stony Brook

SUNDAY, MAY 19 10:15-11:45AM (CONT.)

12. ANATOMY OF SEX: NEW PERSPECTIVES ON THE HISTORY OF SEXUALITY AND MEDICINE | Basswood

Chair: John Parascandola, University of Maryland College Park

Better Sex – Reframing Definitions of Sex and Gender in the Treatment and Management of “Hermaphroditic” Children at the Johns Hopkins Hospital, 1940-1956

Sandra Eder, University of Zurich

The Diminutive Homologue to the Penis: Reconsidering Anatomical and Gynecological Representations of the Clitoris in the Twentieth Century

Sarah Rodriguez, Northwestern University

“V.D. is No Camp”: Communicating Information about Venereal Disease Amongst Men Having Sex with Men in New York and Beyond in the 1960s

Richard McKay, King's College London

13. NEGLECTED DISEASES, ESSENTIAL MEDICINES: CRITICAL STUDIES OF GLOBAL PHARMACEUTICALS | Dogwood

Chair: Jeremy Greene, Johns Hopkins University

Bayer 205: Propaganda, Rivalry, and Drug Therapy Research in Africa, 1920-1930

Deborah Neill, York University

Pentamidine, from Colonial Wonder Drug to Essential Medicine. An Inquiry into the Past, Futures and Collective Bodies of Global Health

Guillaume Lachenal, Université Paris Diderot

From Colonial Disease to NTD: Sleeping Sickness and Global Health in Historical Perspective

Mari Webel, Emory University

14. CONTESTING ECLECTICS | Salon I

Chair: William Summers, Yale University

Hydrotherapy in India: Colonial, Globalized, Transnational or Vernacular?

Projit Mukharji, University of Pennsylvania

Resisting the “Sanitary Dictatorship”: Homeopathy and the Contestation against the Regulation of the Medical Profession in Mexico, 1917-1942

Jethro Hernandez-Berrones, University of California-San Francisco

ABSTRACTS

ALPHABETICALLY BY AUTHOR

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EVA ÅHRÉN

National Institutes of Health, Bethesda, Maryland, USA (1)

CURATIVE ACTION: JOSEPH J. KINYOUN AND THE DIPHTHERIA ANTITOXIN

Joseph Kinyoun was director of the Hygienic Laboratory of the Marine Hospital Service (forerunner of the NIH), from its opening in 1887 until 1899. In 1894 he was in the audience at the International Congress of Hygiene and Demography in Budapest, when Emile Roux delivered his famous address on diphtheria antitoxin. This was the first cure for a common disease to come out of the laboratories of microbiology. Pasteur’s widely published rabies treatment in 1885 was a major triumph for the germ theory of disease. But rabies was rare, and diphtheria was a widespread and lethal childhood disease—the antitoxic serotherapy therefore received even more attention in the science community and the public at large at the time. Kinyoun himself had lost a daughter and one of his first patients to the disease.

Producing diphtheria antitoxin was a complicated process demanding advanced microbiological knowledge and equipment. After the Budapest conference, Kinyoun went to the Pasteur Institute in Paris to learn to manufacture the antitoxin in his own laboratory. He also spent a month at Robert Koch’s laboratory in Berlin. His enthusiastic telegrams from Europe were quoted in popular and medical press, and immediately spurred domestic efforts to manufacture the serum. The MHS recruited the Department of Agriculture to care for a healthy horse, which was immunized to produce the serum. Upon returning the US, Kinyoun invited public health physicians to study the manufacturing process in the Hygienic Laboratory, and distributed the precious antitoxic serum for free.

This paper examines Kinyoun’s role in introducing, producing, and propagating the use of diphtheria antitoxin in the US. It traces competition and collaboration between federal, municipal, and commercial laboratories, and discusses ensuing calls for regulating “biologics”. Challenging the notion of a bacteriological “revolution” and capturing a hybrid moment in microbiology, I will argue that public health leaders rather than basic scientists introduced microbiology in the US: the new methods and techniques of microbiology (bacteriology, serology, and immunology) complemented other tools available to the laboratories of public health in the 1890’s (i. e. epidemiology and sanitary science and engineering).

LEARNING OBJECTIVES:

1. Understand the role of public health leaders in introducing microbiology in the United States
2. Recognize the dynamic relationships between federal, municipal, and commercial laboratories for research on and production of pharmaceuticals
3. Identify historical changes and continuities regarding federal government support of medical science and public health

HENRICE ALTINK

University of York, York, UK (1)

FROM A CLINICAL TO A PUBLIC HEALTH PROBLEM?: THE PREVENTION, CONTROL AND TREATMENT OF TUBERCULOSIS IN JAMAICA, C. 1918-1982.

BCG-based vaccination and availability of anti-tuberculosis drugs after the Second World War meant that in many countries tuberculosis shifted from being seen as a clinical to a public health problem. Tuberculosis programmes moved from a focus on 'cure' in sanatoria that prescribed rest and carried out clinical procedures to an emphasis on 'prevention' through vaccinations and testing, and an ambulatory drug regime-based cure.

Based on wide-ranging primary materials – including government papers, WHO files and newspaper reports – this paper will claim that these shifts were neither universal nor unproblematic in developing countries. This, in turn, resulted in complexities in field practice that left deep imprints on the reception, reformulation and implementation of national and international disease control policies. Such policy intricacies are deserving of detailed examination.

Jamaica made many steps to define tuberculosis as a public health problem after the War. Between 1951 and 1953, it carried out a mass BCG campaign sponsored by the WHO. And its tuberculosis sanatorium stopped performing surgical procedures in 1963 and became a chest hospital in 1974. But twenty years after independence tuberculosis was still largely a clinical problem. In 1982, for example, there was only one clinic, based in the capital Kingston, where people could be tested. Men and women tested positive were, like those from rural areas suspected of having tuberculosis, sent to the chest hospital. Only those hospitalised in this institution were given anti-tuberculosis drugs. Furthermore, BCG was routinely administered to newborns in the University hospital, the maternity hospital in Kingston and rural health centres but only in Kingston could children and adults be vaccinated.

This paper will argue that this failure to universalise the definition of tuberculosis as a public health problem was not just because of Jamaica's financial circumstances and shortage of well-trained staff but also its failure to reorganise the health services after independence. By 1982, the health service was still divided between a 'curative' side controlled by central government and a 'preventative' side largely run by local government, with little communication or oversight between the two.

LEARNING OBJECTIVES:

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

ELI ANDERS

Johns Hopkins University, Baltimore, MD, USA (1)

“A PLEA FOR THE LANCET”: BLOODLETTING AND SCIENTIFIC MEDICINE IN LATE NINETEENTH-CENTURY AMERICA

This presentation examines late nineteenth-century American debates about bloodletting. By the 1870s, bloodletting had largely disappeared as a mainstream therapeutic practice. Though Guenter Risse has argued that bloodletting experienced a brief “renaissance” around 1900, historians have treated the period between the 1870s and 1900 as one in which bloodletting was completely discredited. In contrast, I use debates in American medical journals to show that the proper use of therapeutic bleeding was far from settled during this period. Many physicians, particularly older, rural practitioners, advocated for the use and revival of bloodletting in a number of clinical conditions, particularly pneumonia and other inflammatory diseases.

This advocacy reflected twin concerns. First, orthodox physicians sought to rebuff challenges from homeopaths and other 'irregulars' who had sharply criticized the use of bloodletting. In promoting bloodletting, orthodox practitioners sought to articulate their moral and professional values and contrast their sense of professional identity with that of 'irregular' practitioners. Second, bloodletting proponents invoked a set of epistemological commitments about the proper grounding for therapeutics. Many bloodletting critics argued that the practice had been discredited by laboratory discoveries in pathology, physiology, and bacteriology; advocates, in contrast, affirmed their belief in the priority of clinical experience and bedside judgment over the claims of 'scientific' medicine to validate and guide medical practice.

Though much of the bloodletting debate reflected these professional and epistemological conflicts, there were a wide range of practitioners and perspectives represented in the discussion. While some traditionalists argued for the wholesale revival of bloodletting on the basis of their personal experience, others thought it remained appropriate only in limited conditions. Some even appealed to experimental and physiological discoveries to justify reviving bloodletting on a new scientific foundation; offering new rationales and explanations for the efficacy of old therapies was as much a part of 'scientific medicine' as was the search for new remedies and therapeutic agents. I conclude that debates over bloodletting were an argumentative terrain upon which physicians articulated and elaborated various ideas about professional identity, epistemology, and the relationship between bedside practice and medical progress.

LEARNING OBJECTIVES:

1. Develop a historical understanding of the influences of epistemological and evidential debates on patient care.
2. Acquire a historically nuanced understanding of the organization and values of the medical profession in the United States.
3. Recognize the historical relationship between professional values and agreed-upon standards of evidence and treatment.

JOHN ANDRICK

University of Illinois at Urbana-Champaign, Urbana, IL, USA (1)

THE HYPNOTIC MAGAZINE AND ‘CHICAGO SCHOOL OF PSYCHOLOGY’: SUGGESTIVE THERAPEUTICS AS PUBLIC PSYCHOLOGY IN FIN-DE-SIÈCLE AMERICA

The Hypnotic Magazine, edited by Sydney Flower, served as the unofficial organ of the ‘Chicago School of Psychology’, a ‘college’ of suggestive therapeutics under the direction of Herbert A. Parkyn, medical superintendent. Although resisted by orthodox medicine, the school catered to physicians, dentists, and elements of the general public desiring to learn more of the psychology of suggestion and the therapeutic applications of hypnotism. In addition, Parkyn conducted a clinic where patients suffering from various nervous afflictions sought relief through hypnotic therapeutics, with the case reports appearing in the magazine. The Hypnotic Magazine, under various titles and formats, ran monthly from 1897 to 1906, and discussed a wide range of psychological issues of interest to the public, including spiritualism, Christian Science, crowd psychology, hypnosis and crime, and psychical research. Through the journal and its class offerings, the ‘Chicago School of Psychology’ became the most nationally recognized school of suggestive therapeutics and helped deliver a variety of self-help and therapeutic ‘public psychology’ which the American reading public was eagerly consuming. As a conceptual category of psychological activity, public psychology has been recently conceived as printed and/or instructional discourses of popular and professional psychology directed at targeted audiences among professional classes and the informed reading public. Suggestive therapeutics, with its ‘scientific’ claims but strong occult associations, reflected the latest developments of what Eugene Taylor has termed the “French-Swiss-English-American” psycho-therapeutic axis. Eventually, The Hypnotic Magazine became identified with the New Thought movement, as its changing titles and content would show. At a time when neurologists were still bound to somatic therapies, and with psychotherapy instruction in medical schools virtually non-existent, schools of suggestive therapeutics became chief purveyors of a public psychology which brought hope of relief from a range of sufferings to large numbers of men, women, and children during the age of “American nervousness.” Such schools helped generate tremendous interest in psycho-therapeutics and paved the way for the enthusiastic reception of public psychologies such as the Emmanuel Movement and Emile Coué, which followed in the immediate years and decades after the disappearance of the ‘Chicago School of Psychology’.

LEARNING OBJECTIVES:

1. Gain an appreciation of the plurality of therapeutic approaches in medical psychology, including mind/body medicine and contemporary CAM.
2. Develop an awareness that who speaks for medicine, psychology, and science at particular historical moments is always contested.
3. Historically understand that psychotherapeutic treatments offered today do not resemble practices a century ago, even if treatment nomenclature remains the same.

RIMA D. APPLE

University of Wisconsin, Madison, WI, USA (1)

“COMMUNITY HEALTH CARE: STRUGGLES AND CONFLICTS OF AN EMERGING PUBLIC HEALTH SYSTEM IN THE UNITED STATES IN THE FIRST HALF OF THE TWENTIETH CENTURY”

Concern for community health inspired public health projects in the United States in the first half of the twentieth century. State and local boards of health and school boards initiated programs. Philanthropic and charity agencies sent public-health workers into local communities. The number and the diversity of efforts indicate that U.S. society strongly believed in their effectiveness. Yet, their very number and diversity raised issues that limited their potential to improve the lives of their communities, a situation echoed in today’s circumstances. Not infrequently, a county nurse, a city nurse, a Red Cross nurse, and a school nurse could practice in the same locale. Both state public-health physicians and local doctors could offer medical services to community members. These organizations and individuals supplied important health care and instruction, but their activities overlapped, resulting in inefficiencies and conflicts. This paper examines the processes and procedures that health-care practitioners employed to negotiate blurry professional roles. Written policies of various agencies give some insight into their particular goals. However, it was the unwritten practices -the day-to-day interactions between healthcare professionals -that illustrate the potentials and the obstacles inherent in such a multifaceted public-health system.

These pivotal events are reconstructed through a detailed study of published and unpublished records left by practitioners themselves. The Wisconsin State Historical Society Archives holds narrative reports of state and county nurses, statistical analyses of public health efforts across the state, the annual reports of local and state boards of health, and the records of philanthropic and charity agencies. Evaluating these essential primary sources in light of organizational histories of government and non-governmental public-health agencies, the published and unpublished memoirs of practitioners, and newspaper and journal articles provides critical background for the study of public-health work in the period. The specifics of every-day life document the tensions and achievements of public health-care workers struggling with an inchoate public health system. Their examples offer useful points for the analysis of evolving public health systems today.

LEARNING OBJECTIVES:

1. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.
2. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems
3. Identify successes and failures in the history of medical professionalism

GABRIELLE BARR

Johns Hopkins University, Baltimore, MD, USA (1)

CHARITY, CARE, AND THE CONVALESCENT MOVEMENT IN 19TH CENTURY BRITAIN

Many scholars have discussed convalescent organizations and institutions in their historical accounts of medicine and philanthropy in the nineteenth century. However, no study has concentrated on the social connotations of the convalescent care movement and its relationship with the broader charitable landscape in Britain during this period. As both a surgeon and a philanthropist, William Blizard was instrumental in instituting convalescent care at a significant and organized level as illustrated by his founding of the London Samaritan Society in 1792 for discharged patients of the London Hospital who were unable to resume their activities of daily living.

Blizard's mission to assist the recovering underprivileged served as a model for Samaritan societies and convalescent homes that emerged in nineteenth century Britain. Between 1850 and 1860, the number of Samaritan societies increased and became more specialized like the hospitals with which they were associated. Convalescent homes also became a prominent part of the convalescent care movement in the latter half of the nineteenth century largely due to the fact that medical spaces were needed for those cured but seriously weakened by the devastating cholera and scarlet fever outbreaks during the 1860s. These venues embodied the values and characteristics of the Victorian age from the benefits of the countryside to domestic virtues. Nevertheless, issues with organization, advertising, and mode of funding left the search for more resources to be a constant quest for these institutions. Employing newspapers, periodicals, pamphlets, and tracts from the eighteenth and nineteenth centuries, this paper demonstrates how the humanitarian efforts of the London's Samaritan Society sheds light on the growing importance of philanthropy in the Victorian era and was part of a new way of viewing the indigent. Important figures in British society such as Catherine Gladstone, the wife of Prime Minister William Gladstone, and the philanthropist Louisa Twining had a central role in championing these institutions, but it took an entire nation to support them. From Anglican sisterhoods to workingmen's friendly societies, a wide range of associations established and fundraised for convalescent homes, imbuing their personal interests into the character of these healing centers.

LEARNING OBJECTIVES:

1. To demonstrate the impact William Blizard's revolutionary London Samaritan Society had in shaping the convalescent movement in the 1800s.
2. To describe the interplay between the convalescent movement and the rise of hospitals.
3. To show how Victorian values and culture affected convalescent societies and homes.

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THE FDA VS. THE NCI – ROOTS OF RIVALRY BETWEEN TWO HEALTH GIANTS

What is at the root of the ongoing tension between the FDA and the NCI? Does competition between two national health agencies operating in a close and sometimes overlapping policy area have positive or negative implications for the public? This study addresses the rivalry between the FDA and the NCI that arose in the early 1970s and its impact on public health until the present.

The research presents in detail the first two instances of conflict between the FDA and the NCI that led to ongoing rivalry between the two organizations.

The first case of tension was sparked in 1970 by the NCI's desire to oversee new clinical trials of a new class of chemotherapeutic treatments. In response, FDA officials, concerned with maintaining their authority over all clinical trials, aggressively attempted to rewrite regulations governing clinical trials for combination chemotherapy. The second case arose in 1973 when a study at the University of Chicago confirmed suspicions linking thyroid cancer in adulthood to irradiation treatment for a variety of infectious and inflammatory diseases in childhood such as enlargement of the thymus gland, hypertrophy of tonsils and adenoids, ringworm and acne. The NCI responded with a media campaign warning the public of the long-term risks of therapeutic irradiation. Both cases were linked to cancer-related issues which resulted in conflict between the two agencies.

Based on official protocols, formal announcements, court rulings, newspaper archives, and other documentary evidence, this study describes how competition developed between the FDA and the NCI – rivalry rooted in their closely-related and sometimes overlapping policy areas.

LEARNING OBJECTIVES:

1. What effects do health agencies operating in a closely related policy area have on each other?
2. What obligation do medical institutions have to warn their patients of the possible consequences of medical treatment even after a long time has elapsed?
3. What was the sequence of events that led public health organizations such as NCI to expose the risks of radiation treatment to the public, and why did the FDA avoided such action?

STEPHEN BEITLER

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FROM SENSATION TO EXPERIENCE: CHANGING NOTIONS OF PAIN AFTER 1945

Since its publication in 1975, the McGill Pain Questionnaire (MPQ) has become the most widely deployed pain measurement tool in the world. It has been translated into more than 50 languages and used in more than 500 studies of acute, chronic, and laboratory-induced pain. Developed primarily by Canadian psychologist Ronald Melzack, the MPQ's cultural and linguistic assumptions, its multidimensional model of the pain experience, and its utility across patient groups and medical settings have been the subjects of hundreds of studies by clinicians and social scientists. The history of the MPQ is an instructive chapter in the larger story of how the understanding and treatment of pain have evolved among medical professionals and their patients.

The MPQ uses structured word groups, drawings, and questions to help patients describe how their pain feels, its intensity, and the emotional reactions it produces. The paper examines how the MPQ's content and structure articulated a significant shift in the medical and cultural understanding of pain that emerged after World War II. This shift was from a notion of pain as a uniform stimulus-and-response mechanism to a concept of pain as fundamentally subjective, extremely diverse, and shaped by an individual's cognitive and emotional circumstances. This change was driven by a convergence of neurophysiological research, clinical experience, and theoretical contributions from a group of physicians and scientists whose experiences in World War II, and with patients whose pain did not yield to simple categorization, were crucial in developing a more complex conception of the pain experience.

The paper argues that the MPQ embodied an emerging concept of pain that increasingly matched the experiences of doctors and patients after 1945. The career of the MPQ, which is part of the history of pain measurement that encompasses dozens of scales and procedures, has reflected broader issues in how medical knowledge of pain has evolved and how changes in the clinician-patient dynamic in the explanation and management of pain have occurred. The history of the MPQ provides a rich window on the evolution of pain from sensation to experience.

LEARNING OBJECTIVES:

1. To show how changes in the measurement of pain have affected the understanding and treatment of pain.
2. To articulate the significance of the McGill Pain Questionnaire (MPQ) in the history of pain measurement.
3. To connect historical understanding of the MPQ to larger cultural currents in drug-taking, self-directed pain management, and changes in medical authority in the 1970s.

ADAM BIGGS

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DEMENTIA AMERICANA: BLACK DOCTORS AND THE PROBLEM OF RACIAL SCIENCE

In 1910, Thomas Murrell, a medical doctor serving at the Genito-Urinary Dispensary of what is now Virginia Commonwealth University, published an article in the "Journal of the American Medical Association" characterizing African Americans as a degenerate disease-soaked race unfit for modern society. Murrell's article was one in a long line of medical reports that portrayed African Americans in denigrating terms, reflecting the racist stereotypes commonly associated with the Jim Crow era. Later that same year, a cadre of black doctors responded, questioning the rigor behind his study. The editor-in-chief of the "Journal of the National Medical Association," Charles Roman, argued Murrell's and similar works reflected, not objective scientific analysis, but racial prejudice. Characterizing the article as a thinly veiled effort to disparage African Americans and justify discrimination under the guise of scientific authority, Roman called attention to the study's flawed reasoning and its grossly distorted depictions of African-American health. Unlike a traditional academic work, however, Roman's response took the form of a polemic, using sarcasm, satire, and caricature to illustrate his point. According to Roman, after reviewing many such works, he had uncovered a previously unknown disease peculiar to Southern whites termed, "Dementia Americana," which led its victims to become wholly irrational when dealing with matters of race. Simply mention the word "Negro" to an afflicted individual, he wrote, and regardless of educational background or social status he "at once loses his intellectual bearings. Passion supersedes judgment, prejudice usurps the throne of reason, and opinion subverts evidence." Contending "Dementia Americana" had clearly afflicted Murrell, Roman played off the evolutionary implications of mental health disorders to suggest that, rather than sick black Americans, it was prejudice white Southerners who were unfit for society.

Roman's response provides a unique opportunity to explore the contours of racial reasoning in early-twentieth century medical science. Focusing on this exchange, my paper explores the different ways African-American doctors responded to derogatory studies of African-American health as part of their larger efforts to use professional medicine as a tool to advocate for racial improvement and address the problem of race in medicine.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history.
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education.
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.

ROBERTA BIVINS

University of Warwick, Coventry, UK (1)

'EAT WISELY, FEEL LIVELY': IMAGES, ETHNICITY & ASSIMILATION IN BRITISH HEALTH EDUCATION, 1970-85

As Britain's diverse South Asian communities developed from migrant enclaves to settled multi-generational ethnic communities, local, regional and central authorities created a rich body of educational materials specifically targeted towards their perceived health needs. Read alongside the internal documents charting their construction, health education pamphlets, films, posters and other documents reveal the changing (and sometimes unchanging) assumptions made by British medical authorities, practitioners, researchers, and health educators about communities initially treated as culturally static and inherently non-compliant. Using these sources, I will argue that models of medically-driven assimilationism persisted well into the era of official multiculturalism. I will explore the ways in which these models -- promoted by some divisions of the medical state even as an alternative discourse of 'race relations' gained the sanction of law -- were challenged or supported by local efforts to end health disparities.

I will show that ethnic community organisations, changing biomedical perceptions of the 'British diet', and the increasingly evident 'politics of race' in Britain destabilised the long-standing conflation of hygienic citizenship with assimilation to 'British' norms. However, they could not eradicate it altogether. Instead, officially sanctioned visual representations of health and healthfulness still presumed that migrant and ethnic communities would and should adopt 'British' dietaries and cultural practices. Such views persisted even in health education materials and interventions specifically designed with 'cultural translation' in mind. Moreover, they survived despite increasingly strenuous efforts on the part of a wide range of actors to produce better information about different British South Asian ethnic communities, their quotidian health behaviours, and their self-perceived health needs and goals. The medical literature, and educational materials prepared for health professionals reflect similar trends and assumptions. Finally I will discuss what these historical interventions have to tell us about contemporary representations of 'Asian' (and other ethnically-marked) health practices and behaviours, and current approaches to health education for communities often still facing an uphill battle against persistent health inequalities.

LEARNING OBJECTIVES:

1. Identify successes and failures in the history of health education and public health campaigns, particularly in relation to cross-cultural medical encounters and health interventions;
2. Develop an historically informed sensitivity to the diversity of patients (including in particular an appreciation of interactions between class, socio-economic status, and ethnicity);
3. Respond to the demands of working in a multi-disciplinary and multi-ethnic healthcare team, guided by a historically informed concept of professional responsibility and patient advocacy.

WINSTON BLACK

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POPULARIZING MEDICINE IN THIRTEENTH-CENTURY EUROPE: THE EVIDENCE FROM SERMONS

Thirteenth-century Europe witnessed a medical revolution, in which the teaching and practice of medicine were increasingly rationalized, institutionalized, and professionalized, and claimed as the prerogatives of a literate, male elite. Most historians have focused on the formal writings of a handful of university-trained physicians in order to tell the story of this revolution. Yet equally important for the history of medicine were the methods by which scholastic medicine was broadcast to a wider audience; scholastic medicine would not have succeeded if it had not been accepted as intellectually and economically valid by a significant portion of the population, at least in urban areas. One of those methods came in the form of sermons delivered by bishops and mendicant friars, in which references to medicine became common in the thirteenth century. While preachers had used medical metaphors, like "Christ the Physician", since at least the third century AD, it is only in the thirteenth century that preachers expected a detailed knowledge of medicine from their audiences. Many thirteenth-century bishops and friars, while not usually trained in medicine, had nonetheless studied in the new universities such as Paris, Bologna, and Oxford, where rationalized medical knowledge formed a key part of their requisite training in philosophy. In this paper I will examine references to medicine and healing made in the sermons of the bishop of Paris William of Auvergne (c.1180-1249) and the Dominican friars William Perault (c.1190-1271) and Jacobus de Voragine (c.1230-1298). All three preachers make frequent and elaborate use of medical terminology and metaphors, including discussion of Christ's bodily humors, forms of medical practice, types of fever and paralysis, treatments of wounds and pain, and theories of generation, digestion, and physiology, all in the service of delivering a moral or theological lesson. These sermons demonstrate that their authors had an expansive knowledge of contemporary, academic medicine, and that they expected their audiences, be they lay or clerical, to recognize and appreciate that knowledge. Sermons can thus serve as a gauge for measuring the extent to which academic medicine had permeated European society in the later Middle Ages.

LEARNING OBJECTIVES:

1. Demonstrate the medical knowledge of educated clergy in thirteenth-century Europe.
2. Outline the application of scholastic medical ideas in the context of popular, religious sermons.
3. Examine the viability of sermons as a window onto popular knowledge of scholastic medicine in the thirteenth century.

ELLIOTT BOWEN

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"HOW INTIMATELY ARE CONNECTED THE MEDICAL AND SOCIAL ASPECTS": OLIVER C. WENGER, THE UNITED STATES PUBLIC HEALTH SERVICE, AND THE EVOLUTION OF VD CONTROL STRATEGIES IN HOT SPRINGS, ARKANSAS, 1921-1936"

To date, the life and work of Oliver C. Wenger has been understood primarily through examinations of his involvement in the Tuskegee Syphilis Study (1932-72) and the Chicago Syphilis Control Project (1937-40). Before becoming involved in either of these projects, Wenger was the head of the Hot Springs (Arkansas) VD clinic, a government-run treatment center the public health official directed for sixteen years (1921-36). Drawing upon Wenger’s published and private papers, this study tells the story of the federal government’s anti-venereal endeavors in a city known throughout the United States as the “Mecca of the American Syphilitic.” In doing so, it presents a more complex picture of Wenger and shines new light on the early-twentieth century disease-control efforts of the Public Health Service, a federal agency whose efforts to eradicate syphilis have often been depicted as callous, coercive, and unresponsive to the problems faced by the nations’ venereally-afflicted men and women. In Hot Springs, a different dynamic prevailed. Over the course of his tenure as clinic director Wenger crafted a VD program designed to address the day-to-day concerns of his syphilitic patients, individuals whose circumstances - in addition to the cataclysmic economic downturn that was the Great Depression - had an immense influence on this southern city’s response to syphilis. Over time, his encounters with Hot Springs’ venereal visitors prompted Wenger to stress the environmental determinants of America’s VD “epidemic,” and thus to focus his disease-fighting efforts on the social and economic causes of syphilis – a malady whose causes and cure the PHS official increasingly conceived of not in terms of germs and drugs, but instead in terms of food, shelter, and other subsistence needs. Reorienting the PHS’ anti-venereal strategies around the alleviation of poverty, the correction of certain structural faults in American society, and other environmentally-centered measures, Wenger’s experiences in Hot Springs raise interesting questions about the government’s VD control efforts, especially with respect to the role that moral concerns, racial beliefs, and gendered assumptions played in its campaigns to stamp out syphilis and gonorrhea.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Deepen our understanding of illness and suffering
3. Recognize the dynamic interrelationship between medicine and society through history

MARY AUGUSTA BRAZELTON

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FIGHTING EPIDEMICS IN WARTIME CHINA: THE RISE OF COMPREHENSIVE VACCINATION STRATEGIES IN SOUTHWEST CHINA DURING THE WAR WITH JAPAN, 1937 – 1945

The Second World War made vaccination a cornerstone of public health in China. When Japan invaded eastern China in 1937, the Nationalist government moved its wartime capital to Chongqing, in the southwestern province of Sichuan. Physicians, biomedical researchers, and medical students fled with the Nationalists to China's southwest borderlands. Many found refuge in Kunming, capital of Yunnan province. In this small city, a biomedical community emerged whose members focused their wartime work on the development of vaccines.

I argue that this gathering of biomedical professionals in wartime Kunming gave vaccination new meaning as a comprehensive, essential practice in twentieth-century China. These experts developed a variety of new vaccines that found widespread use, and which were later incorporated into nationwide health policies. The paper draws on archival research in Kunming, Chongqing, Beijing, and Shanghai, as well as the Archives of the League of Nations in Geneva.

While most studies of vaccination in China focus on the nineteenth-century introduction of Jennerian inoculation to port cities, my work demonstrates that research institutes in China's wartime southwest fostered programs that mandated both urban and rural public vaccination against a variety of diseases. As the war raged, plague and cholera outbreaks made immunization a new priority for disease prevention. The refugee National Epidemic Prevention Bureau (NEPB), led by bacteriologists Tang Feifan and Wei Hsi in Kunming, became a leading developer and producer of vaccines against many diseases, from smallpox to cholera, typhoid fever, and plague.

Vaccination revealed changing relationships between public health and medical science in wartime China. Because vaccines were used for therapy as well as disease prevention, their implementation required new, extensive cooperation among physicians, immunological researchers, and manufacturers. In Kunming, the NEPB worked with military medical teams, refugee medical students, and international agencies like the League of Nations-Health Organizations. Together, they supplied local health departments with materials and staff for immunization campaigns.

Ultimately, these cooperative efforts produced an enduring model for vaccination practices and policies. Wartime Kunming's biomedical community produced a strategy of mandatory, comprehensive, and multiple vaccinations for the public that became a fundamental part of health policy in postwar China.

LEARNING OBJECTIVES:

1. Understand the origins of vaccination's role in modern Chinese public health.
2. Realize the effects of the Second Sino-Japanese War on medicine and public health in China.
3. Analyze the contingent relationships between bacteriological research, clinical medicine, and public health in twentieth-century China.

HUGH CAGLE

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PRE-MODERN LEPROSY: AN IMPERIAL HISTORY OF CALCULATED IMPRECISION

Together, a century of microscopy and more recent genetic analysis have produced knowledge of the causal relationship between two pathogens of the genus *Mycobacterium* and the disease called leprosy. As the other two papers here suggest, the global history of leprosy since at least the late-nineteenth century is in part a story of precision. But much earlier too—according to recent scholarship on the period between the twelfth and seventeenth centuries—discussions of leprosy emphasized precision of various kinds, as university-trained physicians across Europe debated the identification, explanations, and categorization of what were often thought to be distinct forms of leprosy.

By contrast, this paper argues that when a disease termed “leprosy” first became a topic of concern among members of a global medical network, such an emphasis on precision was undesirable. The network in question was one that emerged as part of Portugal’s empire. Each theatre of Portuguese settlement produced reports of leprosy. Initial accounts of an illness termed “lepra” came from West Africa in the 1480s and from both Goa, India and Bahia, Brazil by 1550. These reports spurred the foundation of the Hospital of St. Lazarus—an institution focused on the care of patients afflicted with lepra—in the latter two locations.

And yet, although the identification of lepra and the maintenance of hospitals devoted to the care of those afflicted with it were empire-wide pursuits, the illness never became the object of concerted medical study. Why? I use evidence drawn from fifteenth and sixteenth-century colonial sources, including diagnostic terminology and descriptions of illness, together with archival material about the colonial missionary order (the Jesuits) often charged with running the St. Lazarus hospitals, to show how empire-wide political tensions and competing economic interests favored a more, rather than a less, capacious disease category.

The pursuit of imprecision characterized the first global discussion of a disease called leprosy. If we cannot be sure what exactly early modern observers saw, their accounts certainly raise the possibility that one or both of these *Mycobacterium* species were present on all three continents. How they got there and when remain open questions.

LEARNING OBJECTIVES:

1. Better understand the ambiguous nature of historical evidence related to the global history of health and disease
2. Recognize the dynamic interrelationship between medicine and society through history, in this case, particularly with relationship to contexts of colonial domination
3. Develop the capacity for critical thinking about the nature, ends and limits of medicine

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ADJUSTING FOR PERSONALITY: THE MENTAL HYGIENE MOVEMENT IN TEXAS, 1940-1970

In the early 1900s, psychiatrists looked for a way to move beyond the walls of institutions for “the insane,” eventually succeeding in reaching a population of “normal” people whose everyday problems could be aided by psychotherapy. At the same time, ‘lay’ reformers took up the cause of “mental hygiene” for the masses as a public health issue on par with other kinds of preventive medicine. By the 1930s, the mental hygiene movement, influenced by eugenic and public health campaigns, had established child guidance clinics, state organizations to promote mental hygiene, campaigns to revise commitment laws, and widespread educational efforts aimed at communities, parents, and students. While historians have written insightfully about the popularization of psychiatric thought and practice, mental hygiene, the most direct predecessor of our contemporary “therapeutic culture,” has not received sustained historical attention.

This paper will look at the development of mental hygiene/health from 1940 to 1970 in Texas, which had one of the most dynamic state movements in the nation. The cause in Texas was led by the Hogg Foundation for Mental Hygiene, located at the University of Texas, Austin. Its leader, Robert Sutherland, was one of the most prominent sociologists and policy-makers in the country, active in race relations, prison reform, youth concerns, and mental health.

Using 30 years of Hogg Foundation records, my paper examines the organizational and intellectual impact of the movement. I argue that proponents succeeded in influencing popular discourse even though they failed to gain long-term institutional traction. The stigma of mental illness made possible “clients” wary of clinical treatment and many psychiatrists saw “public” efforts as contrary to self-interest. Yet the movement succeeded in spreading psychiatric theories of personality--and its “adjustment”—to the broader culture. Paradoxically, the sympathies held by Sutherland and other advocates toward the poor, racial minorities, and women were undercut by the profoundly functionalist theories they put into practice, as the movement came to equate psychological health with adjusting to the existing social order.

LEARNING OBJECTIVES:

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

PETER COLLOPY

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VIDEO THERAPY: SELF-CONFRONTATION AND THE DEVELOPMENT OF A PSYCHIATRIC TECHNOLOGY

In the middle of the twentieth century, psychiatrists adopted the new medium of video as a therapeutic technology. Although their first experiments were oriented towards pedagogy—showing psychotherapy to medical students and residents without their disruptive presence during a session—by the early 1960s psychiatrists began showing tapes from sessions to patients themselves. “Giving patients a chance to see themselves as others see them,” wrote Floy Jack Moore, Eugene Chernell, and Maxwell West, “will have a marked and beneficial effect on their degree of improvement.” In 1965, the three therapists demonstrated such increased improvement in a controlled study of 80 mental hospital patients, most diagnosed with depression and schizophrenia..

Psychiatrists interpreted this experience of watching oneself on a video monitor as self-confrontation, forced reflection upon one’s own behavior. Video had greater therapeutic potential than film, they argued, because it could be played back immediately. This meant a therapist “could play back their sessions during their sessions,” as sociologist Victor Gioscia suggested, providing instant feedback. A psychiatrist could also show a patient a single tape repeatedly, allowing them to explore deeper layers of their self-image, as psychoanalyst Lawrence Kubie advocated.

In introducing video to psychotherapy, psychiatrists were aware they were bringing a material technology developed for television into a space dominated by the social technology of psychoanalysis. “The development of video in psychiatry is comparable to the development of the microscope in biology,” wrote Milton Berger, providing the discipline with a new system of instrumentation and thus new phenomena to explore. Psychiatrists, Berger suggested, should join other medical specialists in outfitting their offices with technical equipment in order to offer more services to their patients and expand their own knowledge of the mind.

In this paper, I will draw on Berger’s 1970 edited volume “Videotape Techniques in Psychiatric Training and Treatment,” a 1973 issue of the art magazine “Radical Software” devoted to video therapy, psychiatric journal articles, and theses and dissertations in order to tell the story of video therapy in the context of related artistic, political, and educational uses of video that developed during the same period.

LEARNING OBJECTIVES:

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

JULIEN COMTE

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ABSTINENCE, SEX EDUCATION, AND SUBLIMATION IN THE UNITED STATES, 1900-1930

This paper examines the place of male abstinence in early-twentieth century US sex education materials. In particular, I focus on the debate over the health hazards of prolonged abstinence in order to analyze the contested nature of scientific truth.

I begin by examining the connections between reformers in different parts of the Atlantic world and how these connections shaped the emerging movement for sex education. The development of sexology helped legitimize the bourgeois aspirations of reformers like Prince Morrow, the founder of the American Society of Sanitary and Moral Prophylaxis. Drawing on this new body of medical knowledge, reformers in Europe and the Americas argued that abstinence was not detrimental to men's health. But despite what reformers like Morrow argued, the debate over the health hazards of abstinence had not reached a definite conclusion. In part due to the work of Sigmund Freud, some physicians on both sides of the Atlantic remained unconvinced that prolonged continence was harmless.

By pointing to the importance of sexual sublimation in US sex education programs, I argue that sublimation was one aspect of Freudian psychology that American sex educators were ready to embrace. Even if they preached abstinence, these sex educators remained ambivalent towards the ability of their fellow countrymen to exert self-control. Sports and other physical and mental outlets remained necessary. I use the poster series "Keeping Fit," launched in 1918 by the United States Public Health Service and the Young Men's Christian Association, to demonstrate this ambivalence.

Historians have been quick to read US sex education pamphlets as attacks on the "doctrine of necessity." But if we take into account the emergence and international spread of psychoanalysis, we see that sex education materials reflected the contested nature of emerging scientific understandings of male sexuality. Both sides of the debate on the health hazards of prolonged abstinence mobilized what they saw as cutting-edge science to support their argument, and both sides saw their facts as morally neutral.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

DAVID COURTWRIGHT

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ADDICTION NEUROSCIENCE AND HISTORY

Research breakthroughs in the last half century have made possible a new science of addiction and a new model of pathology. “The NIDA brain disease paradigm” holds that addiction is a chronic, relapsing brain disease with a social and genetic component, comorbidity with other mental and physical disorders, long-term changes in brain structure and function visible in imaging studies, and a defining loss of control over drug craving, seeking, and use despite adverse consequences. This paradigm currently dominates, and may one day unify, scientific work in the addiction field.

Drug history has likewise flourished over the last half century. The new social history, STS, cultural studies, freshly opened archives, and a growing concern with drug abuse has reenergized and redirected the field, which now has its own international organization and a growing reputation for innovative scholarship.

But the prospering scientists and busy historians have mostly ignored one another. Indeed, some historians have been actively hostile to addiction neuroscience. Like social scientists generally, they have criticized the NIDA paradigm as reductive, imperialistic, and allied to repressive drug policies.

I will examine these criticisms but also suggest ways in which historians might make effective use of the new addiction neuroscience, whose revolution resembles the one in internal disease a century before. Both fields were characterized by paradigm-shifting micropathological discoveries linked to advances in scientific instrumentation; gross oversimplifications and premature claims as well as lasting breakthroughs; and, initially, few practical therapeutic applications. These would come later for infectious diseases, and may yet come for drug abuse and addiction. Meanwhile historians can avail themselves of the new addiction science to throw light on such phenomena as the commodification, globalization, and transcultural popularity of dopamine-augmenting substances; the correlation between proximity to drug supplies and rates of use and addiction; the flexibility of different drugs’ demand curves; the commercial and social pairing of mutually reinforcing drugs like alcohol and nicotine; the frequency with which abstinence-oriented treatments have failed, or, conversely, why methadone and buprenorphine have produced superior clinical results in a variety of cultural settings.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends, and limits of medicine.
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education.
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.

ARTHUR DAEMMRICH

Harvard Business School, Boston, MA, USA (1)

VULNERABLE SUBJECTS, VULNERABLE KNOWLEDGE: LINKING CHILDREN’S CHEMICAL EXPOSURE TO HEALTH OUTCOMES IN THE UNITED STATES AND EUROPEAN UNION

Methods for identifying health risks in children – and the characterization of children as a vulnerable population – have undergone significant transformations in recent decades. Attention to the risks posed by industrial chemicals has expanded from waste to commercial products, and from surveying the environment for known toxins to mapping the ‘body burdens’ of hundreds of synthetic substances found in humans. While the outcomes of worker biomonitoring studies have been controversial for decades, methods including taking blood samples and tracking cancer rates were only rarely the focus of differences among regulators, industry, and academic scientists. By contrast, children’s studies proposed in the last two decades have been highly contentious and in many cases, testing initiatives failed as stakeholders disagreed over research methods and funding was politicized. This outcome is puzzling in light of the remarkable success of the multi-decade Framingham heart study, demands of NGOs for more research into chemical risks, and industry’s stated support for testing programs.

This talk describes findings from research into efforts to initiate long-term (typically fifteen year or longer duration) testing programs using children as subjects in the United States and Europe. In both settings, children came to be understood as vulnerable to synthetic compounds absorbed through breast milk or through exposure to cleaning compounds and plastic toys. Test methods, especially plans to recruit minority participants through financial incentives, proved more controversial in the United States than in the European Union. At the same time, different EU member states carried out competing studies and regulators found it impossible to integrate monitoring results. Furthermore, issues of cooperation among otherwise competing firms and between the industry and government regulators plagued efforts in the United States, while the complexity of fitting children’s testing into a major new regulatory framework for chemicals slowed testing in Europe. The talk thus presents an analysis of testing programs that is useful to practicing physicians and public health leaders and offers historical and comparative insight on initiatives intended to generate new regulatory knowledge that proved disruptive to existing governance systems and the social roles occupied by physicians, industry, government regulators, and health-oriented NGOs.

LEARNING OBJECTIVES:

1. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
3. Gain historical / analytical perspective on changing requirements for biomedical research, especially when involving children or other vulnerable populations.

DEANNA DAY

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Chemical Heritage Foundation, Philadelphia, PA, USA (2)

DOMESTIC THERMOMETRY AND PATIENT LABOR, 1873–2013

Katie Singer’s *The Garden of Fertility* is a widely-cited guide to the practice of natural family planning, the system by which a woman measures physiological signs like her temperature to track fertility. In the first chapter of this book, Singer describes this woman as an unexpected figure: a scientist. “In the same way that a meteorologist predicts weather by observing patterns of heating and cooling,” she writes, “a woman of childbearing age can observe her body’s fertility signals.” In the foreword, Justina Trott, M.D., confirms: “The fertility charts [in this book] shift authority over women’s health.... This is clinical research.” Over the past century, we have characterized the American patient primarily as a consumer, controlling her health by educating herself and exercising her rights at the point of sale. In this paper, I challenge this popular and scholarly assumption by arguing that the American patient has also been a scientific laborer, using the same tools, methods, and epistemology as her physicians.

I trace the history of this patient labor by following one particular consumer medical technology, the thermometer. After entering the home in the late-nineteenth century, the thermometer quickly became a tool primarily of women who performed health care for their families. Additionally, by midcentury the thermometer became an indispensable tool for determining women’s fertile periods. Both uses involved intimate, repetitive technological application. Understanding this practice as scientific medical labor, rather than as mere consumption of a technology, reveals the ways that patients have had their agency both enabled and constrained, helped to create scientific knowledge outside the laboratory, and profoundly reshaped their own subjectivities.

This paper builds on the literature on the history of medical technologies by arguing that, like the professional workers studied by scholars such as Howell and Sandelowski, patient laborers also experienced dramatic epistemological shifts during periods of technological change. I also draw on Nancy Folbre’s notion of caring labor and Rima Apple’s characterizations of scientific motherhood, extending these concepts to the work nonprofessionals perform. I use a range of primary sources including health care manuals, articles in women’s magazines, advertisements, and medical and corporate records.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the relationships between patients and medical professionals.
2. Acquire a historically nuanced understanding of consumer medical devices.
3. Recognize the dynamic interrelationship between medicine and society through history

DALILA DE SOUSA SHEPPARD
Spelman College, Atlanta, GA, USA (1)

"ESTABLISHING MEDICAL AUTHORITY IN THE LUSOPHONE COLONIAL EMPIRE IN AFRICA: 1850's-1950's"

My work has aimed to integrate the role of medicine in general, and of physicians' research and writing on race in particular, into scholarly discussions about the history of racial segregation and racism in Brazil. Recently, I began looking at medical literature on Lusophone African colonies as part of the history of Portuguese Imperialism in Africa.

Based on articles in the journals of the Instituto de Higiene e Medicina Tropical in Lisbon and on reports submitted to the Department of the Royal Navy and to the Department of Overseas Affairs, my paper will offer an analysis of Portuguese medical literature on the health issues of African and Portuguese populations in colonies their country controlled in the continent.

A preliminary content analysis of these articles and reports indicates that Navy doctors were among those in the very frontlines of Portugal's conquering armies as support staff to care for soldiers wounded in Guinea, Angola, and Mozambique.

Immediately following the very early stages of conquest, Navy physicians realized that they were confronted with the need to help soldiers survive another type of war wounds, namely those brought about by the African disease environment. Their reports clearly indicate their curiosity and anxiety about devastating tropical diseases. In the decades following these two initial phases of conquest, physicians played dual roles ensuring the viability of colonial society both for white settlers and for Africans hired to work in plantations, mines, and rural or coastal towns.

Those journals also indicate that these physicians maintained a vibrant correspondence and participation in meetings with their counterparts in France, England and Germany. These make clear that Portuguese physicians played significant roles in constructing a body of knowledge that contributed to the development of Tropical Medicine as a legitimate dimension of medical profession in the West.

Furthermore, their recommendations in official reports helped construct a narrative that established medical authority in shaping policy at the level of the colonial government and of colonial agrarian or mining companies from the early 1800's through the mid-1900's.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Understand the dynamic history of medical ideas and practices, their implications for patients of different race or national origin
3. Recognize the dynamic interrelationship between medicine and society through history

MICHELLE DIMEO

The College of Physicians of Philadelphia, Philadelphia, PA, USA (1)

LORI M. JAHNKE

Emory University, Atlanta, GA, USA (2)

DAVID JONES

Harvard University, Boston, MA, USA (3)

MAXIMIZING THE MEDICAL HERITAGE LIBRARY'S USEFULNESS FOR RESEARCH: NEW CONTENT, NEW TOOLS

The Medical Heritage Library (MHL), a digital curation collaborative among some of the world's leading medical libraries, promotes free and open access to quality historical resources in the health sciences. The MHL's growing collection of digitized rare books, pamphlets, journals, and films number in the tens of thousands, all of which are available through the Internet Archive. In 2011-2012, to gain a better understanding of user practices and how the MHL might serve unmet needs, we interviewed more than 50 researchers, faculty, students, administrators, and technologists on their use of digital content in research and teaching. In this lunch session, the MHL proposes an expansion of that conversation in two of the areas that emerged of greatest interest.

Collection development: The need for complete runs of journals, an issue that arose in interviews, was also emphasized by the MHL's Scholarly Advisory Committee. The MHL's current project, digitization of 6,000 volumes of historical medical journals from 1797 to 1923, responds to this concern. How should the MHL further develop its collection? We will seek audience feedback on the types of materials and topics that would be particularly beneficial to enable history of medicine to contribute to a deeper understanding of human health and society.

MHL data: Interviews revealed two types of use: context-oriented use, where researchers explore digital facsimiles as objects, paging through PDFs the way they would page through the physical object, and data-oriented use, where researchers, who are primarily interested in the information contained in the object rather than the object itself, access large amounts of content to assess its relevance, manipulate and transform content for use in a scholarly product, develop datasets using multiple sources and formats, extract data for maps, or create digital projects of their own. The MHL has downloaded and indexed the content and catalog records of its text-based holdings to create a prototype database. With this MHL dataset, data-oriented users can, for example, search for terms across the entire library. Other data-oriented functions, such as visualization, may be possible. We will demonstrate the database and seek audience feedback on its further development and use.

LEARNING OBJECTIVES:

1. Learn how to gain free access to quality pre-1923 material in the health sciences that will enhance the physician's understanding of the history of medicine
2. Develop a capacity for critical thinking about how we view digitized historical records, and how this shapes our understanding of the patient narrative
3. Conduct subject searches on professional branches of medicine to chart the development of professionalism across several hundred years

LORRAINE DONG

University of Texas at Austin, Austin, TX, USA (1)

RECORDS AS AGENTS: THE ROLE OF MATERIALITY ON THE LIVES OF AFRICAN AMERICAN PATIENTS IN A STATE MENTAL INSTITUTION

This paper will examine the impact of recordkeeping practices and the materiality of records on the medical and social treatment of mental institution patients. The research site is Central State Hospital (CSH) in Petersburg, Virginia. Originally named the Central State Lunatic Asylum for the Colored Insane, it remains an active state mental institution that is most notable for its role in African American mental health care in the United States. It was the first mental hospital specifically for African American patients when it was created in 1870. The author is currently involved in an archival project to preserve and provide access to the hospital's historical document collection dating from 1870 to 1970.

The CSH archives reveal a variety of materials and methods for organizing patient information that assisted hospital staff in maintaining a sense of documented order at the institution. The records are the result of the culture of classification in the psychiatric profession. On the other hand, the physical construction and design of the recordkeeping materials were arguably strong factors in determining what patient information was recorded or not, regardless of new diagnostic and administrative needs. For example, until the development of the case file in which documents could be placed in individual patient folders, there were only case books and registers. Such a switch in institutional record forms contributed to a change in both office recordkeeping practices and the archival corpus, providing a more detailed longitudinal picture into a patient's treatment and care.

The paper will argue that the official materials in which patients were documented were an ingrained and tacit part of the hospital culture at CSH. The keeping of records and the types of information considered worthy of recordings at any given time period affected the relationships between the various actors associated with the hospital network. The records acted as mediators between staff and patients, as well as administrators and staff. While the records cannot reveal the many facets of African American patients' lives at CSH, they do offer insight into how the record users (e.g., doctors and now us as historians) characterize mental institution patients.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history
2. Critically appraise clinical management from a historical perspective
3. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

HEATHER DRON

University of California, San Francisco, California, USA (1)

REINTERPRETING THE RISK OF CONGENITAL MALFORMATION: NEW DIRECTIONS IN RESEARCH ON ENVIRONMENTAL ETIOLOGY AND CHEMICAL EXPOSURE (1940-1971)

Teratology is an old field that gained new vigor in the mid-twentieth century as part of a resurgence of ecological thinking about disease. The rising interest in chemical causes of congenital anomalies in the 1960s was inextricably linked to dramatic deformities caused by the sedative thalidomide. In concert with a rising environmentalist movement, increased medical research on and intervention in pathological pregnancies redefined understandings of risk and hazard during pregnancy, with consequences for the health citizenship of the mother. This paper examines medical research on chemical exposure and congenital malformation in the mid-twentieth century, with an eye to how it shaped the way that governmental agencies, businesses, pregnant women, and advocates perceived and acted upon potential chemical hazards. It traces an increase in environmentalist concerns about teratogenesis combined with increasing scrutiny of the ecology of the womb and the behavior of the mother.

This study is based on the medical literature of the 1950s and 1960s. These books and articles show lively debate among clinical researchers, toxicologists, experimental pharmacologists, and epidemiologists about the environmental causes of congenital malformation. Chemical hazards were important in these debates, which had evolved from early 20th century studies of x-ray exposure and nutritional research on folate and vitamin A. The linking of rubella exposure to birth defects in 1940 sparked interest in the effects of the fetal environment on development. However, it was the dramatic malformations (including phocomelia) associated with exposure to thalidomide in 1960 and 1961 that refocused medical research on chemicals as a source of infant deformity. At this point, the term teratogen became associated with chemical exposure (instead of infectious disease, genetics, or other maternal malady). Public and medical interest in preventing birth defects shaped evolving concepts of risk that discouraged the consumption of drugs by pregnant women and led to self-regulatory patterns of behavior.

LEARNING OBJECTIVES:

1. Describe the primary concerns of medical researchers working on the environmental causes of congenital malformation in the mid-twentieth century.
2. Describe the ways in which epidemiologists, toxicologists, and experimental pharmacologists provided incomplete, conflicting or contentious information about what caused congenital malformations and how to prevent them.
3. Trace how these medical studies shaped understandings of risk and hazard associated with chemical exposure during pregnancy.

SARA DUBOW
Williams College, Williamstown, MA, USA (1)

FROM CONSCIENCE CLAUSES TO CONSCIENCE WARS: THE HISTORY AND POLITICS OF REFUSAL, 1973-2012

On June 18, 1973, President Nixon signed into law the Health Programs Extension Act, extending for one year the funding of a dozen public health programs. This law included the first federal conscience clause, which allowed physicians and hospitals receiving federal funds to refuse to perform abortions or sterilizations for reasons of religious belief or moral conviction. The conscience clause had been added to health bill earlier that year in an amendment proposed by Senator Frank Church. The Senate had passed it by 92:1, and the House of Representatives by 372:1. Over the next several years, almost every state would pass some version of a conscience clause. On August 1, 2011, the Department of Health and Human Services announced new guidelines that would require health insurance plans to cover contraceptives, including emergency contraceptives. Welcomed by public health experts, women’s health advocates, and Congressional Democrats, the recommendation was attacked by the United States Conference of Catholic Bishops, the Family Research Council, and Congressional Republicans. Despite the fact that the Obama administration included an amendment exempting religious institutions from offering contraception services, the Family Research Council issued a statement claiming that the decision “undermines the conscience rights of many Americans.”

Asking how something almost unanimously accepted in 1973 became such a partisan and contentious issue in 2011, “From Conscience Clauses to Conscience Wars: The History and Politics of Refusal, 1973-2011,” examines the origins, development, and consequences of so-called “conscience clauses,” or “refusal clauses,” that allow health care providers with moral or religious objections not to perform abortions or in some cases sell contraceptives. This paper will explain how and why these so-called conscience clauses have evolved since they were first put into law in 1973, and examines the periodic eruption of “conscience wars” in congressional debates, courtrooms, doctors’ offices, pharmacy counters, and public discourse. Debates over conscience clauses emerge at the fault line of American law, religion, medicine, and politics. Tracing this forty-year history reveals how the courts, legal activists, bioethicists, party politics, professional organizations, social movements and individuals have shaped this fault line in the context of reproductive health.

LEARNING OBJECTIVES:

1. What are the origins of conscience clauses?
2. What explains the fact that conscience clauses were so uncontroversial in 1973 and so controversial in 2012?
3. How and why have medical institutions and health care providers’ responses to conscience clauses changed over time?

JACALYN DUFFIN

Queen's University, Kingston, Ontario, Canada (1)

DRUG SHORTAGES IN THE 21ST CENTURY: RECENT HISTORY OF A MYSTERY

Temporary shortages of prescription drugs are not new. In 2008, however, patients and pharmacies across North America began reporting more severe shortages affecting more numerous drugs: some injectables; some pills; all older, cheaper, off-patent remedies, called “generics.” By 2010, the problem ballooned to crisis proportions for certain conditions. Cancer patients went without chemotherapy and anti-nausea agents. Children with epilepsy could not find anticonvulsants. Anesthetics, anti-depressants, painkillers, and anti-Parkinson drugs disappeared, sometimes for weeks, sometimes months. Pharmacists suggested more expensive, brand-name products as substitutes. Shortages are now reported in Africa, Australia, Europe, South America, and India; the latter is facing a lack of anti-malarials for children. The U.S. Food and Drug Administration (FDA) tracked missing drugs, and in October 2011 President Obama issued an executive order requiring manufacturers to provide six months notice of shortages, or face heavy penalties.

Using media reports, scientific articles, interviews, government documents, and the evidence of previous shortages from as early as World War II, this paper will trace the history of the current drug shortage crisis. It will also delve deeper into the pharmaceutical past to identify potential causes. Some causes entail scant raw materials and business decisions about their uses. Some affect products with short shelf life. Some result from the long-standing division between the so-called, research-based pharmaceuticals and generic companies. Some stem from lower prices set by Medicare and the anti-trust behavior of large Group Purchasing Organizations. Following the global economic crisis of 2008-9, lax manufacturing standards led the FDA to issue more warnings requiring factory improvements that, in turn, provoked more slowdowns. In June 2012, a congressional committee blamed the FDA.

Curiously, governments have been loath to tackle the problem by exposing its root causes; none are mapping its extent. Media reaction to each acute shortage silo’s them by disease or region; interest wanes when “nobody dies.” In June 2012, bioethicists at Emory U hosted an international conference to determine ways to cope with unavailable drugs. But proposals to mitigate the consequences do not address the causes, which remain a mystery. The paper closes with health policy implications of this historical research.

LEARNING OBJECTIVES:

1. To recognize the history, patterns, and extent of the global drug shortage of the early 21st century.
2. To identify the possible causes for these shortages in the recent and more distant past.
3. To recognize how historical research methods can provide data with crucial implications for health policy.

ZIV EISENBERG

Yale University, New Haven, CT, USA (1)

A MAN'S PLACE IS IN THE KITCHEN: MEDICAL EXPERTS, PREGNANT WIVES, AND THE RECONFIGURATION OF EXPECTANT FATHERHOOD IN THE UNITED STATES, 1930S-1950S

Between the 1930s and 1950s, American husbands were offered newly active roles in responding to their wives' pregnancy and the birth of their newborn. Through pregnancy classes and prescriptive literature designed specifically for "expectant" fathers, pregnancy experts taught men to become better husbands and fathers by helping their wives practice prenatal care and by performing traditionally-female household tasks like cooking, changing diapers, and bathing their baby. This paper uncovers the dilemmas, anxieties, hopes and determination of expectant men, who challenged the traditional gendered division of domestic labor and sought to demonstrate that cooking for their pregnant wives or changing a diaper were symbols of robust masculinity rather than feminization.

The new attitudes toward men's place in their households were a response to the Depression's destructive impact on families. Since breadwinning was a husband's traditional source of authority, unemployed and underemployed men lost their confidence and sometimes the respect of their families. Believing that the American democracy depended on strong families, experts framed modern fatherhood as therapeutic, an opportunity for a man to prove his value and create strong marital and paternal bonds. For men who struggled to earn money and tried to maintain or regain their masculine identity and authority, the whole nine months of pregnancy and the arrival of a new baby became unique opportunities to keep busy and find a new purpose in life.

This paper converges with recent studies on the broader history of men's role in reproduction, and challenges scholarship on American families, which tends to marginalize the place of medical expertise in the lives of married expectant parents. In examining the history of parenting, family historians have often concentrated on the work of social sciences-trained experts (with the exception of psychiatrists). However, obstetricians, gynecologists, general practitioners, nurses, and other medical experts had a profound impact on couples during the prenatal months, a critical period in which expectant parents had formed and performed a parental identity. My project opens a new window into the production of medical knowledge and its impact on family dynamics and gender relations in a tumultuous period in modern American history.

LEARNING OBJECTIVES:

1. Deepen understanding of pregnancy
2. Understand the dynamic history of ideas about women's bodies and gender roles
3. Recognize the dynamic interrelationship between medical experts and society through history

RACHEL ELDER

University of Pennsylvania, Philadelphia, PA, USA (1)

MAKING SEIZURES SAFE: ACCIDENT, IMPAIRMENT, AND THE SCHOOLYARD INVENTION OF EPILEPTIC STOICISM IN POSTWAR DETROIT, 1945-1956

In the years immediately following World War Two, staff and students at Detroit’s White Special School, the first public school for epileptic children, embarked upon a novel project to prove the relative safety of seizures and seizure-prone bodies. Abruptly reversing earlier protocols designed to insulate and protect epileptic students, postwar pupils were suddenly sent on fieldtrips, enrolled in sports, and granted permission to travel the hallways unattended. The school’s administration compiled numerous reports attesting to the statistical rarity and harmlessness of convulsions and circulated them widely to educators and industry. These developments marked a significant transformation in the conceptualization of epilepsy, its perceived dangers, and the relationship of seizure sufferers to society. Equally, however, such changes reflected a broader shift in what it meant to be safe in the postwar era.

Taking the White Special School as a case study, my paper examines seizures in the context of a safety-saturated postwar America. After World War Two, I suggest, safety emerged as the premiere framework through which epilepsy and “the epileptic” were understood; paramount was the question of whether or not such bodies could be “safe.” Yet, while historians of medicine have long considered issues of therapeutic and environmental risk, such studies have tended to regard safety as a standard addressed by medical professionals rather than an expansive cultural category negotiated largely beyond the purview of medicine. At the White School, however, where numerous material and social strategies emerged in addition to medical treatment, I argue that the perspective of safety reveals more of epilepsy’s actual management, lived experience, and way in which disease categories are made and remade.

To better understand how a group of lay and medical actors constructed and navigated seizure safety in the postwar period, I draw upon Detroit Public School records and associated medical documents, as well as wider newspaper and popular magazine sources. I place this uncharted history in the broader contexts of safety debates, child protectionism, and the significance of seizures and their containment in postwar America.

LEARNING OBJECTIVES:

1. To place a medical condition in the broader cultural context of safety
2. To consider non-medical management strategies of illness and disability beyond the clinic
3. To understand something of epilepsy’s currently uncharted social history in the second half of the twentieth-century

MICHAEL FLANNERY

University of Alabama at Birmingham, Birmingham, AL, USA (1)

THE MEDICAL LIBERTARIANISM OF ALFRED RUSSEL WALLACE: AN ALTERNATIVE BIOLOGICAL NARRATIVE FOR THE VICTORIAN AND EDWARDIAN ERAS

Alfred Russel Wallace (1823-1913), naturalist and explorer of South America and the Malay Archipelago, secured his place in history by independently discovering the theory of natural selection. His letter outlining the theory was sent from Ternate in eastern Indonesia and received by Charles Darwin (1809-1882) on June 19, 1858, prompting the now-famed evolutionist to rush his languishing manuscript to press. Wallace’s contributions to evolutionary biology, biogeography, and anthropology have been the subject of numerous studies. Formerly dismissed as a crank for his commitments to spiritualism, land nationalization, and other heterodox beliefs, Wallace’s reputation has more recently been refurbished. Nevertheless, his medical beliefs have received less attention. This paper will examine what is best described as Wallace’s “medical libertarianism,” a phrase that in light of his leftist views warrants explanation.

Wallace’s political views are crucial to understanding his role in the medical arena of his day. Long sympathetic to the left, Wallace openly declared for socialism in 1889. Ever the independent thinker, however, he was wary of centralized coercion; individualism and personal liberty were always important counterbalances to the collective good. In the *Christian Socialist* (1884) he insisted that “the tyranny of capital over labour” could be alleviated “by carrying out the true system of laissez-faire, now so much abused as if it had failed, when really it has never been tried.” Calling his curious position “logically unassailable,” Wallace never recanted.

Wallace’s socialism often obscures the significant and recurrent libertarian themes in his thinking, which are most obvious in his vocal and unwavering alliance with William Tebb (1830-1917) and the anti-vaccination movement and his equally vocal and unwavering opposition to the rising eugenics movement. By examining Wallace’s writings, especially his *Forty-five Years of Registration Statistics* (1885), *Darwinism* (1889), *Man’s Place in the Universe* (1903), and his *Social Environment and Moral Progress* (1913), his medical libertarianism—not just expressed as a contrarian nihilism but more positively as a progressive vision toward personal freedoms culminating in women’s liberation—will be placed against the larger context of reductionist scientism and intrusive social Darwinism in the Victorian and Edwardian eras.

LEARNING OBJECTIVES:

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

LARA FREIDENFELDS

Princeton Research Forum, Princeton, NJ, USA (1)

Independent Women Scholars' Salon, Cambridge, MA, USA (2)

ABORTION DEBATES AND EARLY PREGNANCY LOSS: "LIFE," "CHOICE," AND LOST BABIES

As I have previously argued, over the course of the twentieth century, Americans developed a new discourse around early pregnancy loss. What had previously been a late menstrual period, or a suspected pregnancy which simply failed to gel into a real pregnancy, has become an early miscarriage, and for many Americans, the loss of a child. A range of social, cultural, medical, technological and demographic changes contributed to this shift. In this paper, I examine specifically the role played by the Roe v. Wade decision and abortion debates from the mid-1960s through the present as one of the most profound shapers of this new discourse. I consider five aspects of the abortion debates' influence:

1. Once abortion was legal, safety issues receded, and moral questions about the status of early pregnancy could come to the fore.
2. The pro-life movement developed a position that "life" begins at conception, and then in popularizing that position, often talked about a "baby" from the moment of conception. This rhetorical shift masked the fact that more often than not, conceptions do not result in full-term babies.
3. The pro-choice movement adopted the language of "choice" in reproduction. "Pro-choice" came to stand for a wide range of claims about autonomy and bodily integrity. This language masked the lack of choice in miscarriage and infertility.
4. In the context of the abortion debates, pregnancy became a topic of public discussion. Young people first thought about the meaning of pregnancy as an abstract moral issue, often long before they were contemplating having children. Pro-life adherents learned to think of every conception as a baby, before they were actually considering and experiencing their own pregnancies. For pro-choice adherents too, embryos became abstract objects of moral consideration, "real" entities they might otherwise never have contemplated as such without the abortion debates.
5. Imagery and language from the pro-life movement was folded into the emerging pregnancy loss support movement. The pro-life movement had created a discourse of sadness and regret around ended pregnancies, and it was easily modified to be comforting for those who had unwillingly had pregnancies end.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history
 2. Understand how the words and concepts patients use to describe their experiences, in and out of the clinic, shape their emotional responses to health issues
 3. Recognize that seemingly abstract moral and political debates may powerfully shape patients' experiences of health issues, and that the impact of culture and politics may vary by religious conviction and cultural background
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XAQ FROHLICH

Northeastern University, Boston, MA, USA (1)

FOOD OR DRUG?: THE 1960S 'CHOLESTEROL CONTROVERSY' AND PROFESSIONAL DEBATES OVER RESPONSIBILITY FOR EATING VERSUS TREATING

This paper examines the debates among physicians associations, food companies, and the U.S. Food and Drug Administration in the late 1950s and 1960s over whether to allow health claims on foods regarding their polyunsaturated-to-saturated fatty acids content, or “P/S” ratio, and its relationship to heart disease. The paper describes the emerging medical, followed by popular interest in this period in the “diet-heart thesis,” the argument that there was a correlation and thus a link between certain diets and incidences of heart disease, and then examines how that interest was translated into new advertisement campaigns for products like vegetable cooking oils and special margarines. For businesses, such health food campaigns provided an avenue for the diversification of “taste” through the diversification of new product lines, creating demand when consumers already had “the basics”; but it created headaches for the American Medical Association and FDA regulators who were in the process of completing new and stricter drug labeling rules, and sought to maintain a neat division between ordinary food products for ordinary consumers, and the category of “special dietary food” products for special groups like patients. In part, the stakes were institutional: should consumers be empowered to take dietary decisions into their own hands, or does this subvert the role of the doctor in treating a patient? But the debate was also an argument about what was meant by an “ordinary” consumer and “risky” food.

This colorful chapter in the history of food labeling presaged a variety of concerns today with “nutritionism” and the obesity epidemic, as well as FDA interest in “black box warnings.” It also raises interesting scholarly questions for how businesses reconstitute medical knowledge and seek to exploit medical expertise, thereby reshaping popular understandings of diet and health. Using the case of the “cholesterol controversy,” it explores how organizations like the FDA and AMA negotiate the boundaries, in both legal and public health terms, between what is (mere) information, (desirable) education, or (misleading) puffery, and more broadly, what ought to be the role of public versus private institutions in shaping people's personal eating habits.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine.
2. Recognize the dynamic interrelationship between medicine and society through history.
3. Understand the important role of markets and marketing in popularizing, but also problematizing medical knowledge.

CAITJAN GAINTY

University of Wisconsin, Milwaukee, Milwaukee, WI, USA (1)

THE “SMOOTH FLOW” OF BIRTH: STREAMLINING AND THE OBSTETRICAL OEUVRE OF JOSEPH B. DELEE, 1930-1940

In the 1930s, a new form of birth was born: the streamlined birth. Drawing on the contemporary streamlining design trend, itself an aestheticization of the late 1920s engineers’ charge to attend to the aerodynamicity and thus efficiency of planes, trains and automobiles, the streamlined birth encapsulated the great power of the streamlined aesthetic in material, medical form. Both for its emphasis on painlessness and forgetfulness in the process of childbirth and for its “smooth flow,” meant to call to mind the ideal state of biologic functions, the streamlined birth came to seem a quintessentially modern birth experience.

The streamlined birth demonstrated that medicine could effectively transform one biologic state into another in a way that seemed to improve immensely upon nature. Unlike surgery, there were no long periods of recovery and recuperation, no scars or debility, no signs that anything had changed, save the shifted position of the baby from inside to outside. A pregnant woman was transformed into a new mother in what purportedly felt to her like an instant.

In the particular hands of Joseph B DeLee, often identified as one of the chief proponents of this method, the great power of the streamlined birth was reproduced and reiterated even more emphatically in filmic terms, through the canon of films of childbirth DeLee made over this period. In these films, we see not the eschewal of the natural for the artificial, but DeLee's optimistic attempts to re-create a proxy for "natural" childbirth through the manufactured reality made possible by the still-new technology of the motion picture camera.

Though we tend now to see DeLee's work, and the streamlined birth movement more generally, as anathema to natural childbirth, this presentation offers a glimpse of a moment when natural and artificial were not diametrically opposed but were instead irrevocably related.

LEARNING OBJECTIVES:

1. To think critically about the nature of medicine as a cultural and medical enterprise
2. To understand the history of medical ideas and practices and their sometimes radical changes over time as a way of gaining perspective on current medical ideas and practices
3. To understand the kind of power that non-medical technologies have had and continue to have in the shaping of medical practice, for both patients and physicians alike.

MARTHA N. GARDNER

Massachusetts College of Pharmacy and Health Sciences, Boston, MA, USA (1)

“OVERDOING” AND “FAILURE TO DO”: THE ROLE OF THE NURSE IN THE CONTROL OF STAPHYLOCOCCAL INFECTIONS IN AMERICAN HOSPITAL NURSERIES, 1950S-1970S

On loan from the US Children’s Bureau, public health nurse and infection control expert Margaret W. Thomas conducted extensive research into the current “Nursing Procedures in the Management of Staphylococcal Infections” for the CDC in 1959. This investigation was prompted in part by the numerous letters that nurses had written to the CDC requesting guidance about appropriate infection control techniques in patient care. The nursing staff at the CDC had found it difficult to provide such guidelines “with integrity” because of the lack of evidence available. In the ensuing study of thirteen teaching hospitals (focusing specifically on their newborn units), Thomas concluded that the CDC still could not be “dogmatic” about what proper procedures to recommend. Current hospital practices, she had found, were highly variable, and did not illustrate clearly what methods were best. Sometimes, staff “overdid” it, doing things like washing down the walls of the nurseries with a hexachlorophene solution when there was no indication that such a measure did anything. At other times, staff failed to do enough, leaving up heavy curtains without routinely dusting or disinfecting them. Which methods worked best was impossible to determine in light of rampant inconsistency.

Underlying this confusion was a widespread divide in the hospital community between those who advocated new antimicrobials like the hexachlorophene-infused pHisoHex and those who focused upon the traditional hygiene practices that predated them. On the one hand, many had embraced new antimicrobial cleansers. These advocates turned to the visual and imaginative appeal of a chemical that could wipe out deadly staphylococcus germs. On the other hand, others used rhetoric of the nurses’ responsibility to maintain cleanliness and care. They warned that the effect of antimicrobials was unproven, and cautioned that their use too often resulted in the neglect of less exciting, traditional hygiene practices. This paper explores the tension between these two camps, and the difficulty of designing and implementing an effective infection control program in this period of great concern over resistant staph infections.

LEARNING OBJECTIVES:

1. To understand the nurse's role in US hospital nursery infection control, 1950s-1970s
2. To explore American nurses' and physicians' attitudes concerning synthetic antimicrobials, 1950s-1970s
3. To understand the epidemiology of and attitudes about staphylococcus spread in US hospital nurseries, 1950s-1970s.

DANIEL GOLDBERG

Brody School of Medicine/East Carolina University, Greenville, NC, USA (1)

TRUTH, DOUBT, & OBJECTIVITY: SILAS WEIR MITCHELL, JOHN KEARSLEY MITCHELL, AND CONCERNS REGARDING PHANTOM LIMB PAIN IN MID-TO-LATE 19TH C. U.S. NEUROLOGY

This paper claims that the views of Silas Weir Mitchell and his son John Kearsley Mitchell on phantom limb pain reveal the immense conceptual difficulties pain without lesion represented for mid-to-late 19th c. U.S. neurological paradigms. These difficulties contributed to the increasing dubiety with which both lay and professional observers regarded such pain over the long 19th c. Building on the author's prior work on the history of pain without lesion in the U.S. and Britain, the paper contextualizes changing views of such pain within the contemporaneous rise of what Lorraine Daston and Peter Galison term 'mechanical objectivity.' Specifically, the paper analyzes how the epistemic and veridical components of mechanical objectivity influenced understandings of phantom limb pain. Because under mechanical objectivity, natural objects were invested as sites of Truth, the veracity of illness and disability increasingly became a function of material dysmorphologies and lesions. In their absence, observers often lodged skepticism regarding the pain and nervous ailments about which sufferers complained.

The paper draws from a variety of primary sources including papers and private correspondence of both Mitchells, journal articles and treatises authored by each, and documents relevant to Weir Mitchell's Philadelphia-based clinical care of neurological patients. The paper analyzes a set of surveys the Mitchells administered to amputee veterans in the 1890s regarding their experiences with pain and nervous disease, offering a rare glimpse of late 19th c. patient narratives of phantom limb pain. When juxtaposed with the Mitchells's attempts to account for such pain, the surveys show the tension with models of medical science increasingly predicated on the existence of discrete pathologies that could be clinically correlated with illness complaints.

The paper concludes by noting that while Weir Mitchell is well-remembered for introducing the phrase 'phantom limb pain' into white, bourgeois American vernacular, it is often forgotten that he helped do the same for the phrase 'malingering.' The paper shows that issues of veracity and skepticism surrounding pain without lesion in mid-to-late 19th c. America cannot be apprehended without a deeper understanding of the Mitchells's perspective on phantom limb pain and the rise of mechanical objectivity.

LEARNING OBJECTIVES:

1. Describe some of the difficulties Silas Weir Mitchell and John Kearsley Mitchell experienced in accounting for phantom limb pain;
2. Articulate the connection between changing views of pain without lesion and the rise of mechanical objectivity in the mid-to-late 19th c. U.S.;
3. Describe links between concerns over malingering and pain without lesion in the mid-to-late 19th c. U.S.

MONICA GREEN

Arizona State University, Tempe, AZ, USA (1)

DISCOVERING A DISCOVERY: THE TWO NEW GLOBAL HISTORIES OF LEPROSY

The first publication announcing the proposed “new” leprosy bacillus, *Mycobacterium lepromatosis*, appeared in 2008. I would not learn of this proposed new species, identified by Xiang Yang Han, until 2012, when I was finalizing a course, “Health and Disease in the Middle Ages,” which examined the medieval history of leprosy in detail. Discovering Han’s discovery, I experienced a cascade of revelations that pushed me through a framework for thinking about global disease that I had already created for another course, “Global History of Health.”

This “global framework” involves thinking deep and thinking broad. Because *M. lepromatosis* was first described on the basis of its genetic difference from the “old” leprosy bacillus, *M. leprae* (discovered by Hansen in 1873), it was immediately obvious that it must be very old. *M. leprae*, first fully sequenced in 2001 with major phylogenetic studies appearing in 2005 and 2009, had almost ceased to evolve, so comfortable was it in the niche it had found in humans. Any speciation event that resulted in *M. lepromatosis* must have happened a very long time ago.

Second, thinking broadly, the fact that the clinical condition, diffuse lepromatous leprosy (DLL) that is most distinctively connected to *M. lepromatosis* seemed to be densely clustered in Central America raised questions of global dissemination. If the organism evolved in Africa (as seemed most likely given its age and relation to *M. leprae*), then how did it get to Central America? The narrative I had created for the global history of leprosy, which had assumed dissemination out of Europe, now fell apart (or at least became more complicated).

Constructing a new, better global history of leprosy—two histories, in fact, since the paths of both organisms now need to be charted—is not a matter of historical curiosity. It is an urgent public health concern. Despite the worldwide availability of multi-drug therapy since 1995, around 250,000 new cases of leprosy are diagnosed every year. Whether they are “Hansen’s disease” or “Han’s disease,” an alliance of History and the historicist sciences will be necessary to reconstruct the two global histories of leprosy.

LEARNING OBJECTIVES:

1. Better understand the ambiguous nature of historical evidence related to the global history of health and disease
2. Recognize the dynamic interrelationship between medicine and society through history, in this case, particularly with relationship to contexts of colonial domination
3. Recognize the active interconnections between clinical concerns and bench science, on the one hand, and historical questions, on the other, all of which can have unexpected and immediate implications for global health

JENNIFER GUNN

University of Minnesota, Minneapolis, MN, USA (1)

“ ‘THE ULTIMATE SOLVING OF THE PROBLEM WILL BE IN RURAL AREAS’ ”

In the years following WWII, states from Michigan to Tennessee and Texas, adopted plans to address the shortage of rural health care personnel and facilities. One of the best known, the Kansas Rural Health Plan, featured repeatedly in popular magazines at the time and became the model for a national plan endorsed by the National Farm Bureau in 1948. The state approaches combined elements ranging from scholarships for medical students who promised to practice in rural areas, rural communities building clinic facilities, services to match doctors with rural towns, and mandatory rural precepteeships for medical students to recruiting future nurses through 4-H. Farm organizations, PTAs, universities, Blue Cross and other organizations were parties to these plans.

State conferences, medical society discussions, and correspondence between local communities and state medical leaders reveal the complex issues being rolled together under the guise of solving the rural health problem. The unequal distribution of medical and health resources were perceived as the Achilles heel of the US medical system. As one New York physician who hoped to find an “adequate substitute” for Truman’s pending national health insurance plan wrote, “the ultimate solving of the problem will be in rural areas, and if a satisfactory plan can be evolved to cover the areas where medical care is not available, the more crowded areas will follow in line.” The creator of the Kansas Rural Health Plan pointed out that national health insurance coverage would do nothing for rural people who lacked doctors and hospitals. Underneath the popular publicity about the plans, medical leaders were realistically cynical about the measures’ abilities to ameliorate the gap between rural and urban medical service under the current system. Their goals were to avoid intervention by the “centralizers” in Washington and to use the rural health problem to advance self-interest in garnering legislative dollars for health professional schools, increasing private health insurance enrollment, negotiating the future of general practice, and protecting the Hill-Burton hospital construction act. The real plan for rural health care was to write it off.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history
2. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system
3. Develop an historically informed sensitivity to the obstacles diverse patients (including class, gender, socio-economic status, ethnicity, and geographic location) have faced in gaining access to health care.

BERT HANSEN

Baruch College History Department, New York, NY, USA (1)

THE UNNOTICED PLACE OF ART AND ARTISTS IN PASTEUR’S SCIENTIFIC BIOGRAPHY

This study enriches the standard biography of Louis Pasteur by revealing his overlooked, yet substantial involvement in the social world of artists. Pasteur is usually seen as a dour, rigid, and unsociable workaholic with no interests outside of the laboratory—even neglecting his devoted wife and children at times. Without denying the primary lineaments of the standard picture, we explore his enthusiastic personal connections with painters and sculptors and with the internationally significant art exhibitions of the Paris Salon.

His engagements with art were far more than chatting with painters while sitting for portraits. On several occasions, he interrupted his normal work day in the laboratory to take his daughter Marie-Louise to her portrait sittings because he enjoyed discussing art with the man doing her portrait, Jean-Jacques Henner, whom he also invited to informal suppers at his house. Pasteur welcomed into his family circle Albert Edelfelt, a promising young Finnish artist. Edelfelt’s 1885 painting of Pasteur contemplating rabies-infected nerve tissue in a drying bottle set into play a new iconography that pictured physicians and scientists actively at work. Though not a physician, Pasteur attended the sculptor Jean-Joseph Perraud on his deathbed, along with the renowned painter William-Adolphe Bouguereau.

Pasteur used his connections to secure favorable notices of paintings by artists he favored, and he tried to ensure their paintings would be accepted into the Salon with favorable placement in the galleries. Additionally, he often took a more active role in planning portraits than other sitters did, and he commissioned art works for the opening of the Pasteur Institute. Such activities throughout an inordinately busy and productive career as a scientist have neither been traced by scholars nor acknowledged even in passing in the comprehensive biographies, which call attention only to the drawings that a teen-aged Pasteur made of his family and their neighbors and to his teaching chemistry at the Ecole des Beaux Arts for a few years in his early forties.

Research for this paper was undertaken as a joint project with the late Richard E. Weisberg.

LEARNING OBJECTIVES:

1. To learn that one of history’s most successful medical scientists cultivated a deep and active engagement with the fine arts.
2. To understand ways that new research can revise the standard biography of a scientific genius.
3. To appreciate the variations in how biomedical researchers have been portrayed in biographies and in pictorial works.

EMILY HARRISON

Harvard University, Cambridge, MA, USA (1)

EXPORTING HEALTH: INFANT MORTALITY AND MEDICAL EXCHANGE IN ECUADOR 1949-1965

In spring of 1951, New York City Health Commissioner Dr. Leona Baumgartner traveled to Quito to advise local directors of the new maternity clinic “Isidro Ayora.” Sponsored by UNICEF and the Institute of Inter-American Affairs, the clinic was outfitted with scientific and organizational technologies then at the vanguard of North American biomedicine. The issue they targeted was emerging as a policy concern on both continents: Maternal health and infant mortality, young among the dominant disease control paradigms of international health, were also prominent concerns in the “global” city of New York as it struggled to curb a high rate of infant mortality among its immigrants.

How did this particular transnational exchange in Latin America, mediated by health technologies, register in the ideas and actions on each side of the relationship? How was the science of infant mortality constructed in each setting; what was gained and lost in the process? Baumgartner would eventually administer the new United States Agency for International Development and play a key role focusing it on health. Her ideas about infant mortality were shaped by her experiences abroad, while her political priorities and social context shaped the translation of these ideas into policy. But what about the implementation side of the Ecuadorian exchange, that of Doctors Luis Alcivar and Isidro Ayora, the Junta of Public Assistance, and the women and infants receiving this new form of care? This paper draws on archives of the Maternidad Isidro Ayora and the Junta de Asistencia Publica in Quito and the Baumgartner papers in Boston to examine from both ends the interconnections constructing infant mortality and maternal health as objects of concern in the postwar world.

The individuals and institutions in this case are significant in the history of global health and economic development. Infant mortality has an important place in a host of disciplinary approaches to global health and the valuing of child lives. Positioned outside of silo-ed disciplinary perspectives, this paper takes a synoptic approach, threading analyses across economic, ethical and experiential registers to examine how infant lives were valued at one local interface of global health and development.

LEARNING OBJECTIVES:

1. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, the interrelationship between medicine and society and need for interdisciplinary learning
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
3. Critically appraise clinical management from a historical perspective.

CAROLYN HERBST LEWIS

Louisiana State University, Baton Rouge, LA, USA (1)

WRITING THE GOSPEL OF GOOD OBSTETRICS: JOSEPH B. DELEE AND THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY, 1895-1931

In 1895, Dr. Joseph Bolivar DeLee founded a maternity dispensary in the hope of saving the lives of Chicago's impoverished women and paving the way for a transformation in obstetrical practice in the United States. DeLee absolutely saved lives, and his impact on obstetrical practice is immeasurable. Yet there is a vast difference between the specific obstetrical practices that DeLee is best remembered for advocating and the actual policies he implemented at the Chicago Lying-in Hospital and Dispensary (CLHD). At the CLHD, DeLee championed home births, "watchful waiting," and non-intervention—but within a few decades, he also was known in the larger medical profession as a leading advocate for hospital deliveries, the prophylactic use of forceps, episiotomies, and the twilight sleep. Historians have argued that this contradiction is best resolved by focusing on DeLee's broader commitment to preventive obstetrics. I believe that there is something more important than this in DeLee's work at the CLHD. By looking more closely at the CLHD, rather than at DeLee's later medical publications, we can glimpse an alternate obstetrical universe and explore a maternity system that, despite its undeniable success, was rejected as a viable option for mainstream American obstetrical medicine. This presentation explores what the CLHD can teach us about the political, economic, medical, gendered, and cultural choices that helped create the profession and practice of American obstetrics. Using material gleaned from the archives of Northwestern Memorial Hospital, the University of Chicago, and elsewhere, this presentation focuses on the practices established at the CLHD between its founding in 1895 and 1931, when the main hospital facility was absorbed into the University of Chicago while the remaining out-patient maternity service dispensaries were renamed the Chicago Maternity Center. I want to consider the goals and motivations that DeLee and his associates had in creating an institution to provide medically-assisted yet low-intervention home-births to Chicago women, but also to explore the response of the neighborhood women and the larger medical community to the CLHD. This presentation will raise significant questions about the obstetrical future envisioned by DeLee and the reality that emerged.

LEARNING OBJECTIVES:

1. Identify successes and failures in the history of medical professionalism
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
3. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

RESISTING THE “SANITARY DICTATORSHIP”: HOMEOPATHY AND THE CONTESTATION AGAINST THE REGULATION OF THE MEDICAL PROFESSION IN MEXICO, 1917-1942

In 1917, the post-revolutionary Mexican government centralized sanitary administration in the Department of Public Health, an office that coordinated local governments’ efforts to police epidemic diseases, a policy that sanitary authorities themselves called the sanitary dictatorship. New sanitary authorities, most of who were recruited from the former Sanitary Board of Health, used their position to further previous Board’s programs to regulate medical practice all over the country. Originally, this control consisted in the creation of a national medical registry and regulations that forbade both the issuing of death certificates to unregistered physicians and the promotion of medical services for which a practitioner was not trained. But later modifications of the Sanitary Code progressively refined these measures to cope with the resistance of medical practitioners, most of them homeopaths.

Homeopaths constituted a group of physicians and medical practitioners who since the late 19th century did not recognize traditional centers of medical authority and created their own educational institutions and professional associations. Following the revolutionary tenet of education for the working class, homeopaths organized the Free School of Homeopathy in 1912. When the sanitary dictatorship started neglecting the medical registry to graduates from this school in 1920, homeopaths carried out a series of actions to stop the sanitary measures that regulated the medical profession.

Using the Historical Archive of the Ministry of Health, this paper traces the negotiations between homeopaths, sanitary authorities and other government offices to regulate medical practice. It shows that the transition from a liberal to a state co-opted Mexican medical profession was less smooth and straightforward than Mexican historians of medicine have assumed for this period. This work demonstrates that the convoluted political history and the diversity of Mexican government’s interests in the 1920’s and 30’s turned the dream of sanitary authorities to control medical practice into a nightmare, one that placed homeopaths in the landscape of the medical profession. The homeopaths’ triumph evidences the contradictions of state support in the development of the medical profession in Mexico in the first half of the 20th century.

LEARNING OBJECTIVES:

1. To identify successes and failures in the history of medical professionalism
2. To recognize the dynamic interrelationship between medicine and society through history
3. To understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

LAURA HIRSHBEIN

University of Michigan, Ann Arbor, MI, USA (1)

HISTORICAL PERSPECTIVES ON SMOKING CESSATION AMONG THE MENTALLY ILL

Smoking has a long history among the mentally ill. In 1892, a venerable American psychiatrist commented that tobacco could win the cooperation of any psychiatric patient in the hospital. As smoking prevalence rose in the U.S. in the first half of the twentieth century, cigarette use became part of the culture in mental hospitals, and psychiatrists sometimes harnessed patients' enthusiasm for smoking to effect behavioral change. Psychiatric patients and mental health settings seemed to be exempt from the first waves of tobacco control interventions in the 1970s and 1980s, and relatively few psychiatrists expressed interest in tobacco issues. By the 1990s, though, psychiatric hospitals were caught up in the wave to make hospital settings smoke free. Recently it has become increasingly clear that psychiatric patients constitute a disproportionately large proportion of the remaining smokers in the United States. In the last decade, tobacco control advocates have emphasized smoking cessation efforts directed toward the mentally ill.

It is certainly possible to see this story as an evolution of knowledge and public health policy applied toward a traditionally underserved group. Yet the well-meaning push toward smoking cessation in this population in recent years has been complicated by a number of issues, including the multi-industry (tobacco as well as pharmaceutical) interest in nicotine products and their derivatives, the challenging question of the role of nicotine in the brains of mentally ill individuals, the professional turf battles of mental health providers, and economic issues faced by many of the mentally ill.

This paper explores the emergence of smoking cessation efforts targeted toward mentally ill populations in the context of changes in mental illness conceptualizations and treatment settings. Although tobacco control enthusiasts push the issue of smoking cessation to the point of nicotine abstinence, some advocates for mentally ill smokers argue for patients' rights to smoke, while others encourage a harm reduction approach. The specific case of tobacco cessation in populations of U.S. mentally ill illustrates potential conflicts between values and goals in public health, the role of industry, power dynamics in provider-patient relationships, and definitions and boundaries of mental health and illness.

LEARNING OBJECTIVES:

1. Critically appraise clinical management from a historical perspective.
2. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.
3. Recognize the dynamic interrelationship between medicine and society through history.

RANA HOGARTH

University of Illinois at Urbana Champaign, Urbana, IL, USA (1)

“THAT THE ASYLUM FOR DESERTED NEGROES IS NOW COMPLETE FOR THEIR RECEPTION...”: SURVEILLANCE AND SICKNESS IN EIGHTEENTH-CENTURY JAMAICA

On May 23, 1788, the Hospital and Asylum for Deserted Negroes was ready to receive patients. According to the Kingston vestry minutes, the announcement of the hospital’s opening was to appear in all of the city’s newspapers for four weeks, the town guard was ordered to apprehend all Negro transients and place them before a magistrate to determine their eligibility for admission, and Doctor William Coakley was appointed as chief medical caretaker.

Influenced by both charitable impulse and economic motivation, the hospital functioned as an institution of care and a site of social surveillance. Hospital personnel not only regulated patients’ movements and controlled all aspects of their convalescence; they also publicly reported the names, owners (if known), the legal status, and health status of the hospital’s black patients in Kingston’s widely read newspaper, *The Royal Gazette*. In contrast, white patients housed at the separate public hospital in the city remained “invisible,” shielded from public scrutiny by their racially privileged status.

By the late eighteenth century, blacks outnumbered whites ten to one in Jamaica. The island’s white minority, mindful of the need to maintain social order, enacted measures that forced acquiescence upon the colony’s black population. The Hospital and Asylum for Deserted Negroes reflected white self-interest in constructing a medically useful space born out of a need for discipline and control. Although most eighteenth and nineteenth-century hospitals treated and regulated patients’ movements and behaviors as routine practice, public hospitals in slave societies had the added responsibilities of preventing its inmates from absconding from service, adopting new “free” identities, and fomenting insurrection.

The hospital remains a neglected site of historical inquiry: only a handful of scholars refer to its existence, and its internal records are lacking. To shed light on this obscure medical institution, I use eighteenth-century records from the Kingston vestry minutes, the *Royal Gazette* newspaper, and the *New Jamaica Almanack and Register* to reconstruct the organization of Kingston’s public slave hospital. In doing so, I demonstrate the ways in which white anxieties over monitoring black populations outside of the plantation milieu catalyzed the early formation of Jamaica’s public medical infrastructure.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history
2. Demonstrate how the slave system aided in the development of Atlantic World medical infrastructure
3. Evaluate the multiple functions of medical institutions within socially and racially fragmented societies

MAZIE HOUGH

University of Maine, Orono, Maine, USA (1)

“A RURAL PRACTICE OF ABORTION AND THE CRIMINAL JUSTICE SYSTEM: THE LOSS OF COMMUNITY CONTROL”

In this paper I argue that a major transition occurred in women’s access to abortion in the rural areas of Maine at the beginning of the twentieth century as the state expanded its control. Although Maine outlawed abortion in 1841, it was still widely practiced at the turn of the century as community members continued to believe that abortion prior to quickening was not a crime and local doctors responded to women’s appeals for assistance. As court documents and newspaper accounts reveal in four highly publicized trials of abortion-related deaths from 1904 to 1914, there was a wide spread practice in rural areas of women assisting others in finding a doctor to perform an abortion, attending her during it, and taking care of her in their own homes afterwards. The trials also make clear that a variety of local doctors performed the abortions and called in others when necessary. These doctors hoped to increase their practice, but they also were responding to an individual woman’s plight. As a contemporary doctor commented about abortions he had performed on women too poor to raise a child ‘To know it is to become responsible.’ (NYT 23 June 1912)

The press described the sufferings of those involved in great detail and thus made clear the price that would now be paid to anyone who assisted in an abortion. In 1921 the Maine legislature criminalized being an accomplice, but already the practice of abortion in the rural areas had changed. The trials which followed highlighted women who sought abortions on their own. They traveled to urban areas to consult with known (and often notorious) providers and were advised to keep their experience to themselves. This new practice, by isolating the woman and enjoining her to secrecy, protected “abortion” doctors from criminal investigation. The change occurred because the criminal justice system of the state replaced the traditional local control which preceded it. While community members insisted on placing an individual within her context, criminal justice professionals insisted that it was the crime and not the criminal that should be judged according to universally applied laws.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society throughout history
2. Develop an historically informed sensitivity to regional (especially rural) diversity of patients.
3. Understand the dynamic history of medical ideas and practices and their implications for health care.

KATHRYN IRVING
Yale University, New Haven, CT, USA (1)

THE COMMODIFICATION OF DISABILITY: IDIOT SCHOOLS AND CUSTODIAL CARE IN NINETEENTH-CENTURY AMERICA

In October 1848, young Willie Harris* left the Boston almshouse to join the inaugural class of the Experimental School for Idiotic Children. The experiment, as approved by the Massachusetts legislature, was for Dr Samuel Gridley Howe to test a new educational method to make idiot children “happy and useful.” Sixty miles away in the town of Barre, the enterprising physician Hervey Wilbur welcomed the wealthy Edwin Coolidge* to his Private Institution for Feeble-Minded Youth. Like Howe, Wilbur was inspired by French treatments for supposedly-incurable idiots; but it was parents, rather than politicians, whom Wilbur had to convince.

In this paper, I will explore how Willie Harris and Edwin Coolidge both found their way into idiot schools in the mid-nineteenth century, despite their markedly different upbringings. The Experimental School—renamed the Massachusetts School for Idiotic and Feeble-Minded Youth—reflected Howe’s connection to antebellum American reform movements and his own conviction of the perfectability of man. The Barre school was a product of both the opportunities and challenges of a medical career in the mid-nineteenth century. Wilbur recognized that the development of a therapy for idiocy generated a market of idiots, who were previously supposed to be incurable. Accordingly, Wilbur offered a service to wealthy families: he would attempt to educate their idiot children, and if they could not be made self-supporting, he would care for them indefinitely. In contrast, Howe aimed for a rapid turnover of students in the Boston school: because it was funded with tax dollars, Howe needed to extend the school’s benefit to as many children as possible. The trend towards custodial care was thus hastened in the private school, but delayed in the state school, for local economic reasons.

Many disability scholars have attempted to explain the emergence of segregated “special education” and custodial care for children with disabilities; the nineteenth-century idiot schools are central to these developments. Drawing on records from the public and private idiot schools in Massachusetts—annual reports, manuscript case notes, census data, and advertisements—I will explore the trend to institutionalization by examining the choices made by parents and politicians.

*pseudonyms

LEARNING OBJECTIVES:

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

JULIA F IRWIN

University of South Florida, Tampa, FL, USA (1)

THE SPREAD OF U.S. MEDICAL INFLUENCE IN THE WAKE OF FOREIGN NATURAL DISASTERS

U.S. citizens have often treated earthquakes, hurricanes, floods, and other calamities as agents of “creative destruction,” events that clear away outdated infrastructures and thereby create opportunities for novel forms of development. Historians of disaster, including Kevin Rozario, Ted Steinberg, and others, have analyzed this tendency within the United States, and particularly its significance to the history of the built environment. Few, however, have considered its implications for either the history of U.S. foreign relations or the history of medicine. This paper begins to fill the gap in the literature.

As my paper will argue, U.S. American health professionals have consistently used natural disasters in other countries as occasions to introduce their medical theories and practices to foreign populations. When major calamities occur around the world, they severely affect the health services of afflicted areas. They destroy local hospitals and clinics and disrupt normal approaches to care and social welfare. Moreover, they often generate new public health emergencies. Since the early twentieth century—and with increasing frequency after the Second World War—American physicians, nurses, and other health professionals have responded to foreign disasters with both material aid and expert advice. In the process, they have often endeavored to replace local health traditions with avowedly more “modern” American models of health care.

In many respects, I argue, this propensity constitutes a sort of medical imperialism, and should be analyzed as such. And yet, this process generally occurs, at least in part, by invitation. It begins when host governments accept U.S. offers of assistance and continues as native health professionals voluntarily collaborate with American aid workers. Nonetheless, the result is in many ways the same as in more formal instances of medical colonialism: indigenous ideas and methods are transformed to more closely resemble those of the metropole.

Through case studies of major global catastrophes, including an earthquake in Guatemala in 1917, an earthquake in Chile in 1960, and a cyclone in Pakistan in 1970, my paper will explore the spread of U.S. medical influence in foreign disasters while interrogating the geopolitical and biomedical power dynamics at play in these events.

LEARNING OBJECTIVES:

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

DAVID JOHNS

Columbia University Mailman School of Public Health, New York, NY, USA (1)

THE SALT HYPOTHESIS: EVIDENCE, SKEPTICISM, AND THE POLITICS OF PUBLIC HEALTH

For over a century the question of whether high salt consumption has an adverse impact on health has been a matter of scientific dispute. As early as 1904 a team of scientists in France began to argue that eating too much salt increases blood pressure, and by the early 1970s the notion that slashing sodium intake would reduce rates of hypertension and improve population health had attained the status of consensus truth. USDA dietary guidelines and reports from the US Surgeon General began to exhort Americans to eat less salt. In 2010, one analysis suggested cutting salt might save the lives of as many as 100,000 Americans annually. In the last two years both the FDA and the New York City Department of Health launched initiatives aimed at reducing the sodium content of packaged foods.

And yet the heated scientific controversy over the quality of the evidence implicating salt has not subsided; indeed, the acrimony has only increased. In 2011, two authors of a new systematic review of the evidence on sodium conducted for the Cochrane Collaboration, among the most respected institutions involved in evidence-based analysis, declared, "It is surprising that many countries have uncritically adopted sodium reduction, which probably is the largest delusion in the history of preventive medicine." In response several scientists long convinced of the dangers of elevated salt intake asserted that "denial and procrastination" about dietary sodium reduction would cost lives and would be "ethically irresponsible."

What does this protracted scientific dispute over salt represent? This paper examines the history of the salt debate, with a focus on two interlocking questions: 1) the evolving standards of evidence that have prevailed over the last 40 years the salt controversy, and the means by which scientists determined what did and did not count as evidence; and 2) the manner in which scientists who had committed institutional or reputational resources to a particular "side" in the debate stage-managed their authority. This paper contributes the first archival exploration of the salt hypothesis, with an emphasis on the circumstances that allowed sodium reduction to be initially translated into policy.

LEARNING OBJECTIVES:

1. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education;
2. Recognize the dynamic interrelationship between medicine and society through history
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

LORI JONES

University of Ottawa, Ottawa, ON, Canada (1)

REACHING THE POOR? INTENDED VERSUS POTENTIAL AUDIENCES FOR CONTAGIOUS DISEASE TRACTS IN LATE MEDIEVAL AND EARLY MODERN ENGLAND

Late medieval and early modern English medical treatises were often dedicated to the ‘common man, woman, and child.’ Historians typically dismiss prefatory and inter-textual dedications, however, as being little more than sales tactics. They suggest instead that only medical practitioners and the highly educated elite had access to, and read, the treatises. At the same time, historians consider treatises such as contagious disease tracts to be mirrors of contemporary medical beliefs and practices. This ambiguity results in a historiographical disconnect between the tracts’ potential and actual audiences and their influence on or reflection of popular beliefs and practices.

To discern more fully the audience of contagious disease tracts, this presentation explores contemporary medical literacy and literary practices through the textual dedications, codicological features (primarily typeface, number of pages, and physical size), and print histories of the tracts. I will focus on six representative English tracts: ‘De epidemia’ (mid-fifteenth century), the ‘Canutus’ tract (1485), and those attributed to Moulton (1475), le Forestier (1485), Caius (1552), and Phayer (1553). The analysis suggests that, rather than being homogeneous, the tracts targeted different audiences, depending on their authors’ backgrounds and their disease focus, context, format, and level of technical and theoretical detail. Their potential and actual audiences, as a whole, were broad and included not only all those who could read, but also those who had someone to read to them. The analysis also demonstrates that the perceived popularity of plague tracts, based largely upon their ubiquity among contemporary printed medical texts, fails to acknowledge that more than half of the almost seventy English editions printed before 1600 were reprints of just three tracts, each of which was a translated adaptation of a much older treatise whose medical content had remained static for upwards of 250 years.

While the impact of print on the circulation of medical ideas and information was profound, this presentation will demonstrate that previous scholarly assumptions about who might have read the tracts do not stand up to a closer examination, and that regardless of their potential or actual audiences, we cannot assume that the tracts reflected contemporary medical beliefs.

LEARNING OBJECTIVES:

1. To understand how codicological analysis can be used to challenge historical assumptions about the readership of contagious disease tracts in late medieval and early modern England.
2. To appreciate the nuances that existed between different kinds of contagious disease tracts.
3. To explore the extent to which scholarly disease treatises such as contagious disease tracts can be said to have reflected contemporary beliefs and practices.

MARIAN MOSER JONES

University of Maryland College Park, College Park, Maryland, USA (1)

RED CROSS NURSES IN THE 1935 DUST BOWL: A CASE STUDY OF DROUGHT, DOUBT, AND THE POLITICAL USES OF MEDICAL NEUTRALITY

In the United States, drought has long stood at the problematic edge of the disaster construct. Many government and philanthropic leaders in the late nineteenth and early twentieth centuries viewed natural disasters like earthquakes and hurricanes as Acts of God whose innocent victims merited outside assistance, but saw drought as an economic hazard of farming—and one for which farmers should bear the consequences. At the same time, medical aid has played a unique role in bridging ideological divides about who merits assistance in an emergency. The case study explored in this paper, the American Red Cross' (ARC) medical aid program to people suffering from respiratory conditions caused by the Dust Bowl, expresses both the legacy of ambivalence toward drought as a disaster and the penumbra of neutrality surrounding medical and nursing aid.

The particular difficulties of drought relief date to at least 1887, when President Grover Cleveland vetoed a Congressional appropriation for victims of a Texas drought and proclaimed: "The lesson should be constantly enforced that though the people support the Government, the Government should not support the people." In 1930, Herbert Hoover took a similar position toward government relief when drought spread across the country, even quoting Cleveland's statement. However, Hoover pressured the ARC to assist victims of drought and related economic distress. This program, which provided people with cloth, grain, seeds, and livestock feed, but not food or money, expressed Americans' lingering ambivalence toward drought relief even as the Depression worsened. The New Deal replaced this in-kind aid with direct federal cash assistance and work programs, but did not end the public argument about who deserved such government aid.

In the midst of this contentious climate, the ARC conducted its medical and nursing relief program to Dust Bowl victims. The Dust Bowl provided a convenient opportunity for the organization at a point when its role in disaster relief seemed to be supplanted by federal agencies. Here I argue that such medical and nursing care, protected by a cloak of neutrality, served as a wedge for the Red Cross to insert itself in post-New Deal disaster relief regimes

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Recognize the dynamic interrelationship between medicine and society through history
3. Understand natural disasters and emergency medical treatment of disaster victims in their social, historical, and political context

CARLA KEIRNS

Stony Brook University, Stony Brook, NY, USA (1)

DEATH ISN'T WHAT IT USED TO BE: FROM HOSPICE AS ASPIRATION TO IMPERATIVE

The 1922 edition of Emily Post's, *Etiquette*, includes instructions for a home funeral. Over the twentieth century, death moved to the hospital, as technologies, traditions, and demographics brought birth, death, and illness into institutional settings. In the 1970s, the hospice movement began bringing it home. In 1982 Medicare, the US federal insurance program for the elderly, added a new benefit to pay for a new category of services, inpatient and home hospice. While most Americans continue to die in hospitals, nursing homes, and institutional settings, over the past decade uptake of hospice has expanded to as much as 20 to 30 percent in some communities.

The history of institutional death has been taken up by many scholars of hospitals, a few writing about nursing homes, and footnotes and asides in the histories of asylums. The decline of home death is in part a story of medical progress and access to care. But it is also a story about urbanization, changing family structure, and culture change. Historians of nursing and caregiving, as well as ethicists and policymaker predominantly from nursing, have written compellingly about the professionalization of nursing at home, the roles of visiting nurses, and the anxieties and challenges faced by American families who choose to care for their loved ones at home as well as those who end their lives in nursing homes.

In the past decade, increasing acceptance of a "right to die" and of palliative approaches to cancer, heart disease and other terminal illnesses have coincided with financial pressures on inpatient hospitals and families. Under intensive case management, utilization review, and other approaches to manage the financing of acute hospital care, patients who are no longer receiving specific treatments or technologies that cannot be delivered at home are considered candidates for discharge even as they are dying, reminiscent of the rules many acute care hospitals once had against admitting "incurables." For some, the choice of hospice and home death has become a financial imperative even as the capacity of families to provide extensive unpaid caregiving may be in decline due to mobility and demographic change.

LEARNING OBJECTIVES:

1. Participants will be able to describe some of the demographic changes in age, location, and circumstances of death in the United States over the past century
2. They will be able to explain the impacts of insurance, professional home nursing, and changing family structure on caregiving at the end of life
3. Participants will be able to analyze the family, institutional and cultural factors that affect the location of death in modern America

TINA M. KIBBE

University at Buffalo, Buffalo, NY, USA (1)

“MEASURING THE ‘FITNESS’ OF THE AMERICAN CITIZENRY: EUGENICS FIELD WORKERS AND PUBLIC HEALTH NURSES IN THE UNITED STATES, 1910-1925”

In the early twentieth century as both the eugenics and public health movements gained tremendous support and momentum in the United States, eugenics field workers and public health nurses operated as agents on the front lines, collecting information about individuals based on job-specific training, as well as on value-laden subjective assessments informed by their own belief systems and cultural norms. The on-site assessments and the identification of “defective” characteristics made by eugenics field workers, along with the attempts of public health nurses to establish normative standards of personal hygiene and behavior, all combined in an overall effort to improve the overall fitness of the population. These assessments contributed to definitions of “fit” and “unfit” within a larger framework of notions of normality. Many male eugenicists and public health physicians believed that as “natural” caretakers, women made the best choice as field agents to gain access into homes and garner the confidence of their informants. However, these women were much more than mere collectors of information.

Eugenics field workers and public health nurses were keenly aware of their positions as professionals and as women. Utilizing both of these advantages, they gained access into homes and obtained information that may not have otherwise been gained. They also made observations through a gendered lens, noting especially the appearance and behavior of other women. Their contribution to the definitions of “fitness” and to the knowledge base used to categorize bodies and behaviors was integral to the formulation of later policies and practices. Using the legitimating language of science and medicine, eugenics experts and public health officials together constructed a discourse about “fitness” based on a system of production and reproduction of knowledge between “field” agents and medical and scientific “experts.” In other words, legitimate “facts” about what constituted “fitness” based on scientific objectivity were actually representations based on subjective processes of the experts constructing them. Eugenicists and public health authorities then used these representations to formulate policies and practices in their effort to manage and contain the “fitness” of the American citizenry.

LEARNING OBJECTIVES:

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

JEANNE KISACKY

Independent Scholar, Ithaca, NY, USA (1)

GROUP PRACTICE AND EARLY TWENTIETH-CENTURY AMERICAN HOSPITAL DESIGN

This paper relies on extensive archival and visual records of early twentieth-century American hospital buildings to reveal how changing medical practices interacted with modernizing hospital design.

Nineteenth-century hospitals, like the Johns Hopkins Hospital, occupied facilities made up of a number of separate buildings each of which was intended to function as an independent hospital. To minimize disease transfer, doctors, patients, nurses and staff of one building were to have little direct interaction with those from other buildings. This building structure was efficient for a hospital practice that assigned each patient to one ward and one doctor. Such pavilion hospitals were the norm in the late nineteenth century from Atlanta's Grady Memorial Hospital to the Newport Hospital in Rhode Island.

The Mayo Brothers' development of group medical practice required a number of specialists to consult on the diagnosis and treatment of each patient, and often required the patient to visit a number of different buildings in the hospital to take advantage of specialized diagnostic equipment and therapeutic facilities. Pavilions proved cumbersome for such extensive circulation and interaction. Early twentieth-century hospital designers struggled to balance the traditional requirements of hygienic decentralization and the new need for efficient spatial integration. While some hospitals, like the Cincinnati General Hospital, continued to build pavilion facilities, many others, like the new Bellevue Hospital in New York City, Barnes Hospital in St. Louis, or the Galloway Memorial Hospital in Nashville, followed a middle road between pavilions and high-rise centralization.

By the 1920s, increasing interest in functional spatial planning hailed the appearance of the centralized, high-rise 'modern' hospital, like the Fifth Avenue Hospital and Columbia-Presbyterian Hospital in New York City, the Passavant Hospital in Chicago, the Allegheny County General Hospital in Pittsburgh, or the Los Angeles County General Hospital.

The paper concludes that in hospitals, medicine and architecture are integrally interwoven. While changing spatial requirements of medical practice influenced hospital design; the spatial realities of hospital layouts inevitably influenced medical practice.

LEARNING OBJECTIVES:

1. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

WENDY KLINE
University of Cincinnati, Cincinnati, OH, USA (1)

COMMUNICATING A NEW CONSCIOUSNESS: HOME BIRTH IN MODERN AMERICA

Thirty-five years ago, the growing popularity of home birth among some populations of the middle class in the U.S. raised the concern of organized medicine and the media. In 1977, Dr. Warren Pearse, the Executive Director of the American College of Obstetrics and Gynecology, publicly noted the “rising tide of demand for home delivery,” describing it as an “anti-intellectual--anti-science revolt.” Newspapers showcased “irresponsible” midwives and “negligent” parents who opted out of hospital deliveries.

In response, birth activists (consumers and practitioners) repackaged home birth as something new -- a modern, rational choice backed by scientific research. Creating surveys, photographs, newsletters, and documentary films, they demonstrated home birth’s potential to capture a diverse following – from fundamentalists to feminists. Those who opted for home birth contributed further by sharing unique birth announcements, photos, and stories that stressed the transformative and empowering nature of the experience.

This paper draws on archival sources and interviews to argue that the “new homebirth” of the 1970s complicated assumptions about reproductive knowledge and practice. Blending science with spiritualism, its promoters portrayed home birth as both meaningful and practical. In their words and images, the modern midwife combined ancient wisdom with modern intellect to facilitate a different kind of birth. Yet in the context of 1970s social movements, professionalizing home birth presented something of a unique challenge. More was at stake than simply promoting an alternative to hospital birth; this was an alternative that incorporated antithetical values. Forward-looking feminists wed to ideas of consciousness raising and individual empowerment; religious fundamentalists morally opposed to the technology of hospitals; anti-establishment liberals distrustful of modern medicine and corporate capitalism; how could all be incorporated into one package? An analysis of the juxtaposition of images and ideas from ancient to modern and across the political spectrum explains the ability of home birth to remain a legitimate, if still controversial, alternative to hospital birth today.

LEARNING OBJECTIVES:

1. Understand the dynamic history of medical ideas and practices, specifically in the area of birth
2. Recognize the dynamic interrelationship between medicine and society through history
3. Acquire a historically nuanced understanding of out-of-hospital birth practices

RODION KOSOVSKY
Yale University, New Haven, CT, USA (1)

PLANTING FOR EMPIRE: THE ESTABLISHMENT OF CINCHONA PLANTATIONS IN INDIA 1852–1863

In this talk, I examine the intersection between botany, imperialism, and the pharmaceutical industry to reveal how the British state created the technical knowledge and biological resources needed for the mass production of quinine, the first anti-malarial drug. Using the archives of the India Office, the Royal Botanic Gardens at Kew, and the Royal Geographic Society, I demonstrate the close connection between European imperialism and the emergence of the modern pharmaceutical industry. I examine a key pivotal moment in which science became a means to solve certain challenges of colonialism. In this case, the challenge was a shortage of quinine needed for British troops and civilians. The problem laid in the shortage of South American cinchona-bark from which quinine was extracted. For this reason, scientists in India began urging the East India Company in 1852 to establish cinchona plantations in India. Although the Company agreed in principal to the project, it refused to fund scientific expeditions to gather the cinchona seeds and saplings needed for an experimental plantations. Instead, the Company thought that it could dispense with scientific expertise and use H.M. Consul agents to perform the actual collecting. These attempts failed and the Company shelved the project. The Sepoy Mutiny gave new urgency to the need for a stable supply of quinine. Without an adequate supply of quinine, the Raj risked losing India. Therefore, the Raj actively began seeking a scientist to organize collecting expeditions to South America. They settled upon Clements Markham to coordinate three collecting expeditions. During the expeditions, the scientists ignored all claims of biological ownership by the South American nations. The scientists dispatched the plants to Kew Gardens and from there they were forwarded to India where an experimental plantations was established. This plantation developed the cultivation methods needed to transform the cinchona plant into a plantation crop. Finally, the Raj proceeded to engineer a free market for cinchona-bark. The establishment of cinchona plantations in India and Java deprived South American nations of a valuable source of revenue and enriched European pharmaceutical companies. This large and steady source of revenue launched the modern pharmaceutical industry.

LEARNING OBJECTIVES:

1. Develop knowledge and understanding of medical innovation
 - Deepen understanding of the effects of drug shortages on patient care
 - Understand the political factors involved in the manufacturing of drugs and the impact on patient care
 - Gain a historical perspective on the impact of drug shortages on the medical profession
2. Expand our understanding of medical research
 - Demonstrate the reciprocal nature of scientific innovation and the medical profession
 - Acquire a historical perspective on the role of government funding in medico-scientific research
3. Develop a historical understanding of the interaction between civilian and military medicine

MARTIN KUHAR

Croatian Academy of Sciences and Arts, Zagreb, Croatia (1)

NOT IN YOUR GENES: ANDRIJA ŠTAMPAR'S REJECTION OF EUGENICS

Andrija Štampar (1888-1958), the public health czar in the 1920s Yugoslavia, a leading Rockefeller and League of Nations health expert and one of the founders of the World Health Organization, stands among the most fascinating figures of public health history. Besides his internationally recognized work in promoting ideas of social medicine, he was also an advocate of negative eugenics during the 1910s and early 1920s. Following the footsteps of Alfred Grotjahn's social pathology, Štampar envisaged a chronically sick society in dire need of elaborate state measures to counteract degeneration, which weakened nations and threatened to lead them to political extinction. However, in his 1940 social medicine university textbook, Štampar toned down his enthusiasm towards eugenics and noted that in some aspects it represented an oversimplified and reductionistic project. What happened in the late 1920s and 1930s for Štampar to marginalize eugenics? I propose four reasons. First, Yugoslavia struggled with public health issues and limited financing, and Štampar's top priorities while working at the Ministry of Public Health were to establish institutional foundations of modern social medicine. In that context, organizing and executing wide eugenic measures was out of the question, not least because of the larger problems of low birth rate and high mortality. Second, Štampar lost his position in the Ministry in 1931, not long after King Alexander proclaimed dictatorship. National tensions erupted, and Štampar was perceived by Serbian authorities as a Croatian nationalist; his nemesis, Stevan Ivanić, was a radical right-wing eugenicist. This episode made Štampar painfully aware that eugenics can easily be adapted to nationalistic agendas. Third, after his removal Štampar was recruited by the League of Nations to help erect modern public health institutions in China and this project occupied him throughout the 1930s. Fourth, Štampar's personal diaries reveal deep resentment towards Nazism and Fascism. Štampar's insistence on environmental factors in shaping people's health and decreasing interest in eugenics a year prior to the establishment of the Nazi puppet-state, Independent State of Croatia, was an important counterweight to the emerging nationalistic and racial interpretations of eugenics, coming from a well-respected authority in social medicine.

LEARNING OBJECTIVES:

1. Deepen knowledge about the establishment of modern public health in pre-World War II Yugoslavia.
2. Understand the position eugenics occupied in Andrija Štampar's social medicine, and how it changed in time.
3. Recognize the interrelation of science, politics and predominant health problems in shaping major goals of public health in Yugoslavia.

DARWIN LABARTHE

Northwestern University Feinberg School of Medicine, Chicago, IL, USA (1)

THE EPIDEMIOLOGIC TRANSITION IN CARDIOVASCULAR DISEASE: THE CURIOUS COURSE OF A CAPTIVATING CONCEPT, 1971-2012

Abdel Omran, Egyptian-trained obstetrician-gynecologist and Columbia University demographer, published in 1971 “The Epidemiologic Transition. A Theory of the Epidemiology of Population Change” – a transition “in which degenerative and man-made diseases displace pandemics of infection as the primary causes of morbidity and mortality”, and one “still underway in less-developed societies.” Three successive stages were described: the ages of “pestilence and famine”, “receding pandemics”, and “degenerative and man-made diseases”.

The “theory” gained wide currency in the field of cardiovascular disease epidemiology and prevention, where a sharp rise in coronary heart disease mortality was observed in western societies from the early 20th century. The same would occur in the rest of the world, according to Omran. Meanwhile, the field focused on cardiovascular issues in western industrialized countries. The concept of epidemiologic transition continued to be cited widely in the public health literature, so appealing was the idea of forecasting major changes in population health in terms of potentially controllable societal determinants.

However, this paper argues from multiple sources both that the “theory” failed as a predictor of the course of cardiovascular disease development in ensuing decades, not only in developing countries, but in varied settings throughout the world; and that it may have contributed importantly to delayed recognition of epidemic cardiovascular disease in the developing world.

To accommodate multiple deviations from Omran’s three-stage model, additional phases of transition and additional models, or patterns, of change were posited by Omran and others. The literature reveals a proliferation of supplemental “stages” to accommodate developments unanticipated by the “theory” and multiple models of change even within the originally conceived stages. In addition, review of data published through the World Bank reveals that epidemic levels of cardiovascular mortality were already established in every region of the world, at least by 1985; but decades later references persisted to “emerging epidemics” in developing countries.

The “theory” failed as a predictor of epidemic cardiovascular disease and has plausibly had a negative impact in delaying interventions against cardiovascular disease in much of the world.

LEARNING OBJECTIVES:

1. Better appreciate the dynamic history of medical ideas and practices within public health
2. Better understand the consequences for public health policy and the public health of developing nations of post-dictive theorizing
3. Better comprehend the disciplinary and social politics behind important concepts such as the epidemiologic transition within public health

GUILLAUME LACHENAL

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Institut Universitaire de France, Paris, France (2)

PENTAMIDINE, FROM COLONIAL WONDER DRUG TO ESSENTIAL MEDICINE. AN INQUIRY INTO THE PAST FUTURES AND COLLECTIVE BODIES OF GLOBAL HEALTH

This paper is the biography of pentamidine. A product of 1940's British chemotherapy, pentamidine became a wonder drug against sleeping sickness in the 1950's. It was hoped that the drug, which was said to protect healthy individuals against trypanosomes for up to one year, would lead to the eradication of sleeping sickness. In the tense context of decolonization, pentamidine chemoprophylaxis was seen as a technological fix to the main cause of Africa's underdevelopment – and as the ultimate contribution of colonial medicine to Africa's modernization.

Mass campaigns of preventive injections were implemented throughout Africa. In spite of growing concerns about the efficiency and safety of Pentamidine for individuals, injections were made compulsory (with the exception of European patients) in the name of collective good – for the “health of the race”. But the miracle was short-lived: following series of massive accidents, preventive pentamidine was abandoned in the 1960's. The drug and the dream of eradication it carried were actively erased from medical memories.

In the eighties, Pentamidine was rediscovered: the drug was found to be the best cure and prevention of “PCP” pneumonia, one of the most frequent and severe opportunistic infections associated with HIV/AIDS. Its production resumed, and prices rocketed, and Pentamidine eventually became an “essential medicine”, which required the generosity of big pharma to make it accessible in Africa.

I will place this biography in a critical genealogy of global health. The history of pentamidine prophylaxis – a technology evaluated, administered and marketed at the scale of the collective body – has many echoes with the current hype for mass “preventive therapies” in Africa. It reveals how the classic opposition between the individual and the “common good” (which is often taken as an universal, a-historical, tension of public health) has often been unthinkable in the African context; in this case the very instability of the drug's behavior radicalized the racialization of medical rationality. This paper is also a reflection on the relationship of global health interventions with their own past – a past of lost hopes and failed promises, which is at once acknowledged and ignored.

LEARNING OBJECTIVES:

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

ELAINE LAFAY

University of Pennsylvania, Philadelphia, PA/Northeast, USA (1)

“FATAL TO A SLIGHT SCRATCH:” DISSECTION WOUNDS AND PROFESSIONAL IDENTITY, 1810 - 1860

Dissection was a risky undertaking for 19th century medical students. During dissection, students sometimes cut themselves and the wound could prove fatal. This paper examines the array of medical responses to wounds received during dissection, paying particular attention to what they reveal about professional identity and the relationship between dissectors and the bodies upon which they worked. When a dissection wound occurred, the cadaver—a medical object over which physicians were supposed to exercise absolute control—became the site of a momentary lapse of authority. Rather than lying prostrate, harmless, waiting for physicians to uncover the hidden secrets of human entrails, cadavers contained a passive threat of infection. The number of cases is relatively small, but the emotional impact and symbolic significance of dissection wounds is greater than the number would lead one to believe. Prior scholarship has focused on the trafficking of cadavers and the act of dissection as a cornerstone of professional identity among students. This paper argues that dissection threatened not only the physical body of the practitioner, but also the medical authority contained in an orderly dissection. Making use of previously overlooked case studies, medical student lecture notes, and the private papers of practitioners, this paper examines dissection wounds as a glitch in the system of medical control over the body, asking what new insights it provides about 19th century medical power, identity, and authority.

Victims of dissection wounds, who were frequently medical students, were portrayed as martyrs in the medical literature. An intriguing detail about these case studies is that the authors were often the victim’s professor, who in many cases performed the dissection on the dissector. This paper argues that case studies served a wider effort at memorializing students or colleagues who succumbed to a putrefying dissection wound. The result was that traditionally detached clinical articles were instead personal, deeply felt accounts of tragedy. Victims, often depicted as young, promising medical students, were portrayed in contrast to the paradigm of the careless dissector whose scalpel slipped, clumsily, on the cadaver. While not all dissection wounds were fatal, those who perished were posthumously ascribed preeminent medical status.

LEARNING OBJECTIVES:

1. Think historically about the practice of dissection
2. Identify successes and failures in the history of medical professionalism
3. Recognize the role of dissection wounds as a contributing factor to medical professional development during the 19th century

JENNIFER LAMBE
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THE TECHNOCRAT AND THE PATRIOT: THE MAZORRA MENTAL ASYLUM IN U.S.-OCCUPIED CUBA, 1906-1909

From 1900 to 1909, Edward St. James Greble and Dr. Lucas Alvarez Cerice were the principal architects of a massive reconstruction project undertaken at Havana’s Mazorra Mental Asylum. As the point person for Cuban charitable work under two U.S. occupation governments (1899-1901 and 1906-1909), Greble, a major in the U.S. Army, worked closely with Alvarez Cerice, a hero of the Cuban wars for independence who had been handpicked by the Americans to lead Mazorra. Their efforts rescued the asylum from the brink of despair, where a particularly noxious decade of Spanish colonial administration had left it. Greble, a prototypical U.S. technocrat, prized imperial efficiency and pragmatism, while Alvarez Cerice styled himself in the exalted mode of Cuban patriotism. Nevertheless, their approaches coincided in the classic model of moral management, which had driven the rise of the mental asylum elsewhere in the nineteenth century.

This paper examines the debate over the status of Mazorra that erupted during the second U.S. occupation of Cuba. While the Cuban medical profession and its political representatives argued for the relocation of the hospital to the jurisdiction of a soon-to-be-founded Department of Public Health, Greble and Alvarez Cerice continued to insist on the art of administration as the bulwark of asylum management. Greble fought to maintain the facility under the auspices of the Department of Governance, arguing that a mental asylum was not a medical institution and could not be entrusted to mere physicians. Greble’s campaign capped the process, initiated during the first U.S. occupation, of converting Mazorra into a State institution, overseen and funded by the central government. His vision of mental patients as wards of the State correlated closely with Alvarez Cerice’s paternalistic stance as asylum administrator. In exalting moral management by military men, Greble and Alvarez Cerice swam, ultimately unsuccessfully, against the tide of Cuban medical opinion. These battles over Mazorra highlight the political tensions of charitable work under an occupation government and the medical uncertainties of asylum management at a transitional moment for the psychiatric discipline. Both struggles, however, would continue at Mazorra long after the end of the age of occupation.

LEARNING OBJECTIVES:

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

SEAN HSIANG-LIN LEI

Institute of Modern History, Academia Sinica, Taiwan, Taipei, Taiwan (1)

WHY HYGIENE (WEISHENG) IS NOT ABOUT GUARDING LIFE: THE INVISIBLE STRUGGLE BETWEEN TUBERCULOSIS AND WASTING DISORDERS (LAOBING) IN REPUBLICAN CHINA

Weisheng, literally “guarding life,” serves as the Chinese translation for the English term hygiene. Nevertheless, the respected author of a Chinese textbook on public health from 1934 stated in his preface: “Weisheng is about ‘maintaining health’ and not at all about ‘guarding life.’” When read against the rise of weisheng in Ruth Rogaski’s sense of “hygienic modernity,” this statement reveals a local and alternative conception of weisheng during the Republican period. Like many historians even today, public health advocates of that time saw little value in this popular discourse and mostly disregarded it. This paper, on the contrary, takes this subjugated practice of weisheng as “guarding life” seriously, tracing its emergence, articulating its specific features, and exploring its historical significance as an alternative to the notion of hygienic modernity.

Among the spectrum of local practices popularly associated with the concept of weisheng, one major aspect was built upon the prevalent and persistent experience of a traditional disease named laobing. Most often rendered into English as “Wasting Disorders,” its major cause was identified as overwork. Because laobing was also one of a handful of terms used to translate Tuberculosis into Chinese, this term covers an invisible struggle between two conceptions of disease, two kinds of hygienic practices, and two ways of experiencing and guarding one’s life. As some Chinese abandoned the concept of laobing and replaced it with that of tuberculosis, conditions that had traditionally been regarded as pathogenic, like over-work, became normalized within the new hygiene of tuberculosis as the normal state of life, as the individual’s functional adjustment to the new social order of industrial capitalism. While this shift might have signaled the rise of a capitalist body in China for some, for others the persistent experience of laobing preserved an embodied alternative to the bio-politics imposed by modern public health measures. In light of this hitherto neglected struggle, the modern history of weisheng is essential for understanding the persistence, transformation, and local innovation of cultural values in twentieth-century China.

LEARNING OBJECTIVES:

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

LESLIE LEIGHTON

Emory University, Atlanta, Georgia, USA (1)

THE DECLINE IN CORONARY ARTERY DISEASE MORTALITY: TRACING ITS ORIGINS, CONTRIBUTING FACTORS AND UNRAVELING THE MYSTERY

Coronary artery disease is by all accounts a twentieth century illness although evidence of the disease can be traced to the ancients. Long before the groundbreaking work of James Herrick there was angina pectoris, but coronary disease, as we know it today was largely an undiagnosed and poorly understood disorder. The disease reached epidemic proportions through two world wars and the great depression with little treatment and seemingly little knowledge of contributing factors and risk prevention. Coronary artery disease mortality waxed and waned through the turbulent events of the early twentieth century. It's mortality declined during war only to later strongly rebound. But strangely and without explanation, by the late 1960s the mortality of this disease was starting to show a sustained downhill trend. This initial decline has been largely unexplained. A 1978 NIH Conference addressed this issue with substantiation of the data, but without clear explanation of the well-documented decline that began 10 years earlier. It is clear that after 1970 risk prevention and an assortment of treatment modalities contributed to improvement in the morbidity and mortality of this disease but decline in mortality was already well underway when most of the interventions we know today became commonplace. The decline in mortality was evident before coronary care units were widely in place, before interventional cardiology and coronary artery bypass surgery had become standard practice, and before risk prevention became uniformly accepted as a way to reduce the morbidity and mortality of disease. The surgeon general's report on smoking had only been recently published when decline in mortality was already evident. This paper explores and discusses the contributing factors for the early sustained decline in the mortality of coronary artery disease. My data has been collected through a series of interviews and oral histories with authorities involved in the field during the period in question as well as archival work. The results of this presentation are interesting, surprising and somewhat contradictory. Finally, I explore a number of different hypotheses and attempt to establish a consensus of opinion historically on the origins of the early decline in coronary artery disease mortality.

LEARNING OBJECTIVES:

1. To review the history of coronary artery disease in the 20th century for the purpose of demonstrating its importance for current practitioners.
2. To recognize and convey the factors that may have impacted the early morbidity and mortality of coronary artery disease as they apply and contribute to the disease today.
3. To challenge conventional wisdom and paradigms on the natural history of coronary artery disease and in so doing demonstrate that factors that we currently consider to be important in the treatment and care of patients with coronary artery disease do not fully explain the disease.

JIMMY ELAINE WILKINSON MEYER,
Independent Scholar, Lancaster, OH, USA (1)

KIMBERLY LENAHAN
Cuyahoga Community College, Cleveland, OH, USA (2)

“ACCESSING CONNECTIONS: RACE, WOMEN AND HEALTH CARE IN CLEVELAND”

The Women & Health Care in Cleveland Project analyzes the role of women in health care in American cities, using Cleveland, Ohio, as a case study. This paper explores the impact of race on the web of connections and organizations active in Cleveland in the early 19th century.

WHCC has argued that female health care pioneers identified service gaps, then launched and sustained organizations to fill the void. Lacking professional experience or financial means, they tapped the expertise of others to create change (similar to K. Sklar’s “power brokers”). This paper examines the limits of connection and cooperation in the face of racial difference. Yet the authors demonstrate even in the presence of racial tension, leaders and outsiders still manipulated extant connections to address health needs.

Many blacks and former slaves, including the Bryant family migrated to Cleveland in the late 1800’s. Eliza Simmons Bryant (1827-1907) realized that many elderly African Americans had no one to care for them. Existing homes for the aged did not admit people of color. Bryant followed the same course as white women and men when addressing the problem. In 1893, she recruited volunteers within her church and acquaintance networks, who organized the Cleveland Home for Aged Colored People (CHACP). In its early days, the home’s board of trustees raised funds within the sphere of friendships and associations in the local black community. When those sources failed to generate enough revenue, leaders adopted a new strategy and tapped into other local networks. Laura Spelman (Mrs. John D.) Rockefeller provided an initial contribution. This stamp of approval provided an entrée into Cleveland’s philanthropic circles. CHACP gained the support of Cleveland’s white community for emergency initiatives to maintain the Home’s existence (and a segregated facility), but fell short of gaining a consistent revenue stream until state and national support became available.

This paper analyzes the ways in which the black community of Cleveland struggled to maintain its identity while accessing resources that supported the white health care system. It highlights the social and cultural influences on health care networks and delivery.

LEARNING OBJECTIVES:

1. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
2. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
3. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

PAUL LOMBARDO

Georgia State University, Atlanta, GA, USA (1)

EUGENICS AND CRIME: THE HILLBILLY HOMICIDE OF 1936

In April of 1936, against all advice, sixty year old bachelor farmer Dan Shine married his twenty-four year old housekeeper Pearl Hines. When Dan’s body was found only five days after the wedding, the cause of death appeared to be suicide, but within hours his bride was charged with murder. Pearl’s mother Minnie was the locally notorious head of a family that included seventeen other children. The degenerate ways of that clan were so infamous that years earlier a student at the state university made it the focus of her thesis in social work. Minnie also became a suspect in the killing. Soon three men—a cousin, Minnie’s common law husband, and Pearl’s harmonica playing” hobo” lover-- joined the list of conspirators charged with Dan Shine’s murder.

For the next eighteen months, coast to coast coverage in hundreds of newspaper articles along with features in three national detective magazines described the five different trials, guilty verdicts and prison sentences that followed for Pearl, the “hard-boiled backwoods bride” and her partners in crime. Less public documents memorialized the final act in this domestic drama, which occurred offstage as Pearl’s youngest siblings were sterilized in state institutions to snuff out any potential for another generation of family mischief.

This paper will analyze the “hillbilly homicide” and its aftermath. The episode demonstrates the resilience of eugenic mythologies about “problem families” that harkened back to Richard Dugdale’s 19th Century saga of The Jukes, still used in this late 1930s true crime saga to frame popular understandings of crime, poverty, and social disorder.

LEARNING OBJECTIVES:

1. Attendees will recognize the “The Jukes” as a classic story in the “hereditary problem family” studies genre of eugenic literature;
2. Attendees will understand the significance of theories of inherited criminality in explaining the prosecution of crimes;
3. Attendees will appreciate the notoriety of a “true crime” story that formed part of the justification for eugenic sterilization of children.

HEATHER MACDOUGALL

University of Waterloo, Waterloo, Ontario, Canada (1)

PUBLICIZING PREVENTION: THE HEALTH LEAGUE OF CANADA AND IMMUNIZATION, 1933-1977

Today vaccine hesitancy and/or resistance challenge public health officials. How has this problem arisen and what can be done to counter it? By examining the successful campaigns which the Health League of Canada created between 1933 and 1977, history offers some guidance. Starting with support for the Toronto Health Department's campaign to immunize school children and their preschool siblings with diphtheria toxoid, the Health League, which was a voluntary group dedicated to educating Canadians in the rules of good health, adopted modern publicity techniques to convey its message. Using radio, newspapers, pulpits, posters and pamphlets, the annual League campaigns were so effective that in 1940 Toronto was the first city over 500,000 worldwide to have no cases and no deaths from diphtheria. This signal achievement prompted the British Ministry of Health to undertake a similar approach in 1942 and also led Canada's Dominion Council of Health to ask the League to organize national immunization weeks. Starting in 1943 and continuing until 1977, the League led by Dr. Gordon Bates initially focused its efforts on increasing uptake of smallpox, diphtheria, tetanus and whooping cough vaccines. In addition to using official channels such as school medical inspection and well baby clinics, the League drew on the services of women's groups, local advertising agencies and national media to 'educate' parents and the public. Its monthly magazine, Health, contained articles by noted pediatricians and medical researchers about the origins and benefits of childhood immunization. With a circulation of 22,000 by 1950, Health was well-positioned to provide information to Baby Boom mothers and to alert them to new vaccines for polio (1955) and measles (1963). But as women joined the workforce and local health departments ceased to provide preschool clinics and school nurses once all Canadians had access to medical services after 1968, the public-voluntary group partnership that had provided an annual reminder about the importance of childhood immunization ended. Understanding the methods and analyzing the rhetoric of the Health League publications and ad campaigns will provide modern health planners with a variety of insights regarding the multiple means of shaping public understanding of immunization.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature and ends of preventive medicine
2. Recognize the dynamic interrelationship between medicine and society throughout history
3. Acquire a historically nuanced understanding of the organization and practice of preventive medicine in the Canadian health care system

THE MAKING OF A MEDICAL HYPNOTIST: ALBERT MOLL (1862-1939)

Hypnosis was a controversial topic of medical, legal and public debate in Imperial and Weimar Germany. The therapeutic potential of hypnotic suggestion was balanced against the dangers of a mental state that made the individual a powerless subject of the hypnotiser’s will and commands. The risks of induced nervousness and hysterical fits, of sexual abuse of hypnotised persons, and of criminal suggestions were invoked when treatment with hypnosis was discussed. Moreover, in the eyes of its critics medical hypnosis had uncomfortable resemblances with the Mesmeric or ‘magnetic’ treatments of lay healers, the stage performances of lay hypnotists, and the trance states of spiritualist mediums in occult séances. The Berlin physician and psychiatrist Albert Moll (1862-1939) was a key participant in these debates and established himself as a leading expert in hypnosis and suggestion therapy. However, while Moll’s work in other areas, particularly in medical ethics, sexual science, and parapsychology, has recently been examined in detail, we lack an analysis of his numerous contributions to the field of hypnosis.

This paper will examine Moll’s role in the contemporary discourse on hypnosis (or ‘hypnotism’, as it was often referred to). It discusses Moll’s efforts to establish hypnotic suggestion as a therapeutic method following the School of Nancy and the international reception of his successful textbook ‘Der Hypnotismus’ (1889, Engl. transl. 1890, 5th German edn 1924). Moreover, I will highlight his experimental research on the rapport between hypnotiser and subject and its connection with the concept of the ‘Double-Ego’ of his friend, the Berlin philosopher and psychologist Max Dessoir (1867-1947). I will also draw attention to Moll’s expertise in the forensic field of ‘hypnotic crime’, which made him known in a wider public. My paper will close with Moll’s views on the legacy of hypnotism for the development of psychotherapy and his increasingly hostile comments on Freud’s psychoanalysis in the 1920s. I will ask why Moll, though professionally and publicly recognised in his time as an expert in the psychological aspects of medicine, was soon overshadowed by Freud and largely forgotten.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Identify successes and failures in the history of medical professionalism
3. Critically appraise clinical management from a historical perspective

JOHN MANTON
LSHTM, London, UK (1)

RESOURCING HISTORIES OF MEDICINE IN NIGERIA AND CAMEROON

This paper reflects on three projects, each specifically concerned with discovering, using, and publicising new sources on the history of medicine in West and West-Central Africa, and with which the presenter has been involved as principal investigator or collaborator. The paper aims to identify key strategies for resource discovery and use, and emphasise models for collaboration which enhance the research and resource capacity of African scholarly networks.

The paper opens with a discussion of the presenter's research on the history of leprosy control in Eastern Nigeria, which was mostly conducted at hospital sites, and brought to light problematic and significant aspects of working in such sites, not least the difficulties involved in preserving written and paper materials, and convincing medical stakeholders of the value of obsolete records.

It was in the light of such meditations that the presenter joined with collaborators in the UK, France and the Netherlands to investigate the nature of memory and commemoration in relation to medical research on Africa. The project, entitled "Memorials and remains of medical research in Africa. An anthropology of scientific landscapes, ruins and artefacts", examines three sites in respect of their written, visual and monumental traces of medical research. Our Cameroon site (investigated with Guillaume Lachenal) is a significant public health and training centre, and together with public health workers and local scholarly collaborators, we sought to uncover the resonances of historical medical enterprise at the site, thus aiming to avoid the often seemingly alien and extractive nature of archival research.

Linked to this project is a partnership conceived by the presenter and Gérard Chouin of IFRA-Nigeria, and funded by the British Academy, aimed at encouraging scholarly research in the history of medicine at Nigerian universities. It consists of a training and research proposal development workshop, emphasising the identification and use of new archival resources, and a fieldwork grant competition to facilitate a research programme.

Together, the projects describe a learning process and a long-term engagement with archival discovery and use in relation to West Africa's under-researched and under-resourced medical history.

LEARNING OBJECTIVES:

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

HILARY MARLAND

University of Warwick, Coventry, UK (1)

HOUSEHOLD MEDICINE AND THE ACTIVE PATIENT IN NINETEENTH-CENTURY ENGLAND

When historians consider the household as a place of care and curing from the Victorian period onwards, they conventionally envisage a shift from traditional approaches towards faith in patent medications and the lure of the druggist's shop, from experience and self-knowledge to the growing incursion of the trained physician into domestic spaces. There is also a presumption that the home as a therapeutic space and site of decision-making was displaced by growing medical authority and institutional provision of care. While US historians, notably Charles Rosenberg, have challenged this view, in the British context these assumptions remain relatively unexplored, especially when compared with growing interest in household practices in the early modern period, particularly in connection with recipe book collections. Through an analysis of a selection of the substantial collections of nineteenth-century recipe books held at the Wellcome Library and elsewhere, this paper explores how these rich and complex sources provide insight into the ways in which household members collected and compiled medical recipes, potentially transforming themselves into active patients. This involved a multiplicity of interactions and transits of information on health and healing, via neighbourly and familial exchanges, local doctors and chemists, and print media. Some compilations take the form of commonplace books or scrapbooks and alongside handwritten notes and recipes, contain pasted in excerpts and newspaper clippings. Recipe books provide valuable insights into everyday family health concerns and practices as well as growing fascination with collecting remedies from around the globe. The recipe books also indicate how household members trained themselves in therapeutic and health promoting activities, which were also encouraged by access to an expanding range of household manuals and health periodicals, and druggists' domestic guides, which provided intricate detail on techniques to manufacture recipes in the home and on dosage. The paper argues that the nineteenth century, rather than being marked by a reduction in opportunities to treat at home, saw the continuation of traditional healing practices and the addition of new approaches bolstered by increased access to medical products and information.

LEARNING OBJECTIVES:

1. Develop a historically-informed understanding of the range of patient practices, technical competence and knowledge.
2. Deepen understanding of the priorities of 'active patients' in health and healing.
3. Identify the multiplicity of ways in which medical information was transmitted in the historical past.

RICHARD MCKAY
King's College, London, London, UK (1)

"V.D. IS NO CAMP": COMMUNICATING INFORMATION ABOUT VENEREAL DISEASE AMONGST MEN HAVING SEX WITH MEN IN NEW YORK AND BEYOND IN THE 1960S

In 1964, the Mattachine Society of New York – then one of the United States' largest groups advocating for the public understanding of homosexuals – found itself under pressure to address the issue of venereal disease (VD). Amid nation-wide concern that VD rates had been increasing steadily for a number of years, several reports highlighted the seemingly new and prominent role of homosexual men in the spread of sexually transmitted infections, particularly syphilis. Private physicians were urged to maintain a higher "index of suspicion" and to be mindful of chancres concealed in "unexpected" bodily locations. Meanwhile, public health officials called for education efforts to address this socially stigmatized group. In 1964 – at a time when homosexual relations were still penalized by law and many homosexual men were deeply uneasy about co-operating with public authorities – the New York Mattachine Society collaborated with the city's health department to publish an informational leaflet, entitled "V.D. is no camp", which was aimed specifically at homosexual men.

Using archival materials, newspaper articles, and public health publications, this presentation will examine the delicate navigations undertaken by members of the Mattachine Society to produce and distribute its leaflet. It will contrast the organization's collaboration with the city's health department, on the one hand, with the suspicion of public health authorities advocated by its Californian contemporaries on the other. The presentation's focus on these debates will highlight the need to complicate a conventional historical periodization which implies that VD did not emerge as a serious concern for men having sex with men until the 1970s. Finally, by tracing the leaflet's circulation beyond U.S. borders, the presentation suggests that a transnational framework may be important when analyzing responses to VD during this decade.

LEARNING OBJECTIVES:

1. Develop a historically informed sensitivity to the diversity of patients.
2. Recognize the dynamic interrelationship between medicine and society through history.
3. Acquire a historically informed understanding of the barriers to healthcare experienced by patients from different social groups.

GRAHAM MOONEY

Johns Hopkins University, Baltimore, MD, USA (1)

MARY FISSELL

Johns Hopkins University, Baltimore, MD, USA

LUNCHEON WORKSHOP: OPEN ACCESS AND THE FUTURES OF SCHOLARLY JOURNALS

Open Access policies and associated shifts in the economics of scholarly publishing are changing the landscape for scholarly journals. We propose a lunch session that will explore these issues for scholars, editors, publishers, librarians, and editorial board members. We seek to foster dialogue amongst these different communities, all of whom are invested in the future of scholarly publication, but who often have different perspectives. "Open Access" itself can mean different things to different participants, so we see this lunch as a way for us all to educate ourselves about this ever-changing topic. Scholarly journals, for example, operate with a variety of business plans which make for a range of reactions to the possibilities and perils of the open access movement. Editors from 4 of the leading English-language journals in the history of medicine have expressed interest in participating, as well as a scholar and librarian, a representative from a publisher, and members of editorial boards.

LEARNING OBJECTIVES:

1. Promote tolerance for ambiguity of theories and the nature of evidence.
2. Critically assess different models for the dissemination of scholarly research.
3. Deepen understanding of the contingencies of knowledge production.

BRADLEY MOORE

University of Wisconsin - Madison, Madison, WI, USA (1)

PREVENTATIVE MEDICINE AND POLITICAL MILIEU: THE ASCENDANCY OF PUBLIC HEALTH STRUCTURALISM IN 1950s CZECHOSLOVAKIA.

Dominant narratives in the history of public health describe a crisis of professionalization in the years after World War II. The introduction of effective antibiotics combined with general improvements in nutrition, urban infrastructure, and hygiene in the West allowed the menace of acute infectious disease to transform into a more manageable problem of epidemiological surveillance and popular education. Without the threat of uncontrolled contagion, there was no imperative to adopt environmental public health reforms which directly targeted the material conditions of work and daily life - especially since such structuralist approaches typically involved large public investments or legal-regulatory frameworks that presented a direct threat to the interests of private capital and laissez-faire economics. Under these socio-political pressures, most chronic diseases transformed into issues of lifestyle, and individual behavior became the most feasible site of public health intervention.

Yet the case of preventative medicine in Czechoslovakia demonstrates how deeply integrated these developments were with the Cold War political milieu. The Interwar First Republic was immersed in public health trends from Western Europe and America. Many of the state's most prominent hygienists, through grants provided by the Rockefeller foundation, received advanced medical training in modern approaches to public health from Johns Hopkins and Harvard University. In addition, well-known figures in the movement for social medicine, such as Alfred Grotjahn and René Sand, were no less influential among east central European physicians and researchers than they were among their Western counterparts.

But in the post-war era, the communist milieu had a very different impact on preventative medicine. No less rooted in medical developments and debates from the 1920s and 1930s, the crisis of epidemiological transition in Czechoslovakia was met with a focused embrace of public health structuralism, while behaviorist interventions popular in the West were largely disregarded. A powerful state apparatus, the centralization of design, planning, and construction, as well as the ideological imperatives of socialist-humanism and dialectical-materialism, provided an ideal platform to advocate for an active and materially interventionist public health program that sought the direct development of salubrious external conditions for the entire body politic.

LEARNING OBJECTIVES:

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

KEVIN MOOS
UC San Francisco, CA, USA (1)

'FROM DEATHS TO DOLLARS': COST, PRICE AND THE WORLD HEALTH ORGANIZATION'S EFFORT TO CALCULATE THE VALUE OF MALARIA ERADICATION, 1955-1980.

In 1955 the World Health Organization initiated an ambitious global effort to eradicate malaria. Partnering with university researchers, philanthropic foundations, national health authorities and other international organizations, the WHO organized a series of studies to demonstrate that malaria eradication was not only a medical necessity for those individuals suffering from the disease, but also a global economic imperative. Lifting the disease burden caused by malaria, according to the WHO and its supporters, would remove a serious impediment to economic growth in developing countries.

To raise support for malaria eradication the WHO hired Dr. Sonti Dakshinamurty, a malariologist who had previously worked for the League of Nations, to conduct research that would demonstrate the economic benefits of their proposed projects. Using analytical tools developed by economists and researchers at American business schools, Dakshinamurty blended cost-benefit analysis with his training in social medicine to translate, from 'deaths to dollars', the exact monetary benefits to be had from malaria eradication. Over the course of the 1960s he made an impassioned, yet ultimately unsuccessful, effort to garner support for malaria eradication through his particular combination of social medicine and economic analysis.

International organizations and global health movements in the post-war period struggled to balance the humanistic values of early twentieth century social medicine with the economic discourse and priorities of the second half of the century. Although these academic traditions have often been portrayed as supporting competing values and activities (economics and business vs. humanism and medicine) they both ultimately shared a common intellectual origin in the early twentieth century Progressive Era and often referenced each other to discuss what contributed to general societal well-being. Using archival materials from the WHO (1955-1980) and the analysis of the business literature cited in WHO malaria studies, this paper demonstrates the common academic origins shared between social medicine and business focused research as well as the WHO's struggle to balance humanist principles with quantitative research methods.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Recognize the dynamic interrelationship between medicine and society through history
3. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

IAN MOSBY

University of Guelph, Guelph, Ontario, Canada (1)

ADMINISTERING COLONIAL SCIENCE: NUTRITION RESEARCH AND HUMAN EXPERIMENTATION IN ABORIGINAL COMMUNITIES AND RESIDENTIAL SCHOOLS, 1942-1952

Between 1942 and 1952, some of Canada’s leading nutrition experts - in cooperation with various federal departments - conducted an unprecedented series of nutritional studies of Aboriginal communities and Indian Residential Schools. The most ambitious and, perhaps, best known of these was the 1947-1949 James Bay Survey of the Attawapiskat and Rupert’s House Cree First Nations. But less well known were two separate long-term studies that went so far as to include controlled experiments conducted, apparently without their informed consent or knowledge, on malnourished Aboriginal populations in Northern Manitoba and, later on, in six residential schools. This paper explores these studies and experiments, in part, simply to provide a narrative record of a largely unexamined episode of exploitation and neglect by the Canadian government. At the same time, it also situates the studies within the context of broader federal policies governing the lives of Aboriginal peoples, a shifting Canadian consensus concerning the science of nutrition, as well as changing attitudes towards the ethics of biomedical experimentation on human beings during a period that encompassed, among other things, the establishment of the Nuremberg Code of experimental research ethics.

The paper argues that – during the war and early postwar period – bureaucrats, doctors, and scientists alike increasingly came to view Aboriginal bodies as ‘experimental materials’ and residential schools and Aboriginal communities as kinds of ‘laboratories’ that they could use to pursue a number of different political and professional interests. Nutrition experts, for their part, were provided with a rare opportunity to observe the effects of controlled nutritional interventions on malnourished human subjects while, for many government officials, nutrition offered new explanations for – and novel solutions to – the so-called ‘Indian problems’ of susceptibility to disease and economic dependency. In the end, these studies did little to alter the structural conditions of that led to malnutrition and hunger in the first place and, as a result, did more to bolster the career ambitions of the researchers than they did to truly improve the health of those identified as being malnourished.

LEARNING OBJECTIVES:

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

PROJIT MUKHARJI

University of Pennsylvania, Philadelphia, USA (1)

HYDROTHERAPY IN INDIA: COLONIAL, GLOBALIZED, TRANSNATIONAL OR VERNACULAR?

Hydrotherapy in India today forms part of 'Naturopathy'. The latter in turn is incorporated into India's officially sanctioned medical pluralism. While this does not amount to equality with biomedicine, or even India's other classical traditions like Ayurveda, Siddha and Unani, State-recognized colleges offer degrees in Naturopathy and such degree-holders are eligible for jobs in the public health apparatus.

Though Naturopathy today is presented in India as an essentially indigenous system whose roots are to be found in the Sanskrit classics of remote antiquity, academic opinion usually sees hydrotherapy as having been developed by an early nineteenth-century Silesian farmer called Vincenz Preissnitz in Gräefenberg (now Lázně Jeseník) in the Czech Republic. This emphasis on origins naturally obscures the actual histories of transmission and connectedness. The earliest books that enabled and sustained the popularity of 'Jal-chikitsa' or hydrotherapy in the 1920s and 1930s, however, reveal a much more complex and non-linear history. The putative sources for the authors of the 1920s were neither exclusively ancient Indians nor nineteenth-century Europeans, but included a range of Indian, European and even American authors. To complicate matters further, writings in different Indian languages borrowed and adapted from each other at various points. A range of professional and personal connections sustained these diverse transmissions.

Historians of medicine are today increasingly sensitive to issues of transfer/ circulation of knowledge beyond the 'West', but how best should we study the mechanisms for such knowledge circulation? Many competing conceptual models and vocabularies ranging from 'colonialization', 'globalization', 'transnationalization' and 'vernacularization' have been offered as ways to understand the process. Hydrotherapy, as a relatively discrete tradition with a geographically wide-ranging past, offers a perfect case study to test the strengths and weaknesses of these conceptual models. Learning from the strengths of each of these conceptual models, we will propose, "networked vernacularization" as the best way to understand this kind of knowledge transfer.

LEARNING OBJECTIVES:

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

HEATHER MUNRO PRESCOTT

Central Connecticut State University, New Britain, CT, USA (1)

A NEW MIDDLE GROUND: THE WOMEN'S CONGRESSIONAL CAUCUS AND REPRODUCTIVE HEALTH ACTIVISM IN THE 1980S AND 1990S

On March 1, 1991, Congresswoman Pat Schroeder (D-Colorado) told CNN that the National Institutes of Health (NIH) had “done nothing in contraceptive research since the 1960’s,” because of “fear about the abortion issue and pressure it may bring from the ‘far right’.” Agnes Donahue, director of the Public Health Service’s Office of Women’s Health, was aghast. In a memo to HHS Assistant Secretary James Mason, Donahue expressed disappointment that Schroeder and other members of the Women’s Congressional Congress did not recognize in a public forum “the advances made in establishing an Office of Research on Women’s Health,” and ignored the significance of appointment of Bernadine Healy as the first woman to head the NIH in 1991.

Schroeder’s remarks represented a new direction for the Women’s Congressional Caucus (WCC), which was a bipartisan group founded in 1977 to work for political and economic equality for women. Initially the group took no position on abortion because they agreed they “would work only on the issues that united them, not on those that divided them.” As abortion rights were eroded in the 1980s, Schroeder and her Caucus co-chair Olympia Snowe (R-ME) began to look for what they called “a new middle ground” in the abortion divide by pressuring NIH to engage in research aimed at preventing unintended pregnancy through improved contraception. This put the WCC in direct conflict with NIH director Healy, who as a conservative Republican supported President George H.W. Bush’s ban on research on the medical abortifacient RU-486 (mifepristone).

This paper will show how the actions of the WCC are an example of a trend described by Sanda Morgen in which the concerns of feminists and other progressive health care activists “trickled up” to federal agencies responsible for public health and medical research. This paper will also use the WCC’s work on reproductive health as an example of important continuities between the health activism of the 1980s and 1990s and that of Second Wave feminism.

LEARNING OBJECTIVES:

1. Explain the ways in which the Women’s Congressional Caucus helped advance reproductive health research at NIH.
2. Understand historical continuities between various waves of women’s health activism in the twentieth century.
3. Critically appraise the role of federal agencies in addressing women’s health issues.

RAUL NECOCHEA

University of North Carolina, Chapel Hill, NC, USA (1)

GAMBLING ON THE PROTESTANTS: THE PATHFINDER FUND AND BIRTH CONTROL IN PERU, 1958-1965

Rapid population growth in developing countries in the second half of the 20th century gave rise to initiatives including the mass promotion of birth control services and population limitation policies. Among the agencies involved in population control activities, none scored as many early victories in Latin America as did the Pathfinder Fund, founded by Procter & Gamble scion Clarence Gamble. Using the Gamble papers at the Countway Library and Archives, this paper analyzes the work of the Pathfinder Fund in Peru, the organization's beachhead in South America, and shows how Pathfinder personnel allied themselves with local Protestant institutions to bring about changes in popular attitudes and practices related to contraception.

The Pathfinder Fund's early activities in Peru reveal a new side of the global family planning movement, one that shifts the spotlight away from politicians and elite scientists, and towards the day-to-day relationships that fieldworkers established with religious organizations. Such liaisons demonstrate the existence of a culture of rapid intervention in the global family planning movement, one that contrasted and competed with the more cautious approach embraced by organizations such as the IPPF, the Population Council, the Ford Foundation, and the USAID, which placed much stock on influencing politicians and establishing clinics. Instead, its Protestant allies furnished the Pathfinder Fund with critical help setting up and managing rapid interventions such as the production of pamphlets, the international smuggling of contraceptives, and the direct enrollment of physicians as promoters of intra-uterine devices (IUDs).

Religious organizations shaped family planning activities to an important extent in Latin America. Local Protestant pastors, lay leaders, and physicians negotiated with Gamble's staff the terms on which to provide contraception services, including the content of pamphlets, the contraceptives to be imported, and the manner in which to recruit physicians for the IUD program. Protestant leaders benefitted from Gamble's funding, which turned their Church into an important site for the dissemination of contraception information and supplies. At the same time, it was a partnership weakened by the status of Protestants as a religious minority and the antipathy they elicited among the leaders of the powerful Catholic Church.

LEARNING OBJECTIVES:

1. Define what "rapid intervention" meant in the context of global family planning initiatives in the 1950s and 1960s.
2. Explain how organized religion played a role planning the first global population control efforts.
3. Explain why private philanthropies participated in contraception distribution projects in the developing world.

JESSICA NICKRAND

University of Minnesota, Minneapolis, MN, USA (1)

LUNCH SESSION: WORKING OUTSIDE THE ACADEMY

The American Historical Association has recently reported signs of improvement in the number of advertised job openings, but the number of new History PhDs is still significantly higher than the jobs available at universities. Historians of medicine who may previously have been focused on academic positions have now begun to expand their horizons because of the changing landscape of higher education. Additionally, the multidisciplinary nature of our field attracts people from policy, medicine, and other scientific fields who have had goals of non-academic positions since their first day of graduate school.

This lunch panel will feature historians of medicine who have worked outside a university setting. Each panelist will provide a brief introduction, indicating their training, what they do or have done outside of academia, and the path taken to get to that point. The remainder of the session would be an informal, moderated question and answer session between the attendees and the panelists. This session is the result of a conversation over the AAHM grad student list serve.

Audra Wolfe, Principal of The Outside Reader; Michael Sappol, Historian at the National Library of Medicine; Eric Boyle, Historian at the National Museum of Health and Medicine; Shera Moxley, a health policy analyst at MITRE's Center for Transforming Health, and Lori Jones, current University of Ottawa graduate student with extensive work in International Health and Development, are the panelists. These five scholars all have worked both inside and outside of a university setting and this will lead to insightful contributions from each of the panelists. Additionally, Nathan Crowe, a postdoc at Arizona State working primarily in digital humanities, has agreed tentatively to speak about the diversity of work available within a university setting. Jessica Nickrand, a student at the University of Minnesota, will moderate.

It is the intention of this lunch panel to provide graduate students and those interested in switching careers with some information needed to work outside academia. Also, this will provide AAHM members interested in non-academic careers with a network within our national organization, expanding our goals and reach of the group keeping up with the changing trends of our field.

By the end of this activity, the learner will:

LEARNING OBJECTIVES:

1. Have the information needed to think about working outside the academy
2. Be able to reflect on the changing nature of our field
3. Think critically about the goals of AAHM, and the audience for our annual meeting

HYUNG WOOK PARK
Nanyang Technological University, Singapore

DISEASE CATEGORIES AND DISCIPLINARY BOUNDARIES: EXTRAMURAL FUNDING PROGRAMS FOR GERONTOLOGY IN THE NATIONAL INSTITUTES OF HEALTH, 1945-1965

This paper discusses how gerontologists, scientists of aging, succeeded in creating their own niche in the extramural funding program of the National Institutes of Health (NIH) after World War II. As Stephen Strickland has described, the federal budget for American biomedical research underwent a substantial growth during the postwar years. But it was initially difficult to justify research on aging for NIH funding, despite the enhancing American concern for health, mental adaptation, and job fitness for the elderly upon the enactment of the Social Security Act. When the Gerontological Society was established in 1945, gerontologists argued that aging was an important problem that crossed disciplinary boundaries as well as disease categories. But such an argument did not lead to an independent funding committee in the NIH, when the funding decisions were made through study sections and research institutes created according to the very categories that gerontologists hoped to cross. While aging was certainly a background factor of various chronic diseases, it did not precisely fit in any of the disease categories that drew the NIH's internal institutional boundaries. But I argue that gerontologists eventually secured a stable and enlarging source of money from the NIH after the 1940s. Above all, their multidisciplinary organization-which included physiologists, anatomists, statisticians, and psychologists-was compatible with the NIH's structure that crossed disciplinary boundaries while observing disease categories. Gerontologists' emphasis of the multidisciplinary nature of their work could thus be considered favorably by interdisciplinary review panels organized according to disease categories. Simultaneously, gerontologists established the NIH Center for Aging Research as an organization for facilitating cross-institutional communication on aging and assisting prospective funding applicants in gerontology. In the 1950s and 1960s, the center played a pivotal role in enhancing the acceptance rate of multidisciplinary proposals in gerontology as well as increasing the budget for aging research in general. It thus paved the way for creating the National Institute on Aging in 1974. By analyzing this development, this paper contributes to our historical understanding of the interaction between the NIH and gerontology, which have been studied by Paolo Palladino, Tiago Moreira, and W. Andrew Achenbaum.

LEARNING OBJECTIVES:

1. Develop a deeper view of the dynamics in American health research funding
2. Improve our understanding of the complex relationship between disease categories and disciplinary boundaries in medical and bioscientific research
3. Understand the enhancing significance of aging as a socially as well as medically meaningful factor

NEIL PEMBERTON

University of Manchester, Manchester, UK (1)

EMMA JONES

THE 1953 TEN RILLINGTON PLACE MURDERS AND THE CHANGING POLITICS OF THE BACKSTREET ABORTION TRADE IN POST-WAR BRITAIN

This paper examines the practices and cultural representations of backstreet abortionist in modern Britain between the years 1949-1971, focusing on one exemplary murder investigation featuring a killer who posed as an illegal abortionist. In modern-day imagination Ten Rillington Place was the home to the post-war serial killer John Christie, who came to be readily identified as the archetypal figure of the nightmarish backstreet abortionist. Armed with rubber tubing and gas, understood as his 'anaesthetising' equipment, by which he 'did away' with his unfortunate victims, many of whom thought they were getting an abortion, and posing as 'the Doc' in a run-down working-class district, John Christie embodies cultural fears of the male abortionist who, in direct contrast to the image of the conventional female practitioner (for example Vera Drake), potentially possessed ulterior sexual and sinister motives.

This paper scrutinizes how the link between Christie and the backstreet abortion, so apparent in the modern-day British public imagination, was not a given at the time when the bodies of six women were discovered at his house in 1953. This absence is, I contend, historically and culturally revealing of both medical culture and popular attitudes surrounding the practice of illegal abortion in post-war Britain. For police investigators, legal advocates and journalists, the subject of criminal abortion posed distinct social and cultural obstacles, which sharply curtailed the public discussion of the investigation of criminal abortion. Crucially, the image of Christie as an dangerous abortionist practitioner was written into the medical-legal understanding of the case in the 1960s, when the Christie case re-opened and reinterpreted against a new powerfully progressive and permissive public discourse; involving a broad interrogation of the interrelationships between morality and law within which the profile of the abortion trade had a key role. This new climate set the stage for interrogating and assessing the role of the backstreet abortion trade in British life, which had seemingly provided the perfect cover for a serial murderer to hunt down his victims. The paper demonstrates the value of examining the historical embedment of the illicit practices of the illegal abortion trade in mid-twentieth-century Britain.

LEARNING OBJECTIVES:

1. To consider the illegal abortion trade in a historically specific context
2. To examine medical-legal and forensic investigations into the practices of the illegal abortionist
3. To interrogate the changing public moral discourse surrounding abortion and how this shaped medical, forensic and legal discussions of and investigations into criminal abortion.

CONSTANCE PUTNAM

Independent Scholar, Concord, Massachusetts, USA (1)

NURSE AS NEEDED: THE DOCTOR'S WIFE PRESSED INTO SERVICE

Most physicians' memoirs largely recounts what the doctors themselves accomplished in their careers with only occasional reference to the nurses who assisted them. Especially in rural general practices, however, doctors depended heavily on having assistants who could take on nursing responsibilities while they themselves made house-calls.

In the middle decades of the 20th century, such help was frequently provided by the doctor's wife. Some were qualified R.N.s; others were devoted spouses trained solely by their doctor-husbands. The critical role played by doctors' wives who became "nurses as needed" merits further analysis. Numerous accounts of the way the old family doctor (almost all male) worked in the "Golden Age" of rural general practice have created a gendered picture of the way medical care was delivered. The nurses who assisted, in particular the physicians' wives who carried out nursing tasks without formal training, have not had much of a voice.

An intimate portrait of the physician's wife who found herself called upon to be not only a bookkeeper and general office assistant, but nurse, is still lacking. Just such a story lies buried in a unique archive, a still largely untapped cache of letters written between 1936 and the late 1970s by the wife of a rural general practitioner in northern New England, who was called into service because her husband could not afford to hire a nurse. She learned on the job—and became a critical part of the medical team.

Full of details about what this woman was learning and how her husband trained her, these letters to family members and friends give an intimate picture of the way medicine was practiced by one physician in rural New Hampshire and Vermont. The letters give insight into the role that could be played by a doctor's wife in a mid-century medical practice. The hypothesis that makes examining this woman's "nursing" career important is that she is unlikely to have been unique. Doctors' wives, whether trained as nurses or required to learn nursing on-the-job, almost certainly played a far larger role than has been recognized in providing medical care to rural populations.

LEARNING OBJECTIVES:

1. Discover how delving into a private archive can illuminate the way a rural medical practice actually functioned in the 1930s, 1940s, and beyond;
2. Acquire information that challenges the gendered view of "heroic" male physicians in rural practices doing it all on their own;
3. Be better positioned to discuss the pros and cons--professional and personal--of having a doctor's wife (especially one without formal training) work in her doctor-husband's practice.

ELIZABETH REIS

University of Oregon, Eugene, OR, USA (1)

Visiting Scholar, Harvard University, Cambridge, MA, USA (2)

THE MAINSTREAMING OF CIRCUMCISION IN THE 1950S: GOOD FOR THE JEWS?

Various aspects of neonatal male circumcision have long been challenged, and not just by non-Jewish critics. This paper examines a particularly controversial time and place, 1950s New York City. Analyzing the records of the New York Board of Rabbis during this period, I will examine the tension among religious Jews regarding circumcision: All agreed on its singular importance, but they argued over the meaning and particulars of the ritual itself in the context of broad changes in the contemporary practice of medicine.

During the 1950s, circumcision rates soared in the United States, and for most of the (non-Jewish) population physicians performed the procedure in a hospital, shortly after a boy's birth. By contrast, Jewish law required circumcision performed by a mohel, a ritual circumciser, on the infant's eighth day. Less religious Jews often wanted what they perceived to be the most modern and medically sound procedures, and so they too began to prefer doctors to mohels, a threatening departure from tradition. Would a circumcision performed by a physician rather than a mohel count, according to Jewish law? At a time when hospitals were discharging new mothers and babies from the hospital before eight days had elapsed, would it be allowable for a Jewish boy to have a circumcision before the eighth day? Rabbis debated these questions while their Jewish constituencies demanded various changes.

The rabbis were not averse to all change; in fact, they understood secularization and sought to place mohels in hospitals, so that Jewish families could opt for religious ritual more easily. But this trend came with its own problem: should hospitals allow non-physicians to perform surgical procedures? This paper argues that Jews were caught in a bind between tradition and medical protocol. If physicians and hospitals embraced circumcision as a secular health measure, and doctors performed them on any day, without the requisite prayers, rabbis worried that this would undermine Jewish religious observance generally, or even promote the decline of Jewishness altogether. How rabbis, Jewish parents, mohels, and hospital physicians navigated this new terrain influenced the acceptance of the ritual for non-Jews as well as Jews.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and religion in the mid-twentieth century
2. Critically appraise a significant religious tradition from a historical perspective.
3. Understand that some procedures we have come to think of as routine, like circumcision, often have a contested past.

HÉLÈNE RICHARD

Université Paris I- Institut d'Histoire et de Philosophie des Sciences et des Techniques, Paris, France (1)

THE HISTORY OF PRENATAL DIAGNOSIS IN FRANCE FROM 1821 TO 1970

“Prenatal diagnosis has developed in the early 70s to provide an answer to the distress of couples who had given birth to a child afflicted by a very serious affection and who learned that the risk of having another affected child was high”(Dommergues, M., “Diagnostic prénatal, pratiques et enjeux”, Inserm, Paris, 2003, p.5).

This way of introducing prenatal diagnosis is widely spread in secondary literature. Prenatal diagnosis is indeed more specifically associated with the diagnosis of fetal genetic diseases and many experts in the field assert that its first appearance corresponds to the development of medical imaging (ultrasound) and molecular biology during the 70s.

Nevertheless, we would like to prove in this presentation that these assumptions are misleading, both for historical and epistemological reasons. Clinical examinations, such as the abdominal palpation or the auscultation of fetal heart beats through a stethoscope introduced in 1821 by Alexandre Lejumeau de Kergaradec, have been prevalent since the mid-nineteenth century, and followed by radiography or endocrinology at the beginning of the twentieth century. Their clinical use has grown in conjunction with public health in favor of birthrate and maternal protection in France, for example organized screening of infectious diseases in hospitals from the early twentieth century. So the secondary literature strongly underestimates both the historic and scientific scope of prenatal diagnosis, whose clinical use was already well established since the nineteenth century and whose techniques are not restricted to the detection of genetic diseases. The study of the primary literature, like obstetricians handbooks, and the exhaustive study of the first publication specialized in the field of gynecology and obstetrics (systematic reading from 1874 to 1970) will prove the existence of these techniques for nearly 150 years. So the history of prenatal diagnosis in France between 1821 and 1970 will help reevaluate its rich roots, providing a more complete analysis of its techniques as well as its medical indications and its social context. We will thus offer a more accurate epistemological study of the foundations of fetal medicine, based on both a diagnostic capacity and also a therapeutic power from its beginnings.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history: this history shows how some particular diseases were chosen to be screen in interrelationship with their social representations in order to understand current programs of prenatal screening.
2. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems: the context of this presentation is the French national health care system in favor of birthrate and maternal protection.
3. Elicit and write a patient's history worthy of an historian: this presentation stresses the birth of the concept of the “patient intra-uterine” since 1821.

SAMUEL ROBERTS

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Mailman School of Public Health Dept of Sociomedical Sciences (Columbia Univ), New York, USA (2)

DRUG POLICY, DRUG USE, AND POLITICS IN COMMUNITIES OF COLOR

In this paper I describe an approach to thinking historically about drug policy, drug use, and politics in communities of color in the United States (specifically African American and Latino communities).

While contributing much to our general understanding, historical studies of illicit drug use, policy, and race have nonetheless fallen in offering analyses of political mobilization in communities of color. To the virtual exclusion of considerations of how drug use and drug policy has shaped politics within communities of color, research thus far has focused on three aspects:

- Racialization of certain drugs or methods of drug use
- The social world of drug users
- Effects of law enforcement practices

Approaches to racialization typically begin with one of two questions. The first pertains to how some combination of medical experts, law enforcement officials, cultural producers, etc. may construct a dominant public perception of a certain drug or a certain method of using a drug as being prevalent (for whatever reasons) within specific ethnic groups. The second question regards, on the other hand, how particular drug using behaviors might enter social networks described by (among many things) ethnicity. The second aspect (studies of social world of drug users) emerged from the move to social history in the 1970s and 1980s, but drew implicitly from the variety of observational ethnographic work among drug users which has been in vogue since the 1950s. There have been few specific studies of law enforcement practice, but instead most examinations of race almost naturally incorporate consideration of law enforcement.

Not discounting obligatory references to agency, for the most part these three approaches have taken nonwhite drug users and communities as objects: of racialization, of law enforcement scrutiny, or of ethnographic inquiry. I suggest several reasons for this, including the role of ethnography in exoticizing drug users and the near absolute neglect of drug users by political scientists, who otherwise are positioned to frame drug users as historical agents. I end the paper with suggestions for directions in thinking about how to study users and former users in the context of politics and social movements, 1960s-1980s.

LEARNING OBJECTIVES:

1. Literature review of race and addictive drugs in history
2. Consideration of community politics
3. Discussion of historical methods.

KATHLEEN ROBINSON

University of Wisconsin, Madison, Madison, WI, USA (1)

“MILITANT FATS”: NAAFA’S STRUGGLE AGAINST THE MEDICALIZATION OF FATNESS

Since the Second World War, the American medical community and public increasingly framed large body size as a medical concern. Medical professionals conceptualized “obesity” as a disease, but not everyone agreed. Founded in 1969, the National Association to Aid Fat Americans (NAAFA) led a movement to uphold the civil rights of fat people and to argue against claims linking fatness and poor health. Historians have paid scant attention to this movement and the contested medicalization of fatness. How have fat people resisted dominant medical models of fatness? Who is in the position to produce or challenge medical knowledge?

In this paper, I utilize such key texts as Lewellyn Louderback’s *Fat Power* and NAAFA Newsletters, and interviews conducted with longstanding NAAFA members to explore these questions. I argue that NAAFA helped to challenge obesity science but that internal divisions limited the organization’s efforts to exert a major influence on the medical community. Enlisting the work of physicians and scientists such as Ancel Keys, Jean Mayer, Albert Stunkard, and Susan Wooley, NAAFAs argued that obesity was not clearly linked to increased morbidity and mortality. They further argued that fat stigma, rather than fatness itself, led to negative health outcomes.

Yet, medical issues surrounding fatness remained controversial within the organization. Rank and file NAAFAs prioritized creating positive social opportunities, and often avoided the contentious topics of dieting and health. Women, especially, noted the gendered ramifications of fat prejudice and sought a social safe haven. Ultimately, the predominance of fat stigma limited NAAFAs’ ability to function as medical knowledge producers.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
3. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

SARAH RODRIGUEZ

Northwestern University, Chicago, IL, USA (1)

THE DIMINUTIVE HOMOLOGUE TO THE PENIS: RECONSIDERING ANATOMICAL AND GYNECOLOGICAL REPRESENTATIONS OF THE CLITORIS IN THE TWENTIETH CENTURY

In 1973, Diana Scully's and Pauline Bart's "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks" analyzed gynecology textbooks published between 1943 and 1972. They found only one published after the late 1960s, when "Human Sexual Response" supposedly solidified the clitoris as the sexual organ for women, that labeled the clitoris as central to female sexual sensation. Twenty years later, two articles similarly analyzed representations of the female body in anatomy texts: in 1992, Susan Lawrence and Kae Bendixen published "His and Hers: Male and Female Anatomy in Anatomy Texts for US Medical Students, 1890-1989," in which they included an analysis of clitoral representations, and in 1995, Lisa Jean Moore and Adele E. Clarke published "Clitoral Conventions and Transgressions: Graphic Representations in Anatomy Texts, c1900-1991," in which they centrally examined how anatomy texts represented – or failed to represent – the clitoris through images and accompanying labels and descriptions. All three articles continue to be cited by those engaged in historical and contemporary discussions regarding medical representations and understandings of the female body.

Looking at these articles, one could assume the clitoris was absent, neglected, or not fully described in terms of its structure or sexual capabilities in gynecology and anatomy texts published for the majority of the twentieth century. But all three analyses, driven by an understandable desire to reclaim the female body, lacked the conceptual framework to uncover the nuance within descriptions of the clitoris in these texts. In this paper, I re-examine these three analyses of anatomy and gynecology texts' representations of the clitoris by reconsidering how the clitoris was represented within these medical texts. I will not argue that representations of the clitoris in gynecology or anatomy texts were equivalent to how feminist health texts published in the 1970s regarded the organ. Nor will I argue that representations of the clitoris within these texts were unproblematic. What I will argue is that the critique found within these three articles is too simplistic (and sometimes factually wrong), complicating the narrative of physician ignorance of (or even hostility to) the female sexual body.

LEARNING OBJECTIVES:

1. Be familiar with the historiography of the critique of anatomy and gynecology texts representations of the clitoris;
2. Critically evaluate this historiography;
3. Realize the heterogeneity of representations of the clitoris in anatomy and gynecology texts published in the 20th century.

KAREN ROSS

Troy University, Troy, AL, USA (1)

"LIKE MAGIC": THE DEVELOPMENT OF THE ANTIMENINGITIS SERUM AND THE MAKING OF OF SCIENTIFIC MEDICINE, 1907-1913

Before the advent of antibiotics, bacterial meningitis carried a mortality rate of up to 80% in sporadic outbreaks in early twentieth century North America. At the Rockefeller Institute for Medical Research, Simon Flexner drew from congruent developments in the fields of microbiology and immunology to create an antimeningitis serum that proved to be effective in reducing that rate to roughly 20%. The story of how Flexner developed his serum, determined its efficacy in animals, and then transferred this knowledge to human subjects beginning in 1907, demonstrates the evolving standards of scientific medicine as practiced at the bench and in the clinic.

The outlines of what was meant by scientific medicine were clear to the laboratory-oriented reformers of this period: medical research that sought to replace the perceived failings of clinical observation with rigorous experimental design. However, no single path to the creation of scientific medicine and no prevailing definition of what was meant by scientific existed. The first part of Flexner's meningitis research, establishing the etiology of bacterial meningitis in laboratory animals followed by an experimental serum therapy, illustrates the evolution of Flexner's own standards of practice at the bench and his early attempts to define the significance of his experimental data.

Part two of his research program, testing the efficacy of the serum therapy in humans, sheds light on the history of clinical trials and Flexner's struggles to adapt his methods and standards to the clinic. This history has largely centered on British Medical Research Council sponsored therapeutic trials of the 1930s. However, Flexner assembled dozens of physicians to conduct what was arguably the largest clinical trial before the influenza vaccine trials of 1918-19. Over six years, more than 1,300 patients received the "Flexner serum" in ten countries. In the *Progress of Experiment* Harry Marks argued that similar cooperative trials from the 1920s seldom resulted in definitive changes to therapeutic practice due to the inherent difficulties of conducting such large trials with multiple participants. However, the success of the antimeningitis serum trial demonstrates that in at least this instance Flexner was able to overcome these obstacles due to the authority and resources of the Rockefeller Institute, as well as the desperation of physicians faced with high mortality rates.

LEARNING OBJECTIVES:

1. Understanding the development of standards of laboratory practice for early 20th century medical reformers
2. Contributing to a neglected period of the history of clinical trials
3. Considering the relationship between laboratory and clinical standards in an early cooperative trial

WALTON SCHALICK

University of Wisconsin, Madison, WI, USA (1)

Central Wisconsin Center, Madison, WI, USA (2)

“PIN THE TAIL ON THE ...:’ DISABILITY, MEDICINE AND CHILDREN’S PLAY IN THE WEST OVER THE LAST MILLENIUM”

For the last thousand years, children and play have interacted variously with disability.

Many games invoked a physical or sensory impairment, like Blind Man’s Bluff or hopscotch. Breugel’s “Children’s Games” (1559/60) showed kids mimicking various disabilities, while his “The Fight Between Carnival and Lent in Vienna” (1559) depicted impaired adults, dressed up in childlike costumes alongside able-bodied children at play. Medieval and early modern children’s theater presented biblical healing of disabilities. The child actors had to portray disability sufficiently well to convince their peers.

Sometimes games could be cruel. Remembering his 17th-century Suffolk childhood, William Coe described leading a blind beggar into a lake as a game. Equally, Thomas Scott two centuries earlier climbed a tree to maim a bird; he fell thirty feet, surviving with his own compensatory disability.

The able-bodied child could see in disability a sense of "otherness." Thus excluding the disabled from play, like Rudolf the Red-Nosed Reindeer, affected children across time. Emerging from a confluence of self- and family-advocacy, gaming culture, and the growth of electronic multi-modality technology, the last fifty years has seen a geometric growth of non-exclusion. By 2007, Scope, the UK disability advocacy organization, published a booklet, “Games All Children Can Play.”

Finally, play was a cornerstone for therapy in the burgeoning area of pediatric rehabilitation dating from the nineteenth century in Europe and the United States. Napoléon Laisné (1810-96), in Paris, used war games and music to stimulate the recuperation of children with disabilities. Konrad Biesalski (1868-1930) in Berlin, Charles West (1816-98) in London, as well as Bronson Crothers (1894-1959) and Winthrop Phelps (1894-1971) in the US, variably advanced play therapy for children with a spectrum of disabilities. They stressed play as a medium for children’s rehabilitation and as a focus of analysis of the effects of their impairments.

Using information from clinical documents, art, literature, diaries, child-rearing manuals, and archival sources, this paper brings to light a cultural phenomenon nearly ubiquitous in ‘Western’ culture but little explored. In it, ‘child’s play’ emerges as an important and polyvalent feature for introducing, stigmatizing and adapting children to disability’s lived experience.

LEARNING OBJECTIVES:

1. Recognize the interrelationship between culture and disability;
2. Understand the role of play in pediatric disability;
3. Respond to the changing nature of disability over time.

ROBIN SCHEFFLER

Yale University, New Haven, CT, USA (1)

REDEFINING CANCER AS AN INFECTIOUS DISEASE: THE SPECIAL LEUKEMIA VIRUS PROGRAM AND MOBILIZATION AGAINST CHILDHOOD ILLNESS, 1948-1968

The release of the Human Papilloma Virus (HPV) vaccine as a means of preventing cervical cancer has reignited discussion of cancer as an infectious illness. However, most histories of cancer take its diagnosis and treatment, rather than its etiology, as their central focus. The HPV vaccine draws our attention to one often overlooked instance where the study of etiology also promised a lasting cure, if not the elimination of, cancer: viral carcinogenesis. While attention to human viral carcinogenesis waxed and waned, vaccination against leukemia drew considerable enthusiasm the 1950s, resulting in the National Cancer Institute's creation of the multimillion dollar Special Leukemia Virus Program (SLVP) in 1964. Current accounts view this enthusiasm as the consequence of the greater visibility of viruses thanks to molecular instrumentation such as the electron microscope. However, laboratory-based explanations seem to be lacking. The SLVP came into being at a time when no virus causing human leukemia was known to exist—it preceded research rather than following it.

Planners of the SVLP envisioned a unique program of directed research linking laboratory and clinic in order to accelerate the development of a human leukemia vaccine. The key factor in the SLVP's foundation, I argue, was less laboratory science than the redefinition of leukemia as a childhood and potentially infectious disease. The political success of cancer virus studies was a function of the efforts of its advocates to associate cancer viruses specifically childhood diseases. However, research efforts against childhood diseases exemplified by leukemia chemotherapy and polio vaccination, were of a very different type than prior, more restrained anticancer efforts. They stressed the need for results over the need for knowledge. The central problem of the SLVP became not if but when a human cancer virus would be found and a vaccine provided. To address the new found demands placed upon cancer virus research, the SLVP's architects turned to Cold War military management models to engineer speed into the process of research. In the process the SLVP inaugurated an influential alternative to the system of individual investigation that preceded later twentieth century biomedical mobilizations such as the Human Genome Project.

LEARNING OBJECTIVES:

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

WILLIAM SCHNEIDER
Indiana University, Indianapolis, IN, USA (1)

THE HISTORY OF WESTERN MEDICINE IN CHINA, 1800-1950: ARCHIVAL RESOURCES

This presentation will discuss results from a three-year grant by the Henry Luce Foundation to encourage research on the establishment and activities of hospitals, medical schools and other institutions in medical care, education and public health campaigns in China from 1800 to 1950. We have identified major archival holdings and other documents on the history of the subject within and outside of China. In order to make these resources more readily available to researchers, finding guides for several major repositories have been created, and selected primary source documents and limited circulation publications are being digitized and made available via the internet. This and other information will be accessible via a website portal, including links to existing bibliographies, databases, and inventories of archives and libraries, as well as a searchable inventory of hospitals, medical schools, nursing schools, and pharmacy schools in China, 1800-1950.

Guides to relevant material in selected archival repositories:

In North America:

- The Burke Library (Columbia University Libraries) at Union Theological Seminary
- Harvard University
- Presbyterian Historical Society
- Rockefeller Archive Center
- United Church of Canada Archives, Toronto
- United Methodist Archives
- Yale University

In China:

- Peking Union Medical College, PUHSC
- Huaxi Medical School Sichuan University
- Sun Yat-sen University Medical School
- South Central University, Xiangya School of Medicine Changsha (former Yale-in-China)

LEARNING OBJECTIVES:

1. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
2. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems
3. Recognize the dynamic interrelationship between medicine and society through history

CHRISTOPHER SELLERS

Stony Brook University, Stony Brook, NY, USA (1)

POLLUTION AND POLITICS AROUND POST-WWII ATLANTA: THE LONG SHADOW OF UNDERDEVELOPMENT

Surveying and situating the pollution experience of Atlantans in the years after World War II, this paper will suggest a kinship between the environmental dilemmas there and in the developing world. Whereas in other more industrialized and wealthier regions of the US, concerns arose about a new kind of pollution, less natural and more ominous than germs, Atlantans did not so easily or readily share these worries. Atlanta suburbanites over early postwar decades agonized less over pollution they saw as “synthetic” or “industrial”—smog, detergents, DDT, or other chemicals. The new ideology of environmentalism of Rachel Carson, framing the worst health threats as human-made, gained less purchase over Atlanta’s environmentalists as they began to mobilize just prior to and after the first Earth Day. Seeking to explain why, my paper will draw out surprising parallels between this postwar city’s environmental health and that in metropolises of the developing world.

My argument draws on evidence ranging from local and state archives to oral history interviews to GIS reconstructions. Atlanta’s growth relied less on manufacturing than many other American cities, and circa 1960, industrial and auto related pollution proved measurably less. Other more subtle regional differences were also influential. In other parts of the country, public health interventions over preceding decades had enabled perceptions of a “victory” over germs, but Atlanta’s version of public health circa 1960 could not as easily declare this “mission accomplished.” Given the Atlanta region’s lesser development of sanitary infrastructure and oversight—itself a legacy of the area’s longer history--the continued presence of environmental threats from malaria to typhus and rabies continued to nourish worries about infectious disease. For these as well as other reasons, the organizers of the Georgia Conservancy first considered but then pivoted away from pollution issues. Unlike around New York or Los Angeles, they and other Atlanta-area environmentalists prioritized land preservation instead. And the local pollution about which they did worry was more “old-fashioned” and infectious in nature, more like that afflicting metropolises south of the American border.

LEARNING OBJECTIVES:

1. Understand the dynamic history of health ideas and practices, their implications for public health and health care providers
2. Recognize the dynamic interrelationship between public and environmental health and society in the twentieth century
3. Deepen understanding of the environmental and political relations of illness and suffering

JOLE SHACKELFORD

University of Minnesota, Minneapolis, MN, USA (1)

CLINICAL CHRONOBIOLOGY AND THE PURSUIT OF THE BIOLOGICAL CLOCK

Writing to a former graduate student in 1974, Frank Whitney Finger somewhat bitterly described the upcoming meeting of the International Society for Chronobiology as excessively oriented toward medical applications and too little towards problems that interested research biologists, such as he was. Finger's perspective on the study of biological rhythms was no doubt biased by the fact that he was trained as in psychology and came to chronobiology from a background in rat behavior studies, but it is also clear that he put his finger, so to speak, on a fissure within the rhythms research community that was also perceived by others as divisive and counterproductive. Finger was concerned that, among other reasons, human applications should not be rushed until adequate animal studies had been completed. Clinical researchers, for their part, complained that too much attention was devoted to the search for biological clock mechanisms and too little to medical application. As was evident from discussion at a meeting held in Minneapolis 12-13 May 2012, which brought together biologists, clinicians, historians, and philosophers to share ideas about the history of biological rhythms research, this division left its scars in the field and even some unhealed wounds that persist. Grumbling about the proper goals for rhythms research reflect a problem of resource use that is fundamental and recurrent in twentieth-century policy discussions – whether to spend money on pure or applied science – but in this case the rift has bifurcated a community of researchers that was in its early years seeking unity and identity.

Using archival materials and printed scientific scholarship, I propose to examine the historical roots of the friction between biological rhythms researchers and clinical chronobiologists from the 1950s, when the chief problems of the field were being framed, to the 1980s, when breakthroughs in molecular biology validated the search for the inner clock, with an eye toward assessing the current state of this field.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine. Historical study of differing perspectives on the mission of medical research within the larger scope of biological science directly addresses this objective.
2. Identify successes and failures in the history of medical professionalism. Chronobiology has had notable success in specific therapeutic applications, but has fallen far short of reform of diagnostic procedures.
3. Recognize the dynamic interrelationship between medicine and society through history; in this case "society" means the larger scientific community.

KAVITA SIVARAMAKRISHNAN
Columbia University, New York, NY, USA (1)

DAVID JONES
Harvard University, Cambridge, MA, USA (2)

CARVING A SPACE FOR CARDIAC SURGERY IN A WORLD OF TROPICAL INFECTIONS: MEDICAL MISSIONS AND MODERN NATION BUILDERS IN INDIA, 1947-1962

In 1956 the Executive Board of the World Health Organization considered a resolution to establish a program on cardiovascular disease. The timing is not surprising: the epidemic of coronary artery disease was approaching its zenith in the United States and Europe. What does surprise is the source of the resolution: it came from Rajkumari Amrit Kaur, the first Minister of Health of independent India. Kaur was not alone in her concern with cardiovascular disease in India. Boston surgeon Reeve Betts moved in 1949 to the Christian Medical College in Vellore to establish thoracic and cardiac surgery there. Indian surgeon P.K. Sen completed training in cardiac surgery in Philadelphia and then returned to establish a program at the KEM Hospital in Bombay. Both programs performed their first open heart surgeries in 1961. Kaur, meanwhile, recruited another Harvard-trained surgeon, Sujoy Roy, to lead the Department of Cardiology at the new All India Institute for Medical Sciences in New Delhi, established in 1956. Why would Kaur, a vocal advocate of social medicine in a developing country still devastated by malnutrition and infectious diseases, take up the cause of a disease associated with the rich, industrialized west? What role did cardiology and cardiac surgery have in a country where most people had no access to basic primary care? Whom did the surgeons and cardiologist claim to serve?

Based on an analysis of Indian medical journals and archives in Vellore and Delhi, this paper traces the emergence of cardiology and cardiac surgery in India between 1947 and 1962. Three concerns motivated these developments. First, Indian leaders expected that an epidemic of cardiovascular disease would strike India if it modernized successfully. Second, elite Indian physicians found that their professional agenda aligned with the goals of independent India's new leaders, who sought to understand and recast western models of scientific modernization and technological development. Third, rheumatic heart disease bridged the traditional concerns of social medicine, infectious disease, and maternal and child health to the emerging glamorization of cardiac surgery as the embodiment of modern medicine. These interests created a space for cardiology and cardiac surgery in India.

LEARNING OBJECTIVES:

1. To analyze how the language of science and expert knowledge is translated across contexts.
2. To understand the changing social constituencies of medical practice in public and private settings.
3. To analyze the fluid categories and construction of infectious and chronic disease.

ELLEN SPEARS

University of Alabama, Tuscaloosa, Alabama, USA (1)

INDUSTRIAL HYGIENE AND TOXIC CHEMICALS POLICY: THE INTERWAR YEARS AS A FORMATIVE PERIOD

Scholars most often locate rising concern with environmental public health in the post-World War II period. Indeed, the widespread use of commercially produced synthetic organic chemicals rose sharply after 1945 and public concern about exposure to toxic chemicals did not increase significantly until after Rachel Carson published *Silent Spring* in 1962. However, the interwar years—during which polychlorinated biphenyls (PCBs) were first produced commercially in the U.S., at Anniston, Alabama—were formative in the chemical revolution and its impact on environmental public health. Industrial hygiene research yielded growing knowledge about the health effects of toxic chemicals. Researchers noted, for example, the estrogenic impact of chlorinated hydrocarbons, anticipating contemporary understandings of endocrine disruption by nearly fifty years.

This paper combines narrative account—of the early production of chlorinated hydrocarbons and industrial hygiene research on their effects—with historical argument—that the interwar years were crucial in the development of industrial strategies to manage worker concern about the health effects of synthetic chemicals. Work on the toxicity of chlorinated hydrocarbons carried out in the 1930s by Cecil Kent Drinker, Katherine Rotan Drinker, and their colleagues at the Harvard School of Public Health as well as other researchers gives evidence of one approach to industrial health research and the chemical industry’s response to the findings. Some of the chlorinated hydrocarbon studies also illustrate how medical understandings were intercut with the racial views.

Fundamental industry approaches to worker concerns about environmental health—attributing ill effects experienced by chemical workers to impurities in raw materials, establishing maximum allowable concentrations that disregarded knowledge of the effects of prolonged low level exposure, focusing on individual worker hygiene instead of instituting manufacturing controls, and, as environmental health historian Christopher Sellers has noted, setting “conventions of confidentiality,” were largely in place prior to the end of World War II. The federal government moved to regulate synthetic organic chemicals during this period. The 1938 Food and Drug Act took a precautionary approach, but excluded non-food and non-medicinal chemicals. The basic elements of chemical regulation that were established during this time have reverberated through subsequent decades, with profound and often negative consequences for public health.

LEARNING OBJECTIVES:

1. Understand the dynamic history of industrial hygiene research and its effects on toxic chemicals policy.
2. Recognize the interrelationship between medical research in environmental health and society, with attention to impact on specific populations, including workers and racial groups

PAUL STEPANSKY

Weill Cornell Medical College, New York, NY, USA (1)

Montclair NJ, USA (1)

WHEN GENERALIST VALUES MEANT GENERAL PRACTICE: FAMILY MEDICINE IN POST-WWII AMERICA

This paper explores the significance of community general practice in America in the 1950s and 1960s by focusing on the career of the author’s father, William Stepansky, a gifted and versatile generalist of the Post-World War II era. As the coming to fruition of significant medical advances of WWII, postwar general practice was fully modern in its scientific grounding and clinical modus operandi. But it was an era without the advanced imaging technologies, invasive diagnostic procedures, and high-technology specialty surgeries that would become available in the final quarter of the century. The convergence of a medicine that was procedurally driven but less-than-contemporary in its diagnostic and interventional modalities created a historical opening for highly motivated and procedurally gifted generalists such as William Stepansky to provide comprehensive care to their patients in a world increasingly dominated by medical specialists and specialization.

The decision in the late 1960s to make “family practice” a specialty among specialties, with its own residency requirements and board certifying examination, had the ironic effect of undermining general practice (even as it enshrined generalist values). It did so by circumscribing the prerogative of motivated “family practitioners” to become “total physicians” by acquiring and employing procedural skills outside the framework of residency training. The emergence in the 1980s and thereafter of clinical practice guidelines, treatment eligibility criteria, and credentialing organizations further contributed to the transformation of American family physicians from hands-on providers to medical advisors, frontline prescribers, and coordinators of specialty care. The paper considers what has been gained and lost by this transformation and acknowledges exceptions to the rule. It concludes with internist David W. Stepansky’s transposition of generalist values to contemporary primary care.

This paper is drawn from my book, "The Last Family Doctor: Remembering My Father’s Medicine" (2011), which is based on primary sources and recent monographic histories. The material has been reframed and refined on the basis of continuing research on the history of primary care medicine in America.

LEARNING OBJECTIVES:

1. Develop the capacity for critical thinking about the nature, ends, and limits of medical specialization in post-WWII America.
2. Develop an historical appreciation of the interrelationships among generalist values, general practice, and procedural medicine in 20th-century American medicine.
3. Develop an historically informed awareness of what has been gained and lost in the transformation of post-WWII general practice into contemporary primary care medicine.

KARA SWANSON

Northeastern University, Boston, MA, USA (1)

ALTERNATIVE INSEMINATION: WHEN MEDICAL GATEKEEPING ENDED

Throughout much of the twentieth century, doctors acted as gatekeepers to women’s access to reproductive controls, including contraception, abortion, and assisted conception for the involuntarily childless. As has been explored by previous United States historians with respect to abortion and contraception [Reagan (1997); Tone (2001)], medical gatekeeping was exercised in conjunction with legal regulation. Continuing the project begun in Swanson (2012) to analyze the interaction between law and medicine with respect to assisted conception, this paper focuses on the medical use of artificial insemination with donor sperm in the second half of the twentieth century, in a changing legal landscape. Until in vitro fertilization became a possibility in the late 1970s, donor insemination was the most successful form of fertility treatment. By the 1950s, the uncertain legal status of children conceived by donor insemination was leading to court cases, and proposed legislation. Using the American legal and medical literatures, legal cases, court archives, statutes and legislative history, and the popular media, I analyze the transition between medical restriction of the technique to married heterosexual couples, who were encouraged to think of the procedure as “semi-adoption” and to pass off their children as the biological offspring of both parents, to the development of a consumer-driven assisted reproductive industry, in which what became known as “alternative insemination” was increasingly available on demand to all women with sufficient resources. I argue that the demise of medical gatekeeping occurred under pressure from outside the medical profession as what had been primarily an internal discussion about the appropriate uses of donor insemination became a legal discussion in the 1960s and 1970s, influenced by the politics and social changes of the time, a discussion which partially undid decades of effort by doctors to medicalize “instrumental impregnation.” As well as the decriminalization of abortion and birth control, the legal context for the change in medical practice included new state laws recognizing the legitimacy of children conceived by donor insemination, increased legal rights for nonmarital children, and new approaches to adoption.

LEARNING OBJECTIVES:

1. Understand the dynamic history of medical ideas and practices in light of changing laws, the implications for patients and health care providers, and the need for lifelong learning.
2. Recognize the dynamic interrelationship between medicine and society through history, particular how the medical practice of infertility treatments influenced law, and how the legal status of children conceived by donor insemination influenced medical practice.
3. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations) and the ways medical professionals have responded to that diversity.

COURTNEY THOMPSON
Yale University, New Haven, CT, USA (1)

FROM BÊTE NOIRE TO BULLDOG: THE MAKING OF A PUBLIC MEDICAL DEBATE IN THIRD REPUBLIC FRANCE

Medical policy was a matter of national politics in Third Republic France (1870-1940), but the ways in which these politics played out in the public eye were manifestations of Second Empire (1852-1870) cultural legacies as much as Third Republic political and social concerns. During the Second Empire, the press vigorously critiqued the medical profession, especially psychiatry, as a symbol of the unpopular imperial regime. In the Third Republic, members of the profession made new use of the press as an agent of professional advancement and political power. Medical professionals became elected members of government and used the popular press as a platform, mobilizing the vocabulary of the Third Republic while using the idiom of the Second Empire; they thus transformed the press from the *bête noire* of the medical profession into its bulldog and mouthpiece.

I examine this transformation in the relationship between the press and the medical profession through an exploration of one exemplary case, the debate over laicization. From the late 1870s through the 1890s, the public, the press, politicians, and the medical profession debated and ultimately decided in favor of laicization, the process by which the nursing orders of nuns were removed from the nation's hospitals by the Republican government and replaced by professional lay nurses.

Historians have interpreted this episode chiefly as a manifestation of anticlerical sentiments of the Third Republic, inflected as well by a gendered struggle for authority in hospitals. I reframe this debate as an exemplary episode in the history of medical politics, illustrative of a newly-forged relationship between the press and the medical profession. I will focus especially on Désiré-Magloire Bourneville, the architect of laicization and a consummate physician-legislator and journalist, who was only one of many medical polymaths implicated in a new, broader conception of medical decision-making in which the public, through the press, also took part. I will place laicization within the context of late-nineteenth-century French medical history, arguing for continuity between the Second Empire and Third Republic contexts as well as for the significance of popular print and political milieu for the creation of a popular medical politics.

LEARNING OBJECTIVES:

1. To learn about the life and work of Désiré-Magloire Bourneville and the laicization episode
2. To reflect on the role of the popular press in the shaping of medical policy and politics, and the relationship between the public and the profession
3. To consider the ways in which medical controversies are conducted in multiple registers and for multiple audiences

NOEMI TOUSIGNANT

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RAW MATERIALS OF EMPIRE OR ‘TREASURES OF THE PEOPLE’? THE VALUE AND PLACE OF MEDICINAL PLANTS ACCORDING TO FRANCK GUICHARD AND JOSEPH KERHARO, (EX)COLONIAL PHARMACISTS.

Imperial projects and networks intensified global traffics in botanical matter and particularly in medicinal plants. As they traversed the globe, plants also exited, entered and intersected contrasting systems of knowledge-production, material exchange and healing. Much scholarship has productively focused on plant trajectories to understand how, as they are moved, they acquire and lose, share or steal, diverse forms of value. But might we arrive at a different picture of the relationship between mobility, knowledge and value if we focus on the trajectories of those who studied medicinal plants rather than those of the plants themselves? We explore this hypothesis by focusing on two important figures of French colonial ethno-pharmacological research: Franck Guichard and Joseph Kerharo.

As members of the colonial health corps, these two pharmacists moved a lot: between France and the colonies, from one posting --in Vietnam, West Africa, the Caribbean-- to another, and on field missions to survey medicinal plants that were financed and facilitated by colonial governments. In some respects, their mobilization as experts within imperial networks enabled the displacement of medicinal plants from indigenous locations (seen as sources of raw materials) to colonial and metropolitan spaces of value-extraction. Yet both researchers also engaged with scientific networks, governments, as well as local healers, communities and environments, in other ways.

Their biographies, which extend beyond ‘the colonial’ in both space and time, contain diverse --coexisting and contradictory-- ways of enacting and imagining the (de)localization of plant matter, knowledge and value. This paper tells their stories in order to discuss the methodological and theoretical implications of focusing on scientists’ biographies for the history of science in the colonies and the critical study of ethno-pharmacology. We describe how such an approach can contribute to debates on the use of the term ‘colonial science’ and illuminate the complex political, material and epistemological stakes of ‘prospecting’ indigenous plant wealth and knowledge.

LEARNING OBJECTIVES:

1. Identify successes and failures in the history of medical professionalism and research
2. Understand the dynamic history of medical ideas and practices and learn to identify the influence of political and social context on knowledge-formation and reflect on their implications for patients and health care providers
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

SARAH TRACY

University of Oklahoma, Norman, OK, USA (1)

COLD WAR CARDIOLOGY—PAUL DUDLEY WHITE, ANCEL KEYS, MEDICINE, AND US-USSR DIPLOMACY, 1955-65

At the height of the Cold War, between 1955 and 1965, Harvard-trained American cardiologist Paul Dudley White became a household name as President Eisenhower's cardiologist, following Ike's 24 September 1955 heart attack. White supervised Ike's medical care and prescribed a course of treatment to restore the President to health, . Eisenhower's treatment combined light exercise with the low-fat dietary regimen championed by Minnesota-based cardiovascular epidemiologist Ancel Keys.

Friends and collaborators, White and Keys were instrumental in inaugurating the transnational pursuit of knowledge about risk factors for heart disease at the population level. White and Keys perceived cross-cultural studies of heart disease as an important way to elucidate and eliminate the greatest source of mortality across the industrialized world, and to foster international peace and good will, particularly between the Soviet Union and the United States. In fact, less than a year after the President's heart attack, White and Keys led a team of American clinicians and epidemiologists to the USSR, where they toured medical facilities and met with leading Soviet cardiologists. Thus began an ongoing dialogue and exchange between American and Soviet cardiologists and epidemiologists during the Cold War. White and Keys worked intimately with the U.S. Department of State as they organized these US-USSR meetings and built a global medical community through the International Society of Cardiology.

Relying on Congressional hearings, published scientific papers, newspaper coverage, and variety of archival documents, this paper looks at cardiology as a vehicle for diplomacy during the Cold War. This decade inaugurated both a new age of transparency in presidential health, with significant political repercussions, and a new era of international scientific exchange in the attack on heart disease in Communist Bloc and Western nations. The paper explores the internationalist agendas of Paul Dudley White and Ancel Keys as advanced through White's connections to Eisenhower, his and Keys' orchestration of scientific exchanges between the US and USSR, and the formation of the International Society of Cardiology, which became a vehicle for spreading transnational good will, training heart disease researchers, and disseminating the gospel of the low-fat diet across the developed and developing worlds.

LEARNING OBJECTIVES:

1. To reveal the relationship between the medical specialty of cardiology and Cold War politics.
2. To demonstrate the importance of medicine and public health to US-USSR diplomatic efforts at the height of the Cold War
3. To show how Eisenhower's heart attack affected the larger politics of the Cold War

ADAM TURNER

University of Oregon, Eugene, OR, USA (1)

EXPECTING "NORMAL" BABIES: GENETIC COUNSELING, REPRODUCTION, AND DISABILITY IN THE MID-TWENTIETH CENTURY

Prospective parents have long worried about the health of their future children, and over the course of the twentieth century increasingly came to rely on science and medicine to help guarantee "normal" babies. Scholars have described the ways motherhood became increasingly medicalized during the twentieth century, including the ways doctors and public health officials encouraged parents to seek medical advice. These works, however, have not adequately addressed the impact of developments in the areas of genetics and prenatal testing.

The first clinics offering to analyze clients for hereditary conditions that might affect their future children--what came to be called genetic counseling--opened in the early 1940s. By 1968 their number had increased to more than 100 clinics in the United States and Canada. This growth was driven by clients' desires for children that matched their expectations of "normality" and by genetic counselors' desires to stop the spread of genetic conditions. I argue that genetic counselors and their clients (primarily white and middle class) reciprocally shaped each other's thinking about reproduction in the mid-twentieth century and that they both played a role in determining the focus and direction of the genetic counseling profession.

Early genetic counselors expressed strong opinions in professional literature on genetics and genetic counseling and in personal correspondence about who should or should not have children. Their concern to avoid the coercive elements of the eugenics movement, however, led them to establish a policy of non-directiveness that still guides genetic counseling today. Sources such as published case studies and articles in popular publications, while they conveyed a desire to use genetic science to ensure "normal" babies free of disease or disability, did not provide specific guidance to clients about what to do with the genetic information counselors provided. At the same time, these sources suggest the ways both counselors and clients defined the boundary between difference and disability.

My paper explores the history of genetic counseling to expand our understanding of the ways scientists' and parents' assumptions and expectations about reproduction influenced each other at the intersections of reproduction, science, and disability.

LEARNING OBJECTIVES:

1. To establish the origins and influences of the contemporary genetic counseling profession.
2. To examine the multiple perspectives of geneticists and genetic counseling clients towards reproduction and the potential for children with genetic conditions.
3. To situate the historical significance of genetic counseling within a wider context of reproductive decision-making and social concepts of disability.

MAGNUS VOLLSET

University of Bergen, Bergen, Norway (1)

IMPACTS OF A MEDICAL ‘DISCOVERY’: INTRODUCING THE LEPROSY BACILLUS, 1870S-1920S

“I cut out nodules and examined them, but could not find any bacilli. (...) Obviously I was forced to conclude: This is not a leper.” (G. A. Hansen, 1897.)

At the first international leprosy conference in Berlin in 1897 the leprosy bacillus was accepted as ‘the virus of the disease’. The Norwegian physician Gerhard Armauer Hansen was honored as ‘the discoverer’, and the German physician Albert Neisser as the one who confirmed the findings. Instead of focusing on the genesis of the bacillus, this paper will investigate how the pathogen was given meaning in international discussions among physicians regarding diagnosis and treatment of leprosy.

Before the bacillus, diagnosis was based on recognizing clinical symptoms. How was Hansen’s attempt at redefining the disease to mean the presence of a bacillus (above) received? What happened when detection of the bacillus did not correlate with clinical judgment? What impact did the bacillus have on treatment and the possibility of being cured?

In the paper I will show that despite never fulfilling Koch’s postulates, the introduction of the leprosy bacillus changed the disease in several ways. From the first decade of the 20th century some leprosaria began releasing patients from confinement despite still looking like ‘lepers’; the bacillus opened for new (and creative) research into treatments; the bacillus became a rationale for organizing transnational circulation of knowledge, with Hansen, the ‘discoverer’ as a natural focal point. While appropriation differed in different locations, ultimately the bacillus was ‘proof’ that the disease was the same all over the world, and that experiences and medical trials elsewhere had local relevance.

The paper is based on an upcoming PhD thesis which investigates how the scientific understanding of leprosy was ‘globalized’ between the 1850s and the 1930s. The source material is primarily English, German, Norwegian and French language medical journals (such as *Lepra Bibliotheca Internationalis*, *Medicinsk Revue*, *Journal of Tropical Medicine*, *JAMA*, *BMJ*, *Annales d'hygiène et de médecine coloniales*, *Archiv für Schiffs- und Tropenhygiene*), medical textbooks, proceedings from international conferences, correspondence and archival material from the League of Nations Leprosy Commission.

LEARNING OBJECTIVES:

1. Have a better understanding of ambiguity of theories, the changing nature of medical evidence, evaluation of appropriate patient care, research, and education
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
3. Learn how history can provide insights relevant for current medical questions

LOUISA WALL
Emory University, Atlanta, USA (1)

OPINIONS ON COMFORT-CARE IN ANCIENT GREEK MEDICINE

In antiquity, patients and physicians disagreed on the role of “comfort-care” in healing. Ancient Greeks expressed different views on how a physician should care for patients. While patients believed in the importance of comfort-care, philosophers and doctors were weary of the practice. These differing opinions likely strained the doctor-patient relationship, especially in end-of-life situations when comfort-care was all there was to offer. This presentation seeks to address the role of comfort-care and the limits of medicine in ancient Greece from three perspectives. First, I will discuss the patient’s perspective using evidence from a selection of honorary decrees dated before 250 BC found in Athens and Cos, along with healing inscriptions and inventories from the temples of Asklepios at Epidaurus and Athens. Patients, while they ultimately desired to be healed, appreciated comfort in their medical care. Second, I will analyze the philosopher-bystanders perspective, primarily Plato’s, based on excerpts from his writings on physicians. According to Plato, those physicians who understood the limits of their profession were the admirable ones. He suggested that those healers who provided merely comfort-care to ignorant patients practiced “cookery.” Third, I will explore the Hippocratic physicians’ perspective using the Hippocratic Corpus. The Hippocratics believed that a doctor must draw boundaries in order to be a successful healer. Appreciating medicine’s limits was part of their medical care. These perspectives shed light on the tensions and frustrations that arose when a Hippocratic physician attempted to meet his patients’ needs.

LEARNING OBJECTIVES:

1. To contrast patient, philosopher/ bystander, and physician perspectives on comfort care in ancient Greek medicine
2. To appreciate the differences between comfort care and the limits of medicine in ancient Greek medicine
3. To understand the dynamics of the physician-patient relationship in ancient Greek society

MARI WEBEL
Emory University, Atlanta, GA, USA (1)

FROM COLONIAL DISEASE TO NTD: SLEEPING SICKNESS AND GLOBAL HEALTH IN HISTORICAL PERSPECTIVE

Recent years have seen an expansion of interest in neglected tropical diseases (NTDs) as a way of organizing efforts in global health. One of a set of 17 NTDs currently slated for eradication or elimination, sleeping sickness ostensibly benefits in the present from its past exclusion from public health programs. However, as scholars of colonial medicine, African history, and international health have demonstrated, sleeping sickness is an iconic disease of the colonial encounter and was of signal social and political importance. Its story in the twentieth century is one of intensive interventions on a massive scale in sub-Saharan Africa and smoldering mortality amid social, political, and environmental upheaval. Entangled, too, are the histories of global pharmaceuticals and drug development and delivery, deeply colored by the controversy over the orphaning and re-adoption of eflornithine in the late 1990s.

This paper explores connections between the past and present of sleeping sickness and the emergence of NTDs as scientific and political entities. It argues that studying the rise, ebb, recurrence, and present decline of sleeping sickness in sub-Saharan Africa illuminates the development of the NTD as an operative and imaginative category in global health. New research draws upon key documentary materials from the World Health Organization alongside oral histories collected from participants in the WHO and bilateral organizations during the parallel emergence of global health and the designation of certain diseases as NTDs. Together with research on the colonial history of sleeping sickness, these materials build a narrative that bridges colonial understandings of sleeping sickness, post-colonial concerns over health and development, and constructions of NTDs in global health. This research locates the emergence of NTDs as a useful category in a specific post-colonial cultural and political context, using sleeping sickness to flesh out the historical trajectory of the category itself. This research counters the predominantly future-oriented discourse of global health programs, emphasizes continuities in modes of intervention and approaches to sleeping sickness across the past century, and explores how current categorization of diseases as NTDs open up or limit our understandings of their specific and diverse histories.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history
2. Understand the impact of sleeping sickness morbidity and mortality in the twentieth century on communities in sub-Saharan Africa.
3. Locate the development of drugs for neglected tropical diseases in a social, political, and epidemiological framework and in historical perspective.

LEIGH WHALEY

Acadia University, Wolfville, Nova Scotia, Canada (1)

PHILANTHROPY AND MEDICINE IN 17TH CENTURY FRANCE: PAUL DUBÉ, “PHYSICIAN OF THE POOR”

In Europe, during the seventeenth century, an unprecedented number of charitable medical booklets or livrets de santé were produced by physicians in response to a public health crisis. The lack of a sufficient number of physicians in the rural areas along with the high cost of medical care meant that access to medicine was out of reach of the majority of people, particularly the poor. Physicians “were among the most outspoken advocates of special care for the poor” (Stroup 36). One physician who distinguished himself for his treatment of the poor was Paul Dubé. Dubé (1612-98) practiced medicine for sixty-five years in the Loire region of France, specifically in Montargis (J.C. Dubé 63).

The purpose of this paper is to introduce Dube’s brand of medicine through the medium of his livrets de santé. The paper will examine the philosophy behind and purpose of philanthropic medicine in the French countryside through the lens of Dubé, a pioneering “poor man’s physician. Dubé published his first book focusing on the most common diseases which afflicted the poor in 1669. Entitled "Le médecin et le chirurgien des pauvres", this textbook is based on forty years of practice as a rural physician. Its primary objective was to serve the needs of the rural poor by providing simply prepared, inexpensive and locally produced remedies for common ailments, and most importantly, specific diseases which afflicted this sector of the population. Dubé called the specific health problems “diseases of the poor”, which he linked to diet, primarily bread, and lifestyle. In his texts, Dubé focused on ergotism (ergot is a fungus which infected wheat), also known at the time as St. Anthony’s fire (due to burning sensations in the limbs), as well as kidney problems principally nephritic colic, kidney stones and ulcers of both the kidney and bladder. When the infected wheat was consumed, the patient developed gangrene, and hallucinations. Dubé was one of four rural doctors who brought the severe impact of St. Anthony’s fire on the rural population to the attention of Dr. Denis Dodart at the Royal Academy of Sciences.

LEARNING OBJECTIVES:

1. To stress the role and importance of Dubé’s remedies and therapy for specific illnesses which afflicted the rural poor, primarily Ergotism or St. Anthony’s fire and kidney diseases.
2. An understanding of the relationship between Christian charity (a key motivating factor for Dubé) and medical care in early modern France.
3. To communicate Dube’s brand of medical care to rural communities which otherwise would not have access to health care. Dubé addressed his texts to fellow physicians in addition to surgeons, apothecaries, and charitable persons which made health care accessible to the poor sick.

SHANNON WITHYCOMBE
Duke University, Durham, NC, USA (1)

START YOUR CHILD RIGHT: PRENATAL HEALTH CARE IN EARLY TWENTIETH-CENTURY AMERICA

In 1890, Philadelphian physician George Napheys published the domestic health manual, “The Physical Life of Woman: Advice to the Maiden, Wife, and Mother.” In his chapter on the hygiene of pregnancy, Napheys included sections typical for such a work that discussed the signs of pregnancy, proper diet, clothing, exercise, and how to avoid miscarriage. In 1915, Mary Mills West published, via the newly formed U.S. Children’s Bureau, a book that shared a remarkable similarity to Dr. Napheys’ work, carrying virtually the same topics. Significantly, and very much in contrast to Napheys, West titled her work “Prenatal Care.”

An investigation into these two books that communicated almost identical information reveals one important medical transformation of the early twentieth century – namely the change from “pregnancy hygiene” to “prenatal care.” This shift in focus from the mother to the child signifies an important move in pregnancy thinking at the dawn of the twentieth century. Advice was no longer merely guidance to preserve a woman’s health or to cultivate a successful pregnancy. Instead, this information was reformulated to focus on the child, or perhaps more significantly, on the fetus.

This paper will examine how and why domestic health advice shifted from concentrating solely on the mother’s body and health in pregnancy to focusing on the body and health of the unborn child. By examining the language and images put forth to pregnant women in popular health guides and medical publications, I demonstrate how doctors attempted to convince women to consider their pregnant bodies in dramatically new ways. I explore, for example, how doctors utilized tools such as popular embryology, x-ray technology, and fears about changing demography and increasing immigration to convince women that they should consider themselves as carrying a second body and/or person during pregnancy. Although historians have not yet examined the origins of prenatal care, the language and ideas that arose in the context of early twentieth-century pregnancy continues to shape discussions about private and public policing of pregnancy, as well as debates about women’s rights and abortion.

LEARNING OBJECTIVES:

1. Recognize the dynamic interrelationship between medicine and society through history.
2. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.
3. Develop a historically informed sensitivity to the diversity of patients.

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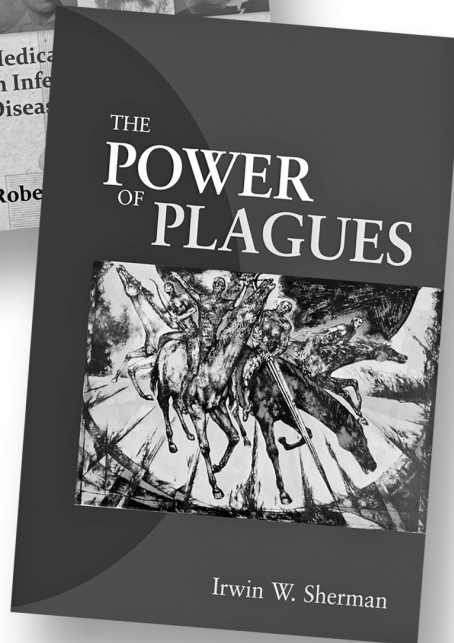
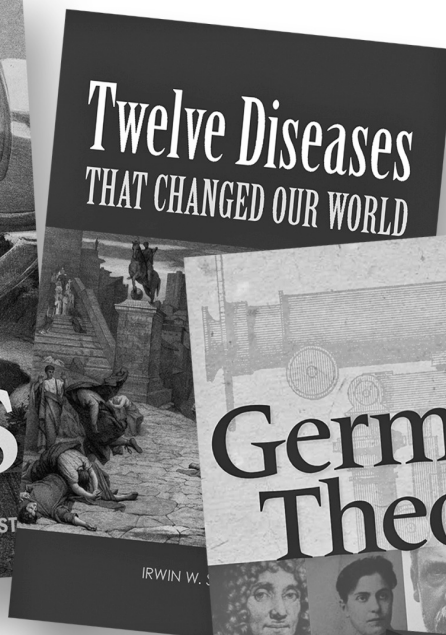
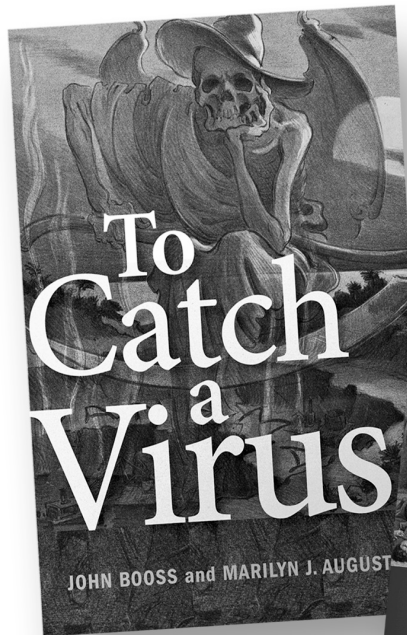
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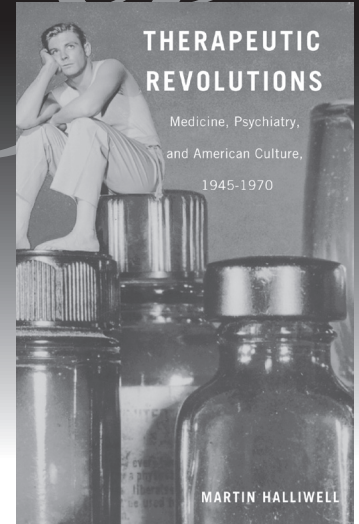
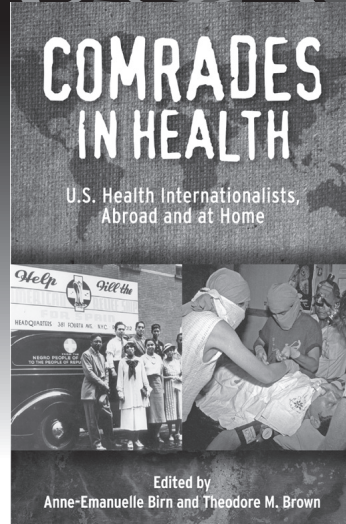
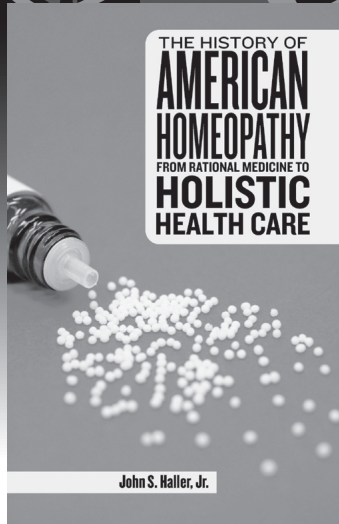
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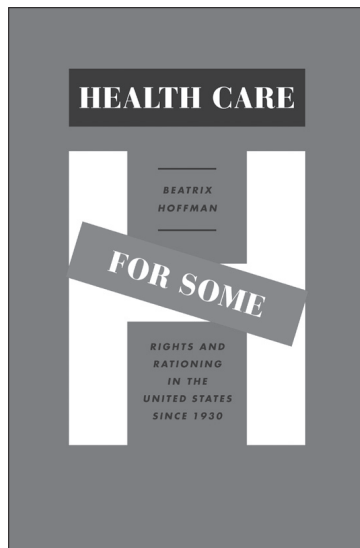
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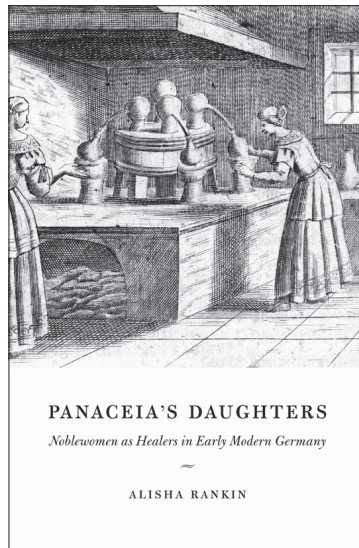


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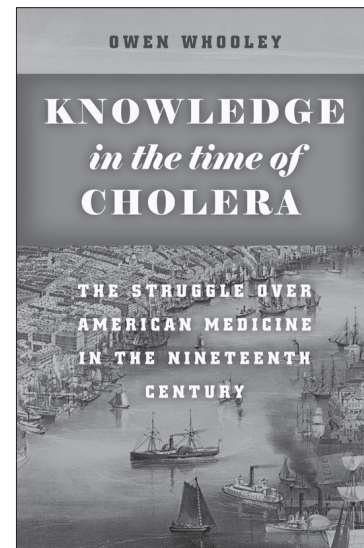


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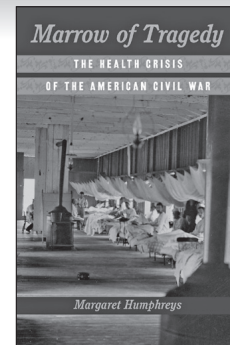
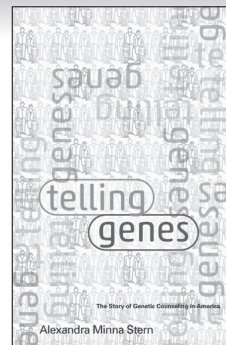
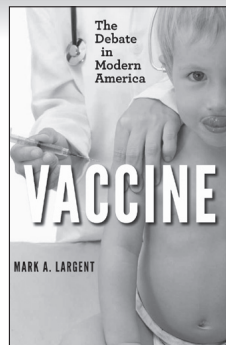
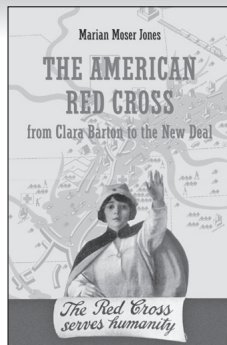
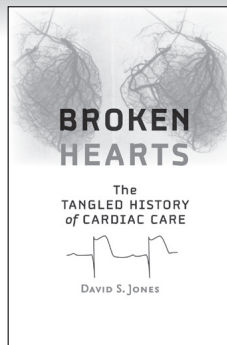
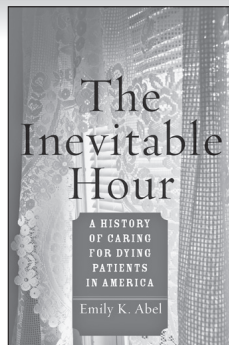
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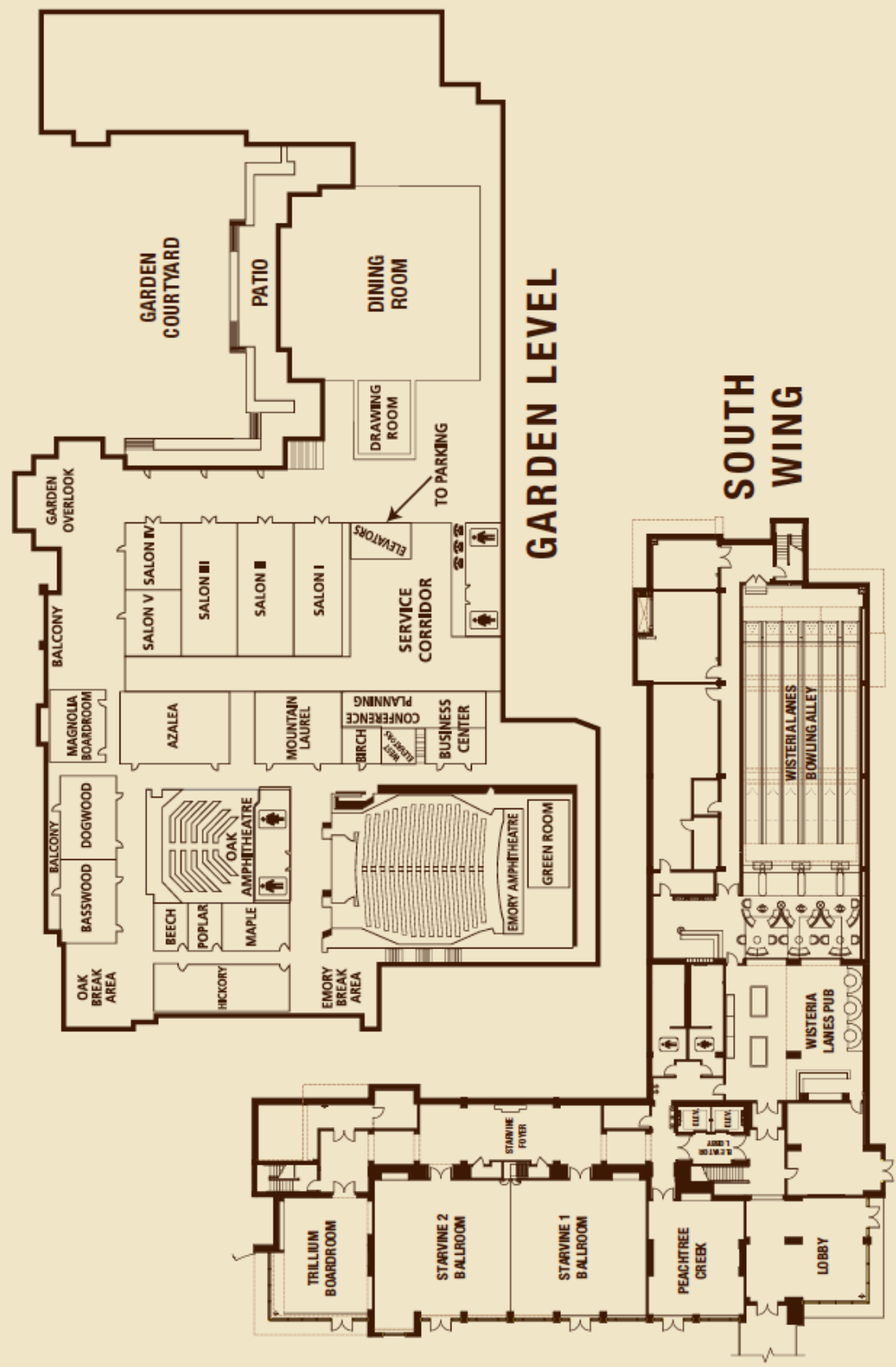


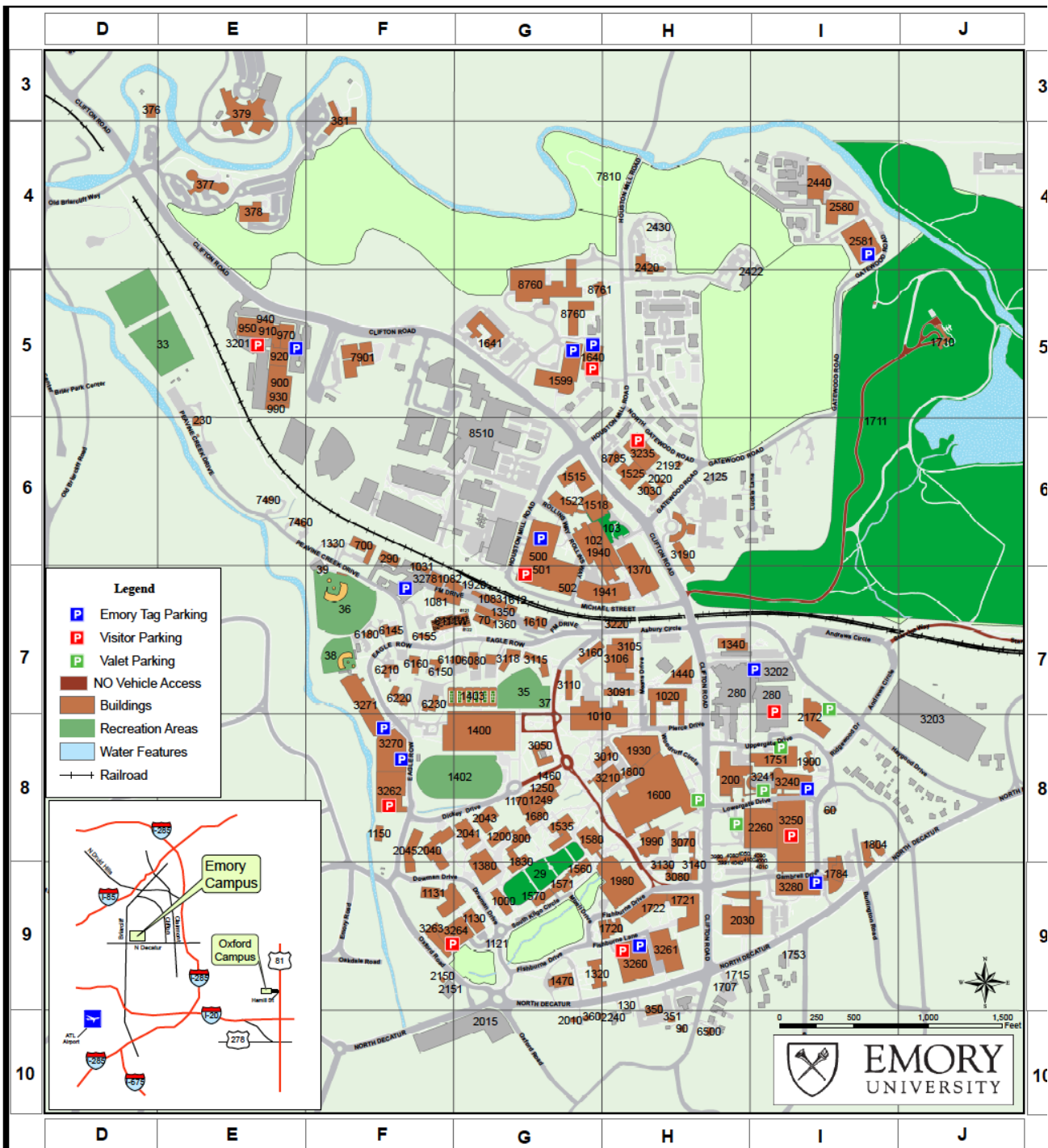
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90	VITDING FACULTY HOUSE	H10	1402	WOODRUFF P E TRACK	G8	2172	EMORY CHILDREN'S CENTER	H7	6080	ZETA BETA TAU FRATERNITY	G7
100	BIOCHEMISTRY BUILDING	H6	1402	WIRCO OUTDOOR TENNIS COURTS	H8	2173	GATEWOOD RD	H8	6100	1318-D CLIFTON	I8
103	HEALTH SCIENCE QUAD	H6	1440	WOODRUFF HEALTH SCIENCES ADMINISTRATION	H7	2240	CREATIVITY AND ARTS	H10	6110	PI KAPPA ALPHA FRATERNITY	G7
110	1655 N. DECATUR	H10	1460	ANTHROPOLOGY	G8	2260	EMORY CLINIC BUILDING - B	H8	6111	SORORITY VILLAGE A - ALPHA KAPPA ALPHA	G7
115	BRIDGE ON WHEEL DRIVE	H8	1470	GLENN CHURCH AND AUDITORIUM	G8	2302	MILLERWARD ALUMNI HOUSE	H4	6112	SORORITY VILLAGE B - DELTA SIGMA THETA	G7
200	EMORY CLINIC BUILDING - A	H8	1515	NELL HODGSON WOODRUFF NURSING	G8	2422	LUCE CENTER	H8	6113	SORORITY VILLAGE C - KAPPA KAPPA GAMMA	G7
220	CANDLER FIELD RESTROOMS	E6	1518	GRACE CRUM BUILDING	G6	2430	HOUSTON HILL HOUSE	H4	6114	SORORITY VILLAGE D - KAPPA ALPHA THETA	G7
230	RECYCLING OPERATIONS	H7	1522	CLAUDIANNA JONES ROLLINS BUILDING	G6	2440	YERKES MAIN BUILDING	H8	6115	SORORITY VILLAGE E - DELTA PHI EPSILON	G7
280	CHOA IN CLIFTON	H7	1525	1525 CLIFTON	H6	2580	YERKES NEUROSCIENCE BUILDING	H4	6118	SORORITY VILLAGE G - ALPHA DELTA PI	G7
290	PEAYNE DARR FACILITY	F6	1530	CALLAWAY MEMORIAL CENTER	G8	2581	YERKES PARKING DECK	H4	6119	SORORITY VILLAGE H - ALPHA EPSILON PHI	G7
350	GLENN MEMORIAL YOUTH BUILDINGS	H9	1550	BOWEN HALL	G8	3010	ALABAMA HALL	H8	6119	SORORITY VILLAGE I - GAMMA PHI BETA	G7
360	1641 N. DECATUR	H10	1570	MICHAEL C. CARLOS HALL	G8	3030	CLIFTON TOWER	H8	6121	SORORITY VILLAGE MECHANICAL ROOM	G7
370	WESLEY WOODS ADMIN	D3	1571	MICHAEL C. CARLOS MUSEUM	G8	3050	DOBBS HALL	G8	6122	SORORITY VILLAGE APARTMENT	G7
377	WESLEY WOODS TOWERS	E4	1580	CANDLER LIBRARY	G8	3070	HOPKINS HALL	H8	6145	BETA THETA PI FRATERNITY	F7
378	WESLEY WOODS BUDD TERRACE	E4	1599	1599 CLIFTON RD	G8	3080	HOPKINS HALL	H8	6150	ALPHA TAU OMEGA FRATERNITY	F7
379	WESLEY WOODS GERIATRIC HOSP	E3	1600	EMORY HOSPITAL	H7	3091	TURMAN RESIDENCE HALL	H7	6155	ALPHA PHI ALPHA FRATERNITY	F7
381	WESLEY WOODS HEALTH CNTR	F3	1610	FM BLDG - H (STEAM PLANT)	G7	3105	LONGSTREET-MEANS HALL	H7	6180	KAPPA SIGMA FRATERNITY	G7
500	MICHAEL STREET PARKING DECK	G6	1612	FM BLDG - I (BOLSER #9 BLDG)	H7	3115	FEW HALL	G7	6210	SIGMA ALPHA EPSILON FRATERNITY	F7
501	MICHAEL STREET CHILLER PLANT	G6	1620	ROCK HOUSE	I7	3118	EMORY INN	G5	6220	PHI DELTA THETA FRATERNITY	F7
502	BIOLOGY GREENHOUSE	G7	1641	EMORY INN	G5	3120	MCTYPERE HALL	G7	6230	ALPHA EPSILON PHI	F7
700	VISUAL ARTS	F6	1642	EMORY CONF CTR HOTEL PARKING DECK	G7	3130	BIRTH HALL	H8	6351	1655-N DECATUR - HOUSE	G10
800	CANNON CHAPEL	F8	1646	EMORY CONF CTR HOTEL PARKING DECK	G7	3140	THOMAS HALL	H8	1700	H15	
900	1762 CLIFTON ROAD SUITE 800	E8	1650	MODERN LANGUAGES	H8	3140	THOMAS HALL	H8	1760	SPANISH HOUSE	E9
910	1762 CLIFTON ROAD SUITE 910	E8	1711	LULLWATER - ESTATES	J6	3180	WOODRUFF RESIDENTIAL CENTER	H8	7400	ASBURY HOUSE	E9
920	1762 CLIFTON ROAD SUITE 920	E8	1715	1715 DECATUR	H8	3201	1752 CLIFTON PARKING	H8	7510	HAIN FOREST	H4
930	1762 CLIFTON ROAD SUITE 930	E8	1720	RICH MEMORIAL BUILDING	H8	3202	1752 CLIFTON PARKING	H8	7701	CLIFTON SCHOOL AT CLIFTON	F5
940	1762 CLIFTON ROAD SUITE 940	E8	1721	GOIZETA BUSINESS SCHOOL	H8	3203	DRUID HILL HIGH SCHOOL	J8	8610	CENTER DISEASE CONTROL	G9
950	1762 CLIFTON ROAD SUITE 950	E8	1722	GOIZETA FOUNDATION CENTER	H8	3210	COOL HALL	H8	8760	EMORY HOTEL + CONF CNTR	G5
960	1762 CLIFTON ROAD SUITE 960	E8	1751	WINSHIP CANCER INSTITUTE	I8	3220	DOOLEY'S DEN	H8	8761	EMORY CONF CTR PAVILION	G5
970	1762 CLIFTON ROAD SUITE 970	E8	1752	WINSHIP CANCER CHILLER PLANT - 1751	I8	3225	1525 BLDG PARKING DECK	H8	8762	EDGESTON CYTIC FIBROSIS	H8
980	1762 CLIFTON ROAD SUITE 980	E8	1753	CATHOLIC CENTER	I8	3240	PHYSIOLOGICAL PARKING DECK	H8			
1000	UNIVERSITY ADMINISTRATION	G8	1754	NORTH DECATUR BUILDING	I9	3241	LOWER GATEWAY VALET PARKING LOT	H8			
1010	DOBBO UNIVERSITY CENTER (DUC)	G8	1800	TELECOMMUNICATION	H8	3250	LOWER GATEWAY PARKING DECK	H8			
1020	JAMES B. WILLIAMS MEDICAL EDUCATION BLDG	H7	1800	BURLINGTON ROY PERFORMING ARTS	I8	3261	PHYSIOLOGICAL PARKING DECK	H8			
1030	FM BLDG - C (ICF - PM&C)	F7	1830	PITTS THEOLOGICAL LIBRARY	H8	3261	PHYSIOLOGICAL PARKING DECK	H8			
1082	FM BLDG - D (AUX SVRVC)	F7	1900	TUFTS HOUSE	I8	3262	PEAYNE SOUTH PARKING LOT	F8			
1093	FM BLDG - F (WOORTH SHOP)	G7	1920	FM BLDG - E (RECEIVING)	F7	3263	OXFORD ROAD BUILDING	G7			
1121	EMORY VISITOR INFORMATION BOOTH	G9	1930	WOODRUFF MEMORIAL RESEARCH BLDG	H8	3264	OXFORD ROAD PARKING DECK	F8			
1130	BOISFELLET JONES CENTER	G9	1940	WAYNE ROLLINS RESEARCH CENTER	G6	3270	PEAYNE SOUTH PARKING DECK	F8			
1131	MATHEMATICS AND SCIENCE CENTER	F9	1941	WHITFIELD BIOLOGICAL RESEARCH BLDG	G7	3271	PEAYNE NORTH PARKING DECK	F8			
1150	EMORY ELECT SUB-STATION	F9	1980	ROBERT W. WOODRUFF LIBRARY	H8	3278	FM PARKING LOT	G7			
1170	TARBUTTON HALL	G8	1990	ELH EDUCATION ANNEX	H8	3280	LOWER GATEWAY SOUTH PARKING DECK	I9			

Meeting Venues Map



Emory Conference Center (8760)

Emory Point

CDC (8510)

Claudia Nance Rollins Bldg. (1522)
Grace Crum Rollins (1518)

Woodruff Health Sciences Library (1370)

Eagle row: Delta Delta Delta and Gamma Phi Beta

Woodruff Health Admin Bldg. (1440)

Means Drive