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## **A1. Contested Disorders: Diagnosis, Therapeutic Power and the Patient's Voice**

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### *Drawing the Thin Red Line: The Measurement of Pain and Its Discontents*

From the 1940s through the 1990s, researchers and physicians worked to find a workable scale to measure the subjective phenomenon of pain, in part to use in the assessment of analgesics and other pain therapies, but also to create an objective measure of pain that equated with other parameters of physiological well-being. The psychophysical studies of Hardy, Woolf and Goodell at Cornell described a graduated scale between pain threshold (initial perception) and maximum pain tolerance that was linked to stimulus intensity; but their "Dol" scale, developed on volunteer subjects, was criticized as not reflective of the experience of the clinical pain patient. Two types of measures developed in the 1960s and 1970s in the attempt to better calibrate pain to individual experience: the first, exemplified by the McGill Pain Questionnaire, used verbal descriptors to describe the intensity, quality, and impact of pain, linking these to a numerical scale based on a group consensus. Although widely used, the McGill and its

sister scales have been validly criticized as likely to vary based on language, patient cultural background, physician-patient interactions, and other confounders. The second type of scale requires the patient to define the pain as a number between 0 and 10, by simply stating the number, locating a point on a ten-centimeter line or selecting a numerically defined “face”, on a scale from smiling to sobbing, that matches his/her interior state. The ease of use of such measures and their ready adaptability to therapeutic assessment have ensured their widespread adaptation in clinical and research settings around the developed world. But chronic pain patients continue to find these measures inadequate to calibrate their experiences, and, through the internet, have published alternative pain scales, with the stated goal of helping fellow sufferers to communicate better with their physicians. In this paper, I present this history and show how physicians, while honestly trying to develop true measures of clinical pain, could not escape from their own perceptions of what they thought pain was and should be. To construct objective measures of pain, they continued to deny the relevance of the patient’s individual experience.

#### Objectives

1. Understand the process by which therapeutic measures of pain have been socially constructed
2. Understand the role of the patient in the development of therapeutic assessment tools
3. Think critically about the nature and limits of diagnosis and assessment of subjective disorders

#### **A1. Contested Disorders: Diagnosis, Therapeutic Power and the Patient’s Voice**

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#### *Therapist-Patient Sex: From Feminist Reform to Borderline Personality*

Today it is axiomatic that sex between therapists and clients is verboten. This professional standard, however, is a product of historical struggle. In the 1970s and 1980s, feminist therapists organized to raise awareness and then to revise professional codes to include an absolute prohibition against sex with patients. The first part of this paper tells this story, situated at the juncture of the “sexual revolution,” the growth of a therapeutic culture, and second wave feminist critiques of sexual coercion and abuse. The psychiatric professions increasingly viewed sex with a client as a serious abuse of power, not a clinical “mishap.” Part two of my paper explores how as it became harder to rationalize sexual relationships as a mere mistake, or “mishandled transference,” pushback took another form. Rather than an indicator of unresolved conflicts from the therapist’s past, sexual violations became increasingly understood as “partly created by the patient’s pathology”—specifically women with Borderline Personality Disorder. By the 1980s and 1990s a substantial literature described “borderline patients” as eliciting, provoking, or seducing therapists into sexual and other boundary violations. For some experts, a patient’s ability to elicit the therapist’s “overt wrongdoing” was pathognomonic of borderline personality. In other words, therapeutic boundary violation called not for self-recrimination but for a diagnosis of BPD. This was not a conspiracy of experts; many authors were sincere in their efforts to help women diagnosed with BPD. Nevertheless, when feminists successfully confronted a pattern of sexually coercive behavior by therapists, a strange inversion of power occurred. Women diagnosed with BPD assumed the role of abuser while therapists become the victims of coercive, despicable, and seductive “borderlines.”

#### Objectives

1. Understand the dynamic history of psychiatric ideas and practices
2. Understand the relation between social movements, like feminism, and the history of professions
3. Develop the capacity for critical thinking about the nature and limits of psychiatric diagnoses

### **A1. Contested Disorders: Diagnosis, Therapeutic Power and the Patient's Voice**

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#### *Defining Chronic Fatigue Syndrome: Conflicts between Patients and Doctors*

After the Centers for Disease Control chose the name Chronic Fatigue Syndrome (CFS) for a new cluster of symptoms in 1988, most observers relied on psychology to understand the cause. In 1992 medical historian Edward Shorter asserted that the “violent” rejection “of psychiatric diagnoses by chronic fatigue patients” was “itself a characteristic of the illness.” For many years similar ideas infused the little research conducted on the disorder. The psychiatric bias was especially pronounced in Britain, where mental health professionals set the research agenda. In 2005 they inaugurated the massive, \$5 million study, the “PACE Trial,” which found that patients needed cognitive behavior therapy and graded exercise therapy. The results were reported not only in *The Lancet* but also in the popular press and shaped medical care in the United States as well as in Britain. Patients and advocates erupted in fury, noting that exercise of any kind exacerbated symptoms and that psychotherapy was inappropriate for a condition with a physical basis. After waging a long battle to obtain the research data, experts demonstrated that serious methodological flaws plagued the study. A 2015 report by the Institute of Medicine represented a victory for patients and their allies, defining CFS as “serious, debilitating” condition and condemning the “misconception that it is a psychogenic illness or even a figment of the patient’s imagination.” A few months later the National Institutes of Health asserted that most investigators had ignored the organic basis of the disease and called for research to uncover its mechanism. Nevertheless, patients continue to encounter doctors who proclaim that CFS results solely from unresolved psychological issues. Increasingly well-organized groups of advocates argue that the level of research funding remains abysmally low.

#### 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 and their implications for patients and health care providers
3. Understand the controversies surrounding chronic fatigue syndrome.

### **A2. Public Discourses on Private Violence in the Twentieth Century United States**

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#### *Early Responses to Campus Rape as a Women’s Health Issue*

In the early 1970s, women's liberation feminists began challenging the ways rape was understood and addressed. As Black freedom organizers before them understood rape as a means to exert white power, and organized resistance as such, women's liberation feminists articulated their own analyses of power and sexual violence in the early 1970s. Feminist writings from that moment reflected this, as did anti-rape organizing on and off college campuses. As a byproduct of larger shifts in feminist thinking and organizing, plus the increased enrollment of women in colleges, American universities were sites of student organizing and expansion of women's services to address rape. By the mid-1970s, university students, faculty, and staff across the nation were organizing anti-rape seminars, self-defense classes, rape crisis programs, and counseling services. Their work was often situated in or affiliated with college women's centers and health services. As such, many of these early responses addressed campus rape as a women's issue and women's health issue, both feminist and health-oriented in their approaches to prevention and providing services. In this paper, I examine oral histories and materials from college newspapers, university archives, and women's history archives on the development of campus resources to prevent rape and provide services to women who experienced violence. Focusing on Columbia University and Barnard College, I analyze *Columbia Spectator* articles, oral histories with Columbia and Barnard staff who worked from the late 1960s to the early 1990s, and other materials to show how college students, faculty, and staff leveraged feminist analyses of power and organizing frameworks to develop new knowledge about women's health, innovative health services, and compassionate protocols for providing care to people who experienced sexual violence. I argue that the feminist anti-rape movement fundamentally changed health services and health promotion on American college campuses.

#### Objectives

1. Understand the dynamic historical interrelationship between health care and feminist ideas and organizing
2. Critically appraise clinical protocols from a historical perspective
3. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy

## **A2. Public Discourses on Private Violence in the Twentieth Century United States**

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### *Unfit to Wed: Domestic Violence on the Silver Screen in America, 1910 – 1929*

Between 1910 and 1920, Hollywood produced over 50 films graphically depicting domestic violence for wide release. On the silver screen, American viewers watched in horror as husbands beat, whipped, strangled, and slammed their wives on the ground. Building on the work of scholars, such as Martin S. Pernick, my talk examines these films as a previously unexplored set of health films from the silent era of American cinema. These films attempted to both entertain and educate the American public to change their everyday behavior for the sake of better health. They provided an explanation for intimate partner violence rooted in eugenics: abusive men suffered from poor heredity. Generally speaking, the films relied on a specific formula in which a woman had a choice of two men to marry—one aggressive and the other meek—and she makes the wrong choice. After marrying the aggressive man, her life descends into poverty, abuse, and misery. The nice and meek suitor remains on screen to remind the woman and the viewer what her life could have been. While the films clearly condemned the husband,

they contained an unresolved tension of depicting the wife as both the innocent victim and perpetrator of her own suffering. Furthermore, the struggled to free the wife of her abuse. Unwilling to promote divorce, the wives usually only escape when their husbands suffer a convenient death. Relying on stock tropes of the unfit, I argue that Hollywood taught Americans that abusive husbands came from poor eugenic stock that helped to cement an association between alcoholism, poverty, and abuse in the public imagination that continues until today.

Key words: intimate partner violence, film, eugenics

#### Objectives

1. Study how media has shaped perceptions of health
2. Explore changing explanations for intimate partner violence in the US
3. Provide historical insight into contemporary stereotypes of gender based violence

## **A2. Public Discourses on Private Violence in the Twentieth Century United States**

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*A Violation to the Community at Large: The Native American Women's Health Education Resource Center v. City of Lake Andes*

In the summer of 1990, the Native American Women's Health Education Resource Center (NAWHERC), the first of its kind in the US, requested a zoning variance in Lake Andes, SD. The issue at hand was the establishment of a domestic violence shelter within city limits which would primarily serve members of the Yankton Sioux. Given the high rates of domestic violence for tribal members—estimates suggested that 4 in 5 Native women experienced violence in their lifetimes—the shelter was much needed. A zoning variance should have been an easy achievement for the NAWHERC; that is until the Deputy State's Attorney for the county stood to give a public statement during the zoning meeting. A racist tirade followed in which the DSA attacked Native Americans for being "godless," insisting that a domestic violence shelter in city limits would allow the violence he saw as "natural" to Native society to move into the predominantly white community. After this meeting, the zoning board rejected the variance. But the NAWHERC sued the city of Lake Andes and the men on the zoning board charging them with a civil rights violation. Although their lawsuit was ultimately unsuccessful, the NAWHERC used the opportunity of the lawsuit to counter negative images of Native Americans and to show the connections between racism, intimate partner violence, and a lack of support for the health and well-being of Native American women. Many white leaders imagined violence against Native American women as being race-based, a symptom of a "diseased" culture beyond redemption. The state, as shown in part by the zoning board, believed its responsibility was to protect white society from the violence believed to be endemic to Native Americans. However, the NAWHERC used this court case as an opportunity to argue that violence wasn't endemic to Native American culture; rather, a history of imperialism, racism, and paternalism had robbed Native American women of their bodily autonomy, placing their lives at risk. The solution to this health problem wasn't only to provide a safe space, but to counter the government's understanding of, and approach to, interacting with Native communities.

#### Objectives:

1. Recognize the relationship between racism and the health effects of violence

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

### **A3. Race, Disease, and Non-Traditional Healers in the Nineteenth and Twentieth Century Caribbean and the United States**

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#### *Medical Comedies and the Education of Race in Nineteenth Century Cuba*

Between 1790-1821, Cuba imported nearly a quarter million African slaves – the same number that were brought to the island during the previous century. After the abolition of the Atlantic slave trade in 1808, the Spanish empire largely ignored the ongoing illicit trade in favor of supporting its most productive American colony. White Cuban elites gained enormous wealth from slave labor. Many became key patrons of Cuban science, medicine, and the arts, seeing these institutions as means to reinforce their cultural hegemony. In response to this patronage, Cuban playwrights portrayed white male doctors as the vanguard of a modernizing Cuban society, lauding their tireless efforts to maintain healthy populations amid tropical disease, changing demographics, and technological advances. Doctors' "assistants" (often free or enslaved black Cubans) were portrayed as naïve and superstitious, but nonetheless dutiful. Meanwhile, non-white doctors were shown as ineffectual, herb-peddling charlatans, profiting off of unsuspecting white Cubans, especially white Cuban women. This was particularly true for characterizations of Chinese doctors. Chinese "coolies" were viewed as racialized others and sources of disease when they began arriving in Cuba during the late 1840s. As these examples suggest, this paper will reveal an unexplored medical-cultural medium that was used to transmit ideas of medicine, whiteness, and racialized otherness to broader Cuban society. The sources for this paper are nineteenth century medical comedies located in the archival holdings of the National Library in Havana, Cuba. Following the work of historians of medicine Maríaluz López-Terrada and Mary Fissell, I demonstrate that medical comedies disseminated ideas of medicine, disease, and race to the elite and popular levels of Cuban society. As published texts and live performances, medical comedies served as didactic tools for slave-holding elites and the emerging Cuban medical profession to communicate racialized ideas of bodily health while emphasizing racialized and gendered medical professional hierarchies.

#### Objectives

1. Deepen our understandings of the history of medicine in Cuba and in Latin America more generally
2. Demonstrate that historians of medicine must pay attention to the history of race and racism, particularly for medical-cultural representations of doctors and patients
3. Demonstrate that the history of medicine, medical education, and medical practice in Cuba cannot be separated from the history of slavery.

### **A3. Race, Disease, and Non-Traditional Healers in the Nineteenth and Twentieth Century Caribbean and the United States**

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*Rickets: Deconstructing a “Racial Disease”*

Rickets, the calcium metabolism disorder most associated with soft or bent bones in children, seems to be a perfect subject for probing the concept of “race-specific” diseases. Rickets is often caused by insufficient vitamin D in the blood, and while the nutrient can be supplied in the diet, sunlight shining on skin is all a healthy body needs to produce sufficient vitamin D. With skin color—the ultimate proxy for race in American culture—so intimately entwined in the process of natural vitamin D synthesis, and given the current and historical demographics of rickets—with a disproportionate number of rickets cases identified as “African-American”—it has been tempting to assume that this apparent racial proclivity must reflect biological reality—that far from being a socially-constructed phantasm, rickets must be that *rara avis*: the bona fide “race-specific disease.” This talk will start by surveying the history of rickets’ reputation as a “racial disease.” That perception predates the discovery of vitamin D and the skin’s role in manufacturing it. “The American negro is very subject to rickets,” wrote a Pittsburgh physician in 1895, adding “it may be said that every northern negro child is more or less rachitic.” Next, I will make the argument for social construction, with economic realities, diet, the built environment, and cultural practices major drivers. Finally, I’ll present, as a complication to the hard social construction argument, the vitamin-D equivalent of the “Inuit Paradox”: the complex relationship between vitamin D levels and the incidence of rickets in Arctic-dwelling Native Americans—dark-skinned individuals living at high latitudes. My conclusion will try to navigate some thorny questions about clinical and public health applications of the lessons of race and vitamin D deficiency.

Objectives

1. Recognize the dynamic relationship between medicine and society through history
2. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning.

**A3. Race, Disease, and Non-Traditional Healers in the Nineteenth and Twentieth Century Caribbean and the United States**

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*Through the Looking-Glass: A Haitian Healer on the Romana Sugar Mill in the Dominican Republic (1938)*

This paper uses archival materials, press accounts, and other contemporary sources to examine the gray zone between unsanctioned “healers” targeted by the emerging Dominican biomedical state led by the Rafael Trujillo regime (1930-61) and emergency healthcare providers stationed on private company lands within the country. Between the 1910s and 1940s, US authorities and interests helped strengthen the Dominican state by centralizing government and improving infrastructure. Starting in the 1910s in La Romana, specifically, the New York-based South Porto Rico Sugar Company of New Jersey contributed to these processes by establishing a sugar mill. By the 1930s, the Romana sugar mill’s close ties to Trujillo gave it great autonomy in managing its conflicts with laborers and in organizing its medical system.



Concurrently, hundreds of Haitians and blacks from the non-Hispanic Caribbean toiled on the mill in some capacity. Several Haitians, including Mauricio Gastón, served there as “medical practitioners,” typically providing urgent care to workers in the form of quinine injections and basic treatment for hard labor-related injuries. Gastón did so at a sensitive time, following the October 1937 Parsley Massacre, a Trujillo regime-ordered genocide of Haitians living on the Hispaniolan borderlands. In early 1938, Dominican police and military officers investigated accusations made against Gastón which suggested he was a careless and discriminatory healer, especially vis-à-vis Dominicans. While the Dominican state pursued healers for practicing “illegal medicine,” Romana administrators recruited them as “medical practitioners.” The sugar mill represented a strange parallel world in this regard. Considering Gastón’s story in Dominican, Hispaniolan, and circum-Caribbean context shows that popular healthcare providers fluctuated between different categories of healer depending on factors like place and historical memory. Thus, healing was as much about politics as it was about disease, medicine, and health.

#### Objectives

1. Recognize the dynamic interrelationship between medicine, society, and politics through history
2. Identify the key agents in state biomedicine, private medicine, and popular healing in the Dominican Republic between the 1910s and 1940s
3. Understand the tense and tender exchanges between medical stakeholders and patients in the context above

#### **A4. From Couching to Laparoscopy: Surgery in Historical Context**

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##### *Anatomical Experience, Visual Theory, and Cataract Couching in the Early Modern Period*

It is only towards the end of the seventeenth century that clear evidence of knowledge that cataracts consist of an opacification of the crystalline lens is found. Before then, it was generally believed that cataracts were separate concretions deposited in front of the lens. The most common surgical procedure for blindness due to cataracts was couching—that is, inserting a special needle behind the corneoscleral junction, and then depressing these supposed concretions underneath the vitreous humor. The seventeenth century also saw a revolution in visual theory involving a shift in the seat of vision from the crystalline lens to the retina, principally thanks to Johannes Kepler’s new camera obscura model of vision proposed in his 1604 *Ad Vitellionem* paralipomena. These two shifts have long been connected by historians, but a detailed account of the reception of the retinal theory is still lacking, and because of this our knowledge of the interaction of these the two events cannot be put on solid ground. This talk will offer a new, more detailed account of the reception of the retinal theory, along with a new account of shifts in the dynamics of epistemic authority, and thus provide a new context for the controversy over the nature of cataracts. In disciplinary terms, this seemingly simple discovery was a result of the complicated interaction, over more than a hundred years, of anatomy, surgery, mathematical optics, and natural philosophy. In terms of the practitioners involved, it pitted the experience of surgical specialists against that of anatomists, it involved physician-philosophers weighing intellectual concerns against empirical evidence (both personally witnessed and reports by others), and it called for all involved to reevaluate their commitments to ancient authorities. All the while, the disciplines themselves, and the social status of the various practitioners involved, underwent major changes

## Objectives

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

### **A4. From Couching to Laparoscopy: Surgery in Historical Context**

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*“An Explosion of Interest”: Spreading and Controlling the Laparoscopic Revolution through Surgical Training, 1990-2000*

The introduction of laparoscopic cholecystectomy (LC), or minimally invasive gallbladder removal, generated such enthusiasm that concerns were soon raised over the potential for hastily-trained surgeons to cause irreparable damage to patients. Only months after the first demonstration videos were presented, editorials began to caution that inadequate training would result in high complications rates and harm the reputation of the promising new procedure. Nevertheless, surgeons throughout Europe and North America quickly scrambled to learn the new technique in order to meet the rapidly growing patient demand. Though LC survived as the predominant treatment for gallstones, poor execution of the technique did lead to a period of negative publicity, as predicted. The emergence of LC, with its radically different implementation compared to traditional open surgery, created a situation where the general standard of “see one, do one, teach one” was no longer sufficient. This provided an opportunity and impetus to develop more standardized forms of continuing medical education for surgeons. Indeed, the development of formal courses by surgical associations became a strategy to control the “explosive” spread of LC. Still, there were some courses, particularly in the US, that had the effect of allowing it to spread more widely. With the use of course advertisements in surgical journals and newsletters, training manuals, and trainee feedback forms, this paper will examine the development of training for LC to determine the elements and contexts that allowed early courses to spread and control the technique. It will bring new insights into how medical training evolves by focusing on an episode in medical history where the introduction of a technological innovation drastically changed the very basic motions of surgery. This work will also contribute to a wider understanding of medical education by considering training as a means to control the spread of new technologies and knowledge.

## Objectives

1. Understand the dynamic history of medical ideas and practice and their implications for patients and health care providers
2. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy
3. Identify successes and failures in the history of medical professionalism

### **A4. From Couching to Laparoscopy: Surgery in Historical Context**

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### *Laparoscopic Cholecystectomy: Its Impact on Surgical Innovation*

It has been 30 years since the first laparoscopic cholecystectomy (LC) safely removed a gallbladder; the operation changed abdominal surgery forever. In 1989, every abdominal operation required a large, painful incision demanding a prolonged recovery, whereas today nearly every case can be performed laparoscopically through tiny keyhole incisions. Other historians like Thomas Schlich and James Zetka have examined the emergence of this new technique, but my paper moves beyond the point of discovery. It relies on archival documents and published literature to investigate the implications of LC on the field of surgery. I argue that LC functioned as a catalyst that fundamentally altered the attitude and practice of surgeons worldwide. Prior to LC, surgical approaches to disease had not changed for decades. Compared to the rest of American medicine, almost no other field had similarly stagnated. Certainly, new specialties like organ transplantation and vascular surgery expanded the breadth of the field, but the underlying operative approach remained identical to that of Billroth and Halsted from the late 1800s. LC changed the practice of surgery. The method of separating the gallbladder from the liver was no different but the size of incision did change, and the marked success of this radical departure from a “bigger is better” philosophy enabled the questioning of other longstanding practices. Multi-decade dogma surrounding length of hospital stays, early mobilization, post-operative feeding, and the use of nasogastric tubes similarly came in doubt. Innovations in operative technique led to an entirely new way of managing patients post-operatively. The potential of LC was not limited to just making smaller incisions. Rather, the crucial importance of this innovation was its ability to force the profession of surgery to question – and ultimately alter – longstanding practices and change the way it treated patients, both inside and outside the operating room.

#### Objectives

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

### **A5. Pharmaceutical Endeavors: Medicaments in European Societies, 16th-18th Centuries**

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#### *The Social Life of Theriac in Eighteenth-Century Bologna*

In 1717, the Medical College of Bologna issued a notification against the adulteration of medicaments and added a new mandate: now, during their quarterly inspections of apothecary shops, inspectors must register each shop’s stock of theriac. Why did the College reserve so much attention to this one medicament over all others? Despite the ubiquity of theriac in the medical literature from Antiquity to the eighteenth century, little is known about theriac’s material existence—that is, its production, supply, and use. Historians have generally held that after centuries of uninterrupted use, theriac consumption began to slowly decrease in the eighteenth century. It is true that medical literature about theriac decreased from the second quarter of the eighteenth century across Europe, but did the sale and use of theriac decrease with it? In other words, did the practical economy of theriac move in tandem with its

cultural, social, and medical relevance? What was the relationship between medical literature and the use of this medicament? This study examines the inspection records of apothecary shops in eighteenth-century Bologna to compare theriac's practical life—its production, retail, and economic impact—with its life 'in theory', that is, as it was culturally and socially constructed in medical and academic treatises and by medical institutions.

#### Objectives

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

#### **A5. Pharmaceutical Endeavors: Medicaments in European Societies, 16th-18th Centuries**

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#### *Merchandise for Profit and Merchandise for Honour: Artisans of Secrets who Enhanced Early Modern Italian Pharmacopoeia*

Early Modern pharmacopoeia was a much more nuanced concept than what we may assume. From 1550 to 1797 the Venetian Health Board allowed over 350 individuals to manipulate and sell medicinal secrets—as were currently named—that they invented in the private of their homes by spending sleepless nights experimenting on *Materia Medica*. It was a procedure of patenting granted to commoners which followed a regulation code different from the well-known one reserved to the Italian quacks' secrets. These individuals were notaries, colour-sellers, distillers, apothecaries etc. but many of them were simply artisans of secrets, that is to say ordinary people—male and female—and entire households of middling sort status involved in the provision of medical treatment and remedies. What did distinguish their secrets from the quacks' concoctions? First of all, by law, they had to be original in comparison to the official pharmacopoeia. A few of them turned out to be so efficacious and original that, following various patent renewals, the Republic of Venice decided to include them in the official pharmaceutical supply of the city: a highly significant bottom-up circulation of knowledge. Secondly, these medicinal secrets were characterized by high selling prices, even though some of them were freely handed out as it was a matter of their inventors' honour to help the community. Anyway, regardless of whether for profit or for honour, all the artisans of secrets were proud of their inventions. As to the mid-18<sup>th</sup> century we have a series of selling prices of this specific category of medicaments which can give us an idea of the consumers who might afford to use them. We can also rely on an original source which explains what contemporary laypeople did expect from such medical secrets in comparison to other medicaments.

#### Objectives

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

## **A5. Pharmaceutical Endeavors: Medicaments in European Societies, 16th-18th Centuries**

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### *The Business of Pharmaceutical Distillation in Early German Print*

Throughout the early modern period, distillation and distilled remedies were widespread and popular with humble householders, the nobility, and medical practitioners and patients of all stripes. As well as moving freely across social boundaries, distillation intersected a range of intellectual and practical traditions, from alchemical and medical texts to the production of proprietary elixirs, mineral acids, or strong drinking spirits. This paper explores a hitherto neglected source base, the printed *Destillierbücher* books of distillation which appeared in the German lands at the beginning of the early sixteenth century and spawned numerous translations and imitations across Europe. Read alongside archival records of medical practice and artisanal culture, they allow us to explore how distilled medicines were conceptualised as efficacious remedies, artisanal products, and valued commodities, and how they functioned within economies of pharmaceutical production (in the shop or in the household) and medical practice (for money or for charity). Considered as medical commodities in themselves, these books also show how practical pharmaceutical knowledge was codified in vernacular print.

#### **Objectives**

1. Understand how distillation connects pharmacy and other trades
2. Understand how pharmaceutical distillation was codified in print
3. Understand how early-modern distillation emerged out of a variety of intellectual and practical medical traditions

## **A6. Preventive Medicine in Social Context**

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### *Playing at the Preventorium: The Role of Children's Play in Early 20th Century Anti-Tuberculosis Efforts*

In the early decades of the twentieth century, a new understanding of children as invisible carriers of tuberculosis cemented an abiding relationship between childhood and tuberculosis in the American medical and lay imagination alike. In this spirit, the attention of anti-tuberculosis crusaders turned toward prevention efforts for the “pre-tubercular” child. Healthy children from urban centers were thus routinely sent to countryside residential institutions known as preventoria, where it was hoped that a “prescription” of heliotherapy, prolonged exposure to open air, fresh milk, and a steady diet of outdoor play would shore up their resistance to infectious disease and teach good hygienic practices to those considered high risk (i.e., children of the urban poor and immigrants). A focus on “pre-tubercular” children also tapped into heightened anxieties about disease in urban centers, as children returning from the preventorium were meant to disseminate newfound knowledge of hygienic practice to their families and neighbors in crowded city tenements. Invoking the child as the driving force of anti-tuberculosis efforts, the preventoria idea leveraged the potency of the figure of the child to ensure the health of the nation. It also served to authorize intervention into family life by relocating children to

“curative” outdoor spaces and attempting to surveil their bodies and behaviors there. In this paper I will examine the ways in which medical professionals positioned children’s play as curative, as well as the ways in which play was actually “taken up” by children at three state-run preventoria in the Mid-Atlantic region of the United States. In examining how play was “prescribed,” I will consider the preventorium movement as an early manifestation of the medicalization of children’s play. In examining how children actually engaged with “play forms,” I will consider the ways in which children’s play can both adhere to and defy adult management.

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

### **A6. Preventive Medicine in Social Context**

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#### *Reproductive Revolution: History, Memory, and Infant Mortality in China, 1940-1960*

Official histories claim that the new government of the People’s Republic of China (PRC) brought hygienic midwifery to rural areas for the first time in the 1950s, rapidly reducing infant mortality. Here, the Communist state purportedly succeeded where the prior Nationalist regime had failed. Historians, while noting Nationalist-era midwifery education programs, have largely affirmed this official narrative pointing to a precipitous drop in infant mortality as quantitative evidence of the success of Communist policies. But, as PRC public health officials regularly pointed out, Nationalist-era demographic data remained scarce and unreliable, especially for rural areas. How can we draw such stark contrasts between the “feudal” past and the “new China?” How do we know that Communist policies rapidly decreased the infant mortality rate? This paper argues that the political dynamics of the early PRC produced this lasting narrative of a reproductive revolution, which, by design, obscured a longer, slower decline in infant mortality. More broadly, this paper shows how political conditions shaped the construction and interpretation of demographic facts. By analyzing official newspapers, magazines, and speeches from the 1940s and 1950s, this research shows how infant mortality became a scientific and putatively neutral index for demonstrating China’s socialist transformation. In this context, midwives and gynecologists who had worked for decades to mediate between vernacular healing practices in the rural interior and the state’s biomedical programs repudiated their pre-revolutionary work. While many suffered persecution for their prior ties to missionaries and Western philanthropies, the most vocal critics of the Nationalist regime’s failures weathered political purges. They reframed the effects of their longstanding efforts as the immediate consequences of Communist policies. They also helped produce a historical narrative of a radical, reproductive revolution in the early PRC, which persists to the present day.

#### Objectives

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

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

## **A6. Preventive Medicine in Social Context**

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### *Searching for a ‘Balanced’ Narrative: Prenatal Genetic Counseling for Down Syndrome*

As prenatal diagnosis became increasingly commonplace in US after 1980, its main target was Down syndrome. Genetic counseling, a new master’s level profession, grew quickly alongside prenatal diagnosis. The primary goal of genetic counselors was to facilitate patients in making informed choices based on medical information and personal values. After a prenatal Down syndrome diagnosis, women faced a difficult decision about “preventive” abortion. The great majority chose abortion for Down syndrome, which they understood—based on societal narratives and medical descriptions—to involve significant intellectual and physical impairments. During the 1990s, disability advocates prominently critiqued the “eugenic” implications of prenatal diagnosis, arguing that women chose abortion due to negative depictions of Down syndrome by physicians and genetic counselors. To facilitate informed and unbiased choice, advocates believed that women needed more positive narratives of Down syndrome. Drawing on recent work by historians of medicine Beth Linker and Ilana Lowy on the challenges of integrating medical and disability perspectives, this presentation examines joint efforts by physicians, genetic counselors, and disability advocates to formulate a “balanced” portrayal of Down syndrome for dissemination after prenatal diagnosis. In 2009, the interdisciplinary Down Syndrome Diagnosis Study Group published a consensus pamphlet. Three years later, however, Down syndrome advocacy groups that had initially approved the pamphlet rescinded their endorsements and created their own competing documents. Based on interviews, archives, gray literature, and publications, I historicize these events and explore the nature of longstanding divides, which led to this breakdown of consensus. I argue that differing perspectives on medicine’s shortcomings in providing a “balanced” view of disability were central to the failure of achieving a widely acceptable pamphlet. For Down syndrome advocacy groups, highlighting positive narratives alone was insufficient so long as pregnancy termination—which they viewed as discriminatory and oppressive—was still presented as a standard intervention.

#### **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

## **L1. The Inquisitive Ear: Listening and Sound in the History of Medicine**

Melissa Lo: University of California, Los Angeles, Los Angeles, CA, USA  
Kirsten Moore-Sheeley: Cedars-Sinai Medical Center, Los Angeles, CA, USA  
Jessica Holmes: University of California, Los Angeles, Los Angeles, CA, USA  
Kristina Jones: Cedars-Sinai Medical Center, Los Angeles, CA, USA

How has listening to the body, as well as the value placed on listening as a way of knowing, changed in the practice of medicine? How have the soundscapes of hospitals and other medical spaces been reconfigured over time? Which forms of medical listening are common across chronologies and cultures, and what does that tell us about the experience of healing and suffering? Although listening has long been a vital technique in medical practice, it has been given short shrift in the history of medicine. The senses of sight and touch, by contrast, continue to dominate the historiography. Similarly, while sound and silence have been ever-present fixtures of healing encounters, these sensations remain underexplored in the field. Historians often talk about silences in the archives, but rarely about the silences brought about by the advent of private hospital rooms or the silences broken with the beeps of new diagnostic machines. Inspired by the ongoing Inquisitive Ear project of the Cedars-Sinai Program in the History of Medicine, this panel aims to open up conversations about how to study listening, sound, and silence in the history of medicine, and why this line of inquiry can be fruitful for expanding the field in new directions. It will bring together panelists from Cedars-Sinai's Inquisitive Ear project—who have backgrounds in the history of medicine, history of science and technology, sound studies, deaf/disability studies, musicology, medicine, and psychiatry—to discuss this highly interdisciplinary subject. Attending to listening in medicine's history, we suggest, is not only useful in understanding the changing value people have placed on certain ways of knowing and healing in medicine; it is also critical to understanding current attitudes toward medical listening and its seemingly reduced importance in the physician's toolkit. This panel promises to be of interest to people with interest in sound studies, the history of the senses, the history of the hospital, the history of medical technology, and deaf and disability studies, as well as current clinician-historians.

#### Objectives

1. Deepen understanding of the role of listening and sound in medical practice
2. Recognize the dynamic relationship between listening and medical knowledge through history
3. Critically appraise healing technologies and techniques from a historical perspective

## **L2. Coming Across: Rethinking Translations in the History of Medicine**

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Projit Mukharji: University of Pennsylvania, Philadelphia, PA, USA

Sietske Fransen: Cambridge University, Cambridge, UK

Dror Weil: Max Planck Institute for the History of Science, Berlin, Germany

Translation has played a significant role in history of medicine. Translations across different linguistic systems were key to the making of major multi-lingual medical paradigms, from Galenic to Chinese medicine. On the other hand, translations were also instrumental in how colonial medicine interacted with local systems, practitioners and patients. Translations also constitute part of the historical awareness that informs how medical practitioners locate themselves within their practice. In this workshop, we look at instances of translations from the medieval to the modern period investigating how “translation” can serve as an analytical category in the history of medicine to understand movement across linguistic, practical and sign systems. The first paper reexamines the Translation



Movement in the history of Islamic medicine (ca. 9th century CE), which was key to the development of Galenic medicine around the Mediterranean. The paper looks at translation as a mode of archive-making, which involved acquisition and organization of texts, as well as their movement across languages. The second paper moves to the works of Liu Zhi (1660-1730), a Chinese savant instrumental in studying Arabo-Persian natural philosophy. It examines the ways Liu Zhi reconstructed Islamic views on the body and its operation from bits and pieces of Islamic works on theology and jurisprudence. The third paper uses the example of an English 17th-century physician and his personal notebooks, to study private translations as forms of educational practice and archive building. Focusing on translation within notebooks, the paper shows how both canonical and vernacular knowledge of the body was incorporated into local systems of understanding human health. The final paper moves to 19th-20th-century Bengal, looking at Braja Nath Shaha's work, a successful Bengali practitioner of "Western" medicine, who explored a new materio-spiritual body, which drew on an older European tradition of inspirited matter or hylozoism. The paper uses Shaha's writings to uncouple "translation" from the discourse of "hybridity" and the implication that knowledge traditions are homogenous monoliths. Instead, it rethinks the interaction of "Western" and "Eastern" knowledges in a way that is adequately sensitive to the internal heterogeneity of these traditions through the metaphor of braiding.

#### Objectives

1. Recognize the dynamic interaction between medicine and society through history
2. Understand how culturally distinct patterns of health and medicine interact with each other
3. Critically examine the role of cultural and politics in shaping medical practice

### **L3. What was Global Health? New Perspectives from the History of Medicine and International History**

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Heidi Tworek: The University of British Columbia, Vancouver, BC, Canada

Lucas Mueller: Massachusetts Institute of Technology, Boston, MA, USA

Emily Harrison: Harvard University, Boston, MA, USA

Kavita Sivaramakrishnan: Columbia University, New York, NY, USA

Global health has emerged as the latest in a series of approaches aiming to address health conditions and inequity in the "developing countries" in the early twenty-first century. This approach promised to overcome the boundaries between prevention and treatment and the previous focus on infectious diseases and malnutrition. Historians of medicine have studied the continuities across colonial medicine, international health, and global health regimes in shaping the "lives of other peoples." International historians, too, have become interested in medicine as an area of twentieth-century international relations; the study of health lays bare the role of international organizations, experts, knowledge, and technologies in shaping international affairs. Other have called for in-depth studies of local and national actors to reveal how they reacted, appropriated, and transformed these schemes within national and local contexts. The panelists, whose multi-sited research integrates global developments and local affairs, will explore this generative tension, discussing the following questions. Which health issues have become internationalized, and which have not? How did this process of "globalization" work? How have ideas, such as development, nationalism, internationalism, or scientific concepts, and things, such as drugs, technologies, or commodities, shaped health internationally and locally? Which roles did actors,

including patients, activists, local and foreign physicians, and bureaucrats, play in advancing, resisting, subverting, and appropriating these international programs on the ground? In which ways did organizations, such as national governments, international organizations, non-governmental organizations, and philanthropic organizations facilitate or impede these movements? How were these developments shaped by wars, colonialism, decolonization, Cold War, economic interests, global trade, and human rights? In which ways did health programs shape the international system and global governance in the twentieth century? Based on their studies of infant mortality, HIV/AIDS, cancer and food contaminants, aging, epidemics, and communication across different continents and time periods, the panelists will delineate the viability of such cross-scale studies, offering new perspectives and methods to study the global and international history of global health and its predecessors.

### **Objectives**

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

## **B1. Encountering Disease: Medical Negotiations and Healing in the Early Black Atlantic**

### **World**

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#### *“This Man is of Great Use To Me Among the Sick People”: The Troubled Career of Doctor Nassaw*

In the spring of 1774, Richard Henry Lee graciously thanked another slaveholder in Virginia for “the assistance I have received from Nassaw.” As an enslaved physician, Nassaw practiced medicine on white and black patients in the Northern Neck between 1758 and 1778. He became renowned for his skill in therapeutic bleeding, administering purgative and cathartic drugs, and using pharmacological knowledge gleaned from his master’s tutorials in European and Native American *materia medica*. Nassaw even treated patients with a white assistant, an apothecary named Haynes—an unusual arrangement in the colonial Chesapeake. He studied African herbal medicine as well from healers at nearby plantations, such as Tom of Nomini Hall. This paper explores Nassaw’s medical career to deepen our understanding of the lives of enslaved physicians in British America. Though Nassaw often succeeded in treating his patients, his later cases reflect his struggle with alcoholism and deteriorating mental health on the plantations surrounding Sabine Hall. By 1770, Nassaw began administering medicines and performing surgery on free and slave patients while drunk, causing misdiagnosis, mistreatment, and death. Moreover, Nassaw routinely ignored patients as their illness worsened. His addiction led to open conflict with his master and increasingly violent punishments for his malpractice. In 1778, Nassaw fled Richmond County, leaving behind his wife, family, and friends. Drawing on the scholarship of James Sweet, Rana Hogarth, and Pablo Gómez, this paper analyzes how practicing medicine offered enslaved people opportunities for developing healing techniques and medical expertise. However, the responsibilities of a healer could also be severely distressing and anxiety-inducing as well. Nassaw primarily attended patients whose illness or debility originated from plantation labors and punishment. Examining Nassaw’s troubled career illuminates how even skilled enslaved healers could not always use medicine to challenge or evade the violence of slavery.

Key words: enslaved healers; colonial Virginia; alcoholism

#### Objectives

1. Understand the connected histories of plantation medicine and slavery in the colonial Chesapeake Bay
2. Acquire a historically nuanced understanding of the limited agency of enslaved healers in British America
3. Develop the capacity for critical thinking about the nature and limits of interpreting archival materials involving enslaved healers

### **B1. Encountering Disease: Medical Negotiations and Healing in the Early Black Atlantic**

#### **World**

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*“Where Putrid Fevers Ride on Every Sun-Beam”: Health and Illness in Antebellum Anti-Colonization Discourse*

One noteworthy way antebellum black abolitionists in the United States undermined the American Colonization Society (ACS) was by depicting the Republic of Liberia as “pestilential.” Free blacks often remarked upon emigrants’ increased morbidity along the Grain Coast, going so far as to label Liberia the “colonization graveyard.” And while recent works by historians like Ousmane Power-Greene have given sustained attention to the challenges free blacks posed to the colonizationist scheme, the careful construction of Liberia as insalubrious remains underexplored. This paper examines the role of health and illness in African-American efforts to resist colonization, and particularly their ability to delimit the boundaries of freedom. By insisting they had a greater chance of survival in places like the United States and Canada, as opposed to Liberia, free blacks articulated both a conception and a geography of freedom necessarily bound up with health. For decades following the foundation of Liberia in 1822, the ACS and its agents worked hard to persuade Americans of the small country’s unique suitability for individuals of African descent. However, when it became clear that emigrants were dying from disease in record numbers, part of the process also involved defending the region’s epidemiological climate. In order to slough off Liberia’s reputation for blight, the main organ of the ACS, *The African Repository and Colonial Journal*, relied heavily upon statistics to uphold the colony’s salubrity, all the while condemning the condition of densely-populated cities of Baltimore, Philadelphia, and New York. Still, the vast majority of black anti-colonizationists refused to think of the coastal area of western Africa as anything less than pernicious. And while free blacks successfully undermined many of the ACS’ spurious claims, they may have also unwittingly reproduced the very same language and logic that antebellum reformers directed towards them in the process.

#### Objectives

1. Recognize the way categories such as “healthy” and “unhealthy” have framed the debate on slavery and colonization
2. Foreground the voices of people of colour within histories of medicine
3. Consider the transatlantic nature of ideas about health and disease during the nineteenth century

## **B1. Encountering Disease: Medical Negotiations and Healing in the Early Black Atlantic**

### **World**

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#### *Enduring Inoculation: Smallpox Inoculation, Slavery, and Kinship in the Greater Caribbean*

Thousands of enslaved people endured compulsory smallpox inoculations in the Greater Caribbean during the second half of the eighteenth century. Euro-Americans inoculated enslaved people to prevent smallpox outbreaks from affecting vulnerable Euro-American families and destabilizing commerce and social life in the colonies. Yet, the historiography concerning smallpox inoculation has predominantly focused on variolation in the North Atlantic. The few scholars who have addressed slavery and smallpox inoculation in the Caribbean have tended to focus on enslaved Africans who performed inoculations, enslaved Africans who informed European physicians about West African smallpox inoculation methods, and European and Euro-American physicians who performed inoculations on enslaved people. My paper departs from these historiographical trends to consider the histories of enslaved people who endured smallpox inoculation in the Greater Caribbean region during the second half of the eighteenth century. Using Spanish, French, and British published medical treatises, physicians' account books, slaveholders' journals and correspondence, and newspaper articles, I examine the compulsory inoculation procedures that enslaved people endured, the contexts in which they were inoculated, and their encounters with the free and enslaved medical practitioners who inoculated them. Euro-Americans' gendered and racialized conceptualizations of enslaved people's bodies coupled with slaveholders' disregard for enslaved people's kinship networks shaped the inoculation procedures that enslaved people underwent. Enslaved people's responses to compulsory inoculations reaffirmed their kinship networks in ways that mirrored the spiritual and social components of African inoculation practices.

### **Objectives**

1. Develop a historically informed sensitivity to the diversity of patients
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

## **B2. Consent, Choice, and Coercion: Global Perspectives on Human Reproduction**

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#### *"Stop at Two": Voluntary Aspects of Zero Population Growth During the 1970s*

Zero Population Growth (ZPG), the largest grassroots population organization in the United States, has been around since 1968. Yet, little scholarship exists on this group beyond its coercive aspects, in which ZPG contemplated compulsory tactics to curb population growth. As a result, scholars have largely

overlooked the extent to which members of ZPG attempted to deal with overpopulation using voluntary means. This happened primarily on the local level, by removing barriers to having few or no children through educational, legal, and social strategies. ZPG members questioned reproductive motives of Americans, asking whether bearing children was truly desirable or based on pressure within a pro-family, pronatalist society. My paper addresses the voluntary aspects of population control by focusing on ZPG's promotion of smaller families, particularly their promotion of birth control, abortion, and sterilization for both men and women. I argue that emphasizing ZPG's coercive and politically conservative beliefs has distorted understandings of their contribution to reproductive justice, especially for women. Such a unilateral focus also reinforces associations of ZPG – and population control as a whole – with neo-eugenic thought, compulsory sterilization, and mandatory fertility policies such as China's One-Child Policy. This paper offers a more comprehensive understanding of ZPG to illuminate the multifaceted nature of the history of population control in the United States.

#### Objectives

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

## **B2 Consent, Choice, and Coercion: Global Perspectives on Human Reproduction**

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*“A serious obstacle”: African Men, Apartheid and Family Planning, South Africa c. 1970-1990*

In 1974, 26 years since the institutionalisation of apartheid, the National Party (NP) government launched its National Family Planning Programme. Although its architects claimed otherwise, this endeavour was explicitly aimed at curtailing the fertility of the black population. Legitimising their actions through the mobilisation of Malthusian population theories, the goal of the state was for 50% of all child-bearing women to use contraception by 1980. According to contemporary thinking, African Men were proving to be “a serious obstacle” to this programme – the success of which was deemed central to the future prosperity of the minority white population, and to the endurance of the body politic. Through analysing parliamentary debates, governmental produced education leaflets, and the archival papers of the African National Congress (ANC), I argue that the apartheid state attempted to present Family Planning as a politically neutral and benign development issue. In particular, the paper focuses on the ways in which the state sought to prioritise the (re)-education of the African male – linking greater Family Planning knowledge to broader discourses of consumerism and modernisation. Despite the NP's intentions, the eschewal of contraceptive methods became a way for the African majority to resist the eugenic logic of the apartheid regime. Yet, the responses of African men to the NP's Family Planning programme highlights the coalescence between African and white settler patriarchy whereby African women were rarely trusted to control, and make autonomous decisions regarding their own reproductive labour. In doing so, this paper sheds further light on the connections between citizenship, family planning and population control in the Global South.

#### Objectives

1. Identify successes and failures in the history of medical professionalism

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

## **B2 Consent, Choice, and Coercion: Global Perspectives on Human Reproduction**

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### *Ovariectomy, Consent, and Truth-Telling in Victorian Britain*

The question to what extent nineteenth-century doctors informed their patients and sought their explicit consent before treatment remains notoriously difficult to answer. In the early 1980s, the heyday of Anglo-American debates on informed consent, the historical interpretations of Jay Katz and Martin Pernick clashed. While Katz described a “silent world” in which paternalistic physicians expected patients to trust them without questions, Pernick aimed to show that in America consent-seeking was part of an “indigenous medical tradition” already in the nineteenth century. More recent studies by Kathleen Powderly on the USA, Karen Nolte on Germany, and Sally Wilde on Britain and Australia have pointed to various forms of “negotiation” between nineteenth-century doctors and their patients, especially if a risky treatment or mutilating operation was proposed. In this paper I focus on an English legal case from the 1890s, *Beatty v. Cullingworth*, which demonstrates that even if a patient was informed and the proposed treatment discussed, consent could be a contested issue. In 1896, Alice Beatty, a professional nurse, accused the senior obstetric physician of St. Thomas’s Hospital London, Charles Cullingworth, of having removed her ovaries without her valid consent. The various dimensions of this case - professional ethics, law, gender, and the history of gynaecological surgery, in particular of ovariectomy - add to its complexity, and I will highlight some specific contexts. Beyond this, however, I will argue that the key to its understanding and to the problem of consent more generally lies in nineteenth-century medical traditions of restricted truth-telling in serious illnesses – an aspect which has hitherto been mostly regarded as a separate matter.

Key words: ovariectomy, consent, truth-telling

#### Objectives

1. Understand historical obstacles to information and consent
2. Appreciate socio-cultural contexts in the history of gynaecological surgery
3. Understand the historical relationship between restricted truth-telling and consent in medicine

## **B3. Professional Authority and Public Health in the Nineteenth and Early Twentieth Century**

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### *From Social Purity to Social Hygiene: Gender, Faith, and Narrations of Medical Innovation at the Turn of the Twentieth Century*

Historians have identified the turn of the twentieth century as a moment when doctors executed a significant shift in concern with prostitution and venereal disease. Most prominent in this cast of characters was Dr. Prince Albert Morrow, the “father” of the American social hygiene movement. Both Morrow’s contemporaries and historians have credited him with launching physicians’ attack on sexual double standards and a “conspiracy of silence” surrounding venereal diseases. However, medical women including such luminaries as Dr. Elizabeth Blackwell were already active in the social purity movement, which was dedicated to challenging sexual double standards and preventing venereal diseases. The crucial difference between the movements was that social purity came earlier, was spearheaded by women physicians, and was explicitly Protestant in its moral framework. I argue that the seemingly sudden transformation in physicians’ priorities with the advent of social hygiene was only produced by the erasure of three decades of work by women doctors. That erasure was enacted through what I am terming the “narrative of the new,” a rhetorical bait-and-switch whereby Morrow and his predominately male medical allies reinvented social purity in their own image. Imparting a shallow veneer of scientific innovation to rebrand many of the basic tenants and tactics of earlier activism while only minimally diverging from preexisting ideological frameworks, they succeeded in rewriting their profession’s past and convincing historians to retell their story. This case study therefore invites a larger consideration of how narratives of newness and invention shape how history gets written and has implications for how historians and medical practitioners alike respond to apparent moments of transformation in medical thought and practice. At stake is our shared ability to avoid intellectual thefts and practices of professional exclusion, gendered or otherwise, as well as historians’ likelihood of perpetuating misleading narratives when they occur.

#### Objectives

1. Explore the role of rhetoric and language in professionalization processes and their history, including how they shape professional ethics and diversity
2. Recognize dynamic interrelationship between medicine and society through history
3. Identify successes and failures in the history of medical professionalism

### **B3. Professional Authority and Public Health in the Nineteenth and Early Twentieth Century**

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#### *“A Quick Deciding Plague”: Intimacy in the Time of Cholera*

Using the example of the 1832 cholera outbreak in Philadelphia, this paper refigures the history of a disease through the rubric of intimacy, and considers how disease-specific symptoms, epidemiological theories, and treatments of disease have material and intimate impacts on the cultures and societies that survive. Disturbing as it did the entire digestive system at once—and, by extension, the lungs, brain, and spine—cholera took over the patient’s body. Accounts written by some physicians read like body horror, describing the rice-water evacuations of cholera patients with a kind of morbid fascination. To wrest control of the body back to the patient required the utmost diligence of the caregiver, as well as a willingness to almost literally immerse oneself in the patient’s effluvia. Furthermore, cholera brought the bodies of white physicians into intimate contact with sick and dying black bodies, refracting intimacy through a racial lens. Historians have largely ignored the role of taste, touch, and smell in nineteenth-century American medicine, but much of the work of treating cholera patients depended upon these three intimate senses. To cure cholera required prolonged and intimate contact with the patient;

administering oral medications rarely sufficed on its own. Even physicians who subscribed to the doctrine of heroic medicine used intimate care practices. Cupping, bleeding, bathing, rubbing—these were active, sustained treatments that often had to be performed regularly. Since most physicians assumed cholera could not be transmitted from person to person under any circumstances, physicians were willing, without fear for their own safety, to engage in intimate care practices when treating cholera.

Key words: intimacy, cholera, epidemic

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

### **B3. Professional Authority and Public Health in the Nineteenth and early Twentieth Century**

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#### *Obsessing over Excrement: British Colonial Fears of Germs in the Late Nineteenth Century*

At the height of jingoist fears over national generation via the health of troops and increasing rates of infant mortality, in the last decade of the nineteenth century British public health officials re-envisioned a longstanding obsession with human excrement. No longer the general object of prevention strategies, epidemiological case-tracing and bacteriological confirmation suggested that only the discharges of those suffering from specific infectious diseases could harm communities. The elusive question that remained, as is well-known, was how best to apply the new public health strategies of identification, isolation, and disinfection. This paper questions the received wisdom about disinfection practices across the late Victorian British Empire. In doing I extend Graham Mooney's recent concept of state surveillance in the late Victorian period (Mooney, *Intrusive Interventions*, 2015), but complicate it by exploring disinfection practices across the British Empire, particularly in South Africa and India. By narrowing in on the objects of disinfection—bodies, goods, and environments—this paper demonstrates the uneven engendering of disinfection upon not just liberal subjects, as Mooney has shown, but colonial subjects. The reformulation of the dangers of excreta narrowed in on the discharges of persons with particular infectious diseases—particularly plague, cholera and typhoid fever—but did so in irregular ways that mapped onto conceptualizations of race, identity, gender, and healthy or ill environments. Examining the public health practices of disinfecting excrement—as opposed to just the rhetoric of state surveillance—this paper demonstrates how boundary objects—goods, clothes, material technologies, and even human excrement—were inescapably tied to imperial identities of sturdy British masculinity and diseased indigenous “other.”

#### Objectives

1. Facilitate a discussion about the emergence of anti-germ practices in colonial locations
2. Engage historians of medicine on critical questions of race, labor, imperialism, and public health
3. Educate scholars about the history of public health



#### **B4. Disability and “Risky Bodies” in Historical Context**

Neil Pemberton: University of Manchester, Manchester, United Kingdom  
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##### *Co-choreographing Care: Codependence and the Making of the Guide Dog Partnership in Modern Britain*

Over the last three decades, disability theorists and activists have challenged the medical model’s conceptualisation of disability as an individual problem resulting from a biological impairment. These critiques reconceptualised disability as the product of social and material barriers rather than as a “condition” to overcome or pitied. This social model undergirds disability rights activism and has resulted in changes in public awareness and legislation. As important as it is in challenging ableist norms, disability identity remains rooted in the same binaries of independence/dependence, self/other that have devalued persons with disability and is grounded the pursuit of individual rights that presupposes autonomous, independent subjects contained within individual bodies. This paper pursues a different story, one that moves beyond the dependent/independent dichotomy so commonly found in discussions about disability to explore questions of interdependence or codependence. The case study for the paper comprises 15 in-depth oral history interviews with visually impaired people who have had guide dogs for over thirty years to explore their shared, lived experience. Instead of considering the service dog as no more than that of a tool or stick, I argue that guide dog owners framed their relationships with their dogs as highly affective partnerships that manifest a cooperative and shared nature of being as togetherness made with mutual regard, mutual care, and mutual attention. Significant attention is given to the reconstruction of the everyday co-created care practices through which this relationship was intimately realised and lived. Using histories of the guide dog partnership, this paper makes the case for construing the relations of codependence and shared vulnerabilities as subjects for critical historical inquiry.

##### Objectives

1. Deepen understanding of disability and ideas about care
2. Elicit and write the history of the lived experience of visual impairment and counter commonsense understandings about blindness and disability
3. Nuance understandings about the assistance provided by service dogs

#### **B4. Disability and “Risky Bodies” in Historical Context**

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##### *Feelings as Important as Facts: Parents, Guidebooks, and the Construction of Childhood Disability*

In his 1982 guide, *Down’s Syndrome: An Introduction for Parents*, psychologist Cliff Cunningham discussed the value that parents of children with Down syndrome would find in hearing from other parents. As he wrote, “feelings about having a child with Down’s syndrome are just as important as facts. And parents have made it quite clear to me that information about how other parents felt and coped with their feelings when the baby was born was of great help to them.” Cunningham’s belief in the importance of feelings echoed throughout his work and other parent guides, which were often peppered with quotes from parents about their families, experiences, joys, and fears. Parents acted as

an essential source of the knowledge necessary to care for a child with Down syndrome throughout the latter twentieth century, shaping the meaning of this disorder through their participation in writing and reading guidebooks. As parents of children with Down syndrome sought understanding in guidebooks, parents of children with autism did the same, finding similar references to the importance of parent experiences along with words of wisdom from more practiced parents. While guidebooks offered both sets of families a site for the establishment of imagined communities of the afflicted where parents with a new diagnosis could share in the identity of caretakers, advocates, and experts on behalf of their children, the narratives of autism and Down syndrome that threaded through these parent accounts differed. The clear chromosomal etiology of Trisomy 21 contrasted with the unsettled nature of autism's biological or psychoanalytic origins, and parents' concerns about blame, fears, and expectations for the future varied accordingly. Analyzing these different parent narratives as contained within guidebooks illuminates the differing constructions of these disorders amidst the cultural and medical controversies surrounding them in the late twentieth century.

#### Objectives

1. Recognize the dynamic interrelationship between medicine and society throughout history
2. Develop an historically informed sensitivity to the construction of a disorder
3. Deepen understanding of the role of patients' families in caregiving

#### **B4 Disability and "Risky Bodies" in Historical Context**

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*Insuring Sub-Standard Lives: Life Insurance Medical Examinations and the Classification of Risky Bodies, 1820-1920*

During the nineteenth century, life insurance became a thriving financial industry that promoted the ideals of an emerging middle-class. At its heart was the problem of selecting which lives to insure and which ones to reject. Before the Civil War, prominent life insurance firms only insured so-called good lives, that is, individuals who could demonstrate that they and their family history were free from diseases. At the heart of this process was the testimony of physicians. By the 1820s, it became standard practice for life insurance firms to require an applicant's physician to conduct a physical exam, reporting its findings on a form returned to the firm. If an applicant did not have an attending physician, the exam would be conducted by the firm's own staff physician. After the Civil War, the rapid expansion of life insurance business in the United States stimulated professionalization within the industry, represented by the American Life Convention, which quickly formed a Medical Section, and the Association of Life Insurance Medical Directors of America in 1889. During the 1890s, life insurance firms seeking to broaden their customer base began to insure so-called sub-standard lives based on medical knowledge provided by industry physicians. Sub-standard lives described individuals that suffered from various diseases, were not perfectly temperate in their habits, or engaged in dangerous occupations—factors that posed financial risk to the underwriters. To determine the proper rates, which were higher than those for standard lives, a joint committee of various professional groups studied mortality among sub-standard lives, creating the first, highly-detailed, coding and classification system for rating various risks posed by lifestyle and disease. After the Civil War, the medical exam itself fundamentally changed as well. The direct, albeit superficial, gaze of Gilded Age and Progressive Era physicians was supplemented by new technologies such as urinalysis, blood pressure measurement, and x-rays. This paper explores

how medical examination practices worked to commodify life itself by classifying risky bodies according to their financial value to life insurance firms. The professionalization of life insurance medicine demonstrates how medical knowledge underpinned capitalist interest and the emergence of the modern healthcare economy.

#### Objectives

1. Present a historical narrative explaining the professionalization of life insurance medicine in the United States
2. Interpret the social implications of medical classifications of unhealthy bodies and the financial risks they posed
3. Point out the confluence of medical knowledge and capitalist economic interests beyond the direct interests of the medical profession and healthcare system

### **B5. Bodies Crossing Borders: Exporting Health Beyond the People's Republic**

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#### *Safe and Natural? Chinese Herbal Medicine and American Drug Regulations*

In 1983, the Ninth Circuit Court of Appeals, in the *Fmali v. Heckler* decision, struck down an FDA rule that prohibited the importation of food additives that had not been proven safe after prolonged use in the United States (under the 1958 Generally Regarded As Safe rule). At issue was Siberian ginseng imported from China. The judges determined that FDA regulations that denied the admissibility of evidence of sustained safe usage in a non-Western country was discriminatory and burdensome. Manufacturers and retailers of herbal remedies have since lauded the decision as vital to their industry. It allowed for a number of substances to be imported to the U.S. as foods, rather than under the more tightly-restricted category of food additives. This paper traces how Chinese medicine, when brought into the American market, challenged the structures and assumptions of food and drug regulations. I argue that disparities over how the public and the medical profession define terms such as safety and efficacy has resulted in a regulatory system that has struggled to cope with non-biomedical therapies. Chinese herbal medicines, supporters claimed, were safe and natural as compared to mainstream drugs. These substances had not, however, been vetted through controlled clinical trials, nor did they have a documented history of use (among whites) in the U.S. Using industry publications and herbal medicine guides, I highlight how concepts of safety and efficacy in the popular realm have been at odds with definitions used by regulatory bodies. Furthermore, the case of Chinese herbal medicines demonstrates the ways in which ideas about racial and cultural difference influenced assumptions about safety and efficacy of food and herb products. My work builds not only upon the history of drug regulation and dietary advice but is also informed by historians of race and medical practice.

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

## **B5. Bodies Crossing Borders: Exporting Health Beyond the People’s Republic**

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*Pinpricks: The Curiosity of Analgesia and Gate Control Theory (1950-1970)*

Acupuncture analgesia seemed relatively straightforward. The patient lay awake as a practitioner needled selected sites on the body to induce numbness for surgery. Numerous reports emerging from China in the 1970s featured men and women resting on operating tables, smiling into the camera, surrounded by doctors who attended to the excised region—the esophagus, brain, reproductive organs, heart, or lungs. Thousands of news articles heralded acupuncture analgesia as embodying the spirit of Communist politics. It rendered the patient an alert and active participant in performing medical expertise and it legitimated the legacy of a modern Chinese medicine. Yet, readers were as amazed as they were skeptical. To one critic, acupuncture analgesia worked, but it only worked on Communist Chinese bodies. To others, it confirmed Ronald Melzack and Patrick Wall’s theory of gate control. The dual appeal of analgesia induced by selective needling and visualizing potential paths at the periphery that “opened” and “closed” pain sensory receptors at in the spine invoked procedures that were equally hard to pin down. By drawing on approaches in postcolonial STS and history of medicine, this paper explores the life of analgesia and gate control theory as they came together in public display and private conversation. It makes use of unpublished drafts and correspondences to understand how individual encounters with a range of sensation competed with conceptions of numbness. I furthermore use of these encounters to make sense of the personal the political and social role of numbness—a distinct sensation defined by the lack of sensation—in the absence of the brain. If the brain were only a passive mediator for particular kinds of sensation, then what sorts of tools were needed to measure feelings that lay between the mind and the body?

### Objectives

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

## **B5. Bodies Crossing Borders: Exporting Health Beyond the People’s Republic**

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*Ethnic Health and Socialist Revolution: Curing Syphilis on the Pastoral Frontiers in the People’s Republic of China, 1949-1964*

As soon as the People’s Republic of China (PRC) was established, the Chinese government initiated a syphilis control program among the pastoral population in Inner Mongolia and the eastern Tibetan regions. Based on historical data and sample surveys, Chinese public health authorities in the early 1950s believed that there was a severe syphilis crisis among the nomadic people in the frontier regions. Ethnic Mongols and Tibetans reportedly were in particular facing a depopulation crisis because of the rampant syphilis epidemic. The Ministry of Health, together with the State Ethnic Affairs Commission,

organized medical expedition teams from Beijing to carry out massive-scale diagnosis of syphilis and provide free treatment in Inner Mongolia Autonomous Region and the Tibetan areas in the provinces of Qinghai, Gansu, and Sichuan. By the year 1964, Chinese health authorities declared that syphilis became effectively under control throughout the country. Drawing on state and local archives, this paper will examine the specific methods with which the Chinese medical teams conducted syphilis diagnosis and treatment among the ethnic minority population in the frontier regions. The paper will also discuss the strategies the Chinese medical teams adopted to deal with the issue of stigmatization usually associated with syphilis. The paper will further argue that the PRC government utilized public health as a tool of civilizing mission and an expression of state benevolence to consolidate its legitimacy in the ethnic minority regions. While the anti-syphilis project did bring benefits to the minority population, it also complicated cultural stereotypes of the ethnic minorities and paved the way for the PRC regime to intervene into the local societies and implement its blueprint of socialist transformation in Inner Mongolia and Tibetan regions.

#### Objectives

1. Develop a historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
2. Recognize the dynamic interrelationship between medicine and society through history
3. Deepen understanding of illness and suffering

#### **B6. Medicine in Early Modern Europe**

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##### *The Virtue of Stones: Lapidary Medicine and the Treatment of Disease in Medieval and Early Modern England*

This paper explores the use of lapidary cures within medieval pharmacology, offering an analysis of the types of physical and mental afflictions that were popularly treated with minerals during the Middle Ages and the changes to lapidary theory that occurred in the sixteenth century due to the rise of Paracelsian medicine and the expansion of global trade. In the thirteenth century, members of mendicant orders authored several natural studies that detailed the healing properties of stones, including four encyclopedias intended as teaching texts for preaching friars. Drawing upon the lapidaries contained within Vincent of Beauvais' *Speculum majus*, Bartholomaeus Anglicus' *De proprietatibus rerum*, and *Mineralia* by Albertus Magnus, this essay presents an analysis of the physical and mental ailments stones were (and were not) thought to cure. It argues that the mendicant focus upon serving society and their desire to spread healing knowledge actively facilitated the dissemination and circulation of a common lapidary theory and practice throughout Western Europe, one that was later integrated into popular printed medical advice manuals of the fifteenth and sixteenth centuries. The study then shifts focus to the medical marketplace of early modern England, drawing upon popular medical advice manuals and apothecary records to evidence a sixteenth century expansion of lapidary theory and practice. New stones from Asia and the Americas debuted in early modern lapidaries as cures for existing diseases, such as plague, while other gemstones and minerals popular since classical times had their usefulness expanded beyond their original purpose and applied for the first time to sexually transmitted diseases, such as gonorrhoea. While this essay stands as the first analysis of both physical and mental ailments associated with lapidary medicine, it also looks beyond any one healing

practice to draw larger conclusions about the circulation of medical ideas over the course of a millennium.

#### Objectives

1. Recognize the role of minerals within the pre-modern pharmacopeia
2. Explain how mendicant authors of the 13th century conceptualized the natural *materia medica* of the classical world
3. Identify changes to the practice of lapidary medicine that occurred in early modern Europe due to the popularization of Paracelsian theories and the expansion of global trade

### **B6. Medicine in Early Modern Europe**

Beth Petitjean: Saint Louis University, St. Louis, MO, USA  
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#### *Scientific Networks: Shared Methods of Thermal Water Analysis in Early Modern Medicine*

Between 1660 and 1740, several Italian physicians published treatises about the thermal waters of Tuscany. Physicians had written about these baths for centuries, but during the early modern period, the language in the treatises changed due to the development of new scientific methods and tools used to analyze the mineral content of the waters to improve patient care. In this paper, I argue that baths were key nodes in the network through which knowledge about chemistry circulated among university medical professors, the practicing physicians who treated patients at the baths, and the scientific communities in Tuscany and elsewhere. I will trace the evolution of testing methods from the chemical experiments performed by members of the *Accademia del Cimento* in Florence in the 1660s, to the adaptation of those experiments by Samuel Duclos of the Royal Academy in Paris and Martin Lister of the Royal Society of London in the 1680s, and conclude with the transmission of these new methods back into Tuscany after the turn of the century. This transmission of scientific methodology culminated in the work of Jacopo Filippo Bastiani (fl. 1710-1733), a doctor at the baths of San Casciano in southern Tuscany. I posit that Bastiani's relationship with the Sienese *Accademia dei Fisiocritici* connected him with the scholarship produced by physicians and chemists in France and England. Consequently, Bastiani incorporated new chemical methods for testing the water and new concepts to describe the water, but continued to treat patients for the same diseases and with the same treatments that physicians had been using for centuries.

#### 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. Acquire a historically nuanced understanding of how changing methods and theories about the natural world impacted medical writing and patient care

### **B6. Medicine in Early Modern Europe**

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## *Revealing and Treating the Hidden: Injections in Anatomy and Medicine in the Fifteenth and Sixteenth Centuries*

The history of injections has generally focused on specific timeframes. Anatomical injections, primarily as used for investigating the vascular features of the body, are most prominent in studies of the seventeenth century, while therapeutic injection tends to begin its history with the invention of hypodermic syringe in the nineteenth century. But descriptions of injecting fluids into the body both to treat illness and to investigate its hidden properties can be found earlier, including in the late fifteenth and early sixteenth centuries. The descriptions of that era reveal a world in which those involved in medical practice and those pursuing anatomical discovery (often the same person) sought to probe the internal parts of the body, deliver medications to key locations and manipulate causes of suffering such as stones. In this talk I look at the use of injections described in three sources – a fifteenth-century *practica* by Matteo Gradi, a work on the treatment of ulcers written early in the sixteenth century by Angelo Bolognini and an anatomical text by Berengario da Carpi written in 1521. These three texts are not randomly chosen, but have close connections with each other, including citations of earlier texts by the later ones. Comparing their descriptions of injections reveals the existence of a common set of techniques that tied together therapy and investigation in attempts to penetrate the surface of the body to examine and treat what was normally hidden from view.

### 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 the capacity for critical thinking about the nature, ends and limits of medicine
3. Recognize the dynamic interrelationship between medical theory and medical practice through history

### **C1. Flash-Talk Session #1**

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### *Fighting Microbes with Microbes: The Use of Bacteria in Plague Control in Bombay, India, 1896-1910*

In the fall of 1896, Dr. P. C. H. Snow, Municipal Commissioner of Bombay, received a daunting report: a number of rats were seen wandering the streets of Bombay or emerging from sewers in sickly or dying condition. By the end of September, bubonic plague had taken hold in the district of Mandvi. Panicked, nearly a quarter of the city's population fled, carrying the pestilence with them to their rural refuges. Over the next decade, the annual reappearance of plague in Bombay sent the Indian imperial government scrambling for treatments and preventatives for the lethal disease. It was in the midst of a search for a tenable solution that reports arose from the Pasteur Institute and the Toronto agricultural department: there appeared to be a number of bacteria which, while nonharmful to humans, showed promise in exterminating rats. Flirtations with the use of the Danysz Virus and Common Sense Rat Exterminator in the Bombay plague epidemic showcase evolving medical and scientific perspectives on microbial life. As understanding of microbial agents expanded at the turn of the twentieth century, their role in human society shifted. No longer simply microscopic hostiles to be exterminated, by the early twentieth century bacteria had become individualized, commodified, and introduced into the British imperial networks; in their living form, they were perceived to be capable of both help and harm. This

flash talk will explore the significance of the Danysz virus and Common Sense Rat Exterminator within this framework. Tracing advertisement of the microbes through British imperial government networks and experiments that tested and ultimately dismissed the utility of these bacteria for plague control, I will argue that experiments with these bacteria demonstrated changing perceptions of microbial life and carried implications for the use of microbes in urban and rural spaces in the British Empire.

#### 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

#### **C1. Flash-Talk Session #1**

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*Hot-Blooded Teens and Silver Screens: Transnational Sex Education between the United States and Sweden, 1910-1960*

Throughout the twentieth century two countries played prominent roles in the global creation of sex education: the U.S. and Sweden. My paper is a transnational cultural history that investigates the development of the movements for sex education in the U.S. and Sweden from 1910 through the 1960s and their signature method of education, the sex education film. I examine how Sweden and the U.S. worked together to craft their respective sex education programs and how the two countries exchanged sex education ideas, materials, and films. Two women helped to form this significant transnational relationship: Margaret Sanger, famed birth control advocate and founder of the first permanent birth control clinic in the U.S., and Elise Ottesen-Jensen, founder of the Swedish Association for Sexuality Education (RFSU—*Riksförbundet för sexuell upplysning*). I investigate the influence and relationship between these two powerful women in the sex education movements and explore how they crafted a strong, if occasionally contentious, working relationship. Sanger emphasized birth control as the key movement for women, both in the U.S. and abroad, and she spent her life fighting for women's rights for access to contraception. On the other hand, Ottesen-Jensen looked to sex education as the solution for unwanted pregnancies, overpopulation, and fulfilling sexual lives. While the two never abandoned their original goals, my archival work shows how Sanger turned to Ottesen-Jensen for advice on sex education while, in return, Ottesen-Jensen turned to Sanger for guidance on birth control. Examining this relationship reveals how these sex education advocates worked alongside one another to overcome their institutional weaknesses. As the first scholar to examine the transnational relationship between the U.S. and Sweden in connection with sex education and its films, I contribute to the scholarship through my use of film and archival research.

#### Objectives

1. Identify successes and failures in the history of medical professionalism
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

#### **C1. Flash-Talk Session #1**



Claire Macindoe: University of Otago, Dunedin, New Zealand  
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### *The Radio Doctor—Broadcasting Health into the Home*

During World War Two the health of New Zealand's population became a key concern to the Labour government, as enlistment medical examinations revealed a high number of preventable health problems. Paper for posters and pamphlets was scarce, however a new, non-traditional, method of communicating to the masses was now available to the government for the first time – radio. This talk explores the creation of New Zealand's "Radio Doctor" and why he was key to communicating health during a period of war. Broadcasting six days a week, the "Radio Doctor" created a unique health phenomenon during a time when visits to the doctor were not always a regular occurrence, and made all the more difficult due to the war. By creating a radio doctor, broadcast into the home and featuring a friendly voice, the government made health information accessible to all New Zealanders. Pragmatically, this prevented unnecessary burden on an overwhelmed and understaffed health system, while also educating the wider population on the basics of health, nutrition and child development. The living room became the doctor's consultation room, with the audience, mostly women, taking note of the advice that was given, diagnosing and treating illness within their own home. Preventative medicine was key, and the talks focused on developing young children into healthy adults. The true impact of these talks, however, can be measured by the public response. At a time when the doctor's word was considered the last word, these talks allowed for the creation of a "relationship" between presenter and listener, and in turn a dialogue was created between the "Radio Doctor" and listeners who wrote in requesting that he address specific issues, provide written material, or questioned what they had heard. Radio, usually associated with entertainment, was given authority within the home and the "Radio Doctor" became a trusted authority to keep the nation healthy and informed.

Key Words: radio, public health, World War Two

#### Objectives

1. Recognise and understand the dynamic interrelationship between medicine and society through history
2. Understand the crucial links between technological developments and the communication of health education
3. Develop an understanding of how the "Radio Doctor" created a unique opportunity for government-implemented health education and why it was so well received by the wider public

#### **C1. Flash-Talk Session #1**

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### *Prohibitory Practice: Understanding Alcoholism in Prohibition Era Ohio*

America's war on alcohol, known as Prohibition, was waged between 1920 and 1933. During this tumultuous period the physician's office became a combat zone rather than a neutral ground, as it was and is in any other "substance epidemic." The change and contention brought by Prohibition did not simply exist between the sober and drunk, the nativist and immigrant, but also between one doctor and

another. My study looks at how these issues played out in central Ohio, then (as now) a frontline in medical debates about substance abuse. My work builds on recent histories about Prohibition (McGirr 2015, Okrent 2010) as well as medical historians' contributions to better understandings of alcoholism and addiction as complex diseases rather than simple moral faults (Courtwright 2001, Tracy 2005, White 1998). During Prohibition Ohio physicians refined their understanding of alcoholism and more broadly substance use disorders, particularly with respect to temporality, using distinctions such as acute versus chronic and alcoholic versus alcoholism. My work explores that discussion in the state's medical journal, the main forum of discourse among Ohio medical professionals, and then tracks its translation onto the patient through the records of St. Francis and St. Anthony's hospitals in Columbus, the state capital. A patient's history, then a point of emphasis even more than it is now, translated into increasingly "precise" diagnoses concerning the longevity and time-based criterion for a patient. This historical narrative suggests a diagnostic conundrum we still struggle with today. New conditions are not so much discovered as much as old ones are transformed or subtyped, particularly in the realm of substance abuse. The field of medicine stands to gain not just through the lessons learned in this early exercise of fine-tuned diagnostics but also in understanding community-level differences in diagnosing.

### Objectives

1. Develop knowledge and understanding of professional behaviors and values
2. Develop the capacity for critical thinking about the nature, ends and limits of medicine
3. Understand the dynamic ideas of medical ideas and practices, their implications for health care providers, and the need for lifelong learning

### **C1. Flash-Talk Session #1**

Kuan Ting (Michael) Chen: Queen's University, Kingston, ON, Canada  
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#### *A Panel Decision for Every Woman: Therapeutic Abortion Committee at Kingston General Hospital, 1970-1988*

Abortions were illegal in Canada until the 1969 passage of the Criminal Law Amendment Act, 1968-1969 (Bill C-150) which decriminalized therapeutic abortions for specific cases. Women and their physicians could apply to the Therapeutic Abortion Committee (TAC) of an accredited hospital, where the procedure would be performed if the TAC determined that continuing the pregnancy would endanger the patient's life or health. In the wake of the *R. v. Morgentaler* decision in 1988 the Supreme Court of Canada ruled that the abortion laws in the Criminal Code were unconstitutional and abortions were subsequently legalized. Between 1969 and 1988 access to abortions and regulations varied greatly across the country. Only a fraction of accredited hospitals appointed TACs, and while some TACs liberally approved almost all requests, others were excessively restrictive. Moreover, because the definition of "health" was not clearly stated in the law, TACs were free to interpret which conditions, medical or psychosocial, might result in "endangering the patient's health". Drawing on archival records from Kingston General Hospital, along with oral interviews with physicians involved in abortions during this era, this paper will examine the applications received and approved by the TAC between 1970-1988. This paper will also explore the demographics of patients who sought abortions, the protocols of the TAC, its definition of "health," the approved indications for abortions, and finally, dissent from within the hospital. Contrary to the belief that TACs served to curtail abortion access, this paper argues that some TACs tended to trust the opinion of referring physicians and often "rubber-stamped" approvals. Despite appearing as impartial tribunals, they exercised little true decision-making power since

gatekeeping occurred with the referring physicians, rather than at the committee level. This finding has not been well-integrated into the historiography of abortions in Canada.

Key words: abortion, therapeutic abortion committee, Morgentaler

#### Objectives

1. Understand the nuanced and complex history of abortion laws in Canada
2. Analyze the function of Therapeutic Abortion Committees to contextualize their history within the larger story of reproductive health in Canada
3. Recognize the dynamic interrelationship between medicine, law, and society

#### **C1. Flash-Talk Session #1**

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#### *Mining Bodies: U.S. Experimentation and Ethics in Guatemala*

My dissertation investigates the discovery that, beginning in the 1940s, physicians with the U.S. Public Health Service (USPHS) deliberately infected sex workers, soldiers, disabled, gay, lesbian, and indigenous Guatemalans with sexually-transmitted infections (STIs). The USPHS, which has been responsible for enforcing the U.S. border with Mexico by inspecting immigrants, has also operated in Guatemala but with a different set of moral and ethical parameters. Yet, in describing how an American medical research network was created in Guatemala that enabled doctors to conduct these experiments, my dissertation takes great care to examine this history from the perspective of Guatemalans themselves. I argue that Guatemala's "Ten Years of Spring" (1944-1954), known as a revolutionary and progressive era, when a new government worked to build a more equitable and just country, was a key factor in making Guatemalans medical subjects for U.S. doctors. U.S. and Guatemalan doctors, viewing themselves as leaders of revolutions in healthcare and political and social *regeneración* (regeneration), formed a diplomatic alliance to do experiments that furthered both of their causes. Doctors contended with challenges to their power in their respective nations. Research on sexuality and reproduction remained controversial in the United States and doctors worried about potential lawsuits. In Guatemala, doctors' vision of reform was beset by financial constraints, political instability, and moralizing attitudes. Influenced by the paternalism in medicine during this time period and by patriarchal attitudes that informed their entitlement to access Guatemalan bodies for experimentation, the doctors made a deal. Together they created a hidden research space in which to conduct experiments. U.S. doctors took advantage of the international health infrastructure in Guatemala in order to do experiments away from laws and potential critics in the United States. Guatemalan doctors offered poor and indigenous Guatemalans for experimentation in return for medical resources, knowledge, and career advancement.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Critically appraise critical management from a historical perspective

#### **C1. Flash-Talk Session #1**

Carmen Niemeyer: University of Wisconsin-Madison, Madison, WI, USA  
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*Leveraging Inter-state Public Health: The Sanitary Council of the Mississippi Valley and its Position Amongst Local and National Boards*

Historians of nineteenth century American public health often focus on the tensions between national authority and local or state authority in administration of quarantine and sanitation practices. Yet scholars rarely address regional, co-operative public health endeavors that lay between the municipal and the federal in the public and professional view. Investigating the motivations, actions, and levels of success of regional health boards complicates the established relationship between intermittent local and centralized public health bodies and reveals a commitment to interstate sanitation cooperation apart from the National Board of Health. Through examination of the proceedings and activities of the Sanitary Council of the Mississippi Valley, and further scrutiny of the goals of John H. Rauch, the organization's secretary, this paper evaluates the influence of regional authority in post-Civil War American public health. Rauch and other leaders used their positions and sanitary prominence in the region to initiate the council, inviting representatives to the board from around the river valley to sustain it. Based on initial research, I contend that the council leveraged cooperation for and against less effective local boards of health, but also leveraged their position with the National Board of Health in the Mississippi Valley. By fulfilling the public's desires for both central authority and local consideration, the council succeeded in recognizing the autonomy of municipal and state boards of health where the National Board of Health could not. Driven by a public call for wider-reaching quarantine authority in the wake of the 1878 yellow fever scourge, the regional body, under the influence of Rauch, filled the void of federal power to defend citizens and commerce from disease in the much-afflicted Mississippi Valley.

Objectives

1. Acquire a new understanding of the role of centralized medical or public health authority to local counterparts
2. Identify successes and failures in the history of medical professionalism
3. Acquire a nuanced understanding of the role of cooperative action in public health practice

**C2. Flash-Talk Session #2**

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*Fluoride: Savior of Children's Teeth or Industrial Poison? Historical Debates Over the Fluoridation of Public Water in Britain and America*

My paper follows 20th- century discourse on the merits and dangers of fluoridating public water supplies in Britain and America and its relationship to children's health. I argue that debates over fluoridation were first and foremost debates over the role that artificial goods and products should play in everyday life. Debates over the use of fluoride in public water supplies stood in for larger debates between proponents of "natural living" and those who championed better living through artificial "modern" enhancements. In turn, concerns over children's health—intensified by health and depopulation concerns following World War II—became a battleground for a war of legitimacy and control fought by scientists, parents, and government agencies. The debate over fluoridation is structured within larger transnational discussions of the utility of artificial goods and products and the role that science and governments should have in the public's daily health. The debate over water

fluoridation was composed primarily of two competing sides. On the pro-fluoridation side, many researchers argued that although toxic in high doses, adding fluoride to public water supplies in low concentrations offered a drastic decrease in dental cavities and tooth damage, while posing minimal risks to public health. These arguments quickly gained traction in the post-war environment as concerns with children's teeth in the West were at an all-time high. On the other side, anti-fluoridation advocates argued that fluoride was fundamentally toxic and an unnecessary artificial adulterant. Some claimed that fluoride was simply a temporary fix for the overwhelming sugar consumption epidemic, while others argued that the prospect of public fluoridation was appealing to governments because it gave them a convenient use for copious amounts of fluoride found in industrial waste. Debates over fluoride's efficacy crossed international lines as British and American authors, newspapers, and government agencies constantly used each other's research to both defend and attack the fluoridation of their own water. My paper explores both sides of this transnational debate and its relationship to children, families, and the larger fight between proponents of natural and artificial living.

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

### **C2. Flash-Talk Session #2**

Eva Ward: University of Strathclyde, School of Humanities and Social Sciences, Glasgow, United Kingdom  
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#### *Public Health and Opium Consumption in the Colonial Philippines*

The Philippines formed part of the Spanish Empire for over three hundred years until the United States gained control of them in 1898 following Spain's defeat in the Spanish-American War. Opium was used widely across Southeast Asia at the time, and the Philippines were no exception. Under the Spanish colonial system, there was a strict monopoly in place, under which a handful of distributors were allowed to import and sell opium to the Philippines' Chinese inhabitants. (Gootenberg ed. 1999) It was thus in the interest of these distributors to prevent competition from alternative sources, and a ban on selling opium to native Filipino inhabitants of the islands kept the practice of opium smoking mostly contained to the Chinese population. When the US took control of the Philippines, the monopoly system was discarded in favor of strict prohibition due to the influence of prohibitionist movements in domestic American politics, including from the medical establishment, and the work of foreign missionaries such as Bishop Charles Brent. (Madge 2001) The ban on non-medical opium use led to a massive increase in smuggling, as the practice was no longer confined to a small number of distributors selling only to the Chinese population. The increase in opium use is clear; what is less apparent, however, is who comprised the new population of opium users and how the practice of opium smoking spread from the Chinese population to Filipino society at large. My research as a PhD candidate seeks in part to determine the demographics of drug use in the Philippines during US colonial rule, drawing on the papers of Dr. Victor Heiser, director of Public Health for the Philippines (1903-1915) and furthermore examining census records, customs records and court cases relating to the trade and consumption of drugs, particularly opium.

## Objectives

1. Identify successes and failures in the history of medical professionalism
2. Recognize the dynamic interrelationship between medicine and society throughout history
3. Evaluate the impact of US medical ideas on drugs policy in overseas territories

### **C2. Flash-Talk Session #2**

Naomi Rendina: Case Western Reserve University, Cleveland, OH, USA  
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#### *Pushing Too Hard: Oxytocin in the History of American Childbirth; 1900-1950*

The analyses of childbirth in the United States are deep and varied, both praising and criticizing the effects of professional medicine. A portion of the existing historical literature analyzes the medicalization of childbirth in the United States, including prenatal surveillance, fetal monitoring, pain management, and surgical intervention. This paper focuses on the development and introduction of labor-inducing pharmaceuticals. During the first decades of the 20th century, the fungus--ergot of rye--was used to hasten labor and stop post-partum hemorrhage. Ergot fell out of favor as synthetic oxytocin popularized. The implementation of pharmaceutically based induction focused on financial gain rather than public health interests. Through analysis of scientific studies published in medical journals and pharmaceutical development documentation, I argue that despite the many studies of the medicalization of childbirth, the route to heavy pharmacological intervention has been inadequately traced.

## Objectives

1. Critically examine clinical management from a historical perspective
2. Respond to changes in obstetric practice
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate research

### **C2. Flash-Talk Session #2**

Paul Stein: University of Wisconsin-Madison, Madison, WI, USA  
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#### *Serology, Racial Pathology, and the Tuskegee Syphilis Study*

The Tuskegee Syphilis Study hardly needs introduction: between 1932 and 1972, Public Health Service (PHS) physicians followed 600 African-American men in Macon County, AL, 399 of whom had syphilis. Throughout the study, PHS physicians denied treatment to the syphilitic men, thereby conducting a longitudinal study of untreated syphilis. Much of the current historical literature focuses upon the racial motives for the Tuskegee Study, while minimizing the dual roles of pathological examination and serological testing. This project examines how PHS surgeons used syphilis serology during the Tuskegee Study. I argue PHS officials minimized issues with the serological tests in order to support a preconceived notion that the studied men must have had syphilis. Finally, I demonstrate that PHS physicians ignored results from the serological tests and ambiguous physical exam results due to a racialized concept of syphilis pathology. This paper revisits the well-trodden published medical reports about the Tuskegee Study, as well as correspondence between PHS officials. In addition, I explore

previously overlooked articles about syphilis test reliability. In the end, I forge a middle ground between explanations based on racial motivations for the Tuskegee Study and explanations based on medical motives.

#### Objectives

1. Place concerns about diagnostic technologies in a historical context
2. Identify successes and failures in the history of medical professionalism
3. Critically appraise clinical management from a historical perspective

### **C2. Flash-Talk Session #2**

Amanda Lynn Haislip: Michigan State University, East Lansing, MI, USA  
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#### *Sustenance, Therapy, and Control: Feeding the Mentally Ill in an Early-Twentieth-Century Mental Hospital*

This paper examines early-twentieth-century reform efforts concerning food, mental illness, scientific expertise, and economic rationality alongside patient perspectives in St. Elizabeths federal mental hospital in Washington, D.C. In so doing, the paper highlights unexplored intersections of scholarship on the Progressive Era, food history, institutions, and psychiatry. My analysis focuses on the administration of William Alanson White—famous psychiatrist and early supporter of psychoanalysis in the U.S.—as St. Elizabeths’s superintendent, particularly through his annual reports and three congressional investigations into his management of the hospital in 1906, 1919, and 1926. White’s changing management of food during his tenure shows how evolving concerns about patient health alongside the growing influence of scientific expertise, centralized administration, and economic efficiency changed how patients in the hospital were fed. As Superintendent, White increasingly relied on the advice of nutrition experts and by 1926 he hired the first dietitians to the staff of the hospital. During his tenure, patient diets became more varied and more attention was paid to patient diet. Individual perspectives of patients, many of whom were committed to the hospital against their will and some of whom ascribed to food fads of the period, reveal an underlying struggle for agency and control through special dietary requests and complaints. Overall, this paper provides insight into the heretofore overlooked importance of food in the administration of mental hospitals and patient health—both mental and physical—as part of the progressive reform period.

#### Objectives

1. Critically appraise clinical management from a historical perspective
2. Recognize the dynamic interrelationship between medicine and society through history
3. Deepen understanding of illness and suffering

### **C2. Flash-Talk Session #2**

Ashna Asim: Queen’s University, Kingston, ON, Canada  
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#### *History of Narrative Medicine in Canadian Medical Education: A Survey*

Stories and storytelling have long been a part of medicine. However, a self-conscious awareness came with Dr. Kathryn Montgomery Hunter's *Doctors' Stories: The Narrative Structure of Medical Knowledge* (1991) and Dr. Rita Charon's proposed model for "narrative medicine" in 2001, that helped to trigger attention for "narrative competency" in medical education. Narrative competency in medical education has been given increasing attention, but its integration in medical education varies drastically across schools. Our objective was to uncover the history, methods and uses of narrative medicine in Canadian medical education. We were interested in the mechanisms for implementation, types of facilitating supports, perceived barriers, and hopes for its future. Our method included a review of literature and an online survey (via SurveyMonkey) consisting of a combination of open-ended questions, partially categorized questions, and closed-ended questions. Two demographic questions specified the respondent's identity as faculty, student, or other and the name of the medical school. Participants were given the option to follow-up with the principal investigator to give more detailed answers or feedback. The method has approval from Queen's Health Sciences Research Ethics Board (IRB00001173). All seventeen medical schools responded to the survey by the time of this submission. The earliest narrative medicine programs in Canada began at Dalhousie and Queen's around 1989, although the label "narrative medicine" was not used. Six Canadian schools claimed to have no narrative medicine, and 11 stated to have some narrative medicine component. Names of programs have varied and include labels such as "medicine and literature." Supports for such programs include faculty and funding. Barriers included competition for curricular time and a lack of administrative interest. This historical study represents a first step to better understanding of the uses, barriers and supports for narrative medicine programs in Canadian medical schools.

#### Objectives

1. Understand the dynamic history of ideas and practices in medical education
2. Promote tolerance for ambiguity of theories, the nature of evidence, the evaluation of appropriate patient care, and novel educational strategies
3. Deepen understanding of the paradigm of illness and its incorporation in medical education and professionalism

#### **C2 Flash-Talk Session #2**

Bima Hasjim: University of California, Irvine, Orange, CA, USA

#### *The Trendelenburg Position: A Fundamental and Timeless Technique in Surgery*

Friedrich Trendelenburg (1844-1924) was born in Berlin, Germany and studied medicine at the University of Glasgow, the University of Edinburgh, and *Charité-Universitätsmedizin*. Although known for his work in vascular surgery and the waddling gait, the Trendelenburg position was born through his experience with his true passion, genitourinary surgery. As a professor of surgery at Bonn University, he first used the inclined inverted position in 1884, and routinely by 1887. However, the inclined inverted position can be traced as far back to Aristotle (384-322 B.C.), who described its use during the sterilization of animals. In the 13th century, Roland of Parma wrote *Chirurgia Rolandina* while attending the School of Salerno, an institution recognized for integrating medical principles from the Arabs with Greco-Roman philosophies. Included was a detailed description in which, "the patient being placed on the bench, having a head and shoulders depressed that the entire intestine falls down to the chest for better visualization...." Notably, in 1833, the *Académie des Sciences* in France recognized J. Z. Amussat, Leroy d'Etiolles, Jean Civiale, and Charles-Louis-Stanislas Heurteloup for their "rectangular operating table" and "somersault maneuver". The inclined inverted position was later used most popularly in



Obstetric and Gynecologic, Otolaryngologic, and Urologic procedures – where it was adopted by the man whose name is now synonymous with the position. Through time, the Trendelenburg position remains a fundamental technique to better facilitate pelvic operations. Coupled with our understanding of physiologic principles, the position has been applied to various clinical scenarios; from treating air embolism to cardioverting supraventricular tachycardia. Although some have overextended its abilities (e.g., managing hypotension and decompression sickness), the Trendelenburg position has withstood the rigorous trials of contemporary research methods. Most importantly, the rise of today’s complex laparoscopic and robotic surgery benefits from the Trendelenburg position, ensuring its use for centuries to come.

#### Objectives

1. Understand that seemingly archaic techniques of medicine and surgery, within the context of today’s technological advances, are still relevant today
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

### **D1. Public Health and Activism in Minority and Underserved Communities**

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*“Not for Lack of Trying” : Family Histories and Attitudes about Indigenous Health at the Sioux Lookout Zone Hospital, 1969-1996*

The Sioux Lookout Zone Hospital was a federally-funded hospital for Status Indians in Northwestern Ontario. Between 1969 and 1996, physicians from the University of Toronto ran the medical services at the hospital in partnership with the Canadian federal government. The hospital served a patient population of approximately 13,000 people, most of whom lived on federal reserves. A rich collection of letters, cases reports, memorandums and other primary sources related to the University of Toronto’s health program at the Sioux Lookout Zone Hospital resides at the University of Toronto Archives. These Sioux Lookout Zone Hospital records are exciting source material not only because of the depth of the collection but also because they have not yet been studied by scholars. In addition to this collection, many self-published family histories are held at the Sioux Lookout Public Library, which make reference to careers at the Sioux Lookout Zone Hospital and the relationship between non-Indigenous staff members and Indigenous patients. In exploring the actions and attitudes of staff and patients regarding Indigenous Health, I analyze the narratives that mention the Sioux Lookout Zone Hospital and Indigenous Health in the family histories at the Sioux Lookout Public Library. For example, in a collection of local narratives called *Tracks Beside the Waters II*, Pat Goyman, a former nurse, responded defensively to the criticisms of Indigenous patients, writing, “if we didn’t always serve our patients in the manner they hoped for, it was surely not for lack of trying.” I argue that the family histories of non-Indigenous hospital staff reveal pride in their work, and resistance to criticism of the hospital’s racially-segregated care revealing a duality between the humanitarian aims of individual staff members and the assimilationist policies of the federal government.

#### Objectives

1. Critically appraise clinical management from a historical perspective

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 Canadian healthcare system, and of other national health care systems

### **D1. Public Health and Activism in Minority and Underserved Communities**

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#### *Determinants of HPV Vaccination Uptake in Appalachia*

In 2006, the U.S. Food and Drug Administration (FDA) approved a new vaccine, Gardasil, to protect against the sexually transmitted human papillomavirus (HPV) in females. This virus is actually a group of viruses of different types that cause 70% of all cervical cancers and 90% of all genital warts in the U.S. Initially approved just for females, in 2009 Gardasil's reach extended to males as well. Adoption of this, by all medical accounts effective and safe vaccine, has not been as widespread as many hoped. It has been controversial for several reasons, including questions of safety as well as the notion that preventing a sexually transmitted disease at such a young age could lead to earlier sexual activity or promiscuity. This low rate of acceptance is particularly true in Appalachia, a historically medically underserved portion of the country that also has a higher rate of cervical cancer than other areas of the country. Informed by the history of health care in Appalachia, histories of vaccination controversies that have been prevalent in the U.S. since the smallpox vaccination was introduced in the 1700s, and theories borrowed from the discipline of health communications, this paper examines determinants of intent to vaccinate among several groups in Appalachia. It delves into the knowledge, beliefs, and attitudes of parents of age-eligible children, young adults, community leaders, and healthcare providers towards HPV, the HPV vaccine, and the cancers that it prevents. The bulk of my sources are contemporary published studies in health communications, medical, and scientific journals.

#### Objectives

1. Understand the role of the history of health care in Appalachia to explain its residents' responses to the HPV vaccination
2. Understand the importance of culturally informed communication strategies to improve vaccination uptake in rural communities
3. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, socio-economic status, ethnicity, cultural orientations)

### **D1. Public Health and Activism in Minority and Underserved Communities**

Hanne Blank: Denison University, Granville, OH, USA  
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#### *Evolving a Black Women's Feminist Healthcare Model: Conceptualizations of Health and Self-Help in the National Black Women's Health Project, 1983-1993*

What is "health" for Black women in the United States? How does inherited oppression and trauma as well as personal experience of racism, poverty, and what historian Darlene Clark Hine characterizes as a protective "culture of dissemblance" necessitate alternative models of "health" and "wellness" than

those in the mainstream, majority White, U.S. medical and public health cultures? Founded in 1983 in the wake of the first visionary national conference on Black women's health, the National Black Women's Health Project (NBWHP) sought to answer those questions with a practical self-help healthcare model based in a controversial and organizationally distinctive form of psychopolitical self-analysis. This methodology made the NBWHP a galvanizing grassroots force in the lives of many thousands of Black American women. This methodology, based in a program called "Black and Female: What is the Reality?", worked in complicated, largely underappreciated, ways. The NBWHP had difficulty proving its efficacy to funders and governmental organizations: processing trauma and healing the psychic wounds of generations did not always succeed in creating conventional or easily quantified outcomes, e.g. increased numbers of women receiving PAP smears or receiving contraceptives. Nor were majority-white health organizations prepared to understand the complexity and resource demands of a Black women's health agenda that not only had to bridge gaps of purely medical accessibility, affordability, and education but simultaneously attempt to address Black women's profound need for the social, emotional, economic, and political support that would allow them to more consistently improve their health and that of their families. Despite the overwhelming success of the NBWHP's programs, the staggering weight of the organization's complex, resource-intensive health model soon became too heavy to carry. The making and unmaking of the National Black Women's Health Project and its innovative models of "health" and "self-help" is a history that speaks, loudly and distinctly, to present-day attempts to devise methods that address the intersectionality of social determinants of health.

#### Objectives

1. Develop an understanding of possible approaches to social determinants of health inequalities
2. Understand the dynamic history of concepts of "health" and patient involvement in their own healthcare.
3. Identify successes and failures in the history of attempts to address social determinants of health inequalities.

## **D2. The Politics of American Nursing Education, 1950-1975**

Kylie Smith: Emory University, Atlanta, GA, USA  
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*"And then we called it therapy": The Development of Advanced Practice Education in American Psychiatric Nursing after WWII*

The restructuring of the mental health professions in the United States during and after WWII set the scene for a refiguring of psychiatric nursing practice, but not without tensions. This was a period of intense public debate about the very idea of mental health and its role in social stability, and nursing needed to find its own space in this milieu. Nurse leaders stressed the importance of university based graduate courses taught by nurses themselves, containing nurse specific content, but this was not an easy process. Nurses themselves could not agree on what form and content graduate courses should take, and they needed Federal funding and support to make them happen. This paper examines the development of educational programs in psychiatric nursing in the US after WWII. Money from the National Institute of Mental Health meant that nurses were now free to experiment, and new courses established at NYU and Rutgers demonstrate the extent to which nurses varied in their ideas about what mental health nursing should look like. The paper draws on archives from the collections of nurse

leaders, their writings and publications, and the official archive of nursing organizations, to explore the ideas that informed new programs. In the 1950s and 60s, psychiatric nurse leaders were able to establish university based graduate courses aimed at producing the advanced practice psychiatric nurse. In this process, they imagined an autonomous role for the nurse, and developed nurse specific knowledge aimed at the improvement of patient care. The extent to which they were able to operationalize these ideas was limited, however, which continues to create issues for the profession today.

#### Objectives

1. Understand the historical development of psychiatric nursing as a specialty
2. Appreciate the diverse opinions of nurses themselves about their own work
3. Analyse the social and political contexts of American psychiatry

### **D2. The Politics of American Nursing Education, 1950-1975**

Karissa Haugeberg: Tulane University, New Orleans, LA, USA  
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#### *Resisting Civil Rights: Cook County School of Nursing, 1964-1972*

By the mid-1960s, African Americans had secured employment throughout Chicago's Cook County Hospital. They worked as pharmacists, cooks, janitors, and physicians, in both rank-and-file and supervisory roles. While the hospital's staff gradually began to reflect the diverse patient population at the state's largest hospital, one exception persisted: the county's nursing school remained stubbornly hostile to non-white applicants. Cook County School of Nursing (CCSN) was not unusual. CCSN, like most of the nation's nursing diploma schools, systematically discriminated against black applicants, even as other medical professions implemented modest reforms to comply with the 1964 Civil Rights Act. The persistence—and in many cases, the acceleration of—race discrimination in nursing education in the 1960s proved especially consequential for African American women as avenues for becoming a professional nurse narrowed. Drawing upon the records of the CCSN, the personal papers of prominent Cook County politicians and civil rights activists, and oral histories, Karissa Haugeberg investigates how CCSN administrators flouted civil rights legislation intended to make the nursing profession more accessible to more people in the midst of a national nursing labor shortage.

#### Objectives:

1. Develop a knowledge of the history of institutionalized behaviors
2. Develop a knowledge of the diverse ways that medical professionals responded to desegregation
3. Develop an knowledge of the ways that changes in nursing education affected African Americans who aspired to become nurses

### **D2. The Politics of American Nursing Education, 1950-1975**

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#### *They Meant Well: Nursing Education, Anthropology, and the Shaping of Cultural Competence*

Cultural competence, which first appeared in nursing literature in the early 1990s and is now a mainstay of nursing education, has been defined as a “process in which the health care provider continuously strives to achieve the ability to work effectively within the cultural context of the client.” Originally intended to improve care for an increasingly diverse population, the model has since been intensely critiqued. To understand what cultural competence has become, it is necessary to understand the political, professional, and educational context of nursing and nurse researchers in the years preceding its development. To this end, this paper will draw on published materials, institutional records, and personal papers of nurse researchers and program administrators. This paper will pay particular attention to the US Public Health Service’s Nurse Scientist Graduate Training Grants (1962-1977), and the work of the nurses who pursued degrees through these programs. These grants subsidized doctoral study by nurses in behavioral science fields, including anthropology. The nurse-anthropologists who received their Ph.D.s through these grants went on to be among the first doctorally prepared faculty of nursing schools, enshrining culture as a subject of inquiry in the field of nursing education. One of the best known graduates of these programs was Madeleine Leininger, who developed the theory of Transcultural Nursing in the 1970s. Leininger introduced the idea of “cultural congruence,” which preceded and informed cultural competence. Leininger’s theory became the canonical work which informs nursing literature today. The original nurse-anthropologists believed understanding the patient’s culture was key to providing better patient care. However, cultural competence has proved difficult to teach and to translate into practice; studies of its efficacy in improving clinical outcomes are discouraging. Today, theorists are developing new models which address institutional structures and social determinants of health in order to provide more effective health interventions.

#### Objectives

1. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy
2. Understand the dynamic history of medical ideas and practices, their implications for patients and healthcare providers, and the need for lifelong learning
3. Promote critical analysis of theories, the nature of evidence, and the evaluation of appropriate patient care, research and education

### **D3. Gender and the Imagined Mind Sciences**

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#### *Healing the Phrenological Body: Gender, Knowledge, and Practices in the Early Nineteenth Century*

This paper examines the gender dynamics of phrenological practice in early nineteenth-century America to illustrate the intersection of cranial analysis and therapeutics. A knowledge system focused on measuring and mapping the shape and contours of the skull, phrenology also dealt with the brain and body in tandem, incorporating character analysis with a variety of physiological concerns and somatic therapies, from plasters and compresses to exercise to mesmeric passes. While phrenology has long been of interest to historians of medicine and science, many have studied it as a theory of the mind, and as a science of the brain detached from the body. And as “medicine,” most have focused on its principles and prescriptions, rather than the “hands-on” work of practitioners. This paper describes phrenology as not just a “science of the mind,” but was also an epistemology of the body, as it operated in the context and healing cultures of the early nineteenth century. This study demonstrates the many

intersections of phrenology and physiology, phrenology and healing, by looking closely at the work of two lesser-known practical phrenologists, Deiadamia Chase and Henry B. Gibbons, both from upstate New York. It uses a unique set of sources, unpacking Chase's biography and mining Gibbons' diaries and personal papers. Men and women both engaged in phrenological work and used some similar tools and methods, but they often sold their services differently, highlighting gendered skills and expertise, and constructing differential gender identities. Ultimately, this paper will also show how phrenologists and clients imagined relationships between the brain and body, especially gendered and racialized bodies. As practitioners tried to bolster their positions in a competitive field of healing, clients, particularly women clients, strategically constructed the brain and body as both separate and inseparable.

#### Objectives

1. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
2. Recognize the dynamic interrelationship between medicine and society through history
3. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

### **D3. Gender and the Imagined Mind Sciences**

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*"Women in White": Gender and the Fictional Woman Neurosurgeon in the First Half of the 20th Century*

In the 1930s and 40s, decades before the first female surgeons were to receive board certification in neurosurgery, a feminist literature developed in the United States that depicted women doctors performing brain surgery. Confronting pervasive and harmful stereotypes about supposed female characteristics deemed inimical to a surgical career, these fictional stories were aiming to challenge a broad audience to rethink ideas about women's place in the medical profession and in society more generally. At the same time, the authors were working within specific cultural constraints, and they created heroines who managed to perform the most challenging and (at the time) male-gendered kind of surgery – i.e. brain surgery – while also retaining traditionally feminine attributes and aspirations (such as love and marriage). This paper analyzes these fictional stories, including a novel, a short story, and a Broadway play, and considers both the narratives themselves and the ways in which they were received by literary critics in published reviews. In addition, I set these stories against the backdrop of the development of neurosurgery as a deeply gendered medical specialty in the first decades of the twentieth century, and show how the early all-male brain surgeons asserted their masculinity in the face of potential challenges created by their self-described "delicate" work. Meanwhile, their fictional female counterparts rejected the sexist gendering of their brains, bodies and abilities while fighting for recognition and equality as competent, life-saving "women in white." This paper thus foregrounds the role of gender in the embodied work of neurosurgeons, both real and fictional.

#### Objectives

1. Recognize the dynamic interrelationship between medicine and society through history
2. Identify successes and failures in the history of medical professionalism
3. Understand the cultural roots and the historical contexts that inform the development of professional identities, as well as the role gender plays in this process

### **D3. Gender and the Imagined Mind Sciences**

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*Brains in Jars, Scientists in Suits: The Sex of Brains and the Gender of Neuroscience*

In 1887, a woman named Helen Hamilton Gardener engaged in a high profile debate in *Popular Science Monthly* with one of the most famous neurologists of the 19th century—Dr. William Hammond, former Surgeon General and a founding president of the American Neurological Association. Hammond claimed that he had discovered 19 distinct ways women’s brains differed from men’s and that these differences explained why women should not enter college or the professions. Gardener cried foul and engaged in her own amateur brain research by enlisting the help of another pioneering neurologist, Dr. Edward Spitzka. Gardener pitted Spitzka’s methods and conclusions against those of Hammond. Hammond, for example, drew on anthropological evidence; Spitzka had a laboratory full of specimens. Ultimately, Gardener proposed a challenge—she would send Hammond twenty brains from Spitzka’s collection and if he could accurately determine their sex by sight, she would concede. Hammond counter-proposed that it was not differences between individual brains that mattered, but averages. To even the scales, Gardener and her friend Elizabeth Cady Stanton pledged to donate their brains to the Burt Wilder Brain Collection at Cornell. Stanton’s heirs refused, but the study of Gardener’s brain prompted the *New York Times* to declare “Woman’s Brain Equal to Men’s.” Her brain remains on display jarred in formaldehyde in a glass case outside Cornell’s psychology department. This paper compares the ways in which Hammond and Spitzka drew information about brains as well as how both the sex of brains and the gender of brain scientists was at play in these debates. The paper will also allude to the legacy of Gardener’s brain—it has been featured in many news stories and in the recent brain exhibit at the Wellcome Trust—analyzing the meanings about sex difference her brain is still purported to convey.

Key words: brains, sex difference, neurology

#### Objectives

1. Recognize the dynamic interrelationship between medicine and society through history
2. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
3. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

### **D4. Race, Knowledge, and Empire: Curating Difference through Medicine**

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*Race, Empire, and the Erasure of African Identities in Harvard’s “National Skulls”*

In 1847, upon his retirement, John Collins Warren gave his entire anatomical collection to Harvard’s medical school, including a collection of “national skulls” that would grow to include more than 150 objects. Collected through a network of white elites spread across a world increasingly connected by commerce and colonialism, the national skulls were organized in the Warren Anatomical Museum by

simple racial categories, narrating a white supremacist understanding of race and ethnicity to medical students. While the collection housed skulls from subordinated peoples the world over, in this presentation, I specifically analyze how skulls from the black Atlantic were collected and dubbed “African,” attempting to erase their individual and cultural identities in favor of their simple racialization. In the larger project, I focus more on the history of the collection and arrangement of skulls in the museum, but here, I wish to tell the story of two skulls of African descendants, an unnamed leader from the 1835 Muslim Uprising in Bahia, and another of Sturmann, a Khoe man from Namaqualand who committed suicide in Boston in 1860 while a living exhibit. In telling their stories, I have two goals. First, I will posit a method for writing the history of racist museum exhibitions that does not continue the silencing of subaltern voices at the heart of those exhibits. Second, I argue that medical schools were intimately connected to the violence of slavery and empire. They purchased, displayed, and published racist descriptions of peoples whose lives were upended by commodification and colonialism, but through giving attention to the experiences of the skulls’ living antecedents, I show that museum exhibitions and tables of craniometric data do not have to be these objects’ only stories. Instead, hidden in these records are histories of rebellion, politics, and survival in the age of empire.

#### Objectives

1. Develop an historically informed sensitivity to the diversity of patients
2. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems
3. Elicit and write a patient’s history worthy of a historian

#### **D4. Race, Knowledge, and Empire: Curating Difference through Medicine**

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*“I have no experience of hybrid races, except in Jamaica...”: Measuring “Miscegenation” in the Aftermath of Slavery*

In the early twentieth century, white eugenicists grew alarmed by racial intermixture between blacks and whites. Even though race mixing between these groups had occurred for centuries, it was framed as a new public health threat by the likes of Charles Davenport, a leading American eugenicist. Davenport warned that the offspring of black and white unions could “pass for white,” and, more importantly, disrupt the assumption that racial identity was legible through skin color. This concern about the fixity of the color line was hardly new. Twenty years earlier, British biostatistician Karl Pearson investigated “negro-white hybrids” in Jamaica in an attempt to catalogue their physical traits. While Pearson and Davenport disagreed on how skin color was passed to offspring in black and white racial crosses, both agreed that race crossing merited intense study. Both men also viewed the British colony of Jamaica as the ideal place to undertake such study. The island’s legacy of slavery, supposedly lax attitudes about interracial sex, large numbers of mixed race people, and predominantly English speaking inhabitants made it a convenient place to measure miscegenation. Convenience, however, only partially accounts for why eugenicists turned to Jamaica to study race crossing. As this paper demonstrates, Davenport made an example of Jamaica in order to condemn a practice that was largely perpetrated by white men across all former slave societies. Moreover, his focus on Jamaica meant he did so without having to acknowledge the complicity of generations of white Americans. Davenport amplified the foreignness of Jamaica and, as I argue in this paper, deliberately framed race crossing as a problem caused by the loose morals of black women and white men whose morals had suffered due to living in an allegedly



permissive Caribbean. Beyond that, this paper situates the race crossing studies by Pearson and Davenport within an already existing body of medical lore about mixed race people's bodies that had its roots in the era of slavery—such as “mulattoes’ ” alleged infertility or the long standing myth of racial throwbacks. In this way, I highlight how legacies of slavery shaped the contours of early eugenic science.

#### Objectives

1. Highlight the interplay between colonialism and the eugenics movement
2. Analyze relationships between slavery, eugenic science, and attitudes about race
3. Provide new perspectives with which to consider the lasting impacts of eugenic race crossing studies

#### **D4. Race, Knowledge, and Empire: Curating Difference through Medicine**

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##### *Native Health and Indian Removal*

This paper focuses on the various ways that US state and federal governments deployed Indigenous health struggles as a justification for ethnic cleansing in the first half of the nineteenth century. A common explanation by imperial agents and authorities during the removal era was that Native people could not live safely in contact with white settlers. Andrew Jackson famously said as much in front of Congress while seeking its approval of the 1830 Indian Removal Act. Removal advocates also referenced to Native population loss and the supposed opportunity for Natives to flourish and recoup their numbers, away from settlers. Clearly this was a smokescreen for ethnic cleansing, but it raises the question of how imperial agents' understanding of Native health and population loss played into removal proposals. No less pertinent to this paper is how Native people themselves thought about the health and well-being of their communities in their homelands as opposed to Indian territory or reservations. Were Native parties to removal treaties convinced by state and federal arguments about Native health and population loss? What particular concerns about health and population decline did Native people bring to negotiations? This paper will examine oral traditions and ethnographic materials, data collected in Native communities, and government reports to uncover the role of Native health in Indian removal from the eastern United States before 1850.

#### Objectives

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

#### **D5. Reframing Grand Historical Narratives in East Asian Medicine**

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##### *Eastern Medicine as the Fulcrum of Social and Cultural Renaissance in 1930s Korea*

The period when Japan annexed Korea reveals a complex interplay of cultural and political forces that gave rise to an unusual form of colonial medicine. My paper argues that the particular circumstances of that period in Korea led to a unique form of East Asian modernity that integrates elements of older cultural and medical practices with new scientific ideas. With the introduction of Western medicine, Korean healers and Koreans generally insisted on continuing to strengthen their traditional healing practices, such as herbal medicine, lifestyle preventive medicine, and religious ritual. My focus on traditional medicine physicians and shamans shows that the Korean defiance in the face of attempts to marginalize their medical practices and healing rituals manifested as a key area of resistance to Japanese colonial rule. Gradually, Japanese colonial rulers surprisingly came to embrace traditional Korean medicine as though it was their own. This experience in Korea even contributed to their reevaluation of their Kampo medical tradition back in Japan. Examining through the lens of medicine the integration of different aspects of what at that time was just being defined as “traditional” and “modern” in Korea provides many insights into the hybrid form of modernity that broadly manifested in twentieth-century East Asia. In this paper, I will focus on the two-day conference on East-West Medicine Research held in Seoul, Korea, in 1939. Korean physicians declared it as a genuine cultural Renaissance. They further declared that the Renaissance would be an initial step in transmitting Eastern Medicine to the world as a global medical system. Whether Eastern Medicine made a mark in the world or not, the conference was but one sign that, by the 1930s, there was very little doubt that this form of medicine was well established as central in the life of Korean people.

#### Objectives

1. Understand medicine as a form of political resistance
2. Understand Korea as an unusual case of colonial medicine
3. Understand Eastern Medicine in East Asia as a form of cultural resistance to the West

#### **D5. Reframing Grand Historical Narratives in East Asian Medicine**

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#### *Revisiting Theory and Practice in the Current Historiography of Chinese Medicine*

The present-day historiography of Chinese medicine leans towards focusing on bodily practices and experiences in historical clinical encounters because of: 1) reactions to the New Cultural History that reduced the “real” body in history to representations and 2) the end of the Cold War that makes the body and the bodily experiences alternatives to the Cold War binary divisions such as self/ other and West/China. This current historiography helps avoid rendering Chinese medicine an essential theoretical “foundation” contrast to Western biomedicine, and contributes to presenting bodily experiences in history without anachronistic biological assumptions. However, this historiography renders Chinese medicine in history mainly based on subjective experiences and practices without dominant theories. In this way, the “traditional” Chinese medical theories are reduced to doctrines and traditions subject to experiences and practices in clinical encounters. Modern TCM (Traditional Chinese Medicine) that highlights empirical experiences in clinical practices, due to historical and political reasons, also helps make the current historiography of Chinese medicine “experiential.” This essay brings the dominant theories to the center of the historiography of Chinese medicine in late imperial China without de-centering the bodily experiences and practices in history. By focusing on the “paradigmatic” dominant pulse taking theories and their “shifts” in the early 17th century China, this essay shows that the clinical

practices and experiences were subject to these dominant theories and their controversies. Moreover, this essay also sets in relief how the illustrations of the viscera created in the early 17th century presented a new understanding of the viscera when the “paradigm shift” of the dominant pulse-diagnostics theories took place. Through detailed analysis this essay indicates that the “paradigm shift” of the dominant pulse taking theories actually led to a “paradigm shift” of the understandings of what meant the twelve viscera in late imperial Chinese medicine.

#### Objectives

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

### **D5. Reframing Grand Historical Narratives in East Asian Medicine**

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#### *From Colonial Medicine to International Health in East Asia*

This paper argues that the influence of Japanese institutions in public health lasted well into the post-war period in East Asia. The post-war United States dominated healthcare policies and institutions, but little studied is that the health architecture throughout East Asia was mainly built on Japanese foundations. The Japanese colonial empire had invested much in public health. Thus, my premise is that American health initiatives in the region demonstrate continuities. To demonstrate my argument, I first examine the historical background of colonial medicine in East Asia and its transition to an international health initiative. Pre–World War II activities by the League of Nations Health Organization helped bypass Westphalian principles in East Asia. The Eastern Bureau was established in Singapore with an Advisory Council formed from the colonial states. The Far Eastern Association of Tropical Medicine, established in 1908, cooperated with the League of Nations Health Organization and created a new framework to integrate colonial governments and national sovereignty around public health concerns. The Rockefeller Foundation’s hookworm eradication program became a focal point for many other East Asian medical programs and helped to link Eastern and Western health concerns prior to World War II. Finally, I examine the influence of the Cold War with the decline of aid from the Rockefeller Foundation. Consequently, numerous nonprofit organizations arranged large scale aid to the region, related to the United States’ economic and political interests. With respect to the history of the changing international health system in East Asia, although there were continuities, there was also change. The move was from the formal colonialism of the pre–World War II era and a new, invisible form of colonialism in the postwar era that emerged, building on Japanese prewar institutional foundations.

#### 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

## **D6. Relationships Between Patients and Practitioners in Extreme and End-of-Life Circumstances**

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### *“Nearing the Terminal Stage”: End-of-Life Care in New York City*

This paper explores the shifting forms and expressions of end-of-life care in the United States, focusing particularly on the care of terminally ill patients in New York City. The twentieth century witnessed a flurry of medical innovations such as artificial respirators and cardiac pacemakers that enabled the prolongation of life. The advent of medical technology and the willingness of physicians to use these new tools often resulted in prolonged deaths for patients, which invited discussions about how to humanize the care of the dying. Recent studies have traced the development of the hospice and the changes in the ways in which Americans cared for the terminally ill in the early 1970s. Despite the surging interest in the histories of dying and transformations of end-of-life care, however, historians have paid less attention to how death was situated in a complex web of connections that affected the subjective experiences of people as they provided end-of-life care. To fully understand this dimension of death, it is imperative to recognize the ways in which social networks shaped how patients and their caregivers interpreted the dying process. Drawing on medical social workers’ reports, annual reports, medical journals, and research publications, this paper examines the interactions between terminally ill patients, family caregivers, physicians, and medical social workers regarding end-of-life care. I argue that webs of connections associated with dying reflected the intersections of class, race, ethnicity, and local conditions, which led to different subjectivities of dying. Identifying these connections will enable scholars to deconstruct the elusive meanings of death and to integrate them into a broader discussion of life.

### Objectives

1. Deepen understanding of terminal illness and experiences of caring for the dying
2. Develop the capacity for critical thinking about the nature, ends and limits of medicine as they relate to end-of-life care
3. Recognize how the history of end-of-life care shapes the contours of contemporary discussions over terminal care and aid-in-dying legislation

## **D6. Relationships Between Patients and Practitioners in Extreme and End-of-Life Circumstances**

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### *Do Everything: Changing Power Dynamics around Promises and Demands to “do everything” During Critical and Palliative Care*

Utterances of the phrase “do everything”—whether spoken by someone providing or receiving critical or end-of-life medical care—appear to have increased since the 1990s. The aim of this paper is to contextualize and explain this perception historically. We suggest that patients’ and families’ demands to “do everything,” as well as recent calls from physicians and ethicists to banish the phrase, represent a significant recalibration of power dynamics within doctor-patient relationships in the 21st century. Our approach is to treat the phrase “do everything” as a curious found artifact—the origins, meanings, and uses of which are not immediately apparent to us. The sites we are excavating are medical, ethical, and

historical bodies of scholarship, as well as archives of institutional records and databases of historical periodicals. Our findings indicate that demands or promises to “do everything” are situated within the long historical trajectory from hospice (a place to be saved religiously) to hospital (a place to be saved medically), and within more recent and rapid historical changes: the advent of informed consent, cost-benefit analyses, and patient autonomy. We also show the significance of discordant shifts in attitudes towards death among healthcare providers and recipients during the twentieth century. This research illuminates a recent transformation—one characterized by: 1) conflicts that emerge around medicine’s seemingly limitless capacity to prolong life, 2) evidence-based medicine and definitions of therapeutic futility, and, 3) expanding social policies that promote patient autonomy and the rights of non-experts in complex medical decision-making. We conclude that contested, shared, and substitute decision-making are not new—indeed, we find these concepts and activities embedded in medical cases throughout a 400-year period—but their applications and implications are magnified by the availability of newer life-sustaining technologies.

### Objectives

1. To analyze historical medical cases that show changing attitudes to palliative and critical care decision-making
2. To investigate the effects of informed consent, cost-benefit analyses, patient autonomy, and substitute decision makers on clinical care plans
3. To demonstrate the utility of historical methods and findings to clinical decision-making and healthcare policy discussions

## **D6. Relationships Between Patients and Practitioners in Extreme and End-of-Life Circumstances**

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### *A Calculus of Compassion: Life and Death in the Casebook of A. B. Holder*

In his brief life and career, Mississippi native Dr. Andrew Bowles Holder (1860-1896) moved through and practiced in very different sites: Reconstruction-era rural Mississippi; a Crow reservation in Montana; and Memphis, as a professor of medicine. Holder’s short career is well documented in a remarkably complete set of case notes, photographic albums, and journals, which cover his time as a young physician in rural Mississippi and on the reservation. Holder is best remembered, if at all, for his work among the Crow, particularly his writings on the bote, an example of “sexual inversion” cited by Havelock Ellis in his works. However, Holder’s recently recovered casebook preserves a different facet of his career, allowing the historian to glimpse the “dailiness” of rural medical practice and his emotional investment in the lives—and deaths—of his patients. In this paper, I use Holder’s casebook to interrogate the extent to which aspects of identity—gender, race, age, and class—impacted the doctor-patient relationship in the Reconstruction context. In particular, I turn to the cases of birth and death to discuss how medical care in extremis prompted (or failed to elicit) introspection and compassion in the medical practitioner. I will compare similar cases, with similar diagnoses and therapies, in Holder’s repertoire and from the casebooks of other contemporaneous physicians in order to explore the ways in which identity impacted not only outcomes, but also the nature of care and compassion in this interaction. This paper, as part of a broader comparative project focusing on the doctor-patient relationship in the late nineteenth century, centers interpersonal dynamics and identity markers as contributing factors to historical and contemporary health inequities in the rural South.

## Objectives

1. Explore the life and work of Andrew Bowles Holder through recently acquired manuscript sources
2. Consider how aspects of identity impact the doctor-patient relationship and medical care
3. Interrogate the emotive components of the doctor-patient interaction in historical context

### **E1. Women on a Mission: Gender, Activism, and Proselytism in the Middle East and Britain**

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*Foregrounding Identities: Gender, Nationalism, and Transregionalism in Modern Iraq's Nursing History, 1890 - 1958*

In the first half of the twentieth century, Iraq was one of the few countries in the Middle East that suffered from prolonged medical labour shortages. As a result, nurses had access to social spaces and groups otherwise beyond the reach of the state. However, the state exploited this skilled cadre. Nurses were often stationed in understaffed clinics, hospitals, or makeshift posts that lacked adequate equipment, drugs, or ancillary services. The contradictions that Iraqi nurses witnessed during their practice directly undermined the dogmatic rhetoric endorsed in their lessons and contributed to the epistemological transformation of nursing education locally and regionally. Moreover, the nursing profession provided a level of freedom unmatched by other professional opportunities available for Iraqi women during the first half of the twentieth century. This shows that Iraqi nurses contributed to shifts in social and gender ideologies in Iraq's modern history. This paper is interested in examining how nurses shaped, resisted, or collaborated with national agendas. With the British occupation of Iraq following World War One, medical colonialism reframed the medical profession along gendered and class relations. It is because of the feminizing efforts of colonial medical agendas that development in nursing becomes an important lens through which the intricate relationship between the state and its intermediaries is underpinned. One of the main objectives of this paper is to plot the role of Iraqi nurses within the overall history of modern Iraq. Iraqi nurses were historical actors who played important roles in shaping, resisting, or compromising with colonial and government agendas. Their agency highlights the shifting social and gender relationships and the changing social position of middle-class women in the Middle East during the first half of the twentieth century. Iraq's ethnolinguistic and religious diversity adds a unique dimension to this study. Iraq's minorities made up a significant portion of the nursing workforce. Marginalised groups pursued the medical profession as a vehicle for social and political integration within the Iraqi state. In examining the history of Iraqi nurses during the first half of the twentieth century, a more nuanced picture of nursing as a cross-cultured profession emerges.

## Objectives

1. Understand the relationship between biopolitics and modern forms of governance and subjectification
2. Understand the confrontations that emerge between the state and its intermediaries
3. Recognize the nuanced picture of gender and class dynamics in the making of medical labor

### **E1. Women on a Mission: Gender, Activism, and Proselytism in the Middle East and Britain**

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## *Proselytizing for the Nursing Profession: American Mission Nurses in Iran, 1907-1947*

This paper explores the expansion of American mission nursing in Iran. American mission nurses operated the only nursing schools in Iran between 1916 and 1936. This paper argues that missionary nurses in Iran transitioned from a religious mission to a professional mission during the interwar period. I draw on scholarship that explores American nurses and imperialism in other contexts, such as Ellen Walsh's work on Protestant missionaries and Americanization in Puerto Rico. Twenty-three nurses applied to the Presbyterian Board of Foreign Missions during this period. They emphasized their desire to evangelize in their applications. In fact, many applicants mentioned that they pursued nursing because it would benefit their missionary aspirations. Once they arrived in Iran, they carried out professional activities, often at the expense of evangelistic ones. They increasingly privileged and pursued professional goals. Their mission was to develop the nursing profession and "produce fine nurses for Iran." In effect, they proselytized for the nursing profession. They also redefined Christian service as they went along. This work sheds light on professional identity formation among a group of religious women. While science and faith are often viewed as conflicting categories, this work considers how missionary nurses re-conceptualized their religious and professional identities in light of their experiences within the specific place of Iran. Ironically, missionary nurses' efforts to cultivate American nursing standards in Iran intersected with the Iranian government's modernizing initiatives. In the twentieth century, the Iranian government increasingly regulated and restricted the work of American physicians, but mobilized American nursing knowledge and manpower in its construction of state medical services. I use interviews, memoirs and mission records (nursing and hospital reports) to argue that nursing internationalism fostered Iranian nationalism. I draw on work by Warwick Anderson and Deborah Neill, who have explored physicians' involvement in transnational medicine, but I use nurses and nursing history to explore transnational medicine in Iran. This paper considers the ways that missionary nurses contributed to new understandings about professional nursing in Iran. Missionary nurses' professional goals intersected with national goals in a way that led missionary nurses to serve the Iranian nation.

### Objectives

1. Recognize the dynamic interrelationship between science and faith through history
2. Identify successes and failures in the history of medical and nursing professionalism
3. Develop an historically informed understanding of US medical influence and contributions to Iranian healthcare

### **E1. Women on a Mission: Gender, Activism, and Proselytism in the Middle East and Britain**

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#### *"It's not easy to ask questions": Activists, Scandals, and Cervical Cancer Screening in 1980s Britain*

This paper examines activists' efforts to urge the reorganisation of cervical cancer screening in mid-to-late 1980s Britain. These followed high profile media coverage of deaths from cervical cancer of women who, at the time, had been deemed too young to be screened. Labelled a "shambles" by opposition politicians, UK screening services struggled to keep up with demand. Backlogs left many women waiting weeks and even months to learn the results of smear tests they'd been urged to get, while services grappled with quality control in smear reading. Finally, public discussions were further complicated by a

growing emphasis on a sexual etiology for cervical cancer—epitomised by junior health minister Edwina Currie’s advice to young women: “don’t screw around”. Activists across the UK responded with highly visible campaigns intended to speak both to and for everyday women. As one Scottish group put it, patients found, “It’s not easy to ask questions when you’re on your back.” But activists claimed they could take concerns and complaints to the NHS, while in turn delivering better information about screening to UK women. How did the activists urging changes to cervical cancer screening programmes negotiate the multiple possible identities available to them? Were women at risk of cervical cancer and in need of improved screening services betrayed patients, unhappy consumers, tragic victims, or promiscuous women? How, I ask, did activists present themselves and their cause, especially given new knowledge about HPV’s role in cervical cancer? In particular, I look at how these activists responded to the familiar charge that the problem with cervical cancer screening was that “the wrong women” were getting tested—the complaint that women at low relative risk burdened the service with demands for unnecessary tests, while women at high risk refused invitations to be screened.

### Objectives

1. Gain insight into the roles patient activists can play in reforming quality of care
2. Reflect on how medical information management systems can learn from past failures and public scandals
3. Understand how different groups have comprehended the benefits and harms of screening

## **E2. Health Risks and Gendered Injury: Policies about Contraception, Fetal Protection, and Toxic Shock Syndrome**

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### *The Right to Medical Privacy: The Unexpected Aftermath of Toxic Shock Syndrome*

In 1980, the media alerted women to a new and frightening illness associated with menstrual periods and tampon use: toxic shock syndrome (TSS). The illness raised grave concerns because it struck healthy individuals, and 70% of women used tampons. In addition, the early symptoms deceptively resembled the flu, which quickly deteriorated into septic shock and death. The Centers for Disease Control (CDC) conducted epidemiological studies and worked in conjunction with state and local public health agencies to track outbreaks and identify co-factors of the illness. While the studies determined that all super-absorbent tampons carried risk, the Rely tampon manufactured by Procter & Gamble (P&G) demonstrated the highest rate of all. The company bore the brunt of the bad publicity and voluntarily withdrew Rely tampons from stores, sparing itself from an official Food & Drug Administration (FDA) recall. While P&G publicly received accolades for taking responsibility for its product and alerting women to the dangers of Rely, behind-the-scenes it fought for access to data. This paper examines the aftermath of the recall, and the ways in which P&G pressured, challenged, and sued the CDC for the right to identify informants and access to their medical records. It utilizes archival documents and oral histories to trace arguments amongst FDA, CDC, and corporate lawyers concerning the nature of a patient’s right to privacy. Procter & Gamble exerted strong commercial interests in seeking to retrieve the data that the CDC collected, presumably to discover epidemiological errors. The company proceeded to subpoena records, which the CDC contested, and resulted in *Farnsworth v. Procter & Gamble* (1985) which ultimately provided protection to the CDC and patient privacy. At stake was the very system of trust which patients and informants voluntarily gave, and the CDC depended upon, for quality data.



Key words: women's health, health privacy, medical devices

#### Objectives

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

### **E2. Health Risks and Gendered Injury: Policies about Contraception, Fetal Protection, and Toxic Shock Syndrome**

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*"Little More Than A Smokescreen": Fetal Protection Policies and Sex Discrimination in the Vinyl Chloride Industry, 1974-1980*

The National Institute for Occupational Health and Safety (NIOSH) was just four years old when it issued its 1974 "Recommended Standard for Occupational Exposure to Vinyl Chloride," advising that fertile women not be employed in vinyl chloride operations due to the heightened susceptibility of a potential growing fetus to toxic exposures. The recommendation prompted companies like Firestone Plastics to institute fetal protection policies, barring women from positions where they might be exposed to the vinyl chloride. These policies would set off a decades-long contest between the chemical industry, government agencies, and the courts over how to balance the uncertain risk of toxic exposure against sex discrimination. In the wake of Title VII and the Occupational Health and Safety Act, industry became entangled in competing regulatory prerogatives: to increase female hiring in male-dominated positions, and to heed precautions that fertile women should not be placed in those positions. This paper will use newly available primary sources including the internal correspondence, minutes, and records of vinyl chloride companies to anchor the history of workplace fetal protection in the turbulent early years of federal regulatory control over American industry. The inner workings of the vinyl chloride industry reveal how Firestone and its peers skirted liability by insisting that sex discrimination law and occupational safety regulations placed them in a "Catch-22." Their genuine uncertainty about reproductive risks manifested in reactive, inconsistent policies that relied on principles of biological essentialism, ultimately reproducing a gendered division of labor and freeing them to pursue profit without compromise.

#### Objectives

1. Recognize the dynamic interrelationship between occupational health and society through history
2. Identify successes and failures in the history of health regulation
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate public health interventions, research, and education

### **E2. Health Risks and Gendered Injury: Policies about Contraception, Fetal Protection, and Toxic Shock Syndrome**

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### *The Pill and Its Side Effects - A Transnational History of Hormonal Contraceptives in West Germany*

When Anne-Marie Durand-Wever, the vice president of the West German family planning association Pro Familia wrote the American Planned Parenthood founder Margaret Sanger that a “German pill” was introduced by pharmaceutical giant Schering in 1961, she was excited that the new medication had fewer side effects than the American product. Only a few weeks later, reports about women developing blood clots in connection to hormonal contraceptives emerged in Britain and in Los Angeles. Pro Familia then issued a warning in its bimonthly journal in late 1962. Planned Parenthood did not mention thromboembolism in its brochures until 1968. My proposed paper will analyze in a transnational perspective how family planning associations dealt with thromboembolism as a serious side effect of hormonal contraceptives. Examining archival records from the Planned Parenthood Federation of America and the West German Pro Familia, my paper will look at how knowledge about blood clots travelled across the Atlantic and reached patients in different countries. It will start out with the first reports about patients developing blood clots in Britain and the US in 1961/62. Then it will look at how Pro Familia president Hans Harmsen obtained the 1967 FDA report on the safety of the pill, translated it and circulated in the organization. A third part will analyze the coverage of the 1970 US Senate Subcommittee hearings on pill safety in the West German press, before a last part will look at how the women’s health handbook *Our Bodies, Ourselves*, and its German translation (1980) dealt with side effects of the pill. The underlying thesis of my paper is that since doctors in West Germany were informed about serious side effects as early as 1962, they were much more careful to prescribe oral contraceptives. This affected both numbers of pill users and the way the feminist movement in the 1970s demanded access to contraceptives rather than informed consent. My presentation will show how the different information policy of Planned Parenthood and Pro Familia regarding serious health effects of the pill had long-term effects in creating different cultures of contraceptive use.

#### Objectives

1. Identify successes and failures in the history of medical professionalism
2. Recognize the dynamic interrelationship between medicine and society through history
3. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy

### **E3. Making a Profession: American Physicians in the Nineteenth Century**

Maria Daxenbichler: University at Buffalo, Buffalo, NY, USA  
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#### *Medicalizing Abortion: Dilation and Curettage at the End of the 19th Century*

In 1890, Guillard Thomas, one of the leading physicians in the emerging fields of obstetrics and gynecology, claimed in a lecture that if an “intelligent physician” performed an abortion, “the prognosis [for the patient] is not bad.” Thomas’s claim was remarkable because, as many historians such as James Mohr have pointed out, physicians had demonized abortion and worked to criminalize the procedure since mid-century. At the same time, physicians knew that abortion was an extremely important intervention that saved patients’ lives. This paper argues that physicians at the end of the century reconciled these two conflicting interests by promoting the criminalization of elective abortions on the one hand and medicalizing the operation on the other. Citing medical journals and textbooks, I show

that starting in the 1880s physicians developed techniques for a new operation—dilation and curettage—that remained one of the preferred ways to induce abortions throughout the twentieth century. The method was exclusive to physicians since it required professionals with medical training utilizing technologies such as metal dilators, curettes, ether, and disinfectants. Because the technique was so reliant on specialized knowledge and access to technologies, physicians freely discussed best practices in professional publications. Drawing on notes from medical students, I demonstrate that physicians also lectured on dilation and curettage in medical schools. Unlike discussions about abortion in general, discourses about dilation and curettage rarely included moralistic warnings. Physicians assumed that the nature of the operation assured that only medical professionals who shared the profession’s rejection of elective abortions would use it. Physicians such as Thomas thus could boast about practitioners’ ability to perform safe abortions because by using a heavily medicalized technique they were free from the suspicion of providing “criminal” abortions.

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

### **E3. Making a Profession: American Physicians in the Nineteenth Century**

Jonathan Riddle: Wheaton College, Wheaton, IL, USA  
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#### *The Science of Human Life: Vitalism, Materialism, and the Rise of Physiology in the Antebellum United States*

In antebellum America, physicians sought to put medicine on firmer scientific footing by emulating European physicians’ emphasis on pathological anatomy and physiology. While this story is well known, the religious implications of these new ways of understanding the human body have not yet been explored. This paper begins just such an exploration. Examining the American reception of European physiologists reveals that the vitalist-mechanist controversy crossed the Atlantic with the works of Lawrence, Broussais, and others. This controversy shaped discourse surrounding the rise of physiologically-informed medicine in the United States. The American vitalist-mechanist controversy focused on the place of the soul in the study of the body. To religious observers, accounting for human life in material terms implicitly denied the existence of anything spiritual and amounted to philosophical materialism. They had reason to be worried, for radical physicians like Thomas Cooper and Charles Knowlton not only denied the usefulness of the soul hypothesis in physiology, they embraced materialism outright. In so doing, they confirmed ministers’ fears that medical training in anatomy, physiology, and chemistry inculcated irreligious sensibilities. Vitalism debates operated as boundary disputes between two professions—the long-dominant Christian ministry and the increasingly-confident medical profession. When physicians denied the relevance of the soul to medical care, clergy argued, they banished ministers from the sickroom and from the study of human nature. While some doctors were content with a material-spiritual division of labor between the two professions, more radical physicians claimed total authority in anthropology, insisting ministers had as little to do with human nature as they did with astronomy. Tracing the Abernethy-Lawrence debates in the American press and the subsequent controversy over the materialist tendencies of medical physiology, this paper reveals an

untold episode in the history of medicine and religion while illustrating the hurdles confronting scientifically-inclined physicians in antebellum America.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends, and limits of medicine
2. Identify the successes and failures in the history of medical professionalism
3. Develop a historically-informed sensitivity to the diversity of patients, including religious diversity

### **E3. Making a Profession: American Physicians in the Nineteenth Century**

Sarah Naramore: The University of the South, Sewanee, TN, USA  
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#### *The Medical Network: Social Ties and Expertise in American Medicine, 1780-1820*

Medicine of the late eighteenth century has been characterized as a marketplace. While this concept is helpful in explaining the variety of theories and the function of multiple medical systems within a society, it leaves unanswered questions surrounding the relationships between medical practitioners and the attainment of professional status before diplomas or licenses were compulsory. This is especially the case for the American medical profession in the decades following independence. Between 1789 and 1813 nearly 3,000 medical students received instruction from Benjamin Rush in Philadelphia. These young men, on average, spent a little more than a year of their lives in a formal medical school. Despite their short stays in Philadelphia this cohort of American doctors formulated a national and professional identity grounded in their shared relationship with individual practitioners. Past studies have described these men as followers of a medical system. An examination of documents produced by these men, however, indicates that who you knew was at least as important as what you knew. This paper argues that more can be uncovered about this foundational cohort by viewing them as a social network. Personal connections and professional lineage provided status and a sense of belonging in a geographically diffuse medical community. By using large data sets extracted from manuscript sources and digital mapping this project uncovers patterns of migration and communication for a self-identified group of Rush students. A combination of pattern identification and traditional close reading of correspondence, ledgers, and journal articles shows the choices young medical men made, how they shared information, and developed expertise. The techniques used for this project including data organization and analysis are generally applicable to research on predominantly manuscript sources and have the potential to be used across additional data sets in the future.

#### Objectives

1. Identify successes and failures in medical professionalism
2. Understand the dynamic history of medical ideas and practices
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of patient care

### **E4. Pathologies of Class, Sex, and Race in the Eighteenth Century**

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### *Pathologies of Blackness: The Emergence of Race-Medicine in Eighteenth-Century Britain*

This paper explores the emergence of “race-medicine” in the second half of eighteenth-century Britain. Turning away from the emphasis, in most of the secondary literature, on questions of morphological structure and hence on racialised anatomy (questions shared between natural history and medicine), I ask instead about more specifically medical racial physiologies and, particularly, racial pathologies. When does one find the first instances of diseases conceived of as 1) characteristic of a given race and 2) caused not by the same kinds of environmental factors that produced racial difference in the first place, but rather by racialised physical differences between (for example) black and white bodies? Or, to phrase this another way, when does race become a cause of illness, rather than (like most diseases of the period) an effect of climate, diet, and other environmental factors? To provide an answer, I explore a number of the heterodox and racist positions that were increasingly defining a real and significant minority in European conversations. By 1780, one can begin to locate precisely the sorts of arguments that had been absent in the first half of the eighteenth century, arguments where medical logics and racial logics were combined and where racialised physical differences were described as causing characteristically racial medical differences. At the end of the century, race-medicine was beginning to emerge.

#### Objectives

1. Understand the history of race
2. Understand the relationship between the history of slavery and abolitionism on the one hand and medicine on the other
3. Understand the roots of contemporary thinking on race and medicine

#### **E4. Pathologies of Class, Sex, and Race in the Eighteenth Century**

Kevin Siena: Trent University, Peterborough, ON, Canada  
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### *Plague, Predisposition and Poverty: Towards a Classed Physiology in Long Eighteenth Century Britain*

One of the more salient features of the cultural turn for medical history was the emergence of what came to be termed the history of the body. Groundbreaking scholarship demonstrated how eighteenth-century physicians inscribed the categories of gender and race on physiology, especially within the field of anatomy. Yet for the period before the nineteenth century, the associated category of class has been almost entirely absent from this scholarship. This paper suggests that a shift of focus from anatomy to pathology can go a long way to establishing that seventeenth- and eighteenth-century doctors apprehended class as a significant physiological distinction, one that was especially important during epidemics. We will explore how the concept of predisposition—i.e. assumed pre-existing levels of susceptibility to contagious diseases—provided doctors with a powerful mechanism for differentiating between rich and poor. This development has its roots in plague, when doctors felt the heat to offer a theoretical basis for the starkly different mortality rates witnessed in richer and poorer sections of London. The explanation they hit upon—that the poor had slightly putrid blood—would remain an orthodox feature of medical discussions of epidemics until the dawn of the nineteenth century, long after forms of fever had supplanted plague as the most pressing domestic biohazard posed by the urban poor. After charting these ideas through a series of eighteenth-century epidemic flashpoints, the paper will conclude with thoughts on how biological notions class in the enlightenment relate to medical

constructions of racialized bodies, which scholars (notably my co-panelist) have shown underwent significant development at the same cultural moment.

#### Objectives

1. Understand how social class influenced theoretical formulations of disease and the body
2. Appreciate more fully how the memory of plague continued to structure British medical thought about other diseases for well over a century after plague's last attack
3. Prompt reflection on the intersectional relationship between biological formulations of class and race at the dawn of modernity

#### **E4. Pathologies of Class, Sex, and Race in the Eighteenth Century**

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##### *Sexuality and the Poxed Body in 18th-Century England*

What do we learn about the sexual culture of 18th-century England by examining instances of venereal disease? There is an abundance of scholarship on sexuality in the eighteenth century, a period marked by both increased sexual activity and increased repression of women's sexual behavior. My study brings disease to bear on these seemingly contradictory phenomena. Using court records and medical cases spanning the late 17th to early 18th centuries, I analyze how the poxed body served as shorthand for sexual transgressions. In cases published in non-learned medical writing on venereal disease, I found healers who diagnosed the disease, in part, by convincing patients to divulge their sexual dalliances. The disease played a similar role in 18th-century depositions from London's central criminal court, the Old Bailey. Venereal disease was equated with illicit sexual behavior, serving as proof of guilt in cases of sexual assault or proof of innocence in its absence. Both sets of sources reveal how bodies infected with venereal disease were used to define moral corruption and characterize a range of archetypes, from the philandering husband to the duplicitous servant maid. Yet, I suggest, venereal disease did more than reflect 18th-century anxieties about rampant sexuality. It offered a vocabulary for articulating a broad range of concerns involving gender and sexuality, including maternity, marriage relations, and domesticity. As such, my paper offers novel insights into the history of venereal disease and demonstrates what we can gain by examining 18th-century sexuality from the perspective of the diseased body.

#### Objectives

1. Show how cultural assumptions can become embedded in conceptions of disease
2. Analyze disease as a site for examining the history of sexuality
3. Demonstrate new approaches to the history of venereal disease

#### **E5. Racial Psychiatry and Childhood Development Studies from the 1950s to the Present**

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*From Delinquent to Disturbed and Back Again: African-American Children and the "Crisis" in Child Mental Health, 1960-present*

In June 1969, the congressionally-funded Joint Commission on the Mental Health of Children reported that only one-third of the 1.4 million emotionally disturbed children in the United States received any mental health care. This damning assessment declared a “Crisis in Child Mental Health,” as the report was titled. But where had this crisis come from? Using archival sources and government and mental health literature, this paper argues that the sudden declaration of a child mental health crisis was primarily due to the recategorization of thousands of African-American children as emotionally disturbed rather than criminally delinquent. In the report, child mental health experts declared that poverty and racism had led to a groundswell of emotional disturbance among African-American children. But these children had not emerged out of thin air. While severely troubled white, middle-class children were increasingly being treated at progressive residential treatment centers (RTCs) in the 1950s and 1960s, many troubled African-American children requiring institutionalization were sent to punitive training schools with little to no psychiatric care available. A few lucky African-American children from New York could be sent to Wiltwyck, an RTC which specifically sought to treat children from racial and ethnic minority groups and promoted its progressive approach to racial integration. Gradually, increasing numbers of African-American children were accepted and treated at other RTCs. However, growing anti-institutional sentiment, an emphasis on community care, and funding difficulties in the 1970s and 1980s made RTCs an untenable solution for thousands of untreated African-American youth. As a result, many of these children remained under the auspices of the juvenile justice system, relabeled as criminally delinquent. Today, the criminal justice system is the largest child mental health provider in the country, providing minimal psychiatric care to thousands of racial and ethnic minority children with severe mental illness.

#### Objectives

1. Understand how the declaration of a “child mental health crisis” in 1969 was dependent on the recategorization of African-American children as emotionally disturbed rather than criminally delinquent
2. Examine the ways in which psychiatric diagnosis and race interacted in the late twentieth century in the United States
3. Assess how the history of African-American child mental health can help us understand the current limitations of the juvenile justice system

#### **E5. Racial Psychiatry and Childhood Development Studies from the 1950s to the Present**

Dennis Doyle: St. Louis College of Pharmacy, Saint Louis, MO, USA  
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##### *Seduction of the Invisible: Child Guidance Literature and the Erasure of Black Homosexuality, 1954-1955*

This paper examines how sessions psychiatrist Claude Zeer conducted with then-twelve-year-old Samuel R. Delany at the Northside Center for Child Development in Harlem became a case study presented in psychologist Kenneth B. Clark 1955’s *Prejudice and Your Child*. An anti-racist activist and psychologist best-known for his contributions to the landmark 1954 *Brown v. Board of Education* Supreme Court case, where he helped argue that racial segregation psychologically harmed African Americans, Clark intended for this work of popular psychology to support that argument and expose more Americans to it, tapping into the growing postwar market for child guidance books on juvenile delinquency. One of the Center’s former psychiatric patients, whose case file Clark mined for material, was acclaimed science fiction writer, Samuel R. Delany. A comparison of *Prejudice and Your Child* and Delany’s recollections of those encounters reveals that Clark had chosen to leave out any mention of homosexuality and sexual

fantasy—the main problems Delany’s psychiatrist Zeer had been working on with his patient. Clark’s omission of sexuality—homosexuality in particular—is glaring considering it featured prominently in many popular postwar books on delinquency including Robert Lindner’s *Rebel Without a Cause* and Fredric Wertham’s *Seduction of the Innocent*. This paper will argue that Clark withheld evidence of his patient’s same sex-desire as a civil rights strategy, generating unintended consequences. Clark excluded any mention of homosexuality’s presence in Harlem so as not to distract from his argument that racism and other factors external to the black community were responsible for social problems it experienced. Nevertheless, one consequence was that this elision helped reinforced a concerted effort on the part of black political elites to shore up the black community’s reputation for “respectability,” rendering sexual nonconformity politically invisible.

#### Objectives

1. Analyze the role that political considerations that can possibly play in the decision to transform a psychiatric case file into either a publishable case study
2. Examine the ways in which the public presentation of medical information has sometimes generated unintended consequences for the patient communities involved
3. Raise awareness of the complex ways in which ideas about race and homosexuality can intersect in the framing of the public discourse regarding a mental health issue

#### **E5. Racial Psychiatry and Childhood Development Studies from the 1950s to the Present**

Nic John Ramos: Brown University, Providence, RI, USA  
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#### *Pathologizing the Crisis: Psychiatry, Policing, and Racial Liberalism in the Long Community Mental Health Movement*

The community mental health movement has been generally regarded as a benevolent movement that replaced old notions of psychiatric racism with new ideas about the normality of race. Few studies, however, have explored the movement for its active support for new surveillance and policing strategies, particularly broken windows theory, a policing approach partly responsible for the expansion of prisons in the United States after the 1970s. Looking to racially liberal approaches to psychiatry in the 1960s and 1970s crafted by integrationist psychiatrist Louis Jolyon West and black nationalist psychiatrist J. Alfred Cannon at the University of California, Los Angeles, this paper demonstrates that cultural and biological explanations for racial violence in civil rights and black nationalist discourses renewed surveillance on poor people of color that resulted in increased forms of incarceration, segregation, and discrimination for them by the 1980s. Rather than forward racial justice, I argue that psychiatric discourses arguing for the racial sameness of white and black minds in the 1960s and 1970s relied on scientific and cultural narratives centered on child development, gender, and sexuality that obscured the processes of racial capitalism that continued to produce poverty and sickness in black communities.

#### Objectives

1. Analyze how etiological and epidemiological explanations for violent and anti-social behavior rooted in culture and biology coalesce around discussions of race and class
2. Illuminate the role medicine plays in supporting and reinforcing new policing practices such as broken windows policing



3. Account for psychiatry's general shift away from methods focused on psychoanalysis, social psychiatry, and social welfare programs before the 1960s and towards methods in biological psychiatry, neuroscience, and psychopharmacology

## **E6. Art and Architecture Through the Medical Lens**

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### *Jean-Martin Charcot and the Medicalization of Religious Experience in the Late Nineteenth Century*

Nineteenth century Europe witnessed a startling number of well publicized cases of extreme spiritual experiences. Dozens of women, and especially young girls, claimed to have visions or encounters with the Virgin Mary; some regularly experienced the bloody stigmata of the crucifixion on their own bodies; others witnessed the miraculous healing of injury and disease after visiting a shrine. Consistent with the anticlericalism that dominated medical circles in late nineteenth century Paris, neurologist Jean-Martin Charcot regarded such experiences as instances of hysteria that were misinterpreted by the mentally ill through the distorting lens of piety. He insisted that these women—and, less frequently, men—were, like their saintly predecessors of centuries past, actually victims of hysteria that only a society that had reached an advanced stage of development could correctly identify. He and several of his colleagues devoted articles and books to the analysis of religiously themed art, pointing out how closely the poses depicted in the works resembled the four stages of the classic hysterical attack that he had described and illustrated. But while Charcot characterized his own patients' accounts of religious experiences as delusions and hallucinations, he nevertheless found them worthy of concerted and repeated study. Although historians have tended to see Charcot's publications on religion and mental illness as unduly influenced—even outright distorted—by his anticlerical politics, this paper argues that in the later stages of his career, Charcot's work on hypnosis, on "retrospective diagnosis" in art, and contemporary research on the influence of ideas on the senses, led him to a more nuanced understanding of the complex interaction between psycho-spiritual states and physical pathology. Using the text *Les Démoniaques dans l'art* (1887), co-written by Charcot and the anatomist/artist Paul Richer, and Charcot's essay "*La Foi qui guérit*" (1892), my paper also suggests that Charcot's well documented interest in the visual representation of mental illness opened another pathway—largely unrecognized by scholars—for him to see the connections between mind and body.

#### Objectives

1. Recognize dynamic interrelationship between medicine and society (esp. religion, art, politics)
2. Promote tolerance of unconventional and ambiguous sources of evidence
3. Understand dynamic history of medical ideas

## **E6. Art and Architecture Through the Medical Lens**

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### *The Changing Design of the Minimum Effective Hospital (and its Consequences) 1900-1950*

If the unhealthiness of the inhabitants of small towns, rural areas, and underprivileged communities in America was a matter of deep national concern in the early twentieth century, the solution seemed obvious—provide those communities with modern hospitals. The anticipated outcomes were impressive—hospitals would modernize the local “backwoods” practitioners; attract more doctors to underserved areas; provide access to modern medical treatment to all citizens; and improve the health of the nation. The architecture of the hospital was critical to obtaining these results. A traditional pavilion-ward facility (full of large wards and little else) was outmoded, incapable of supporting modern medical practice. The additional spatial requirements for a modern hospital, however, were expansive and expensive. Journals and newspapers were full of the latest and greatest hospitals with their hundreds of beds; diagnostic, therapeutic, outpatient and surgical departments; clinical and research laboratories; specialized medicine and collaborative spaces; sterile laundries and centralized services; and physicians’ offices, lockers, and lounges. Such a facility was well beyond the reach of small communities. The small (yet still fully-equipped, efficient, and cost-effective) general hospital posed an intensely difficult design problem even for experienced hospital architects and consultants. It was an impossibility for architects and doctors in remote locations with no prior hospital experience. A number of publications (including John Hornsby’s 1916 article series on “Small Community Hospitals”; the *Modern Hospital’s* small hospital design competitions of 1922 and 1944; Appendix “A” of the Hospital Survey and Construction Act of 1946; and the 1948 Public Health Service, Division of Hospital Facilities’ type plan for a “Twenty-Five Bed Hospital”) functioned as sources of information for remote hospital projects. They set the “standards” for the minimum effective hospital of the time. This talk discusses the changing designs provided by these publications. Whether they set the bar too low or too high, they established not only the physical shape of the small hospital, but the nature of “modern” medical practice across mid-century America.

#### 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

#### **E6. Art and Architecture Through the Medical Lens**

José Carlos Avelãs Nunes: CIUHCT - InterUniversitary Centre for the History of Sciences and Technology, University of Lisbon, Lisbon, Portugal  
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#### *Between Three Coffin Boards—a Healing Breeze. The Sanatoria: Architecture as (the) Treatment for Tuberculosis (1870-1950)*

Between the end of the 19th century and throughout most of the 20th century, tuberculosis became the focus and the microscope of the Portuguese society as the most lethal and worrying contagious disease. Sanatoria architecture was the exclusive instrument capable of fighting the white plague, in the sense of prophylaxis and treatment, assuming functions of disease container, while replicating the organization of the city at a micro-scale. As spaces of science, architecture and medicine, sanatoria allowed a close symbiosis with mutual dependencies between these various areas of knowledge. Nevertheless, the consumptive patient was cloistered into four walls: from months to several years. How did they survive in a therapeutic prison? Values like sociability, architecture and prophylactic measures applied in an entire society: specifically, inside a health city dissimulated as an epithet of panopticon. Architecture played the main role in the theatre; physicians, doctors, architects and other defining actors were side-

by-side, defining a mutated typology. Evolution, mystification and transformation from the inside body to the outsider playground, from cure gallery to the isolation room must be analyzed using various light focus, or even pluricentriclamps. To such level had medicine configured healing architecture? Through sanatoria's building and architectural plans, organizational schemes and typological preponderance, there will be analyzed the stages of the tuberculosis combat involving various actors—physicians, architects and a profile of power—using a multidisciplinary prism. From plans to actions, based on intensive archive research, the prism will show the many colors from the same white architecture. At the same time, it is proven that architecture of tuberculosis is only explained by the history of medicine (and by STM approaches).

#### Objectives

1. Gain a deeper understanding of illness and suffering; a broader understanding of drugs and treatments, the importance and the role of techno scientific places and institutions
2. Demonstrate the importance of the history of sanatoria and hospitals in further architectural projects and medical programs, for healthcare
3. Learn from the past to predict future consequences and how to deal with the uncertainty; comprehensive study of the importance of architecture to the wellbeing of patients

#### **L4. Digital Tools for Teaching Early Medicine to a New Generation**

Mary Fissell: The Johns Hopkins University, Baltimore, MD, USA

Emily J. Clark: The Johns Hopkins University, Baltimore, MD, USA

Kathleen Crowther: University of Oklahoma, Norman, OK, USA

Elaine Leong: University College London / Max Planck Institute for the History of Science, London, UK

Lisa Smith: University of Essex, Colchester, UK

This lunchtime session presents a range of digital humanities tools for teaching pre-modern medicine, either as a part of a larger survey, or on its own. Mary Fissell opens with an introduction to the challenges of teaching early medicine, which can seem remote or irrelevant to an undergraduate, and then the panel introduces a range of digital tools to address some of these challenges. Kathleen Crowther discusses assigning the writing of Wikipedia entries, covering practical strategies for using Wikipedia in the classroom, including examples of articles written by students on early medicine topics. She will also address some of the pedagogical benefits of Wikipedia assignments, one of which is making students careful and critical users of Wikipedia. Lisa Smith demonstrates some of the assignments and projects that her students have completed using her Sloane Letters Project (digitized correspondence of Sir Hans Sloane). Elaine Leong will represent the Early Modern Recipes Online Project, which creates searchable full-text versions of handwritten medical and culinary recipe books, introducing how colleagues teach students to become "citizen humanists." Leong and Emily Clark will use the Reading Early English Medicine project to discuss Platin, Voyant, and Palladio, freely-available data visualization tools. After the formal presentation, each speaker will join a lunch table to foster conversation and answer questions. Our goals are to convey our enthusiasm for teaching early medicine and to illustrate specific pedagogical tools and techniques. To make the session accessible to a broad audience, all presentations will be posted to the AAHM's teaching blog ([teachhistmed.com](http://teachhistmed.com)), where discussion can continue.

#### Objectives

1. Characterize challenges associated with teaching early medicine
2. Assess a range of digital tools for teaching history of medicine topics
3. Demonstrate the use of data visualization tools in the classroom

#### **L5. Roundtable: History of Medicine in Africa**

Anne Pollock: King's College, London, UK

Ogechukwu Williams: Creighton University, Omaha, NE, USA

Julia Cummiskey: University of Tennessee, Chattanooga, TN, USA

Heidi Morefield: The Johns Hopkins University, Baltimore, MD, USA

Abena Dove Osseo-Asare: University of Texas, Austin, TX, USA

This roundtable symposium focuses on the challenges and rewards of studying the history of medicine on the African continent. Africa has been historically underrepresented in narratives of the history of medicine and public health—with this discussion, we hope to explore not only why this is (including the under-representation of African scholars in the field; the difficulty in locating sources; and a lack of perceived “significance” to broader narratives, particularly for pre-colonial time periods) but also ways in which we can work to overcome these problems. Roundtable participants have worked in a geographically diverse range of African countries, including Ghana, South Africa, Nigeria, Uganda, and the Democratic Republic of Congo, and with a range of sources, including archives, personal papers, oral histories, and ethnography. We hope to bring historians of medicine interested in all geographic areas together to discuss ways in which we can broaden the field to include more African content, sources, and scholarship, especially in the teaching of survey courses. We will also seek to problematize the politics of representation, particularly for non-African scholars working at US-based institutions.

#### **Objectives**

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

#### **L6. Historians, Reproductive Justice, and the Shaping of Women's Reproductive Health Policy**

Deirdre Cooper Owens: CUNY, New York, NY, USA

Wanda Ronner: University of Pennsylvania, Philadelphia, PA, USA

Margaret Marsh: Rutgers University, New Brunswick, NJ, USA

Elizabeth Watkins: University of California, San Francisco, San Francisco, CA, USA

Johanna Schoen: Rutgers University, New Brunswick, NJ, USA

Jacqueline Wolf: Ohio University, Athens, OH, USA

In 2005, R. Albert Mohler, an influential American Evangelical, called the “separation of sex from procreation”—whether through contraception or the use of assisted reproductive technology—one of the most “ominous” characteristics of contemporary society. In 2009, one in three births in the United States was by cesarean section, and leading obstetricians defended that development using the language of reproductive “choice.” In 2017, a pregnant immigrant teen in federal custody had to bring

suit against the government to obtain an abortion. In 2018, New York City removed a statue of J. Marion Sims, who developed his techniques in gynecological surgery by experimenting on enslaved and poor Irish immigrant women, from its prominent position at the edge of Central Park. As the first three scenarios attest, the reproductive rights that many American women have taken for granted for two generations are now in jeopardy, and the removal of one statue does not reverse this trend. Not only is reproductive health care increasingly beyond women's reach, whether due to race, poverty, or geography, but the term "reproductive choice" has been exploited to inhibit criticism of the overuse of unnecessary and invasive procedures that are often harmful to women, particularly during childbirth. The proposed interdisciplinary panel brings together scholars whose research encompasses a broad range of reproductive issues, from contraception, to infertility and assisted reproductive technology, to childbirth, to the role of race and class in the history of gynecology and reproduction. This workshop suggests how historical scholarship can be used to assess and change the direction of contemporary public policy affecting women's reproductive rights. The brief presentations by each panel member are designed to spark robust discussion.

### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Deepen understanding of illness and suffering
3. Identify successes and failures in the history of medical professionalism

### **F1. From the Cradle to the Grave: Infanticide, Euthanasia and Reproductive Surveillance in American History**

Felicity Turner: Georgia Southern University, Savannah, GA, USA  
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#### *The Physician, the Midwife, & the Corpse: Interpreting Infanticide in the Nineteenth-Century United States*

In May 1858, a jury of inquest convened in Haywood County, North Carolina, to investigate the death of a newborn infant. The community suspected Caroline Morrow of infanticide. A range of witnesses testified at the inquest. Those who spoke before the jurors were local farmers and the wives of those farmers, people who worked in the fields and never read a medical journal. Yet, the residents of Haywood County spoke with authority about the body of Caroline Morrow and her pregnancy, testifying about Morrow's smell; what she looked like; what they heard; and how the afterbirth tasted and felt to the touch. Together, the people of Haywood County shared their understanding of a woman's pregnant body. Two white, male medical doctors also attended the inquest. Their interest was the infant's corpse, not the body of Caroline Morrow. The jurors, therefore, heard from the doctors too, who were unhelpfully equivocal about the status of the infant—dead or alive—at birth. Drawing upon the information from these multiple sources—midwives, the accused woman, nosy neighbors, and the physicians—the jury of inquest constructed a narrative, one that endeavored to make sense of the infant's death. Drawing on inquests from across the nineteenth-century United States, the paper argues that ordinary Americans used the legal forum of the inquest as a site to negotiate and interpret bodies, both dead and alive. Nineteenth-century Americans did not privilege professional expertise, such as that possessed by medical doctors or lawyers as singularly authoritative. Rather, inquest records

demonstrate that local communities drew upon multiple sources of information including autopsy reports, medical pamphlets, the accumulated experience and wisdom of midwives, and legal treatises in order to assess evidence and reach determinations about culpability in cases of infant death and infanticide.

#### Objectives

1. Analyze the role played by gender and race in constructing knowledge about the body in history
2. Identify the function of the legal process and law in constituting knowledge of the human body in history
3. Recognize the dynamic interrelationship between medicine and society through history

#### **F1. From the Cradle to the Grave: Infanticide, Euthanasia and Reproductive Surveillance in American History**

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*“I had Murder in my Heart towards my Child”: Laboring Women and Infanticide in Early New England*

This paper examines the history of the body as seen through cases of women executed for the crime of child murder in New England between 1690 and 1770. These so-called “marginalized” figures—Native American, black, enslaved, and poor white women—have not typically been the focus of Anglo-American colonial history. These women, I argue, were crucial actors in the process of knowledge production regarding women’s bodies and labors—particularly in the gendered concepts of cleanliness, sexuality, spirituality, and domestic labor. Through close readings of printed confessions, conversion narratives, execution broadsides, and manuscript court records, I argue that we can recover something of the perspectives and experiences of marginalized women regarding their sexual, working, and spiritual lives. Though highly mediated by male authorities, these sources reveal close interactions and negotiations between elite men and condemned women in shaping cultural understandings of the body as both corrupting and life-giving. Cultural discourse surrounding the act of infanticide challenged the idea of women’s “natural” reproductive bodies, being seen as both unnatural and unwomanly. Similarly, expectations of obedience and servitude framed the acts of fornication and the concealment of pregnancy as among the highest sins. However, women themselves emphasized their roles as dutiful workers in order to reframe their own criminal narratives. Details of the material realities of these women’s everyday domestic labors were woven into the fabric of their printed narratives, crucially shaping how their lives and bodies were imagined, communicated, and retold. The physical bodies of women who supposedly rejected their roles as mothers were presented as culpable in child murder; those same bodies were also crucial to some women’s salvation and spiritual “motherhood.” The view from the margins that these “infanticidal mothers” provide sheds light on women’s experiences and networks of cultural power that are otherwise obscured.

#### Objectives

1. Analyze the physical and emotional experiences of enslaved and working women
2. Identify understandings of the gendered and reproductive body in history
3. Broaden the racial and social picture of early New England

## **F1. From the Cradle to the Grave: Infanticide, Euthanasia and Reproductive Surveillance in American History**

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*“A Painless and Peaceful Death”: Women Physicians and Euthanasia in Progressive-Era America*

In 1905, Oregon physician Ella Dearborn proposed a radical solution to what she saw as a growing crisis of degeneracy in America. She argued that the nation needed a systematic program of extermination for its problem populations. Unlike other pro-euthanasia physicians who advocated for the legal killing of “deformed” infants, Dr. Dearborn believed that adults categorized as incurably ill, insane, criminal, or degenerate also should be humanely euthanized. Each state, she suggested, could form a Board of Euthanasia—an organization staffed with the most qualified physicians and tasked with adjudicating cases. Those deemed unfit for life would be given a “painless and peaceful death” with chloroform. Responding to critics who feared all Americans, not just degenerates, would be required to pass her life-or-death examination, Dr. Dearborn challenged her readers, “Well, why not? Are you afraid you are below par?” [1] This paper will examine the role of women physicians in the Progressive-Era euthanasia movement. It will first explore how medical women situated the procedure within a maternalist eugenics framework. Physicians like Dearborn advocated a three-step process to uplift: first, accessible birth control information for the masses; second, a “breeding up” program for elite families; and third, sterilization or euthanasia for populations deemed “feeble-minded” or “unfit.” Eugenic uplift was not merely a medical project, it was also a patriotic one. This paper will demonstrate how pro-euthanasia physicians often relied on nationalist rhetoric to argue for the reproductive surveillance of marginalized populations. Finally, this paper will examine how by the 1920s, many women physicians increasingly racialized these arguments, some proposing the elimination of African and Asian Americans through sterilization and euthanasia policies.

[1] *The Spokane Press*, “Would Slay Criminals, Insane, Incurably Ill, and Degenerates,” Sept. 22, 1905, 3.

### **Objectives**

1. Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
2. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy
3. Recognize the dynamic interrelationship between medicine and society through history

## **F2. Diseases of Modern Life**

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*Material Histories of Diabetes Management*

The history of diabetes is most often told as a history of biochemistry and pharmacology, the discovery of insulin, its marketing and standardization, and ends with diabetes becoming a chronic condition rather than a death sentence. Histories of public health then look at the emergence of type II diabetes as a public health concern and at the history of various intervention initiatives. This paper takes a novel

approach to the history of diabetes, reconstructing it through the history of the objects and practices of diabetes management. It applies methods of material culture studies to the analysis of historical apparatus for urine and blood sugar measurement and shows how these apparatus not only present biochemical and technological innovations, but also reflect changing expectations both from and about apparatus users. The transition from physician management to self-management was enabled by a series of innovations in glucose analysis methods, which shifted distributions of skills and competences from physician-experts to apparatus and patient-users. The needs of these patient-users, now living with diabetes, rather than dying from it, led to modifications in apparatus to adapt them to various lifestyle needs, preferences, and skills capacities. Perceptions of this diversification of monitor users is reflected in the proliferation of blood glucose monitor models. Analyzing exemplary apparatus and equipment held in the Insulin and Diabetes Management Collection of the National Museum of American History, this paper explores their design and practices and what they reveal about intersections between the demands and constraints of users and apparatus and the ways in which they shaped one another.

Key words: diabetes, medical apparatus, material culture

#### Objectives

1. Develop awareness for diversity of patient experiences
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 in medical apparatus design

## **F2. Diseases of Modern Life**

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### *Diabetes and Socialism: The Patients' View of a Chronic Disease in Former East Germany*

The second half of the twentieth century saw a sharp rise of diabetics around the globe. Regarding this disease, the world was not divided but socialist countries like East Germany also faced a drastic increase in the numbers of patients with diabetes since the 1950s. With Gerhardt Katsch and his institute, the German Democratic Republic (GDR) inherited a world-leading institute in the research and treatment of the disease in its territory after the Second World War. In this way, diabetes and its treatment also became part of the ideological struggle during the Cold War; especially to claim superiority towards Western countries. In general, the state healthcare system was always praised as being the greatest achievement of Socialism: the GDR Health Minister Ludwig Mecklinger stated in 1981 “[i]n the encounter with the health, and social, care system, Socialism has a name, face, and address for the citizen.” In my paper, I want to discuss the experiences of patients with diabetes in the healthcare system of the GDR. By using archival sources and accounts of eyewitnesses, I will exemplify the way of how patients received their diagnosis, built their disease into their everyday life and life narrative, and how this medical condition influenced their social environment (family, colleagues, and friends). I will argue that the most striking difference between the life of diabetics in the GDR and other countries was the rejection of grass-roots initiatives of self-aid among patients by East German authorities.

#### Objectives

1. Deepen understanding of illness and suffering
2. Develop a historically informed sensitivity to the diversity of patients



3. Acquire a historically nuanced understanding of the organization of other national health care systems

## **F2. Diseases of Modern Life**

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### *The Surprising Epidemiology of Peptic Ulcers and the Historicity of Disease*

In 1959, the RAND Corporation issued a report on the dangers of the “Ulcer Problem.” As bleeding and perforation from ulcers heightened concerns across postwar US and Europe, two epidemiologists in Manchester’s renown Department of Social and Preventive Medicine set out to dissect the rising curve of ulcer incidence. This couple, Zena Stein and Mervyn Susser, recent refugees to Manchester from Apartheid South Africa, found their new project surprisingly complex. Peptic ulcers had been described to them as a classic disease of civilization, rising steadily in the industrialized world under the stresses of modern life. But one afternoon as Zena peered at the data over her husband Mervyn’s shoulder—later remembered as the eureka moment—they saw something unexpected. Although ulcers were on the rise in 1959, each successive new birth cohort seemed to carry a reduced susceptibility to the disease. Their analysis suggested that the incidence of peptic ulcers had crested, and was now in decline. Although this prediction proved accurate, and became a celebrated example of the power of cohort analysis, the results were ignored. Biomedical interests remained focused chiefly on the essential, stable qualities of disease or on short-term changes in diseases that were being “beaten down,” or on the rise. The odd sinusoidal curve of ulcer epidemiology only came back into focus in the 1980s after the discovery of a causal role for the bacterium, *Helicobacter pylori*. The epidemiology of ulcers now hinted at a global microbiological ecology of the gut, changing rapidly over a single century, with the disease seeming to outrun the pace of human social change. A minor research program emerged attempting to explain these rapid bio-historical shifts, although as one gastroenterologist lamented, as he struggled to account for the disease, “we are not social historians.”

#### Objectives

1. Understand more about the twentieth-century epidemiology of peptic ulcers
2. Place the investigation of peptic ulcers into the historical context of mid-century epidemiology
3. Characterize how debate over peptic ulcer epidemiology diverged from more conventional views on the historicity of disease

## **F3. Moo-dern Medicine: Medicine and Animals in the Age of Factory Farms**

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### *Government Cheese: The Fall of Therapeutic Husbandry and the Rise of Methadone Therapy at Lexington Narcotic Hospital, 1935-1970*

When Barney Ross, a former boxing champion, entered Lexington Narcotic Hospital in 1946, newspapers broadcast his upcoming treatment. “Since few of the addicts know a trade, the hospital is equipped to teach some skills,” one reporter stated. The reporter continued, “the big layout includes clothing and

furniture factories, a dairy farm, laundry, bakery.” Abraham Wikler, Lexington’s director of research, averred in 1951 that Lexington provided to patients “a wholesome environment with adequate educational, recreational, and occupational facilities.” By the late 1970s, however, the cows were gone. Quite literally, the cows that had once distinguished the treatment regimen, were put out to pasture. How do we explain the fall of therapeutic husbandry, and, by extension work therapy, at Lexington? One possible answer regards methadone. Historians have persuasively interpreted the rise of methadone maintenance in terms of urban renewal, economic recession, and medical optimism and nihilism alike. I, instead, retell the rise of methadone through the fall of therapeutic husbandry at Lexington. The US Public Health Service-run hospital in Kentucky was the largest research and treatment site for drug users in the United States, perhaps ever. Its research shaped how clinicians across the United States approached addiction throughout the twentieth century. Whom did physicians and therapists believe benefitted from farm work and occupational training? What therapeutic value did they see in milking cows? Did clinicians become disillusioned with work therapy, especially in comparison to methadone and newer treatment modalities? And, what can the fall of therapeutic husbandry and the rise of methadone therapy at Lexington reveal about the perceived etiology of addiction between the mid-1930s and early 1970s? Using Lexington’s hospital records and psychiatry and psychology journals, I show how physicians’ pessimistic interpretations of the US labor market in the mid-1960s dissipated trust in work therapy, and fostered support for methadone.

#### 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. Deepen understanding of illness and suffering
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

### **F3. Moo-dern Medicine: Medicine and Animals in the Age of Factory Farms**

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#### *Dairy Colonialism: Milk and American Indian Reservations, 1900–1935*

“The health of the Indians is not what it should be,” August Duclos wrote to the commissioner of Indian affairs in February 1917. Duclos, the agent at Colorado River Reservation in western Arizona, suggested that “if each family has a good supply of milk and butter, it will gradually improve their state of health.” But the introduction of dairy represented a larger agricultural and epidemiological transition across Indian Country; cows were both agents of colonization and able to soften its effects. As tuberculosis ravaged Indian boarding schools and reservations, milk was the primary therapy employed to strengthen the sick. Though, bovine tuberculosis in unpasteurized milk could also infect the bodies it was supposed to cure. In this paper, I utilize federal reports and correspondence about dairy herds and Native health to argue that the introduction of cows and their milk to reservations and boarding schools is an understudied dimension of Native health, nutrition, and environmental transformations to Indigenous lands in the early twentieth century. Native health had declined precipitously by 1900 because of 1) efforts to change Indigenous farming methods and food preparation, limiting American Indians’ ability to access healthy foods, and 2) the simultaneous influx of infectious diseases like tuberculosis. Cows, then, illuminate the connections between land and water use, food preparation and consumption, and federal assimilation efforts against Indigenous people (like boarding schools and land allotment

policies). The historiography of disease and the environment posits a narrative arc from the permeable body, easily influenced by the environment, to the individualized, discrete body that triumphed with the rise of public health in the Progressive Era. However, close examination of debates about and acts of dairy production and consumption reveal the continued significance of the environment to settler colonial ambitions of conquest and the transformation of Native bodies and lands.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Develop an historically informed sensitivity to the diversity of patients, including American Indians and Alaska Natives
3. Understand the dynamic history of medical ideas and practices and their implications for patients and health care providers

### **F3. Moo-dern Medicine: Medicine and Animals in the Age of Factory Farms**

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*From Farm to Pharm and Farm, Again: Tracing Oxytocin in Human and Agricultural Medicine from 1930*

Oxytocin is often described as the “love drug”: a hormone naturally produced in the body to aid in social bonding, reproduction, and childbirth. As a pharmaceutical product, doctors administer oxytocin—called Pitocin—to induce labor and aid in milk let-down for breastfeeding. However, oxytocin’s benefits span outside the scope of human medicine. Dairy farmers use oxytocin to aid in the lactation management of cattle. Echoing prior scholarship in the history of reproduction, a closer examination into the history of oxytocin reveals a complicated exchange between the United States’ pharmaceutical and agricultural industries. Before oxytocin was synthesized in 1953, cattle provided the postpituitary extract necessary for Pitocin production. Parke Davis pharmaceutical company relied on animals and the larger agricultural industry for decades, not only to produce Pitocin but other animal-derived vaccines. Once synthesized, enabling better management and manufacturing consistency of the hormone, doctors popularized the use of oxytocin in efforts to actively manage human childbirth. Veterinarians and dairy farmers also turned to oxytocin for labor management in agricultural animals, and by 1960 dairy farms administered oxytocin to help cows let down their milk. Combining historical methodology with anthropological inquiry, this paper interrogates the decades-long institutional entanglements found between human and animal reproductive medicine. It uses materials from pharmaceutical publications, agricultural journals, farmer and mommy blogs, farm visits, and the Parke Davis Collection from the National Museum of American History to trace the history and current use of oxytocin in both medical and agricultural spheres. I argue that the case of oxytocin raises important questions about how reproductive expectations carry across humans and animals, including how labor and milk production should be experienced and regulated. Oxytocin’s history thus simultaneously reinforces and challenges current debates about the use of hormones in human medicine and the American dairy industry.

#### 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. Recognize the dynamic interrelationship between medicine and society through history
3. Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education

#### **F4. Reinterpreting HIV/AIDS: Imperial Eradication Campaigns, Venereal Disease in New York, and Patient Activism**

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##### *Invisible Suffering: AIDS, Activism, and the Politics of Medical Treatment*

In 1984, a San Francisco AIDS patient with the skin cancer Kaposi's sarcoma (KS) visited a private dermatologist and participated in a private clinical study for an experimental drug. The drug, dinitrochlorobenzene (DNCB), was affordable and easily accessible yet unapproved by the Food and Drug Administration. KS was known to attack suppressed immune systems and lowered patients' T-cells, which are used to fight infections. The physician, however, found that after "painting" DNCB on his patients' KS lesions, their T-helper and T-suppressor cell counts increased, signaling that their immune systems were not entirely compromised. This marked the beginning of a campaign to share the makeshift drug with other PWAs and get the drug authorized by the FDA. Known as the Guerrilla Clinic (GC) and comprising of middle-class gay white male PWAs, the organization utilized physicians and journalists as an extension of their group. While physicians shared their research with the GC, journalists published physicians' progress reports on DNCB's effectiveness. This paper examines how race and class enable the group's success in their quest for participatory scientific research. Their accomplishments not only showed the importance of patient advocacy but were also part of a larger process that rendered the experiences of black AIDS patients and activists invisible. Many physicians failed to recognize that white PWAs' concerns were not the same as their poor and working-class black and Latino counterparts and reinforced longstanding health inequalities. Scholars focusing on late-twentieth century black health issues have documented the AIDS crisis as part of a longer black struggle for adequate health care. By using the Guerrilla Clinic as a case study for a broader argument, one can understand how race-based health and health care disparities contributed to the AIDS crisis in black communities and how unconventional approaches to the epidemic in black communities were overlooked.

##### Objectives

1. Examine the Guerrilla Clinic's preventative measures during the early stages of the AIDS epidemic
2. Recognize physicians' approaches to AIDS patients from different racial, economic, and cultural groups
3. Critically examine ways in which AIDS activist organizations challenged longstanding health care disparities

#### **F4. Reinterpreting HIV/AIDS: Imperial Eradication Campaigns, Venereal Disease in New York, and Patient Activism**

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##### *Yaws Eradication, the World Health Organization, and the Origins of HIV/AIDS*

In recent years, scholars have begun identifying the historical roots of HIV/AIDS. Genetic comparison of archival sera indicates that HIV first appeared among humans in the 1920s, and its subsequent spread

throughout Africa has been linked to mass treatment campaigns carried out by Western imperial authorities in the 1930s and 40s. In addition to being a legacy of the colonial past, HIV/AIDS was a product of the Cold War—and in particular, of the World Health Organization’s yaws eradication program. Between the 1950s and 1980s, the WHO made yaws a centerpiece of its disease control efforts, launching “mass penicillin campaigns” in dozens of countries across Africa, Asia, and the Pacific. During this period, the global prevalence of yaws declined from 50 million cases to just over 2 million. This decline notwithstanding, the WHO’s efforts were not an unmitigated success. In the 1950s, scientists expressed concerns about potential negative consequences of the WHO’s anti-yaws work—including the possibility that this might facilitate the spread of syphilis, a disease caused by bacteria (*Treponema pallidum*) so genetically similar to that which causes yaws (*Treponema pertenue*) that the two confer a degree of immunological cross-protection on each other. Experimental laboratory studies supported this theory, and during the 1960s and 70s, syphilis began appearing in many countries that had launched anti-yaws campaigns. In its official pronouncements, the WHO presented syphilis’ spread as evidence that “civilization” had spread to the Third World, but its own yaws eradication project was equally at fault. Moreover, in inadvertently triggering syphilis epidemics throughout the Global South, the WHO’s anti-yaws efforts also facilitated the spread of HIV—whose rates of contraction are higher among those with pre-existing syphilitic infections. Tying together these epidemiological threads, this study contributes to our understanding of the origins of AIDS.

#### Objectives

1. Identify successes and failures in the history of the World Health Organization’s disease-control efforts
2. Develop a capacity for critical thinking about the nature, ends, and limits of medicine and public health
3. Acquire a historically nuanced understanding of the World Health Organization, and the many national healthcare systems it has interacted with

#### **F4. Reinterpreting HIV/AIDS: Imperial Eradication Campaigns, Venereal Disease in New York, and Patient Activism**

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#### *Gay and Queer-Identified Men in New York City Recall Their Experiences of Venereal Disease before HIV*

This presentation will examine attitudes toward and experiences of venereal disease (VD) before the onset of the Acquired Immune Deficiency Syndrome (AIDS) epidemic, as recalled by older gay and queer-identified men in New York City. The research forms part of a broader study exploring the apparent rise of sexually transmitted infections among men who had sex with men in England and North America during the mid-twentieth century. In March and April 2018, eighteen respondents born between 1935 and 1957 completed a questionnaire distributed online and at Manhattan’s main LGBT senior center. Of these individuals, twelve participated in audio-recorded follow-up discussions: nine attended focus group sessions, two sat for individual interviews, and one took part in an interview and a focus group. A trans woman in her eighties also participated in an interview in lieu of a questionnaire. Together, their reminiscences provide a more nuanced picture of gay and queer patients’ VD experiences during decades often overshadowed by the ensuing AIDS epidemic and for which scant documentary evidence is available. These individuals related their knowledge and attitudes about sexuality and disease, including perceived risks, methods of risk reduction, and their most memorable

experience with a venereal complaint before 1981. They predominantly shared stories about syphilis and gonorrhea—with additional discussions of hepatitis, herpes, genital warts, amoebiasis, and crabs—including reflections on their treatment and the quality of care they received. The participants also located their recollections within broader concerns relating to their health and personal fulfillment during the 1960s and 1970s, including fears of violence and the unwanted disclosure of their sexual orientation. Their stories combined levity, seriousness, and poignancy, and were often coloured by the intervening trauma of the AIDS epidemic. Throughout, the presentation will give consideration to the methodological challenges of conducting participatory research on sensitive sexual histories.

#### Objectives

1. Develop a historically informed sensitivity to the diversity of patients
2. Acquire a historically nuanced understanding of patient experiences of venereal disease/sexually transmitted infections
3. Develop an understanding of the methodological issues involved in conducting participatory research on sensitive sexual histories

### **F5. Spirits, Herbs, and Dirt: Medical Knowledge Around the World**

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#### *Medical Research and Hospital at the Juncture of Science and Religion in South Korea*

I analyze the activities of Korean creationists engaged in biomedical practices. Ronald Numbers, Edward Larson, and other historians have studied creationism, especially in the American contexts. However, few have dealt with its Korean variant, and nobody has investigated creationists with biomedical expertise. This presentation will illustrate an interaction between biomedicine and creationism in Korea, which enabled the Korean Association for Creation Research (KACR) to survive and prosper despite the strong scientific criticism. Established in 1981 after Henry Morris, Duane Gish, and other American creationists' visit to Korea, KACR underwent a substantial growth. According to Numbers, Korea became "the creationist capital of the world," with more than 30 percent of its population rejecting evolution. In KACR, leading members with biomedical expertise made crucial contributions to this growth. In creationism, they found many useful things: it prompted some of them to shape and assert their bioethical views amid heated debates on human stem cell research, while leading others to design their research following biblical themes. Among them, a virologist-creationist attempted to find a cure for cancer using viruses, with his belief that they, as God's creatures, were not evil before Original Sin. Another creationist tried to demonstrate the truth of the Genesis Flood using human cells, whose lifespan increased in a high air-pressure condition, which mimicked the elevated pressure under the Antediluvian water vapor canopy that supposedly lengthened biblical figures' longevity, inferred from the Book of Genesis. Yet this research contradicted KACR's bioethical standpoint against abortion, as it relied on cell lines that had been developed from aborted fetuses' bodies. By analyzing these issues, I illuminate an important dimension of the biomedicine-religion relationship, involving creationists' active appropriation of both Scriptures and sciences, which often led them to contradict themselves. Yet I will also explain how this contradiction made creationism so hard to dismantle.

#### Objectives

1. Recognize the dynamic interrelationship between medicine and society through history

2. Promote an appreciation of the significance and problems of religion in modern biomedical exercises
3. Foster a deeper historical understanding of medical research in Asian contexts, facilitating a cross-cultural medical conversation

#### **F5. Spirits, Herbs, and Dirt: Medical Knowledge Around the World**

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##### *Discerning Disease and Divine in the Reformation: A Dialog of Anglican Eucharistic Doctrine and French Plague Theory*

In the sixteenth century there existed an intellectual frontier between the realms of religion, magic, and medicine. This frontier is the world of healing and health. Both physicians and theologians laid stakes that their methodology held the answers for life, health, and longevity. Yet these domains were not mutually exclusive, as theologians borrowed medical language to explain the world around them. This borderland of medicine and theology was opened during the early years of the English Reformation. Catholic theologians and former Catholics not only used the language of medicine to explain their adversaries' positions but believed that improper belief was the cause for the sickness and disease in the world. This debate that started the discourse on healing and medicine was none other than a children's textbook. The document that sparks the intellectual fire is a primer (textbook).[1] This primer is the last-ditch effort of a Catholic theologian to publish a Catholic work in England before Catholicism would be officially stamped out. With the Henry VIII's divorce and declaration naming himself the Head of the Church of England, this document is the one of the final pleas to the Catholic faithful before their island home would be enveloped with the "pestilent infection" of the Protestant faith. This dialog sparked a debate on how much control over perceived right belief affected not only one's soul, but their physical bodies and wellbeing. In this paper I argue that the fledgling Church of England uses spiritual means such as traditional prayers, material objects, and the sacraments of Baptism and the Eucharist as spiritual medicine with physical consequences to combat sin, heresy, and disease and by this manner establishing themselves as the means of health and salvation in England.

[1] The full title of the primer is *A prymer in Englyshe with certeyn prayers [et] godly meditations, very necessary for all people that vnderstonde not the Latyne tongue. Cum priuilegio regali.*

##### Objectives

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

#### **F5. Spirits, Herbs, and Dirt: Medical Knowledge Around the World**

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##### *The Social Construction of Pathogenic Dirt: Changing Interactions Between Medicine and Cleanliness Practices in the Nineteenth Century*

“Everyone universally finds dirt offensive,” anthropologist Mary Douglas, the founder of the field of cleanliness studies, suggested before continuing: “But what counts as dirt? It depends on the classifications in use.” Her point was that dirt does not consist of a certain kind of matter, but is rather defined in the eye of the beholder. Taking the assumption that cleanliness practices and definitions of dirt are historically shaped as my starting point, I will examine the historicity of contemporary attitudes and practices to cleanliness. In order to do so, I will investigate the historical change of some characteristics of contemporary cleanliness beliefs: that dirt spreads disease, that it can be identified by its stench, that it should be kept in check by daily cleaning, that it may be present even when it can be neither seen nor smelt, and that the body needs to be clean even beneath the clothes for a person to be truly dirt-free. Using 8,807 digitised yearly reports from Swedish provincial doctors between 1820-1900 as sources, I claim that most of these aspects of our contemporary conceptions of cleanliness emerged during the late nineteenth century. These definitions of cleanliness were created through a conflation of three different sets of cleanliness practices which had previously focused on separate objects, used distinctive ways to determine the presence of dirt, and employed dissimilar methods of cleaning. I call these three categories “everyday dirt,” “miasmatic dirt” and “contagious dirt”: each relates to filth, the putrid, and germs, respectively. “Everyday dirt,” the dirt created from everyday living, thus became a central object for medical intervention by merging with two other categories of dirt which during the early nineteenth century had been separate from it. That everyday dirt could be seen as being detectable by smell, hidden, pathogenic and potentially lethal, were all properties transferred from the categories of “miasmatic” and “contagious” dirt at the end of the nineteenth century.

#### 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

#### **F6. The Physician in Literature**

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##### *The Physician as Consulting Detective: From Baker Street to Harlem (1920-1934)*

“I thought I’d been called to a patient, not a corpse,” says Dr. John Archer at the outset of the investigation in *The Conjure-Man Dies* (1932), written by Harlem Renaissance writer and physician, Rudolph Fisher (1897-1934). It centers upon the mysterious death of the eponymous “conjure-man,” N’Gana Frimbo, a psychic and spiritualist. Throughout, Fisher is at pains to show that the acts of diagnosis and detection share a common lineage—combining reasoning, speculation, investigation, and case narrative. As such, Archer becomes central to the investigation alongside the NYPD detective Perry Dart. A radiologist and researcher, Fisher was equipped with particular insight into diagnostic processes and the uncovering of hidden truths. *The Conjure-Man Dies* is situated within the mode of classical detective fiction, which absorbs contemporaneous notions of medical epistemology—clinical reasoning, scientific inquiry, and an emphasis on the rational. Indeed, Archer shares much with his Victorian antecedent, Sherlock Holmes, the “consulting detective” whose investigative techniques were modeled on those of Arthur Conan Doyle’s surgery professor Dr. Joseph Bell. The novel was also published at the



peak of the inter-war “Golden Age” of detective stories, enmeshing Fisher amongst writers such as R. Austin Freeman, Agatha Christie, and Dorothy Sayers. This paper presents Rudolph Fisher and *The Conjure-Man Dies* as a key, and under-studied, moment within a cultural and intellectual history of diagnosis and detection in the U.S. Using literary, biographical, archival, and published medical sources, it argues that Fisher deploys traditional detective and diagnostic tropes only to upend them. Displacing the myth of the lone, rational detective or detached, hyper-logical physician, he instead presents a doctor and detective rooted in the Harlem community and a mystery embedded in civic life. It is an investigation where rationalistic inquiry proves to be insufficient in the context of complex mystery, mediated by racial politics, folk culture, and mysticism. Fisher in fact broadens the epistemological scope of the detective novel and the diagnostic method, taking up questions about the validity of scientific inquiry, racism and nationalism, and how humanity produces and understands knowledge writ large.

### Objectives

1. Understand the history of diagnosis in American medicine as influenced by sociopolitical, cultural and literary currents such as detective fiction, the Harlem Renaissance, and World War I
2. Further the dynamic intellectual and cultural history of African-American physicians and writers in the development of American biomedicine and culture
3. Engage with skepticism, uncertainty, and ambiguity surrounding issues of diagnosis, detection, and surveillance, particularly viewed through the lens of under-represented historical and cultural voices

### F6. The Physician in Literature

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#### *Surgery and Ulysses: A Chronicle of James Joyce and Leopold Bloom*

James Joyce was the most significant and innovative novelist of the 20th century. His novel *Ulysses*, among the greatest works of world literature, is a masterpiece that integrates multiple literary techniques. *Ulysses* is a celebration of the commonplace, a one-day chronicle of events in the life of Leopold Bloom, an “everyman”, on an otherwise inconsequential day in Dublin, Ireland, June 16, 1904. In this remarkable work, Joyce revealed the essence of humanity and created a vital and compelling rendering of society. Very little has been written about the importance of surgery in both James Joyce’s personal life and in *Ulysses*. James Joyce was born in 1882 and entered medical school at University College Dublin in 1902. He spent only six months studying medicine before transferring to the Sorbonne, but enjoyed many evenings in the doctors’ quarters of Dublin hospitals for their social aspects. Joyce had an intense knowledge of human disease. Illnesses, medical students, doctors and hospitals are central in *Ulysses*. Joyce viewed medicine as a societal and scientific force and made it a critical component of his characters’ lives. As an example, Chapter 8 of *Ulysses* concerns itself with the gastrointestinal tract; Joyce describes its prose as “peristaltic”. Joyce critics have commented upon the significance of the physiological digestive details to this chapter’s structure. The alimentary model shapes the narrative form and links to the content. Leopold Bloom’s hunger conveys alimentary connotations to everything he sees; he attributes every person he meets with edible qualities. Stylistically, the episode symbolizes digestion. Borborygmi sporadically interrupt the text as onomatopoeia. Bloom appears to be immersed in a text that linguistically replicates the physiology of digestion. This chapter is a delight for the alimentary tract surgeon. Joyce’s personal medical problems also had a considerable influence on his life and his art. Herein, his glaucoma and its accompanying ten

operations and resultant blindness, his alcohol abuse, and final acute abdominal surgical illness will also be discussed.

#### Objectives

1. Develop the capacity for critical thinking about literature and surgery
2. Recognize the dynamic interrelationship between medicine and society through literature
3. Identify successes and failures in the history of glaucoma and peptic ulcer disease treatment

### **F6. The Physician in Literature**

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#### *Nervous Men and the Doctor-Patient Relationship in the Fiction of S. Weir Mitchell*

Dr. S. Weir Mitchell, famous for proscribing the “rest cure” to American neurasthenics in the Gilded Age, was also a prolific novelist. His fiction was popular and widely distributed. He often used his own patients to inspire the characters in his novels, drawing from his experience on battlefields during the Civil war or in his Infirmary for Nervous Disease. He portrayed common cases of neurasthenia: exhausted, anxious men, overworked by the demands of modern American life who felt nervous about revealing that any vulnerability to a physician. He also characterized physicians as sympathetic experts who understood the pressure of the modern American man very well. While historians often classify neurasthenia as a woman’s disease, Mitchell took men’s mental and emotional distress seriously. This paper argues that he used fiction to recast neurasthenia as a respectable condition for ordinary American men to have; furthermore, Mitchell’s novels offered a doctor-patient script that permitted men’s vulnerability without feminizing them. This body of fiction contributed to changing gendered boundaries between health and illness in the Gilded Age.

#### Objectives

1. Emphasize the role of medical humanities in helping us understand clinical practice from a historical perspective
2. Assess the interplay of social and medical ideas to examine how patients and doctors define illness and health
3. Explore the intersection of medical and cultural history by investigating ways novels and fiction can illuminate historical questions about diagnosis and treatment

### **G1. Institutional Solutions for Incurable Conditions? Heredity and Treatment in Intractable Physical and Mental Illness**

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#### *A Political History of Molecular Medicine*

Recent discussions of “precision” or “translational” medicine have focused on the novelty of using the insights of molecular biology for therapeutic gains. However, molecular medicine has much deeper historical antecedents. It arose as much from efforts to address failure as from hope in its therapeutic

potential. In particular, political maneuvering by scientists and policymakers in the aftermath of the disappointment of the 1970s War on Cancer contributed significantly to the development of molecular medicine as a goal for doctors, scientists, policymakers, and, later on, biotechnology entrepreneurs. Although launched with great fanfare, the results of research strategies embraced by the War on Cancer, such as chemotherapy and vaccine, lagged far behind the promises that had been made on their behalf. This opened space for intense disillusionment in the late 1970s, earning it the epithet a “medical Vietnam.” Environmentalists and labor activists condemned the “cancer establishment” for focusing the disease in the laboratory rather than addressing its broader social roots. The budget of the National Cancer Institute (NCI) started to decline. The NCI’s eroding political fortunes were matter of intense concern to the emerging ranks of molecular biologists, who regarded cancer research as vital to the future growth of their field. These two groups seemed unlikely to cooperate. Molecular biologists had fervently opposed the War on Cancer’s effort to direct basic research towards therapeutic gains. However, in the early 1980s the potential of framing cancer as a molecular disease caused by “oncogenes” instead of viruses or chemicals provided a means of bridging the political goals of basic science and clinical practice. This promise succeeded in shoring up the alliance between the federal government and molecular biology, while forcing broader questions regarding the social and environmental roots of disease back to the periphery of medical policy discussions.

#### 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

#### **G1. Institutional Solutions for Incurable Conditions? Heredity and Treatment in Intractable Physical and Mental Illness**

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#### *Violent Shocks and Reverses of Fortune: The Etiology of Criminal Insanity in Gold Rush California*

On June 11th, 1857, Ohio native Stephen Dorsey was admitted to the California State Insane Asylum in Stockton. Dorsey, who was noted to be “violent-at-times and dangerous,” had been “crazy for about ten days” following a “loss of property.” Two months later, Horace Cassi was admitted as well, this time due to “masturbation and disappointment in mining.” In the two decades following the 1848 discovery of gold in Coloma, California, the state came to gain a nationwide reputation for its apparently high rates of insanity—during this time, “miner” was the most common occupation of patients in the state asylum. Admissions and discharge records reflected brief stays, with the cause of insanity often assigned to circumstantial conditions such as disappointment, “ill success,” or “failure in business.” As California’s population expanded, physicians and county judges found it increasingly difficult to evaluate the mental state of the criminal insane: those patients who stood at the intersection of insanity and criminal behavior. With causes so often attributed to circumstantial conditions, authorities struggled to distinguish between the criminal sane and insane throughout the processes of diagnoses, incarceration (whether in the prison, the asylum, or both), and treatment. While heredity came to dominate theories of the etiology of criminal insanity among California’s medical community from the 1870s onward, the 1850s and 1860s saw frequent debate about the validity, uses, and abuses of the diagnostic category, as well as its perceived ties to Gold Rush culture. Using commitment registers, hospital and prison reports,

and medical journals, this paper will examine the evolution of the etiology of criminal insanity, and argue that local understandings of insanity and criminality were deeply influenced by contemporary perceptions of the fast living and unsettled conditions that characterized the miner's camps of the 1850s and 1860s.

#### Objectives

1. Help attendees to understand the dynamic history of medical ideas and practices, and their implications for patients and healthcare providers
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 throughout history

### **G1. Institutional Solutions for Incurable Conditions? Heredity and Treatment in Intractable Physical and Mental Illness**

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#### *Escape from Custody: An Alcoholic Pathography from the Mid-Twentieth Century*

Robert Straus, a pioneering medical sociologist, published six books and more than sixty articles exploring the relationship between alcohol and health. One classic, *Escape from Custody: A Study of Alcoholism and Institutional Dependency as Reflected in the Life Record of a Homeless Man*, was published in 1974 following a rapid period of transition from carceral to community-based addiction treatment in the United States. Part biography, part institutional history, the book traces the life of Elliot Stone through his correspondence with Straus. From their initial meeting in 1945 until Stone's death in 1972, Straus and Stone exchanged letters as Stone cycled between periods of incarceration, hospitalization, independent work, and homelessness. I draw on processed archives of their correspondence and Straus's notes as well as the published book in order bring to light enduring insights for scholars of addiction treatment history. First, Straus's concept of "institutional dependency" implicates the social organization of alcoholism treatment in cycles of abstinence and relapse. In this framework, "dependence" is not located in the psychology or biology of the alcoholic individual, but instead is co-produced by a system of supposedly supportive structures that facilitated Stone's life-long cycles of self-destruction and "rehabilitation." In addition, unlike histories which emphasize differences in the treatment of alcoholics and drug addicts following the repeal of national alcohol Prohibition, Stone's story highlights striking similarities between the systems of treatment and punishment for both groups of users in the mid-twentieth century.

#### Objectives

1. Recognize the dynamic relationship between medicine and society through history
2. Elicit and write a patient's history worthy of an historian
3. Deepen understanding of illness and suffering

### **G2. The Shaping of Civilian Medicine by Military Contexts**

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*Vaccination and Neonatal Care: ROKA (Republic of Korea Army) Civic Actions during the Vietnam War, 1964-1973*

During the Vietnam War, the South Korean army undertook numerous “civic actions” as part of its outreach to Vietnamese villages, with these activities including free haircuts, anti-parasite campaigns, and a combination of vaccinations and neonatal care. The last of these three forms the basis for this paper, which interrogates the complex set of motives informing the Korean medical intervention in Vietnam. In part, this public health activity limited the spread of disease in areas in close proximity to ROKA troops, thereby ensuring the relative safety of the surrounding environment. Moreover, the goodwill earned during these campaigns also helped to shape a more favorable impression among the local population, a helpful gesture at a time when this was not always the case. The Korean military typically preceded these actions with its presence, meaning that Vietnamese experienced the troops first, and the medical/soft power only later. Adding to this nexus of affect, material assistance, and outreach is the attempt of South Korea to undertake these actions as part of its desire to build upon its own recent developmental experience (1954-1961), having been the recipient of aid during the Korean War (1950-1953) a decade prior. Now a country in “take-off” mode, according to Walt Rostow’s language, South Korea aimed to return the favor, and would soon begin sending its doctors on overseas missions as early as 1968, in this case, to newly decolonized nations in Africa.

Objectives

1. Understand other national health systems
2. Understand the symbolic and material impact of biomedicine during the Cold War
3. Understand the use of biomedicine in contingent circumstances, such as wartime, emergency, disaster

**G2. The Shaping of Civilian Medicine by Military Contexts**

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*“Physically unfit” or “Highly employable”? Debating Invisible Disabilities, Employability, and Veterans’ Rehabilitation after the Great War*

“We have no work in our factory which we could give to disabled [veterans]... [It] is all rather heavy and requires men capable of lifting...,” explained Hartford’s Abbott Ball Company to U.S. Veterans’ Bureau rehabilitation officials in 1922. Indeed, many dozens of employers argued that disabled Great War veterans were “all physically unfit” or threatened by factories’ heat and machinery. Yet hundreds of other employers eagerly sought out disabled veterans for industrial and other positions. General Electric identified 24,538 “employment possibilities” in its Schenectady plant, covering fourteen disability categories: including arms, eyes, general debility, hernia, legs, lungs, and shell shock. What explains these conflicting perceptions of newly disabled veterans’ bodies and the largely “invisible disabilities” so associated with the Great War: shell shock, overall debility, chronic pain from shrapnel wounds, and lung injuries from gassing and tuberculosis? How did emerging medical understandings, along with the idea of rehabilitating disabled people into taxpaying citizens, translate to the public as “disability” coalesced as a political, economic, and medical concept? Although the post-Great War rehabilitation program has been castigated as a corrupt failure, this paper argues that its medical and prescriptive literature nevertheless helped to rewrite popular understandings of disabled veterans’ capabilities and,

in so doing, shaped notions of what we today term “invisible disabilities.” Unlike the impoverished disabled Civil War veterans—100,000 disfranchised as institutionalized dependents—by 1930, most disabled Great War veterans labored in the paid workforce. Their success is striking given that, by the 1920s, disabled civilian workers found themselves excluded by workmen’s compensation, pre-employment medical examinations, and industrial safety physicians who defined disabled workers as unsafe and irresponsible. This paper draws on Veterans’ Bureau reports, prescriptive literature, and correspondence with employers, unions, and chambers of commerce; veterans’ rehabilitation case files; census records; popular media and medical articles.

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

### **G2. The Shaping of Civilian Medicine by Military Contexts**

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#### *The Drugs of War in Early Eighteenth-Century France: Medical Entrepreneurs and Military Patrons*

The soldiers of early eighteenth-century France were twice as likely to die of campaign diseases than they were from battlefield wounds. The privately-contracted army hospitals where sick soldiers were cared for were widely seen as administratively corrupt, unsanitary, and insalubrious places, where soldiers were more likely to get sicker than to recover. State officials in the latter reign of Louis XIV recognized these problems and actively solicited new drugs that would heal quickly, getting soldiers out of the hospitals and sending them back to active duty. Rather than relying solely on urban apothecaries and the conventional pharmacopoeia for the drug supply, they received proposals from a more heterogenous set of therapeutic entrepreneurs, who offered novel proprietary remedies against diseases like dysentery and intermittent fevers and promised “radical cures.” The state actively organized trials on patients, and when their drugs were successful, these entrepreneurs were rewarded with lucrative contracts to supply their drugs in bulk quantities to the Sun King’s armies. Many of these entrepreneurs were also rewarded with royal monopolies on the sale of their drugs in the “civilian” marketplace. Drawing on sources from the French military archives, my talk will outline the careers of two medical entrepreneurs, exploring how they forged relations with their military patrons. It will also contribute to the ongoing re-evaluation of the eighteenth-century “medical marketplace” by considering the role of the early state in shaping markets not only as a regulator, but also as the largest consumer of many of the drugs it licensed.

#### Objectives

1. Develop a historical appreciation of how the state has shaped health care in different contexts
2. Critically interrogate the concept of the “medical marketplace” by viewing state actors as medical consumers
3. Explore the role of military rationality in shaping concepts of both disease and cure

### **G3. The Power of the Personal in the Early Twentieth Century United States**

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*The Permeable Institution: How Families Built and Disrupted Institutions for the Feeble-minded, 1890-1910*

Histories of eugenics have framed sterilization and institutionalization as expert-driven campaigns that coercively imposed white middle-class values. This paper uses records from the “clinic-by-mail” conducted by the Pennsylvania State Training School for Feeble-minded Children at Elwyn (hereafter, Elwyn), to instead explore institutionalization through on-the-ground decisions rooted in intimate experiences of impairment. These records contain families’ narratives about their children’s symptoms, the suspected causes of their impairments, and their hopes for how the institution would help their child. Focusing on the years 1890-1910, this paper demonstrates that while Elwyn’s chief physician Dr. Martin Barr and his colleagues entered the twentieth century convinced of mental defect’s incurability and envisioning a new custodial era of care, that was not how families engaged the institution. Families’ complex emotional, medical, and material needs also did the work of filling institutions in the eugenic era. Building on Allison Carey’s groundbreaking work on parental disability activism in the 1950s and 60s, this paper considers how parents and guardians not only built but also disrupted institutional life at the turn of the century. Families often advocated for their children’s inherent curability by insisting that heredity was not to blame for their child’s symptoms. Families visited, inmates ran away for short and long periods of time, parents visited their children and, following historic forms of education such as apprenticeship, regularly removed them once they deemed them improved enough to support themselves. Inmates also challenged their diagnostic labels, and they protested their segregation by flouting institution rules, persuading their parents to bring them home, or running away. In the first decade of the twentieth century, the institution for the feeble-minded, though it was designed to serve expert goals, was a permeable space. By those same experts’ standards, then, it was also a eugenic failure.

#### Objectives

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

### **G3. The Power of the Personal in the Early Twentieth Century United States**

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*Mothering a Movement: Blanche Van Leuven Browne and the “Crippled Child” Experience*

In 1896, a 15-year old polio survivor told her doctor at St. Luke’s Hospital that she intended to use her unique knowledge to open her own institution, as “I know even better than the doctors can know what a crippled child wants and needs.” By the time of her death in 1930, she had not only opened her own hospital-school in Detroit; she had also articulated an ideology about the needs of children with disabilities which continued to inform a broad-based crippled children’s movement. This paper uses

“Mother” Blanche Van Leuven Browne’s life and work, drawing from her papers as well as local, national, and movement periodicals, to highlight how her experiences as a former “crippled child,” and her empathy for the children in her care, informed her revolutionary attitude toward the rehabilitation, education, and meaning of the crippled child. Previous scholarship, such as Byrom’s “Hospital-Schools in Progressive America,” has suggested institutions such as Browne’s were part of a larger Progressive rehabilitation movement in which nonmedical philanthropists played a significant role in creating institutions and organizations. This paper argues that Browne’s institution and writing show a more unusual and more specific story about a disabled woman modeling an institution after her own experience. Moreover, it suggests that her work informed subsequent efforts for crippled children. Her ideas laid the groundwork for the later iterations of this movement—the centrality of disabled people’s experiences in informing goals, actions, and rhetoric; investment in education and long-term interest in the child’s well-being; definitions of what or who a crippled child was. Only one major component of her ideology was abandoned by later advocates: her passionate opposition to surgical attempts at curing these children, which led to a break with her own institution in 1918.

#### Objectives

1. Promote tolerance for ambiguity of theories, the nature of evidence, and the 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. Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy

### **G3. The Power of the Personal in the Early Twentieth Century United States**

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#### *The Alpine Experiment: Medicine, Religion, and the Rural United States in the Great Depression*

At the height of the Great Depression, the planned community at Alpine, Tennessee, marked an ambitious attempt to remake the rural United States. Led by Bernard and Anne Taylor, whose years at New York’s Union Seminary instilled a commitment to political and religious liberalism, Alpine sought to transform all aspects of rural life. The Taylors worked to develop schools, teach efficient agricultural techniques, and improve the overall “social mores” and “moral standards” of the one thousand residents. But what connected these diverse efforts was an underlying language of health and medicine. The foundation for all their efforts, the Taylors argued, was a desire to “heal the sick.” Eliminating disease and improving public health united their ambitious social, religious, and political agendas. Unfortunately for the Taylors, however, their religious and political outlook undermined their effort to bring modern notions of medicine and health to rural Tennessee. In particular, their advocacy of birth control alienated their religiously conservative churchgoers. So, too, many of Alpine’s residents resisted modern categories of diagnosis and wished to preserve medical practices they had known for generations. This paper explores how Alpine, which was supported by the Rockefeller Foundation and was a model for similar efforts, embodied both the possibilities and the limits of attempts by liberal religious leaders and institutions to spread new ideas about medicine and public health. Historians have long noted that rural healthcare changed significantly during the Depression, driven largely by the burgeoning federal bureaucracy. New Deal agencies deployed physicians and healthcare workers who were deeply committed to progressive values. Religious leaders with progressive commitments proved



no less determined to instill notions of modern health and medicine in rural areas. But by binding new understandings of medicine to religious liberalism, these reformers faced unanticipated resistance in religiously conservative regions.

#### Objectives

1. Recognize the dynamic interrelationship between medicine and society through history
2. Develop a historically informed sensitivity to the diversity of patients
3. Understand the dynamic history of medical ideas and practices

#### **G4. Medicalizing Psychoactive Substances in the 19th and 20th Centuries**

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*“The Curiosity of Physiologists and People of the World”*: Medicalizing Cannabis in a Century of Empire, 1830-1850

During the 1830s and 1840s, dozens of pharmacists and physicians working in Calcutta, Madras, Cairo, Algiers, Nuremberg, Heidelberg, Brussels, Paris, London, Edinburgh, and Albany, developed and prescribed cannabis-based medicines to combat a variety of ailments and diseases, including the plague, tuberculosis, cholera, and insanity. These medical practitioners did not work in isolation and often communicated and debated their findings on medicalized cannabis in the pages of peer-review journals, such as *The Lancet* (London), *L'Union médicale* (Paris), *L'Abeille médicale* (Paris), *The American Journal of Insanity* (Utica), *Jahrbuch für praktische Pharmacie* (Heidelberg), and *Repertorium für die Pharmacie* (Nuremberg). A careful reading of the nearly 100 essays and articles on medicalized cannabis that appeared in these and other journals during the 1830s and 1840s, as well as of the dozens of monographs and dissertations on the drug published around this time, reveals that medical ideas about cannabis in the 19<sup>th</sup> century—ideas that continue to underpin prohibition policies and addiction treatment programs today—emerged from a trans-imperial medical discourse that often codified the drug as an “Oriental intoxicant” or “Indian medicine” with dangerous psychotropic properties reflective of an untamed and savage world. Interestingly, this racialized typecast of cannabis as a quintessentially Oriental intoxicant mostly stimulated research into and use of the drug in the West during the 1830s and 1840s, as many practitioners and particularly pharmacists viewed cannabis as an important proving ground for the civilizing power of Western science and medicine. But when cannabis-based medications repeatedly proved ineffective due to misdiagnosis and inconsistent dosages, the same typecasts that helped fuel the rise of cannabis in Western medicine during the 1840s were marshaled by a new generation of doctors in the 1850s and 1860s to argue against the efficacy of the drug and to support their diagnoses of “hashish poisoning” and “hashish-induced insanity,” particularly among the newly colonized subjects of Asia and North Africa.

#### Objectives

1. Illuminate the ways in which race-based thinking contoured medical logic and treatment in France during the middle 19th century
2. Recognize the dynamic interrelationship between medicine and society throughout history
3. Better understand the comparative “career cycles” of drugs

#### **G4. Medicalizing Psychoactive Substances in the 19th and 20th Centuries**

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### *The Making of a Psychedelic Therapeutic Method*

While people across the world have used psychoactive substances for thousands of years, the synthesis of LSD in 1938 and its first use in 1943 marked a new period of experimentation in Western psychiatry. At a time of explosive innovation in psychopharmacology during the early years of experimental psychiatry, researchers hoped LSD might serve diverse purposes: as a key to understanding psychosis, as a possible psychochemical warfare agent, and as a prospective wonder drug in psychotherapy. While research on the first two fronts faded, LSD's promise as a therapeutic drug continues into the present. By the late 1950s, a network of those studying LSD in the U.S., Canada, and U.K. had developed a special method of care for administering the drug in the context of therapy. This method has remained largely intact today in clinical trials of MDMA, psilocybin, DMT, and other psychedelic drugs being tested as potential treatments for a variety of illnesses and conditions. Using medical journal articles, correspondence between therapists, memoirs, and video footage from the 1950s, I trace the development and circulation of the practices that coalesced under the term psychedelic therapy. I focus on the kind of labor involved and the failures of experimentation that led to a protocol still in use today, both in underground psychedelic therapy and in FDA-approved clinical trials of psychedelics. Along the way, I ask for whom and for what purposes was psychedelic therapy developed? And, given the dramatic changes in psychiatry, drug policy, and international politics since the 1950s, why is the psychedelic therapeutic method being taken up now in much the same way it was sixty years ago? Understanding the historical roots of this therapeutic method, and its inspiring and troubling implications, is vital to evaluating the place of psychedelics in medicine today.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Deepen understanding of illness and suffering
3. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

#### **G4. Medicalizing Psychoactive Substances in the 19th and 20th Centuries**

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#### *"I Wouldn't Be Sitting Here Puffing Away": US Physicians and Tobacco Industry Strategies Just before the 1964 Surgeon General's Report*

In the spring of 1960, four years before the first Surgeon General's Report on Smoking and Health declared definitively that cigarette smoking caused lung cancer, the Group Attitudes Corporation conducted an in-depth survey of 108 American physicians from five geographical areas across the country concerning their attitudes about smoking and the tobacco industry. The survey was conducted for the Tobacco Institute, the industry's public relations and lobbying arm, to help tobacco companies shape their strategies to keep smoking legitimate and popular. Physicians were key to continued cigarette consumption, as worried smokers asked doctors for advice and noticed their smoking behaviors. Thorough epidemiological studies, pathological observation, and animal studies had all

provided convincing evidence of the cigarette-cancer connection beginning in the early 1950s, but this survey--and others--indicated that most physicians continued to smoke and did not yet feel that the link between smoking and cancer was fully proven. Additionally, their perception of tobacco companies was largely favorable, with a sense of appreciation for tobacco companies' funding of research on the subject. While spokespeople from nonprofit health organizations like the American Cancer Society (ACS) had accepted the link between cigarettes and lung cancer and had begun to warn strongly against smoking, the American Medical Association and most American clinicians had not. Physicians interviewed for the survey voiced suspicion that the ACS was spreading an unproven health scare. On the recommendation of Hill and Knowlton, their public relations firm, Tobacco Institute strategists redoubled their influence campaign towards physicians, flooding medical offices with their *Tobacco and Health Research* newsletter, doing what they could to keep doctors and their patients smoking. Although physicians' consumption of cigarettes was on a downward trend throughout the 1950s, such industry efforts slowed it, and obscured the overall acceptance of the harms of cigarette smoking.

#### Objectives

1. Understand the development of epidemiology and public health in the US during the 1950s and 1960s
2. Recognize industry strategies to influence scientific knowledge and public health
3. Examine the interrelationships between public health organizations, individual clinicians and industry

### **G5. Debility and Disclosure: Memoirs as Sources for Medical History**

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*"There is Nothing to be Ashamed Of": The Mood Memoirs of Mental Health Practitioners*

The persuasive power of narrative has been known since the time of Cicero, so it is unsurprising that patients seeking to humanize and de-stigmatize disease have turned to illness memoirs. Possibly no conditions need humanizing and de-stigmatizing more than psychiatric disorders; as psychologist Norman Endler put it in his memoir, *Holiday of Darkness: A Psychologist's Personal Journey out of his Depression*, "It is probably more socially acceptable today, in the 1980s, to be a delinquent, drug addict, criminal, homosexual, or lesbian than to be labeled as mentally ill." The particular exclusion faced by members of this population has earned their writing its own genre: mood memoirs. While disclosing mental illness is always risky, the consequences mental health practitioners face by revealing that they suffer from the disorders they are supposed to control in their patients are potentially catastrophic. This paper analyzes this subset of memoirs, in which psychologists and psychiatrists such as Endler, Kay Redfield Jamison, Lauren Slater and others recount their own despair, hallucinations, self-injury, and suicide attempts. These authors share the same goal of eliminating stigma, and all privilege embodied expertise over their years of medical and academic training. But even more instructive are their points of departure: how these narratives intersect with both gender and temporality in their approach to status, etiology (particularly in their reliance on the medical or social model of disease), treatment and the potentially transformative power of human connection.

#### Objectives

1. Develop familiarity with this subset of mood memoirs
2. Recognize the privileging of embodied expertise over academic and medical training as a tactic to fight stigma

3. Observe how these narratives provide particular insight into the intersection of gender and temporality with beliefs about health and sanity

### **G5. Debility and Disclosure: Memoirs as Sources for Medical History**

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#### *Darkness Legible: Depression Memoirs and the History of the Antidepressant Era*

Before William Styron's *Darkness Visible* appeared in 1989, public disclosure of depression was rare. Since then, depression memoirs have become a major entry into the flourishing of published illness narratives. What are the limits and strengths of these memoirs for historians? This paper will consider what biases may lead certain narratives to be published, but also argue that the memoirs comprise an indispensable source of the antidepressant era. The torrent of memoirs might be partly to the success of Styron's book. But while Styron was already a famous author, his book appeared shortly after Prozac's introduction. Prozac became a cultural preoccupation, as did the illness it is meant to treat. The memoirs share an urgency to convey an experience the authors sense to be misread by people who have not had the illness, and a frustration with the ambiguity of "depression" referring to a medical syndrome but also a universally-known mood. The "realness" of the illness is at stake. Biological understandings of depression can function in the memoirs as a proxy for "realness." Yet the memoirs also show ambivalence about biological reductionism, and about antidepressants. The ambivalence is as due to questions posed about selfhood as it is to clinical questions about efficacy and adverse effects. Questions about selfhood can be further challenged by identity issues. Depression has been gendered as a female malady, a figuration that can pose challenges for both male and female sufferers. The growth of depression memoirs has been mirrored by a growth in depression historiography. Emphases in this historiography have included fashions in diagnosis, debates over the efficacy of medications, and pharmaceuticals in consumer culture. There has, though, been little attention to patients' rendering of their experience, despite the priority such attention has been given in the wider historiographies of psychiatry and medicine.

#### Objectives

1. Develop familiarity with depression memoirs as historical sources
2. Deepen understanding of the experience of depression in the age of antidepressants
3. Further knowledge about gender and depression

### **G5. Debility and Disclosure: Memoirs as Sources for Medical History**

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#### *Rehabilitating Masculinity through Memoir during World War II*

In *A Soldier's Account of Valley Forge*, Russell Williams--a former soldier who lost his sight after being struck by German gunfire on August 10, 1944--recounts his rehabilitation journey at Valley Forge General Hospital where he learned, through orientation and mobility training, how to successfully adjust to life as a blind person. As Bledsoe put it in his memoir, "Training was slow going at first, and I often got frustratingly lost, but as I came to know more and more people in the hospital and learned routes to the

hospital gymnasium, artificial eye clinic, and patients' dining room, I regained confidence and thought to myself that if any of these blinded guys were going to make it in life, it would be me." This paper uses Williams' memoir to illuminate how a mode of documentation designed to communicate individuated memories became a tool for managing disability in the United States during and after World War II. Because Williams was successful in completing the orientation and mobility training he received, he was selected for a role as a counselor and teacher at Valley Forge. The administrators at Valley Forge claimed that because Williams gained the skills of blindness and adjusted to life as a blind person, he could identify with the newly blinded veterans as they began their journey of rehabilitation at Valley Forge. As a result, his memoir became a critical part of the rehabilitation process itself. Williams' memories provided evidence that the program at Valley Forge could turn the despondent war-blind into a cadre of independent and confident men able to regain their masculinity. As a significant element of Valley Forge's rehabilitative apparatus, Williams' memoir served as a prime exemplar of whom the war-blinded could and should become to assimilate back into their old life successfully and as a tool to help restore the masculinity of the war wounded.

### Objectives

1. Understand the role of personal narrative in disability
2. Contextualize the role of rehabilitation in the articulation of gender
3. Deepen understanding of disability in the aftermath of military conflict

## **H1. Prosthetics, Pediatrics, and Progressives: How WWI Revolutionized Hospitals**

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### *Reshaping the Veteran: Propaganda and Agency in WWI Reconstruction Hospitals*

One-hundred years after the Great War, debates about the future of the veterans' healthcare hold significant implications not only for veterans but for every stakeholder in America's modern healthcare system. Debates about veterans' entitlements draw upon contemporary perceptions of veterans and the nation's obligations to its wounded warriors, and since WWI, propaganda has been a powerful tool in shaping those perceptions. This paper will examine the interactions between modern medicine, propaganda, and veterans' agency in shaping the sociocultural understanding of veterans and their entitlements in the First World War. After the United States entered the war, the Wilson administration charged the Committee on Public Information (CPI) with influencing public opinion in favor of the war. The desire to create and control a unified, hopeful message inspiring faith in the government was soon adopted by the U.S. military. General Pershing authorized the creation of the *Stars and Stripes* to boost morale while supporting the propaganda and messaging efforts of the CPI. The Office of the Surgeon General began publishing *Carry On*, an official magazine promoting the Army Medical Department efforts in the reconstruction of disabled soldiers. And following the armistice and subsequent lifting of censorship restrictions, dozens of smaller publications began to appear in military units and at reconstruction hospitals, offering a medium of expression for soldiers now free of the censor's constraints. An examination of these later, long-neglected sources provides contemporary insight into the complex relationships between official policy goals, propaganda, censorship, veterans' experience, and real outcomes. Considering that the Great War reconstruction hospital system formed the basis of the modern Veterans Administration, an examination of the context in which it developed can provide insight into modern challenges to the system, their potential ramifications, and possible solutions.

## Objectives

1. Explore the dynamic interactions between top-down directives and bottom-up grassroots efforts in shaping the foundations of the modern veterans' healthcare system during the First World War
2. Deepen understanding of wounded veterans' experiences in the Great War by exploring their communal perspectives.
3. Acquire a critically nuanced historical understanding of the modern veterans' healthcare system and its potential implication on the national healthcare system

### **H1. Prosthetics, Pediatrics, and Progressives: How WWI Revolutionized Hospitals**

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#### *"Crippled" Children and the Development of Rehabilitation Hospitals in the Progressive Era, 1900-1925*

The early 20th-century US witnessed a proliferation of "crippled children's hospitals," as evidenced in Edith Reeves Solenberger's 1914 report for the Survey Associates entitled *The Care and Education of Crippled Children in the United States*. Most of those hospitals were actually in-patient rehabilitation facilities serving children affected by tuberculosis of the bones and joints, rickets, the after-effects of polio, congenital conditions such as club foot, and trauma. Modes of treatment developed for child patients in such facilities influenced the emerging fields of physical and occupational therapy and the development of reconstruction hospitals for wounded soldiers during and after World War I. In this paper, I will explore the landscape of crippled children's hospitals in the first two decades of the 20th century. I will then demonstrate how the program for reconstruction of soldiers influenced one pioneer of "crippled" children's rehabilitation (orthopedic surgeon Willis Campbell of Memphis) to bring the benefits of old and new therapeutic practices to adult civilians by founding the Hospital for Crippled Adults in Memphis. I conclude by arguing that the modern rehabilitation hospital owes its origins not only to reconstruction hospitals for soldiers and hospitals for "crippled" children, but also to the efforts of people like Campbell who sought to draw from the experiences of both to create a new type of institution that would extend the benefits of modern rehabilitation to civilian adults.

## Objectives

1. Understand the emergence of children's rehabilitation hospitals in the early 20th century
2. Understand the significance of reconstruction hospitals for wounded soldiers during and after World War I
3. Understand how children's rehabilitation hospitals and soldier reconstruction hospitals influenced the emergence of rehabilitation facilities for civilian adults in the 1920s

### **H1 Prosthetics, Pediatrics, and Progressives: How WWI Revolutionized Hospitals**

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#### *"The Health of the Child is the Power of the Nation": The 1918 Children's Year and the Children's Hospital*

During WWI, the National Children's Year Campaign was launched. A public health initiative that grew directly out of concern for the poor health demonstrated by those rejected for induction, the Children's Year focused on strengthening the health of children in order to ensure the future vitality of the nation. The components of the campaign included the training and education of mothers, health celebrations in schools, a massive effort to measure all children under six years of age, and the mobilization of local governments to register all births. Institutions enlisted in and influenced by this campaign included churches, city halls, clinics, and children's hospitals. This paper explores the impact the 1918 campaign had on the children's hospital by examining the role the institution played and the side it found itself on as the child welfare movement of the early 20th century was divided into two camps, one biomedical and the other social. While the legacy of the 1918 Children's Year in pediatrics, public health, and social welfare has been well-documented, its influence on health care, and particularly a health care institution such as the children's hospital has been given less consideration. Seen as a child-welfare-promoting institution, the children's hospital played an important role in 1918 as it served as a headquarters for key components of the campaign, including measuring children and administering vaccinations. This was not a new approach to promoting children's health for this institution. Pioneering hospitals founded in the late 19th century adopted socio-moral-medical missions, which resulted in the offering of a wide-range of services, including long-term stays to feed malnourished children to the setting of broken bones. Did its involvement and the legacy of the 1918 campaign cause this institution to take a biomedical turn? And if so, at what cost?

#### Objectives

1. Understand the role of the children's hospital in the 1918 National Children's Year campaign
2. Identify the influence the federal government has had on the history of pediatric health care
3. Recognize the dynamic relationship between the children's hospital and the production of medical knowledge through history

## H2. Reframing Birth

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### *Midwives and Pregnant Transgender Men: A History of Less Intervention and a Future of Greater Inclusion*

Midwifery organizations have recently expanded their scope of practice to include transgender men. These patients are men who have transitioned but still have female reproductive organs, and thus can get pregnant by a partner or sperm donor, carry a pregnancy, and give birth. Traditionally, midwives have tended to the healthcare needs of women only—during pregnancy and birth, of course, but also for routine care, like vaccinations, birth control or pap smears. Opening their doors to transgender men has done more than merely expand their client base. Some midwives, represented by national accrediting organizations, have been trying to make their practices welcoming to transgender men by including transgender education in their curriculum and also by revising the language of their materials. Instead of referring solely to “women” and “mothers,” the American College of Nurse-Midwives, for example, has recently changed the wording in their documents to include men as child bearers. This has not come without controversy. My paper will set the current debate in historical context, which involves bitter disputes regarding the meanings of womanhood, motherhood, and feminism. Janice Raymond's provocative book, *The Transsexual Empire: The Making of the She-Male*, first published in 1979,

articulated many of the anti-trans attitudes that circulate today, particularly the idea that trans women are just men who want to infiltrate women's culture. Much has happened in the almost 40 years since the book's publication. And yet questions persist: Does the inclusion of transgender men in the most "womanly" of events—delivering babies—have to mean the erasure of women? And if, in the future, transgender women can have babies too—artificial wombs and uterine transplants raise this possibility—will Raymond's words acquire new significance? And, finally, how can understanding the history of midwifery help today's providers become more sensitive to their transgender patients?

#### Objective

1. Appreciate some of the difficulties facing transgender people seeking sensitive medical care
2. Begin to understand some of the ethical concerns facing midwives regarding transgender-specific healthcare
3. Develop a historically informed sensitivity to the needs of pregnant transgender men

## H2. Reframing Birth

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### *Birth Anesthesia and Birth Control: A Historic Relationship in Reproductive Health*

The medical intervention of "twilight sleep," or the use of a scopolamine-morphine mixture to anesthetize laboring women, caused a furor among doctors and early twentieth-century feminists. Suffragists and women's rights advocates led the Twilight Sleep Association in a quest to encourage doctors and their female patients to widely embrace the practice. Activists felt the method revolutionized the notoriously dangerous and painful childbirth process for women, touting its benefits as the key to allowing women to control their birth experience at a time when the maternal mortality rate remained high despite medical advances in obstetrics. Yet many physicians attacked the practice as not only dangerous for patients and their babies, but antithetical to the expectations for proper womanhood and motherly duty. Historians of women's health have rightly cited Twilight Sleep as the beginning of the medicalization and depersonalization of the childbirth process in the twentieth century. This article instead repositions the feminist political arguments for the method as an important precursor for the rhetoric of the early birth control movement, led by Mary Ware Dennett (a former leader in the Twilight Sleep Association) and Margaret Sanger. Both Twilight Sleep and the birth control movement represent a distinct moment in the early twentieth century wherein pain was deeply connected to politics and the rhetoric of equal rights. The two reformers emphasized in their publications and appeals to the public the vast social significance of reproductive pain—both physical and psychological. They contended that women's lack of control over both pregnancy and birth represented not only the greatest hindrance to women's fulfillment of their political rights, but also a danger to the healthy development of larger society. In their arguments for legal contraception, Dennett and Sanger placed women's pain front and center as the primary reason for changing a law that hindered women's full participation in the public order.

#### Objectives

1. Develop the capacity for critical thinking about the nature, ends and limits of medicine
2. Deepen understanding of illness and suffering
3. Identify successes and failures in the history of medical professionalism



## H2. Reframing Birth

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*Psychedelic Birth: R. D. Laing and the Transformation of Psychiatry*

“Losing control,” wrote patient X to his psychiatrist, R. D. Laing, in November of 1976. “Helplessness. Body taking over control, shaking of limbs, flickering before the eyes,” he reported. Then he described why he felt this way. “Slipped into mother’s body, realized nothing to fear in her body. Fighting. Struggling. Fear of suffocation. Fighting to get out. . . . Exhausted, felt trapped, wanted to escape, be born.” Patient X, as it turns out, was describing his experience on LSD, which he had been using in treatment with Laing since 1968. He, along with Laing, firmly believed that LSD held therapeutic value. By promoting LSD as a therapeutic research tool that could heal wounds from traumatic birth, Laing along with other psychiatrists positioned their craft as cutting edge, thereby transforming their profession. While many historians have noted Laing’s influence on psychiatry, few have noted his interest in birth. He was featured in an award-winning documentary produced by New Zealand birth activist Helen Brew, and during his 1972 tour to the U.S. he met with rebirthing guru Elizabeth Fehr to discuss the role of birth trauma in therapy. As a result of these exchanges, Laing began to focus on birth trauma in his practice and writing. By theorizing upon the significance of birth trauma and the ability of LSD to reconnect and release a patient’s memories of birth, Laing helped to transform the field of psychiatry. By taking trauma well beyond Freudian theories of childhood development and back into the womb, Laing was able to convince many that LSD was not just a risky, hedonistic party drug of the counterculture, but a research tool that could tap into higher consciousness and heal deep wounds.

### Objectives

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

## H3. Medical Research, Modernity, and the Neurosciences in Europe and the United States

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*Spanish Modernity and the Anatomy of Fatigue in José de Letamendi’s Modern Life Considered from a Medico-Social Viewpoint (1874)*

José de Letamendi (1828-1897) remained a towering figure in Spain’s intellectual life throughout the better part of the nineteenth century. He was a celebrated anatomist, physician, professor, philosopher, artist, composer, poet, and social theorist who served as Professor of Anatomy in Barcelona, and as Professor of General Pathology in Madrid. From the beginning, one of Letamendi’s major concerns had to do with the relationship between progress (social and cultural growth and development) and the human body. It has long been a familiar charge against Letamendi that he often filtered empirical observations about progress and society through the speculative and abstract concepts of his neo-Hippocratic and anti-positivist convictions. Recently, critics have documented the critical reception of Letamendi’s work noting the partial view that has obscured a number of his important contributions to

Spanish medical science. While there are disagreements concerning how to properly approach Letamendi's work, it is worth revisiting his notion of progress and the human body, particularly its effects on the bodies of modern laborers in one of his more important works, *The Advantages and Disadvantages of Modern Life Considered from a Medico-Social Point of View* (1874). As I will argue, Letamendi offers one of the most important treatises in late nineteenth-century Spain on how the machinery of progress was radically altering modern life and concepts of the so-called laboring body. My objective is threefold. First, I will contextualize and clarify Letamendi's approach to medical science paying particular attention to the neo-Hippocratism and anti-positivism that subtended his thinking. Second, I will examine the implications of Letamendi's neo-Hippocratism and anti-positivism with respect to his understanding of progress and fatigue, taking advantage of historian Anson Rabinbach's study *The Human Motor*, which offers an overview of the "laboring body" in nineteenth-century Europe. Third, I will argue that to acquire a clearer picture of Letamendi's life and work, it is best to consider him through a more encompassing perspective as a reformer of Spanish medical theory and practice.

#### Objectives

1. Understand the importance of medicine and labor theory in the history of European medicine
2. Appreciate how physicians approached the problem of fatigue in the nineteenth century
3. Recognize the importance of José de Letamendi's work

### **H3. Medical Research, Modernity, and the Neurosciences in Europe and the United States**

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#### *Healing the Feeling Heart: Applying Psychobiology in Laboratory and Clinic at Ohio State University, 1960-1980*

In 1960, the psychobiologist, Samuel Corson, joined Ohio State University (OSU) to oversee the development of a new research program in "experimental" psychiatry. Generous funding from the Ohio Department of Mental Health enabled OSU to build a state of art facility, complete with 15 Pavlovian conditioning chambers and all the necessary equipment required for classical and instrumental conditioning experiments. Corson was expected to apply psychobiological science to understand and improve emotional health in the clinical setting. This paper historically reconstructs the challenges faced in successfully "translating" experimental research with dogs to clinical application. Corson conducted early psychopharmaceutic research which, working with L. E. Arnold and other clinicians, produced a promising dog model for childhood hyperkinesia. However, this research was ultimately overshadowed by a serendipitous line of work, where the dogs themselves bridged the distance between experimental and clinical practice. Corson's laboratory was located within OSU's psychiatric hospital, with clinical wards on floors above and below. In 1969, patients hearing barking asked and were allowed to see Corson's dogs. Gradually, ad-hoc visits grew into a systematic investigation where experimental "laboratory" animals began to be used in the "clinical" setting to improve and stimulate patient recovery, eventually becoming so-called "Pet-Facilitated Psychotherapy." Corson believed human mental and emotional health could be improved through the use of highly trained animals; he saw a future where mental health would be treated by highly trained "Feeling-Heart" dogs. By contrasting these two distinct medical uses of the same dogs, this paper reveals how human relationships with animals emerge as novel spaces for medical intervention. The paper considers why the "laboratory" is so often considered a site of "conflict" when it comes to human-animal relations, whereas the clinic is

more easily construed as one of “cooperation” and “companionship.” Even when the animals concerned are one and the same.

#### Objectives

1. Recognize the dynamic interrelationship between medicine and society through studying a historical case which reveals how societal and medical values shape each other
2. Develop an historically informed sensitivity to the diversity of patients by learning how patient voices can improve and shape their care
3. Identify explanations for “successes” and “failures” in the history of medical innovation by contrasting two closely related case studies

### **H3. Medical Research, Modernity, and the Neurosciences in Europe and the United States**

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#### *Building the Brain Span: Aging, Plasticity, and the Search for the Cognitive Fountain of Youth*

“People have been told they’re losing 100,000 nerve cells per day after age 30,” explained neuroanatomy researcher Marian Diamond to the *Los Angeles Times* in 1982, “but our research is beginning to show that great numbers are not being lost so early in a person’s life.” The “course of aging is not time-locked,” the article encouraged, “it’s possible for an 80-year-old to have a 30-year-old brain.” In the final quarter of the twentieth century, a growing group of neurosciences researchers developed and circulated theories of the aging brain as “plastic”—structurally and chemically modifiable—until the very end of life. Interdisciplinary teams of researchers at the University of California-Berkeley, among others, challenged prior views of the old brain as immutable, arguing that the aging brain could maintain its structure and function—and even grow—throughout the entirety of the life course. Their optimistic theories offered new hope for the aging brain, but also contributed to the rise of “use it or lose it” movements and a controversial commercial “brain fitness” industry. This paper analyzes the transformation of aging brains from petrifying organs into eternally plastic “muscles,” and the implications of this transformation on the practices of healthy aging in the late twentieth century United States and into the twenty-first. Drawing on archival collections, clinical literature, and brain fitness marketing, this paper situates the development of contested new theories about the aging brain and analyzes the emergence of new models of life-long plasticity. It argues that new theories of plasticity in old age provided optimism for continued health and cognitive functioning, while simultaneously producing oppressive new standards for health maintenance into later life. It furthermore shows how healthy brain aging came to require an increasing investment of time and resources, and in doing so, reinforced existing inequalities of class and gender.

#### Objectives

1. Identify the interrelationships between medicine, science, and commercial industries in shaping narratives of healthy aging and old age
2. Provide historical context for current commercial brain training industry
3. Develop a deeper understanding of attitudes toward aging and preventive health

#### **H4. From Alimentary Canal to Zygote: Humor, Faith, and Resistance in Global Contexts**

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*The Representation of Abortion in Postcommunist Romanian Film, Women's Reproductive Agency, the Abortion Ban in Communist Romania*

This paper investigates the representation of back-alley abortions in postcommunist Romanian film and unpacks the history of trauma of banning abortion during the socialist period 1966-1989, when Decree 770 was in effect. These coercive pronatalist policies hinged on the role of women's reproduction for socialist construction and offer a cautionary tale of government's control over women's bodies. The acclaimed Romanian film *4 Months, 3 Weeks and 2 Days* (2007) directed by Cristian Mungiu that won a Cannes award, tells the story of a university student, who has to resort to an illegal abortion and shows the fear and despair she goes through to obtain an abortion. This story is not unique, but tragic by its ubiquity among women in communist Romania, a country with the most draconian population control policies. Nonetheless the female characters in Mungiu's film show reproductive agency, resisting the gaze of the government and that of the secret police, who were actively scrutinizing of their reproductive bodies. Back alley abortion became a way of reclaiming Romanian women's bodies from the state and was an attempt of self-empowerment. Mungiu also shows how the underground abortion social networks worked between procurers and providers. In the documentary *Children of the Decree*, director Florin Iepan explores Ceaușescu's pronatalist policies by subversively juxtaposing official propaganda images with a series of interviews with medical professionals, abortionists and women who experienced back alley abortionists. The male dominated secret police and the medical establishment all monitored and controlled women's fertility. Women suspected of inducing abortion were often threatened with arrest. Doctors performing illegal abortions were imprisoned if caught. The militia was in charge of the hospitals and gynaecology wards. Doctors forcefully checked for pregnancy in factories (Iepan 2005). Women were disproportionately carrying the reproductive burden, as they had to procure illegal abortions or raise the children. Such reproductive choices were also motivated by the scarce availability of food in the 1980s. Romanian women showed resistance to the state control of their reproduction, by accessing a deadly system of illegal back-alley abortions, often performed by amateurs lacking medical knowledge.

##### Objectives

1. Understand the complicity of medical professionals in surveilling women's reproduction in the Socialist Republic of Romania
2. Understand the role of the state and secret police in enforcing pronatalist policies in the Socialist Republic of Romania
3. Understand the abortion black market in the Socialist Republic of Romania

#### **H4. From Alimentary Canal to Zygote: Humor, Faith, and Resistance in Global Contexts**

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*Affect and Body Voyaging in Mid-Twentieth-Century American Culture*

Best known for a trio of travel parodies written under the pseudonym “Walter E. Traprock,” American author George Shepard Chappell (1877-1946) also journeyed “through the alimentary canal with gun and camera.” Published at the height of the Great Depression in 1930, this fat little volume is full of puns and inside jokes (literally). It is written in the rambling discursive style of a comedian on a burlesque stage, or of a humorist holding court in a lounge over just the right number of martinis. The anatomy of the human body that the adventuresome quartet explores (Herr X) serves as more of a Simonidean memory palace for a variety show of vignettes than as a Hippocratic head-to-toe framework for a lecture in popular anatomy. According to a movie reviewer in 1966, “[Chappell’s] pioneer work first appeared between hard covers, like a turtle, and, like a turtle, slowly sank from sight.” *Through the Alimentary Canal* experienced a modest revival with the premiere of Richard Fleischer’s feature-film *Fantastic Voyage* (1966). Although the living human body the “bionauts” enter is again that of a Central European—defector Dr. Beneš, who has had a stroke—the stakes of this exploration of a living human body are much higher. The proposed paper will compare and contrast these two body voyages and their contexts in mid-twentieth-century American science, medicine, and culture. My readings are informed by body scholar José van Dijck’s concept of “the endoscopic gaze,” or looking from the inside “in.” I will further pay particular attention to the ways in which emotions such as fear, wonder, and even humor informed contemporary understandings of what it meant to inhabit a human body, if only temporarily as (un)invited guests.

#### Objectives

1. Think critically about the aims and limits of medicine
2. Recognize the dynamic interrelationship between medicine and society
3. Describe the changing nature of the U.S. healthcare system in relation to other national systems

#### **H4. From Alimentary Canal to Zygote: Humor, Faith, and Resistance in Global Contexts**

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#### *Paediatric Radiology and Clinical Pediatrics - medicalizing child maltreatment as syndrome 1960-1980s*

In 1962, the publication of “The Battered Child syndrome” in *JAMA* by Kempe et al. caused child abuse to be transformed from a social problem to a medical diagnosis. Today, child abuse occupies a unique position in medicine. Reporting of suspected child maltreatment is one of the few instances of a required breach of confidentiality between physicians and patients. Medicalization describes how social problems become the concern of the medical profession. Often studies on medicalization are framed as a harmful intrusions of the medical institution into previously normal life events, but medicalization can refer to helpful contributions. While Kempe et al.’s publication in 1962 was seminal in the development of child abuse, it was not the first medical description of child maltreatment. Abrose Tardieu was a French forensic pathologist who first described child maltreatment in 1860. In this study I will outline the reformulation of the social problem of physical child abuse as a medical issue. I argue that the naming of abuse as a “syndrome” was a vital step in medicalization, which in turn was a power trigger for legal and social institutions to rally around. Medicalization, along with the development of X-Ray technology allowed for Kempe to be successful nearly a century after Tardieu’s attempt. This paper will also investigate the development of pediatric radiography as a medical science. I will look at primary papers in the medical literature which were seminal to the development of child abuse, along with textbooks of pediatrics to study the uptake of ideas. I will situate my argument within the sociological framework of medicalization (Rosenberg, Frawley). Medicalization, along with the development of

radiography, allowed for Kempe et al. to reshape the medical profession's responsibility in managing child abuse nearly a century after Tardieu's failure to do so.

#### Objectives

1. Understand the historical development of child abuse as a diagnosis, culminating as a syndrome in 1960, including failed attempts in 1860
2. Recognize how medicalization and diagnosis are influenced by social values and available technology
3. Appreciate the professional responsibility of medical professionals to vulnerable paediatric populations in particular changes in response to technological and sociological innovation

### **H5. Bodies and Disease from the Middle Ages to the Nineteenth Century**

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*Schoolgirl Scoliosis: Physicians' and Educators' Responses to Spinal Curvature among Female Students in Enlightenment Britain, France, and the United States*

Surging medical interest in child health from the mid-1700s to the 1830s often focused on orthopedics. In particular, British, French, and then American physicians diagnosed widespread spinal curvature in girls and blamed the problem on school. This paper traces worries about spinal curvature through physicians' and educators' discourse and resulting educational practices. Concerns about school-induced scoliosis renewed a long-held fear that the scholarly lifestyle was pathogenic. Frail health among both teachers and students seemed to take many forms over the centuries: melancholy, dyspepsia, neurological derangement, and, starting around 1800, pulmonary consumption. Spinal curvature was the first scholarly symptom believed to apply uniquely to girls and women, noted as early as Nicolas Andry de Bois-Regard's *L'Orthopédie* in 1741. Boston physician John Collins Warren advised the American Institute of Instruction in 1830 that half of the educated women he knew, but almost none of the men, had curved spines. Warren and others indicted how schools and parents treated girls' bodies. Middle-class girls increasingly pursued advanced education and long hours of needlework instead of vigorous physical housework, whereas most boys ran and played after school. In response to these alarms, physicians and educators promoted schemes to straighten out female students. Collars, braces, mechanical beds, and exercise equipment would manipulate the spine, while recommended exercises for both lower and upper body would develop the muscles. The first physical education manual written in the United States, *A Course of Calisthenics for Young Ladies* (1831), dealt with exactly this challenge. The perceived crisis contributed significantly to the establishment of school exercise. Decades before Dr. Edward Clarke's now notorious *Sex in Education; or, A Fair Chance for the Girls* (1873) urged that women entirely avoid higher education for health reasons, physicians and educators teamed up to address apparently school-induced scoliosis in female students.

#### Objectives

1. Deepen understanding of historical ideas about the negative health impact of education and sedentary lifestyle, particularly for women
2. Understand the connection between concerns about children's health and the origins of school exercise
3. Understand the history of interactions among physicians and educators as related to child health, particularly regarding orthopedics

## H5. Bodies and Disease from the Middle Ages to the Nineteenth Century

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*“The Worms Crawl In, The Worms Crawl Out”: Vermian Medicine in the Middle Ages*

The thirteenth-century poet, Rutebeuf, gave words to an itinerant herbalist, “I will ... teach you how to cure worms, if you will hear me.... Is no gentleman... going to ask me from what worms come? I will tell you.” This huckster echoed medieval audience’s interests. Worms as corporeal interlopers were provocative in disease and treatment. In 1335, the royal physician, Guido da Vigevano, sought for a mouse resistant to wormwood poisoning. Eventually he found worms eating aconite roots. Surprised at their survival, Guido ground them into soup. After consuming it, he vomited multiply and realized the worms were either an antidote or effective emetic. By contrast, Savonarola’s *De vermibus* offered charms to expel intestinal worms. A skein of authors from Rhazes to Hildegard, Maimonides and Saint-Amand show the worm crossing barriers of discipline, gender, age, and religion and binding a broad array of themes. Scholars have identified a fifteenth-century painting of St. Roche depicting a “Guinea worm” emerging from the saint’s leg. While upheld as the earliest such representation, recent, genetic studies of pre-modern latrines suggest that the parasites were nearly universal. Consequently, medievals were fascinated by such ailments, demonstrated by the vermian language of poets, theologians and artists. In this paper, we examine worm-based theory and practice, language and imagery. Using vernacular and Latinic sources from archives, editions and databases, I suggest that, though largely unstudied by moderns, medieval worms had serpiginous roles in medicine and culture. From their regenerative power in graves to their nerve-likeness in thirteenth-century “neuralistic” disabilities worms gave physicians influential heuristics. What emerges is a pre-modern version of the post-modern body-within-the-body, embracing the Everyman’s life-after-death, before Shakespeare, to the life-within-a-life, predating *Alien*. Fried or fresh, the medieval worm crept in and out of texts, digesting anew our understanding of premodern health and disease.

### Objectives

1. Have a wider understanding of medieval vermian illnesses
2. Understand the cultural impact of vermian medical imagery
3. Appreciate the breadth of worm-based medical theory

## H5. Bodies and Disease from the Middle Ages to the Nineteenth Century

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*Feeding Convalescent Bodies: Nutrition Science and the Art of Cookery in Late Victorian England*

Throughout the late nineteenth century, British physicians and medical philanthropists devoted increasing attention and resources to treating convalescence as a distinct stage of illness requiring special management and care. Yet experiences and understandings of convalescence in late Victorian England were shaped more by the practices and regimens prescribed by caretakers and convalescent homes than by medical theory. Using cookbooks and institutional dietaries, this paper examines one such set of practices: the dietary regimens prescribed for convalescent patients. Prevailing narratives

about nutrition science in the late nineteenth century have emphasized its increasing reductionism, as the laboratory language of calories and chemical constituents replaced the humoral language of food “qualities.” Convalescent cookery, however, cannot be fully explained through the lens of dietetic reductionism. Nurses, physicians, and cookery experts argued that how food was prepared and presented was just as important as what patients ate; food had to be palatable, tempting, and digestible, lest convalescents’ digestion be overtaxed and nutrients go unabsorbed. These nuances revise the dominant picture of late nineteenth-century dietetics, from one in which nutritional components held uncontested sway, to one in which sensitivity to bodily affects, appetites, and dietetic individuality were also understood to be essential. Moreover, attending to the dietary advice and regimens prescribed for convalescent patients sheds light on the role of convalescence as a cultural practice in the nineteenth century. The provision of liberal, varied, and tasty diets by convalescent homes reflected the belief that the convalescent body required a different regimen than the laboring body or the body of the workhouse or prison inmate. Convalescence represented a necessary respite from the economy of work and waste, a temporary period in which careful management and attention to the patient’s affect and desires, and not just their corporeal productivity, was essential.

#### 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