

Alphabetical List of Participants and Sessions

PC = Program Committee; OP = Opening Plenary; GL = Garrison Lecture;
FL = Friday Lunch; SL = Saturday Lunch; RW = Research Workshop;
SS = Special Session; SC = Sigerist Circle; DF = Documentary Film

Åhren, Eva – I1
Anderson, Warwick – OP, E1
Andrews, Bridie – D2
Apple, Rima – A5

Baker, Jeffrey – A3
Barnes, Nicole – B5, C1, PC
Barr, Justin – D4, E5
Barry, Samuel – A2
Bhattacharya, Nandini – D2
Bian, He – D2
Birn, Anne-Emanuelle – H3
Bivins, Roberta – F5
Blibo, Frank – C4
Bonnell-Freidin, Anne – B2
Borsch, Stuart – E3
Boster, Dea – I4
Braslow, Joel – E4
Braswell, Harold – C5
Brown, Theodore M. – I3
Bruchhausen, Walter – F3
Burnham, John – F5

Carmichael, Ann – PC
Carpentieri, Nicola – A2
Casper, Stephen – FL2, C2
Chapin, Christy – SL5
Chaplin, Simon – F1
Charters, Erica – G2
Chernesky, Jason – G5
Chowkwanyun, Merlin – SL5
Clark, Claire – E2
Condrau, Flurin – D1
Conis, Elena – SL4
Connerton, Winifred – D5
Connolly, Cynthia – A5
Connor, Jim – A4
Contois, Emily – C5
Cook, Harold – FL1, H5
Cooper, Glen – PC
Courtwright, David – G3
Cummiskey, Julia – A1
Daemmerich, Arthur – SL4

De Borros, Juanitia – E1
DeMio, Michelle – F1
Dodman, Thomas – G2
Dong, Lorraine – I5
Downey, Dennis – E4
Downs, James – F2
Dubois, Marc-Jacques – C4
Duffin, Jacalyn – G1
Dufour, Monique – A5
Dwyer, Ellen – E2
Dwyer, Erica – A1
Dwyer, Michael – E2

Eaton, Nicole – A4
Eder, Sandra – C2
Edington, Claire – E1
Engelmann, Lukas – A1
Espinosa, Mariola – FL2, H4
Evans, Bonnie – A2
Ewing, E. Thomas – F1

Fissell, Mary – C1, G2
Flannery, Michael – RW

Gambino, Matthew – SL3
Geltzer, Anna – H3
Gerber, David – H2
Gómez, Pablo – F2, PC, C1
Green, Monica – FL2
Greenberg, Stephen – RW
Greene, Jeremy – B1
Greenhouse, Linda – SS
Gross, Miriam – B5
Gutas, Dimitri – A2

Hamlin, Christopher – G5, PC
Hanley, James – I5
Hansen, Bert – I1
Hanson, Ann Ellis – B2
Hanson, Marta – A1
Hansson, Nils – D4
Harris, Nichola – H5
Haushofer, Lisa – F4

Heitman, Kristin – FL1
Herzberg, David – G3
Higby, Greg – B4
Hildebrandt, Sabine – C3
Hoffman, Beatrix – SC, I3
Hogan, Andrew – C2
Hogarth, Rana – H4
Howell, Joel – I4
Huisman, Frank – F2
Humphreys, Margaret – OP, GL

Imada, Adria – C5
Inrig, Stephen – PC, D1

Johnson, Russell – RW
Jones, David – C4
Jones, Kelly – B4
Jones, Lori – E3

Karimullah, Kamran – A2
Kazanjian, Powel – H3
Keirns, Carla – SL4
Kenny, Stephen – H4
Kernahan, Peter – E5
Kershaw, Hannah – D3
Kirk, Robert – D4
Klaffke, Lauren – F3
Knoblauch, Heidi – B3
Ko, Kevin E. – E1
Kuehnl, Nathan – I3
Kunzel, Regina – SL3

Lass, Molly – H2
Laveaga, Gabriele – OP
Lederer, Susan – C3, E5
Lewenson, Sandra Beth – G4
Lindemann, Mary – PC
Little, Jason – F5
Little, Lester – E3
Lucey, Emer – A3
Ludmerer, Kenneth – I4
Lyons, Christopher – RW
Mabika, Hines – F3

Mahoney, Amanda – I2
 Marino, Katherine – B2
 McKay, Richard A. – D1
 Medeiros, Aimee – C5
 Metaxas, Virginia – G4
 Mitman, Gregg – DF, FL2
 Mix, Lisa - RW
 Moffett, Alexander – I1
 Mohr, James – C3
 Mold, Alex – D3
 Monnais, Laurence – C4
 Mooney, Graham – H2
 Mooreville, Anat – G4
 Morabia, Alfredo – FL1
 Morrissey, Jake – C1
 Mukharji, Projit Bihari –C1

 Neill, Deborah – E1
 Newsom Kerr, Matthew – I5
 Novak, Stephen – RW
 November, Joseph – B1
 Nunokawa, Hiroshi – D1

 Ott, Julia – SL5
 Ozaki, Koji – G3

 Park, Saeyoung – B4
 Parsons, Anne E. – SL3
 Pater, Joseph – G1
 Pearson, Trais – G5
 Peckham, Robert – C3
 Pemberton, Neil – D3
 Peri, Alexis – A4
 Perry, Heather – G4
 Pichichero, Christy – G2
 Pols, Hans – E1
 Posner, Miriam – B3
 Prescott, Heather – SS
 Prieto, Laura – D5
 Radin, Joanna – B1

 Ramalingam, Chita – B3
 Ramsden, Edmund – D4
 Raz, Mical – SL3
 Read, Ian – H4
 Reagan, Leslie J. – G1
 Reis, Elizabeth – G1
 Reznick, Jeffrey S. – F1
 Reverby, Susan – SL5
 Robertson, Sara – I4
 Rodriguez, Sarah – G1
 Rosenberg, Charles – C1
 Rosner, David - GL
 Rossi, John – A3
 Ruis, Andrew – A4

 Sappol, Michael – B3
 Savelli, Mat – E4
 Schalick, Walton –B2
 Schlick, Thomas – D4
 Schmidt, Marion – C2
 Schull, Natasha – B1
 Shaner, Arlene - RW
 Shen, Wen – E5
 Shen, Yubin – D2
 Sicherman, Barbara – SS
 Siegel, Reva – SS
 Sivaramakrishnan, Kavita -C4
 Smith , Susan – E2
 Snelders, Stephen – F2
 Snow, Stephanie – D4
 Spinney, Erin – I2
 Stark, Laura – SL4
 Staub, Michael – SL3
 Steere-Williams Jacob –I5
 Steinke, Hubert – F3
 Stevens, Rosemary – SS
 Suh, Soyoung – F4
 Sullivan-Fowler, Michaela -RW
 Summers, William C. – F5
 Tabar, Judy – SS

 Thompson, Courtney – F4
 Thompson, C. Michele – H5
 Timmerman, Carsten – F1
 Tobbell, Dominique – B4
 Tomes, Nancy – F4
 Toon, Elizabeth – D3, F1
 Tousignant, Noémi – C4
 Tuchman, Arleen – F5

 Urban, Kelly – F2

 Van Bergen, Leo – F2
 Van Vleet, Stacey – H5
 Vargha, Dora - H3
 Varlik, Nükhet – E3
 Verbrugge, Martha – A3

 Wall, Barbra Mann – I2
 Walsh, Ellie – D5
 Warner, John Harley - OP
 Warren, Adam – I1
 Weisse, Travis – I3
 Weisser, Olivia – G5
 Weston, Janet – E4
 Whelan, Jean – I4
 Whitfield, Nicholas – C4
 Willoughby, Christopher – I2
 Worboys, Michael – F1
 Wu, Yi-Jui – B5

 Yang, Luwei – B5
 Yearl, Mary – H2
 Yudell , Michael – A3

 Zeller, Neici M. – D5
 Zumthurm, Tizian – F3

Continuing Medical Education Credit Information

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of The School of Medicine, State University of New York at Stony Brook and the American Association for the History of Medicine. The School of Medicine, State University of New York at Stony Brook is accredited by the ACCME to provide continuing medical education for physicians.

The School of Medicine, State University of New York at Stony Brook designates this live activity for a maximum of 23 **AMA PRA Category 1 Credit(s)[™]**. Physicians should only claim the credit commensurate with the extent of their participation in the activity.

Disclosure Policy: All those in control of CME content are expected to disclose any relevant financial relationship with a commercial interest (defined as any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients) that relates to the content that will be discussed in the educational presentation.

All commercial relationships that create a conflict with the planners, speakers, author's control of content must be resolved before the educational activity occurs.

Overall Learning Objectives for the Meeting:

1) Develop knowledge and understanding of professional behaviors and values

By the end of this activity, the learner will:

- Develop the capacity for critical thinking about the nature, ends and limits of medicine
- Deepen understanding of illness and suffering
- Identify successes and failures in the history of medical professionalism
- Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
- Recognize the dynamic interrelationship between medicine and society through history

2) Contribute to the improvement of patient care

- Critically appraise clinical management from a historical perspective
- Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)
- Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems
- Elicit and write a patient's history worthy of an historian
- Respond to changes in medical practice guided by a historically informed concept of professional responsibility and patient advocacy.

ACKNOWLEDGEMENTS

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The Local Arrangements Committee gratefully acknowledges generous support from the John P. McGovern Award Lectureship Fund at Yale Medical School. In keeping with the McGovern Lectureship's aim of fostering critical attention to the fusion of the art and the science of medicine, and of the sciences and the humanities, we are pleased to designate one panel each day as a John P. McGovern Session:

Friday, May 1, 3:30 - 5:00 p.m.: "Performing Versatility:
Historiographic Openings across Divisions of Health Work."
Saturday, May 2, 10:30 a.m. - 12:00 p.m.: "Creating the Surgeon's
World: American Surgery, 1880-1980."
Sunday, May 3, 10:30 a.m. - 12:00 p.m.: "Medical Education and
Professionalization: 19th-C. U.S."

The Local Arrangements Committee Chair thanks the following individuals for their help and support of the meeting:

Toby Appel	Jenna Healey	Joanna Radin
Mary Brazelton	Jancy Houck	Naomi Rogers
†Gerard Burrow	Stephen Inrig	Mindy Schwartz
Ann Carmichael	Carla Keirns	Carolyn Slayman
Henry Cowles	Daniel Kevles	William Summers
Keith Della Rocco	Ewa Lech	Michele Thompson
Deborah Doroshov	Ramona Moore	Nancy Tomes
Florence Gillich	Kelly Perry	Frank Torti
Melissa Grafe	Heather Munro Prescott	Susan Wheeler
Katherine Hart		

With enormous gratitude to the AAHM Secretary Jodi Koste for her guidance, patience, generosity, and indispensable institutional memory.

With great appreciation to Sara Machowski of Yale Conferences and Events for her for her attention to detail, creativity, professionalism, and much needed calm throughout this process. And with special thanks to Dismayra Martinez, Operations Manager for the Section of the History of Medicine at the Yale School of Medicine, for her deft support, good humor, and ability to hold it all together.

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we are pleased to announce that the interactive version of
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Annual Meeting in New Haven at www.historyofmedicine.com.

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We look forward to your comments on the user experience, and will appreciate your
suggestions for improvements to this new version of the standard reference work,
which will be freely available to all.



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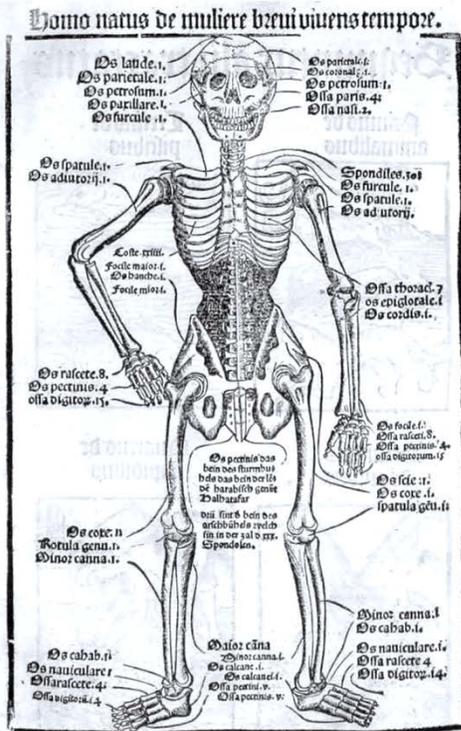
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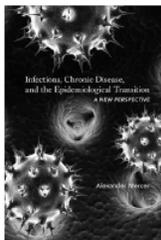
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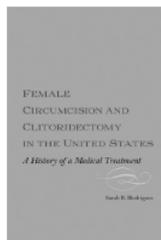
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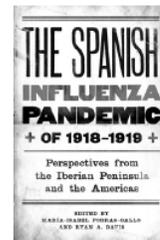
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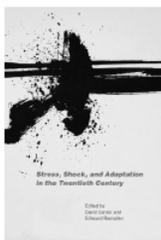
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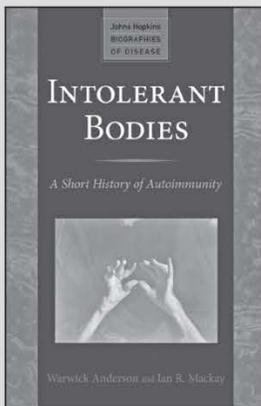
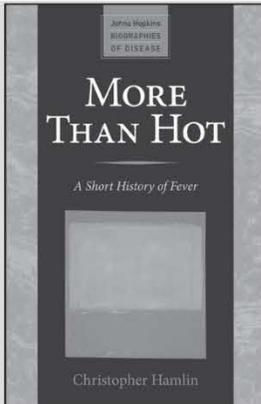


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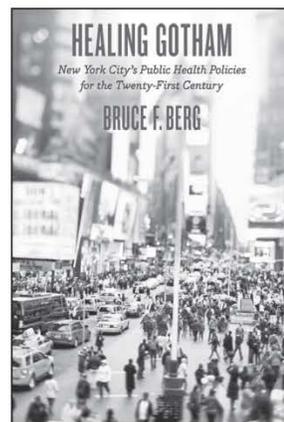
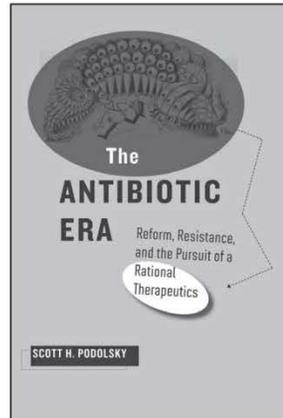
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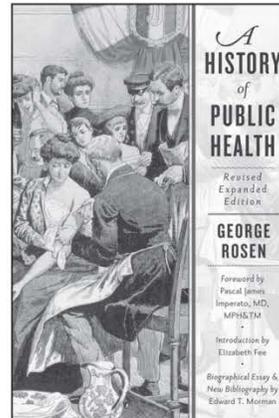
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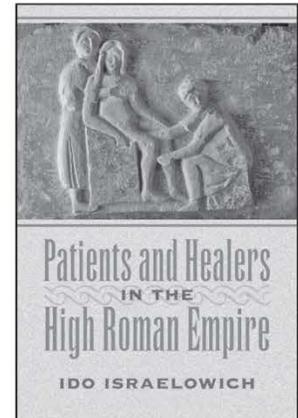
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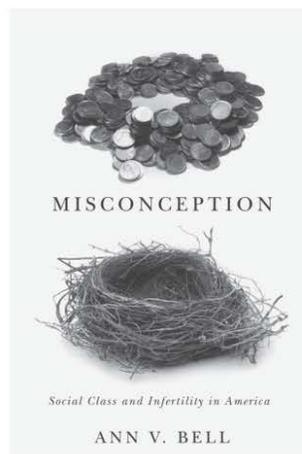


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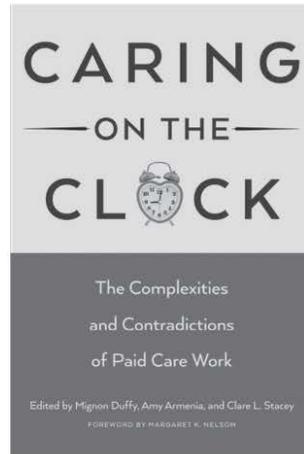
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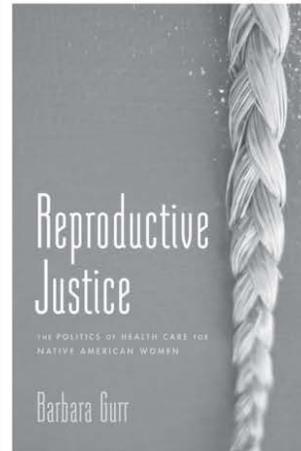
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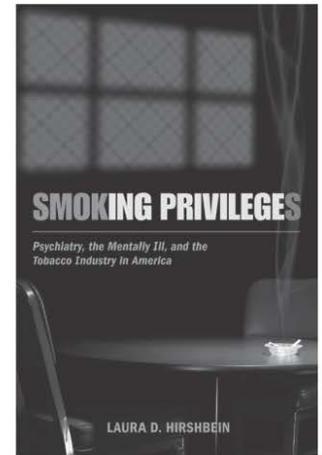
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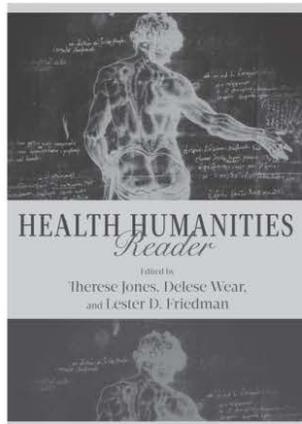


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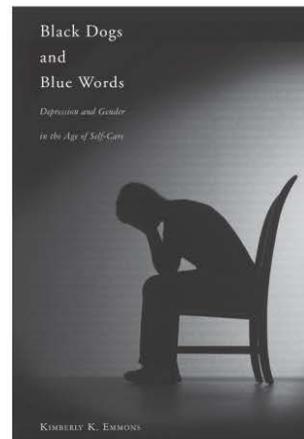


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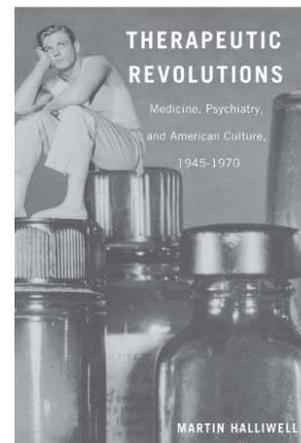
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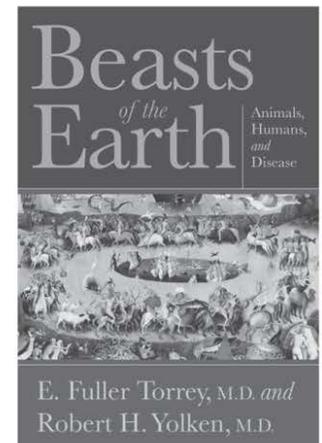
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AAHM Program 2015: Brief Overview

Wednesday, April 29th

4:00-6:00 pm ALHHS Steering Committee/Omni: York

Thursday, April 30th

10:00-7:00 pm Meeting Registration/Omni: Pre-Assembly

12:00-5:00 pm AAHM Council Meeting/Omni: Wooster

3:30-4:30 pm Yale Art Gallery Tour/Meet at Art Gallery Information Desk
(1111 Chapel St.) at 3:20;
For escort from Omni, meet in lobby at 3:10 pm
(Sign up at time of Registration)

3:00-4:30 pm Yale Medical Historical Library/Teratology Exhibition/
Cushing Center Tour/Meet at Library Circulation
Desk (333 Cedar St.) at 3:00
For escort from Omni, meet in lobby at 2:30 pm
(Sign up at time of Registration)

3:30-4:45 pm Walking Tour of Yale Campus/Meet at the Yale Visitor
Center (149 Elm St.) at 3:25
For escort from Omni, meet in lobby at 3:10 pm
(Sign up at time of Registration)

3:30-5:00 pm Sigerist Circle Business Meeting/Omni: Chapel

3:30-5:30 pm Research Workshop/Omni: Church
*Finding What's Out There: Library Resources in the
History of the Health Sciences.*

4:00-7:00 pm Book Exhibit Setup/Omni: College

5:00-7:00 pm Special Session/Omni: Ballroom
(Sigerist Circle Co-sponsor)
*Reproductive Rights after Griswold:
A Fifty-Year Retrospective*

7:00-9:00 pm Opening Reception/Omni: Ballroom D & Pre-Assembly

9:00-10:30 pm Documentary Film/Omni: Ballroom
"In the Shadow of Ebola" Gregg Mitman, presiding

AAHM Program 2015: Brief Overview

Friday, May 1st

7:00-8:00 am	President's New Member Breakfast/Omni: Church
7:00-8:00 am	<i>Bulletin of the History of Medicine</i> /Omni: Chapel BC
7:00-8:00 am	<i>J. Hist. of Medicine & Allied Sciences</i> /Omni: Whalley
7:00-8:30 am	Continental Breakfast/Omni: Pre-Assembly
7:00 am-6:00 pm	Meeting Registration/Omni: Pre-Assembly
8:30-10:00 am	Opening Plenary/Omni: Grand Ballroom BC

Jeremy Greene, Moderator

Welcoming Remarks:

John Harley Warner, Chair, LAC

Margaret Humphreys, President AAHM

Re-situating Biomedical Research

Warwick Anderson,

The University of Sydney, Australia

Gabriela Soto Laveaga,

University of California, Santa Barbara

10:00-10:30 am	Coffee Break/Omni: Pre-Assembly
10:00 am-5:00 pm	Book Exhibit/Omni: College
10:30 am-12:00 pm	CONCURRENT SESSIONS A1-A5

A1: Mapping Epidemics: Cases from the Third Plague Pandemic (USA), Yellow Fever (Uganda), and XDR-Tuberculosis (South Africa).

Location: Omni: Grand Ballroom C

A2: Genesis, Translation, Transformation: Critical Concepts in Arabic Medicine

Location: Omni: Grand Ballroom A

A3: Creating Autism: The Formation of a Disorder

Location: Omni: Temple.

A4: Research on Hunger and Nutrition in the First Half of the Twentieth Century

Location: Omni: Wooster

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A5: Children's Health at School and Play, Pre-1960s United States

Location: Omni: George

12:00–1:30 Graduate Student Lunch/BAR, 254 Crown St. New Haven
(Sign up at time of Registration)

12:00-1:30 pm Luncheon Sessions 1-2 (Sign up at time of Registration)

Lunch 1: Seventeenth-Century Origins of Population-Based Health Sciences

Location: Omni: York

Lunch 2: Witnesses at the Creation: The West African Ebola Crisis and Its Implications

Location: Omni: Grand Ballroom B

1:30-3:00 pm CONCURRENT SESSIONS B1-B5

B1: New Histories of Medical Technology: Information, Infrastructure and Identity

Location: Omni: Grand Ballroom C

B2: Language and Imagery of Health in Pre-modern Contexts

Location: Omni: Grand Ballroom A

B3: Picturing the Medical Subject: Aesthetics, Rhetoric, and Showmanship in Medical Photography, 1850-1970

Location: Omni: Temple

B4: Regulatory Regimes in the Past Half-Century

Location: Omni: Wooster

B5: Emergence of Modern Medical Paradigms in an Evolving China

Location: Omni: George

3:00-3:30 pm Coffee Break/Omni: College Foyer

3:30-5:00 pm CONCURRENT SESSIONS C1-C5

C1: Roundtable on Vernacularizing Medicine

Location: Omni: Grand Ballroom C

C2: Medicine in Translation: Local Interpretations of Medical Knowledge, Naming, and Practice

Location: Omni: Grand Ballroom A

AAHM Program 2015: Brief Overview

C3: Ethics and the Use of Human Cadavers in Modern Medical Education and Research

Location: Omni: Temple

C4: Performing Versatility: Historiographical Openings Across Divisions of Health Work (*John P. McGovern Session*)

Location: Omni: Wooster

C5: The Identity of Patients and Subjects: Processes of Medicalization and Self-Definition

Location: Omni: George

6:15-7:15 pm

FIELDING H. GARRISON LECTURE/

Yale: Levinson Auditorium, Sterling Law Building
(Buses leave Omni starting at 5:30 pm)

Margaret Humphreys, AAHM President, Presiding
David Rosner, Ronald H. Lauterstein Professor of Sociomedical Sciences
and Professor of History, Columbia University
"Trying Times: Reflections on History, the Courts and Defining Disease"

7:15-9:00 pm

Garrison Reception/Yale: Sterling Memorial Library

Saturday, May 2nd

7:00 am-6:00 pm

Meeting Registration/Omni: Pre-Assembly

7:00-8:30 am

Clinician Historians' Breakfast/Omni: Chapel

7:00-8:30 am

Continental Breakfast/Omni: Pre-Assembly

8:00 am-5:00 pm

Book Exhibit/Omni: College

8:30-10:00 am

CONCURRENT SESSIONS D1-D5

D1: Sexually Transmitted Diseases in Cultural Context

Location: Omni: Grand Ballroom C

D2: Asian Pharmaceutical Research

Location: Omni: Grand Ballroom A

D3: Unruly Publics and Public Health in Post-War Britain

Location: Omni: Temple

AAHM Program 2015: Brief Overview

D4: Innovation, Controversy and Renown in Twentieth-Century Surgery

Location: Omni: Wooster

D5: Conflict and Control: Nurses in the Caribbean, 1898-1969

Location: Omni: George

10:00-10:30 am **Coffee Break/Omni: Pre-Assembly**

10:30 am-12:00 pm **CONCURRENT SESSIONS E1-E5**

E1: New Directions in the History of Colonial Medicine

Location: Omni: Grand Ballroom C

E2: Therapeutic Research and Experimentation, Mid-Twentieth Century

Location: Omni: Grand Ballroom A

E3: Imagined Plague-Scapes: Imagining the History and Geography of the Plague over Time and Space

Location: Omni: Temple

E4: Mental Health in Comparative Perspective

Location: Omni: Wooster

E5: Creating the Surgeon's World: American Surgery 1880 – 1980

(John P. McGovern Session)

Location: Omni: George

12:00-1:30 pm **Luncheon Sessions 1-3 (Sign up at time of Registration)**

Saturday Lunch 1: New Directions in the Historiography of Mental Health: U.S. Psychiatry and the Politics of Everyday Life

Location: Omni: York

Saturday Lunch 2: Teaching History of Medicine: Strategies for Engaging with Emerging Growth Areas

Location: Omni: Grand Ballroom B

Saturday Lunch 3: History of Capitalism and History of Medicine: What Can the AAHM Learn from History's Hottest New Field?

Location: Omni: Chapel

AAHM Program 2015: Brief Overview

2:00-3:30 pm **CONCURRENT SESSIONS F1-F5**

F1: Big Data and the Medical Humanities

Location: Omni: Grand Ballroom C

F2 Comparative Health, Disease and Health Reforms in Island States

Location: Omni Grand Ballroom A

F3: Practicing Humanitarian Medicine

Location: Omni: Temple

F4: Consuming Medicine: Medicine and Consumption in Historical Perspective

Location: Omni: Wooster

F5: Genetic Theories and Human Populations

Location: Omni: George

3:30-4:00 pm **Coffee Break/College Foyer**

3:30-4:30 pm **Yale Art Gallery Tour/Meet at Art Gallery Information Desk**
(1111 Chapel St.) at 3:20
For escort from Omni, meet in lobby at 2:10 pm
(Sign up at time of Registration)

3:00-4:30 pm **Yale Medical Historical Library/Teratology Exhibition/
Cushing Center Tour/Meet at the Library Circulation
Desk (333 Cedar St.) at 3:00**
For escort from Omni, meet in lobby at 2:30 pm
(Sign up at time of Registration)

3:30-4:45 pm **Walking Tour of Yale Campus/Meet at the Yale Visitor
Center (149 Elm St.) at 3:25**
For escort from Omni, meet in lobby at 3:10 pm
(Sign up at time of Registration)

4:00-5:30 pm **CONCURRENT SESSIONS G1-G5**

G1: Dissenting Voices in Later Twentieth-Century Healthcare

Location: Omni: Grand Ballroom C

G2: War, Medicine, and Humanitarianism in Enlightenment Europe

Location: Omni: Grand Ballroom A

AAHM Program 2015: Brief Overview

G3: International Narcotics Control

Location: Omni: Temple

G4: New Research on Medical Mobilization during and after the Great War

Location: Omni: Wooster

G5: Contests over Professional and Colonial Authority in the 18th and 19th Centuries

Location: Omni: George

5:30-6:30 pm AAHM Business Meeting/Omni: Gr. Ballroom B

7:00-9:00 pm 90th Birthday Party and Awards Ceremony/
Yale: The Commons

Sunday, May 3rd

7:00-8:30 am Post-mortem Breakfast/Omni: Church

7:00-8:30 am Women Historians' Breakfast/Omni: Chapel

7:00 am-1:00 pm Meeting Registration/Omni: Pre-Assembly

7:00-8:30 am Continental Breakfast/Omni: Pre-Assembly

8:30-10:00 am CONCURRENT SESSIONS H1-H5

H1: The Medical Mind – Models and Metaphors – [*Withdrawn*]

H2: Seeing the Group: Mid-Nineteenth Century U.S. Social Medicine

Location: Omni: Grand Ballroom A

H3: From Bacteriology to International Health Policies

Location: Omni: Temple

H4: Medicine, Disease, and the Framing of Race in the Slaveholding Atlantic

Location: Omni: Wooster

H5: Pre-modern Pharmacy in Eurasia

Location: Omni: George

10:00-10:30 am Break (no coffee service)

AAHM Program 2015: Brief Overview

10:30 am-12:00 pm CONCURRENT SESSIONS I1-I5

I-1: Representation and Visualization of Medical Knowledge, 1800-1900

Location: Omni: Grand Ballroom C

I-2: Nursing, Race and Gender in 19th-Century Medical Care

Location: Omni: Grand Ballroom A

I-3: Boundaries vs Inclusivity in Later 20th-Century Health Politics

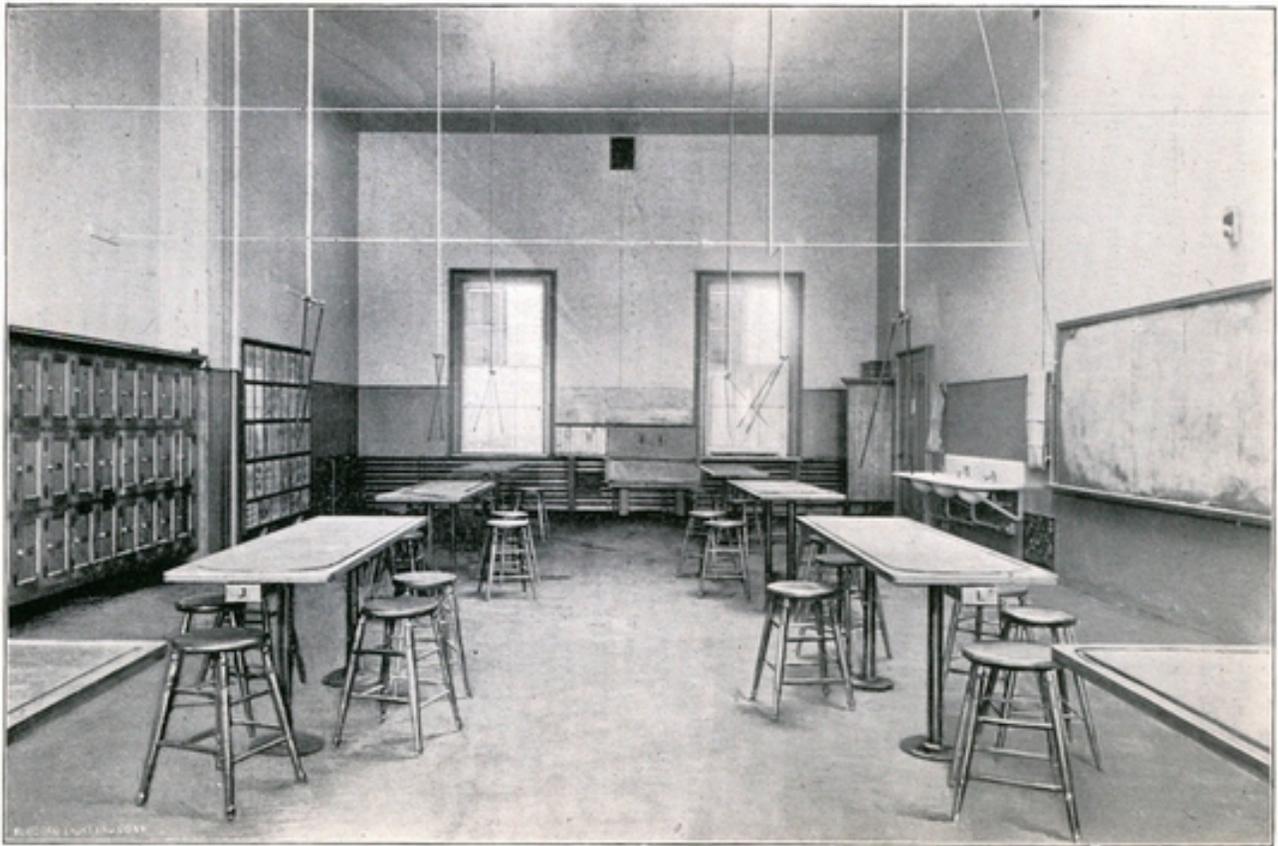
Location: Omni: Temple

I-4: Medical Education and Professionalization: 19th-Century U.S. (*John P. McGovern Session*)

Location: Omni: Wooster

I-5: Later Nineteenth-Century State Medicine

Location: Omni: George



ANATOMICAL LABORATORY.

AAHM Officers:

President: Margaret Humphreys
Vice-President: Chris Crenner
Secretary: Jodi Koste
Treasurer: Margaret Marsh
Immediate Past President: Nancy Tomes

Council Members Through 2015

David Cantor
Jeremy Greene
John Swann
Jacqueline Wolf

Councilors Through 2016

Paul Berman
Lisa Bob
Erika Dyck
Michael Flannery

Councilors Through 2017

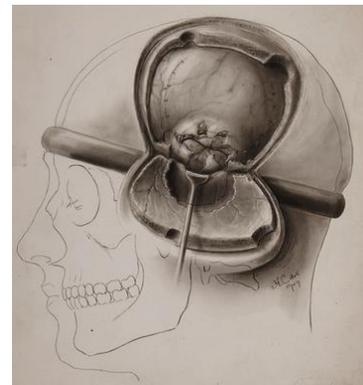
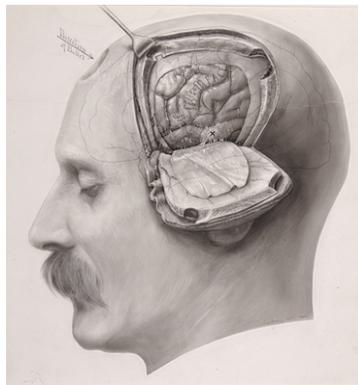
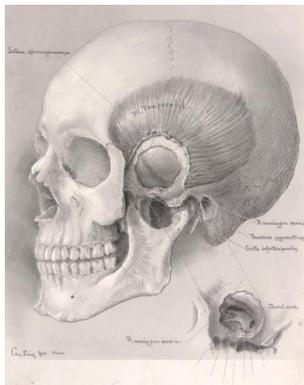
Gary Ferngren
Scott Podolsky
Mindy Schwartz
Alexandra Stern

Local Arrangements Committee

John Harley Warner, Chair
Toby Appel
†Gerard Burrow
Henry Cowles
Deborah Doroshov
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Joanna Radin
Naomi Rogers
William Summers
C. Michele Thompson
Nancy Tomes
Susan Wheeler

Program Committee:

Ann Carmichael, Co-chair
Stephen Inrig, Co-Chair
Nicole Barnes
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Christopher Hamlin
Mary Lindemann



Drawing by H. Cushing, Cushing/Whitney Medical Library, Yale University

AAHM Detailed Meeting Program

Wednesday, April 29th

4:00-6:00 pm ALHHS Steering Committee/Omni: York

Thursday, April 30th

10:00-7:00 pm Meeting Registration/Omni: Pre-Assembly

12:00-5:00 pm AAHM Council Meeting/Omni: Wooster

2:30-3:30 pm Yale Art Gallery Tour/Meet at Art Gallery Information Desk
(1111 Chapel St.) at 2:20
For escort from Omni, meet in lobby at 2:10 pm
(Sign up at time of Registration)

3:00-4:30 pm Medical Historical Library/Teratology Exhibition/
Cushing Center Tour/Meet at Library Circulation Desk
(333 Cedar St.) at 3:00
For escort from Omni, meet in lobby at 2:30 pm
(Sign up at time of Registration)

3:30-4:45 pm Walking Tour of Yale Campus/Meet at the Yale Visitor
Center (149 Elm St.) at 3:25
For escort from Omni, meet in lobby at 3:10 pm
(Sign up at time of Registration)

3:30-5:00 pm Sigerist Circle Business Meeting/Omni: Chapel
Beatrix Hoffman, Presiding

3:30-5:30 pm Research Workshop/Omni: Church
*Finding What's Out There: Library Resources in the
History of the Health Sciences.*
Moderator: Stephen Greenberg

4:00-7:00 pm Book Exhibit Setup/Omni: College

5:00-7:00 pm Special Session/Omni: Ballroom
*Reproductive Rights after Griswold:
A Fifty-Year Retrospective*
(Sigerist Circle Co-sponsor)
Moderator: Barbara Sicherman
Panelists:
Rosemary Stevens
Heather Munro Prescott
Linda Greenhouse
Reva Siegel
Judy Tabar

3. Erica Dwyer, University of Pennsylvania, Philadelphia, PA:
Placing a Local Outbreak on a Global Health Map: Visual Technologies and the Biopolitical Imaginaries of Extensively Drug-resistant Tuberculosis in Tugela Ferry, South Africa

A2: Genesis, Translation, Transformation: Critical Concepts in Arabic Medicine

Location: Omni: Grand Ballroom A

Moderator: Dimitri Gutas

1. Nicola Carpentieri, The University of Manchester, Manchester, UK:
Topics in Arabic Commentaries on the Hippocratic Aphorisms: Mental Disorder and the Body.
2. Kamran Karimullah, University of Manchester, Manchester, UK:
Logic, Experience, Experimentation: Gauging the Influence of Aristotle and Galen on Medieval Arabic Medicine.
3. Samuel Barry, University of Manchester, Manchester, Lancashire, UK: *The Critical Days in Syriac and Arabic Translation.*

A3: Creating Autism: The Formation of a Disorder

Location: Omni: Temple

Moderator: Emer H. Lucey

1. Emer Lucey, University of Wisconsin-Madison, Madison, WI:
Otherworldly Beauty: The Aestheticization of Autism, 1943-1980.
2. Jeffrey Baker, Duke University, Durham, NC:
Contesting Autisms: Constructing a New Syndrome at Johns Hopkins and Bellevue.
3. Michael Yudell, John Rossi, Drexel Sch. of Public Health, Philadelphia, PA:
What's at Stake in the History of Autism?
4. Bonnie Evans, Queen Mary, London, UK:
Autism as an Object of Genetic and Neuroscientific Research in Britain, 1977-2015.

A4: Research on Hunger and Nutrition in the First Half of the Twentieth Century

Location: Omni: Wooster

Moderator: Andrew Ruis

1. Jim Connor, Memorial University, St John's Newfoundland, Canada:
An "ideal laboratory": The International Study of Nutrition and Deficiency Diseases in Newfoundland and Labrador, 1900-1950.
2. Alexis Peri, Boston University, Boston MA:
Nutritional Dystrophy: The Rise and Fall of a Disease Discovered on the Eastern Front.

Friday, May 1st

3. Nicole Eaton, Kennan Inst, Washington, DC; Wesleyan U. Middletown, CT:
German Hunger after the War: Soviet-German Discourse in Kaliningrad and West Germany, 1945-1955.

A5: Children's Health at School and Play, Pre-1960s United States

Location: Omni: George

Moderator: Cynthia Connolly

1. Rima Apple, University of Wisconsin-Madison, Madison, WI:
An Unexamined Catalyst for Rural Public-Health Reform: The School Nurse in the Inter-war Years.
2. Monique Dufour, Virginia Tech, Blacksburg, VA:
"What Is Reading Doing to Johnny?" Literacy Education for the Healthy Personality in the Midcentury U.S.
3. Martha Verbrugge, Bucknell University, Lewisburg, PA:
The Nature of Play: Biomedical Science and the Battle over Segregated Recreation in Washington, D.C., 1942-1954.

12:00-1:30 **Graduate Student Lunch/BAR**, 254 Crown St. New Haven
(Sign up at time of Registration)

12:00-1:30 pm **Luncheon Sessions 1-2** (Sign up at time of Registration)

Lunch 1: Seventeenth-Century Origins of Population-Based Health Sciences

Location: Omni: York

Moderator and Discussant: Alfredo Morabia

1. Alfredo Morabia, Barry Commoner Center, New York, NY:
The Seventeenth-Century Roots of Epidemiology.
2. Kristin Heitman, Independent Scholar, Bethesda, MD:
On Deaths and Civic Management: A Prehistory of the London Bills of Mortality.
3. Harold Cook, Brown University, Providence, RI:
Descartes, Medicine, and Political Arithmetic.

Lunch 2: Witnesses at the Creation: The West African Ebola Crisis and Its Implications

Location: Omni: Grand Ballroom B

Moderator: Monica Green

Discussant: Stephen T. Casper

1. Gregg Mitman, University of Wisconsin-Madison, WI:
Forgotten Paths of Empire: Reshaping Narratives of the Ebola Crisis.
2. Monica Green, Arizona State University, Tempe, AZ:
Situating Ebola within Global History of Health Narratives.
3. Mariola Espinosa, University of Iowa, Iowa City, IA:
Teaching Current Events in the History of Medicine: Ebola in the Classroom.

1:30-3:00 pm

CONCURRENT SESSIONS B1-B5

B1: New Histories of Medical Technology: Information, Infrastructure and Identity

Location: Omni: Grand Ballroom C

Moderator: Jeremy Greene

Discussant: Joanna Radin

1. Jeremy Greene, Johns Hopkins University, Baltimore, MD:
On Call: Toward a Media History of Medicine.
2. Joanna Radin, Yale University, New Haven, CT:
Death and Data: Managing Patients After Life.
3. Joseph November, Dept. of History, Univ. of S. Carolina, Columbia, SC:
Gaming for the Cure: Home Computer Users and Video Gamers in Medical Research.
4. Natasha Schull, MIT, Cambridge, MA:
Health App: Personal Data Tracking as Quantified Self-Care.

B2: Language and Imagery of Health in Pre-modern Contexts

Location: Omni: Grand Ballroom A

Moderator: Ann Ellis Hanson

1. Katherine Marino, Univ. of Massachusetts Medical Sch., Worcester, MA:
I curse...myself?: Understanding Graeco-Egyptian Uterine Amulets as a Medical Means to Control the Female Body in Light of Contemporary Curse Technologies.
2. Anna Bonnell-Freidin, Princeton University, Princeton, NJ:
An Animal Within? Contextualizing a Vision of the Uterus in Ancient Greek Medical Culture.
3. Walton Schalick, Univ. of Wisconsin-Madison/Central Wisc. Ctr., Madison, WI:
"Patiens patiens:" A Contextualized Etymology of the Long Suffering Patient.

B3: Picturing the Medical Subject: Aesthetics, Rhetoric, and Showmanship in Medical Photography, 1850-1970

Location: Omni: Temple

Moderator and Discussant: Chitra Ramalingam

1. Heidi Knoblauch, Yale University, New Haven, CT:
Medical Photography, Record Keeping, and the Doctor Patient Relationship: The Photographic Department at Bellevue Hospital, 1868 – 1906.

Friday, May 1st

2. Miriam Posner, University of California, Los Angeles, Los Angeles:
Head-and-Shoulder Hunting in the Americas: Walter Freeman and the Visual Culture of Psychiatry.
3. Michael Sappol, National Library of Medicine, Bethesda, MD:
Anatomy's Photography: Objectivity, Showmanship and the Reinvention of the Anatomical Image, 1850-1920.

B4: Regulatory Regimes in the Past Half-Century

Location: Omni: Wooster

Moderator: Dominique Tobbell

1. Kelly Jones, State University of New York at Stony Brook, NY:
"Mr. Reston has it helped you?" The 1970s Acupuncture "Fad" and Popular Understandings of Therapy.
2. Saeyoung Park, Davidson College, Davidson, NC:
Contradictory Global Public Health: Privatizing Tobacco and Nation-State Polices in South Korea.
3. Greg Higby, University of Wisconsin-Madison, Madison, WI, and American Institute History of Pharmacy, Madison, WI:
The "archaic" North Dakota Pharmacy Ownership Law and the Realities of 21st-Century Pharmacy Practice.

B5: Emergence of Modern Medical Paradigms in an Evolving China

Location: Omni: George

Moderator: Nicole Barnes

1. Luwei Yang, Washington University in St. Louis, MO:
Tamed or Denied Sense of Suffering: Pain in Childbirth in Modern China.
2. Yi-Jui Wu, Nanyang Technological University, Singapore, Singapore: *Origins of "Manufactured Mental Illnesses (bei jingshenbing)" in Twentieth-Century China*
3. Miriam Gross, University of Oklahoma, Norman, OK:
Between Party, People, and Profession: The Many Faces of the "Doctor" during the Cultural Revolution.

3:00-3:30 pm **Coffee Break/Omni: College Foyer**

3:30-5:00 pm **CONCURRENT SESSIONS C1-C5**

C1: Roundtable on Vernacularizing Medicine

Location: Omni: Grand Ballroom C

Moderator and Discussant: Charles E. Rosenberg

Panelists:

Mary Fissell, Dept. of the History of Medicine, Johns Hopkins University.
Pablo Gómez, Dept. of Medical History and Bioethics, Univ. of Wisconsin-Madison.
Nicole Elizabeth Barnes, Department of History, Duke University.
Jake Walsh Morrissey, Dept. of English Literature, Trent University.
Projit Bihari Mukharji, Dept. of History & Sociology of Sci., Univ. of Penn.

C2: Medicine in Translation: Local Interpretations of Medical Knowledge, Naming, and Practice

Location: Omni: Grand Ballroom A

Moderator: Stephen Casper

1. Sandra Eder, University of Zurich, Zurich, Switzerland:
Translating Medicine, Circulating Knowledge. Transferring Treatment Recommendations for "Hermaphroditic" Children from Baltimore to Zurich.
2. Marion Schmidt, Johns Hopkins University, Baltimore, MD:
Translating Psychiatric Genetics to a New Era: The Redefinition of Deafness at the New York State Psychiatric Institute, 1955-1970.
3. Andrew Hogan, Creighton University, Omaha, NE:
Negotiating Medical Knowledge: Professional Interests, Patient Advocates, and the Localization of Naming Practices.

C3: Ethics and the Use of Human Cadavers in Modern Medical Education and Research

Location: Omni: Temple

Moderator: James Mohr

1. Robert Peckham, The University of Hong Kong, Hong Kong:
Autopsies of Violence: Dissection and Dissent in Nineteenth-Century China.
2. Sabine Hildebrandt: Boston Children's Hosp./Harvard Medical Sch., Boston, MA:
From the Dead to the Living: Ethical Transgressions in Anatomical Research on Victims of the National Socialist Regime.
3. Susan Lederer, University of Wisconsin-Madison, Madison WI:
Bequests of Bodies: Willing One's Body to Medical Science in the 1950s.

C4: Performing Versatility: Historiographical Openings across Divisions of Health Work (John P. McGovern Session)

Location: Omni: Wooster

Discussants: Laurence Monnais, Noémi Tousignant

1. Frank Blibo, David Jones, Harvard University, Cambridge, MA: *Improvising Open-Heart Surgery in Independent West Africa, 1964-1995.*

Friday, May 1st

2. Nicholas Whitfield, Marc-Jacques Dubois, Department of Social Studies of Medicine, McGill University, Montreal, Quebec, Canada:
The Versatility of Minimally Invasive Surgery (MIS).
3. Kavita Sivaramakrishnan, Columbia University, New York; and David Jones: Harvard University, Boston, MA:
Technology, Expertise, and Ideology: Versatility and the Establishment of Cardiac Care in India.

C5: The Identity of Patients and Subjects: Processes of Medicalization and Self-Definition

Location: Omni: George

Moderator: Harold Braswell

1. Aimee Medeiros, University of California, San Francisco, San Francisco, CA:
Medicine, Manhood, and Midgets: Examining Early Growth Hormone Therapy in the U.S.
2. Adria L. Imada, University of California, Irvine, Irvine, CA:
Beyond Staring? Towards a Patient-Centered Optics of Disability and Illness.
3. Emily Contois, Brown University, Providence, RI:
The Rise and Fall of the Thrifty Genotype Hypothesis

6:15-7:15 pm

FIELDING H. GARRISON LECTURE/

Yale: Levinson Auditorium, Sterling Law Building
(Buses leave Omni starting at 5:30 pm)

Margaret Humphreys, AAHM President, Presiding

David Rosner, Ronald H. Lauterstein Professor of Sociomedical Sciences
and Professor of History, Columbia University

"Trying Times: Reflections on History, the Courts and Defining Disease"

7:15-9:00 pm

Garrison Reception/Yale: Sterling Memorial Library

Saturday, May 2nd

7:00 am-6:00 pm

Meeting Registration/Omni: Pre-Assembly

7:00-8:30 am

Clinician Historians' Breakfast/Omni: Chapel

7:00-8:30 am

Continental Breakfast/Omni: Pre-Assembly

8:00 am-5:00 pm

Book Exhibit/Omni: College

8:30-10:00 am

CONCURRENT SESSIONS D1-D5

D1: Sexually Transmitted Diseases in Cultural Context

Location: Omni: Grand Ballroom C

Moderator: Stephen Inrig

1. Hiroshi Nunokawa, Hiroshima University, Higashi-Hiroshima, Japan: *Venereal Disease and Social Structure: Hiroshima Immediately Following after Defeat.*
2. Richard A. McKay, University of Cambridge, Cambridge, UK:
"Evil is in the Eye of the Beholder:" Venereal Disease and Homosexuality in Vancouver's Bathhouse Debates.
3. Flurin Condrau, University of Zurich, Zurich, Switzerland; Lukas Engelmann, University of Cambridge, Cambridge, UK:
The Swiss Model of HIV/AIDS Prevention between Local and Global Health.

D2: Asian Pharmaceutical Research

Location: Omni: Grand Ballroom A

Moderator: Bridie Andrews

1. He Bian, Princeton University, Princeton, NJ:
"Ready-made Formula" in Dispute: Understanding Pharmacological Virtuosity in Early Modern China.
2. Yubin Shen, Georgetown University, Washington DC:
State Bio-prospecting and Cinchona Cultivation in Yunnan (China), 1932-1948.
3. Nandini Bhattacharya, University of Dundee, Dundee, UK:
Pharmacy in Colonial India: Interrogating the Narrative of Professionalization.

D3: Unruly Publics and Public Health in Post-War Britain

Location: Omni: Temple

Discussant: Elizabeth Toon

1. Alex Mold, London School of Hygiene & Tropical Medicine, London, UK: *Picturing Public Health: Visual Culture and Public Health in Post-War Britain.*
2. Hannah Kershaw, University of Manchester, Manchester, UK: *"Is this perhaps too controversial even for us?" The Production and Dissemination of AIDS Education Packs for Children by the Family Planning Association in Late 1980s & Early 1990s.*
3. Neil Pemberton, University of Manchester, Greater Manchester, UK: *The Death of the Dog-House: The Interspecies Politics of Dog-fouling and Dog-walking in Modern Britain.*

Saturday, May 2nd

D4: Innovation, Controversy and Renown in Twentieth-Century Surgery

Location: Omni: Wooster

Moderator: Justin Barr

1. Nils Hansson, University Medical Center, Goettingen, Germany; and Thomas Schlich, Dept. of Social Studies of Medicine, Montreal, Canada:
Enacting Excellency: Awarding Nobel Prizes (or not) to Surgeons in the Twentieth Century.
2. Robert Kirk, University of Manchester, Manchester, UK; and Edmund Ramsden, Queen Mary University of London, London, UK:
Dogs as Co-workers? Cross-species Collaboration and the Translation of Medical Science for the American Public, 1948-1966.
3. Stephanie Snow, University of Manchester, Manchester, UK:
Global Paradigms and Local Practices: The Development of Stroke Services since the 1990s.

D5: Conflict and Control: Nurses in the Caribbean, 1898-1969

Location: Omni: George

Moderator: Winifred Connerton

1. Winifred Connerton, Pace Univ. College of Health Professions, NY, NY:
Nationalist Messages in Government and Missionary Nursing Education – Puerto Rico, 1900-1917.
2. Laura Prieto, Simmons College, Boston, MA:
Dazzling Visions: American Women, Race, and the Imperialist Origins of Modern Nursing in Cuba, 1898-1922.
3. Ellie Walsh, Governors State University, University Park, IL:
"We Must Have the White Girl:" The Institutionalization of Racial Hierarchies in Nursing Education in Early Twentieth-Century Puerto Rico.
4. Neici M. Zeller, William Paterson University, Wayne, NJ:
Convenient Service: Dictatorship, Modernization, and Nursing in the Dominican Republic (1930-1961).

10:00-10:30 am **Coffee Break/Omni: Pre-Assembly**

10:30 am-12:00 pm **CONCURRENT SESSIONS E1-E5**

E1: New Directions in the History of Colonial Medicine

Location: Omni: Grand Ballroom C

Moderator and Discussant: Warwick Anderson

1. Hans Pols, University of Sydney, Sydney, Australia:
From Colonial Medicine to Independence: The Indonesian Medical Profession, 1930-1960.
2. Kevin E. Ko, Yale University, New Haven, CT:
Colonial Ethics in Two Keys: The Multiple Uses of Medical Humanitarianism in a Late Colonial Society.
3. Claire Edington, University of Massachusetts, Boston, MA:
Lessons from Abroad: Experts, Study Trips and the History of Psychiatry in Colonial Southeast Asia.
4. Deborah Neill, York University, Toronto, Ontario, Canada; and Juanita De Barros, McMaster University, Hamilton, Ontario, Canada:
The Business of Tropical Medicine: Transnational Corporations and the Development of the Liverpool School in the Early Twentieth Century.

E2: Therapeutic Research and Experimentation: Mid-Twentieth Century

Location: Omni: Grand Ballroom A

Moderator: Ellen Dwyer

1. Michael Dwyer, University College, Cork, Ireland:
"Experimental Material:" Human Experimentation in Irish Children's Institutions, 1930-35.
2. Claire Clark, University of Kentucky, Lexington, KY:
The Return of Rehabilitative Corrections: Therapeutic Community Research in the US Prison System, 1986-1992.
3. Susan Smith, University of Alberta, Edmonton, Alberta, Canada:
Mustard Gas and Cancer Chemotherapy.

E3: Imagined Plague-Scapes: Imagining the History and Geography of the Plague over Time and Space

Location: Omni: Temple

Moderator and Discussant: Lester Little

1. Lori Jones, University of Ottawa, Ottawa, ON, Canada:
Changing Perceptions of the Origin of the Plague in 14th-17th Century England and France.
2. Nükhet Varlik, Rutgers University-Newark, NJ:
"Oriental plague" or Epidemiological Orientalism?: Revisiting the Plague Episteme of the Post-Black Death Mediterranean.
3. Stuart Borsch, Assumption College, Worcester, MA:
Awful Arithmetic: Body Counts and the Medieval Islamic Imagination.

Saturday, May 2nd

E4: Mental Health in Comparative Perspective

Location: Omni: Wooster

Moderator: Joel Braslow

1. Dennis Downey, Millersville University, Millersville, PA:
Philadelphia Physicians, Public Health and the 'Menace' of the Feeble-Minded, 1880-1920.
2. Mat Savelli, McMaster University, Hamilton, Ontario, Canada:
*"The sum quantity of joy and misery is the same in Slovenia and in Kosovo:"
Suicide Epidemics and Ethnicity in the Balkan States.*
3. Janet Weston, Birkbeck, University of London, London, UK:
The Trials of Forensic Psychiatry.

E5: Creating the Surgeon's World: American Surgery 1880 – 1980 (John P. McGovern Session)

Location: Omni: George

Moderator: Susan Lederer

1. Peter Kernahan, University of Minnesota, Minneapolis MN:
International Alliances: William J. Mayo and Surgical Science in the First Age of Globalization.
2. Wen Shen, UCSF, San Francisco, CA:
Oliver Cope and The 1966-67 Swampscott Meetings: A Surgeon's Crusade to Humanize Medical Education.
3. Justin Barr, Univ. of VA, Charlottesville, VA; Yale Univ., New Haven, CT:
The Training and Education of Surgeons in America, 1900-1960.

12:00-1:30 pm Luncheon Sessions 3-5 (Sign up at time of Registration)

Lunch 3: New Directions in the Historiography of Mental Health: U.S. Psychiatry and the Politics of Everyday Life

Location: Omni: York

Moderators: Matthew Gambino; Mical Raz

Panelists:

Regina Kunzel, Department of History, Princeton University
Anne E. Parsons, Dept. of History, Univ. of North Carolina at Greensboro.
Mical Raz, Department of Internal Medicine, Yale University
Michael Staub, Department of English, Baruch College

Lunch 4: Teaching History of Medicine: Strategies for Engaging with Emerging Growth Areas

Location: Omni: Grand Ballroom B

Moderator: Arthur Daemmerich

1. Arthur Daemmerich, Univ. of Kansas Medical Center, Kansas City, KS:
Responsible Conduct of Research: Courses and Cases.
2. Elena Conis, Emory University, Atlanta, GA:
Teaching History of Medicine & Health across the University.
3. Laura Stark, Vanderbilt University, Nashville, TN:
More than Background: Explaining to Instructors and Students How History Clarifies the Present-Day Practice of Ethics.
4. Carla Keirns, Stony Brook University, Stony Brook, NY:
History as a Tool for Teaching Public Health, Health Systems Analysis, and Health Economics.

Lunch 5: History of Capitalism and History of Medicine: What Can the AAHM Learn from History's Hottest New Field?

Location: Omni: Chapel

Moderator: Merlin Chowkwanyun

Panelists:

Merlin Chowkwanyun, University of Wisconsin-Madison

Julia Ott, New School for Social Research

Christy Chapin, University of Maryland - Baltimore County

Susan Reverby, Wellesley College

2:00-3:30 pm

CONCURRENT SESSIONS F1-F5

F1: Big Data and the Medical Humanities

Location: Omni: Grand Ballroom C

Moderator: Michelle DiMeo

Discussant: Jeffrey S. Reznick

1. Simon Chaplin, Wellcome Trust, London, UK:
Why Creating a Digital Library for the History of Medicine is Harder Than You'd Think.
2. E. Thomas Ewing, Virginia Tech, Blacksburg, VA:
Understanding the Scope and Severity of a Global Epidemic: Research on the Russian Influenza (1889-1893) Using Big Data Methods and Digital Collections.
3. Elizabeth Toon, Carsten Timmermann, and Michael Worboys, with Sophia Ananiadou, Nick Duvall, John McNaught, and Paul Thompson, Univ. of Manchester, Manchester, UK:
Text Mining for Medical Historians: Big Data, Big Questions.

Saturday, May 2nd

F2: Comparative Health, Disease and Health Reforms in Island States

Location: Omni Grand Ballroom A

Moderator: Pablo Gómez

1. Stephen Snelders, University Medical Center Utrecht, Utrecht, The Netherlands; Leo Van Bergen, Royal Netherlands Institute of Southeast Asian and Caribbean Studies, Leiden, The Netherlands; and Frank Huisman, University Medical Center Utrecht, Utrecht, The Netherlands:
The 'Caribbean Corrective': Comparing Leprosy Regimes in the Dutch West and East Indies (Suriname and Indonesia), 1800-1950.
2. James Downs, Connecticut College, New London, CT:
The Coefficient in Epidemiology: The International Cholera Epidemics in the Caribbean.
3. Kelly Urban, University of Pittsburgh, Pittsburgh, PA:
"A Very Nice Square Peg...in a Very Round Hole": The Rockefeller Foundation and the Push for National Health Reform in Cuba, 1935-1942.

F3: Practicing Humanitarian Medicine

Location: Omni: Temple

Moderator: Hubert Steinke

1. Walter Bruchhausen, RWTH Aachen University, Aachen, Germany:
Medical Practice as Charity and Modernity: German Catholic Medical Missionaries during Decolonization.
2. Hines Mabika, Tizian Zumthurn, Univ. of Bern, Bern, Switzerland:
Medical Practice and Networks at the Albert Schweitzer Hospital of Lambarene, 1913-1965.
3. Lauren Klaffke, University of Minnesota, Minneapolis, MN:
Private Networks in Medical Philanthropy: The Political Contexts of Projects HOPE and Orbis.

F4: Consuming Medicine: Medicine and Consumption in Historical Perspective

Location: Omni: Wooster

Moderator: Courtney Thompson

1. Lisa Haushofer, Harvard University, Cambridge, MA:
"Dear Mr Bengel"— Medicinal Foods, Medicine and Consumption.
2. Nancy Tomes, Stony Brook University, Stony Brook, NY:
Aspirin Wars.
3. Soyoung Suh, Dartmouth College, Hanover, NH:
Lifesaving Water, Nation-Saving Medicine: Advertising Medicinal Products in Colonial Korea (1910-1945).

F5: Genetic Theories and Human Populations

Location: Omni: George

Moderator: William C. Summers

1. Jason Little, Mayo Clinic, Rochester, MN; and John Burnham, Ohio State University, Columbus, OH: *Gonadal Radiation Exposure Cards: A Concrete Symbol of the Intrusion of Science into Clinical Medicine in the 1950s*
2. Roberta Bivins, Centre for the History of Medicine, Univ. of Warwick, UK: *From 'Ethnic' to 'Racial'? Thalassaemia in Britain, 1974-2014.*
3. Arleen Tuchman, Vanderbilt University, Nashville, TN: *American Indians, Diabetes, and Thrifty Genes*

3:00-4:30 pm **Yale Medical Historical Library/Teratology Exhibition/
Cushing Center Tour/Meet at Library Circulation
Desk (333 Cedar St.) at 3:00**
For escort from Omni, meet in lobby at 2:30 pm
(Sign up at time of Registration)

3:30-4:30 pm **Yale Art Gallery Tour/Meet at Art Gallery Information Desk
(1111 Chapel St.) at 3:20**
For escort from Omni, meet in lobby at 2:10 pm
(Sign up at time of Registration)

3:30-4:45 pm **Walking Tour of Yale Campus/Meet at the Yale Visitor
Center (149 Elm St.) at 3:25**
For escort from Omni, meet in lobby at 3:10 pm
(Sign up at time of Registration)

3:30-4:00 pm **Coffee Break/College Foyer**

4:00-5:30 pm **CONCURRENT SESSIONS G1-G5**

G1: Dissenting Voices in Later Twentieth-Century Healthcare

Location: Omni: Grand Ballroom C

Moderator: Leslie Reagan

1. Elizabeth Reis, University of Oregon, Eugene, OR:
Tradition and the Oral Suction Controversy.
2. Jacalyn Duffin, Joseph Pater, Queen's Univ., Kingston, Ontario, Canada:
Mrs. Robinson's Revenge: The Medicare Protest Song.
3. Sarah Rodriguez, Northwestern University, Chicago, IL:
*A "Non-Standard Practice of Gynecology:" James Burt's "Love Surgery" and
Questions of Routine Medical Innovation.*

Saturday, May 2nd

G2: War, Medicine, and Humanitarianism in Enlightenment Europe

Location: Omni: Ballroom A

Moderator: Mary E. Fissell

1. Christy Pichichero, George Mason University, Fairfax, VA:
War and Medical Enlightenment: Humanity, Military Medicine, and the Eighteenth-Century Origins of the Red Cross and Geneva Convention.
2. Thomas Dodman, Boston College, Chestnut Hill, MA:
Nostalgia in 1688: The Making of a Deadly Emotion.
3. Erica Charters, University of Oxford, Oxford, UK:
Enlightened Warfare and Medicine: Franco-British Global War during the Mid-Eighteenth Century.

G3: International Narcotics Control

Location: Omni: Temple

Moderator: David Courtwright

1. Koji Ozaki, Ôtemae University, Nishinomiya, Japan:
Why was the Opium Smuggled by John Hartley Seized for Ten Years? Examining the 1870s Anglo-Japanese Dispute over Drug Control.
2. David Herzberg, University at Buffalo (SUNY), Buffalo, NY:
Addicts in Unexpected Places: The Class Politics of Addiction in the 'Classic Era' of Narcotics Control.

G4: New Research on Medical Mobilization during and After the Great War

Location: Omni: Wooster

Moderator: Sandra Beth Lewenson

1. Anat Mooreville, UCLA, Los Angeles, CA:
Trachoma in Palestine: The Very Idea.
2. Heather Perry, University of North Carolina Charlotte, Charlotte, NC:
Hungry for War: Nutrition, Health and the Mobilized Kitchen in WWI Germany.
3. Virginia Metaxas, Southern Connecticut State University, New Haven, CT:
Transnational Women's Health Activism: Ruth Parmelee, M.D., the American Women's Hospitals, and Modern Nursing in Turkey and Greece, 1920-1935.

G5: Contests over Professional and Colonial Authority in the 18th and 19th Centuries

Location: Omni: George

Moderator: Christopher Hamlin

1. Olivia Weisser, University of Massachusetts Boston, Boston, MA:
War of Venus: The Venereal Trade in 18th-century London.

2. Trais Pearson, Wheaton College, Norton, MA:
Forensic Medicine in Nineteenth-Century Siam (Thailand): Unnatural Death & State Sovereignty.

3. Jason Chernesky, University of Pennsylvania, PA:
A "Therm-Antidote" for British Anxieties: Cooling Technologies, Health, and Medicine in Nineteenth-Century India.

5:30-6:30 pm **AAHM Business Meeting/Omni: Grand Ballroom B**

7:00-9:00 pm **90th Birthday Party and Awards Ceremony/
Yale: The Commons**

Sunday, May 3rd

7:00-8:30 am **Post-Mortem Breakfast/Omni: Church**

7:00-8:30 am **Women Historians' Breakfast/Omni: Chapel**

7:00 am-1:00 pm **Meeting Registration/Omni: Pre-Assembly**

7:00-8:30 am **Continental Breakfast/Omni: Pre-Assembly**

8:30-10:00 am **CONCURRENT SESSIONS H1-H5**

H1: The Medical Mind – Models and Metaphors – [*Withdrawn*]

H2: Seeing the Group: Mid-Nineteenth Century U.S. Social Medicine

Location: Omni: Grand Ballroom A

Moderator: Graham Mooney

1. David Gerber, University at Buffalo (SUNY), Amherst, New York:
"Still Sick:" Health Consciousness and Its Consequences among Nineteenth Century European Immigrants to North America.
2. Mary Yearl, American Textile History Museum, Lowell, MA:
The Pemberton Mill Relief Committee and the Economics of Industrial Medicine in 1860.
3. Molly Laas, University of Wisconsin-Madison, Madison, WI:
The Chemistry of Morality: Designing Nineteenth-Century Prison and Asylum Diets in the United States.

Sunday, May 3rd

H3: From Bacteriology to International Health Policies

Location: Omni: Temple

Moderator: Anne-Emmanuele Birn

1. Powel Kazanjian, University of Michigan, Ann Arbor, MI:
Frederic G. Novy, 1889-1933: Early Bacteriologic Investigations in America.
2. Anna Geltzer, Wesleyan University, Middletown, CT:
Surrogate Virtues: Shifting Discourses of Objectivity in Russian Biomedicine.
3. Dora Vargha, Birkbeck College, University of London, London, UK:
When Polio became Global: Cold War Epidemic Management and the Roots of the Eradication Campaign.

H4: Medicine, Disease, and the Framing of Race in the Slaveholding Atlantic

Location: Omni: Wooster

Moderator: Mariola Espinosa

1. Rana Hogarth, University of Illinois at Urbana-Champaign, Urbana, IL:
Of Paper Trails and Dirt Eaters: West Indian Medical Knowledge in the Antebellum South.
2. Ian Read, Soka University of America, Aliso Viejo, CA:
Environmental and Cultural Frames in Histories of Disease: The Case of Smallpox in Brazil.
3. Stephen Kenny, University of Liverpool, Liverpool, UK:
Henry Ramsay, the Georgia Blister, and the Professionalization of "Negro medicine"

H5: Pre-Modern Pharmacy in Eurasia

Location: Omni: George

Moderator: Harold Cook

1. Stacey Van Vleet, Columbia University, New York, NY:
The Medicine Buddha's Alchemy: History, Purity and Precious Pills in Tibetan Buddhist Medical Rituals (17th-Early 20th centuries).
2. Nichola Harris, SUNY Ulster, Stone Ridge, NY:
Manuscripts, Manuals, and Masters: The Role of the Lapidary within the Medical Market Place of Early Modern Europe.
3. C. Michele Thompson, Southern Connecticut State Univ., New Haven, CT: *The Travels and Travails of Tue Tinh.*

10:00-10:30 am

Break

10:30 am-12:00 pm **CONCURRENT SESSIONS I1-I5**

I-1: Representation and Visualization of Medical Knowledge, 1800-1900

Location: Omni: Grand Ballroom C

Moderator: Bert Hansen

1. Eva Åhrén, Karolinska Institutet, Stockholm, Sweden:
Anatomy on the Move: Collaboration, Competition and Circulation of Medical Knowledge in Early Nineteenth-Century Europe.
2. Alexander Moffett, University of Chicago, Chicago, IL:
Generic Images of Disease: The Uses of Collective Investigation, 1880-1900.
3. Adam Warren, University of Washington, Seattle WA:
Contested Images: Medical Photography, Researchers, and Indigenous Subjects in Yale's Peruvian Expedition, 1911-1915.

I-2: Nursing, Race and Gender in 19th-Century Medical Care

Location: Omni: Grand Ballroom A

Moderator: Barbra Mann Wall

1. Erin Spinney, Univ. of Saskatchewan, Saskatoon, Saskatchewan, Canada: "*Neither females nor negroes of either sex were liable to it:*" *Concepts of Racial Immunity in British West Indian Military and Naval Nursing, c. 1780-1825.*
2. Christopher Willoughby, Tulane University, New Orleans, LA:
Learning to Oppress: Racial Thought and Medical Education in the Antebellum United States.
3. Amanda Mahoney, University of Pennsylvania, Philadelphia, PA:
Mary V. Clymer: The Nurse as Technology in The Agnew Clinic.

I-3: Boundaries vs Inclusivity in Later 20th-Century Health Politics

Location: Omni: Temple

Moderator: Theodore M. Brown

1. Travis Weisse, University of Wisconsin-Madison, Madison, WI:
The Queen of Nutrition: (Doctor?) Alvenia Fulton and the Black Natural Health Foods Movement.
2. Nathan Kuehnl, Wayne State University, Detroit, MI:
Local Treatment: Black Medical Professionals and Hospital Integration in Detroit, MI.
3. Beatrix Hoffman, Northern Illinois University, DeKalb IL:
Immigration, Migration, and the Right to Health Care: Toward a Transnational History.

Sunday, May 3rd

I-4: Medical Education and Professionalization: 19th-Century U.S. (John P. McGovern Session)

Location: Omni: Wooster

Moderator: Kenneth M. Ludmerer

1. Dea Boster, Columbus State Community College, Columbus, OH; University of Michigan, Ann Arbor, MI; and Joel Howell, Univ. of Michigan, Ann Arbor, MI: *"Raising Oranges in Canada:" Education, Locality, and Conflict at the University of Michigan Medical School in the Late Nineteenth Century.*
2. Jean C. Whelan, University of Pennsylvania, Philadelphia, PA: *Learning to Work, Working to Learn: Early 19th Century U.S. Nurse Education and Distribution Schemes.*
3. Sara Robertson, Univ. of California, San Francisco, San Francisco, CA: *Divergent Disciplines: The Declining Relevance of Botanical Studies in American Pharmaceutical Education.*

I-5: Later Nineteenth-Century State Medicine

Location: Omni: George

Moderator: Jacob Steere-Williams

1. James Hanley, University of Winnipeg, Winnipeg, MB, Canada: *Act Local, Think National: Public Health in the Victorian Political Imagination.*
2. Lorraine Dong, The University of Texas at Austin, Austin, TX: *"You live and you die by your medical records": The Social Ecologies of Larch Point Hospital Mental Health Records from 1870 to Present.*
3. Matthew Newsom Kerr, Santa Clara University, Santa Clara, CA: *Tracing Smallpox: Hospitals, Cartography and the Health of London.*

ABSTRACTS
Listed by Session

Abstracts: Special Sessions

Finding What's Out There: Library Resources in the History of the Health Sciences

Church Room

Moderator: Stephen Greenberg, National Library of Medicine

This session is envisioned as a two-hour, hands-on introduction/refresher in library resources available for research in the history of medicine and the allied health sciences. The session will be divided into two roughly equal parts. Part 1 will consist of brief presentations by librarians and archivists showcasing their collections.

Panelists:

Russell Johnson, UCLA

Lisa Mix, Cornell University

Arlene Shaner, The New York Academy of Medicine

Christopher Lyons, McGill University

Michael Flannery, University of Alabama – Birmingham

Micaela Sullivan-Fowler, University of Wisconsin – Madison

Stephen Greenberg, History of Medicine Division, National Library of Medicine

The second part of the program will focus on the databases that have become central to modern research. We will focus on four online resources, and will demonstrate in detail the scope, contents, and practical utility of these resources for a broad range of research topics:

Medical Heritage Library (Stephen Novak, Columbia University)

PubMed™, IndexCat™, and Images from the History of Medicine (Stephen Greenberg, NLM)

Learning Objectives:

For those new to the field, we will endeavor to supply a basic map of what's out there and how to find it.

For those with some experience in the field, we will show the latest enhancements to existing collections and resources, be it a new online exhibit of historical materials or the latest improvements to databases and digital collections that cross institutional boundaries.

Special Session: Reproductive Rights after Griswold: A Fifty-Year Retrospective

Ballroom

Co-Sponsored by the Sigerist Circle of the AAHM

Moderator: Barbara Sicherman, Trinity College (Hartford)

Discussant: Rosemary Stevens, University of Pennsylvania/Weill Cornell Medical College

The year 2015 marks the 50th anniversary of the landmark U.S. Supreme Court decision *Griswold v. Connecticut*, in which the court overturned the constitutionality of the state's law that had long restricted access to birth control and contraceptive information.

Abstracts: Special Sessions

In a 7-2 ruling, the Court held that the Connecticut law violated a right to marital privacy. Although the decision only applied to married couples, the right to privacy was later extended to unmarried persons, paving the way for all women to have access to safe and reliable birth control methods.

This roundtable will use the Griswold decision as a vehicle for exploring the recent history and current status of reproductive rights in the United States. The discussion will begin with the first-hand experience of one of the plaintiffs in the case. We will then move on to an examination of the place of Griswold in American memory and its implications for the recent history of reproductive rights. Next, we will explore the legal significance of the case for health policy since the 1960s. We will conclude the formal presentations with a look at how the decision has affected frontline workers in women's reproductive health. The session will then be open for discussion and comments by the audience.

Panelists:

Barbara Sicherman, Kenan Professor Emerita, Trinity College (Hartford)

Rosemary Stevens, DeWitt Wallace Distinguished Scholar in Social Medicine and Public Policy at Weill Cornell Medical College, Department of Psychiatry;
Stanley I. Sheerr Professor Emerita in Arts and Sciences, University of Pennsylvania.

Heather Munro Prescott, Professor of History, Central Connecticut State University

Linda Greenhouse, Knight Distinguished Journalist in Residence and Joseph Goldstein Lecturer, Yale Law School

Reva Siegel, Nicholas deB. Katzenbach Professor of Law, Yale Law School

Judy Tabar, Exec. Dir. and CEO of Planned Parenthood of Southern New England

Documentary Film: *In the Shadow of Ebola*

Omni Ballroom

Moderator: Gregg Mitman, University of Wisconsin-Madison

In the Shadow of Ebola is an intimate story of a family and a nation torn apart by the Ebola outbreak. Caught in an invisible war that is painfully reminiscent of the chaos and confusion they lived through during a fourteen-year civil war, a family and a people find the compassion and inner resolve to combat the virus's spread.

A1: Mapping Epidemics: Cases from the Third Plague Pandemic (USA), Yellow Fever (Uganda), and XDR-Tuberculosis (South Africa).

Grand Ballroom C

Moderator: Marta Hanson, Johns Hopkins University

With its tradition often bound to the infamous Cholera Map of John Snow in 1854, mapping epidemics has become a crucial way of seeing infectious diseases and is at the same time a vastly understudied object in a visual medical history. Mappings shaped as much the field and image of public and global health as they contributed to the understanding and crafting of the nature of many infectious diseases, delivering characteristic pictures and patterns for Cholera as much as for the Plague, Smallpox, AIDS, and more recently, Ebola. But the practice of mapping remains an elusive object: its technologies can be used to transfer the tables and registers of cases onto geographical data – as in Snow’s diagrams – , it can rely on algorithmic modeling to predicting future trajectories or weak spots – as in Gould’s predictive maps of the AIDS epidemic in the USA- , or mapping can be understood more general as a visual technique of assembling, sorting and measuring epidemic data in a meaningful way - as in the mapping of a viral genome or as e.g. in the history of plague photography.

To put disease into place, or on the streets, mappings are bound to the task of capturing the fluid and often incomprehensible nature of disease in space and time. Here, the questions of causality, origin and distribution are revealed, accessed and evaluated to calculate and visualize the significance of a disease in relation to space, populations and their environments. Bringing the *milieu* of disease to the fore, the map serves as tool of choice for ecological disease models and for ways of thinking about the many “relations between viral or bacterial communities, their human hosts and the environment that inhibits or encourages their relationship.” (Koch 2011) One could argue, that in as much as clinical pictures delivers a visual representation of the disease in relation to the anatomy of the human body, mappings deliver an epidemical picture of an infectious disease in relation to the social body.

It is here, where mappings have always been used to visualize more than just a disease. Mappings of colonized territory, of social and cultural spaces of difference and of spatial urban pathologies serve as tools of power. Being it the case of the reconfiguration of urban space, the tracing of a disease’s pathway or the identification of pathological spaces or genes, mappings tend to integrate and catalyze the many stereotypes, clichés and connotations traditionally attached to infectious diseases.

The panel seeks to deploy a set of comparative perspectives in order to broaden the understanding of epidemiological mappings in the history of medicine and infectious diseases. Comparisons will not only include different diseases but will rely also on different disciplinary backgrounds and a variety of visual technologies. Thus, a set of question can be raised that will be addressed in the papers of the panel:

How does the understanding of maps as preliminary research tools in medical geography relate to their usage in public health campaigns?

What is the relation of maps to other medical records and visual technologies, such as medical case files, medical photography or diagrams?
How do maps contribute to a social, ecological or bacteriological/virological understanding of diseases and how were maps used to transform and criticize these understandings?

Lukas Engelmann, *University of Cambridge, Cambridge, UK: **Photographic Mappings of the Third Plague Pandemic in the USA (1899 - 1924)***

The Bubonic Plague arrived in the United States in 1899 via Honolulu, reached San Francisco in 1900 and returned with a major outbreak to Los Angeles in 1924. All three of these events have led to a trail of public health interventions and sanitary measures often fuelled by politics of exclusion and an ongoing endemic plague in rodents until today. All three outbreaks were recorded in extensive photographic series leaving a visual archive of the plague in the USA, that hasn't been subject to historical research. My paper will demonstrate that these photographs should be approached as a technique of mapping, rather resembling the practice of photogrammetry and forensic instead of clinical or medical photography. Therefore, the photographic series will be assessed and discussed against the backdrop of traditional mapping techniques, used to answer epidemiological questions of origin, distribution and responsibility (Koch 2011) or in relation to the racial mapping of Chinatown e.g. in San Francisco (Shah 2001).

In the photographs, Bubonic Plague is presented in a series of documentary pictures that were produced to capture various stages of the specific urban configuration which led to the outbreaks. The extensive albums captured hundreds of buildings either in their original state, or after they were cleaned and sanitized or destroyed. Furthermore, both series covering the first outbreaks in Honolulu and San Francisco have been produced within the ongoing and heated debates on the nature of the plague. Here, miasmatic theories and ecological disease models clash with the rapidly emerging field of bacteriology and reveal the unpopular position of federal bacteriologists. The series of photographs covering the spatial conditions of the outbreaks clearly contribute to these debates, and will be interrogated on their specific contribution to Plague aetiology. Thus, the overall question will be raised if these series can be understood as a specific photographic genre which might be framed as epidemiological photography.

Julia Cummiskey, *Johns Hopkins University, Baltimore, MD: **Viral Landscapes: Mapping Yellow Fever and Burkitt's Lymphoma in East Africa***

In 1961 Denis Burkitt, a surgeon in Kampala, Uganda, consulted Alexander Haddow, an entomologist with the East African Virus Research Institute (EAVRI) in Entebbe, Uganda, on the interpretation of his map of the incidence of a new tumor syndrome in Africa. Comparing the map of what was later known as Burkitt's lymphoma cases with existing maps of yellow fever produced at the EAVRI (formerly the Yellow Fever Research Institute), Haddow proposed a vector-borne viral etiology for the tumor syndrome. This conversation was invoked a number of times by both men and their colleagues as they reflected on the events that followed as the complex etiology of the tumor syndrome was investigated. But little attention has been paid to the set of circumstances that led to the existence

of these two maps, as well as the expectation that comparing them would offer useful insights. The production of these maps was the result of a combination of field, clinic, and lab work. The yellow fever map was produced as part of an effort to understand the epidemiology of yellow fever and in particular the factors that prevented its expansion eastward across the continent and further to the Indian subcontinent. Entomology, zoology, botany, and virology were among the domains that made impressions on the map. Similarly, the map of the tumor syndrome was an exercise in demarcation - as Burkitt himself called it, an attempt to "biopsy the [tumor] belt" by identifying with as much precision as possible the boundaries of the areas in which the syndrome was endemic in order to infer potential causal agents. Both maps were the products of arduous field work and meticulous laboratory investigation. This paper will consider the reasons that geography and cartography featured so centrally in the study of two very different diseases as well as the circumstances that led Hadow and Burkitt to compare them. It will argue that these maps not only illustrated the findings of medical researchers, but also were instrumental in shaping the ways that scientists understood the interaction between viruses, natural environments, and human cultures.

Erica Dwyer, University of Pennsylvania, Philadelphia, PA: Placing a local outbreak on a global health map: visual technologies and the biopolitical imaginaries of extensively drug-resistant tuberculosis in Tugela Ferry, South Africa

In March 2006, extensively drug-resistant tuberculosis (XDR-TB), a form of tuberculosis resistant to most anti-TB drugs, was first reported in Morbidity and Mortality Weekly Report. Several hundred cases were documented across all regions of the globe. By the following January, however, XDR-TB came to be understood by public health experts as a threat emerging from South Africa. More than 52 deaths from XDR-TB had been identified in Tugela Ferry, a small, remote town in KwaZulu-Natal. The New York Times reported that "Virulent TB in South Africa May Imperil Millions" across the continent, and supported this assertion with a map highlighting Tugela Ferry's relative proximity to South Africa's national borders.

Over the second half of the 20th century, global TB interest has been closely linked to stories emerging from specific locations, including Lima, Peru; New York City, USA; and sites in the former Soviet Union. Here I will discuss rhetorically powerful, visual technologies - including GPS maps, flow charts, and hospital photography - that were used to make intimate deaths in Tugela Ferry - where tuberculosis was endemic and AIDS-associated death was unremarkable - legible to the global health enterprise. These technologies tapped into broader historical understandings of tuberculosis as a key disease demonstrating bacterial contagion, and as a prototypical "social disease" which, while affecting everyone, was most common in settings of poverty. Photographic images mobilized Tugela Ferry's specific history as a small, rural town in the former Zulu homeland that was internationally connected through its former mission hospital, but had yet to be successfully incorporated into the public infrastructure of post-apartheid South Africa. By mobilizing the histories of tuberculosis, AIDS, and South Africa, XDR-TB in Tugela Ferry came to be understood not simply as a tragic consequence of poor health care access, but as the avoidable result of a long-standing trajectory of poor

hospital infection control practices, limited community care provision and failing global policies. Drawing on South Africa's history of civic action and globally networked political resistance, XDR-TB in Tugela Ferry was re-envisioned both as a potential source of global contagion and an example that called for global action

A2: Genesis, Translation, Transformation: Critical Concepts in Arabic Medicine

Grand Ballroom A

Moderator: Dimitri Gutas, Yale University

It is well known that Arabic astronomers, mathematicians, and philosophers played an important role as transmitters of ancient Greek science to Medieval Latin scientists. The astonishing creativity and originality of this Arabic scientific tradition is now coming to be recognized. Medieval Arabic medicine is another discipline whose practitioners exerted a lasting influence on the character and progress of pre-modern and early modern European medical thought. Moreover, the increasing popularity of alternative therapeutic practices, many of which are based on ancient Greek and Arabic precedents further recommends medieval Arabic medicine to scholar-physicians interested in a diversity of historical and cultural viewpoints in medical theory and practice.

The medieval Arabic medical tradition is thus a helpful historical source for understanding the conceptual and practical development and cultural transmission of Classical medical thought. The Arabic commentaries on the Hippocratic *Aphorisms* are a privileged corpus for studying this tradition. This corpus extends over a period of eight centuries, encompassing debates, innovations, amendments, and refutations of Hippocratic and Galenic theories. With a grant from the European Research Council, Professor Peter Pormann is currently pursuing a major research project entitled "Arabic Commentaries on the Hippocratic Aphorisms" at the University of Manchester. The project aims to examine the entire Arabic commentary tradition on the *Aphorisms* from the ninth to the sixteenth century. The papers here presented are largely based on the evidence collected during the preliminary phase of this project.

Nicola Carpentieri, *The University of Manchester, Manchester, UK: Topics in Arabic Commentaries on the Hippocratic Aphorisms: Mental Disorder and the Body*

Under the strong influence of Galen, Arabic commentators on the Hippocratic Aphorisms developed ideas about the physiological origin of mental disorders. They expounded on the aetiology, diagnosis, and treatment of melancholy, examined cases of mental pathologies arising from fever, intoxication, age, or seasonal changes, and discussed how changes in the body lead to the recovery from certain mental disorders. In this talk, I survey the Arabic commentaries on the Aphorisms, focusing on vi.11 and vi.21. These two aphorisms proffer an unusual theory; namely, that madness, melancholy and phrenitis may be healed by the onset of hemorrhoids or varicose veins. The two aphorisms generated a lively debate, lasting over five centuries. I analyze this debate showing how the Arabic tradition received Galenic/Hippocratic theories on mental health, documenting each commentator's working method, and singling out refutations of, improvements on, and deviations from the Greek tradition.

Learning objectives:

To highlight the value of the Arabic commentaries on the Hippocratic Aphorisms as a locus for studying the development of medieval medical theory

To document the debates on psychosomatic theories present in the Arabic commentaries

To present new, unpublished medical texts to the public

Kamran Karimullah, *University of Manchester, Manchester, UK: Logic, Experience, Experimentation: Gauging the Influence of Aristotle and Galen on Medieval Arabic Medicine*

Drawing on Classical and post-Classical Greek philosophers and physicians, medieval Arabic physicians were acutely aware of the challenge of reconciling conclusions drawn from medical theory with empirical data drawn from clinical practice. Arabic physicians debated the virtues (and vices) of Galenic theories of scientific experimentation and Aristotelian theories about how scientists arrive at the axioms of scientific disciplines. The nature and scope of these debates as they were waged among medieval Arabic scientists is illustrated in post-classical (after 1100 C.E) Arabic commentaries on the celebrated first aphorism of the Hippocratic Aphorisms. Their comments evince a consciousness of the challenges posed by the physician's need for both deductive and inductive methods. I suggest that medieval Arabic physicians were critically engaging with the thought of Aristotle and Galen in the light of Arabic medical authorities, their medical and philosophical thought, and their clinical practice. I conclude that post-classical commentaries on Book I of Avicenna's (d. 1037 C.E.) Canon may afford an even richer source of texts for Medieval Arabic debates on these philosophical and methodological aspects of medicine.

Learning objectives:

To highlight the link between logic and experimentation in pre-modern sources

To illustrate historical and cultural viewpoint on scientific theories related to deduction and induction

To discuss the quite subtle conceptual foundations of pre-modern medical experimentation

Samuel Barry, *University of Manchester, Manchester, Lancashire, UK: The Critical Days in Syriac and Arabic Translation*

Uniting judicial astrology with medical prognosis, the theory of critical days in fevers was an important debating ground for issues of scientific epistemology in Greek, Arabic, and European medicine up to the 19th century. While the place of Syriac in the translation into Arabic of the Greek sources for this theory has been noted, detailed treatment of the existing evidence has been lacking. Because of this, subtle yet significant changes produced by the process of translation remain underappreciated. In this paper, I will begin to address this lacuna by making a comparison of the terminology of Sergius of Reš 'Aynā's (d. 536) Syriac abridgement of book three of Galen's treatise *On the Critical Days* with the texts on the subject in the Syriac translation of the Hippocratic Aphorisms. I will then consider what conclusions may be drawn on this basis regarding the influence of Syriac upon the famous translator Ḥunayn ibn Ishāq's (d. 873) Arabic translations

Abstracts: A2/A3

of these two works. In the process, I will emphasize the important historical role played by Syriac physician-translators in the preservation of Greek medicine.

Learning objectives:

Gain a deeper appreciation of the history of intercultural transmission of medical learning

Develop awareness of the relationship between medicine and other sciences, and the historical variety of emphases given to different sub-fields of medicine

Deepen appreciation of the possibility for highly variant explanations to account broadly for the observed behavior of an underlying phenomenon

A3: Creating Autism: the Formation of a Disorder

Temple

Moderator: Emer H. Lucey, University of Wisconsin-Madison

The current understanding of autism is enmeshed in controversies over vaccine causation and widespread concern over possibly epidemic numbers of children affected. Examining the history of autism reveals the development of the disorder by those invested in its formation in the United States and Great Britain. This panel will explore various facets of autism, from the perspectives of researchers, families, politicians, and historians, showing how different productions of the disorder emerged. By presenting these papers together, the conventional history of autism will be problematized, as this range of perspectives will bring complexity to the development of the diagnosis and its influence in society, historically and contemporarily.

These papers will explore the many ways one disorder can be created and the value such historical work can bring to current debates over autism. By placing autism within the context of broader work on emotional disturbances, Jeffrey Baker will examine how autism became a disorder of privileged white boys. Baker's comparison of the work of two child psychiatrists working on autism and childhood schizophrenia in the 1940s and 1950s will challenge the stability of the meaning of autism, dating to its early identification. Bonnie Evans's work will explore the importance of genetic studies in defining autism in Britain since the 1970s. Examining government archives with autism researchers' archives, she will argue that the genetic research on autism had significant influence on the broader understanding of atypical childhood development and on the availability of social services for children with developmental disorders. Emer Lucey will argue that a belief in the ethereal, physical beauty of children with autism was constitutive to the development of the diagnosis between the 1940s and 1970s. Using scientific literature and parental memoirs, she will show how the aestheticization of autism created a space for the articulation of difference with respect to other childhood developmental disorders. Finally, Michael Yudell will examine the broader stakes involved in writing the history of autism. He will argue that history holds a unique ability to inform our understanding of contemporary ethical issues, particularly relevant to autism. The formation of autism depended on the investment of researchers, physicians, parents, government agencies, and educators, whose work defined and redefined the disorder over its history. As contemporary concerns over autism grow, its history can make visible the

otherwise hidden paths of development of the disorder and speak to issues of ongoing importance for autism.

Emer Lucey, *University of Wisconsin-Madison, Madison, WI: Otherworldly Beauty: The Aestheticization of Autism, 1943-1980*

Between the 1940 and 1970s, parents and professionals alike saw a curious relationship between autism and physical beauty. The aestheticization of autism incorporated its unusual, alienating, and challenging behavior into its distinctive physical attractiveness by characterizing autistic children as ethereally beautiful. This specific physical beauty differentiated autism from other childhood developmental disorders in a manner that was particularly useful when psychogenic etiology of the disorder dominated.

Examining the scientific literature on autism alongside parental memoirs reveals unusual physical beauty to be a constitutive element of the disorder. Within the scientific discourse, autistic children's beauty was underscored by the almost exclusive whiteness and high socioeconomic status of the families, suggesting a racially oriented and class-based perception of the beauty of the children. When evidence emerged of autism occurring among families of all races and socioeconomic statuses in the 1970s—a period that also witnessed the growing acceptance of an organic etiology for autism—the centrality of beauty to the formation of the diagnosis of autism waned.

The psychogenic etiology for autism tied the causation of autism to the mother's withholding of affection. Parents rejected this etiology, seeing the child's physical beauty as disproving the allegations of parentally inflicted damage in the child and using it as a defense against personal blame. Alongside their rejection of psychogenic etiology, parental agreement over the beauty of children with autism established a site for the production of community around autism.

Examining the use of beauty in the formation of autism reveals both its productive quality and its ambivalence. Parents found their children's beauty to be a bittersweet consolation for the otherwise devastating diagnosis of autism, as well as a tragic suggestion of what might have been if not for the disorder. Although the aesthetic importance of autism declined to the scientific community alongside the decline in attribution of autism to a psychogenic, socially rarefied cause, beauty has remained a salient feature of autism to parents through the present.

Learning objectives:

Develop a historically informed sensitivity to the aesthetic construction of a disorder

Understand the development of imagined community by patients and families around the ambivalent qualities of a disorder

Recognize the dynamic interrelationship between medicine and society throughout history

Jeffrey Baker, *Duke University, Durham, NC: Contesting Autisms: Constructing a New Syndrome at Johns Hopkins and Bellevue*

Historical accounts of the "discovery" of autism have typically centered on the Johns Hopkins psychiatrist Leo Kanner, who in 1943 gave a name to what he believed was a new disorder. Autism, most writers assume, was a rarely used diagnosis that mirrored Kanner's description until expanded into a "spectrum" after 1980.

I will argue that even in the 1950s, the meaning of autism in the United States was highly contested. Most clinicians subsumed autism within childhood schizophrenia, an elastic category encompassing children with a wide range of emotional disturbances. This paper will explore published and archival materials to focus on the research programs led by Kanner at Hopkins and Laretta Bender at New York's Bellevue Hospital. Bender accumulated a series of over 200 "schizophrenic" children whom she followed for 35 years, the most important such series in the United States to rival the 150 cases reported by Kanner. Nearly half developed autistic symptoms prior to age two. Out of her experience, which included a support group for parents, Bender constructed a definition of autism that both overlapped with and differed from that of Kanner. Bender's autism presented with different features that varied by age, and could occur in children with medical conditions and mental deficiency.

From a presentist standpoint, Bender's work will strike clinicians as anticipating today's notion of an autism "spectrum." In historical context, however, the more interesting question is that of how class, race, and gender became incorporated into the two constructions of autism. Kanner created an enduring image of autism as a disorder of white males born into highly educated, affluent families. Bender's descriptions reflected the more diverse population served at Bellevue; she rejected any association with social class and qualified the linkage to male gender. Jewish children were prominent in Bender's series, and African Americans were absent from both.

By understanding the emergence of autism as part of a broader development of a nosology of emotional disturbance, we can better appreciate the process by which race, class, and gender have rendered autism visible in some groups but not in others.

Learning objectives:

Describe and compare the two autism research programs of Leo Kanner and Laretta Bender

Discuss how the conception of autism as a continuum rather than a rare categorical category was debated even as early as the 1950s

Discuss how different characterizations of autism effectively linked it to certain social groups and made it less visible in others

Michael Yudell, John Rossi, *Drexel University School of Public Health, Philadelphia, PA:*
What's At Stake in the History of Autism?

The history of autism spectrum disorders (ASDs) remains poorly understood, and historians have only recently begun to pay close attention to this topic. This is surprising for at least two reasons. First, autism is a public health concern. It poses significant challenges to the public's health, including improving diagnostic tools and treatments, providing support for autistics and their families, and developing ethical strategies for communicating risk in research and treatment. Second, from what we do know about the controversial history of autism—from the refrigerator mother theory of autism etiology to misbegotten claims about the relationship between vaccines and autism—understanding this history can inform present day challenges related to ASDs. These challenges include the persistence of stigma around autism and other neurodevelopmental disorders, how changes in autism prevalence have been influenced by historical changes in diagnostic criteria for the diagnosis, and understanding the relationship between the rise in autism prevalence post-World War II and the changing nature of parenting and childhood during this time. This paper will examine several themes in the history of autism including the medicalization of the disorder, stigma around the disorder, and how autism etiology and risk for the disorder have been communicated over time. An analysis of these historical examples will consider how the history of ASDs can inform present day concerns in autism policy and ethical issues.

Learning objectives:

- Deepen understanding of how the history of autism informs current autism policy
- Examine the relationship between autism and public health ethics
- Understand the role that stigma played in the history of autism

Bonnie Evans, *Queen Mary, London, UK:* ***Autism as an Object of Genetic and Neuroscientific Research in Britain, 1977-2015***

In the mid-1970s, Michael Rutter and Susan Folstein from the Institute of Psychiatry in London began a major search for 'all school age autistic twin pairs in Great Britain' to include in what was hailed as the first comprehensive genetic study of autism. They argued that some cognitive impairments associated with autism could be inherited, fuelling debate on the relation between genes and environment in the causation of developmental disorders. What was then regarded as a rare disorder affecting only 2-4 children in 10,000 gradually became the lynchpin for understanding atypical child development in many more forms. The 'psychological deficits' associated with autism were then redefined and increasing numbers of children described under the autism category. Educational services and healthcare services in Britain were also transformed in order to provide for children with an autism diagnosis.

Analyzing both national government archives and autism research archives, this paper examines how politicians, bureaucrats, educationalists, scientists and families worked together to enable genetic studies of autism in Britain. It then explores how these studies, and related neuroscientific studies, have been used to alter health and educational provision for children with autistic symptomatology. Whilst much has been written on the history of genetics and intelligence, few have

examined the history of genetic studies of autism and the significance of these studies to health policy and practice. The genetic study of autism in Britain has often been heralded as a means to understand all forms of atypical psychological development in children. The category has thus held great weight when researchers have collaborated with government and other organizations in gathering, collecting, accumulating and assembling data on childhood populations. Furthermore, research findings have often been used to argue for changes in social organisation to enable greater equality and opportunity for all children. As genetic studies in autism continue to thrive, this paper considers the significance of historical examples to understand political responses to scientific research in child development.

Learning objectives:

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

Recognize the dynamic interrelationship between medicine and society through history

Acquire a historically nuanced understanding of the organization of the British healthcare system

A4: Research on Hunger and Nutrition in the First Half of the Twentieth Century

Wooster Room

Moderator: Andrew Ruis, University of Wisconsin-Madison

Jim Connor, Memorial University, St John's Newfoundland, Canada: *An "ideal laboratory": The International Study of Nutrition and Deficiency Diseases in Newfoundland and Labrador, 1900-1950*

Historians have recognized that during the late nineteenth and early twentieth centuries malnutrition, especially in the British imperial world, was of importance. Historical study of diet, nutrition, and deficiency diseases in twentieth-century Newfoundland and Labrador from its time as an independent British Dominion in the North Atlantic up to confederation with Canada in 1949 is unexpectedly complex and embraces medical, social, and political factors that are regional, national, and international. During this period small, selected segments of Newfoundland's total population of about 300,000 became the subject of intensive medical surveillance and investigation by American, British, and Canadian physicians and researchers (for example, W.R. Aykroyd, B.S. Platt, and W.H. Sebrell who would become leaders in the field and direct organizations such as NIH and the UN FAO). The data obtained from these studies were used first, to address local dietary deficiencies; second, for post-World War Two reconstruction in Europe; and significantly, as fundamental surveys to support two major competing philosophies about the problem of global malnutrition. An essentially European approach saw solutions in structural terms, which understood that malnutrition was less a medical problem and more one of politics and economics. Contrasting it was an American perspective, that as malnutrition was fundamentally a biomedical problem its eradication could be achieved with technical quick fixes such as vitamin

enriched flour and other foods.

Serving as backdrop for this discussion is the development of Western technology used to promote international nutrition standards and to assay vitamin levels in food and humans, for as one of these research teams asserted in 1945, Newfoundland with its isolated communities, was an “ideal laboratory for investigation of the value of various therapeutic procedures.” These studies were often clinically invasive and involved physical and laboratory examination of people selected as subjects who typically came from vulnerable populations, thus the question of their ethics will also be examined. Published accounts of these studies, personal diaries, newspapers and magazine coverage, and government documents are the basis for this discussion.

Learning objectives:

To describe rural medical practice with respect to malnutrition research in an island community

To explain the UK-US-Canada medical nexus in a colonial context in the 1900-50

To explicate the novel historiographical outcomes of this project

Alexis Peri, *Boston University, Boston MA: **Nutritional Dystrophy: the Rise and Fall of a Disease Discovered on the Eastern Front***

WWII was the greatest catastrophe in the already violent and crisis-ridden Soviet Union. But for Soviet scientists, the war was also a most inspirational and productive catastrophe. Medical professionals across Europe, including in Soviet Russia, made huge discoveries in healing war wounds, performing surgeries and blood transfusions, and treating chronic malnutrition—to name but a few. In Leningrad, where the Germans’ blockade and starvation of the city took nearly a million lives, scientists discovered what they deemed a new affliction brought on by extreme hunger. They named it nutritional dystrophy (*alimentarnaia distrofiia*). Dystrophy was the center of intense study in besieged Leningrad. There, doctors carefully documented starvation and malnutrition through its various stages, performed autopsies on the deceased, and experimented with various treatments--all within the enormous constraints laid down by the Stalinist state. Their discoveries, along with those of Soviet researchers in other cities, were deemed so significant that in 1944, British and American doctors created *The American Review of Soviet Medicine* to share this work with the western world.

This presentation charts the emergence of the concept of dystrophy in war-torn Leningrad. It delves into specifics of the medical research on the science of starvation as well as addresses some of the political and cultural ramifications of that work. First, it examines the cooperative and collegiate relations between Soviet and Western doctors that converged around such medical research—relations that would deteriorate during the Cold War. Second, it explores the political consequences of dystrophy in the USSR, where it came to be associated with political crimes like treason and defeatism. Above all, this presentation focuses on the dynamic between science, politics, and ideology.

This presentation is supported by a range of evidence including secret state documents, medical reports, doctors' case studies, and 120 diaries written by civilian Leningraders caught up in this epidemic of dystrophy. This body of material is the result of more than three years of archival research in the Russian Federation.

Learning objectives:

To demonstrate the significance and substance of Soviet medical breakthroughs surrounding the pathogenesis and treatment of extreme starvation.

To gain an understanding of the highly politicized nature of disease constructs and pathological practices, both inside the USSR and internationally during the early Cold War.

To illuminate the mutually constitutive roles of culture and science in shaping our understanding of health and illness and the stigmas associated with disease.

Nicole Eaton, *Kennan Institute, Washington, DC; Wesleyan University, Middletown, CT:*
German Hunger after the War: Soviet-German discourse in Kaliningrad and West Germany, 1945-1955

During the Second World War, soldiers and civilians on the Eastern Front experienced new kinds of hunger and deprivation in the closed spaces created by Hitler and Stalin's regimes. One of the most famous of these was the city of Leningrad, where 30% of the population died of starvation during the 900 days of the German army's blockade. Soviet medical professionals began using the term "dystrophy" to describe the symptom complex arising from extreme chronic malnourishment, and the term became synonymous with the physical and psychological effects of hunger in Leningrad. This presentation will highlight the previously unknown history of "dystrophy" in the postwar period, arguing that "dystrophy" continued to denote cases of extreme chronic malnourishment but gradually took on racial, cultural, and psycho-sexual dimensions that had not been part of the disease's original manifestation.

The presentation uses archival hospital and government records, diaries, memoirs, and oral histories to focus on the Soviet occupation of the German city of Königsberg as it became the Russian city of Kaliningrad (1945–1948), and West Germany, where the term "dystrophy" was transmitted into the German language after the war (1948–1955). Dire living conditions in Kaliningrad led to one of the worst demographic catastrophes in postwar Europe, including an unprecedented outbreak of epidemic disease and starvation among the remaining German civilian population. Although Soviet doctors understood that acute food shortages meant that Germans suffered disproportionately while few Soviet Russians went hungry, they began to blame the Germans themselves, suspecting that the reason that they were dying from their hunger was due not to caloric deprivation, but to contamination with 'fascist ideology.' In West Germany, the "dystrophy" entered German-language usage from Kaliningrad expellees and German doctors returning from Soviet camps, but came to describe a long-term syndrome of psycho-sexual trauma. I argue that "dystrophy" was used most often to describe Germans returning from Russia, implying that exposure to the 'barbaric' conditions of the Soviet Union and the dehumanizing ideology of communism were partially to

blame. "Dystrophy" became a disease of contamination of higher German civilization with racial, moral, and ideological backwardness.

Learning objectives:

Understand the significant incidence of civilian hunger and starvation in Central and Eastern Europe in the years surrounding the Second World War, and not among the direct victims of the Nazis.

Gain an understanding of the transmission of medical terminology across cultures, languages, and time periods, using the case of the term "dystrophy" as it developed in the Soviet and German postwar contexts.

Consider the relationship between culture and our understanding of disease, particularly how "dystrophy" came to denote different symptoms, depending on the value judgments of those making the diagnoses.

A5: Children's Health at School and Play, Pre-1960s United States

George Room

Moderator: Cynthia Connolly, Univ. of Penn. School of Nursing

Rima Apple, University of Wisconsin-Madison, Madison, WI: *An Unexamined Catalyst for Rural Public-Health Reform: the School Nurse in the Inter-war Years*

In 1903, the first school nurse in the United States, Lina Rogers Struthers, so dramatically demonstrated the benefits of such a role that New York City decided to employ trained nurses in schools. The significance of school health programs and particularly the critical role of nurses in schools have been widely acknowledged since that time and yet we know little about what these nurses did in schools, the scope of their practices, and the constraints under which they worked. Examining school health from the perspective of the school nurse will help us understand how medical advances, professional concerns, demographic and geographic factors, and budgetary constraints shaped the evolution of this crucial element of public health.

This paper will present a close reading of reports submitted by school nurses and their supervisors and the correspondence of school nurses and other participants. This analysis will also draw on pertinent secondary literature to establish the context in which these nurses developed their practice.

Wisconsin's Bureau of Public Health Nursing was intimately involved in the creation of many school health programs throughout the state. Their reports of visits to school districts, discussions with school, county, and city nurses, as well as school, city, and town administrators and elected officials and interested civic organizations relate a detailed history. This coupled with material drawn from the records of involved civic organizations and a search of extant school records will provide insight into how the daily lives of school nurses informed the emergence of this new arena of public health. Important secondary sources include, but are not limited to, Buhler-Wilkerson, *False dawn* (1989), and Meckel, *Classrooms and clinics* (2013).

Early public health programs in the rural United States typically began with the work of public health nurses and among their initial efforts were school health programs. By demonstrating the value of school health programs, these nurses gained community and political support for broader efforts in the field. This paper will help us appreciate the pivotal role of nurses in these developments.

Learning objectives:

Identify the factors that fostered and that inhibited the development of school nursing, a significant aspect of early 20th-century public health efforts.

Understand how gender, professionalism, and economics shaped the work of school nursing.

Appreciate the pivotal role of the school nurse in opening new avenues for public health activities.

Monique Dufour, *Virginia Tech, Blacksburg, Virginia*: ***"What Is Reading Doing to Johnny?" Literacy Education for the Healthy Personality in the Midcentury U.S.***

In 1940, University of Chicago literacy scholar William S. Gray (a.k.a. "Mr. Reading") noted a "striking fact": language arts educators and researchers increasingly sought to promote their students' health through reading. Although they still emphasized traditional skills such as phonics, vocabulary, and comprehension, they also now believed that reading could and should develop "rich and stable personalities." By 1948, another leading reading educator, David H. Russell, could declare plainly and without a bit of surprise that "the aim of the reading program extends beyond the acquisition of certain abilities to the effects of reading upon the whole pattern of personality development of the child. The modern teacher does not ask herself, 'What is Johnny doing in reading?' so often as she inquires, 'What is reading doing to Johnny?'"

In this paper, I explain how mid-century US literacy educators tried to promote student health through the act of reading, and how literacy researchers examined and assessed the effects of reading in terms of mental welfare. Guided by their focus on "what reading is doing to Johnny," they turned their attention away from skills and toward the reader's internal experience during reading and toward its after-effects upon the mind and the body. By framing students as "personalities" and by concentrating their work on engendering healthy personalities, literacy educators participated in two midcentury cultural beliefs: that people should be defined in psychological terms, and that modern life posed new and urgent challenges to mental health.

I focus on three key bodies of evidence. I begin by showing how literacy educators participated as key stakeholders in a seminal national policy event: the 1950 Midcentury White House Conference on Children and Youth, "A Healthy Personality for Every Child." Second, I discuss a specific example of literacy education for health: the widely used textbook, *Reading Ladders*. Third, I explain how literacy researchers assessed the effects of these efforts on students' minds and bodies, and attempted to generate knowledge that was simultaneously educational, psychological, and medical.

Learning objectives:

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

Recognize the dynamic interrelationship between medicine and society through history

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

Martha Verbrugge, *Bucknell University, Lewisburg, PA: The Nature of Play: Biomedical Science and the Battle over Segregated Recreation in Washington, D.C., 1942-1954*

Throughout the first half of the twentieth century, most public facilities for recreation and sports in Washington, D.C., were racially segregated. This Jim Crow system allowed white citizens to relax at well-equipped parks and playgrounds, while black families swam in polluted streams, played in dangerous streets, and made do with dilapidated athletic fields and schoolyards. The District's rigid color line provoked heated debates among public authorities, civic leaders, political activists, and ordinary citizens. Confrontations took place in government offices, courtrooms, and neighborhood parks and swimming pools.

Defenders and opponents of segregated recreation often framed their arguments in scientific terms. Their positions on legal, moral, and social questions incorporated medical data, analyses of human character and behavior, and the science of racial difference. Segregationists claimed that blacks' supposed depravity, hypersexuality, diseases, and filth rendered interracial recreation abhorrent and unsanitary. Integrationists countered that mixed activities were safe, natural, and beneficial.

My paper asks why this discursive battle over physical pastimes revolved around scientific reasoning and evidence. As various scholars have elucidated, the science of racial difference figured prominently in many disputes over medical care, public health, and human research in twentieth-century America. My presentation reveals that controversies over recreation also played a critical (albeit forgotten) role in challenging biomedical reductionism and advancing racial justice. The paper argues that the naturalization (and contestation) of "difference" had unique significance at recreational sites—where bodies were in motion, their makeup and abilities were on display, and physical and personal interactions were unscripted. As segregationists and reformers alike understood, social customs and biological myths might easily crumble if everyone could literally exercise their civil rights in any public space.

The analysis focuses on 1942 to 1954—from the establishment of Washington, D.C.'s Recreation Board through the Supreme Court's renunciation of "separate, but equal" public education. Source materials include local newspapers (mainstream and African-American), and numerous archival collections related to the Recreation Board, the U.S. Interior Department, and the NAACP's local chapter.

Learning objectives:

Understand the dynamic interrelationship between medical ideas and social systems in historical context

Acquire a deeper appreciation of critical connections between the history of biomedicine and the history of physical activity
Acquire a more nuanced understanding of concepts and practices of "race" and biological "difference"

Friday Lunch 1: Seventeenth-Century Origins of Population-Based Health Sciences

York Room

Discussant: Alfredo Morabia, Barry Commoner Center, New York, New York

There is a dearth of pre-17th century evidence of counting, grouping and comparing people, worldwide. Renaissance intellectuals, Francis Bacon, René Descartes, and Jean Baptiste von Helmont, laid down the foundations of population thinking. They promoted observations, simplification of hypotheses, and group comparisons. Their ideas made possible the analysis of the data generated by the continuous monitoring of births and deaths in London parishes through the Bills of Mortality by Enlightened scientists such as John Graunt and Christiaan Huygens. The speed at which ideas reverberated internationally almost 400 years ago is gripping. This intellectual synergy seems to have generated the tremendous leverage needed to overthrow the antique speculative tradition. This symposium will review the origin and function of the Bills of Mortality; it will discuss the relevance of the medical thinking of Descartes to the emergence of population thinking, and explore the foundations of group comparisons and population thinking in the work of John Graunt and Christiaan Huygens.

Alfredo Morabia, *Barry Commoner Center, New York, NY: The Seventeenth-Century Roots of Epidemiology*

John Graunt's 1662 "Natural and Political Observations made upon the Bills of Mortality" provides an analysis of 50 year worth of data collected to be disseminated in the Bills of Mortality. It is the first document that uncontroversially derives new knowledge from the analysis of population data. This paper will track the influences -mediated in part by the Royal Society- of Francis Bacon, Rene Descartes and Jean Baptiste van Helmont on Graunt's achievement, and discuss why only a great merchant such as Graunt, used to the manipulation of great quantity of business data in double-entry books could have successfully achieved the analysis of the content of more than 2500 Bills.

Learning objectives:

Population thinking in the health sciences emerges in 17th century Europe after a century of profound intellectual and societal transformation
The process involved the continent and was not restricted to Britain.
Francis Bacon, Rene Descartes and Jean Baptiste van Helmont laid the intellectual foundations, John Graunt and Christiaan Huygens implemented these ideas in the analysis of population data, the concept of lifetable, and the theory of probability.

Abstracts: Lunch L1

Kristin Heitman, *Independent scholar, Bethesda, MD: On Deaths and Civic Management: A Prehistory of the London Bills of Mortality*

The London Bills of Mortality easily rank among the first civic efforts to track a population's health. From at least 1626 forward, they provided weekly reports of the number of burials, parish by parish, across the City of London, in Westminster, and in areas just outside of London's gates. Burial counts within the City of London were also broken out, in a separate section, by cause of death, or "causality."

Many scholars have held that regular data collection began as part of a plague-driven effort initiated by the Crown near the start of the seventeenth century. However, the routine, weekly collection of data on all deaths, regardless of causality, dates from a pair of ordinances passed by London's Board of Aldermen in 1553 and 1555, at the start of the very rocky transition from Edward VI to Mary I. While this new process clearly built upon existing procedures for tracking plague, it explicitly expanded those mechanisms to meet a correspondingly broader civic purpose. The legal requirements that established the ongoing collection of mortality data laid out not a plague-driven national endeavor imposed by the Stuarts but a much broader program set up exclusively in Tudor London by a City government intent on addressing its own issues.

Decoupling the origins of the Bills' data from the concerns of plague obviously raises the question of what their purpose actually was. Any satisfactory answer must include two caveats. First, the historical evidence we have in hand cannot conclusively link the data to any specific City program. Even the very serious matter of imposing plague quarantines cannot fully explain the timing and requirements of the founding ordinances. Second, a parish-by-parish account of every death every week could inform more than one City concern, so it is a mistake to assume that the collection program ever had a univocal or fixed purpose. Nonetheless, by examining the language and context of the founding ordinances, the early collection process and its reporting structure, we can elucidate important aspects of a distinctive approach shaped by London's merchant-aldermen as they attempted to meet their obligations under the City's charter.

Learning objectives:

Identify the main social, political and economic conditions under which the City of London

List three differences between London's practice of collecting data on all deaths throughout the City and plague-driven programs in other parts of England and elsewhere in Europe.

Explain how a tabulated count of deaths differs from a mortality roll, particularly as a tool in making civic decisions.

Harold Cook, *Brown University, Providence, RI: Descartes, Medicine, and Political Arithmetic*

Since the later 17th Century, Descartes has come to represent the power of Reason in history, being famous for his deductive methods in philosophy as his ideas in optics, physics, and mathematics. Less recognized is his deep commitment to medical studies, especially in chymistry and anatomy. His first and most famous

publication, *Discourse on the Method* (1637), declares that the purpose of his philosophy was “the maintenance of health, which is undoubtedly the chief good and the foundation of all other goods in this life,” and “I have resolved to devote the rest of my life to nothing other than trying to acquire some knowledge of nature from which we may derive rules in medicine which are more reliable than those we have up to now.” But was he speaking not only out of personal interest but on behalf of a generation that was looking for fresh ways to describe the fundamental similarities among all embodied humans? He may, then, have been part of a movement that helped to frame political arithmetic and other sciences of human groups that would point toward public health.

Learning objectives:

Recognize Descartes's deep commitment to medical studies

Connect Descartes's precept to the emergence of population thinking

Understand how Descartes ideas may have been part of a movement that helped to frame political arithmetic and other sciences of human groups.

Friday Lunch 2: Witnesses at the Creation: The West African Ebola Crisis and Its Implications

Grand Ballroom B

Moderator: Monica Green, Arizona State University

Discussant: Stephen T. Casper, Clarkson University

On September 23, 2014, the World Health Organization (WHO) Ebola Response Team made a startling, historic statement: “For the medium term, at least, we must therefore face the possibility that EVD [Ebola Virus Disease] will become endemic among the human population of West Africa, a prospect that has never previously been contemplated.” At the time of the WHO report, mathematical projections of the trajectory of the unfolding West African outbreak were suggesting that the number of cases would continue to double every three to four weeks for the foreseeable future, moving quickly into the thousands. Even best-case scenarios for heightened public health interventions offered no hope of being able to keep up with increasing case numbers. In other words, the WHO declaration of endemicity was a signal of failure: the sustained passage of Ebola in an unstopped (and as yet unstoppable) chain of human-to-human transmissions signaled the birth of a new obligate human disease.

The transition of Ebola from a lurking zoonotic threat in West and Central Africa to a sustained human outbreak—all under the intense gaze of worldwide media coverage—has telescoped and conflated the processes of epidemic reaction and historical reflection. There is no need for us, as historians, to wait for an “archival record” to be created by the slow accumulation of doctors’ case histories, investigative commissions’ reports, least of all the slow arrival of print newspapers. The 2013-2014 Ebola outbreak is unfolding in every kind of public media, a massive deluge of fact and opinion only furthered by the open-access publishing practices that have developed in recent years in the sciences. What are our obligations now as historians to document this crisis? What are our obligations to our students, to fellow researchers, to the public at large? In what ways can new media capacities be used to challenge the North-South imbalances in resources? In

Abstracts: Lunch L2

short, how can we actively help instead of being passive observers? This panel—bringing together historians of global health and new media—will address these questions.

Gregg Mitman, *University of Wisconsin-Madison, Madison, WI: **Forgotten Paths of Empire: Reshaping Narratives of the Ebola Crisis***

In late June, I was in Monrovia when the first cases of Ebola appeared in the capital city of Monrovia. Since July, I have focused much of my professional and personal life on writing opinion pieces, making a short documentary film, building an archive of Ebola-related material appearing in Liberian social media and news sites, and participating in a Congressional briefing on the African healthcare crisis, to offer a different framing of the Ebola outbreak, one attentive to the historical and structural issues that have created conditions ripe for Ebola's emergence and spread. In my presentation, I will present clips from the documentary and offer reflections on how the history of Liberia as a laboratory for American biomedical research offers a different narrative frame in which to document, understand, and intervene in this global health catastrophe.

Learning objectives:

Provide a historical context to better understand how the Ebola crisis in West Africa has unfolded.

Raise awareness about the importance of cultural sensitivity in public health interventions in Liberia

Educate the audience about the sacrifices West Africans have made in the advancement of global health

Monica Green, *Arizona State University, Tempe, AZ: **Situating Ebola Within Global History of Health Narratives***

Up until 2014, Ebola Virus Disease has been considered a "local" disease. Of the 23 recorded human outbreaks to date, all had occurred in a band across Central Africa. By July of that same year, Ebola had become a "global" disease. That transition was not due to its having left the African continent: although several American and European healthcare workers would be repatriated to their homelands in August, those patient transfers were not what made Ebola "global." Nor was it the increasing involvement of non-African NGOs (*Médecins Sans Frontières*, etc.) or governments (the US, China, France, etc.). Rather, Ebola became "global" when it became clear that it was undergoing sustained human-to-human transmission: that it had ceased to be a disease caused by an occasional zoonotic jump into humans and instead turned into an organism rapidly evolving and adapting to a new host, human beings. At the time of this writing, that evolutionary transformation shows no sign of cessation.

In becoming a new human disease, Ebola now takes its place with the great global diseases of human history: tuberculosis, smallpox, cholera, HIV/AIDS. This talk will argue that a global history of health analytical framework allows us to quickly draw up main areas for investigating--for historicizing--this new major human disease. Genetics helps us connect the current West African outbreak immediately to other outbreaks in central Africa. Serology and epidemiological mapping have already made apparent that Ebola has been a lurking zoonotic condition in West Africa for

several years, or even decades. These, in turn, can be brought to bear on a historical comparative study, which helps us identify which elements of the histories of other major diseases might be relevant for comparative purposes in elucidating the causes and amplifying factors of the current outbreak. Like smallpox, for example, this is a viral disease with a short timeframe of both incubation and resolution; and like smallpox, urbanized environments are fuel for its flame. History, in other words, provides us with no exact model of this disease. But it does tell us where to look for causes and consequences.

Learning objectives:

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

Mariola Espinosa, University of Iowa, Iowa City, IA: *Teaching Current Events in the History of Medicine: Ebola in the Classroom*

The current Ebola epidemic in West Africa is not only a contemporary epidemic of which we should be aware of as global citizens; it is also a teachable moment. As historians of health and medicine we usually focus the content of our courses on past events. As teachers of historical methodology, we instruct our students on how to analyze a variety of sources. As humanists we are increasingly faced with criticism and challenges from both outside academia and from university administrators about the future and value of the humanities. In this presentation within the luncheon panel I will discuss ways in which we can work with undergraduate students to evaluate the current crisis. In particular, I will share my strategies and resulting experiences in using this case as an example for undergraduate students in an introduction to history methods course. With a group of fifteen history majors I will have evaluated a variety of sources, including information available through the press, state, and global organizations covering the crisis. The resulting analysis will engage students in a way that will reveal to them the usefulness of historical perspective and analysis in the way people understand, respond to, and act on health events in the future.

Learning objectives:

Describe different ways in which to convey to students the value of historical knowledge in evaluating current events.
Highlight the usefulness of humanities in evaluating the barrage of information people are faced with today.
Discuss and problematize the role of the medical historian during an international health crisis.

B1: New Histories of Medical Technology: Information, Infrastructure and Identity

Grand Ballroom C

Moderator: Jeremy Greene, Johns Hopkins University

Discussant: Joanna Radin, Yale University

In recent years, historians and anthropologists of medicine have renewed their interest in understanding the social lives of medical technologies. Moving beyond heroic diagnostic and therapeutic devices such as the X-ray, the CT scan, the iron lung and the pacemaker, the field has gradually broadened its focus to include things like pharmaceuticals, prosthetics, and reproductive technologies. In this session, we seek to extend the history of medicine's engagement with technology one step further by focusing on technologies which mediate the production, management, circulation and use of medical information. Each panelist in this roundtable will present a brief account of a different artifact in the history of medical information technology: the medical history of the telephone, the records of deceased patients, the use of personal computers in biomedical research, the computerization of implantable and wearable technologies, and the rise of the quantified self. The interplay of ethnographic and historical approaches offered by the panelists will explore the many ways in which paying attention to medical information means also attending to the socio-technical systems in which such information comes to be recognized as valuable.

Jeremy Greene, Johns Hopkins University, Baltimore, MD: *On Call: Toward a Media History of Medicine*

To 21st century advocates of the field of telemedicine, health disparities are increasingly portrayed as problems to be solved with communications technologies. In industry events from Health 2.0 to TechCrunch, we are told that geographical differences in morbidity, mortality, diagnostic and therapeutic resources, lack of access to relevant specialists, medical education, and cutting-edge research findings, are being eliminated by new communications platforms, sensors, mobile phone applications, and human-technology interfaces. We are, it seems, always on the cusp of another electronic medical revolution.

A similar breathless wonder can be found in the medical and popular reception of an earlier electrical communication technology, though it is seldom appreciated as a medical technology today. Only a few years after Alexander Graham Bell's first telephonic demonstration of 1876, medical journals on both sides of the Atlantic carried exuberant reports of the medical applications of this new and experimental technology. By the first decades of the 20th century, the telephone had become a necessary part of any modern medical office—and the round-the-clock availability of the "on-call" physician had become a key symbol of the profession. A few decades later, however, the telephone had become an invisible technology, part of the grey infrastructure that potentiated medical practice, perhaps, but no more noteworthy than the technology of the hospital bed, the pneumatic tubes that sent blood samples through hospitals, or the omnipresent pager on the physician's belt. With a few noteworthy exceptions, historians of medicine have contributed to this invisibility, tracking the history of heroic diagnostic and therapeutic technologies

but leaving the history of mundane communications technologies like the telephone largely untouched.

This presentation offers a brief medical history of the telephone as a provocation for new engagements between the history of medicine and the history of technology. Drawing from published accounts of the telephone in popular and professional journals from the 1880s to the 1940s, I will attempt to reconstruct older hopes and fears for electrical medical communication as a technology which promised to eliminate health disparities—but also threatened to disrupt accepted principles of doctor-patient relations and the ethics of clinical practice.

Learning objectives:

To explore the history of electronic medical communications

To understand the relevance of prior "new media" and their transformative impact on the practice of medicine

To study the historical challenges in implementing technological solutions to problems of health disparities

Joanna Radin, *Yale University, New Haven: **Death and Data: Managing Patients After Life***

This paper investigates ethics and epistemological problems raised by the persistence of medical information in an age of Big Data. I focus on how hospital administrators and physicians deal with the disposition of information contained in electronic patient records. In life, the patient record functions as a crucial communication technology, allowing physicians not only to record but to share information about their patients over time. What happens to patient data after death? Despite privacy laws, medical information can be anonymized and aggregated to serve a range of purposes. Sometimes these uses have little, if anything, to do with medicine.

To whom is this medical information useful? What forms of labor are necessary to ensure its maintenance? Under what circumstances can it continue to circulate or travel beyond the hospital to serve the living in other kinds of knowledge projects?

Through historical and ethnographic analyses of the afterlife of data, this paper asks whether and under what circumstances data can ever be allowed to die; to be deleted. This paper demonstrates that it is important to conduct post-mortem analyses of data as well as bodies, themselves. By focusing on the electronic patient record as a powerful communication technology, I am able to provide new perspectives on long-standing controversies over the "right to die," linking them also with with emerging debates over the "right to be forgotten."

Learning objectives:

To direct attention to the important role communication technologies play in the practice of medicine.

To understand what happens to electronic patient information after patients are no longer living.

To consider ethical issues surrounding the management of patient information.

Joseph November, Department of History, University of South Carolina, Columbia, SC:

Gaming for the Cure: Home Computer Users and Video Gamers in Medical Research

Over the last fifteen years, distributed computing technology has enabled research projects to harness the processing power of millions of home personal computers and the brainpower of thousands of video gamers. Many distributed computing projects have medical implications, and they are becoming a significant part of the medical research landscape, especially because distributed computing is often the only affordable means of processing or analyzing the ever-growing volumes of digital research data. However, the history of this increasingly important activity remains poorly understood; often it is dismissed as a short-lived gimmick, and often its ramifications for the relationship between the general public and medical researchers is ignored. By examining two distributed computing projects related to modeling protein folding, Folding@home and Foldit, I hope to show that by drawing large swathes of the public into contributing, sometimes quite actively, to medical research they have created important new opportunities and challenges for many medical researchers. In the case of Stanford University's Folding@home (1999-present) more than 170,000 people have contributed spare processing cycles on their home computers to projects that simulate protein folding. Due to adept outreach on Stanford's part, contributors were made aware of the role of protein folding in dread diseases like Alzheimer's and cancer; further, it is clear from contributors' extensive online communications that they were motivated to donate processing time because they believed they were contributing to cures for diseases. In effect, Folding@home contributors created one of the world's most powerful supercomputers, leading to dozens of published articles in major journals and successful applications to the NSF and NIH for grant support for Stanford researchers, but these same researchers also had to devote considerable time to recruiting contributors and managing their expectations. The University of Washington's Foldit (2008-present), an online game that allowed thousands of players to compete to refine 3-D models of folded proteins, enjoyed similar publication and institutional success. Here, too, medical researchers needed to motivate volunteers (i.e. gamers), but with the added necessities of designing a compelling-yet-useful game, and managing a very large group of highly skilled but undisciplined laborers.

Learning objectives:

Recognize the dynamic, historical relationships between medical research agendas and developments in computer technology.

Understand the historical importance of volunteer work to research efforts and to the general public's perceptions of both diseases and the means of treating those diseases.

Recognize some of the ways in which the generation of large amounts of digital data has changed medical research practices and the public's perception of those practices.

Abstracts: B1/B2

Natasha Schull, MIT, Cambridge, MA: *Health App: Personal Data Tracking as Quantified Self-Care*

As so-called lifestyle diseases linked to everyday consumer behaviors such as overeating, under-exercising, and smoking account for an increasing share of healthcare costs, doctors, hospitals, and insurance companies have become increasingly interested in technologies designed to assist individuals in the project of lifestyle management. At the forefront of this trend are wearable devices whose embedded sensors, analytic algorithms, and data dashboards can track, analyze, and guide behavior. These devices are intended to serve as digital compasses to help consumers navigate the field of everyday decision making, keeping them in constant touch with the many little choices they make so that they can grasp how the bites, steps, and minutes of sleep add up to affect their health.

Drawing on ethnographic fieldwork among designers and users of mobile health technology, my presentation will explore wearable tech devices as key artifacts in a new cultural convergence of medical information technology and self-care that I call "data for life." A pressing concern within this emerging mode of health is how to get various different devices and their data to "talk to each other" so that consumers and doctors can make meaningful correlations across diverse data streams (how hours of sleep relate to mood, for instance). The presentation will focus on the newly announced Apple Health app, which purports to overcome this challenge.

Learning objectives:

To explore the move away from "encounter-based" medicine to mobile health.

To consider how consumer electronics, particularly smartphones and personal data-tracking software, are reconfiguring health practices.

To address the new understandings of health and wellness that are emerging from the "digital health space."

B2: Language and Imagery of Health in Pre-modern Contexts

Grand Ballroom A

Moderator: Ann Ellis Hanson, Yale University

Katherine Marino, *University of Massachusetts Medical School, Worcester, MA: I curse...myself?: Understanding Graeco-Egyptian Uterine Amulets as a Medical Means to Control the Female Body in Light of Contemporary Curse Technologies*

Graeco-Egyptian uterine amulets have been interpreted as means to control the uterus for various purposes. Traditional understandings centered on ideas that they were intended to increase fertility and ease childbirth while more recent arguments appreciate them as a mechanism to sooth a painful organ that, left unchecked, could have significant medical consequences. Recent study of these amulets has also yielded great insight into popular conceptions about functional abdominal anatomy. This paper will demonstrate a heretofore unrecognized mechanism by which these amulets functioned: self cursing.

Curse tablets are well known from the Graeco-Roman world. Typically employed against an enemy or in times of unequal competition, the situations in which they were utilized have been well categorized by Christopher Faraone and others. While curses against specific body parts of competitors, such as the tongues of orators and racehorses' feet are not uncommon, the uterine amulets are unique in using curse language and formulae against the user's own body. Further, the archetypal imagery of these amulets can be traced directly to Egyptian binding and cursing traditions.

This self-directed cursing is unique in the ancient world. It is also unique as a curse being deployed as a medical therapy and begs the question of the notion of the uterus among the population employing these amulets. Was this mechanism understood as a self-curse or was the uterus, as in the tradition of Arataeus, understood as a foreign entity, an enemy within to be mastered and controlled by whatever means necessary? A close examination of the language and imagery found on the amulets and that in contemporary curse traditions will be used to help place these amulets in their cultural and medical contexts. In creating such a picture it will also become evident how great an impact the misbehaving uterus could have on a woman's quality of life, and the drastic lengths to which a desperate woman might go to secure her safety and comfort. Bearing this example in mind may also impact the modern Gynecologist's practice by helping to refocus her approach to dealing with the nebulous and often frustrating complaint of inexplicable pelvic pain.

Learning objectives:

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

Anna Bonnell-Freidin, Princeton University, Princeton, NJ: *An Animal Within? Contextualizing a Vision of the Uterus in Ancient Greek Medical Culture*

In classical antiquity, the uterus was an organ that inspired curiosity, suspicion, and wonder. Some people thought of the uterus as an independent creature, although this idea was repudiated by learned physicians. Plato describes the organ as a *zôon* (Tim. 91c), a "living thing," and Aretaeus, centuries later, explains that it is "like an animal within an animal" (SA 2.11). If the womb could be imagined as or like an animal, what sort of animal was it? This paper will explore one possible answer and will seek to understand its meaning in the context of Greek medical culture, focusing on the works of two physicians, Soranus (first/second century CE) and Galen (second century CE).

Soranus and Galen reject the notion of uterus as an independent creature, but they explore certain aspects of the womb's form and function through comparison with the appearance or behavior of one animal – the octopus. Soranus, for example, cites the anatomist Herophilus who stated that a prolapsed cervix is recognizable by its softness, like the "head" of an octopus (Gyn. 4.36[85].2-3, CMG IV.148.17-

20). This analogy is evocative for several reasons, not least of all because of the reputation of the octopus as a “boundary-crosser” in Greek thought. Furthermore, it resonates with depictions of the organ on medico-magical amulets, which sometimes show so-called octopus uteri – hollow disks with tentacles stretching upwards or downwards (two such amulets, probably dating to the third century CE, will be discussed).

The analogy with the octopus takes on special significance if understood in the context of animal dissection. Human dissection was seen as taboo, save for a period in Alexandria associated with pioneering anatomists, Herophilus and Erasistratus. Animal dissection (and vivisection), however, was a more enduring practice, and Galen’s works provide a window into the culture of anatomical display. I would like to suggest that by understanding the interior of the human body (especially that of the female) through animal dissection, organs were rendered more animal – and thus less human – in medical thought, thereby supporting rationalizing arguments that buttressed popular conceptions of the animal-like (and octopus-like) womb.

Learning objectives:

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

Deepen understanding of illness and suffering

Explore the material record to understand women’s self-care in classical antiquity

Walton Schalick, *University of Wisconsin-Madison, Madison, WI/Central Wisconsin Center, Madison, WI: “Patiens patiens:” A Contextualized Etymology of the Long Suffering Patient*

Medieval philosophers wrote of a *'patiens,'* a receiver of actions by an agent. While not unheard of in Ancient, early and high medieval texts, *'patiens'* only infrequently meant, ‘a patient.’ But by the late 13th and 14th centuries, this nominative term had become nearly synonymous with an individual suffering from an illness and receiving medical care.

Leaping from Latin, *patiens* rapidly penetrated into the Romance *linguae* of the high and late Middle Ages, including medieval French, Italian, Spanish, Anglo-Norman, and English, among others. In English, for example, the first examples of ‘patient’ appear in translations of Lanfranc of Milan’s and Guy de Chauliac’s Latin works in the late 15th and early 16th centuries.

This paper examines the linguistic transition from a less prescriptive term to one of high medieval philosophy to the practicum of elite practitioners and thence to common parlance at a time of medieval (proto)medicalization. It is posited that adaptation and adoption of the term at once added to the primacy of the physician and surgeon over his subjects while lending elite intellectual status to the practitioner, a process which continued to accrete through to the 19th and 20th centuries.

Using a panoply of sources in Latin and medieval vernacular languages, this paper presents a ‘contextualized etymology’ of *'patiens,'* identifying a sequence of

transitions in the meaning of the term ultimately leading to a more 'modern' sense of the medicalized 'receiver of actions' from a physician. As the final transitions occurred in step with the (proto)medicalization of Western Europe, the sequence suggests a tantalizing hypothesis of concomitant cause and effect, if only one waited patiently.

Learning objectives:

The auditor will understand the premodern history of the noun, "patient."

The auditor will understand the premodern processor medicalization as it relates to being a patient.

The auditor will appreciate the cultural expression of being a patient through the lens of language.

B3: Picturing the Medical Subject: Aesthetics, Rhetoric, and Showmanship in Medical Photography, 1850-1970

Temple Room

Moderator and Discussant: Chita Ramalingam, Yale University

Images, most historians would agree, play a key role in the construction and dissemination of medical evidence and identity. Yet 25 years after Ludmilla Jordanova (*Social History of Medicine* 3, no. 1 (April 1, 1990): 89–62) called for increased attention to the visual culture of medicine, we still have fundamental gaps in our knowledge of how images work in the medical professions. How have physicians, surgeons, and anatomists gathered, disseminated, and used photography? What other visual practices have influenced the practices of medical photography? How have medical professionals, their subjects, and the lay public thought about, debated, and participated in medical photography? And how has photographic medical evidence changed over time?

In this set of papers, three authors take on these fundamental questions in the history of medical photography. Heidi Knoblauch (Yale University) draws on extensive scrutiny of medical case files, letters, and scrapbooks to argue that patient photographs have been part of relationships that are far more nuanced than we've understood. Michael Sappol (National Library of Medicine) investigates the rhetoric of anatomical photographs, arguing that they balance mechanical representation with "special effects" to produce a compound subject that evokes the sphere of showmanship. Miriam Posner (University of California, Los Angeles) examines the neurologist Walter Freeman's photographs of lobotomy patients, showing that he drew on previous traditions of patient imaging to produce a lobotomy-ready subject.

Combined, these three papers address some basic questions in the history of medical photography while demonstrating that the close scrutiny of images has a great deal to offer the history of medicine more broadly.

Heidi Knoblauch, *Yale University, New Haven, CT: Medical Photography, Record Keeping, and the Doctor Patient Relationship: The Photographic Department at Bellevue Hospital, 1868 – 1906*

The role of patients has been minimized in previous studies of the clinical case record. But patients, in fact, played a large role in shaping the newly conceived clinical record that appeared in the late 1870s and early 1880s. Many patients collaborated with physicians and photographers to collect photographs for the purpose of documenting disease. While patient photographs represented a new type of scientific aesthetic practice, aligned with graphs and charts, the way photographs were collected during the Nineteenth century mirrored more sentimental and intimate practices such as scrapbooks and albums.

Photograph collection was the impetus for physicians forging closer relationships with patients. Physicians often wrote letters to patients that they had previously treated asking them for a photograph. Often, patients and physicians became “pen pals” writing multiple letters going back and forth about photographs. From 1839 to the mid-1860s, photographs of patients became increasingly important to physicians.

This presentation uses Bellevue Hospital as a case study to show that photography played a large role in shaping the identity of medical professionals, the identity of patients, and the perception of the hospital in the United States. In 1868, physicians associated with Bellevue Hospital created a photographic studio staffed by a professional photographer named Oscar G. Mason who took photographs of patients for physicians to collect in personal scrapbooks and administrators to add to the official record books. The creation of the photographic department at Bellevue Hospital was predicated on the assumption that a written case history was not only difficult, but often times, imperfect. It was the first hospital to build a photography studio in a civic hospital so that patients could be photographed without leaving the hospital grounds. This signaled a shift from relying solely on written case histories, to relying on mechanical technologies to transcribe the progress of patients.

Learning objectives:

- Identify and describe early aestheticization of medical record keeping
- Deepen understanding of sentimental photographic practices in the doctor-patient relationship
- Stimulate discussion of the patient’s role in creating the clinical case record

Miriam Posner, *University of California, Los Angeles, Los Angeles: Head-and-Shoulder Hunting in the Americas: Walter Freeman and the Visual Culture of Psychiatry*

Lobotomy, as Jack Pressman argued in the landmark “Last Resort,” was the product of a way of thinking: an understanding of psychiatric health that emphasized social integration and useful industry. In this presentation, I will argue that lobotomy was also a way of seeing: a therapy with a distinctive visual culture that conjoined several traditions of viewing the human face to argue for a very specific somatic therapy.

Walter Freeman, the world's foremost proponent and practitioner of lobotomy, was also an obsessive photographer. He almost invariably took photos of his patients before and after surgery, often tracking them down years after the operation to capture their images. These cross-country trips to photograph patients, which Freeman called head-and-shoulder hunting expeditions, consumed the physician during the last years of his career. It's tempting to see Freeman's photography as further evidence of the man's eccentricity. But a closer look at the visual culture of psychiatry and neurology reveals that the tradition of the before-and-after patient photo has been part of the profession's repertoire of images for centuries. Freeman in fact modeled his practices on the neurologist Harvey Cushing, who collected more than 10,000 patient photos. The particular innovation of Freeman's photographs, as I show in this presentation, was to conjoin several traditions of portrait photography, from Charcot to Bertillon to Cushing, at a moment when the professions of psychiatry and neurology were in flux. A close examination of Freeman's photographs sheds new light on how the physicians made his case for the procedure: The portraits argue for somatic intervention using the visual rhetoric typically employed by psychiatry.

This presentation starts with an overview of Freeman's photographic practice, then moves backward to trace the traditions of portrait photography on which Freeman drew. I argue that locating these traditions in Freeman's visual rhetoric helps us understand how lobotomy made sense at its particular moment, and suggest possibilities for future lines of investigation of the visual culture of medicine.

Learning objectives:

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

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

Recognize the dynamic interrelationship between medicine and society through history

Michael Sappol, *National Library of Medicine, Bethesda, MD: Anatomy's Photography: Objectivity, Showmanship and the Reinvention of the Anatomical Image, 1850-1920*

For several decades historians have intensively studied ways of medical photography — photographic clinics, medical portraiture, forensic medicine, photomicrography, and so on. But missing from that list is the field that for centuries stood at the heart of the medical curriculum, and whose images had a privileged status in the hierarchy of medical image production: anatomy. Photography, with its famously powerful "reality effect," had many productive uses in medical research methodology and teaching, was an emblematic technology of science and modernity. Physicians and surgeons eagerly adopted it and showed an ardent desire to photographically document pathological conditions, microscopic views, laboratory experiments, surgical techniques, etc. But anatomy was slow to embrace photography. When, in the second half of the 19th century and early years of the 20th, Nicolaus Rüdiger, Eugène-Louis Doyen and other anatomists finally took to it, they took liberties. They manipulated their photographs in

theatrical and painterly ways. They spectacularly cut, sliced, posed, and lit their cadavers and body parts. (In some photographs, the anatomical subject even appears to be wearing make up.) The resultant image was then silhouetted or colored, and outfitted with a halo of captions. The artist's pen and brush is as evident as the anatomist's saw and scalpel—and both are subject to an aesthetic impulse.

The epistemological status, rhetorical advantages, and moral implications, of photographic imaging were then much debated—in art and the law as well as medicine and science. As Peter Galison and Lorraine Daston have shown, photography could be deployed as a technology of “mechanical objectivity” to critique the deceptions and delusions of aesthetics in the making of scientific images. In anatomy the discourse and practice of photography centered on the relative epistemological virtues of the anatomical photograph versus: painting and drawing (as reproduced by engraving and lithography); specimen, cast and model; and the reiterative (and haptic) performance of dissection. There was also a moral critique: anatomy's spectacular photographs blurred the boundary between respectable medicine (and “good taste”) and the popular anatomy show — and contravened an emergent medical ethos of sober presentation that was becoming an ascendant convention of laboratory science.

Learning objectives:

To better understand the epistemological problems posed by the adoption of photography in late 19th and early 20th century medicine.

To better understand the aesthetic impulses underlying the making of medical photographs in the late 19th and early 20th century.

To better understand the ethical implications and cultural meaning of medical photographs in the late 19th and early 20th century.

B4: Regulatory Regimes in the Past Half-Century

Wooster Room

Moderator: Dominique Tobbell, University of Minnesota

Kelly Jones, *State University of New York at Stony Brook, Stony Brook, NY*: ***“Mr. Reston has it helped you?” The 1970s Acupuncture “Fad” and Popular Understandings of Therapy***

On July 20, 1971, readers of the “New York Times” learned that one of the most widely-read journalists of their day, James Reston, had received acupuncture therapy for post-operative pain following an appendectomy in Peking. What became the most famous surgery “since Lyndon Johnson's gallbladder” - as one observer put it - sparked the imagination of the popular media, lay persons, researchers, and clinicians: How did acupuncture affect the nervous system? Could it cure, or only eliminate pain? Who was licensed to practice it? And where or how could one find an acupuncturist? In examining letters written by individuals interested in acupuncture, a set of dual expectations emerges: while the writers - many of whom suffered with incurable chronic illnesses - were anxious to find out

whether an alternative, non-biomedical treatment existed, they also relied upon western medical authorities and regulating bodies for legitimation of such. Alternative medicine in America has typically been viewed in opposition to mainstream medicine: because physicians, scientists, and pharmaceutical companies did not appear to be sympathetic to the needs of patients, patients turned to traditional and unconventional methods of healing. Yet, the letters that readers posted to James Reston (collected in the New York Times Company Archives at the New York Public Library) indicate that for many, the search for new therapies to aid themselves or their chronically-ill loved ones involved looking for acupuncturists who had been authorized by American regulatory bodies, as well as for scientific – or at least overwhelming anecdotal – evidence that acupuncture was effective for their own specific ailment. This tendency is supported by several print articles and television specials that attempt to explain acupuncture to the public within the rubric of western science. Furthermore, this desire to cling to conventional medical standards while groping for new solutions can be viewed as integral to the socio-economic backgrounds of some of these individuals; by mapping the letter writers' return addresses using ArcGIS digital mapping software and overlaying relevant historical census data for employment and household incomes, the author will demonstrate the relatively "middle class" backgrounds of the majority of these writers.

Learning objectives:

Respond to changes in health care delivery guided by a historically informed concept of professional responsibility and patient advocacy.

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

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

Saeyoung Park, Davidson College, Davidson, North Carolina: *Contradictory Global Public Health: Privatizing Tobacco and Nation-State Polices in South Korea*

Tobacco features prominently in the world history of state monopolies from China, Turkey, Poland to France. Many monopolies, including South Korea's KT&G, joined the global privatization wave in the late twentieth-century. For public health advocates, the privatization of state monopolies that market socially problematic goods can seem advantageous, as the state's regulatory and pecuniary interests are more clearly demarcated. Specifically, the government is released from a regulatory double-bind where its public health mission conflicts with the simultaneous promotion of the very consumption that it seeks to diminish.

This paper discusses the history of KT&G and argues that the privatization of psychoactive substance monopolies can have unintended public health consequences. The path to privatization began in the 1980s when the company reacted to the entry of tobacco multinationals and global economic liberalization with marketing innovations such as the promotion of patriotic smoking. The monopoly mobilized labor as well as public demonstrations, and positioned itself as a model of national industry and as a champion of farmers. Echoing rhetoric from

the previous decade of rapid economic development, KT&G equated its interests with those of the Korean nation, and the pressure of foreign tobacco companies with the nation's experience with imperialism. Ultimately, the path to privatization ended with KT&G's maturation into a multinational tobacco company in 2002; today, it markets cigarettes globally (Turkey, China, among others) instead of being limited primarily to domestic markets. Perversely, its framing of smoking as nationalistic has led to a growing customer base that looks less Korean.

Privatization of KT&G has relieved the Korean government from the regulatory double-bind which traps states that condemn smoking while profiting from a state tobacco monopoly. Domestic smoking rates have fallen since privatization, accompanied by rising success in many related metrics of public health. However, this paper suggests that this rosy picture is a result of a nation-state centered public health lens which obscured, and continues to obfuscate possible public health harms resulting from KT&G's transformation into a multi-national tobacco company.

Learning objectives:

Identify successes and failures in the history of medical professionalism
Understand the dynamic history of medical ideas and practices, and how shifting political and social contexts can transform relations between patients, public health institutions, and health care providers
Recognize the dynamic interrelationship between medicine and society through history

*Greg Higby, University of Wisconsin-Madison, Madison, WI, and American Institute History of Pharmacy, Madison, WI: **The "archaic" North Dakota Pharmacy Ownership Law and the Realities of 21st-century Pharmacy Practice***

In 49 of 50 states, the controlling interest in a community pharmacy may be held by non-pharmacists or non-pharmacist-owned corporations. In North Dakota, however, Century Code 43-15-35(e) requires that registered pharmacists hold majority ownership in retail pharmacies.

On November 4, 2014, voters in North Dakota decide the fate of the ownership requirement. If passed, Measure 7 -- the North Dakota Pharmacy Ownership Initiative -- would remove this requirement, which effectively bans chain retailers such as Target, Walgreens, Kroger, and Wal-Mart, from operating their own pharmacies in the state.

From the 1890s through the 1920s, several states had ownership requirements similar to North Dakota's. These laws went unchallenged as almost all retail drugstores were independently owned by pharmacists and the few existing chains were small and pharmacist-owned as well. In 1928, however, the corporate Liggett chain wished to expand into Pennsylvania and was blocked by that state's ownership regulations. Liggett argued that such laws were unconstitutional because they violated the due process clause of the 14th Amendment. The case made it to U.S. Supreme Court, which decided in favor of Liggett (with a pithy dissent from Justice O. W. Holmes). The leadership of pharmacy regarded the

decision as a serious blow to their professional aspirations and the sting lasted for decades. In 1973, the Supreme Court reversed the Liggett decision, allowing the North Dakota law to be enforced.

This paper will examine the pharmacy profession's reaction to the Liggett and North Dakota decisions with a focus on practice autonomy and corporate control. Since the 1960s, the landscape of community pharmacy has shifted dramatically away from a nation of independently owned corner drugstores to the dominance of large chain pharmacies and big box retailers with prescription departments. During the same time, community pharmacy practice has gone through a paradigm shift that places increased responsibility for patient outcomes on pharmacists. The paper concludes with a look at the compatibility of corporate ownership and the evolving practice ideals of the pharmacy profession.

Learning objectives:

Better understand the role of the community pharmacist in the U. S. healthcare system

Identify significant differences among various outlets of outpatient pharmacy services

Consider how the post-war expansion of the chain drugstore industry into rural America has influenced the resulting pharmaceutical care.

B5: Emergence of Modern Medical Paradigms in an Evolving China

George Room

Moderator: Nicole Barnes, Duke University

Luwei Yang, Washington University in St. Louis, MO: Tamed or Denied Sense of Suffering: Pain in Childbirth in Modern China

Childbirth pain, an entity always be depicted as a necessary and unavoidable component of delivery in Traditional China, was seen as suffering experience that could be eliminated by "Western" medicine in Republican China under the discourse of "modern" and "scientific". Using anesthesia and analgesia medication from biomedicine, physicians claimed to tame this horrible monster and create a comfortable childbirth experience for women, which was highly supported by feminist at that time. During early 1950s, the new communist regime, however started a nationwide campaign of promoting the psycho-prophylactic method of delivery (PPMD, known as Lamaze method to the Western world) in order to legitimize its ruling. Unlike biomedicine, PPMD, a "technique" derived from Pavolian theories, directly denied the existence of childbirth pain, and attributed it to women's illusion due to divergence of class. Carried in the form of ideological education, the campaign however vanished in a decade, receiving resistance from both physicians and pregnant women and facing practical problems like financial crisis and low participation.

This paper will trace the cultural history of pain in childbirth from early twentieth-century to early 1950s China, focusing on how this worrying experience was

treated and denied in different political and cultural contexts; analyzing the changing boundaries between biomedicine, Traditional Chinese Medicine (TCM), and Soviet medicine. Finally, I will put the childbirth pain in a broader context, by conducting a comparative study between PPMD campaign in China and the promotion of "natural childbirth movement" and "Lamaze method of delivery" in Europe and America. Physicians in the "Western" world once used anesthesia to legitimize their control of delivery room; their authority, however was challenged by women's request of "natural childbirth", which was similar to PPMD. Though women reproduced in a similar way, there was a great divergence between PPMD and natural childbirth in their motivation and ways of practicing.

Learning objectives:

To understand how medical discourse was influenced by bodily experiences and political factors

To explore the construction of medical boundaries in political and social context

To reveal the divergence of understanding pain in childbirth in different cultures

Yi-Jui Wu, *Nanyang Technological University, Singapore, Singapore: **Origins of "Manufactured Mental Illnesses (bei jingshenbing)" in Twentieth-Century China***

After more than two decades of painstaking legislation process, on 1st of May, 2013, the Mental health Law was finally administrated in China. The adoption of such law at the state level is hoped not only to adjust the potential political abuse of psychiatry, but also to popularize community mental health services, regulate professional and disciplinary functions of psychiatric science, and provide legal grounds for appropriate psychiatric treatments. Right before the administration of Mental health Law, a neologistic catchphrase *bei jingshenbing* (被精神病), which refers to the experience of being misidentified as having symptoms of mental illness resulting in mental hospital admission either for humanitarian or malice intention, suddenly became a buzzword in the media either online or in press. Using historical accounts obtained from the Beijing Municipal Archives, historical and contemporary Chinese medical periodicals and oral interviews collected during my fieldwork in multiple sites with clinical psychiatrists, public defenders, human right activists and individuals who had experiences of *bei jingshenbing*, this paper attempts to draw an overall picture of the misappropriation of psychiatry in 20th Century China from social, cultural, economic, legal and medical perspectives, arguing that the rapid spread of *bei-jingshenbing* in contemporary Chinese society has not only reflected the fear among Chinese people of the punitive nature of psychiatry abut also their growing credence in scientific health governing during the years of social change. It further reflects the disjunctive acceleration of various modernities in China concerning the process of rapid capitalization, the pursuit of equity and justice among disfranchised citizens and the challenge faced by policy makers regarding mental health reform.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history.

Deepen understanding of illness and suffering from cross-cultural perspectives.

Miriam Gross, University of Oklahoma, Norman, OK: *Between Party, People, and Profession: The Many Faces of the "Doctor" during the Cultural Revolution*

The conception of what constituted a doctor in the countryside altered radically during the Maoist era. Changes resulted from the mutual interaction and influence of three different frameworks: top-level Party members, especially Chairman Mao, rural clients, and western-trained medical professionals. During the Cultural Revolution the CCP's conception of "doctor" changed from a symbol of rural modernization to that of Party benevolence. This resulted in the Party moving from Western trained doctors to the "people's doctor" (aka barefoot doctors) as its ideal prototype. By the Cultural Revolution, the Party had successfully made rural primary care accessible and affordable. Due to their relative ease of obtaining medical care, many rural people diverged from the Party's medical model, emphasizing treatment competence instead. Under this criterion, Western trained medical doctors, many of whom had been labeled "bad elements" and sent to the countryside for rehabilitation, were preferable to barefoot doctors and received rural people's support. Finally, while Western trained physicians initially disliked the "people's doctor" ideal and had belittled both Chinese medical practitioners and barefoot doctors, during the Cultural Revolution these diverse conceptions of the doctor became closer due to the leveling effect of terrible rural medical conditions. In addition, Western-trained doctors depended on barefoot doctors for political protection, while barefoot doctors relied on Western-trained doctors' expertise and served the equivalent of a medical apprenticeship under them. By the Reform era, this fragile conceptual nexus created by the contingencies of the Cultural Revolution had fallen apart.

This talk specifically focuses on the development of professionalism, contested ideas about what professionalism means, and the result when it's absent. The paper develops of ideas about what it means to be a doctor. It looks at how the state, patients, and doctors in China each have different ideas about medical practice. Then it examines what the result of their clash is in terms of medical practice and professionalism on the ground.

Learning objectives:

- Identify successes and failures in the history of medical professionalism
- Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
- Recognize dynamic interrelationship between medicine and society through history

C1: Roundtable on Vernacularizing Medicine

Grand Ballroom C

Moderator and Discussant: Charles E Rosenberg, Harvard University

This roundtable will discuss vernacularization as a concept of use to historians of medicine, across a broad spectrum geographically and chronologically. Vernacularization is the process of transforming knowledge or practice from an exclusive form to a broader one intended to have greater social reach. While the term was originally used by scholars to describe a linguistic process, such as the translation of medieval Latin uroscopies into

English or French, we use it as a an analytic for cultural history. How and why are some ideas or practices transmuted into others by being re-framed for broader constituencies? 'Vernacularization' serves as an optic through which we can see processes of adaptation, appropriation, and popularization. It can help us to deepen and problematize processes of translation, transfer, and circulation, themes that have been the focus of recent scholarship. Whereas each of these themes operate mainly on a horizontal scale by tracing connections, tracking flows, mapping networks and so on, 'vernacularization' focuses on the vertical plane of power, negotiation, appropriation etc. Our use of the concept is intended to highlight agency and process alongside power and marginality. Nor is it solely one-way. Any vernacularizer participates in a form of dialogue, however shaped by inequities of power, between his or her more exclusive forms of knowledge and those held by the wider groups he or she seeks to engage. 'Vernacularization' thus examines movement between real or imagined hierarchies of knowledge, and emphasizes social granularity rather than hydraulic networks of circulating texts. our round table will invite each of its participants to present a very brief example, a text, an event, or a process from his or her own scholarship that might be analyzed fruitfully as vernacularization. Our goal in devising this format is to emphasize that vernacularization is a process; we hope that by giving everyone in the room brief examples from a wide range of scholarship we can promote discussions that cut across the customary chronological and geographic boundaries of our field and interrogate the utility of this particular analytic.

Panelists

Mary Fissell, Johns Hopkins University: will look at the work of one of the best-known authors of English medical works for a lay audience: the seventeenth-century healer Nicholas Culpeper. Culpeper proclaims that his work is open to all, criticizing the monopolist practices of physicians, and uses colorful colloquial language, including proverbs and direct address. However, he also relies upon autoptic authority, commanding assent from the reader because he, Culpeper, has performed anatomical dissections that the reader has not. This tension between being open to all yet remaining an authority, underlines the power gradients inherent to the process of vernacularization.

Pablo Gómez , University of Wisconsin-Madison: will discuss the healing practices of Bernardo de Saavedra, a West African slave born in the kingdom of Ardra. By the late seventeenth century, he had become one of the preeminent healers in the Caribbean city of Cartagena de Indias (today Colombia). De Saavedra's rituals, and the explanations he gave for their power, exemplify the richness of the cultural economy of healing of multifarious origins that emerged in the region. Powerful explanations for the natural world that originated in the Caribbean were products of an epistemological revolution headed by ritual practitioners of African descent like De Saavedra. These practitioners became the dominant intellectual forces shaping explanations about the nature of the world for Atlantic people of all origins in the seventeenth-century Caribbean.

Nicole Elizabeth Barnes, Duke University: will discuss how in the early twentieth century, traditional midwives' practices in China were demonized by those schooled in germ theory as the principal cause of neonatal tetanus and puerperal fever, and a

retinue of young women trained in aseptic midwifery began to attend to births, increasingly in hospitals. Currently, China has one of the world's highest rates of births by Caesarean section, yet it took many decades to displace traditional midwifery and home births; the process of vernacularizing hospital births in the inland city of Chongqing is the focus of my presentation.

Jake Walsh Morrissey, Trent University: will discuss how the Dominican friar Henry Daniel vernacularized learned Latin medicine in medieval English. Daniel, an older contemporary of Geoffrey Chaucer, is perhaps the earliest major participant in the so-called "Ricardian translation project" that saw learned Latin scientific, medical, and allied elite discourses enter the English vernacular. Daniel tells us that he produced his two major works, a work on herbal medicine and a guide to uroscopy, for an unlatined English audience. He writes candidly and compellingly about the challenges he faces translating (transplanting, naturalizing) his diverse source material, which represents the full spectrum of medical practice, from the university curriculum to the verbal testimony of empirics and amateurs. Neither work is available in a modern edition, but recent and forthcoming scholarship demonstrates their importance to the study of the early "Englishing" of medical discourse.

Projit Bihari Mukharji, University of Pennsylvania: will discuss the vernacularization of biomedical technologies, focusing particularly on the injection, in 20th century India and Bangladesh. Anthropologists and Public Health officials since the 1970s have documented the "over use" and "abuse" of injections in many parts of the Majority World, including South Asia. Yet no account has been taken of the numerous pamphlets and books through which this medical technology is mediated, adapted and repurposed for local use. Looking at these "injection books", Mukharji will argue, shows us how this global medical technology has been vernacularized in South Asia."

Learning objectives:

Define social and intellectual complexities that may inhibit competent patient practitioner communication

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

Demonstrate the dynamic interplay of changing medical ideas and practices and their implications for patients and health care providers

C2: Medicine in Translation: Local Interpretations of Medical Knowledge, Naming, and Practice

Grand Ballroom A

Moderator: Stephen Casper, Clarkson University

Medical knowledge is often thought to be hegemonic and universalizing, a power that leaves little room for local identities and practices. Yet the global and local history of medicine shows a far more complex and varied picture of negotiations among activist and patient advocacy groups, professional interests, and research paradigms, which influence

local cultures of treatment and medical knowledge. Our panel examines how this knowledge is translated and reinterpreted in different localities by scientists and physicians, minority communities, and advocacy groups. This extends to the nature of diagnosis and treatment, interpretations of what counts as normal and pathological, and discussions about the naming of medical conditions as an expression of social influence. In particular, the panelists pay attention to the transformations necessary to translate medical knowledge from one country, institution, or profession to another, to adapt practices from a local western situation to a more global sphere, and to accommodate the negotiations between health professionals and advocacy groups. Each paper offers a different perspective on how local medical and advocacy communities translate, interpret, name, and manage patient bodies and conditions. The papers are united by a focus on the interaction between different actors and research paradigms, and offer new perspectives on the multiple influential forces in health and medicine.

Learning Objectives:

Give the learner insights into how one's own cultural background shapes medical practices and knowledge.

Make the learner consider the validity and origin of medical practices and knowledge from different cultural contexts.

Raise the learner's awareness for how multiple actors shape medical practice and disease identities.

Sandra Eder, University of Zurich, Zurich, Switzerland: Translating Medicine, Circulating Knowledge. Transferring Treatment Recommendations for "Hermaphroditic" Children from Baltimore to Zurich

In the summer of 1950, Lawson Wilkins, director of Johns Hopkins' Pediatric Endocrinology Clinic, travelled to Zurich, Switzerland, to present a paper at the International Pediatric Congress. With him he brought fresh knowledge of his clinical trials on how to use cortisone for the treatment of "hermaphroditic" children with congenital adrenal hyperplasia (CAH). In Zurich, he met Swiss doctor Andrea Prader who became an important international figure in the study of CAH in particular and of intersexuality in general. This was the beginning of a rich transfer of knowledge between Baltimore and Zurich. This transfer of clinical practices included not only knowledge concerning cortisone usage and dosage, but also recommendations on what sex to choose for "hermaphroditic" children, when to change it, and how to evaluate their behavior and treatment success. A closer look at the patient files from the Zurich Children's Hospital and Prader's published studies shows that the transfer of knowledge was neither straightforward nor uncontested. Though Prader embraced the same therapeutic approach for intersexual children, he relied on a Swiss notion of psychosexuality.

Medical ideas, theories, techniques, objects, people, and technologies travel. They circulate among different clinics, medical facilities, and countries, and among practitioners with differentially defined interests and medical expertise. However, the process of circulation is anything but neutral: it sets into motion a form of translation and appropriation that transforms these practices to fit the particular demands and needs of their new locale. The Hopkins intersex treatment recommendations emerged at the intersection of a specific clinical context and a

particular US-American understanding of gender roles. Using patient records from the Zurich Children's Hospital I argue that Prader's appropriation of these ideas and practices transformed them in a manner that fit Swiss medical practice and Swiss notions of psychosexuality. In doing so, I aim to illustrate, that the circulation of medical ideas and practices is inevitably mediated by the material and social nature of knowledge.

Learning objectives:

Understand the process of translation and adaption of medical ideas and practices between different localities

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

Critically appraise clinical management from a historical perspective

Marion Schmidt, Johns Hopkins University, Baltimore, MD, USA: *Translating Psychiatric Genetics to a New Era: The Redefinition of Deafness at the New York State Psychiatric Institute, 1955-1970*

In psychiatry, the two decades following World War II are mostly remembered as an era of deinstitutionalization and of first introducing psychoactive drugs. Yet it was also a period in which psychiatrists transformed conventional mental health care in order to serve disadvantaged minorities such as African Americans, immigrants or the disabled. At the New York State Psychiatric Institute (NYSPI), Franz Kallmann, a German immigrant, in 1955 established the first specialized mental health care services for the deaf that were conducted in sign language. Kallmann was a controversial figure. Often dubbed the founding father of psychiatric genetics in the US, he was a Jewish-born supporter of national socialist eugenics who had been forced into emigration by national socialist racial persecution. In the US, Kallmann had to translate his eugenic psychiatry to a new political framework. Adapting to the goals of Cold War science, he portrayed genetic psychiatry as a means to achieve a happy family life, a stable democracy and society free of the burden of (mental) illness. The deaf people of New York State became Kallmann's model population to demonstrate these goals.

Yet in interacting with the state's large and well-organized deaf community, NYSPI psychiatrists' perceptions of deafness and deaf people changed. Engaging with deaf adults, psychiatrists came to ambiguous and multilayered definitions of deaf people's particular normalcy and pathology. This, in turn, informed family and reproductive counseling at the NYSPI. Where before deafness was a tragedy to be avoided, it now became a psychosocial characteristic defining a socially disadvantaged minority. The NYSPI thus translated older eugenic paradigms to the logic and rhetoric of minority rights that permeated the 1960s.

The history of the NYSPI mental health project for the deaf illustrates a number of crucial developments in mid-20th century medicine and society: It shows how the interaction between psychiatrists and their objects of research changed therapy and the very definition of pathology; how research objects turned into the activists of the emerging disability, deaf and mental health movements; and how this move allowed

psychiatrists to fashion themselves as social activists supporting the struggle of minorities.

Learning objectives:

Shows the learner how deinstitutionalization influenced the establishment of community mental health programs.

Makes the learner aware of how the close interaction between professionals and activists redefined the understanding of mental health and disability.

Demonstrates to the learner how acknowledging the diversity of patient perspectives led to minority-specific standards of treatment

Andrew Hogan, Creighton University, Omaha, NE: *Negotiating Medical Knowledge: Professional Interests, Patient Advocates, and the Localization of Naming Practices*

In 1960, American geneticist Curt Stern began a campaign to rename Mongolism, the most common known form of intellectual disability. John Langdon Down had coined the term Mongolism nearly a century earlier. However, it had already been widely accepted for decades by 1960 that his understanding of the condition's etiology, as involving the racial degeneration of affected Caucasians to become 'Mongolian', was inaccurate. While Stern and his medical colleagues acknowledged that the term Mongolism was misleading, their primary argument for the name change was professional, not technical. Medical genetics was a burgeoning field around the world, including many practitioners of Chinese and Japanese descent, who found Mongolism to be both ostracizing and offensive. The move away from Mongolism happened slowly, but over the next decade an eponymous name honoring Down was widely adopted.

Eponyms have frequently been adopted for the naming of disorders since the late-19th century. Medical professionals have favored the use of eponyms for a variety of reasons, including their descriptive neutrality and important role in the awards system of medicine. This paper examines the changing processes and interest groups involved in the adoption of eponyms since 1960, when professional considerations alone influenced the choice of eponyms. I draw on archival records, the published medical literature, and interviews to examine the adoption of multiple eponyms to replace existing descriptive, and offensive, terms for medical conditions. This includes Down syndrome to replace Mongolism during the 1970s, Angelman syndrome in place of Happy Puppet syndrome during the 1980s, and Willis-Ekbom disease to replace Restless Legs syndrome since 2000. I argue that beginning around 1980 the process for naming disorders expanded beyond purely professional considerations to include an awareness of patient interests and preferences. As their voices were increasingly recognized in the naming process however, patient advocates did not seek to change the existing medical conventions. Instead, patients and families continued to favor the adoption of eponyms for many of the same reasons that medical professionals had throughout the 20th century. Importantly, this included the role that eponyms played in honoring the contributions of medical researchers in constructing patient's conditions.

Learning objectives:

To think critically about the nature, ends, and means of medical naming.

Abstracts: C2/C3

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

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

C3: Ethics and the Use of Human Cadavers in Modern Medical Education and Research

Temple Room

Moderator: James Mohr, University of Oregon

Robert Peckham, *The University of Hong Kong, Hong Kong: Autopsies of Violence: Dissection and Dissent in Nineteenth-Century China*

From the late eighteenth century until well after the creation of the Republic of China in 1912, when dissection was formally legalized, Western scientific examinations of the bodies of the Chinese dead were to be sources of recurrent tension and flashpoints of conflict. In 1894, during an epidemic of bubonic plague in Canton and Hong Kong, rumors circulated amongst the Chinese population of bodies gruesomely dissected by Western physicians. In Canton, two female missionaries, attacked by "a howling and maddened" crowd, were rescued at gunpoint with an uneasy truce maintained by the presence of a British gunboat offshore. Against this background of epidemic threat and social unrest, the paper examines the issues at stake in the promotion of postmortem procedures in colonial Hong Kong and Treaty-Port China. Linking these themes – the violence of dissection and the dissection of violence – is a concern with the development of anatomic pathology and the increasingly specialized and regulated spaces of scientific research that impinged on the dead: the mortuary and the laboratory, shut off from public view, where cadavers were stored and viscera examined. The paper concludes by considering what the institution of the postmortem in these Western enclaves in China can tell us about the medico-legal assumptions which underpinned the operations of the modern state.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history

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

Develop an historically informed sensitivity to the diversity of patients

Sabine Hildebrandt: *Boston Children's Hospital/Harvard Medical School, Boston, MA: From the Dead to the Living: Ethical Transgressions in Anatomical Research on Victims of the National Socialist Regime*

The historiography of medicine in National Socialism (NS) has long neglected the basic discipline of anatomy. This study reveals complex interactions between the NS regime and anatomists. The *Reichserziehungsministerium* and the *Reichsjustizministerium* (ministries of education and justice) were directly involved

in research funding, recruitment of personnel, and body procurement, including the distribution of bodies of executed persons. Of 162 anatomists for whom political information is available, 55 were dismissed from their positions for "racial" and political reasons. Of the 107 remaining anatomists 88 joined the Nazi party, 31 the SA, and 11 the SS.

All 31 German anatomical departments used bodies of NS victims for teaching and research, as the traditional sources of body procurement changed after 1933. Among the unclaimed dead from psychiatric institutions were those killed within the so-called "euthanasia" programs. The bodies from prisons included increasing numbers of political prisoners, those who died of a "natural" death and thousands of others who were executed, including pregnant women. Also, there were the dead from the new network of concentration camps for forced laborers, prisoners of war, Jews and others. Of the estimated 35,000 bodies delivered to the institutes, at least 3749 stemmed from executed persons. Use of "material" from the executed was traditionally considered a quality standard in German anatomy. After 1933 the quantity and quality of research on bodies of the executed changed gradually. Anatomists welcomed the new abundance of this "valuable material" and used it eagerly and in large numbers. Hermann Stieve collected medical histories of the executed for his research, and Max Clara performed experiments on prisoners before obtaining their tissues postmortem. Finally, Johann Paul Kremer

and August Hirt selected concentration camp prisoners for deadly experiments. Hirt promoted this new source of body procurement at an anatomical conference in 1942. At that time some German anatomists were ready for a change of the traditional anatomical paradigm – the work with the dead human body – to the final transgression from the land of the dead to the land of the living, but "future dead," thus making the death of the prisoner part of the research design.

Learning objectives:

Anatomy had a complex interaction with the NS regime, including body procurement, research funding and recruitment of personnel. Among German anatomists were both, victims of the NS regime and supporters.

All German anatomical departments used the bodies of NS victims for teaching and research purposes, especially bodies of the executed. Anatomical research transgressed the boundary from work with the dead to work with the "future dead", i.e. human experimentation.

Anatomy became part of the NS regime's policies of total physical destruction and annihilation of its perceived enemies.

*Susan Lederer, University of Wisconsin-Madison, Madison WI: **Bequests of Bodies: Willing One's Body to Medical Science in the 1950s***

In 1952, Horace Magoun, chair of the anatomy department at the UCLA School of Medicine, announced in the press that more than 100 friends and alumni from the University had made an unusual gift. They had willed their bodies for use by the medical school. By 1954, the anatomy department had received more than 300 such bequests. In an interview with a reporter, Magoun intimated that one reason for this success was the unusual solicitude such a gift fostered in medical students.

"Although medical students traditionally treat their work in anatomy with utmost respect, there is a special reverence which our students manifest toward these people who have voluntarily made this splendid contribution to medicine." Indeed, the UCLA program became so successful that the following year, the anatomy department stopped taking new bequests for one year, thereafter they attempted to limit bequests to individuals under the age of 50 because of the surplus generated by the willed body program.

Since the late Nineteenth century, a small number of Americans had bequeathed their bodies to medical schools, but the majority of bodies used for research and education came from the indigent and unclaimed whose bodies were made available through anatomical acts. Why and how then did the UCLA program, and others like it, attain popularity in the 1950s? This paper explores the changes in American anatomical sciences and American society that prompted this new and unprecedented reliance on voluntarily donated bodies.

Using archival materials, newspaper accounts, and other media sources, the paper examines the rise of willed body programs, the legal changes required for directing the disposition of one's dead body to a medical school, and the cultural meanings of "donating one's body to science."

Learning objectives:

- Develop insight and appreciation of changing attitudes toward the dead body
 - Deepen understanding of the dynamic relationship between the medical profession and the public
 - Identify changes in laws that made body donation possible
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C4: Performing Versatility: Historiographical Openings across Divisions of Health Work (John P. McGovern Session)

Wooster Room

Discussants: Laurence Monnais, Université de Montréal; Noémi Tousignant, University of Cambridge and Université de Montréal

Histories of the modernization of health work generally highlight the delineation and staking of claims to specific and specialized skills, tasks, roles and knowledge. By tightening the bounds of the medical, multiplying divisions of labor, and narrowing fields of expertise, groups of health workers and their "managers" have specified the terrain upon which demands and expectations of professional, specialized and effective health work could be made. Yet there are many situations -- some highlighted in this panel -- in which modern health professionals have sought to cross, broaden and transform, rather than define, draw and guard, the boundaries of their expertise. This panel asks how attention to "performances of versatility" by health workers can open new perspectives on the demands and expectations placed on their expertise; the ways in which their expertise crosses and connects within and beyond narrow medical domains as well as spaces of practice; the forms of transfer and transformation achieved by these crossings;

and the ways in which versatility has figured in professional claims and identities. Featuring a wide range of geographical case studies and forms of historical change, the papers in this panel further highlight the articulation of different forms and sites of versatility: between skills, knowledge, instruments, spirits and bodies, as well as across differentiations of culture, gender and space. They suggest that versatility may be as useful for understanding the historical role of less visible categories of health professionals as the radical transformation of high status work.

Frank Blibo, David Jones, *Harvard University, Cambridge, MA: Improvising Open-heart Surgery in Independent West Africa, 1964-1995*

In 1993 the World Bank argued that cardiac surgery had such low cost-effectiveness that low-income countries should not include it as part of their essential clinical services: it was not an appropriate technology in areas battling AIDS, maternal and child mortality, and other traditional diseases of poverty. This policy discourse about whether cardiac surgery should exist in low-income countries took place without awareness that it already did exist in many. Cardiac surgery began in West Africa, for instance, in the 1960s, when surgeons in Ghana and Nigeria performed closed heart procedures. In 1974 a team led by Magdi Yacoub completed the first successful open-heart surgery in Nigeria. Similar programs emerged in Francophone West Africa, first in Cote d'Ivoire (1978) and then in Senegal (1995). By 2000 over two thousand cardiac surgeries had been performed in these four countries.

Based on an analysis of West African medical journals (both English and French language), newspapers, archives, and memoirs, this paper documents the emergence of cardiac surgery in Ghana, Nigeria, Cote d'Ivoire, and Senegal in the first three decades after independence, a topic that has received scant attention from historians of medicine. Particular emphasis will be placed on the care of surgery patients, in hospital and at home. Advocates of cardiac surgery argued against two widespread assumptions: first, that heart disease was not a significant public health problem in poor countries, and second, that scarce resources should not be diverted from existing health priorities to resource-intensive cardiac care. As they collaborated with surgeons from Europe and North America to bring expertise to local institutions, they wrote explicitly and pragmatically about the need to improvise and adapt to the limited available resources (whether unreliable electrical grids or inadequate supplies of banked blood). Two developments helped justify their work. First urbanization and industrialization allowed surgeons to invoke the epidemiological transition and make the case that heart disease (whether congenital, rheumatic, or coronary) would require increasing resources. Second, capacity for cardiac surgery became part of the discourse of nationalism and modernization as these countries competed to establish themselves as exemplars of a new post-colonial scientific order.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history.

Acquire a historically nuanced understanding of the organization of the international health care systems and how national and international health care priorities get set.

To analyze the fluid categories and construction of infectious and chronic disease.

Nicholas Whitfield, Marc-Jacques Dubois, *McGill University, Montreal, Quebec, Canada:*
The Versatility of Minimally Invasive Surgery (MIS)

From the late-1980s, surgeons of various specialties in Europe and North America began adopting minimally-invasive (i.e. laparoscopic or “key hole”) techniques then only common to gynecology. Witnesses of the time have since characterized the widespread adoption of minimally-invasive methods throughout general surgery as rapid and revolutionary, disrupting many of the traditional skills associated with open surgical practice. Our paper seeks to understand this alleged technical revolution in modern surgery by using the concept of ‘versatility’, and examining its bearing on the related domains of surgical skills, knowledge, education and technology.

We will explore versatility relative to these transformations in three principle and interrelated ways: First, as surgeons experimented with new ways to apply the tools of laparoscopy and endoscopy, they enacted both the versatility of medical instrumentation and also the versatility of criteria used to adjudicate the outcomes of surgical interventions. Second, by demanding that classically-trained surgeons now master new minimally-invasive alternatives, the adoption of MIS required versatility in learning and practice which in turn prompted discussions about the exact nature of surgical knowledge. Third, by imposing new visual and tactile mediations between surgeons and patients, the rise of MIS underlined the epistemological versatility of bodies and their ailments. What surgeons could know about bodies, and how they could practice their craft, was now reshaped through widespread reliance on laparoscopic and cold light techniques.

Drawing on sources that include the primary literature of medical journals, interviews with different generations of surgeons, and archives from hospitals and instrument manufacturers, our paper explores these three sites of versatility, their interrelations and overlaps, in order to provide an enriched but critical account of an ongoing technical and epistemic transformation in modern surgical practice.

Learning objectives:

Identify successes and failures in the history of medical professionalism.

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

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

Kavita Sivaramakrishnan, *Columbia University, New York;* and David Jones *Harvard University, Boston, MA:* ***Technology, Expertise, and Ideology: Versatility and the Establishment of Cardiac Care in India***

Surgeons in India watched the emergence of open-heart surgery in the United States in 1955 with great interest. They were eager to explore networks of

training and exchange to bring new medical technology and techniques to India, as part of Jawaharlal Nehru's broader project of technoscientific modernization. This paper explores the ideological and technological dilemmas posed by the importation of western medical innovations and tools in India in the 1950s and 1960s. It traces the challenges that faced would-be cardiologists and cardiac surgeons as they tried to import, adapt and indigenize western medical technology relating to cardiac surgery. It demonstrates the versatility (and polyvalence) of medical technology, expertise, and ideology in independent India. Indian physicians such as Kamala Vytilingam, P.K. Sen, A.V. Baliga and Kersi Dastur worked to acquire devices from the United States, whether through purchases or gifts. Their exchanges often cemented relationships between Indian and US/UK physicians, even as they marked an unequal relationship that centered innovation in the west and its use in India. Many of these surgeons, who had served in the British colonial medical service and taken part in Nationalist agitation and resistance to colonial rule, worked to build a post-colonial culture of political and scientific self-reliance. We will explore how Indian surgeons both deepened and 'decentered' these interactions and exchanges. Specifically, we will examine the following questions. How were breakthroughs and progress in medical technology understood as being both derived from the west and also having an originality in its cooptation and indigenization in India? How did Indian surgeons reconcile a place for advanced surgery not simply as a recent western import or as a break or fracture from India's ancient medical past, but as a continuum of India's ancient past of surgical innovations? What and how were multiple alliances cultivated amongst India's political elite and how did these surgeons address the dilemmas of making a wider case for cardiac surgery amongst more urgent health needs? Finally, how did medical exchanges serve the purposes of Indian and American physicians as each nation worked to strengthen its position in the Cold War international order?

Learning objectives:

To analyze how medical technology, the language of science, and expert knowledge is translated across contexts.

To understand the changing social constituencies of medical theory and practice.

To understand the role of past medical traditions in legitimizing new innovations.

C5: The Identity of Patients and Subjects: Processes of Medicalization and Self-Definition

George Room

Moderator: Harold Braswell, Saint Louis University

Aimee Medeiros, University of California, San Francisco, San Francisco, California:

Medicine, Manhood, and Midgets: Examining Early Growth Hormone Therapy in the U.S.

Throughout the nineteenth and early twentieth centuries, Americans flocked to various venues to watch small men sing love songs, ride miniature animals, and perform amazing feats of strength while they were dressed up as generals, cowboys, and gentlemen. Famous male midget entertainers, such as Charles Sherwood Stratton (General Tom Thumb) and Harry Earles (Harry Doll) were celebrated as talented miniature replicas of normal statured men. Flirting with

idealized notions of masculinity, they were able to make a living off of societal expectations about their manhood. So what ever happened to the popular male midget performer?

This presentation aims to answer this question by suggesting that the medical management of short stature as an affliction in need of a remedy made the small statured entertainer seem less of an attraction and more of a subject for medical research. In doing so, this paper takes an innovative approach to pharmaceutical history as it refuses to simplify early medical attempts to manipulate height as failures and therefore not worthy of consideration. Instead, it explores the development of growth hormone therapy during the 1930s and 1940s and its relationship to cultural views on masculinity and stature. It was during this time period, that medical attempts at growth-promoting hormone therapy did not reorient the medical gaze on short stature but rather facilitated its medicalization. Even clinical failures in promoting height contributed to this trend as they were understood as hurdles and not dead ends. While scientists went back to the laboratory to try to solve the impotence of their inventions, growth hormone therapy limped along during the early 1940s. Though a breakthrough in GH technology proved elusive, small statured men's ability to make reasonable fortunes on the cultural presumption of the limits of their masculinity was coming to an end. Subsequently, while early 20th century growth hormone therapy was too rudimentary to be therapeutically effective, this paper suggests that it was potent when it came to shaping cultural perceptions of short statured men and the future of HGH therapy.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history

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

Deepen understanding of illness and suffering

Adria L. Imada, *University of California, Irvine, Irvine, CA: **Beyond Staring? Towards a Patient-Centered Optics of Disability and Illness***

As theorized by Rosemarie Garland-Thomson (2009), people with disabilities or non-normative bodies are objects of intense staring that focuses attention on physical signifiers of disability. But what can attention to the visual practices of patients who are the routine objects of staring reveal about experiences of clinical care, illness, and wellness? Leprosy (Hansen's disease) patients confined to leprosaria in Hawai'i, the Philippines, and Louisiana in the twentieth century were subjected to intimate visual inspections via coercive visual and biomedical experiments and clinical photography that brought them into visibility as non-normative pathogens. Yet photographs of these patients were more than performances of capitulation within "total institutions" (Goffman 1968). Racialized patients exiled in leprosaria repurposed photography to strategically place their bodies on public display or to conceal corporeal differences (e.g., visual stigmata like clawed hands and ulcerated feet) that would mark them as "leprous."

Based on clinical photographs and underexplored images from community albums, medical missionary archives, disability activism, and private patient collections from 1901- 1960, this paper argues that patients keenly understood multiple economies of looking and staring, and tried to manipulate them within and outside these medical institutions. I offer case studies of inventive, counter-hegemonic visual practices, including early-twentieth century patients who adopted conventions of the Victorian family studio photograph in response to the individual clinical mug shot; tourist snapshots of patients who took temporary release from leprosia after the introduction of sulfone antibiotics in the 1940s to embrace the pleasures of mass tourism; and vernacular photograph albums in which Hansen's disease residents forcibly separated from kin recast their social relations through visual assemblages of fictive kin, such as fellow patients, adopted pets, and feral animals. What I call "patient-centered optics" destabilized the "surveillance optics" of disease, degeneracy and unfitness produced by physicians, public health officials, and anthropologists at leprosy colonies. These analyses suggest how a more diverse optics of patient experiences can potentially improve care of medically underserved communities.

Learning objectives:

Develop analysis of the nature, ends and limits of medicine in non-Western contexts.

Develop an historically informed sensitivity to the diversity of patients (including race, gender, socio-economic status, cultural difference).

Learn about patient-centered visual strategies that represent diverse experiences of illness, wellness, and dis/ability.

Emily Contois, *Brown University, Providence, RI: The Rise and Fall of the Thrifty*

Genotype Hypothesis

First published in 1962 by population geneticist James V. Neel, the thrifty genotype hypothesis sought to explain increasing rates of diabetes. Neel posited that mankind had adapted over evolutionary time to cycles of feast and famine. It was "thrifty" individuals who possessed the beneficial ability to store fat in preparation for leaner times. In our modern era, however, Neel asserted that thriftiness increased the risk of diabetes in a complex interaction between genes, the environment, and lifestyle factors. With a narrative that attractively combined the biomedical, the genetic, the evolutionary, the archaeological, and the historical, the thrifty genotype hypothesis quickly captured the scientific and popular imagination, coming to exert an unexpected authority that is only now being seriously questioned.

This paper historicizes the thrifty genotype hypothesis—which has been part of diabetes discourse for more than half a century—examining its origins and meteoric rise within the scientific and lay communities alike. It also explores how and why the thrifty genotype hypothesis became racialized, as nearly immediately, the theory's tenants were applied to specific ethnoracial groups, starting with Indigenous populations and expanding to include Mexican Americans, African Americans, and Asians.

This historical examination of the thrifty genotype hypothesis is also timely as the state of the hypothesis is in a climactically tenuous position. At the present moment, the search for the elusive thrifty gene continues in research labs around the world at the same time that both genetic researchers and social scientists call for the hypothesis' curt dismissal. As such, this history of the thrifty genotype hypothesis provides an instructive case study in the processes of scientific knowledge production, consumption, and adoption, as well as its subsequent disavowal. As "a cultural product" in its own right, the thrifty genotype hypothesis tells a story of genes, disease, race, and scientific thought that engages a cast of characters that includes scientists, academics, public citizens, and the media.

Learning objectives:

Develop the capacity for critical thinking about the ethnoracial implications of medical research and scientific theories.

Identify successes and failures in the history of medical research, using the thrifty genotype hypothesis as a case study.

Promote understanding of the dynamic nature of medical ideas and practices, by tracing how scientific knowledge is produced and consumed, as well as how it can be over-turned.

D1: Sexually Transmitted Diseases in Cultural Context

Grand Ballroom C

Moderator: Stephen Inrig, Mount St Mary's University

Hiroshi Nunokawa, *Hiroshima University, Higashi-Hiroshima, Hiroshima Prefecture, Japan: Venereal Disease and Social Structure: Hiroshima Immediately Following After Defeat*

The prevalence of venereal disease amongst the British Commonwealth Occupation Forces in Hiroshima immediately after defeat was a significant problem. Having sent the most soldiers, the Australian government sought to solve the problem via a "fraternization policy," specifically, intended to control infection via limiting contact between soldiers and Japanese women. The Army surgeons responsible for these venereal disease measures held the same opinions and ways of thinking. They recommended healthy forms of entertainment for the soldiers, and emphasized the establishment of these alternative methods of amusement.

However, one can understand that the Australian government's point of view was a one-sided, especially in regard to the life of the A-bomb survivors, as venereal disease spread. Both the Korean A-bomb survivors residing in Japan and other women survivors went through the most severe experience amongst all of the A-bomb survivors. In general, the former were robbed of their nationality, while the latter were subjected to the strongest experiences of social violence.

While the occupying army strongly emphasized the democratization and non-militarization of Japan, the native inhabitants also positively utilized the traditional social structure of Japan. The spread of venereal disease must be understood within its social and cultural context. The key to grasping this in social and cultural context is the existence of violence and the forms it looks.

The spread of venereal disease and international marriages demonstrated the international and fearless exchange between cultures. The occupation in Hiroshima and Kure, which was referred to as a town of the death, was an issue for soldiers. It is necessary for one to think about such a situation as a valuable and daring exchange between those people more tormented by the extreme violence experienced during and after the war.

Learning objectives:

Discuss venereal disease in a new cultural context

Provide new research on the health of atomic bomb survivors

Add new research findings to the general context of STD dissemination in the wake of war

Richard A. McKay, *University of Cambridge, Cambridge, Cambridgeshire, UK: "Evil is in the Eye of the Beholder:" Venereal Disease and Homosexuality in Vancouver's Bathhouse Debates*

Amid growing alarm about acquired immune deficiency syndrome in the early 1980s, North American bathhouses catering to men who had sex with men became the focal point in an increasingly contentious struggle. Some have reductively treated this episode as a clash between public health efforts to prevent the transmission of a deadly and sexually transmissible infection against attempts by others to defend their sexual and civil liberties. This history has also often been told in isolation, and not as an outgrowth of a conflict that had been brewing for decades. Drawing on newspapers and the archival records of community groups and city officials in Vancouver, British Columbia, this presentation offers a case study for how gay activism - first that of homophile organizers, and later gay liberationists and businessmen - intersected with civic concerns about venereal disease (VD) in bathhouses in the 1960s and 1970s.

The presentation will contrast conflicts from two different historical moments to explore the changing responses to the specter of VD among homosexual men in Vancouver. In 1965, sexual contact between men was illegal in Canada. Reports from provincial VD control officers revealed that men who named male sexual contacts increasingly listed steam baths as sites of syphilis exposure. Vancouver's civic officials opted to address the problem with a by-law amendment: without significant opposition from the Association of Social Knowledge - the recently founded local homophile organization - they voted to require that all bathhouses remove cubicle doors and increase their lighting levels. By the 1970s, the federal government had partially decriminalized same-sex erotic contact. With the resulting growth in the number of commercialized gay establishments, the earlier concerns about VD remained but on a larger scale. Furthermore, the conflict was by then far more public in its discussion and the number of parties involved had proliferated substantially. Incorporating historical actors like lawyers, urban planners, medical health officers, police officers, and gay activists, the presentation will demonstrate the existence of a diversity of attitudes towards bathhouses, venereal disease, and its prevention long before the emergence of the AIDS epidemic.

Abstracts: D1/D2

Learning objectives:

- Develop a historically informed sensitivity to the diversity of patients.
- Recognize the dynamic interrelationship between medicine and society through history.
- Acquire a historically informed understanding of the diversity of stakeholders involved in public health interventions

Flurin Condrau, University of Zurich, Zurich, Switzerland; Lukas Engelmann, University of Cambridge, Cambridge, UK: ***The Swiss Model of HIV/AIDS Prevention between Local and Global Health***

The starting point for this project is the exceptional trajectory of the AIDS epidemic in Switzerland. Although incidence was remarkably higher as compared to most of Europe and the USA, stigmatization, discrimination and political indifference – characteristic features of the AIDS history in the US and elsewhere – remained the exception. Instead, a high level of collaboration between social activism, governmental institutions and medical experts became the standard model of dealing with the emerging epidemic. This resulted in a raised awareness of risk-behavior and preventive tools, rapid treatment access to those in need and a seemingly consensual politic of de-stigmatization and education directed at the general public (EKAF et al. 1989). This way of dealing with the emerging epidemic has been called the Swiss Model – both within the Swiss context and in the context of global disease control. The Swiss Model condensates the Swiss history of AIDS treatment and prevention and serves as an early paradigm for good practice in the containment of AIDS globally, leading to the UN standard model of AIDS prevention in 1992 (WHO et al. 1992). The paper we present aims to adress fundamental questions regarding the historical conditions for the emergence, distribution and implementation of the Swiss model on a local and a global scale. Two main avenues for investigation will be pursued : (1) What characterizes the Swiss Model of AIDS prevention and how is it linked to the specific history of public health, preventive medicine and sexual activism in Switzerland? (2) What are the specific institutional and social features of the fight against AIDS in Switzerland that make it a distinctive case in the global history of AIDS?

D2: Asian Pharmaceutical Research

Grand Ballroom A

Moderator: Bridie Andrews, Bentley University

He Bian, *Princeton University, Princeton, NJ*: ***"Ready-made Formula" in Dispute: Understanding Pharmacological Virtuosity in Early Modern China***

Medicinal formulas are among the earliest extant written records of healing in China since ancient times. The ability to combine and compound a variety of ingredients derived from herbal, mineral, and animal sources constitutes an essential part of training for aspiring physicians, and a particular master's experience has often been transmitted as collection of formulas, passed down among disciples, and much sought after by elite families. In a sense, distinction between "schools" and lineages of medical practice came to be embodied in distinct

sets of formulas. It was not until the turn of the seventeenth century, however, that the notion of “ready-made formula” (chengfang) became a somewhat derogatory term in learned treatises on medicine. While the sixteenth century witnessed an unprecedented boom in medical publishing, especially the establishment of a syncretic medical orthodox by systematic study of previous masters, it became increasingly common among learned physicians to aspire for a new kind of “pharmacological virtuosity”: to understand drug actions outside of existing formulas, and to practice accordingly. In this paper, I use the writings of Miao Xiyong (1546-1627), Wang Kentang (d.1638), Zhang Jiebin (1563-1640), and Li Zhongzi (1588-1655) to illustrate the subtle but decisive turn away from “ready-made formulas”, and argue that as a result of this turn, the physician’s expertise must now be defined by a more flexible approach to drug therapy. I will discuss the role of patient family expectation and commercial apothecaries in shaping the notion of pharmacological virtuosity, and also explore the long-term consequences on Traditional Chinese Medicine today.

Learning objectives:

- To think critically about the importance of formula texts in the history of medicine;
- To understand how the subfields of materia medica and formulaics interacted;
- To reflect on the impact of the early modern period on the features of what's known as Traditional Chinese Medicine today.

Yubin Shen, Georgetown University, Washington DC: *State Bio-prospecting and Cinchona Cultivation in Yunnan (China), 1932-1948*

Cinchona, quinine’s raw material, was firstly introduced to China as a wondrous anti-malarial drug in the late 18th century. But it was not until the early 20th century that Chinese began to cultivate this tropical medicinal plant in southern China. Based on first-hand sources in Yunnan Provincial Archives, this paper reconstructs the history of China’s first successful cinchona cultivation program in Yunnan’s southwest borderlands, especially the Hekou County Experimental Farm for Tropical Plants, from 1932 to 1948. It argues that cinchona cultivation program in Republican Yunnan was not a pure scientific experiment, but part of the Chinese Nationalist, especially the Yunnan provincial government’s state-building and developmentalist projects within a global context.

This program was initiated in the early 1930s by “the developmental state” of Yunnan province to develop and control its semi-autonomous southwest frontiers (part of the so-called Zomia), as well as to eliminate endemic malaria in Yunnan. Later on, during the Sino-Japanese War (1937-45), together with other programs of state-led bio-prospecting medicinal plants in Yunnan (which set up theoretical foundation for the discovery of Artemisinin in the 1960), it then became part of the Chinese state’s national defense project to control epidemics in southwest China. After the war, this program continued to be supported by the Central and provincial governments until 1948, mainly to promote national self-sufficiency and international competition in cinchona and quinine production. A closer examination on this process indicates that it was undertaken within a global network of knowledge, practice and personnel on cinchona cultivation, and the plant cinchona itself.

Learning objectives:

- Recognize the dynamic interrelationship between medicine and society through history
- Identify successes and failures in the history of medical/pharmaceutical experiment
- Understanding medicinal plants and their roles in history

Nandini Bhattacharya, *University of Dundee, Dundee, UK: Pharmacy in colonial India: Interrogating the narrative of professionalization*

"Pharmacy in colonial India: Interrogating the narrative of professionalization"
This paper will explore the 'emergence' and 'development' of the profession of pharmacy in colonial India through its failure to professionalize, thereby looking at a disjuncture in the modernist trajectory of the profession. Narratives of professionalization in the history of medicine follow a now-familiar route of institution-building; the development of a scientific specialism, its institutionalization in a corporate body and specialist journals; the introduction of the specialism within pedagogic institutions and finally its recognition in the public sphere. This holds true of the profession of pharmacy in Europe and North America, and the history of the guild of apothecaries that was transformed into the professional and trained pharmacists in the Nineteenth century. This well-established linear narrative breaks down in an analysis of the histories of pharmacy in colonial contexts.

In looking to the colonial Indian sub-continent, this paper highlights the need to redefine the profession of the modern pharmacist; it will explore the political and social backgrounds of the segmented layers of dispensers in the profession, from the bazaar drug-seller to the trained "chemists and druggist" from Britain who were employed by the dominant medical retailers in urban India. It will investigate how dispensers of indigenous therapeutics responded to challenges from the establishment of western medicine in colonial India. In the process, it will explain why, despite the emergence of teaching hospitals, a large urban consuming public and the development of a vast network of medical professionals, unique colonial realities subverted the attempts to form a viable and inclusive body of pharmacists in India until after Independence.

Learning objectives:

- To critically assess the narrative of an aspect of medical professionalization in a non-western and colonial historical paradigm.
 - To suggest new modes of understanding the history and role of pharmacists.
 - To engage with the heterogeneous traditions of dispensation of drugs in colonial India and understand how the lived everyday experience of medical dispensing blurred the boundaries between western and indigenous medical systems.
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D3: Unruly Publics and Public Health in Post-War Britain

Temple Room

Moderator: Elizabeth Toon, University of Manchester

This panel brings together three case studies of public health strategy, and practice in post-war Britain. Each of the paper seeks to explore critically the construction of 'publics' as a way to reveal changes in the nature of the relationship between public health and their audiences. All the papers undertake a nuanced discussion of the limits of public health promotion as a tool of governance in the face of unruly 'publics' who answer back, ignore advice and will not fit their imagined roles.

Alex Mold examines the politics shaping the design, circulation and circulation of post-war public health in post-war, to unpack the ways in which into the 'public' was increasingly configured as a fragmented entity and less governable. The other two papers expand this agenda, by focusing on two unusual 'publics' in post-war public health discourse: children and the dog-walking couple. Kershaw examines how in the late 1980s AIDS posed considerable difficulties for sex educators designing resources for children, revealing the highly moralizing contexts that frame discussions of young people's sexuality. Pemberton examines how in the 1970s dog-walkers insisted on the health giving properties of dog-walking and of companion animals to undermine attempts to exclude them from public parks, playfully drawing upon and reworking ideas and languages of public health to suit a multi-species agenda.

Alex Mold, London School of Hygiene & Tropical Medicine, London, UK: *Picturing Public Health: Visual Culture and Public Health in Post-War Britain*

The use of visual techniques to communicate public health messages has long been central to efforts to promote good health. From sixteenth century broadsheets to YouTube videos circulated on social media, public health practitioners have employed a variety of methods in order to reach the public. The range of media available to health promoters has increased over time, but what patterns can be discerned beneath the use of images in public health? This paper will examine the visual culture of post-war public health in Britain. Focusing particularly on non-communicable diseases such as lung cancer and obesity, the techniques used by

public health communicators will be delineated. Multiple methods were employed in order to appeal to multiple publics. Analyzing such methods raises deeper questions about the place of the public within public health and the very nature of public health itself.

Drawing on a selection of public health posters, this paper will begin by considering the ways in which public health communicators employed the visual to reach the public. A variety of devices were utilized. Some posters, for instance, used humor to put across their message, some attempted to shock individuals into action, and others located their appeal within wider social tropes. Public health goals were entwined with wider objectives, such as the protection of the nuclear family and encouraging the development of consumerist lifestyles.

The use of such a range of tactics by public health communicators points to their desire to reach multiple publics. Although some appeals were made to a general public, many posters were designed for a specific audience such as women or young people. By the late 1960s, the 'public' within public health was increasingly fragmented. At the same time, public health itself was in flux. The range of actors involved in public health policy and practice grew, encompassing voluntary organizations and corporations in addition to health professionals and researchers. The visual culture of post-war public health is thus an illustration of broader developments in public health and the place of the public within it.

Learning objectives:

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

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

Recognize the dynamic interrelationship between medicine and society through history

Hannah Kershaw, University of Manchester, Manchester, UK: ***"Is this perhaps too controversial even for us?" The Production and Dissemination of AIDS Education Packs for Children by the Family Planning Association in late 1980s & early 1990s***

The representation of HIV/AIDS to children and young adults presented a unique problem for British health educators and policy makers in the late eighties and early nineties. Institutions previously tasked with quietly educating adults about sexual health, or children about 'the facts of life', were thrust into the awkward and publicly prominent new role of sex educators to the nation by the AIDS crisis. Institutions such as the Health Education Authority, British Medical Association and Family Planning Association were well placed to produce up-to-date and authoritative adult education materials on HIV/AIDS as the public health message evolved from one of nebulous risk to more explicit messages on safer-sex, but how were they affected by the complex and difficult task of representing the sexual and morbid aspects of the illness and its prevention to children? Potential educators' attempts to produce coherent and comprehensive HIV/AIDS education material for children were stymied by anxiety over presenting children with explicit content; prohibitions against the inclusion of any content on homosexuality; battles for jurisdiction over the moral and sexual health education of children; and a pervasive sense of urgency.

Despite these difficulties, during the 1980s and 1990s the Family Planning Association (FPA) managed to both consolidate its position as an adult sex educator and become a dominant authority on the production of AIDS education materials specifically for use with children. This paper will examine how the FPA moved from its position in women's reproductive health to become a prominent AIDS educator to children during the 1980-1990s. Focusing particularly on the FPA's teaching packs, it will examine the various techniques employed by the FPA to avoid controversy and censorship but remain true to its institutional ideology, representing AIDS, sex and sexuality as it wished but leaving the ultimate decision of how it should be taught in schools to teachers and parents.

Learning objectives:

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

Recognize the dynamic interrelationships between ideas of childhood, the agency of children, moral citizenship, and sexuality

Understand the dynamic history of education policy and practice, its implications for knowledge production and dissemination and the need for a responsive relationship between producers of sex education and their audiences

Neil Pemberton, University of Manchester, Greater Manchester, UK: *The Death of the Dog-House: the Interspecies Politics of Dog-fouling and Dog-walking in Modern Britain*

Does dog fouling have a history? I am aware that this question invites accusations of triviality, if not hilarity, but, I wager, not from historians of medicine, who have long been acquainted with the rewards that flow from the historical study of human waste – so why not a history of the non-human animal variety?

At the center of this paper will be the interspecies politics of dog-walking and dog-fouling in the 1970s Britain, as a means to highlight the interplay between species relations, public health policy, and the politics of exclusion and filth. The paper critically explores the question raised by Donna Haraway in her Companion Species Manifesto: that is, “who takes care of the shit in a companion animal relationship?” While Poop Scoop laws emerged in New York at the end of the 1970s, no self-respecting British dog walker was willing to partake in the abject role of picking up canine excreta anywhere in public space.

Nor did any local authority expect or demand dog walkers to ‘scoop’. By exploring the medico-moral panic concerning the perceived threats of *Toxocara canis* – the common roundworm found in dogs – to human health, this paper elucidates the ideologies, processes and categories by which dog fouling – and by association – dog-walking came to be defined as an urgent social, health and environment problem, leading to the exclusion of dogs from the nation’s public parks and beaches, which turned Britain into something of a “no-dog’s land”.

My paper will also examine the cultural resources used by dog-walkers to defend not only their access to public parks but also highlight the health benefits of dogs as companion animals and of dog-walking. My focus on dog-walkers’ discourse provides a window on changes in companion species relations, the analysis of which uncovers a shift in attitude and social practice from “ownership” to “parenting”, from “pets” to “companion animals”, as canines gained closer physical and affective proximity to human lives; a trend gaining pronounced social, cultural and material articulation from the late 1960s, leading to what one might call the ‘death of the dog-house’.

Learning objectives:

Promote critical thinking about our multi-species entanglement with dogs and recognize our responsibility to live convivially with other species.

Recognize how the practice of dog-walking can be registers of identities, values

and identities, and how canine-companion living can be implicated in discussion of health and well-being and rooted in citizen's identities. Understand the dynamic history of public health policy and practice, and the need for a responsible dialogue between environmental health policy and dog owners and organizations.

D4: Innovation, Controversy and Renown in Twentieth-Century Surgery

Wooster Room

Moderator: Justin Barr, Yale University and Univ. of Virginia

Nils Hansson, *University Medical Center, Göttingen, Germany*; and Thomas Schlich, *University of Montreal, Canada*: ***Enacting Excellency: Awarding Nobel Prizes (or not) to Surgeons in the Twentieth Century***

The Nobel Prize is probably the most prestigious benchmark of scientific excellence in our time. It is used for ranking universities and gauging the scientific reputation of whole nations. This makes it the ideal example for investigating the mechanisms of scientific recognition. In this presentation, we look at the Nobel Prize in Physiology or Medicine as a case study of how excellence is "enacted", how, in other words, particular achievements in medicine were selected and acknowledged as the most excellent in the field.

We investigate the enactment of excellence by analyzing the original files at the Nobel Prize Archive for Physiology or Medicine in Sweden – a repository that contains Nobel Prize nominations as well as Nobel committee reports about prize candidates, which reflect the, often contentious, negotiations about scientific recognition. We explore how the enactment of scientific excellency plays out in surgery as a field that is particularly practice-oriented and examine how scientific value is attributed under these special conditions.

In surgery we can find an emphasis on ideas of genius, scientific heroism, as well as utopian visions of the scientific solution of insurmountable problems, combined

with an aspiration of going beyond the traditional limits of medical possibilities (for example in fields like transplant surgery, cardiac and brain surgery). We will analyze how these ideas were used as important arguments in the discussions about Nobel Prizes for surgeons (e.g. for Alfred Blalock, Alexis Carrel, Harvey Cushing, Victor Horsley, Theodor Kocher, Egas Moniz, Ferdinand Sauerbruch, Helen Taussig, and Werner Forssmann who were all nominated numerous times or awarded). The files in the Nobel archive provide us with the unique opportunity to examine how priority, originality, creativity, and significance were attributed (or not) to particular surgical achievements.

Our work will thus offer new perspectives on scientific reward mechanisms and the role of credit and priority in medicine, and, more specifically, on how excellency in surgery was being constructed, performed and enacted within the scientific community in the twentieth century.

Learning objectives:

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

Robert Kirk, University of Manchester, Manchester, UK; and Edmund Ramsden, Queen Mary University of London, London, UK: ***Dogs as co-workers? Cross-species Collaboration and the Translation of Medical Science for the American Public, 1948-1966***

On the 26th November 1948 John Tuck, a Pennsylvania dog breeder, was arrested whilst delivering dogs to Johns Hopkins University following accusations of cruelty. For Alan Chesney, Dean of the Medical School, this was the latest example of harassment that threatened not scientific research and education at Johns Hopkins but also the public health of the city, state and nation. This paper examines the scientific professions' response: combining political lobbying at the city and state level with an extensive public relations and education campaign, so as to win a city-wide Referendum in December 1950 securing a legal right for Baltimore institutions to seize impounded stray dogs for scientific research. In this campaign the scientific community effectively appropriated the unique human-dog relationship, hitherto used by antivivisectionists to portray experimentation as cruel, so as to portray dogs as willing participants knowingly contributing to the production of medical knowledge. One dog, Anna, came to symbolize the concept of willing canine collaboration. Through newspapers, personal appearances, and a widely circulated short-film, Anna presented "her story" of how a surgical technique developed with her was translated to save the lives of so-called 'blue babies'. This approach became a model for national campaigns, conducted at state level, which helped to create secure favorable city and state-level climates for animal experimentation in the 1950s.

The controversy surrounding animal experimentation has long posed a problem for the medical years, following a period of silence in large part a response to animal activist threats, the medical community has again committed to 'open' and 'transparent' dialogue with the public on this subject. By examining a historical case where medical scientists 'translated' their work to explain the need for animal experimentation by mounting a defense of the dogs' unique capacity to 'translate' between human and animal, this paper provides historical context to such commitments.

Learning objectives:

- Critically reflect on the nature, ends and limits of communicating medicine to wider publics.
- Develop a historically informed sensitivity to and respect for the diversity of public and patient opinions, values and concerns about medicine.
- Recognize the dynamic interrelationship between medicine, society politics and policy through history.

Stephanie Snow, *University of Manchester, Manchester, UK: Global Paradigms and Local Practices: The Development of Stroke Services since the 1990s*

Since the 1990s, new therapies for acute ischemic stroke which have been implemented worldwide have radically altered the conception of stroke from a terminal to a treatable disease and established new paradigms of treatment. This paper maps and analyses the development and implementation of stroke services since the 1990s through a series of local case-studies situated in different countries including the UK, the US, Sweden, Hong Kong and Australia. It draws on around 50 interviews with health professionals, policymakers and patient groups to explore the interactions between the global paradigms of stroke treatment and the development of local services and practices. It identifies broad universal contestations between the new paradigms of stroke as an acute emergency and historically embedded notions of stroke as an untreatable condition of the elderly. It shows how the key dynamics for each setting were local social factors such as health and political systems, geographies, working cultures and professional identities. It also interrogates the political and professional bias within medicine and health systems to conditions perceived to be open to interventions.

It suggests that the process through which new knowledge about stroke has moved between the global and the local is best conceived as a creative and dynamic activity which is determined by the social and scientific specificities of the particular local context. This encourages us to ask questions about the processes through which new knowledge changes the world and enters practice and reveals the unsatisfactory nature of common terms such as knowledge 'dissemination' and 'transfer' which cast the process as linear, one-directional and one-dimensional. Finally it illustrates the rich value of a historical approach which seeks to bring the global and the local into the same lens for analysis though by no means underplays the additional complexities this creates for the historian.

Learning objectives:

Deepen understandings of stroke which has been one of the leading causes of death in the western world in recent decades and the leading cause of adult neurological disability.

Develop historically nuanced understandings of the organization of different national healthcare systems.

Contribute to the growing historiography on the transnational nature of medicine and the relations between local and global contexts.

D5: Conflict and Control: Nurses in the Caribbean, 1898-1969

George Room

Moderator: Winifred Connerton, *Pace University, College of Health Professions*

This panel explores nursing as a point of intersection for political and social control as well as a locus of negotiation and resistance in the American held Caribbean following the Spanish-American War. Our discussion begins with Prieto's analysis of race and gender in professional nursing using as an example the case of African-American nurses who were

considered qualified for Army work in Cuba during the Spanish-American War by virtue of their immunity to yellow fever, but not for the training Cuban women, by virtue of their race and education. Connerton continues this theme with an exploration of the intimate connection between American nursing and nationalism through an examination of military, colonial and missionary nurse education programs in Puerto Rico. Walsh expands on the theme of ideology in the colonization of Puerto Rico with her focus on the contested concepts of race and gender in the admissions policies of a mission hospital training school. Finally, Zeller demonstrates the persistent influence of ideology on nursing through the intersecting social and political agendas for the formalization of nursing education programs in the Dominican Republic, three decades after U.S. entry into the Caribbean.

The nursing lens offers a unique opportunity to explore gender, class and race within the colonial experience. Additionally, these papers address the complex network of negotiations between multiple stakeholders that influenced colonial and post-colonial public health policy. This panel spans multiple countries, and six decades to present a comprehensive investigation of the intersection of nursing, health policy and power.

Winifred Connerton, *Pace University, College of Health Professions, New York, NY:*
Nationalist messages in government and missionary nursing education – Puerto Rico, 1900-1917

This paper examines nationalist ideology embedded in both colonial government and missionary nursing education programs in Puerto Rico from 1900-1917. The U.S. colonial government promoted the profession of trained nursing as one that would lead to successful self-governance for the territory. Puerto Rican nurse graduates of the colonial training schools were expected to minister to their countrymen and demonstrate proper sanitation and health practices that would “uplift” the population as a whole. Graduates of Protestant mission hospitals were also expected to evangelize Protestant Christianity while also providing health care to their communities, but their approach to health care had distinctly nationalistic tone.

Using administrative records of military and colonial governments, trained nurses’ writings in professional journals, and annual mission reports, this paper explores the strong connection between the evangelical mission goals and the colonial goals of the U.S. government, particularly regarding the power of nursing training to “improve” Puerto Rican society. Just as Protestant missionaries tied their evangelical work to American ideals of democracy, so too did nurses connect trained nursing and scientific medicine to modernity and America. Nurses’ own writings to mission boards and to nursing journals demonstrated that they agreed that they were bringing a special American quality to their Puerto Rican students.

Prior to the American occupation in Puerto Rico nursing care was provided by family members, hired attendants without formal training, or Roman Catholic nursing sisters. U.S. style nursing was inherently different from the existing Puerto Rican medical services, and outside the established social structure, which had no custom of higher education for women, or for women rendering care outside their own families. Previous studies of the American occupation of Puerto

Rico overlook nursing as an avenue for social reform, and also overlook the active role that nurses themselves took in engendering a social change in the territory. This paper argues that nurses were active participants in early twentieth century American colonial endeavors, and that nursing, whether secular colonial or mission, cannot be separated from the American colonial agenda.

Learning objectives:

Identify the overlapping messages of nationalism and health in colonial nursing education.

Explain the connection between health policy and social reform in a colonial setting.

Recognize the supportive role that Protestant missions played in the American colonial agenda.

Laura Prieto, Simmons College, Boston, MA: Dazzling Visions: American Women, Race, and the Imperialist Origins of Modern Nursing in Cuba, 1898-1922.

This paper explores how U.S. ideologies gender and race intersected with professional ideals in recruiting military nurses during the Spanish-American War, especially African-American women nurses.

During the Spanish-American War, the U.S. military tried to preserve the battlefield as a masculine domain, but soon realized that casualties and disease would overwhelm the small number of male nurses on staff. As a consequence, over 1500 women became nurses under contract with the Army and Navy. Some – including dozens of African-American nurses, recruited for their purported “immunity” to yellow fever” – were sent to serve in field hospitals in Cuba. After the war, American women nurses took on an imperialist function: to remake Cuban medical care along “modern” lines. Rose Heavren, for example, was stationed at the Santiago de Cuba U.S. General Hospital in 1899 and later sent to Las Animas yellow fever hospital in Havana; Mary E. Hibbard was put in charge of a hospital training school for nurses at the Hospital Civil, Santa Isabel, in Matanzas. Beyond establishing a corps of Cuban professional nurses, the Americans envisioned those Cuban women nurses as an “advance guard,” poised to fan out through all of Latin America. They thought the possibilities for transforming nursing around the world were simply “dazzling.” Yet at the same time that preparations began to pass the nursing torch to Cuban women, there was a purging of African-American nurses from U.S. military contracts. How then did concepts of race figure into nursing as a modern profession? How did an imperialist context shape American visions of nurse training in Cuba?

This study draws primarily from archival research in the extensive papers of the U.S. Surgeon General’s office, held by the National Archives and Records Administration, and from nurse veterans’ own narratives and commentaries.

Learning objectives:

Understand the historical context in which U.S. nursing professionals first worked abroad.

Comprehend the significance of Cuban nursing in the era of the Spanish-American War and American occupation, as a case study in cultural imperialism.

Recognize how ideological intersections of gender and race shaped nursing ideals and experiences in complex ways at the turn of the twentieth century.

Ellie Walsh, *Governors State University, University Park, IL*: **"We Must Have the White Girl:" The Institutionalization of Racial Hierarchies in Nursing Education in Early Twentieth-Century Puerto Rico**

This paper examines changes in admission policies at the key institution for educating nurses in early twentieth-century Puerto Rico, the Presbyterian Hospital School of Nursing. Founded by mainland missionaries, the school was part of a broader colonial project, Americanization, which sought to modernize all aspects of Puerto Rican life.

The paper argues that, faced with existing local ideologies of race, class, and gender that constructed nursing as work suitable for only darker, poorer women, missionaries set aside their original plans for recruiting middle-class women and instituted an inclusive admission policy, evident in their recruitment of their first student and graduate, an Afro Puerto Rican. However, as Americanization produced significant economic and ideological changes, the school took advantage of the increased participation of women in the waged work force and adopted an admission policy that explicitly excluded Afro Puerto Ricans. Puerto Rican ministers, on two occasions, challenged this exclusion, basing their claims on Americanization's professions of universal equality.

Tracing the evolution of the school's admission policies, this research uses institutional records of the mainland-based Woman's Board of Home Missions and Puerto Rican churches and personal correspondence to elaborate on the multiple factors underlying the change in policy. Examining the differences between mainland and Puerto Rican ideologies of race and the problems these presented for the nursing school administrators, it argues that the shift to the racist policy occurred in a larger context in which racial lines were hardening as the U.S. binary understanding of race came to prevail over Puerto Rico's more fluid, permeable understanding. The research shows how the administrators devised a way to appear to have changed the contested policy, while actually continuing discriminatory practices.

The paper concludes that contestations over the policy cannot be tidily characterized as exclusively "black/white" racial dynamics or framed as solely a conflict between the colonizer and the colonized. Indeed, positions did not neatly align along national or racial lines. Instead, the dynamics of power at play were complicated by hierarchies among Puerto Ricans, by hierarchies between Puerto Ricans and mainlanders, and by radical changes in the political economy.

Learning objectives:

Identify the effects of racial, class, and gender ideologies on the construction of an "ideal" nurse.

Explain how changes in the political economy led to changes in the demographic constitution of the nursing profession.

Recognize the dynamic relationship between various stakeholders in nursing education in this colonial context.

Neici M. Zeller, *William Paterson University, Wayne, New Jersey: Convenient Service: Dictatorship, Modernization, and Nursing in the Dominican Republic (1930-1961)*

This paper examines how the Rafael Trujillo regime (1930-1961) reformed the public health system of the Dominican Republic with assistance from international agencies, claiming "modernization" as its prime goal. Paradoxically – and in spite of external pressures – nursing did not constitute a key element in these plans. The Trujillo administration expanded services through an increase in the number of hospitals and other facilities, while failing to upgrade staff qualifications, salaries, and incentives to fit new international standards.

This research analyzes why Dominican nursing only received lip service at the local level as a vital element of "modern" health, although it consistently attracted the attention of the international agencies in their bid for reform at the Pan American level. Nursing became a point of contention and negotiation among the stakeholders, involving conflicting visions of medical modernity. At the local level, a halting and reluctant implementation of the international reforms fell to the local bureaucracy, the Catholic Church, doctors, nurses, and beneficiary populations of island nation. The main point of contention revolved around state-sponsored nursing schools, with disagreements over who should run such an institution, how it should be financed, who could be admitted, and how the curriculum should be structured. The arguments point to deep-seated issues of class, gender, and religious bias (with decided interference by the Catholic Church, who ran the majority of health facilities at the time), as well as a resistance to the U.S. model of skills-based certification.

This research also looks at the interplay between international health agendas and the Dominican government's priorities in the modernization of its public health system. My findings point to a multivalent debate among the U.S. private and public entities (particularly the Rockefeller Foundation and the Office for Inter American Affairs), the multinational organizations (such as the Pan American Sanitary Bureau and the World Health Organization), with the authoritarian state opportunistically adopting only those measures that would further legitimize its control over the nation.

Learning objectives:

Identify the key agents for change in the nursing profession in Dominican Republic between 1930 and 1960

Understand the dynamic relationship among stakeholders in the professionalization of nursing in the context above

Recognize the role of the authoritarian state in promoting a specific concept of medical modernity

E1: New Directions in the History of Colonial Medicine

Grand Ballroom C

Moderator and Discussant: Warwick Anderson, University of Sydney

In recent years, historians of colonial medicine have expanded the historiography of both colonial rule and the history of medicine and science, working to transcend traditional binaries of local and global, indigenous and European, and colony and metropolis. Even as scholars have widened the scope for enquiry, the question of determining what is specifically colonial about colonial medicine continues to animate much of the literature. As a result, the importance of wider social frameworks tends to be dwarfed in favor of explanations based on the dynamics of colonization: in terms of state repression and resistance, surveillance and evasion. The four papers on this panel aim to shift the emphasis away from the "state" to focus on the important role of transnational corporations, missionaries and professionalizing elites in shaping the history of colonial medicine. In many colonial regions, corporations, plantations, and mining companies initiated and implemented extensive public health projects and built health infrastructures; in comparison, the health initiatives of colonial states dwarfed in comparison. Physicians engaged in missionary activities often provided health care to the indigenous population on a larger scale than the colonial state. While recent historians of colonial medicine have emphasized the extensive interactions between colonies and the metropolis, in several colonial regions the interaction between colonies was more important than that with the medical institutions in the colonizing nations. Unfortunately, most histories of colonial medicine do not consider developments after independence has been achieved; it is the transition from colonial medicine to the medicine of new independent states that has received far less attention. In papers spanning Southeast Asia, Sub-Saharan Africa and the Caribbean, this panel also works to highlight connections across empires in order to re-order traditional frames of both geography and periodization.

Hans Pols, University of Sydney, Sydney, Australia: *From Colonial Medicine to Independence: The Indonesian Medical Profession, 1930-1960*

In this paper, I explore the history of the Indonesian medical profession from the 1930, when it operated in the colony of the Dutch East Indies, to 1960, after Indonesia had become independent. The period from 1930 to 1960 is characterized by great social and political upheaval. In 1942, the Japanese armed forces occupied the Dutch East Indies and ended 350 years of colonization by the Dutch. In 1945, 2 days after the Japanese army capitulated, the Republic of Indonesia declared its independence (17 August 1945). Five years of neo-colonial warfare followed because the Netherlands did not want to give its former colonies. Only in December 1949 was autonomy officially transferred.

Despite these political upheavals, the history of the Indonesian medical profession from 1930 to 1960 displays great continuities. Those Indonesian physicians who occupied leading positions in both the colonial public health service and in the Association of Indonesian Physicians continued to do so during the Japanese occupation, the war of independence, and independent Indonesia. In 1945, they inherited a colonial health system and two colonial medical schools, which they set out to transform in the 1950s to serve the needs of the newly independent nation.

Already in the colonial era, they appreciated the potential nation-building qualities of medicine and participated in regional debates about public health and the organization of health care. Their views were reinforced by representatives of the Rockefeller Foundation who undertook demonstration projects in public health education in Southeast Asia during the 1930s. Their participation in international networks of exchange in colonial medicine prepared them to take up positions of responsibility. The most important meeting in this respect was the 1937 Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene, held in Bandung. During this meeting, various local debates on health and medicine in South and Southeast Asia were transformed into an international discourse on health which, in many respects, provided an important alternative for that provided by colonial states.

Kevin E. Ko, *Yale University, New Haven: Colonial Ethics in Two Keys: The Multiple Uses of Medical Humanitarianism in a Late Colonial Society*

In both scholarly literature and the popular imagination Christian mission hospitals have often been seen as spaces of overt and often coercive religious and ethical uniformity. However, when one surveys the various actors involved in the Calvinist medical mission in Central Java in the early twentieth century what proves most striking is not any religious or ethical univocality but rather the opposite—a remarkable pluralism of religious and social commitments. Although the medical mission represented a small religious minority—Dutch missionaries and their native converts—it brought together a wide and religiously diverse public within its walls, its fundraising networks, and its spheres of discourse. This paper attempts to take stock and make sense of the wide appeal of the Christian medical mission in late colonial Indonesian society, even among groups hostile to its religious leanings. It suggests that this public convergence relied heavily upon various medical and devotional practices and institutional structures that drew clear social and conceptual boundaries between the religious and the secular, the sacred and the mundane, the private and the public within the space of the mission. In doing so, it proved easily coopted into a wide range of social and political projects that included not only Christian evangelism, but also royal patronage and colonial hierarchy and biosecurity. In tracing these public convergences across a diversity of private interests and concerns, this paper hopes to contribute to a lively conversation on the multiple meanings and uses of medical humanitarianism in late colonial settings.

Claire Edington, *University of Massachusetts, Boston, MA: Lessons from abroad: experts, study trips and the history of psychiatry in colonial Southeast Asia*

Between 1891 and 1904 no less than twenty-five French study missions (*mission d'enquête*) visited colonial Indonesia. These fact-finding trips surveyed everything from the management of the local labor force and the specifics of irrigation projects to the creation of botanical gardens. French officials clearly felt they had something to learn. Even as they criticized the Dutch for failing to espouse any sort of colonial ideology tantamount to a civilizing mission, French accounts nevertheless generally presented a "rose-colored picture" of Dutch as benign and effective bureaucrats. When French doctors sought to expand mental health services in Indochina, they did not look to France or even other parts of their own

empire. Rather they traveled to the Dutch East Indies in order to study what they saw as a successful model of a modern psychiatric service.

The story of how French experts came to be interested in Dutch practices does not fit within the narrative typically told by historians of colonial science and medicine, one which tends to emphasize the relationship of metropole to colony as the most important axis of inquiry. Instead this paper draws attention to the regional development of psychiatry, particularly those forms of inter-imperial scientific exchange that have received little attention in the historiography. Here I seek to bring the French and Dutch empires together in a single frame so as less to highlight differences between the two cases but rather to emphasize their co-evolution. With the "study trip" as its focus, this paper is interested in how experts at the time engaged in their own project of comparison and how, in detailing the connections between French Indochina and the Dutch East Indies, they played a vital role in the articulation of Southeast Asia as a coherent unit, as a thing to be known. Drawing on archival materials from both France and Vietnam, this paper argues that studying the history of psychiatry in terms of a history of regional exchanges demonstrates the development of Western understandings of Southeast Asia as a distinctive region that required distinctive brands of expertise.

Deborah Neill, *York Univ., Toronto, Ontario, Canada*; and Juanita De Barros, *McMaster Univ., Hamilton, Ontario, Canada*: ***The Business of Tropical Medicine: Transnational Corporations and the Development of the Liverpool School in the Early Twentieth Century***

Our presentation will address the relationship between the international business community and the Liverpool School of Tropical Medicine (LSTM) in the first decade of the twentieth century. Historians such as Michael Worboys and Helen Powers have argued that the founding of the LSTM was due to the intersection of government, scientific and corporate interests in the late Nineteenth century. All three were very important, but in this paper we will concentrate on the role of transnational corporate interests, arguing that their support was the most fundamental in the establishment of the LSTM. Trading, plantation, and shipping companies from Britain, France, Belgium and elsewhere funded and supported the LSTM in the hope of solving the problems of tropical diseases and thereby expanding their economic reach in the global south. We will discuss some of the transnational corporate interests most active in the founding of the institute, arguing that by throwing their financial support behind the school, this powerful business community was to a certain extent able to set an agenda that responded to their own priorities. These priorities were to protect both white European employees and indigenous and immigrant wage laborers from tropical diseases on ships, in mines, and on plantations in the Caribbean and West Africa. Taking examples of LSTM medical research expeditions targeting colonies in the Caribbean and Central Africa, we will demonstrate how medical and business interests shaped the development of tropical medicine. That those men involved in these intertwined business and medical initiatives hailed from diverse ethnic and national backgrounds indicates the wide-ranging nature of the influences at work. In exploring this subject, we hope to shed light on the broader 20th-century history of the relationship of commercial interests to the funding of medical research.

E2: Therapeutic Research and Experimentation, Mid-Twentieth Century

Grand Ballroom A

Moderator: Ellen Dwyer, Indiana University, Bloomington

Michael Dwyer, *University College, Cork, Ireland*: ***"Experimental Material:" Human Experimentation in Irish Children's Institutions, 1930-35***

In 1930, rival drug companies in Britain and America competed to produce the first alum-toxoid 'one-shot' anti-diphtheria prophylactic. In New York, the pioneer of active immunization, William Parks and his team, conducted laboratory-based experiments of their product before conducting vaccine trials in children's institutions in New York. In London, Richard O'Brien of the Wellcome Physiological Research Laboratory followed a similar pattern of experimentation, however, therapeutic substance regulations introduced in Britain in the late 1920s precluded trialing of experimental antigens in human subjects. While O'Brien publicly bemoaned the lack of opportunities for drug manufacturers to trial their products on children in Britain, Wellcome had made private arrangements to test their experimental alum-toxoid anti-diphtheria antigen on vulnerable Irish children in state care, housed in institutions run by religious congregations. Although no official record of these trials can be found in the surviving archival record relating to central, or municipal government, a trawl of popular medical journals has revealed that at least five such vaccine trials involving 2,051 children across twenty-four, state-funded, residential institutions were used as 'experimental material' to test experimental antigens produced by Burroughs Wellcome Ltd. This paper will explore professional behavior, and ethical values in relation to human experimentation in the early twentieth-century with a focus on bodily integrity, and the child as a rights holder.

Learning objectives:

Identify successes and failures in the history of medical professionalism

Recognize the dynamic interrelationship between medicine and society through history

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

Claire Clark, *University of Kentucky, Lexington, KY*: ***The Return of Rehabilitative Corrections: Therapeutic Community Research in the US Prison System, 1986-1992***

From the 1950s until the 1970s, medical experiments and therapeutic programs flourished in American prisons. In the 1970s, investigations by journalists and elected officials led to ethical challenges, effectively bringing most objectionable behavioral research on prisoners to an end. At the same time, mounting public skepticism about the correctional system's ability to rehabilitate prisoners caused liberals and conservatives to abandon psychotherapeutic prison projects. By the end of the decade, the nation had shifted from a treatment model to a justice model of incarceration.

In contrast to scholars who trace the return of rehabilitative corrections to the drug court movement of the 1990s, I argue that the resurgence of corrections-

based addiction treatment took place at the height of the Drug War. The Anti-Drug Abuse Act of 1986-- which enacted federal mandatory minimum sentences for the possession of small amounts of illicit drugs, imposed harsh new standards for parole, and allocated 97 million dollars to build new prisons-- is usually viewed as the crowning piece of Drug War legislation. But the Act also allocated 241 million dollars for addiction treatment; that allocation helped fund "Project Reform," an influential multi-site study on the efficacy of prison-based therapeutic communities for drug offenders.

According to one government report, Project Reform had a "catalytic effect" on correctional stakeholders in the late 1980s and early 1990s, sparking renewed interest in a treatment model previously associated with the chaotic addiction treatment revolution of the 1960s. The project inspired clinical trials that randomly assigned some prisoners to therapeutic community treatment, bolstering the model's evidence base. Project Reform researchers also created business opportunities for therapeutic community treatment centers; several private centers won contracts to manage the growing prison programs.

Drawing on original oral histories, government documents, and published scientific studies, I show how the Anti-Drug Abuse Act resurrected a past therapeutic project and created new ethical dilemmas, marking a pivotal chapter in the history of prison-based behavioral research and treatment.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history

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

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

Susan Smith, University of Alberta, Edmonton, Alberta, Canada: Mustard Gas and Cancer Chemotherapy

Mustard gas, a chemical warfare agent, directly influenced the development of cancer chemotherapy. This paper investigates how and why scientists and physician-researchers during World War II came to discover that mustard agents, like sulfur mustard (mustard gas) and nitrogen mustard, might be beneficial in the treatment of cancers. Drawing on scientific investigations in the 1940s, this presentation shows that researchers realized the potential benefits while conducting research on chemical weapons. They developed cancer treatments from mustard agents because these were the poisons they knew best. Wartime studies suggested that both mustard gas and nitrogen mustards penetrated the skin to reach the circulatory system and destroy cells. Thus, medical scientists conducted mustard gas experiments on cancer patients in the hopes of developing a new form of cancer control. They sought to extend life through chemotherapy, or treatment with chemicals and drugs.

Many of the major figures in postwar cancer research emerged from this wartime generation of researchers. Dr. Cornelius P. Rhoads, head of the Medical Division of the U.S. Chemical Warfare Service during World War II, bridged the worlds of military and civilian medical research. He first made a name for himself in the field of cancer research in New York City in 1940 when he became director of the Memorial Hospital for Cancer and Allied Diseases. During the war, Rhoads developed a fascination with the potential medical benefits of mustard agents based on information generated from two different directions: clinical evidence from the battlefield at Bari Harbor in Italy and laboratory evidence from mustard gas experiments on the home front. Both avenues suggested to Rhoads, and his assistant Dr. David Karnofsky, that toxic exposures to mustard agents could have surprising benefits for treating certain types of cancer. Dr. Karnofsky later created the Karnofsky performance status scale, which medical oncologists still use today to assess a cancer patient's ability to carry on normal activity, similar to how wartime toxicity studies sought to evaluate a soldier's performance after exposure to mustard gas. Thus the battlefield and the laboratory marked the two paths through which World War II contributed to advancements in chemotherapy.

Learning objectives:

Deepen understanding of how war shapes medical research

Recognize the dynamic interrelationship between medicine and society through history

Critically appraise the potential ambiguity between therapy and experimentation in research

E3: Imagined Plague-Scapes: Imagining the History and Geography of the Plague over Time and Space

Temple Room

Moderator and Discussant: Lester Little, Smith College.

Over the past decade and a half, significant advances have been made in microbiological, genetic, entomological, ecological, epidemiological, archaeological, and historical research that have transformed the ways in which we now understand the history and geography of the plague. This applies in particular to the Second Pandemic, which we know now continued from the thirteenth to the Nineteenth centuries and affected most of Eurasia and North Africa. The research is also providing a greater understanding of the temporal and spatial connections that may have connected the First, Second, and Third Pandemics, providing us with a deeper, bigger picture of the *global* history and geography of the plague.

The people who lived through the plague's recurrent epidemic waves did not, of course, have the benefit of these modern interdisciplinary research results. Instead, they imagined the history and geography of plague – the plague-scape – in ways that fit into their contemporary cosmological, religious, medical, and cultural contexts. While these imagined plague-scapes were necessarily different across time and space, exploring and elucidating them gives us a better sense of how the history and geography of the plague

was imagined by those who actually lived with it. Doing so, in turn, adds further to our understanding of the disease's global history and geography. The members of this panel will share the results of their ongoing research on imagined plague-scapes from a variety of temporal and spatial perspectives.

Learning Objectives:

To appreciate how perceptions of the plague's history and geography changed over time and space.

To explore how modern research on the global history and geography of the plague corresponds with contemporary perceptions.

To understand the broader benefits of examining the plague from spatial and temporal perspectives, using both qualitative and quantitative data sources.

Lori Jones, University of Ottawa, Ottawa, ON, Canada: *Changing Perceptions of the Origin of the Plague in 14th-17th Century England and France*

Perceptions of the plague's history and geography changed considerably between the 'Black Death' in the mid-fourteenth century and the last great plague outbreaks in England (1665) and France (1722). While attempting to situate the plague within the Galenic scholastic tradition, authors of the first medical treatises that addressed the Great Mortality presented the disease as one that was unknown to recent memory, universal, and geographically widespread. By the early modern period, adaptations of those same treatises had recast the plague as a still-feared yet recognized scourge that had temporal and spatial specificity. In other words, the plague had evolved from being discussed and imagined as a novel and 'global' problem to one that was localized in both time and space: the geography and the history of the plague (as a general, universal disease) was replaced by the geography and history of this plague – one that affected particular people in a particular place at a particular time.

To discern more clearly how these imagined plague-scapes evolved, this presentation traces the adaptations made over a 300 year period to two mid-fourteenth century plague treatises, and contextualizes them with contemporary chronicle descriptions of local plague outbreaks. The treatises originally written by John of Burgundy (c. 1365) and Johannes Jacobi (c.1373) are particularly useful for this type of analysis because they were widely disseminated in both England and France for several centuries, in a variety of translations and adaptations. Analysis of the textual adaptations made to these treatises over time demonstrates that, although scholars have long claimed that new editions of the treatises were simply reproduced and disseminated (first in manuscript and later in print) during each new outbreak, there were in fact subtle changes made to the vernacular texts in particular over time that tied them to experiences, expectations, and perceptions of the plague in particular locations at particular times.

Exploring these changing perspectives of the plague's historical and geographical origins sheds a new light on what plague meant to those who anticipated the arrival of, and who lived through, the many epidemic waves that marked late medieval and early modern Europe.

Learning objectives:

To understand how contemporary English and French populations understood the historical and geographical origins of the plague, and how this understanding changed over time.

To appreciate how seemingly "universal" primary sources like plague tracts can be used to study localized experiences of the plague.

To explore the extent to which cumulative experiences of epidemics modified understanding of 'where the plague came from'.

Nükhet Varlik, *Rutgers University-Newark, New Jersey: "Oriental plague" or Epidemiological Orientalism?: Revisiting the Plague Episteme of the Post-Black Death Mediterranean*

In the early modern era, European imaginaries of the plague associated the disease's geographic origin with areas ruled by the Ottoman Empire. This particular imagined plague-scape was nurtured by a constant supply of plague news that came from eastern Mediterranean port cities and the common tropes of the European travel literature about the indifference of the Muslims inhabiting that land, their fatalism, and their failure to understand contagion. Taken as a whole, the early modern European plague episteme was, to a large extent, shaped by observations of or accounts about the Ottoman experience of plague. Especially after the plague (and historical memories of it) had started to recede from western Europe in the later seventeenth and eighteenth centuries, and with the Enlightenment, it was this set of knowledge, beliefs, and ideas that helped to formulate the origins, foci (*foyers de peste*), historicity, and directionality of the "Oriental plague."

This plague paradigm, imbued with unmistakable overtones of epidemiological Orientalism, has had lasting ramifications for the student of the post-Black Death Mediterranean, which is often imagined in epidemiological binaries. In fact, it is fascinating to see how much of that epidemiological imagination has found its way into modern scientific and historical thinking about the plague in time and space. With a conviction that we can no longer afford to keep a Eurocentric vision of this epidemiological past, I will revisit some aspects of the epidemiological imaginaries of the Orient. Following the recent work of environmental historians of the Middle East and North Africa, I will highlight how the Ottoman plague-scape was described by early modern European travelers and how this knowledge was used for formulating a watershed in the European imagination.

Learning objectives:

To understand the historical context in which past perception of the plague developed.

To recognize the development of western notions of the plague in relationship to the epidemiological experience of non-western societies.

To acquire a historically nuanced understanding of the history of the plague from spatial and temporal perspectives.

Stuart Borsch, *Assumption College, Worcester, MA: Awful Arithmetic: Body Counts and the Medieval Islamic Imagination*

Natural disasters left deep scars in the minds of medieval Egyptians, and coping with such disasters was an essential survival skill. Examining how Egyptians attempted to cope by quantifying mortality from plague outbreaks – in particular by counting corpses – reveals much about the ways in which local plague-scapes were imagined. How did they imagine the heavy losses that they had to bear? How did these losses compare to those of other times and other places? Losses were indeed extreme: counters were forced to reckon with daily mortalities in the thousands, for Cairo alone, and with cumulative mortalities as high as 100,000 for a single outbreak. Some counted with a great deal of enthusiasm and expertise, while others seem to have flaunted their lack of skill and their reluctance to engage this issue. Whatever their approach, counting was a coping mechanism to make the plague-scape manageable.

The extent to which medieval chroniclers exaggerated their figures, or more simply were not interested in examining the numbers carefully, also reflects their individual attempts to manage the local plague-scape. The late fifteenth century chronicler al-Biqā'i, for example, whose expert eye took careful and accurate note of Nile and irrigation system hydraulics, paid little attention to plague statistics; he casually rounded summary figures in the thousands and tens of thousands. For others, it is clear that math skills were less than rudimentary. Ibn Iyās, a keen observer of political events in the early 1500s, seems altogether challenged by the rather simple multiplication exercises needed to assemble numbers for plague deaths. In other cases, however, observers like Ibn Taghrībirdī were quite adept at assessing and adding the losses. Ibn Taghrībirdī was particularly fascinated with the grim business of death totals, and with solid mathematical skill tells us a great deal about how the process of counting bodies actually worked.

In this paper I examine the means by which medieval Egyptian chroniclers attempted, with enthusiasm or reluctance, impressive skill or atrocious error, to count plague deaths and what this tells us about how medieval Egyptians imagined and coped with the plague.

Learning objectives:

To understand how an analysis of quantitative data can be used to explore how local populations imagined their local disease experiences.

To appreciate how different contemporary approaches to the same quantitative task – such as counting deaths from the plague – reveals much about personal and community coping mechanisms in the face of epidemic disease.

To explore the extent to which quantitative data can be used to complement more qualitative sources in the study of historical disease experiences and imaginations.

E4: Mental Health in Comparative Perspective

Wooster Room

Moderator: Joel Braslow, UCLA

Dennis Downey, Millersville University, Millersville, PA. ***"Philadelphia Physicians, Public Health and the 'Menace' of the Feeble-Minded, 1880-1920"***

This proposal results from in-depth research into a generation of Philadelphia medical professionals and their influence on public policy directed at individuals with intellectual and developmental disabilities. More specifically, I am interested in how these nationally and internationally recognized physicians shaped the birth of modern public health approaches to the "menace of the feeble-minded."

My focus is Pennsylvania as a case study in the larger national advocacy movement centered in disability policy. I am especially interested in how Philadelphia-area medical researchers laid the foundation for and contributed to the development of public policy regarding the segregation and sterilization of individuals judged to be feeble-minded (to use the language of the day). Their efforts included government legislative advocacy, writing, public speaking, medical education, and leadership in the Charities and Public Health movements. This project is more concerned with the "social politics" of disability, that is the convergence of science and social thought and the resulting political outcomes, and less with intricate medical practices and techniques. These physicians shared to varying degrees a belief that cognitive disability was a heritable trait passed on from generation to generation, and as such posed a grave social and public health threat.

Many were among Philadelphia's "best men" who played an integral role in scientific (medical) and social reform. Their ranks included Isaac N. Kerlin, Martin W. Barr, Joseph Nolt, Charles H. Frazier, Joseph Stokes, James Ewing Mears, Samuel Dixon, and George Stanley Woodward, among others. Some were more openly eugenic in their approach but they shared a common concern about the social and economic implications of hereditary feeble-mindedness. In addition to being heavily involved in training physicians, they became activists in Pennsylvania and national politics. Some formed close relationships with H.H. Goddard, Charles Davenport, Madison Grant, and Harry Laughlin and other figures in the international Eugenics movement. Research includes university, medical school, and government archives and repositories.

Learning objectives:

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

Deepen understanding of the social and political implications of medical research and diagnosis

Understand the dynamic relationship between medicine, society and history

Mat Savelli, *McMaster University, Hamilton, Ontario, Canada*: ***"The sum quantity of joy and misery is the same in Slovenia and in Kosovo:" Suicide Epidemics and Ethnicity in the Balkan States***

As historians have ably demonstrated, suicide waves (whether real or imagined) have been frequently politicized in the modern era. Politicians, poets, and physicians have all instrumentalized people's decisions to end their own lives in order to draw attention to a host of socio-political changes such as industrialization and the end of empire. This paper builds upon this discussion by examining the ethnicization of suicide discourses in Communist Yugoslavia and its successor states.

As a multi-ethnic and religiously diverse federal state, post-WWII Yugoslavia witnessed a series of shifting strategies aimed at managing relations between the country's various national groups. Attempts at creating a pan-Yugoslav identity later gave way to a recognition that ethnicity could not (and perhaps should not) be dictated from above. With that in mind, leaders of the Communist party developed a complex system of quotas, guidelines, and laws which meant that ethnicity was a highly regulated issue, both politically and socially sensitive.

When the country's Statistical bureau and health services started reporting the news that certain parts of the country were undergoing a wave of suicide epidemics, psychiatrists began searching for an explanation. Although they originally elaborated a wide array of potential causes for dramatic increase in the suicide rate, they eventually focused primarily on regional variations. Remarkably, despite the official and unofficial taboos on discussing ethnicity, they would highlight sensitive issues such as religious belief, language, and national customs as being central to the suicide question. In doing so, these individuals were not merely politicizing suicide but ethnicizing it as well. Ultimately, the work of these psychiatrists would be utilized to help push nationalist agendas that contributed to the country's collapse in the 1990s.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history.

Identify successes and failures in the history of medical professionalism.

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

Janet Weston, *Birkbeck, University of London, London, UK*: ***The Trials of Forensic Psychiatry***

In October 1946, Neville Heath was executed at Pentonville Prison for the murder of Margery Gardner. In a case that inspired lurid headlines and set the handsome young Heath apart as one of the more notorious murderers of his era, his status as a psychopath and a sexual sadist was widely accepted. At his trial, however, fundamental disagreements between the three psychiatric witnesses were aired. Did his abnormalities constitute a form of moral insanity or mental defect, or was he simply an 'ordinary sexual pervert' who had finally gone too far?

This paper will use the criminal investigations and trials of a selection of sexual offenders from mid-twentieth century England to consider the rise of forensic psychiatry during this period, and its engagement with sexual crimes. I argue that psychiatric evidence remained a rarity, but that the involvement of energetic defense lawyers as well as vocal psychiatrists began to transform this situation. The influence of psychiatric testimony was hindered, however, by its own conceptual uncertainties as well as the restrictions and occasional hostility of the legal and penal authorities. Diagnoses of sexual sadism and psychopathy became particularly prominent, but the lack of practical alternatives to the usual punitive measures severely limited their impact.

This focus upon the middle of the twentieth century, a time of significant change for both penology and psychiatry in Britain, shifts attention away from more traditional objects of study in histories of law, sexuality, and medicine. It also illustrates some of the differences between ideas of sexual deviance and psychopathy in north America, which have been well documented through the figures of the sexual psychopath and child molester, and the lesser-known English case. Medical disagreements reveal much about mid-century debates in England surrounding legal responsibility and the causes and cures of sexual deviance, while the cases themselves suggest some of the complexities produced by the collision of medical and criminological concerns. The need to provide certain sexual offenders with reformatory psychiatric treatment has become a widely-accepted tenet of contemporary criminology, but the history of forensic psychiatry highlights some of the unsteady foundations of such a belief.

Learning objectives:

Identify successes and failures in the history of medical professionalism

Recognize the dynamic interrelationship between medicine and society through history

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

E5: Creating the Surgeon's World: American Surgery 1880 – 1980 (John P. McGovern Session)

George Room

Moderator: Susan Lederer, University of Wisconsin-Madison

Understudied and under-reported, the history of surgery comprises a simultaneously integral and complementary component to the history of medicine. While the overarching objective of using science to heal patients unites the two modern fields, the definitiveness of an operation and the very invasiveness of its interventions distinguish surgery and invoke further scholarly attention. This panel helps elucidate how modern surgery developed in the United States.

In describing the creation and establishment of modern surgery, the three papers in this panel takes both a top-down perspective to look at issues affecting the field as a whole as

well as encompasses views from individual surgeons, some better known than others, to portray the practice of surgery in 20th century America and how practitioners coped with the stresses inherent to a surgical career in an era of change, expansion, and transformation. The inter-related themes of education, professionalism, and practice among the presentations coalesce to limn a fuller portrayal of American surgery as it ascended in popularity and efficacy. We look forward not only to breaking new ground in the history of surgery through exploring various aspects of this transition into modern surgery but also to bringing to AAHM an off-ignored yet crucial aspect of the history of medicine.

Learning Objectives:

Gain a multi-faceted understanding of various professional and personal aspects of surgery in the United States.

Appreciate the constellation of attitudinal, educational, and intellectual elements that comprise a modern surgeon.

Recognize the varied components necessary for the transformation of surgery in the late 19th and early 20th century in both the United States and abroad.

Understand how surgeons individually prepared intellectually and emotionally for a career of operating.

Peter Kernahan, *University of Minnesota, Minneapolis MN: **International Alliances: William J Mayo and Surgical Science in the First Age of Globalization***

The rapid expansion of surgery in the waning decades of the Nineteenth and first decades of the twentieth century produced a new group of surgical leaders in the United States. Prominent among them, despite an apparently unpromising location in rural Minnesota, were William J Mayo and his brother Charles. Unlike many of their elite peers, the brothers had not travelled to Europe, particularly the German-speaking countries, as trainees. Nevertheless, they became part of the international production and exchange of surgical knowledge during what economic historians have referred to as the first age of globalization. Through the perspective offered by William Mayo's correspondence, this paper will examine the creation, sustaining, and impact of these exchange networks.

Such networks offered elite surgeons the opportunity to share ideas and novel techniques, and address shared scientific and administrative problems. William Mayo's own extensive travels, while balancing the dual roles of busy surgeon and chief executive, document the effort required to maintain these connections. The Great War severely disrupted these networks, and, while strengthening relations between British and American surgeons—exemplified by the friendship between Mayo and Berkeley Moynihan—almost completely severed ties with German surgery; ties that, in the economic dislocations of the Weimar Republic, could not be reestablished. Finally, although the pre-war exchange is often seen as one way, with American surgeons as supplicants, this paper will show that with the rapid professionalization of their field, the Americans quickly brought as much if not more to British and European surgeons as they received in return.

Learning objectives:

- Understand the international history of surgical ideas and practice, and its implications for contemporary patients and practitioners
- Recognize the dynamic interrelationship between surgery and society through history
- Understand how history has shaped the current practice of surgery

Wen Shen, UCSF, San Francisco: *Oliver Cope and The 1966-67 Swampscott Meetings: A Surgeon's Crusade to Humanize Medical Education*

Oliver Cope, MD (1902-1994) was considered one of the foremost surgeon-scientists of his era. During an illustrious career spent entirely at the Massachusetts General Hospital, Cope made numerous impactful contributions to the fields of parathyroid surgery and the treatment of burns. After several decades of success working in the "hard" sciences, however, Cope took a seemingly abrupt detour and dedicated the final 30 years of his life to championing the importance of the psychosocial sciences in medical education and practice.

In this paper I examine the second half of Oliver Cope's career, when he departed from the traditional pathways of biomedical research and focused his attention on the emotional aspects of patient care. Cope implored his surgical colleagues to be more mindful of the psychological needs of their patients, and urged physicians in general to be more empathetic and compassionate. He also blamed medical schools and their science-heavy curricula for inculcating cynicism and detachment in medical students. Cope's crusade culminated in two multidisciplinary retreats held in 1966 and 1967 at an oceanfront resort in Swampscott, Massachusetts. In these week-long meetings, Cope gathered a team of physicians, nurses, psychologists, and an eclectic mix of academics and civilians to discuss the mind-body connection and its role in patient care and medical student education. In my analysis of Cope's career and the Swampscott meetings I identify the factors that propelled Cope to devote himself to studying the mind-body connection in medicine; show how Cope was well ahead of his time in attempting to instill in his surgical colleagues a greater sense of empathy and appreciation for patient-centered care; and trace the impact of the Swampscott meetings on the course of American medical education and surgical training in subsequent decades. Taking place a half-century after the Flexner report, the Swampscott meetings questioned the fundamental goals of medical education and attempted to redefine what constitutes the ideal balance of the biologic and social sciences in the training and practice of physicians (an issue medical schools still struggle with today).

Learning objectives:

- To learn about Oliver Cope, MD, a surgeon-scientist who spent the second half of his career on a crusade to reform medical education through improved understanding of the emotional aspects of patient care.
- To learn about the 1966-67 Swampscott meetings, organized by Cope and composed of an eclectic multidisciplinary team of physicians and other experts gathered to address the perceived lack of empathy and patient-centered care in medical teaching and practice

To better understand the impact of Cope on the course of American medical education, including the eventual creation of Harvard Medical School's "New Pathway"

Justin Barr, *University of Virginia, Charlottesville, VA; Yale University, New Haven, CT:*
The Training and Education of Surgeons in America, 1900-1960

At the turn of the twentieth century, surgeons, a loosely defined term encompassing any practitioner offering an operation, rarely pursued education beyond medical school – and largely did not need any to perform common surgeries of the day. Six decades later, the board certification that came to define surgeons in America required an arduous and regimented four years of training after medical school that included copious operative experience, intense didactic instruction, and original research. This paper outlines the emergence and development of formal graduate surgical education in the United States.

While early academic examples were important, reports of their influence exceed that of their actual impact. Instead, organizations like the nascent American College of Surgeons (ACS), American Board of Surgeons, and American Medical Association sculpted surgery residencies through policies, admission standards, and exhaustive inspections. Drawing heavily on archival records from these professional societies, I show how they molded surgery training and how each organization struggled to remain dominant in a bureaucratic battle for the professional future of surgery. Documents from their collections also expose a heretofore underappreciated role of the Federal government in the dramatic expansion of surgical residencies after World War II. Particularly, the government's promotion of board certification in the military and the VA system, their insistence on ACS standards for their residencies, and their development of hundreds of programs to produce practitioners profoundly influenced the form and trajectory of surgical residency training in this country. Finally, by using the case study of vascular surgery, I demonstrate how the expansion of residencies and thus better trained operators directly led to changes in the practice surgery.

Learning objectives:

Identify successes and failures in the history of medical professionalism
Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
Recognize the dynamic interrelationship between medicine and society through history

Saturday Lunch L3: New Directions in the Historiography of Mental Health: U.S. Psychiatry and the Politics of Everyday Life

York Room

Moderators: Matthew Gambino, Yale University; Mical Raz, Yale University

Recent work on the history of mental healthcare has brought a new focus to the intersection of mental health and civil rights in the modern United States. Early historians

Abstracts: Lunch L3

examined large-scale institutions as the main locus of mental healthcare; subsequent researchers have focused on psychiatric therapeutics, particularly somatic and pharmaceutical interventions. This panel moves beyond these literatures, examining the interplay of psychiatric expertise and questions of social inclusion in both the public and private spheres.

Theories of mental health and illness profoundly shape the daily experiences of men and women from all walks of life. Our session aims to highlight the inevitably political dimensions of this fact. Each of our four panelists will reflect on the ways in which ideologies of mental health have influenced Americans' diverse experiences of their identities, particularly in such political categories as race, gender, and sexuality. We will attend to both traditional and non-traditional domains of psychiatric subject formation, from the analyst's couch and the mental hospital to the public schools and the country's burgeoning prison system. We also anticipate using this opportunity to facilitate a discussion—among panelists as well as audience members—on how the history of mental health might move beyond the history of men and women with psychiatric disabilities to consider broader issues of citizenship and social marginalization. We argue that this new historiographical approach can serve as a lens through which to consider such pressing social issues as mass incarceration, and such emerging concerns as the politics of gender non-conformity.

Regina Kunzel, PhD (Department of History, Princeton University) will discuss her current research on the encounter of sexual- and gender-variant men and women with psychiatry and psychoanalysis in the mid-twentieth-century United States. This work is based on a previously unexplored archive of clinical records from a leading clinician in the field.

Anne E. Parsons, PhD (Department of History, University of North Carolina at Greensboro) will introduce her research on the politics and infrastructure of custodial segregation, examining how the widespread closure of mental hospitals interacted with the rise of mass incarceration on the American social landscape.

Mical Raz, MD, PhD (Department of Internal Medicine, Yale School of Medicine) will draw on material from her recent book *What's Wrong with the Poor?* (2013) on the intersection of race, psychiatry, and civil rights during the War on Poverty, as well as her current work on the active role that psychiatrists played in the surveillance and regulation of addicted men and women during the early years of the War on Drugs.

Michael Staub, PhD (Department of English, Baruch College) will draw on his most recent book, *Madness is Civilization* (2011), to examine how critiques of mental healthcare advanced by the antipsychiatry movement informed anti-war, black liberation, and gay rights struggles.

Learning Objectives:

Identify three ways in which psychiatric thought informed struggles over political identity in the United States during the latter half of the twentieth century.

Abstracts: Lunch L3/L4

Discuss three non-clinical sites through which psychiatric authority has shaped social identity in U.S. history.

Identify two gains and two losses associated with a shift in the historiography from a focus on the history of men and women with psychiatric disabilities to a history of mental health as a political category.

Saturday Lunch L4: Teaching History of Medicine: Strategies for Engaging with Emerging Growth Areas

Grand Ballroom B

Moderator: Arthur Daemmerich, University of Kansas School of Medicine

Arthur Daemmerich, *Responsible Conduct of Research: Courses and Cases*

This brief talk (part of a discussion-oriented luncheon workshop) will present insights gained from designing and teaching a course in the "Responsible Conduct of Research" that meets NIH requirements for such training. Students learn relevant guidelines, policies, and codes relating to biomedical research and develop approaches to identifying and resolving ethical conflicts that arise in research. This

talk will describe the active learning model used in the course, which is built around the analysis of historical and contemporary case studies in research conduct, data management, animal subject protection, human subject protection, conflicts of interest, authorship, peer review, publication, collaboration, mentoring, whistle blowing, and genetics and privacy. I will especially emphasize the use of historical cases and steps taken to build cross-institutional support for the course and its content.

Learning objectives:

Improve pedagogy regarding the science and practice of medicine

Respond to changes in medical education guided by historically informed concepts of professional responsibility and research subject protections

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

Elena Conis, Emory University, Atlanta, GA: *Teaching History of Medicine & Health Across the University*

Graduate and undergraduate programs for students in the health sciences have experienced remarkable growth in recent years. This short presentation, which is part of a discussion-oriented luncheon workshop, will cover approaches to incorporating history of medicine content into health-science focused courses and curricula across the university. The talk will present a set of scenarios: employing history of medicine case studies to teach ethics and cultural competency at the graduate level; using history of medicine content and approaches to teach close reading and critical analysis skills (both emphasized on the redesigned MCAT exam) to undergraduate pre-health students; and partnering with colleagues across

disciplines to ensure that history and humanities of health are represented in health-oriented courses and curricula as they develop.

Learning objectives:

- Improve pedagogy in the health sciences
- Respond to changes in health professional and pre-professional education
- Develop strategies for incorporating history of medicine and public health into diverse and interdisciplinary curricula

Laura Stark, Vanderbilt University, Nashville, TN: ***More than background: explaining to instructors and students how history clarifies the present-day practice of ethics***

The present has its place, even in history. This paper takes an ecumenical view of courses with a present-ist perspective, and proposes ways in which historians can encourage students without formal training in history to use a temporal perspective as a critical tool in thinking about and enacting research ethics and regulation. The paper is based on the author's research on ethics-review boards (published in *Behind Closed Doors*, 2012) and her experience training undergraduate, graduate student and professional audiences in "research ethics." This paper will propose strategies to help explain, both to instructors and students, why history is not only interesting, but actually indispensable, to present-ist courses. In so doing, the paper will also explore with audience members, especially

junior faculty members, how giving practical lectures outside of humanities departments might encourage senior colleagues to see them, not only their subject matter, as indispensable parts of an academic community. This paper emphasizes that history of medicine should be seen as an essential feature of courses with otherwise present-ist perspective, and suggests specific ways in which historians of medicine might intervene in medical curricula and social science research methods courses.

Learning objectives:

- To develop critical tools for learning and enacting research ethics and regulation.
- To collect specific strategies for teaching history of medicine to audiences formally trained in other fields.
- To reconsider the presumed gap between present-ist/scientific and historical/humanistic perspectives on ethics.

Carla Keirns, Stony Brook University, Stony Brook, NY: ***History as a tool for teaching public health, health systems analysis, and health economics***

Students of the health professions, health systems, and public health frequently find the systems of care in the United States difficult to understand. The boundaries of public health, the coverages and limitations of various health insurance and delivery systems, and other features of the modern health care and public health landscape often appear confusing, irrational, and inconsistent to those not schooled in their intricacies. This presentation will discuss using a historical approach to the development of health institutions in order to explore the challenges and needs they were intended to address and the actors who advocated or supported their creation. It will also discuss the ways that the history, political

Abstracts: Lunch L4/L5

origins, and economics at the time of creation of programs can help contemporary patients, providers, administrators, and advocates for change understand some of the interests and barriers that may shape their own contemporary work.

Learning objectives:

After attending this presentation, learners will be able to describe some of the economic and political interests that have shaped the modern health care system
Learners will be able to explain how a historical approach can help make sense of the contemporary health care system

Learners will be able to evaluate whether a proposed change in a program seems likely to work based on the historical origins of the program

Saturday Lunch L5: History of Capitalism and History of Medicine: What Can the AAHM Learn from History's Hottest New Field?

Chapel Room

Moderator: Merlyn Chowkwanyun, University of Wisconsin-Madison

This informal, creatively structured session will focus on what the burgeoning history of capitalism field can bring to historians of medicine. The field has attracted intense levels of attention, culminating in a long New York Times story last year ("In History

Departments, It's Up With Capitalism," April 6, 2013). Yet its presence at AAHM and in the history of medicine field has been less noticeable. This symposium thus serves a second purpose: to take stock of historiographical trends in the field and where we have come since the entry of social history 30+ years ago.

Julia Ott, one of the most prominent new historians of capitalism (featured in the Times article), will give an overview of the subfield, its major questions, and debates within it. Christy Chapin will present an example of how she applied the approach in her new book on the government-aided rise of the mid-century private health insurance market. Susan Reverby, who co-wrote a famous 1979 manifesto on social history in the history of medicine, will then reflect on the legacy of that essay, the limits of the approach it advocated, and how the field might profit from the questions the historians of capitalism are asking. We believe the Q&A will be particularly fruitful, with leading and emerging practitioners from both the history of medicine and history of capitalism fields able to answer questions and discuss ways of bridging the two fields.

Given the enormous attention the history of capitalism field has received, both in the mainstream press and in scholarly venues, we think this panel will draw a sizeable crowd and generate great discussion at the meeting.

Panelists:

Merlyn Chowkwanyun, University of Wisconsin-Madison, Madison, WI, USA

Julia Ott, New School for Social Research, New York, NY, USA

Christy Chapin, University of Maryland - Baltimore County, Baltimore, MD, USA

Susan Reverby, Wellesley College, Wellesley, MA, USA

Abstracts: Lunch L5/F1

Learning objectives:

Provide an overview of the history of capitalism field, its origins, and major questions.

Offer examples of new works that apply the approach.

Stimulate thinking on where the history of medicine has been going historiographically and how it might profit from this new approach.

F1: Big Data and the Medical Humanities

Grand Ballroom C

Moderator: Michelle DiMeo, Chemical Heritage Foundation

Discussant: Jeffrey S. Reznick, U.S. National Library of Medicine

The evolving and expanding digital world is producing vast amounts of information from both digitized physical materials and data generated outright from databases, blogs, web sites, and social media resources. Such "big data" joins a longstanding world that is deeply rich in variety of persistent physical artifacts that contain records of the human condition. As these physical and virtual worlds collide and co-exist, and more scholars begin (and wish to begin to work with "big data" to open new avenues of research, challenges and opportunities abound in terms of cross-disciplinary collaboration, historiography, methodology, interpretation, and expectations of institutions around the world that provide both physical and virtual resources for scholarship.

The panel addresses some of the key philosophical and practical issues impacting on the application of digital humanities techniques for the history of medicine, from the perspective of those actively involved in the construction of digital resources, and those who have used such resources for research. The panel will directly engage with and benefit those involved in resource creation and use, and will encourage wider reflection on and critique of the relationship between "big data" and the medical humanities. Participation in this panel is international and multi-perspective, involving scholars from the United Kingdom and United States as well as leaders of the Wellcome Library and the National Library of Medicine's History of Medicine Division. Serving as moderator of the panel will be the curator of digital collections at the Chemical Heritage Foundation.

Learning objectives:

Develop the capacity for critical thinking about the nature, ends and limits of medicine as the subject is conveyed in historical materials, in modern biomedical literature, and in the current digital world through a variety of virtual resources

Understand the range of digital resources, analytical tools, and methods currently available for historians of medicine and their uses to stimulate new modes of historiographical practice

Explore the relevance of historical analysis for understanding contemporary medical developments appreciate how digital methods can be used to explore past and present medical theories, practices, and events

Simon Chaplin, *Wellcome Trust, London, UK: Why Creating a Digital Library for the History of Medicine is Harder Than You'd Think*

It has never been easier to get access to digital copies of medical texts. Most leading medical journals now have full digital archives created by their publishers: some have also been digitized for public repositories such as the National Library of Medicine's PubMed Central. Google remains committed to its mission to digitize every printed book, while the overlapping work of non-profit organisations such as Hathi Trust and Internet Archive has ensured plurality of access to this growing digital corpus. Medical libraries have taken the lead in putting their own holdings online, individually and through consortia such as the Medical Heritage Library, which has contributors across the US, Canada and now the United Kingdom.

However, the utility of these kinds of initiatives is still primarily at the level of the individual researcher finding and accessing an individual work. This paper addresses the challenges involved in the use of 'big data' in the medical humanities from the perspective of the resource-creator and considers how digital library development is changing in response to interest in techniques such as text and data mining. It identifies three specific issues that have arisen in relation to the work of the Wellcome Library and its partners in recent projects involving archives, public health reports and 19th-century medical books. First, it questions whether collection-level mapping can be used to define the boundaries of the medical corpus and the potential (and limits) of using the contents of the libraries of medical institutions extant in the 19th-century as a proxy guide. Second, it discusses the ways in which text, image and data might need to be processed and presented in order to facilitate programmatic access. Third, it considers whether the exclusion of current historiographical secondary literature from the digital corpus has implications for the ability of historians to construct appropriate semantic analysis tools with which to interrogate the larger body of digitized primary texts. While none of these issues is easily resolved, the paper suggests that a degree of reflexivity will help the creators of digital libraries build resources that sustain the complex needs of future researchers.

Learning objectives:

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

Understand the range of digital resources currently available for historians of medicine and their uses to stimulate new modes of historiographical practice

Recognize the potential, and limits, of data- and text-mining as applied to historical medical texts compared to modern biomedical literature

E. Thomas Ewing, *Virginia Tech, Blacksburg, VA: Understanding the Scope and Severity of a Global Epidemic: Research on the Russian Influenza (1889-1893) Using Big Data Methods and Digital Collections*

The potential value for medical historians of the digitization of scholarly collections and the development of big data analysis for understand the scope and severity of a global epidemic will be illustrated using a case study of the so-called "Russian Influenza," which began in late 1889, spread to countries around the world in early 1890, and continued in successive waves through 1893. This epidemic is well

suitable to developing new methods to determine the extent of a disease as well as its potential impact because the disease occurred at a time when the world was closely linked through networks of information channels, including daily newspapers, wire services, and medical periodicals. To explore these issues of scope and severity, this project uses three distinct methods that are both grounded in the historical context and suitable for advanced digital analysis. First, key word searches across titles, collections, and geographic areas make it possible to trace the spread of disease (scope) and the ways that experts such as physicians and medical societies identified, studied, and predicted the number of cases and deaths (severity). Second, text mining tools, such as tone classification, network analysis, and topic modeling, are used to analyze the content of reporting, the connections across time and space, and changes in medical discourse in both popular and expert forums. Finally, this project uses this historical case study to evaluate the potential value of contemporary tools that use social media, personal data recordings, and user-created content to track diseases, such as influenza, in real time and at scale. This paper thus contributes to new methods of writing the history of medicine in a global context while also assessing the value of contemporary tools for predicting the scope and severity of sudden, widespread, and fast moving disease outbreaks.

Learning objectives:

Identify digital materials and analytical tools useful for research on the history of medicine

Evaluate methods for identifying the scope and severity of diseases outbreaks in historical contexts

Explore the relevance of historical analysis for understanding contemporary medical developments

Elizabeth Toon, Carsten Timmermann, and Michael Worboys; with Sophia Ananiadou, Nick Duvall, John McNaught, and Paul Thompson, *University of Manchester, Manchester, UK:*

Text Mining for Medical Historians: Big Data, Big Questions

Why and how should historians of medicine use new digital humanities tools like text mining? What can – and what can't – such tools do? This talk addresses these questions through an overview of the Mining the History of Medicine (MHM) project. This project, a research collaboration between the University of Manchester's Centre for the History of Science, Technology and Medicine (CHSTM) and the National Centre for Text Mining (NaCTeM), was funded by the UK's Arts and Humanities Research Council in 2014. Our goal has been to explore how text mining might allow historians of medicine to use large full-text corpora innovatively, to pose new questions and to address existing questions in new ways.

We begin by describing the semantic annotation scheme we have developed to identify entities and relationships in typical 19th and 20th century medical and public health texts. Using automated natural language processing methods, we are applying this annotation scheme to two large corpora: the Wellcome Library's London's Pulse collection of Medical Officer of Health reports, 1848-1972, and the British Medical Journal from 1840 to the 1970s. Semantic annotation makes it possible to search large corpora not just for specific terms, but whole classes of

terms, concepts and entities, and to explore and visualize typical and atypical relationships between these. These results can provide a jumping off point for further analysis; likewise, they can reveal relationships that have been difficult to discern in a sea of texts previously.

The presentation discusses some examples drawn from our preliminary results and findings, which have focused on the understanding, treatment, and prevention of respiratory conditions in modern Britain. We will also discuss some of the complications that have arisen in our project. While working with a large and highly varied text base offers great potential, the complex semantic relationships found in the BMJ and in London's Pulse have presented a significant challenge, as has the conflicted, variable, and changing nature of much medical language.

Learning objectives:

- Appreciate how digital methods can be used to explore past medical theories and practices
- Identify tools for analyzing data on past clinical management that are available to both historians and clinicians
- Recognize the potential and limits of text-mining as applied to historical medical texts compared to modern biomedical literature

F2 Comparative Health, Disease and Health Reforms in Island States

Grand Ballroom A

Moderator: Pablo Gómez, University of Wisconsin-Madison

Stephen Snelders, *University Medical Center Utrecht, Utrecht, The Netherlands*; Leo Van Bergen, *Royal Netherlands Institute of Southeast Asian and Caribbean Studies, Leiden, The Netherlands*; and Frank Huisman, *University Medical Center Utrecht, Utrecht, The Netherlands: The 'Caribbean Corrective': Comparing Leprosy Regimes in the Dutch West and East Indies (Suriname and Indonesia), 1800-1950*

Leprosy was a major health problem in the Western colonies in Asia, the Americas and Africa, it's framing closely related to racial stigmas and fears for colonial rule. Western medicine had to deal with the disease, but creating and upholding public health structures in a multicultural colonial context was never simply a matter of exporting biomedical knowledge and implementing it among a passive indigenous population. Disease concepts, diagnostics and therapeutics varied according to time, place and cultural setting, both among rulers and ruled. By looking at the case of leprosy in the Dutch colonial empire, this paper intends to shed light on negotiated relationships between indigenous and imperial medicine. It seeks to understand the complex reciprocity between knowledge, attitudes and practices towards leprosy over time and across the globe by comparing the Dutch East Indies (now Indonesia) and Suriname (Dutch Guiana).

Both contexts differed profoundly. Suriname was originally a plantation society based on slavery, and this heritage continued to exert influence after the abolition of slavery in 1863, the introduction of indentured labor from Asia and up to the

end of direct Dutch rule in 1950. The Dutch East Indies represented a much more complex and differentiated society with a great variety of cultures, ethnicities and languages that to a large extent remained autonomous.

This paper investigates how different organizations of production, ethnic and cultural differences and different ways of governance had important implications for the way leprosy was defined, leprosy sufferers were treated and public health structures were shaped. While the international historiography of leprosy has focused on developments in Asia, especially since the age of imperialism, developments in Suriname (and other parts of the Caribbean) had a dynamic of their own, pioneering policies of involuntary segregation. Within the context of the Dutch colonial empire the influence of Surinamese leprosy politics only diminished with a shift in economic and geopolitical significance to the East in the later Nineteenth century. This paper shows how understanding leprosy in the Caribbean in a comparative way is a corrective to an Asia-centered perspective on the history of the disease.

Learning objectives:

Insight into the dynamics of public health policies around an infectious and stigmatizing disease in a multicultural context.

Understanding fears about transmission and distrust of Western medical interventions in a (post-)colonial society.

Creating an understanding of public health structures as being the provisional outcome of interaction between citizens, the profession and the state.

James Downs, *Connecticut College, New London, CT: **The Coefficient in Epidemiology: The International Cholera Epidemics in the Caribbean***

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

As my paper argues the outbreak of cholera throughout the Caribbean provided an important source of proof to substantiate Snow's findings and further buttress the nascent field of epidemiology. The outbreak of cholera among newly freed slaves and other colonized people in the Caribbean provided British doctors with a large sample set to test Snow's theories. Studying epidemics required a large mass of people as well as a broad geographic terrain in order to map the progress of the bacteria. The Caribbean provided both the people and the place. British physicians, mostly deployed by the federal government, reported on the cholera outbreak, recorded copious notes about its behavior, and documented its symptoms among infected populations. The discourse invariably substantiated Snow's findings and in so doing contributed to a more global understanding of epidemiology. Drawing on research conducted at both the British National Archives and the Wellcome Library

of Medicine, my paper thus reveals how the advancement of modern epidemiology can be traced to slavery and colonialism in the Caribbean.

Learning objectives:

To explore the history of epidemiology.

To consider various locations outside of the major metropolises (London and New York) that helped to shape the emergence of epidemiology.

To investigate how imperialism and slavery shaped ideas about medicine and science.

Kelly Urban, *University of Pittsburgh, Pittsburgh, PA: "A Very Nice Square Peg...in a Very Round Hole": The Rockefeller Foundation and the Push for National Health Reform in Cuba, 1935-1942*

In 1935, the Cuban government invited the Rockefeller Foundation's International Health Division (IHD) to begin cooperative projects on the island. While the IHD saw the partnership as "sentimental," a delayed final chapter in which Americans could finish the renowned sanitation work of the US occupation government (1898-1902), Cubans hoped to use the resources and reputation of the IHD to strengthen public health institutions, which had been shaken to their foundations by recent economic and political turmoil. The IHD established a local health unit outside of Havana, with the hope that this model would take root and spread, transforming the antiquated public health system from the ground up. The health unit was a resounding success -- locally, nationally, and internationally. However, despite concerted efforts by the IHD and their Cuban counterparts, a second unit was never launched. The IHD pulled out of Cuba in 1942, its representatives defeated and pessimistic toward any chance of permanent public health reform in the future.

This paper contributes to recent scholarship on the IHD in Latin America, which has explored the interactions between local conditions and IHD projects, complicating notions of the IHD's power in institution building and spreading models of public health. I argue that a variety of conflicting interests and (mis)understandings contributed to the inability of the IHD to achieve its objectives in Cuba. While the IHD argued that Cubans lacked comprehension of modern public health work, Cubans emphasized more complex factors, such as structural and political barriers to the formation of a public health training school and secure employment opportunities. Furthermore, although the IHD was well regarded throughout Cuba and did not experience serious conflicts during their tenure, Cuban physicians and citizens failed in their attempts to leverage the political capital of the IHD to lobby the government to legislate change; the symbolic and financial resources of the IHD were not enough to uproot patronage in Cuba's public health sector. In sum, this paper speaks to the interaction between local, national, and international dynamics, which not only shaped Cuba's public health landscape, but also the priorities and strategy of a transnational organization.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history.

Identify successes and failures in the history of medical professionalism.

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

F3: Practicing Humanitarian Medicine

Temple Room

Moderator: Hubert Steinke, Institute for the History of Medicine, University of Bern,

Walter Bruchhausen, *RWTH Aachen University, Aachen, Germany*: ***Medical Practice as Charity and Modernity: German Catholic Medical Missionaries during Decolonization***

Although medical missionaries were regarded as rather old-fashioned 'development aid' later they saw themselves and functioned in their medical practice as agents of modernity and Christian charity – at least the German ones between 1950 and 1970 investigated here. When West Germany entered 'development aid' after 1950, the main German medical agents in former or actual colonial territories were medical missionaries. Thus, they received governmental support for their strongly curative work. New Christian aid organizations collected considerable funds and decided the hot debates on 'direct vs. structural aid', i.e. 'charity vs. development', in favor of development. Therefore, medical missionaries were expected to work in line with development policies of integrated projects. On the other hand, increasingly in the 1960, they were suspected of serving an outdated creation of religious communities instead of promoting modern society.

Their self-image and practice was quite different, as exemplified by German Catholic hospitals in Africa and India around decolonization. Spurred by the role model of the earlier generation of mission doctors such as Albert Schweitzer, more German health workers than ever before joined mission service. During this high tide of German mission medicine, their associations and institutes resisted the attempt to absorb them into the new development policies. Instead, they wanted to concentrate on high quality medical practice, often in competition with government hospitals. Therefore they had conflicts with missionary emphasis on counting baptisms as well as with development agencies preferring basic health services for socio-economic improvement.

Specialization by new methods and departments as well as conflicts on 'indigenization' indicate that granting presumed 'modern' standards of treatment was preferred to development which demanded responsibility for native staff. Becoming a government hospital meant for many missionaries that the hospital ceased to fulfill the Christian command of charity. Thus for mission medicine during decolonization, modernity and charity were intimately linked, a link to be dissolved soon by the Primary Health Care concept that contained visions of multiple modernities and of social justice by community participation and health equity instead of charitable health work by expatriate doctors.

Learning objectives:

Understanding the history of the health care system in former colonial territories
Being aware of different motives in delivering medical care
Getting a nuanced understanding of what 'modern' in medicine means

Hines Mabika, Tizian Zumthurn, *University of Bern, Bern, Switzerland: Medical Practice and Networks at the Albert Schweitzer Hospital of Lambarene, 1913-1965*

This paper is a first attempt to describe the daily practice of medicine at the Albert Schweitzer Hospital of Lambarene in Gabon during the lifetime of his founder 1913 to 1965. It is based on an ongoing research project at the University of Bern in Switzerland. Indeed, Schweitzer's hospital first symbolized western philanthropy in medicine. It was then turned to a site of great concern in the wake of colonial criticism in the 1950s and 1960s. It was even portrayed as a hospital where medicine was poorly performed in non-hygienic conditions. These assumptions hardly relied on archival material. Thanks to the recent availability of Schweitzer's archives, including thousands of letters with physicians and pharmaceutical companies around the world, thousands of patient records, operation protocols, etc., this presentation will wave together two significant issues in colonial and postcolonial medicine: network and medical practice.

As an independent hospital without any institutional support, Schweitzer's hospital was compelled to network in order to lure physicians, nurses, and other staffs and means, including drug-supply and funds. How did Schweitzer communicate about

his hospital and about the medical work fulfilled there? The first part of this presentation gives some answers to this question by analyzing some of the letters exchanged between Schweitzer and some of his correspondents. It also looks at the hospital periodical – *Lambarene News* – dedicated to his supporters in Europe, and reveals Schweitzer's rhetoric as well as his humanitarian ideal.

Schweitzer and most of his agents at Lambarene were trained at western faculties and practiced western medicine. How were the patients daily received, cared, and lodged? In other words, how was medicine practiced at the Albert Schweitzer Hospital of Lambarene? The second part of the presentation provides some analytical insights to this question based on sources mentioned above and on interviews conducted with medical agents working for Schweitzer in the 1950s and 1960s.

Learning objectives:

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

Critically appraise clinical management from an historical perspective.

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

Lauren Klaffke, *University of Minnesota, Minneapolis, MN: Private Networks in Medical Philanthropy: The Political Contexts of Projects HOPE and Orbis*

During the Cold War, private networks of medical professionals, philanthropic foundations, and corporations established medical aid projects that served both humanitarian and ideological missions. This paper examines the impact of political context on private networks in medical philanthropy through an exploration of Project HOPE (Health Opportunities for People Everywhere) and Project Orbis, large, mobile medical systems initiated by practicing physicians to provide healthcare and medical education to developing nations in Latin America, Asia, and Africa. In 1958, Dr. William Walsh, a clinical professor of internal medicine at Georgetown University converted a naval ship into a floating hospital with funds from the pharmaceutical industry. Similarly, in 1982, Dr. David Paton, an ophthalmologist at the Baylor College of Medicine in Houston, established Project Orbis. Paton drew support from United Airlines, individual donors, foundations, and professional ophthalmological organizations to convert a DC-8 commercial airplane into a traveling eye hospital.

Though Projects HOPE and Orbis provided access to healthcare and educational opportunities to developing nations, some politicians and medical professionals questioned the practicality of these endeavors, citing, for example, the inability to establish long-term infrastructure. These mobile medical systems, however, had strong symbolic and publicity value, demonstrating American generosity and innovation in highly visible ways. With these projects, provisions for healthcare and education arrived with great fanfare, garnering headlines and further investment in project continuation (cash or gifts-in-kind). Drawing on research in memoirs, media coverage, and medical literature related to Projects HOPE and Orbis, this paper argues that in addition to their medical missions, mobile medical systems represent an enduring response by private networks to ideological and political conflict—each reflects the political culture and dominant ideologies of their respective periods. Project HOPE, established at the height of the Cold War, represented the benefits of the American capitalist system. Project Orbis, on the other hand, developed post-détente and with the emergence of neoliberalism in the United States, typified by the growing emphasis of the Reagan administration on private sector initiatives. Both projects, examined in their respective political contexts, use medical philanthropy to underscore the benefits of the capitalist system.

Learning objectives:

- Understand historical structures of medical philanthropy.
 - Recognize the impact of private networks on medical philanthropy.
 - Consider the many contexts that impact healthcare and health policy.
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F4: Consuming Medicine: Medicine and Consumption in Historical Perspective

Wooster Room

Moderator: Courtney Thompson, Yale University

This panel will argue that studying the connections between medicine and consumer culture can offer new perspectives on familiar historical narratives. When attempting to explore the characteristic shape of medicine in the 20th century, historians and sociologists of medicine have tended to foreground the rise of biomedical science, the centrality of the hospital, the development of the pharmaceutical industry and the laboratory, or the formation of the profession. But the influence of an emerging consumer culture on the medical encounter, on the sale of pharmaceuticals, or on patients' attitudes and choices with regard to the field of medicine remains poorly understood. Drawing on the rich historical scholarship of consumption, consumer culture and advertising, the papers in this session will explore points of contact between medicine and consumer culture in different locations during the first half of the twentieth century. Through detailed analyses of three case studies, the panelists use these points of contact to examine how the rise of consumer culture shaped the medical encounter, brought into question the identities of patients, physicians, and consumers, and prompted a re-evaluation of the boundaries of the fields of medicine and consumption. Nancy Tomes will discuss the battles between drug stores and other retail outlets over which common medicines were safe enough to be sold outside the former's walls, and the kinds of assumptions about consumer intelligence and agency they implied, in the context of the mid-20th-century U.S. Soyoung Suh will consider how Koreans responded to the claim of the "new universal" in medicine and in the economy, analyzing advertisements of two of the most successful drug manufacturers in colonial Korea (1910-1945). Given the Japanese scientific and commercial domination, Korean drug manufacturers disclosed conflicting ideas about the ideal type of medicine and played a significant role in the construction of consumer culture. Lisa Haushofer will analyze the case of Benger's Food, a commercially-produced medicinal food which capitalized on new understandings of the physiology of digestion in late Nineteenth and early twentieth century Britain, arguing that studies of consumption and medicine require a critical reevaluation of familiar categories such as "producer", "medicine", "advertiser" and "consumer." Together, the papers suggest that the relationship between consumption and medicine was at all times dynamic and subject to negotiation. By considering the forces of consumption, historians are encouraged to acknowledge crucial developments in medical history which also add to our understanding of the character of contemporary healthcare.

Lisa Haushofer, Harvard University, Cambridge, MA, USA: "Dear Mr Benger"— Medicinal Foods, Medicine and Consumption

This paper argues that insight from the scholarship of consumption provides a fresh perspective on familiar narratives within the history of medicine, specifically the transformation of the medical encounter and the commercialization of medical knowledge. Historians have recently shown increasing interest in the relationship between medicine and the forces of consumption. They have suggested, for example, how viewing patients as consumers can illuminate medicine's profound transformations within the broader realm of consumer culture. Yet the impact of

commercial products on these transformations remains poorly understood. In this paper, I examine the creation, marketing and reception of "Benger's Food," a commercially-produced medicinal food which capitalized on new understandings of the physiology of digestion in late Nineteenth and early twentieth century Britain. Produced in collaboration between a physician and a pharmaceutical chemist, Benger's food contained digestive enzymes and formed part of a group of so-called artificially digested foods. Using letters written to the Benger's food company alongside company advertisements and medical and pharmaceutical publications, I argue that medicinal foods were situated in a complex network of actors who produced, interpreted and conceptualized these products in ways that profoundly disrupted traditional binaries – pharmacists acted as scientists and commercial producers, medical professionals were at once consumers and prescribers, and patients simultaneously functioned as users and advertisers. At the same time, these new alliances were modeled on familiar relationships, such as the patient-physician encounter, and the producer-consumer relationship. The paper suggests that studies of consumption and medicine critically re-examine traditional categories of analysis, such as "producer", "medicine", "advertiser" and "consumer".

Learning objectives:

Understand the dynamic history of the relationship between consumerism and medicine

Critically appraise current forms of health care organization through a historical perspective

Appreciate the potential of new avenues of historical medical research

Nancy Tomes, *Stony Brook University, Stony Brook, NY: Aspirin Wars*

This paper will examine the mid-20th c. legal battles in the U.S. between drug stores and other retail outlets (primarily grocery stores and variety stores) over the former's efforts to retain an exclusive rights to sell aspirin and other commonly used medicines. Using a variety of sources (trade journals, newspaper stories, reports of state pharmacy boards, and legal cases), I will look at how those battles unfolded in the 1940s and 1950s, after passage of the 1938 Food Drug and Cosmetics Act, which provided for better labeling of over-the-counter drugs. These arguments over what medicine should be sold where reflect important shifts in this era: a changing calculus of what drugs were safe enough to sell without a pharmacist's supervision, the growing trend toward self-service in general; and a greater solicitude for consumer convenience. Through a close look at the "aspirin wars" of the 1930s through early 1950s, this presentation will highlight the impact of broader currents of consumerism on the practice of self-medication.

Learning objectives:

Deepen understanding of the economic context of drug use and its implications for medical practice

Deepen understanding of the impact of consumerism on medical practice

Deepen understanding of self-medication and its implications for medical practice

Soyoung Suh, Dartmouth College, Hanover, NH: *Lifesaving Water, Nation-Saving Medicine: Advertising Medicinal Products in Colonial Korea (1910-1945)*

This paper analyzes the Korean production of medical advertisement under Japanese colonialism (1910-1945). Paralleling the flow of Western and Japanese medical texts, medical commodities began to be widely distributed in Korea during the extensive commercial opportunities of the 1920s and 1930s. Hundreds of medical products, whether originating from millennium-lasting traditional prescriptions or modified from Western/Japanese knock-offs, were circulated for their assumed medical efficacy in both visual and textual forms. With new labels, a modern outlook, and charming catch-phrases in their ads, a few apothecaries and a pharmaceutical company recorded unprecedented sales. By comparing two outstanding cases – the success of Donghwa apothecary’s Hwalmyungsu (the Lifesaving Water) and the Yuhan firm’s unprecedented achievement as a pharmaceutical company – this paper scrutinizes (dis)similar desires and compromises among Korean medical merchants in maximizing their profits under the advancement of biomedicine and capitalism. Given the Japanese colonizers’ domination of the market, the polity, and medicine, how did Koreans respond to the claim of the new universal in medicine and commerce? As latecomers to the Japanese-led Asian economic system, Korean drug manufacturers had a yearning to catch up with Japan’s advanced advertisement technique and superior marketing strategies. Yet, at the same time, successful Korean businessmen conveyed their own advertisement skills with a reliance on the indigenous attributes of medicine and novel connections with American pharmaceutical companies. The evocation of being modern by consuming the latest health supplements was accompanied by the enduring reliance on traditional medicine for its vocabularies of wellness and clinical reasoning. While the commercial representation of medicine disregarded regional and political boundaries, nationalist sentiments to overcome the Japanese initiative persisted in the production and advertisement of medicine. Early twentieth century advertisements are helpful in understanding not only the construction of consumer identity among Koreans but also the changing mode of combining health and profits at the juncture of local and global flows.

Learning objectives:

- Understand the dynamic history of the relationship between consumer culture and medicine
 - Understanding the relationship between advertisement and medicine in a global context
 - Appreciate the potential of new avenues of historical medical research
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F5: Genetic Theories and Human Populations

George Room

Moderator: William C. Summers, Yale University

Jason Little, Mayo Clinic, Rochester, MN; John Burnham, *Ohio State Univ. Columbus, OH: **Gonadal Radiation Exposure Cards: a Concrete Symbol of the Intrusion of Science into Clinical Medicine in the 1950s***

In 1957, William Myers, a pioneer of radiation oncology, strongly advocated that every citizen carry a "Gonadal Radiation Exposure Card" to register each incident when a person was exposed to radiation in a medical procedure. Nothing came of the idea at the time, but half a century later, most people would readily agree that at least individuals who work in settings that place them at special risk for exposure to radiation should have that exposure monitored regularly. But a card that tallies a person's lifetime exposure to medical radiation, to be carried by every fertile member of society just as one would carry a driver's license? Yet that is exactly what Myers proposed. In this paper, I will suggest how Myers came to his idea of a gonadal medical radiation exposure card, and why the idea did not take hold.

In examining the history of radiation protection, three narratives, chronologically distinct yet overlapping, emerge from a review of primary sources as well as the existing histories. The first encompasses an early period defined by the paradigm of radiation as poison, with safety standards established for dose-dependent, deterministic effects. The second period entails preoccupation with the hereditary effects of radiation, coming on the heels of the nuclear fallout controversy as well as Hermann J. Muller's Nobel Prize-winning research on radiation-induced hereditary mutations in fruit flies. The third narrative begins with the addition of cancer as the most important stochastic, genetic sequela of radiation to the early deterministic model.

Archival records of Myers' speeches and correspondence disclose how he effectively bridged the aims of physicians and scientists at a critical turning point in this general narrative of concern about radiation safety. These narratives and Myers' reactions provide a framework within which to understand how science affected ideas about radiation in medicine in the 1950s.

Learning objectives:

Appreciate the complex interplay of science and clinical medicine in the history of radiation safety during the twentieth century.

Recognize the difficulty of obtaining empirical evidence regarding human radiation safety, a field fraught with difficulties imposed by ethical considerations.

Understand the dynamic nature of medical ideas and practices and the need for continual reassessment of their scientific validity.

Roberta Bivins, *Centre for the History of Medicine, University of Warwick, Coventry, UK: From 'Ethnic' to 'Racial'? Thalassaemia in Britain, 1974-2014*

The genetic haemoglobinopathy sickle cell anemia -- famously the first 'molecular disease' -- has attracted considerable historical interest in the last two decades. More recently, historians have begun to examine thalassaemia, also a genetic disorder of the haemoglobin. However, the two conditions have provoked different approaches; while sickle cell has been analyzed primarily in relation to issues of 'race', racial politics and the impacts of molecular genetics, scholars have examined thalassaemia through the optics of international health, reproductivity and eugenics (both old and 'new'). Responses to thalassaemia in the UK offer an opportunity to scrutinize this condition through each of these lenses.

This is in part because in the British context, the identity of the disease changed significantly between the 1970s and the 2000s. Affecting two different immigrant/ethnic communities, the condition raised questions about fertility, 'hygienic citizenship', and cultural integration, but also about the return (or persistence) of biological race. Initially, thalassaemia served as the index disease of a model 'ethnic' community, the Cypriots, who migrated to their former colonial power in large numbers during and after the island's invasion in 1974. By the late 1980s and 1990s, however, observers increasingly linked the condition to Britain's large South Asian communities -- and in particular, consanguineous Pakistani families. The 'discovery' of a genetically inherited condition in this community, already strongly racialized (and closely identified with 'imported' illness) in the 1960s, prompted different reactions. In this paper, I will ask what thalassaemia in these two groups can reveal about the intersection of genetics and community identity in the modern state.

Learning objectives:

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

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

Recognize the dynamic interrelationship between medicine and society through history

3. Arleen Tuchman, *Vanderbilt University, Nashville, TN: American Indians, Diabetes, and Thrifty Genes*

In 1962, James Neel published "Diabetes mellitus: A 'thrifty' gene rendered detrimental by 'progress'?". The geneticist was trying to figure out how diabetes could have become so widely distributed around the world. Why hadn't natural selection reduced its presence in the human gene pool? Neel ended up speculating that a "'thrifty' genotype" might have conferred a selective advantage to early humans by increasing the efficiency with which they stored fat during cycles of feast and famine. When food became plentiful, this advantage would have become a liability.

Even a cursory search reveals the continued popularity of Neel's "thrifty genotype hypothesis" (TGH). Indeed, an NIH fact sheet on "Obesity and Diabetes" claims that scientists "use the 'thrifty gene' theory . . . to help explain why many Pima Indians are overweight." At the same time, Neel's theory has been strongly criticized; one anthropologist recently labeled it "a particularly dangerous view of Indigenous genetics." I share this anthropologist's concerns. Yet both advocates and critics are mistaken about two things: Neel never mentioned American Indians, or any specific populations, in his article; and he acknowledged that his ideas needed to be tested.

This paper is part of a longer analysis of how Neel's hypothesis about "our species" became a scientific theory about "Indigenous genetics." It examines a series of scientific studies in the decades following Neel's publication and looks at the authors' engagement with TGH. Its goals are two-fold. It shows how researchers consistently misinterpreted their peers' conclusions, presenting as fact claims that had been presented as tentative. It also teases out some of the assumptions driving these misinterpretations. My tentative argument is that two assumptions were at play: that genes were the primary cause of diabetes, and that American Indian populations had encountered "civilization" relatively late and thus provided the best opportunity for learning about the early stages of human evolution when, presumably, the genetic basis for diabetes first became established. Together, these two assumptions led researchers to either ignore or explain away anomalies that cast doubt on the legitimacy of TGH. Scientific evidence for this hypothesis remains elusive to this day.

Learning objectives:

To develop the capacity for thinking critically about how medical theories come to be seen as "true";

To recognize how questionable assumptions about the characteristics of populations can influence medical understandings of disease etiology;

To promote appreciation for the ambiguity of theories and the nature of evidence.

G1: Dissenting Voices in Later Twentieth-Century Healthcare

Grand Ballroom C

Moderator: Leslie Reagan, University of Illinois

Elizabeth Reis, *University of Oregon, Eugene, OR: Tradition and the Oral Suction Controversy*

The previously obscure ultra-Orthodox Jewish rite of *metzitzah b'peh* (oral suction) has burst into the news lately and raised questions about circumcision, consent, First Amendment rights, tradition, public health, and the representation of Jews. It refers to a custom performed after a circumcision in which a *mohel* (ritual circumciser) orally sucks the blood away from the baby boy's penis. Most Jews, even observant Modern Orthodox Jews, have discarded the practice. But a small minority defends it, insisting that it is medically safe.

Today the very thought of *metzitzah b'peh* conjures fears about the transmission of communicable disease (since 2000, fourteen babies in New York acquired herpes from the procedure and two died), and indeed the practice has been contested for quite some time in this country and in Europe too. In 1873 four babies in New York City contracted what appeared to be syphilis, and three of them died, after the same *mohel* circumcised them all and performed *metzitzah b'peh*. Then, as now, the Board of Health got involved, though the question of whether the babies died from syphilis at all, much less syphilis caught from the *mohel*, could not be determined definitively. But the mere possibility of such a scenario associated Jewish ritual with uncleanness, irresponsibility, and ignorance.

In this paper, I will place *metzitzah b'peh's* health concerns in historical context in the United States. Elsewhere I have argued that the medicalization of circumcision has not always been good for the Jews, as many less observant Jews turned to obstetricians or pediatricians to circumcise their baby boys, often abandoning the religious element altogether, much to the chagrin of religious leaders. Using primary sources from the New York Jewish Historical Society, I argue here that, ironically, in order to defend *metzitzah b'peh's* safety, ultra-Orthodox religious leaders accept a certain medicalization of circumcision. Despite their insistent portrayal of the procedure as a religious rite, they also characterize it as a surgery, subject to the strictest standards of sterility, hoping to mollify parents concerned about safety and outsiders who might intervene legally.

Learning objectives:

Recognize the evolving dynamic between medicine and religion historically and even today.

Understand a contemporary controversy from a historical perspective.

Understand that even some procedures considered "routine" have a contested past.

Jacalyn Duffin, Joseph Pater, *Queen's University, Kingston, Ontario, Canada: Mrs.*

Robinson's Revenge: The Medicare Protest Song

In 1962, Pete Seeger recorded "The Ballad of Doctor Dearjohn" about Canadian medicare and the Saskatchewan doctors' strike of the same year. How had this New Yorker, recently released from jail, learned of medicare in the distant prairie province? And why was the song never released?

This paper traces the ballad's fortunes through the papers of Seattle-born composer Earl Robinson (U Washington) and the archives of American Medical Association. It is situated in the historiography of folk revival and the expatriate adventures of artistic Americans persecuted in the McCarthy era.

Cleverly trading on medical metaphor, the song parodied an Irish tune about Dr. De Jongh's cod liver oil. Earl Robinson and his artist wife, Helen, published it in September 1962 in *Broadside* magazine. Seeger often recorded *Broadside* songs, although few made it into his albums. Robinson had enjoyed success for his Ballad of "Joe Hill" (1936, later sung by Joan Baez), "Ballad for Americans" (1939, Paul Robeson), "The House I Live In" (1945, Frank Sinatra). He'd performed for Eleanor Roosevelt at the White House and in her New York apartment, but his finances were precarious. His marriage endured many strains, not least being Earl's daytime

philandering while Helen worked. Chronically ill with myelodysplastic disease, she suffered miscarriages and hospitalizations.

By 1962, Robinson was teaching high school in New York, but he kept in touch with Seattle's political left. His circle included theatre founders, Florence and Burton James, who, like him, had been before the House Un-American Activities Committee. Their "crimes" entailed labor sympathies, multi-racial troupes and preserving native culture. In 1952, the James' migrated to Saskatchewan where the socialist government invited them to create a seasonal theatre of arts. En route to Seattle in summer 1962, the Robinsons stopped to visit. It was Helen who composed the parody.

No evidence suggests suppression of the song; rather its Saskatchewan subject probably held little mass appeal. Nevertheless, a year later, Phil Ochs released his "AMA Song," putting an American spin on the same sentiments. This paper offers insight into American views of early Canadian medicare through the novel lens of music.

Learning objectives:

To recognize the political and economic forces that led to medicare in Canada and the 1962 doctor strike.

To explore American reactions to the early medicare adventure in Canada.

To introduce music as source for health-care history.

Sarah Rodriguez, Northwestern University, Chicago: A "Non-Standard Practice of Gynecology:" James Burt's "Love Surgery" and Questions of Routine Medical Innovation

In the mid-1950s, Dayton, Ohio obstetrician gynecologist James Burt began modifying episiotomy repair, and, though not telling his patients he had performed anything other than a standard episiotomy repair, learned from them that their orgasms were better following birth. By the mid-1970s, Burt began offering 'love surgery' as an elective to women, while continuing to perform it on his obstetric patients. Burt practiced medicine until early 1989, a few months after a group of women upon whom he had performed love surgery accused him on national television of performing an experimental surgery on them without their informed consent. After this negative exposure, Burt was pressured to give up his medical license.

The Burt story received a good deal of local and national media attention following the television show, and the stories typically followed the same theme: that Burt performed an experimental operation on trusting women without their consent and that other doctors in the community knew about it but did nothing. This narrative frames Burt as a freakish physician practicing outside the norms of medical practice, one allowed to do so by his peers. But this narrative fails to include questions about routine medical innovation the Burt story brings forth. Taking a cue from a note Robert Aronowitz made in his recent article in the "Bulletin of the History of Medicine" regarding historians having given less attention to "the social and structural realities in which routine medical innovation, training, and practice have occurred," compared to "infamous unethical medical experiments" carried out

Abstracts: G1/G2

on “vulnerable populations,” in this paper I will unpack the dominant narrative of Burt and consider his development of love surgery within normative surgical development, routine medical innovation, and within the historical context of the clinical practice of informed consent for routine procedures since the 1950s.

Learning objectives:

Acquire a historically nuanced understanding of informed consent regarding routine medical procedures;
Critically appraise the issues regarding surgical development;
Critically appraise the issues regarding routine medical innovation

G2: War, Medicine, and Humanitarianism in Enlightenment Europe

Ballroom A

Moderator: Mary E. Fissell, Johns Hopkins University

Eighteenth-century European wars are often characterized as enlightened or cabinet wars, in which enemy officers negotiated over dinner, in the midst of restrained and limited battles. Indeed, modern conventions of wars developed in this period, with medical officers like John Pringle negotiating agreements over neutral and noncombat personnel. These ethical conventions reflected cosmopolitan Enlightenment principles. Yet, the Age of Reason was also characterized by near continuous warfare, impressive in its geographical scope and brutal in its effects. Long campaigns devastated military and civilian resources, while colonial warfare carried soldiers overseas, where they were confronted by unfamiliar tactics and ravaged by foreign diseases. This panel examines the role of medicine in shaping eighteenth-century European warfare, using the methods of cultural and social history of medicine to demonstrate both the brutality and restraint of war. Nostalgia, associated with the trauma and dislocation of military service, highlights the growing tensions between civilian and military spheres. Military medical men often acted as mediators between these two spheres to establish and enforce conventions of war, such as care for prisoners of war. These instances reveal medicine not as an external factor in eighteenth-century war-making, but as a field that shared the patriotic and strategic goals of the army. As this panel demonstrates through an analysis of military medicine, warfare should not be seen as an interruption of Enlightenment progress – an obstacle that disrupted the exchange of medical knowledge – but as a theatre of intra-European knowledge transfer and the birth of modern sensibilities such as humanitarianism.

Learning Objectives:

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

Christy Pichichero, *George Mason University, Fairfax, VA: War and Medical Enlightenment: Humanity, Military Medicine, and the Eighteenth-Century Origins of the Red Cross and Geneva Convention*

In *A Memory of Solferino* (1862), Henri Dunant argued passionately for the creation of a permanent relief agency for wartime humanitarian aid and an international treaty recognizing the neutrality of this agency as it operated in war zones. The first would lead to the establishment of the International Red Cross in Geneva in 1863 and the second became the Geneva Convention of 1864, whose tenets were expanded over the century that followed and still guide the international code of conduct in wartime today. According to Dunant, these humanitarian achievements that won him the first Nobel Peace Prize in 1901 found their most important antecedents in European wars of the eighteenth century. He identified the true forefathers of the Red Cross and Geneva Convention to be medical personnel and military officers of the eighteenth century who forged acts of humanity in war and military medicine that were subsequently codified by their respective states.

Despite Dunant's clear reference to eighteenth-century military medicine and policy, there is a dearth of scholarship on this important genealogy. This paper is based on extensive research into medical primary sources and archival military materials (*Service Historique de la Défense* in Vincennes, France) and investigates the Enlightenment origins of the humanitarian medical movement at the war front. The paper focuses on France as a case study and argues that a specific culture of medical care burgeoned during the 1740s that engendered progress. This culture upheld humanity as its guiding principle and combined philosophical and hygienic medicine, the science and morality of sensibility, and military innovation to improving health care for soldiers in areas of emergency medicine, disease control and treatment, the hospital system, practices of hygiene, and what we now call military psychology. The notion of humanity also encouraged health care professionals to see beyond politics to provide expert care to all wounded warriors regardless of nationality. The paper concludes by considering the dangers of this ideology of humanity as the basis for medical care in war zones. The label of human/humanity operated not only to foster human rights and improved medical care, but inversely to sanction negligence and prejudice against "inhuman" groups.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history

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

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

Thomas Dodman, *Boston College, Chestnut Hill, MA: Nostalgia in 1688: The Making of a Deadly Emotion*

People once died of nostalgia. Technically, they started doing so in 1688, when a nineteen-year-old medical student from the free town of Mulhouse coined the neologism to define a new disease he had heard of while studying in Basel.

Combining insights from seventeenth-century treatises on melancholia and post-

humoral physiology, Johannes Hofer described a severe form of homesickness, a kind of separation anxiety that could prove fatal if left untreated. Although he never quite made it into the annals of medical history, his “nostalgia” stuck and went on to attract much attention across eighteenth-century Europe, especially because of its effects in the ever larger, and ever more regulated armies of the time. By the turn of the century, it was blamed for as many as one in ever twenty deaths during the Napoleonic wars, and physicians scrambled to come to terms with this first codified form of war trauma. What was this condition, and why did it “come into being” as an object of scientific interest then and there (only to quietly disappear later in the 1800s)?

This paper aims to address these and other questions by working backwards, as it were, to the source of the ill: Hofer, medicine, and war in the upper Rhineland in the late Seventeenth Century. First, I will engage in a detailed exegesis of Hofer’s original thesis, based on a new translation of this Latin text—the first in English since Carolyn Anspach’s one published in the *Bulletin of the History of Medicine* in 1934. Second, I will attempt to contextualize this source within intellectual and socio-political contexts marked by change, instability, and the persistent threat of war. I thus seek to show that nostalgia was neither “discovered,” ready-made, nor “invented”, ex-nihilo. Instead, the “making” of this deadly emotion can only be adequately explained in relation to a set of specific historical circumstances that impinged upon the life of a young medical student in Basel in 1688, and that continued to determine the medical practice of so many medical officers throughout the Age of Reason.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history

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

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

Erica Charters, *University of Oxford, Oxford, UK: Enlightened Warfare and Medicine: Franco-British Global War during the Mid Eighteenth Century*

Franco-British wars of the mid eighteenth century pitted the two major European global powers against one another across five continents. Although Britain and France were enemies, military and medical officers of both armies shared the challenging experience of adapting to overseas colonial environments, both culturally and physically. In keeping with eighteenth-century conventions of war, French and British officers exchanged letters, food, prisoners, and medical care.

Enlightened warfare was more sharply defined in colonial contexts, where British and French forces were often at greater risk from the hostile environment than from one another. French and British officers thus acted not only as combatants of rival nations in wartime, but also as members of a cosmopolitan network of scientific knowledge and European civility.

This paper examines how the experience of colonial warfare shaped the nature of eighteenth-century European medicine and, in turn, how eighteenth-century medical men shaped the nature of European warfare, with a particular focus on the development of 'humanitarian' war. As trusted professionals, military medical officers often acted as neutral agents during wartime, securing hospitals as non-combat zones and negotiating the treatment of noncombatants alongside other conventions of war. Indeed, medical officers were often responsible for the care of prisoners of war, further accentuating their role in shaping modern conventions of 'humane' warfare. Yet, while occupying a uniquely nonbelligerent position during conflict, military medicine was by no means a neutral occupation. A detailed examination of French and British military medical personnel at mid century reveals the volatile role of prisoner care in bolstering public sentiment as well as the tangled motivations behind war-time conventions regarding violence and restraint. Indeed, concerns over maintaining European identity and chauvinism in the midst of foreign environments were frequently the rationale behind Franco-British civility and humanitarianism. As this paper demonstrates, eighteenth-century humanitarianism and medical charity were not reactions against the hardships and cruelties war. Instead, they developed in the context of colonial warfare, not as an effort to limit war, but as a patriotic strategy to facilitate more sustainable and more effective war-making.

Learning objectives:

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

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

Recognize the dynamic interrelationship between medicine and society through history

G3: International Narcotics Control

Temple Room

Moderator: David Courtwright, University of North Florida

Koji Ozaki, Ôtemae University, Nishinomiya, Japan: Why was the Opium Smuggled by John Hartley Seized for Ten years? Examining the 1870s Anglo-Japanese Dispute over Drug Control

In 1878, the customs director at Yokohama accused a British trader, John Hartley, of opium smuggling, because Hartley had attempted to smuggle illegal opium into the port twice. However, the consular court, eventually, imposed only a light fine on him and did not permit customs to confiscate the opium in question. The court's judgment was influenced by Harry Parkes, the British Minister to Japan. Parkes was known in Japan as a tough diplomat who had been involved in the outbreak of the Second Opium War in China during the 1850s. Dissatisfied with the judgment, the Japanese government adhered to the confiscation, and sought to appeal to the British Supreme Court. Thus, a dispute over drug regulation was precipitated between the Japanese government and the British delegation. This study discusses

the process of resolving the dispute. One of the crucial questions involved was how would the dispute impact the relationship between the two countries. The present study focuses on the fact that both parties emphasized administrative regulations in resolving the dispute. They no longer preferred the traditional approach, wherein the countries would negotiate a new treaty whenever a problem occurred and then have the consular court deliver a judgment based on the treaty. Instead, they agreed on enacting an administrative regulation and permitting the officers concerned to manage problems at their discretion, but within the regulation. This study discusses the above-mentioned issue with reference to many source materials. I will mainly use documents in the possession of the National Archives in the UK or the Ministry of Foreign Affairs in Japan. In addition, some documents of the Governor-General of Taiwan are useful. I will highlight the fact that the new administrative approach would later be applied to Taiwan, as the Japanese government, when it annexed the island to its territory after the First Sino-Japanese War, adopted the same approach to prohibit opium smuggling. The present study demonstrates that the Japanese government, after resolving its conflict with British imperialism, established its own colonial rule by using the same method developed in its dispute with Britain.

Learning objectives:

Identify the circumstances surrounding the opium trade during the period when Japan was developing as a modern state.

Understand the conditions that enabled a non-European country to establish independent opium jurisprudence despite its conflict with European imperialism. Highlight the roles that Japan played both as a country faced with the advent of European imperialism and as a new empire ruling other Asian regions.

David Herzberg, *University at Buffalo (SUNY), Buffalo, NY: Addicts in Unexpected Places: the Class Politics of Addiction in the 'Classic Era' of Narcotics Control*

Following David Courtwright's influential observation that "what we think of addiction very much depends on who is addicted," historians have very fruitfully explored how Americans' experiences with, and responses to, drugs have been shaped by race (particularly in studies of narcotics and cocaine) and gender (particularly in studies of pharmaceutical sedatives and stimulants). Less explored, however, has been the significance of social class in conceptualizing and responding to addiction. Yet social class has clearly played an important role. In the 20th century, for example, cultural narratives about addiction lingered salaciously on signs of lost economic or class standing, just as they did on sexual depravity and the crossing of racial lines. Indeed, economic consequences have been inscribed so deeply into concepts of addiction that downward social mobility can be thought of as one of the condition's central symptoms, helping experts and popular observers to distinguish between true "addiction" and mere "habits."

My paper explores the class politics of addiction during the "classic era" of narcotics control in the United States (approximately 1920-1960) by examining medical, cultural, and regulatory responses to addiction in two middle-class contexts: narcotic-using physicians, and widespread abuse of barbiturates and amphetamines. In each case, I argue, authorities sought to understand problems of addiction without recourse to the standard drug-war trope of sensationalized downward

Abstracts: G3/G4

social mobility. The interpretations and responses they developed were less punitive, but not necessarily more effective, than dominant strategies designed to address addiction in more marginalized populations.

The paper draws on records from the Wisconsin State Board of Medical Examiners, FDA enforcement records, published medical literature, and popular media.

Learning objectives:

Develop a critical perspective on the history of addiction and its impact on individuals

Deepen our understanding of the relationship between social class and the definitions of mental health and illness

Analyze the interplay between popular and medical concepts of mental health and illness

G4: New Research on Medical Mobilization during and after the Great War

Wooster Room

Moderator: Sandra Beth Lewenson, Pace University

Anat Mooreville, UCLA, Los Angeles, CA: Trachoma in Palestine: The Very Idea

The infectious eye disease trachoma was second only to malaria in importance to Jewish physicians in Palestine and defined its medical landscape for Zionist settlers and visitors at the turn of the twentieth century. I argue that because of trachoma's idiosyncratic biology and regional prevalence, it became a resilient site for Jewish physicians to create and contest cultural demarcations between modern binaries, including East and West, Jewish and Arab, and modern and primitive. I explore the scientific uncertainties surrounding trachoma at the turn of the century, and how it became doubly marked: first, as a disease of "poverty, ignorance and indolence," owing to its particular etiology; and second, as the "blinding scourge of the Orient" due to high chronic incidence rates throughout the Arab East and North Africa. Trachoma was reinforced as a disease of the East through medical travel narratives and the historiography of ophthalmology, which was spearheaded by German Jewish medical historians. As trachoma crystallized as a disease of primitive Arab culture, it became exigent as a health priority to Zionist physicians who sought to distinguish Jews from Arabs, and place the former firmly within the enlightened camp. The idea of trachoma as a mark of Oriental backwardness was not separate from the contest of trachoma as a scientific and medical enigma. Ophthalmologists in Palestine and throughout the world mulled over nearly every facet of trachoma: its causes and transmission, diagnostic markers, and even the name itself. Jewish physicians built a professional scientific infrastructure around trachoma that included a dedicated department in the Nathan Strauss Jewish Health Station, a national survey, and a medical conference, all which launched in 1913 and 1914. Successful ocular research projects would bring international recognition, strengthening the value of Zionist science and justifying national aspirations. Through the use of evidence from published medical journals, conference proceedings, memoirs, and the Hadassah Medical Organization

archives, I explicate how physicians, scientists, travelers, patients and politicians formulated eye health as integral to the cultural modernization of Palestine, as well as to its national scientific development.

Learning objectives:

To understand how the constructed history of a disease has an impact on its societal importance.

To recognize how ophthalmology was an integral part of primary care in the Middle East in the twentieth century.

To deepen understanding of how various modern historical processes, such as colonialism and nationalism, are heavily based on medicine as a scientific discipline.

Heather Perry, *University of North Carolina Charlotte, Charlotte, NC: **Hungry for War: Nutrition, Health and the Mobilized Kitchen in WWI Germany***

"German Women! England has also declared war on you. She is trying to starve out you and yours by blockading imported foodstuffs. Therefore, to arms! The life and death of the Fatherland now hang no less on you, your loyal will, and your crafts and skills than they hang on victory out there in the battlefield."

With these rousing words, the Wiesbaden Municipal Commission for National Nutrition set out to mobilize German women – mothers, daughters, and wives – for war. Unlike their compatriots, however, they were not being drafted into military service nor even enlisted into the munitions factories which have come to symbolize for many the main war-time contributions of women. Rather, these women were being mobilized for duty within their own private homes. In 1915 the Great War entered the kitchen and as the nation's men settled into trench warfare, German women began their own war of attrition – against privation and hunger in Europe's first "total war".

This paper examines how German authorities sought to manage the health and behavior of civilians during World War I. Given the severity of the Allied blockade, food—its procurement, management, preparation, storage, and distribution—became an overwhelming concern not just among civilians, but also within the upper echelons of the German military. Not only did they fear how food shortages on the homefront might impact support for war, but they also worried about the material consequences of poor nutrition on the nation's citizens. Through an analysis of war-time cookbooks, nutritional advice manuals and speeches, scientific studies, and information from the War Foods Office, this research reveals how nutrition experts attempted to mobilize German women on the home front as "kitchen soldiers" whose daily choices could have significant impact on the health and welfare of the nation. In doing so, this paper exposes how the imperial government used health and nutritional science in their efforts to control that most private sphere of the nation—the home, the family, the kitchen, and the body.

Abstracts: G4

Learning objectives:

Illuminate how food security during war (or other conflicts) impacts the health of civilians

Show how the wartime activities of health scientists expanded beyond weapons development or soldier wound care

Explore how governments harness "neutral health objectives" for their own ends

*Virginia Metaxas, Southern Connecticut State University, New Haven, CT: **Transnational Women's Health Activism: Ruth Parmelee, M.D., the American Women's Hospitals, and Modern Nursing in Turkey and Greece, 1920-1935***

An examination of the service of American women nurses, physicians, and missionaries who participated in international health and humanitarian movements in the Near East in the first half of the twentieth century is a big story. The women connected to the American Women's Hospitals worked cooperatively with other organizations working in the field, including local governments, the Red Cross, the American Board of Commissioners of Foreign Missions, and the humanitarian relief organization Near East Relief. This was a watershed period that traversed the time when American medical women internationalized their professional work and transformed it from wartime medical aid to assisting countries such as Greece in, as Dr. Parmelee said, "not only meet[ing] the present emergency, but also build[ing] for the future." By the early 1930s, after more than a decade of providing aid to refugees and training 'native' nurses, Parmelee and her colleague Emilie Willms, R.N., raised the level of nursing education in Greece to meet international standards. Their nurses were the backbone of the growing public health movement in Greece, helping authorities with campaigns against diseases like malaria and tuberculosis. Recognized by nursing associations around the world, and with support from the Greek Government and private donors, modern nursing was permanently established in Greece.

According to Parmelee, "[n]ursing in Greece [wa]s a movement, and a movement cannot be stopped." If Parmelee said that nursing in many of the nations of the world was a movement that could not be stopped, she also would have been right. As Julia Irwin has argued, when World War I ended, many American nurses and physicians who had served overseas did not return home. Instead, they continued to provide direct nursing and medical services, and by training other nurses, they aimed at disseminating American knowledge of disease prevention and public health internationally. Even in the short time between 1919 and 1922, American Red Cross nurses initiated or supported nursing education in countries ranging from Czechoslovakia to the Phillipines. Other networks of American nurses and women physicians continued well into the 1930s in Europe, Asia, and Latin America. In this paper, I will discuss Ruth Parmelee's contribution to the history of nurses' training in Turkey and Greece in the years between the First and Second World Wars.

Learning objectives:

To help expand awareness of the early twentieth century transnational health work conducted by American women;

To understand more fully the history of nursing in an international context;

Abstracts: G4/G5

To understand the relationship between war medicine and public health;
To demonstrate the transition from missionary to secular medical projects.

G5: Contests over Professional and Colonial Authority in the 18th and 19th Centuries

George Room

Moderator: Christopher Hamlin, University of Notre Dame

Olivia Weisser, *University of Massachusetts Boston, Boston, MA: War of Venus: The Venereal Trade in 18th-century London*

Using 40 texts on venereal disease, this paper analyzes the vibrant trade in venereal cures in early eighteenth-century London. Healers published the details of their cases to advertise their cures and publicize their practices. And they also devoted significant space to denouncing one another. Resulting accounts reveal contentious debates about the efficacy of particular remedies, concerns about publicizing sexually explicit cases, and the details of healers' backgrounds and capabilities. My paper analyzes the key features of this competition, including depictions of rival practitioners as greedy, unlearned, and foreign. I argue that it was not just a competitive market that shaped these men's accusations, self-presentations, and practices in the sickroom, but the unique nature of venereal disease itself. The disease was incredibly stigmatizing and patients tended to deny a diagnosis and any behavior that might lead to one. As a result, the concerns and narratives of patients could hinder the proper diagnosis and treatment of venereal disorders. Practitioners demonstrated their expertise, as well as the relative incompetence of their competitors, by their ability to navigate such constraints. Healers deciphered the "true" nature of patients' ailments and cajoled sufferers into disclosing intimate, at times damning information. The moral dimensions of the disease, then, played a key role not only in determining patient demands for secrecy, as some historians have argued, but also in shaping practitioners' self-presentations as shrewd interpreters of patients' bodies and moral status. The fiercely competitive trade in venereal cures illuminates the details of early modern medical practice and professional identity formation, uncovering how an outspoken group of healers constructed their medical authority in unique ways.

Learning objectives:

Develop the capacity for critical thinking about the history of medical rivalry and professional identity formation

Deepen an understanding of the history of venereal disease, sexuality, and early modern medical practice.

Foster a historically informed sensitivity to the ways that a particular disease can shape practitioners' self-presentations and clinical practices.

Trais Pearson, *Wheaton College, Norton, MA: Forensic Medicine in Nineteenth-Century Siam (Thailand): Unnatural Death & State Sovereignty*

The central historical claim of this paper is that the forensic investigation of unnatural death was an important but unlikely arena of political contestation in

late-Nineteenth-century Siam (Thailand). Although Siam was never formally colonized during the era of European high imperialism, it was nevertheless subject to significant constraints on its sovereignty. A series of unequal trade treaties, for example, established extraterritorial legal privileges for foreign residents, who were exempted from Siamese legal jurisdiction. In keeping with these treaties, foreign imperial powers established consular courts to deal with civil and criminal charges against their subjects residing in Siam. When foreign residents were charged with homicide in the death of Siamese subjects, the Siamese state was forced to turn to these consular courts for redress. Both consular court officials and (foreign) juries alike, however, regarded deficiencies in Siamese forensic investigations as sufficient grounds for acquittal or for dismissing the allegations altogether before trial. Events such as this made forensic medicine a topic of public debate in the Bangkok press, and Siamese state officials like Prince Naret Worarit (1855-1925), the Minister of Local Government, took notice. Using evidence from the National Archives of Thailand, this paper charts the growing interest of Siamese officials in forensic medicine in the last decade of the nineteenth century. It reveals how forensic medicine was both an important indicator of the disadvantaged status of Siamese subjects vis-à-vis foreign residents and a potential tool for challenging those inequities. Building on important scholarship on the ways in which forensic medicine was used to mitigate the criminal culpability of white perpetrators of violence in British India (Bailkin 2006; Kolsky 2010), I demonstrate that in spite of its claims to objectivity, forensic medicine in fact admitted subtle but pervasive forms of bias and barriers to entry. The paper concludes that although Siamese efforts to implement forensic medicine were part of a pragmatic response to a distinct set of challenges associated with extraterritorial law, they would have much broader implications for Siamese political life, as medical expertise supported the rise of a more absolutist form of rule.

Learning objectives:

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

Cultivate greater awareness of the effects of medical expertise in cross-cultural encounters

Recognize the interactive dynamics between medicine and society through history

Jason Chernesky, *University of Pennsylvania, PA: A "Therm-Antidote" for British Anxieties: Cooling Technologies, Health, and Medicine in Nineteenth-Century India*

In 1827, Dr. James Ranken published a sketch of a curious machine. In an article titled "On the Public Health of India," which appeared in the "Transactions of the Medical and Physical Society of Calcutta," Ranken suggested that his machine offered one of the best options for cooling stagnant and unhealthy air. The machine was called a "thermantidote" and it was a vast improvement, Ranken argued, over other cooling technologies such as the large, manually operated ceiling fan, or punka.

The creation and use of the thermantidote represents an excellent instance of how the pathologized construction of "the tropics" also engendered technological innovation. A number of historians such as David Arnold, Michael Worboys, Mark

Harrison and several others have explored the long history of tropical medicine and its close ties to European colonization of places such as India, South America, and the Caribbean. They have also shown how “the tropics” came to be a framework for dealing with politically, culturally and environmentally distinctive entities. But this robust medical historical literature has not been put in dialogue with the history of technology. The dearth of historical accounts that address the intersection of tropical medicine, health, and technology thus requires further exploration.

My paper will investigate how cooling technologies were used in India to ameliorate European anxieties instigated by the pathological framing of “the tropical landscape.” In this respect, the creation and use of the thermantidote provides a useful lens in understanding such historical phenomena. I will also explore how air-cooling machines such as the thermatidote became important medical technologies for the British in India. Such technologies can further illuminate how certain British technological systems of cooling factored in European concepts of health and medicine in tropical climates. Moreover, I hope to show how British attempts to create indoor microclimates helped shape European concepts of “tropicality” and public health reforms in Nineteenth-century British India. Using sources ranging from Anglo-Indian medical literature to engineering publications and personal diaries among others, I will argue that cooling technologies were a major and hitherto under-researched aspect of Tropical Medicine’s evolution in its pre-Germ Theory epoch.

Learning objectives

Develop the capacity to critically think about the role technology plays in the history of medicine

Understand the long and dynamic history of how technology, environment, and health

Deepen one’s understanding of medicine and Western colonization

H1: The Medical Mind – Models and Metaphors – [*Withdrawn*]

H2: Seeing the Group: Mid-Nineteenth Century U.S. Social Medicine

Grand Ballroom A

Moderator: Graham Mooney, Johns Hopkins University

David Gerber, *University at Buffalo (SUNY), Amherst, New York*: ***“Still Sick:” Health Consciousness and Its Consequences among Nineteenth Century European Immigrants to North America***

The historical literature on immigrants and health follows several lines of analysis. It has been: centered on immigrant groups, not on individuals; it has derived its conclusions from institutional and state sources; and it has drawn its conclusions at the juncture of state policy, law, nativism, and public contestations over the immigrant body.

I follow a different line of analysis. I have been engaged for many years reading Nineteenth century immigrant personal correspondence, and have published extensively on immigrant epistolarity. In this presentation I read the letters of northern and western European immigrants to the United States and Canada to analyze the self-reporting on health of individuals, a routine aspect of these letters that has not been subject to systematic inquiry.

Through exploration of the experience of seasickness, epidemic disease (especially, cholera) aboard ship and in port towns after disembarkation, and the common seasoning (fever) illnesses, such as malaria, during resettlement, I find immigrants increasing in health awareness. This awareness manifested itself in three ways. First, the language used in letters reveals a growing consciousness that the project of immigration was dependent on maintaining health. Second, immigrants took deliberate steps, such as relocation to healthier locations within North America, to maximize their chances of avoiding illness. These changes of health practices were often themselves dependent on information shared orally or in writing across ethnic networks. Third, immigrants became self-conscious consumers of medical care, critical of the North American doctoring they had experienced and seeking doctors of their own ethnic groups.

These immigrants lived at juncture of two medical regimes, pre-modern and modern, bounded on the one hand by a dawning of scientific awareness manifest in concern for diet and hygiene, but prior to the germ theory of disease of modern medicine and therapies. Within that conceptual and experiential framework, they created habits of informed self-help that looked forward toward a twentieth century health consciousness.

Learning objectives:

Deriving understandings of the consciousness and behavior of ordinary people through their self-reporting

Understanding the impact of emigration and resettlement on health and body awareness

Understanding the transition from pre-modern and modern health regimes.

Mary Yearl, *American Textile History Museum, Lowell, MA: The Pemberton Mill Relief Committee and the Economics of Industrial Medicine in 1860*

On 10 January 1860, the main building of the Pemberton Mill in Lawrence, Massachusetts, collapsed. The scale of the mill building itself, and the large number of employees (918), made this disaster one that was unlikely to be ignored. Even so, the response was staggering. So many donations flowed in to aid those affected that Mayor Daniel Saunders, Jr. ultimately asked that no more gifts be sent to the overwhelmed city. To date, much of the scholarly work on the disaster has focused on the collapse from the perspective of architectural history: how and why the building collapsed, and whether lessons were learnt that affected future mill construction.

For historians of medicine, documents relating to the Pemberton Mill collapse represent an untapped resource. Records created by members of the Pemberton

Mill Relief Committee are particularly rich. On one hand, there are physicians' notes spanning a period of six months that provide some indication as to how named individuals progressed and the nature of their ailments. From these, it is possible to follow patients as their complaints shifted from acute to chronic.

Moreover, notes on economic relief tie directly to studies on the impact of medical crises among workers: entire families and indeed communities were affected by the large-scale loss of earnings. In the case of the Pemberton collapse, I shall argue that the economic impact of physical infirmity recorded in the records of the Relief Committee lends validity to concerns about health that are consistent (and persistent) in the letters that mill girls sent home during those decades when they formed a significant part of the textile labor force. That is, the economic impact documented following the Pemberton disaster demonstrates that workers were right to be concerned about their health and the implicit economic hardship that would follow from illness or injury. While many authors have remarked upon the degree of financial independence enjoyed by mill girls, the Pemberton notes detail just how many of them had dependents. Overall, I shall present the records of the Pemberton Mill Relief Committee as rich resources for the study of medical history.

Learning objectives:

- Identify successes and failures in the history of medical professionalism
- Recognize the dynamic interrelationship between medicine and society through history
- Critically appraise clinical management from a historical perspective

*Molly Laas, University of Wisconsin-Madison, Madison, WI: **The Chemistry of Morality: Designing Nineteenth-Century Prison and Asylum Diets in the United States***

In the 1850s, the Commissioners on Emigration in New York City were faced with an influx of immigrants coming from Europe. Many of the newcomers were escaping war or famine, and were in poor health due to illnesses contracted on the long sea voyage. The commissioners were additionally faced with a tight budget; neither state funds nor private charity were sufficient to meet the immigrants' needs. In order to find ways to cut costs, the commissioners asked not a physician but a chemist, John Stanton Gould, to design an optimally inexpensive institutional diet that would still preserve the health of the inmates. Gould's expertise in prisons and asylums stemmed from his work on prison reform, and his interest in eradicating crime in society was the background for his interest in institutional management. In his 1852 publication "A Report on Food and Diet with Observations on the Dietetical Regimen, Suited for Almshouses, Prisons, and Hospitals," Gould compiled all the information he could find about institutional dietaries in Europe and North America, and used the latest developments in the chemistry of food and the study of metabolism to calculate the constituents of an ideal institutional diet. Gould's work was ahead of its time in its application of contemporary nutritional chemistry and physiology to diet, and in its goal of empirically verifying a chemical understanding of diet through statistical methods. Gould's thinking was also deeply informed by the medical and popular discourse of nutrition in the 1850s as well as the reformist culture of New England Quakers

such as himself. This paper will show how Gould interwove his religious and social beliefs with his scientific and medical knowledge in order to create a framework for managing institutional dietaries that he believed served the ends of both economy and justice. It will also demonstrate how Gould's report was indicative of a pivotal shift in the medical discourse of diet in the mid-Nineteenth century, from the assumption that educated individuals knew how best to regulate their own diet to the idea that experimental science was the chief source of nutritional knowledge.

Learning objectives:

Understanding the dynamic history of social, medical, and scientific ideas about diet and nutrition

Recognize the dynamic interrelationship between medicine and society through history

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

H3: From Bacteriology to International Health Policies

Temple Room

Moderator: Anne-Emmanuele Birn, Univ. of Toronto, School of Public Health

Powel Kazanjian, *University of Michigan, Ann Arbor, MI: Frederic G. Novy, 1889-1933:*

Early Bacteriologic Investigations in America

Frederick Novy (1864-1957) was a leader among a new breed of full-time bacteriologists at American medical schools in the 1890s. Historians have examined bacteriologic work done in American health department laboratories but not in American medical schools during this period. To address this gap, I examine Novy's research and educational activities at the University of Michigan from 1889-1933. For sources, I use Novy's archived letters, laboratory notebooks and lecture notes. Novy was unusual for his time because his training, research program and his educational activities focused on fundamental science and not practical application. Novy first received a doctorate in chemistry then after becoming a physician translated his scientific training to discover objective truths about microbial biology. He investigated the chemical basis of metabolism and respiration to determine how microbes survive in nature. He also developed innovative dynamic culture techniques to grow protozoa and define the changing forms and their behavior as they matured over time. In his bacteriology course, the first full-semester one offered in America, he sought to instill what he called "a spirit of science in medicine"—critical thinking combined with a duty to search for objective truths above practical application.

The story of a first generation American bacteriologist like Novy who was devoted to what his peers called the "pure science" ideal has meanings for medicine, bacteriology and American society. His colleagues and students viewed his devotion to producing new knowledge as adding legitimacy to a medical profession in need of certainty and his medical instruction as establishing a foundation for the reforms

in American medical education and establishment of “basic science” departments that would follow. His work also helped to define bacteriology as a distinct discipline in America, as he was a founding member of the American Society of Bacteriology in 1899. The representation of Novy’s science in American culture can be viewed through the novel *Arrowsmith*. In the novel, Sinclair Lewis used an account of Novy’s activities provided by his student Paul de Kruif to construct and popularize a heroic image of a truth-seeking medical researcher that had widespread and lasting appeal in American society.

Learning objectives:

Develop a capacity for critical thinking about the goals of the first-generation full-time basic physician-scientists working in medical schools in late 19th century America and what they accomplished in their laboratories.
Acquire a historically nuanced understanding of the meanings of the “pure science” ideal—to add pure knowledge without therapeutic implication—for medicine.
Understand the dynamic history of how first generation physician scientists incorporated laboratory science into medicine and medical education.

*Anna Geltzer, Wesleyan University, Middletown, CT: **Surrogate Virtues: Shifting Discourses of Objectivity in Russian Biomedicine***

This paper traces the evolution of the discourse of objectivity in Russian biomedicine. I am analyzing two impassioned debates that occur at very different historical moments. The first is a debate about the proper role of medical cybernetics (and computers more generally) in biomedical science and practice that raged so hotly in Soviet biomedical circles of the Brezhnev era that it even caught on in the state press. The second is an equally impassioned though less publicly contentious discursive campaign to promote the principles of evidence-based medicine (EBM) in post-socialist Russian medical practice. Both debates were deeply implicated in professional politics, and both forced the participants to explicitly articulate not only their epistemic but also their ethical commitments. Thus they provide insight into the epistemic culture of Russian medicine under very different political and economic regimes. The cybernetics debate took place at the height of the Brezhnev era—a period that has been labeled as the era of stagnation, and that party ideologues of the time christened ‘developed socialism’—a time of apparent stability in both the economic and political structures of the Soviet Union. The EBM debate took place under very different circumstances—it began after the collapse of the USSR, when the institutions of planning and control that governed and supported biomedical research were in a state of disarray, and the medical profession was trying to preserve and reassert its position. As a consequence, analyzing these discussions can help provide insight into the relationship between political economy and biomedical epistemology.

Learning objectives:

Understand the relationship between changing evidentiary standards and the political and economic structures within which biomedical knowledge gets produced.
Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

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

Dora Vargha, *Birkbeck College, University of London, London, UK*: ***When Polio became Global: Cold War Epidemic Management and the Roots of the Eradication Campaign***

In 1988, the 41st World Health Assembly adopted a resolution to launch a worldwide polio eradication campaign, setting the target for the year 2000. This was the launch of the Global Polio Eradication Initiative (GPEI), a still ongoing project of several organizations, such as Rotary International, UNICEF, CDC and most recently the Bill and Melinda Gates Foundation.

While the polio eradication campaign seems like a recent development in global public health, in fact the idea of eradicating the disease with live poliovirus vaccine appeared already in the late 1950s. In 1959 Mikhail Chumakov, Soviet colleague of Albert Sabin advocated the new polio vaccine as capable of not only curbing, but also eliminating the disease. A year later the WHO's Third Expert Committee Report on poliomyelitis raised the possibility of a concerted polio eradication with mass oral vaccination campaigns. Such sentiments were based on comparative analyses of epidemiological data from across the globe and on vaccine trials spanning from Mexico through Singapore and the Belgian Congo to Czechoslovakia. Researchers from all over the world shared their data at international conferences, on the pages of medical journals and in private correspondence. The WHO, invested in polio control from the outset, emerged to take lead in coordinating and validating research, choosing the most suitable strains and vaccination methods in an internationally orchestrated effort. Cooperation in vaccine development cut across Cold War divisions, while the evaluation of live vaccines mirrored conventional East-West divides in a concern over global and national security. Based on archival research, medical journal articles and conference proceedings, this paper asks when and for whom polio became a global issue. I argue that the resources and networks fostered by the WHO shaped vaccine research and ideas about prevention and potential eradication, and in turn, polio's emergence as a global problem gave the WHO an important opportunity to position itself as a decisive entity and key player in international public health. In this sense, the paper explores the ways in which scientific practices, intertwined with Cold War politics of the 1950s and 1960s were formative to the current polio eradication campaign.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history

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

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

H4: Medicine, Disease, and the Framing of Race in the Slaveholding Atlantic

Wooster Room

Moderator: Mariola Espinosa, University of Iowa

Rana Hogarth, *University of Illinois at Urbana-Champaign, Urbana, IL: Of Paper Trails and Dirt Eaters: West Indian Medical Knowledge in the Antebellum South*

"Notwithstanding the comparatively frequent occurrence of this affection, among the colored population, it seems to have been entirely overlooked by our medical writers..." -Dr. William Carpenter, 1844

William Carpenter, a physician and professor at the Medical College of Louisiana noted that *Cachexia Africana*, or dirt eating, was not receiving the attention it deserved from southern physicians. A "slave disease," known for its refractory nature and elusive etiology, *Cachexia Africana* disrupted plantation productivity, left its enslaved victims unable to work, and confounded even the ablest of physicians. To remedy the dearth of domestic knowledge about the disease, Carpenter published "*Observations on the Cachexia Africana*" in 1844, which appeared in the *New Orleans Medical Journal*. In the article, Carpenter methodically compiled decades' worth of medical knowledge on *Cachexia Africana*, including case reports of the disease made by more experienced practitioners, many of whom had lived or spent considerable time in the West Indies. The result was a comprehensive overview of the disease, complete with a trail of citations from elite physicians that his domestic audience could follow.

Though a number of scholars have examined how antebellum southern practitioners rendered Blacks racially distinct from whites through the identification of slave diseases, few have investigated the circulation of medical knowledge about those diseases, especially *Cachexia Africana*. Fewer still have acknowledged the transnational nature of this circulation of medical knowledge. In this paper, I examine accounts of *Cachexia Africana* from Jamaica and other West Indian islands, and the published and unpublished medical writings from the antebellum South that cited them. These sources not only provide a "paper trail" with which to trace the development of white medical attitudes towards enslaved dirt-eaters across region and time, but they also demonstrate how the West Indies emerged as a repository of medical intelligence on which antebellum southern practitioners could rely to enhance their overall knowledge on slave health. By drawing attention to these medical accounts, I illuminate the textual spaces where white physicians created Black subjectivities, articulated expectations about Black bodies, and outlined the corporeal standards to which Black bodies had to conform.

Learning Objectives:

To demonstrate how the identification of "slave diseases," such as *Cachexia Africana* allowed white physicians to translate speculative knowledge about racial difference into observable diseased states.

To demonstrate how white physicians' investment in reifying blackness became a hallmark of medical authority and practice across nineteenth-century slave societies in the southern United States and West Indies.

To center medical discussions of black health as a transnational phenomenon that had far reaching repercussions for the development of regional medical knowledge and practice.

Ian Read, *Soka University of America, Aliso Viejo, CA: Environmental and Cultural Frames in Histories of Disease: The Case of Smallpox in Brazil*

In the last thirty years, historians of medicine of Latin America have directed more attention to questions of power, exclusion and oppression than the vast and complex spaces of microbes and living vectors that operated independently or with great influence over human beliefs and culture. In this paper, I explore this idea by tracing the history of smallpox in Brazil. Although smallpox was one of Brazil's top killers for centuries, especially among its indigenous, slaves and poor, it is largely ignored by historians today because it fits imperfectly and uncomfortably within new historiographical norms and interests. For example, its particular cutaneous symptoms and incubation period created a category of affliction that was remarkably stable across centuries and peoples. Furthermore, state action ultimately eliminated this disease, although Brazil's trajectory is hardly triumphant.

A discussion of this particular disease demonstrates the strengths and weaknesses of what might be called the "cultural turn" of the history of medicine in Latin America. Certainly, this disease must be understood within its broader cultural and political context. For example, the bodies of Africans and their descendants were held to be especially "predisposed," and this helped biologize racial or intrinsic difference. Brazil's highly decentralized public health systems of the Nineteenth century could do little, especially for a disease of the *povo* (mostly non-white and poor). After 1850, smallpox began to disappear from Europe and North America, but it worsened in Brazil. Only in the early 1900s when a new Republican government strengthened state authority over vaccination did epidemics stop besieging its largest cities. But this came at the cost of a far more surveillant state that justified intimate intrusions through progressive and medical rationales.

Smallpox must be seen as often providing elite with useful excuses, including racialized or gendered beliefs that privileged their power and self-preservation. Nonetheless, it is also clear that this disease arrived in Brazil and the Americas, tragically killing millions of indigenous peoples beginning in the sixteenth century, but departed in the twentieth century. Changing cultural perceptions and the unique and non-human operations of a biological agent go hand-in-hand.

Learning Objectives:

To trace the changes in the historiography of medicine in Latin America, a sub-field that has undergone a "renaissance of interest" in the last two decades, yet remains largely unknown outside of the region.

To find common ground within the history of medicine and the history of environment through the history of smallpox in Brazil.

To produce the first detailed overview of the rise and fall of smallpox in Brazil in the Nineteenth and twentieth century

Stephen Kenny, *University of Liverpool, Liverpool, UK: Henry Ramsay, the Georgia Blister, and the Professionalization of "Negro medicine"*

With a close focus on the career of physician Henry A. Ramsay, editor of the "Georgia Blister and Critic" (a periodical dedicated to "the diseases and physical peculiarities of the Negro race"), this paper examines how professional medicine in the slave South complicates our understanding of American medical modernity.

The generally accepted academic view is that American medical practice in the pre-Civil War era, especially southern medicine, was a simple 'country medicine' (Stowe, 2004) in need of professional reform and slow to adopt a scientific approach to education and research (Warner, 1998, Devine, 2014). White doctors in the slave South, however, including those in remote rural locations, routinely sent case reports of experiments on slave subjects to medical journals and trafficked black bodies and 'specimens' to medical colleges and societies. White medical students, as a matter of course, expected education and training based on the observation, dissection and experimental treatment of black bodies. Students also wrote graduating theses based on the medical manipulation of black 'subjects' and 'specimens'. Medical museums in the South openly solicited black body parts and medical societies relied on black bodies. All of the key professional training, networks and power bases of southern medicine—apprenticeships, private practice, colleges, hospitals, journals, and societies—operated through slavery's ruthless traffic and exploitation of black bodies. This was, in reality, no ordinary or innocent 'country medicine.'

This paper argues that the whole fabric of antebellum southern medicine, relying upon racist ideology and a systematic exploitation of the enslaved, took the opportunity presented by the bodies of black people to advance white doctors' personal and professional agendas. Through the career of Henry Ramsay, it examines the racist nature of medical training, research, and practice under slavery — and the career opportunities that practice in so-called 'Negro medicine' brought. By reconstructing and analyzing an aspirant southern practitioner's career, the paper will show not only how banal was southern medicine's reliance on the exploitation of black 'subjects', but also how 'Negro medicine' was produced, disseminated and professionalized.

Learning objectives:

To identify successes and failures in the history of medicine.

To recognize the dynamic interrelationship between medicine and society through history.

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

H5: Pre-modern Pharmacy in Eurasia

George Room

Moderator: Harold Cook, Brown University

Stacey Van Vleet, *Columbia University, New York, NY: **The Medicine Buddha's Alchemy: History, Purity and Precious Pills in Tibetan Buddhist Medical Rituals (17th-early 20th centuries)***

Between the seventeenth and the early twentieth century, the same period remembered today for the rise of science along mercantile-colonialist sea routes, a network of medical colleges proliferated within Tibetan Buddhist monasteries across northern China, Mongolia and eastern Tibet. These medical colleges were intimately linked to the propagation of Tibetan Buddhism within the Qing Empire (1644-1911), and to Qing imperial appropriation of Tibetan Buddhist knowledge and legitimacy. Here I discuss how medical rituals performed within these Tibetan Buddhist medical colleges reflected a tension between the increasing importance of materiality and commerce in medical practice across the Qing Empire, and an overwhelming anxiety about policing substances and the boundaries of appropriate Buddhist knowledge. Such anxiety was expressed through debates over the proper form and content of rituals venerating the Medicine Buddha.

Tibetan medicine has been lauded for a distinctive sense of empiricism, manifest in the separation between medical treatment texts and medical ritual texts, and in an increasing focus on materia medica during the Qing period. Medicine Buddha rituals still remained central to the curricula of monastic medical colleges, however, and their relationship with the empirical practice of medicine remains un-historicized. Some Buddhist texts described the Medicine Buddha as primarily a guide to the path of enlightenment, while others understood Medicine Buddha rituals as an alchemical process, carrying the potential to transform practitioners, substances, and even the wider community. In scholarly medical debates of this period, competing visions of medical ritual practice are linked to competing structures of authority, ethical frameworks, and relationships with material substances.

In this presentation I examine and compare curricular documents of Tibetan Buddhist medical colleges (*bca' yig*), demonstrating a previously unrecognized link between medical ritual/historical debates and Tibetan Buddhist doctrinal debates. I show how alchemical ritual practices could encapsulate competing appeals to Buddhist authority, resulting in different recipes for "precious pills," or the consecrated products of Medicine Buddha alchemy. On this basis, I examine how Qing period writers invoked competing claims for the purity of their medical rituals based on criteria of lineage purity, moral purity and the material purity of medicinal ingredients.

Learning objectives:

Relationship of Buddhism and medicine
Historicizing Tibetan medicine

How medicine encompassed subjective and material worlds during the early modern period

Nichola Harris, *The State University of New York (SUNY) Ulster, Stone Ridge, New York: Manuscripts, Manuals, and Masters: The Role of the Lapidary within the Medical Market Place of Early Modern Europe*

The assortment of medical professionals practicing within the early modern medical market place was as diverse and eccentric as the treatments they administered. This paper seeks to add to the established ranks of pre-modern health care providers by recognizing the role of a little-known purveyor of cures and therapies within this community: the lapidary. While commonly defined as one who works with or sells stones and jewelry, print and manuscript sources suggest that a "lapidary," or *lapidarius*, occupied a professional position parallel to an herbalist or apothecary and dispensed material cures recommended by contemporary physicians, midwives, and pharmacopeias. An expert on the natural healing virtues of materials which fell within the pharmacological category of "stones" as established by the natural studies and medical treatises of the ancient and medieval world, working lapidaries sold gemstones and therapeutic items of jewelry while dispensing knowledge about their medicinal properties and correct application. From the fifteenth to the seventeenth centuries, lapidaries catered to the consumer audiences of works such as Johannes de Cuba's *Hortus Sanitatis* and Nicholas Culpeper's *The London Dispensatory*, selling stones intended to ease the pain of childbirth, protect infants from fevers and convulsions, staunch bleeding, neutralize poison or snakebites, and cure melancholy.

To reveal the role of the lapidary within the consumer-driven medical marketplace of early modern Europe, this paper will explore references to and representations of lapidaries in popular print, comparing their status and function to other healthcare professionals operating in the same environment. Drawing on the personal journal of a master lapidary working in seventeenth-century London, it will also closely examine the items for sale within an early modern lapidary shop along with intended uses found within contemporary manuals of popular healing. A combination of personal advice and details drawn from Albertus Magnus' thirteenth-century treatise *Mineralia*, the journal offers practical business guidance for an apprentice or heir. Using print, manuscript and archeological evidence, this study seeks to create a fuller understanding of the medical role of a lapidary and the popular practice of lapidary medicine within medieval and early modern society.

Learning objectives:

Explain the role of a lapidary in prescribing, dispensing, and selling cures within the medical market place of early modern Europe.

Recognize the connection between medical therapies and material cures and those found in early modern pharmacopeias and printed manuals of popular healing.

Understand the circulation and continued use of medieval medical manuscripts within the popular print culture of early modern Europe.

C. Michele Thompson, *Southern Connecticut State University, New Haven: The Travels and Travails of Tue Tinh*

When the Vietnamese monk physician Tue Tinh (c. 1330-c.1389) was approximately fifty-five years old he was sent as a living present to the Ming Dynasty by the Vietnamese royal court. Despite the fact that his travels were involuntary Tue Tinh's journey to China and the medical text he wrote while living there had a profound impact on the history of Vietnamese Traditional Medicine. Tuệ Tinh wrote his most well known text, "*Nam Duoc Thanh Hieu* (Miraculous Drugs of the South)", specifically to explain Vietnamese medicine to the Chinese. Tue Tinh had attracted the attention of the Vietnamese Tran Dynasty (1225-1400) through his work in the medical gardens and clinics attached to most Buddhist monasteries in Vietnam at the time. Through royal land grants and other forms of patronage Buddhist monasteries formed the closest thing to a public health system that Vietnam had and many members of the Vietnamese sangha were healers, pharmacists, and field botanists. Before being sent to China, Tue Tinh had traveled extensively within Vietnam on a common Buddhist circuit of monasteries. While some of his monastic companions spent most of their time studying and writing religious texts, Tue Tinh spent his time studying plants and composing texts in nom (an ancient demotic Vietnamese script) on them. He also gathered local knowledge of plants and their properties. In fact some scholars regard Tue Tinh's work as ethnobotanical in nature. This essay will examine how the geographic mobility Tue Tinh experienced within Vietnam affected his approach to presenting Vietnamese herbal knowledge outside the Vietnamese cultural sphere to the Chinese. Tue Tinh was never allowed to return to his beloved homeland but he had a copy of "Miraculous Drugs of the South" sent to Vietnam and this text became one of the most revered of Vietnamese medical texts. Tue Tinh's knowledge and his medical philosophy made a full circle, from Vietnam to China and back to Vietnam, even if his body did not.

Learning objectives

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

Recognize the dynamic interrelationship between medicine and society through history.

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

I1: Representation and Visualization of Medical Knowledge, 1800-1900

Grand Ballroom C

Moderator: Bert Hansen, Baruch College, CUNY

Eva Åhrén, *Karolinska Institutet, Stockholm, Sweden: Anatomy on the Move: Collaboration, Competition and Circulation of Medical Knowledge in Early Nineteenth-Century Europe*

In 1828, the first international conference ever was held in Berlin, organized by the German Society of Natural Scientists and Physicians. Among the participants

was Anders Retzius (1796-1860), doctor of medicine and professor of anatomy at Karolinska Institutet in Stockholm, who was on a journey to study European anatomy museums. During the meeting, Retzius spent every morning between 8 and 10 in the anatomy museum at the university, discussing anatomical specimens with colleagues. These informal sessions, convened by professor Karl Rudolphi, were opportunities to learn about new anatomical investigations, methods and findings, and to perform them for peers. Prompted by Retzius, Karl Ernst von Baer dissected the ovaries of a dog to demonstrate mammalian ova, which he had recently discovered. Johannes Müller, who developed a close friendship with Retzius, showed preparations and drawings of fetal kidneys, and Friedrich Arnold demonstrated nerve cells in the ear. From this moment Anders Retzius was part of a cohort of young European anatomists, who engaged extensively in scientific exchange by traveling, speaking, corresponding, trading specimens, and publishing.

Taking the Berlin meeting as a starting point, this paper uses Anders Retzius's work to open up a discussion on the transnational circulation of anatomical knowledge in the early to mid-Nineteenth century. Retzius's talks, articles, illustrations, letters, and travel notes will be used to examine how circulated preparations, drawings and printed visualizations of tissues and body parts were used to assert scientific authority; how specimens functioned as mobile (and sometimes contested) bearers of anatomical knowledge; and how traveling connected centers of medical learning on the European periphery. The main purpose is to explore how the increased communication, collaboration, and competition among physician-scientists in this era impacted knowledge production in anatomy, medicine's foundational science

Learning objectives:

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

Understand the dynamic history of medical ideas and practices

Understand the role of networks of knowledge exchange in medical history

Alexander Moffett, *University of Chicago, Chicago, IL: Generic Images of Disease: The Uses of Collective Investigation, 1880-1900*

In an address to the British Medical Association in 1880, the surgeon George Murray Humphry called for the "collective action" of the members of the Association in joining the "work of cumulative observation, or accumulated data"—what would come to be known as collective investigation. Humphry recommended the formation of a committee to identify those aspects of medicine that might be improved by the collection of observations from the members of the Association. The committee would distribute specifically formatted cards on which the members of the Association would be asked to document their clinical encounters with particular diseases. These cards would then be returned to the committee, which would "collate and codify the evidence." A Collective Investigation Committee was formed in 1881 and in the years that followed it would circulate tens of thousands of cards and collect thousands of accounts of medical conditions ranging from pneumonia to somnambulism.

In this paper, I focus on the uses of collective investigation, the ways in which the cards returned to the Committee were "collated and codified," and the types of conclusions that the Committee attempted to draw from them. I argue that Humphry and other early proponents of collective investigation were heavily influenced by the composite portraits of Francis Galton, who combined photographs of individuals of a common type to produce what he referred to as "generic images" of these types. Just as Galton, by combining images of criminals, hoped to produce a generic image of the criminal type, so too did the Committee, by combining the clinical observations of different cases of pneumonia, hope to produce a generic image of pneumonia. However, though the Committee was thus guided by the ideal of the generic, the reports that it published functioned instead to document the heterogeneity of disease, including complete accounts of all observations returned to the committee, often without the attempt to draw specific conclusions from these observations. This move from the generic to the particular represents a shift in focus toward the politics of collective investigation, the collection of observations ultimately intended to contribute to the production of a united profession.

Learning objectives:

Understand the contested nature of medical observation and the note the difficulties encountered in attempts to discipline observers.

Identify the different sites of medical knowledge production and the ways in which such knowledge is made to circulate.

Note the technologies that medical associations have employed in attempts to produce a uniform medical practice.

Adam Warren, University of Washington, Seattle WA: Contested Images: Medical Photography, Researchers, and Indigenous Subjects in Yale's Peruvian Expedition, 1911-1915

Between 1911 and 1915, surgeons and their assistants on the Yale Peruvian Expedition took hundreds of photographs of Quechua and Machiguenga indigenous peoples while traversing the Andean highlands, excavating Machu Picchu, and exploring the high jungle of Peru. This paper asks what a critical reading of expedition members' photographs, along with their reports and diaries, can tell us about indigenous attempts to mediate, contest, and shape encounters with "experts" who engaged in medical and scientific research on their bodies. Catalogued alongside extensive anthropometric records of racial variation and studies of goiter and other diseases that were prevalent in specific communities, the photographs resulted in publications and contributed to the expedition's larger goal of providing what its leader, Hiram Bingham, described as a comprehensive scientific study of the Andes and its peoples. At the same time, the photographic work was far from comprehensive in scope or successful in its inclusion and depiction of different groups. Rather, it reveals an uneven set of relations that emerged as surgeons and assistants, frustrated by their failure to encounter willing subjects and hindered by the problem of preserving and developing camera film in remote areas, tried out new practices of engaging communities, measuring, and photographing residents. Indigenous peoples' responses to these intrusions varied from enthusiastically complying with surgeon's efforts to have them perform as

medical subjects, to reluctantly submitting to their gaze, to refusing to be photographed at all. The resulting archive of images thus contains photos that appear highly staged, as well as others in which the positioning of the subject appears more haphazard, the subject undermines the surgeon's work by looking down or away, or the subject obscures his or her face. Through an examination of these sources, this paper demonstrates that efforts to visually document and portray indigenous subjects as racialized and diseased in fact resulted in a depiction of the limits indigenous people placed on the work of the expedition itself.

Learning objectives:

Develop analysis of the nature, ends, and limits of medicine in non-Western contexts.

Develop an historically informed sensitivity to the diversity of patients involved in medical and scientific research (including race, gender, socio-economic status, cultural difference)

Develop an historically informed sense of the ways in which patients attempted to shape their interactions with medical researchers and influence the ways they would be documented visually.

I2: Nursing, Race and Gender in Nineteenth-Century Medical Care

Grand Ballroom A

Moderator: Barbra Mann Wall, Univ. of Pennsylvania School of Nursing

Erin Spinney, *University of Saskatchewan, Saskatoon, Saskatchewan, Canada*: ***"Neither females nor negroes of either sex were liable to it:" Concepts of Racial Immunity in British West Indian Military and Naval Nursing, c. 1780-1825***

Racial concepts of immunity were crucial components of late-eighteenth and early-Nineteenth century medical ideology in the British West Indies and these beliefs influenced the selection of nursing staff in military and naval hospitals. Medical practitioners believed that African slaves and ingenious Creoles were immune to most tropical diseases and best suited to hard labour in the torrid climate. The unsuitability of the European body to work in this climate without undergoing a process of 'seasoning' justified the formation of the West Indian Regiments composed of slaves in the 1790s. This same rationale was used to justify the use of female slaves as nurses.

The use of slaves as nurses conformed to societal expectations in the islands. Furthermore, this practice was thought to mitigate the high death rates experienced by British forces that placed valuable imperial possessions at risk. Black nurses were seen as better suited to the task of nursing in the Caribbean, whatever their class. "In the colonies, the colored women of every class, whether black, mulattoes, or mustees, make the best sick nurses," observed naval hospital inspector William Fergusson.

The privileging of African and Creole nurses over European nurses has much to say about the characteristics of the ideal nurse and the organization of military and

naval hospitals. The use of slaves in naval hospitals also integrates these institutions into the wider labour market of their communities. Finally, gender remained an important factor in the selection of nurses. While Black women were thought to make the best nurses, even a European woman would make a better nurse than a man.

Learning objectives:

Understand how racial concepts of immunity influenced medical ideology in the British West Indies.

Understand why African and Creole nurses were selected for service in British military and naval hospitals instead of European nurses.

Discover how concepts of race and immunity influenced hospital staff and the labour market of local communities.

Christopher Willoughby, Tulane University, New Orleans, Louisiana: *Learning to Oppress: Racial Thought and Medical Education in the Antebellum United States*

This presentation examines how race was discussed in antebellum medical schools. At the core of this project is a comparative, statistical analysis of when, where, and how students at the Medical University of the State of South Carolina and the University of Pennsylvania discussed the subject of race in their theses. Departing from previous scholars usage of medical theses as individual documents, this projects considers these entire collections of medical theses at each university (approximately 2,000 antebellum theses at each school) as one large source presenting a macro-level image of where race was and was not an issues in antebellum medical thought.

This presentation will posit that there was a significant shift in how race was considered in medical thought in both the North and South from the turn of the Nineteenth century to the dawn of the American Civil War. By the middle of the Nineteenth century, medical professors like Joseph Leidy at the University of Pennsylvania and Samuel Henry Dickson at Medical College of the State of South Carolina presented an embodied, biological racial construct deriving from comparative anatomy, as opposed to environmental, cultural approaches prevalent at the beginning of the Nineteenth century. Additionally, medical student theses provide a unique window into racial science outside of the realm of scientific or medical journalism and in the hands of a potentially average physician. Finally, a comparative approach, considering both northern and southern institutions, avoids the pitfalls, so prevalent in regional histories of southern medicine. These histories have posited an exceptional southern medicine; however a comparative approach shows that in terms of racial thought, both schools studied had far more in common than difference. Regional difference did exist in medical writing in the occasional entrance of a highly politicized language of race by students in South Carolina. However, even this was few and far between. Additionally, students in Charleston were more likely to discuss hands on experience with black patients than those in Philadelphia; however, the large proportion of students from the South in Philadelphia meant that practical experience with black bodies was hardly rare there.

Learning objectives:

Identify successes and failures in the history of medical professionalism.

Recognize the dynamic interrelationship between medicine and society through history.

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

*Amanda Mahoney, University of Pennsylvania, Philadelphia, PA: **Mary V. Clymer: The Nurse as Technology in The Agnew Clinic***

Thomas Eakins' 1889 painting *The Agnew Clinic* is a well-known depiction of late-Nineteenth century surgery. The portrait is often used by historians of medicine to illustrate the advancements of surgical techniques and technologies promoted by great medical educators such as D. Hayes Agnew and Samuel Gross. The role of nurses and nursing in the development of new medical knowledge and practices has yet to be fully explored. In this paper, I will discuss how Mary Clymer, the nurse in *The Agnew Clinic* represents professional nursing as a new technology in the 19th century hospital. Nursing made advancements in medicine such as the mastectomy depicted in the painting possible through nursing knowledge and skill both at the bedside and in the operating theater. New methods and technologies like the ether cone and aseptic technique showcased in *The Agnew Clinic* led to new challenges in patient care and medical procedure, challenges that were often met through the work of professional nurses. The role of professional nurse was rapidly expanding and adapting to meet the needs of the hospital, physician and patient during the late Nineteenth and early twentieth century. Agnew's 1883

Principles and Practice of Surgery describe the work of a surgical nurse as "emptying the basins and replacing them with clean water," while Clymer's own journals and class notes from 1887-1889 describe more complex and specialized preoperative and perioperative procedures for the nursing of surgical patients. Clymer's class notes and clinical journals from her tenure at the Hospital of the University of Pennsylvania Training School for Nurses are a rich source of data on nursing education and the daily practices of nurses and physicians during the late 19th century. These class notes as well as other 19th century nursing textbooks and lecture materials demonstrate the increasing amount of knowledge and technical skill a surgical nurse needed to fulfill this new but increasingly well-defined professional role.

Learning objectives:

Understand the historical background of the 1889 painting *The Agnew Clinic*.

Explore how professional nurses like Mary V. Clymer made advancements in medicine including Agnew's surgical techniques possible through nursing knowledge and skills.

Explore how the presence of a professional nurse shaped the controversial critical response to *The Agnew Clinic* by its intended audience and the general public.

I3: Boundaries vs Inclusivity in Later Twentieth-Century Health Politics

Temple Room

Moderator: Theodore M. Brown, University of Rochester

Travis Weisse, University of Wisconsin-Madison, Madison, WI: *The Queen of Nutrition: (Doctor?) Alvenia Fulton and the Black Natural Health Foods Movement*

The cultural revolution of the 1960s and 70s challenged the national food system in many important ways. Eager leftists, especially Californians, voiced strong concerns about American farming practice, industrial processing procedures, and labeling standards. These counter-culturalists envisioned a transformation to an Eastern-infused pastoralism and rabidly promoted so-called 'natural foods.' Despite the internal political struggles of the youth movement, the natural health food craze lived on long beyond its years in Berkeley, which remains the epicenter of health food innovation.

Yet, this classic California-centric narrative—most vocally elaborated by Warren Belasco—entrenches the privilege of the white middle-class and white middle-class health outcomes in discussions of dietary transformation. Other historians have noted the multitude of culinary shifts among African-Americans, but these narratives tend to ignore the intensely nutritionally focused natural foods movement that emerged among black Chicagoans in the same period, pioneered by the eccentric fruitarian and 'Dietitian to the Stars,' Alvenia Fulton (1907-1999).

Trained in naturopathy, Fulton first achieved notoriety for coaching activist-comedian-athlete Dick Gregory through his famous fasting protests in the Civil Rights era. She continued this health coaching work with a host of other African-American celebrities. In the years that followed, she founded the first all-vegetarian restaurant and health food store that catered exclusively to African-Americans, outside of her home in South Chicago. Fulton came out strongly opposed to the burgeoning return of 'Soul Food,' in her pamphlets and published work. She was incited not by the heavy reliance on pork products like the Nation of Islam, but by rising rates of heart disease and obesity among the black population. Much of the source material for investigating Fulton's career comes from her own newspaper articles and those written about her, video clips from TV interviews, articles from "Ebony" and "Jet," nutritional manuals and Dick Gregory's memoirs.

Alternative healing figures like Fulton illustrate important and underexplored aspects of the relationship between Civil Rights era black communities, gender, and health experts. Despite her non-traditional background, Fulton's legacy carried well into the present by her disciples, dietary manuals she inspired, and products she invented, blossoming into a rich tradition of vegetarianism and fasting among African-Americans.

Learning objectives:

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

Recognize the dynamic interrelationship between medicine and society through history

Promote tolerance for the ambiguity of expertise in nutrition

Nathan Kuehnl, Wayne State University, Detroit, MI: *Local Treatment: Black Medical Professionals and Hospital Integration in Detroit, MI*

In the 1960s, the medical civil rights movement found great success at the national level. Much like the campaign for school integration, however, federal accomplishments in medical equality did not correspond to the continued discrimination taking place in hospitals across the country. Although national efforts created opportunities to challenge segregation and discrimination within the health care system, breaking down racial barriers required the efforts of individuals. In Detroit, the everyday actions and sacrifices of physicians, nurses, and administrators ushered in actual integrated care and ensured that federal reform had a material meaning for African American patients. Looking at the aftermath of *Simkins v. Moses H. Cone*, the passage of the Civil Rights Act of 1964, and the implementation of Medicare and Medicaid, this paper explores the daily lives of black medical professionals who fought professional discrimination and patient segregation in Detroit during the late 1960s and early 1970s. These professionals saw firsthand the mechanics of racism in the American medical system, which gave them greater knowledge on how to address health care inequalities that remained invisible to federal and state governments. They used their status as professionals to challenge daily proceedings, affecting admission standards, patient placement, and hiring practices throughout the city, effectively transforming hospitals into civil rights battlegrounds. Experiences with continued racism often jaded their perceptions of liberal integrationist policies. Their stories contribute to an already complicated understanding of the impact of integration efforts, and illuminate the divide between policy and reality in civil rights. Historians have identified some of the shortcomings of mid-century health care policies and their impact on medical equality. This paper seeks to add to that literature while also identifying the role of black medical professionals in challenging both explicit and implicit, colorblind racism in health care during the 'post-civil rights' era.

Learning objectives:

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

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

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

Beatrix Hoffman, Northern Illinois University, DeKalb IL: *Immigration, Migration, and the Right to Health Care: Toward a Transnational History*

Around 11 million people living in the United States are excluded from the provisions of the 2010 Affordable Care Act because of their status as undocumented immigrants. Although such immigrants are already banned from Medicare and Medicaid and many other U.S. health care programs, the Affordable

Care Act creates a new chapter in this history of exclusion by forbidding undocumented individuals from purchasing a private health insurance product.

The exclusion of the undocumented from U.S. health care reform—made famous by Congressman Joe Wilson’s shout of “You lie!” to President Barack Obama as he announced this provision of the bill—has intensified ongoing international debates about the social rights of immigrants and migrants. Some countries that previously offered full access to their health systems, such as Spain and Greece, have drastically curtailed undocumented immigrants’ right to care due to the recent economic crisis. In Spain, the new government restrictions on immigrant health access have led to widespread protests and civil disobedience by physicians and others demanding enforcement of the human right to health care, regardless of citizenship status.

This paper places current debates on immigrants’ access to care within historical context. It will examine the origins and development of health care access as an enforceable social right, as promulgated by international agreements including the United Nations Covenant on Economic, Social, and Cultural Rights and the European Social Charter. It will then discuss how international bodies and individual nations have addressed the question of health care rights for undocumented immigrants, a topic that has not previously been studied by historians. The paper is based in archival research at the United Nations and World Health Organization Archives in Geneva, Switzerland, government documents, and public health literature on immigrants’ rights to access, from the 1960s to the present.

Learning objectives:

- Develop knowledge and understanding of professional behaviors and values
- Understand the role of medical professionals in providing access to health care for immigrant populations in various countries
- Contribute to the improvement of patient care
- Develop an historically informed sensitivity to the diversity of patients, particularly of immigrant origin
- Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

I4: Medical Education and Professionalization: Nineteenth-Century U.S. (*John P. McGovern Session*)

Wooster Room

Moderator: Kenneth M. Ludmerer, Washington Univ. Sch. of Medicine, Saint Louis, MO

Dea Boster, *Columbus State Community College, Columbus, OH*; *University of Michigan, Ann Arbor, MI*; and Joel Howell, *University of Michigan, Ann Arbor, MI*: ***“Raising Oranges in Canada:” Education, Locality, and Conflict at the University of Michigan Medical School in the Late Nineteenth Century***

In 1889, the University of Michigan Medical School faculty was engaged in heated debate over a proposal to move the school’s clinical curriculum from the small,

quiet community of Ann Arbor to the much larger and economically vibrant city of Detroit. The issue was certainly not new—inaugural faculty member Moses Gunn had supported a move to Detroit in the late 1850s—but by the late 1880s the proposal sparked passionate debate and even scandal in Michigan’s professional and public communities alike. Along with many Michigan regents and community spokespeople, the University of Michigan Medical School dean, Victor Vaughan, publicly took a firm stance against both the move to Detroit itself and its more vocal supporters, particularly faculty members George Frothingham and Donald Maclean (both of whom were subsequently forced to resign). However, institutional records and private correspondence reveals far more nuanced discourse than appeared in the public discussions. While the argument at first glance seemed to center on the relatively small number of Ann Arbor residents and the advantages of Detroit’s larger patient population (and has thus been portrayed in the historical literature), the “Detroit matter” was in fact far more complicated than that. It lay at the heart of significant intersecting (and sometimes conflicting) factors, including: concerns about professional responsibility in “outsourcing” student clinical experiences to Detroit’s hospitals; relationships between the medical school, the state university, and the general public; the growing influence of laboratory science in American medical education; changes in transportation and new plans for Ann Arbor’s University hospital facilities; and different perspectives on the necessity (and propriety) of clinical clerkships. This paper uses a wide variety of primary documents—including minutes of the University Board of Regents, private correspondence, faculty meeting records, and newspaper editorials—to highlight how complexities of the “Detroit matter” exemplify a crucial debate in the history of American medical education.

Learning objectives:

Identify successes and failures in the history of medical education and professionalism in the United States

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

Recognize the dynamic historical interrelationship between science, medicine and society

Jean C. Whelan, *University of Pennsylvania, Philadelphia, PA: Learning to Work, Working to Learn: Early 19th Century U.S. Nurse Education and Distribution Schemes*

Traditionally, professional nurse education in the United States is dated from the latter half of the 19th century, when three schools of nursing loosely based on Florence Nightingale’s ideas opened. Nightingale’s popularity and her reputation as the heroine of the Crimean War lent these schools an aura of respectability and acceptance. More critical historians counter that the 1860 establishment of the educational program at Philadelphia Woman’s Hospital represents the first U.S. school of nursing. For those holding this view, the events of the Civil War as well as the emergence of a larger number of women entering the medical profession created an environment conducive to educating nurses. Little credit is given to the 1838 organization of the Philadelphia Nurses’ Charity as a major influence on the way in which nursing developed. Yet, this organization merits re-examination and analysis. The Nurse Charity, organized by physician Joseph Warrington, and later

subsumed into the Philadelphia Lying-In Hospital and Training School, began operations in 1838 as a benevolent effort to supply nurses to indigent birthing women. As part of this plan, the Nurse Charity offered working women a course of lectures and practical, supervised instruction in nursing which upon completion of the program enabled them to hire out as private nurses. The Nurse Charity operated for sixty years and is a compelling example of an innovative effort to launch a substantial, successful nurse training program in the years before both the Nightingale era and the Civil War. This paper examines the Nurse Charity as a means of illuminating the formation, problems and issues facing 19th century nurse education. It focuses particularly on how the Nurse Charity joined education and practice to form the template of later nurse education programs which inextricably linked education with work. Further, by pushing back the beginning of American nursing education to the early 19th century it recognizes a different social, economic and cultural context from which to examine nursing's development. Finally, it addresses the importance or non-importance of designating any program as the "first" and raises questions about the value of doing so.

Learning objectives:

Identify early U.S Nurse education schemes and their influence on later professional nurse education programs

Develop a deeper understanding of the varied origins of professional nurse education in the U.S.

Recognize the symbiotic interrelationship between nursing education, practice and work.

Sara Robertson, *University of California, San Francisco, San Francisco, CA: **Divergent Disciplines: The Declining Relevance of Botanical Studies in American Pharmaceutical Education***

In the early Nineteenth century, as pharmacists endeavored to establish themselves within medical practice as a specialized profession dedicated to making and dispensing therapeutics, colleges of pharmacy emerged across the American landscape. The curricular decisions established by these colleges represented the types of information pharmacists considered relevant and essential for professional and successful practice. Shifts in curricular trends, then, indicate broader shifts in therapeutics and medical practice. Moreover, through analysis of syllabi and curricula designed for American colleges of pharmacy, and with especial consideration of the shifts in these structures as they occurred in a particular institution, an understanding of botanicals in the history of Western therapeutics emerges.

Plant-based remedies have long accounted for a portion of Western pharmacopoeia. However, the form of plants as drugs has change considerably; from crude preparations of whole plants or specific plant parts to purified, isolated compounds. Throughout the Nineteenth century, regular physicians supported crude plant-based medicine and medical botany texts proliferated. Likewise, colleges of pharmacy offered botany, materia medica, and pharmacognosy courses as both staple and foundational courses. In most colleges of pharmacy in the United States,

the presence of these plant-based courses lasted for at least the entire first century of instruction. Then, pharmaceutical curricula shifted from regarding these plant-based disciplines as entirely essential to largely irrelevant, discarding the courses by the mid-1970s.

This paper aims to highlight the theoretical and practical implications of iatrochemistry for therapeutics through the examination of curricular reform as it occurred in colleges of pharmacy. Through the consideration of lecture notes and exams, textbooks, instructional material, and laboratory instrumentation, this paper analyzes the scope of botanical disciplines as they existed in pharmaceutical curricula during the Nineteenth and twentieth centuries. Moreover, this paper contextualizes the declining relevance of botanical courses and plant-based medicine in its traditional, crude form given broader, concurrent trends in iatrochemistry and pharmaceutical practice. In doing so, it will begin to highlight the manner by which medical practice necessarily transformed a major portion of pharmacopeia to conform to modern therapeutics.

Learning objectives:

Examine how educational institutions reform instruction to reflect newer theories in medicine.

Expand the history of plant-based therapies as they have existed in Western medicine.

Develop an analytical understanding of the tenets of modern therapeutics.

I5: Later Nineteenth-Century State Medicine

George Room

Moderator: Jacob Steer-Williams, College of Charleston

James Hanley, *University of Winnipeg, Winnipeg, MB: Act Local, Think National: Public Health in the Victorian Political Imagination*

In 1872, William Gladstone's Liberal government made the first national grants for public health purposes, underwriting sanitary loans at below market rates and paying for half the cost of sanitary officers and Medical Officers of Health. Although hardly the first instance in which national funds were used for health, these grants appeared to represent a new departure, echoing Disraeli's call for sanitary matters to become national priorities. Several historians have argued they are more properly seen as representing political partisan positions in matters of local taxation. In this paper, drawing on Gladstone's correspondence, cabinet documents, parliamentary debates, and newspaper editorials, I argue that they represented as well a debate over the character of the national and local state, including the duties that belonged to each and the proper means by which they should be delivered and financed. The dispute over local taxation forced local and the national elites to draw distinctions between functions carried out by the state, identifying some as local and some national. Discussion of this taxonomy had occurred before but was given fresh impetus in the 1860s as a result of both academic discussion by authors such as JS Mill and annual parliamentary debates on the matter. These debates

revealed a significant disconnect between national and local elite conceptions of service provision, particularly around public health. Ongoing disagreement over these taxonomies inhibited national assistance to localities and thus significantly influenced the tempo of sanitary reform.

Learning objectives:

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

Recognize the dynamic interrelationship between medicine and society through history.

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

Lorraine Dong, *The University of Texas at Austin, Austin, TX: "You live and you die by your medical records": The social ecologies of Larch Point Hospital mental health records from 1870 to present*

This paper focuses on a portion of my dissertation research to identify the discursive actions that have taken place in and through institutional records over a 100-year period at Larch Point Hospital (LPH).^{*} I will examine two themes: first, what are the key historical social disparities, dialogues, and negotiations between stakeholders that are present in the existing records and expounded upon by interviewees? Second, how can modern day stakeholders of archival mental health records recompense past and ongoing inequities represented by the records?

I ground my research in Actor-Network Theory (ANT) in order to examine the social roles of records as objects that mediate relationships between people. I will present a qualitative analysis of the LPH records over three eras in the hospital's history and highlight the predominant hierarchies and inequalities that have been integral to the creation and retention of this set of records. Within the records are ingrained cultural attitudes and practices regarding race, gender, and mental illness, among other topics.

By utilizing ANT, I have expanded the social ecologies surrounding mental health records. My research takes into account more than the primary actors and actants that currently control the preservation and access to inactive mental health records, e.g., the state hospital and archives, HIPAA, and state laws and policies. By considering all of the stakeholders (both active and those without agency, as is the case with many of the LPH patients named in the records) who have claim over the health records – whether legally, intellectually, or emotionally – I have been able to think about the processes of how we manage active and inactive health records, and how the decision-making about inactive records can become more inclusive and participatory. I will conclude with alternative arrangements and uses for the records that can mitigate historical inequities while upholding current privacy laws and respecting the longstanding relationships between the records and institutional stakeholders.

* LPH is an active state mental facility in the American South that was founded in 1870; due to a privacy agreement with the hospital, I have provided the institution and its staff with pseudonyms.

Learning objectives:

Recognize the dynamic interrelationship between medicine and society through history

Critically appraise clinical management from a historical perspective

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

Matthew Newsom Kerr, *Santa Clara University, Santa Clara, CA: Tracing Smallpox: Hospitals, Cartography and the Health of London*

This paper examines William Henry Power's landmark 1881 and 1884 studies of smallpox in the vicinity of the Fulham Smallpox Hospital in London. A medical investigator for the Local Government Board, Power had been tasked with wading into a particularly bitter public debate about the placement of smallpox hospitals. Residents of Fulham and West London insisted that the recently established Fulham Hospital, which accommodated patients from all over London, constituted a mortal danger to their locality. An outbreak of smallpox in early 1881 provided the opportunity to test these allegations. To the great surprise of many public health officials, Power concluded that the building had created a locus of disproportionate smallpox incidence during epidemic periods. Power deduced, even more controversially, that smallpox must have been emitted from the hospital and broadcast through the air. This seminal epidemiological study gave birth to a three-decades-long professional dispute over so-called "hospital influences" in epidemics – a debate that Anne Hardy has called one of the most "agonized" in the history of preventive medicine. In his long subsequent career, Power went on to gain a reputation as "the prince of epidemiologists." But his hypothesis regarding the distal aerial dissemination of smallpox remained highly controversial and never fully resolved. Time and again, the dispute revolved around the production of spot maps and Power's contention that cartography could effectively act as a device of social observation. My paper places the epidemiological squabble over smallpox hospitals into the late-Victorian contexts of epidemic surveillance and urban investigation, shoe-leather detection and scientific representation. The tracing and inscribing of "hospital influences" illuminates a contentious visual culture of public health science and a tension between competing epidemiological techniques. Yet the debate also reveals wide agreement about novel techniques for spatializing the city and for making London amenable to sanitary government.

Learning objectives:

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

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

Recognize the dynamic interrelationship between medicine and society through history

Disabilities Resources Information

Omni Hotel:

The conference hotel (Omni Hotel at Yale) is centrally located in New Haven with ground level access and elevators to all conference rooms and spaces.

Yale Venues:

Sterling Library (Garrison Reception): Accessible entrance faces Cross Campus (ramp). Ring doorbell for assistance. Elevator is straight back from main entrance. Men's and women's accessible restrooms are on the ground floor in the Music Library.

Yale Commons (Ninetieth Birthday Bash): Entrance is accessible close to the Beinecke Rare Book Library entrance to Woolsey Hall. Automatic door opener is available but sometimes locked; please call Commons Manager at 203 432 0752. Accessible unisex restroom is to the left of this door, closest to the High Street side of the Dining Hall (signs).

Sterling Law Buildings (Garrison Lecture): Entrance is accessible from ramp located on Wall Street. Inside the building, there is a ramp on the left-side. An elevator is located halfway down the walkway on the left-side. Accessible men's and women's bathrooms are located on the basement level.

Yale's Office for Disabilities Resources has information at:

<http://yalecollege.yale.edu/student-services/resource-office-disabilities>

A campus map with disabilities access points is at:

<http://www.yale.edu/rod/accessmap/>

Local Transportation:

Buses

All CTTRANSIT buses have wheelchair lifts or ramps for access by persons with disabilities. Also, the bus can "kneel" to lower the first step height. Please ask the operator to kneel the bus to assist you in boarding or alighting.

Most types of mobility devices (wheelchairs, 3-wheel scooters, and walkers) can be accommodated on the buses. Each bus has a system for securing wheelchairs near the front of the bus. CTTRANSIT safety policy requires a 4-point securement for all mobility devices. Use of the lap belt is recommended for the customer's maximum safety.

Non-wheelchair, mobility impaired passengers may also use the lift or ramp to board the bus. Please ask the operator to deploy the mobility access unit. Passengers standing on the lift device should hold the handrails firmly and watch their head because of the vertical height limitations.

Taxis

Several taxi companies serve the New Haven Train Station (taxi line in front of the station) as well as the Tweed New Haven Airport. Taxis in New Haven cannot be hailed on the street, but must be requested by phone

Metro Taxi Accessible Service (203 777 7777). These taxis comply with The Americans with Disabilities Act and include tie-downs to secure the passenger and his/her wheelchair or scooter offering plenty of headroom easily and comfortably. They offer lowered-floor, rear entry minivans or the new side entry MV-1, a purpose built taxicab made specifically to accommodate passengers with wheelchairs.

The **Metro Taxi Accessible Service** cab is the state's first ADA-compliant taxicab. It is operated by Metro Taxi drivers who have additional training, and earn the company's requisite customer service ethics qualifications.

Metro Taxi Accessible Service is servicing customers who use wheelchairs and scooters in 13 towns and cities in the Greater New Haven area, 24 hours a day; seven days a week.

Directions to Meeting Venues:

Omni Hotel: (145 Temple St.)

Sterling Memorial Library (120 High St.)

From Sterling Law Building: Exit the building, turn left and walk to High St (about 50 ft), turn right on the walkway (extension of High St on your left) and walk about 100 ft to the entrance of Sterling Memorial Library on your right.

From the Omni Hotel, go right along Temple St to first corner, turn left on Chapel St. Follow Chapel one block to College, turn right on College and walk past Old Campus on left and New Haven Green on your right. Walk one block and cross Elm St. Continue one-half block along College, then turn left on "Cross Campus" walkway which leads directly to Sterling Memorial Library entrance.

Levinson Auditorium (Sterling Law Building 127 Wall St)

Exit Omni Hotel, go right along Temple St to first corner, turn left on Chapel St. Follow Chapel one block to College, turn right on College and walk past Old Campus on left and New Haven Green on your right. Walk two blocks, crossing Elm and on to Wall St. Turn left on Wall St. and walk one block crossing High St. Just across High St., the entrance to the Sterling Law Building is on the right. Enter and proceed to the end of the corridor where the entrance to the auditorium is on the right.

The Yale Commons (168 Grove St.)

Exit Omni Hotel, go right along Temple St to first corner, turn left on Chapel St. Follow Chapel one block to College, turn right on College and walk past Old Campus on left and New Haven Green on your right. Walk two blocks along College, crossing Elm St. and Wall St., and proceed to corner of Grove St and Elm St. Enter Memorial Hall (Large Greek Rotunda) which provides the easiest entrance to Yale Commons.

Yale Art Gallery (1111 Chapel St.)

Exit Omni Hotel, go right along Temple St to first corner, turn left on Chapel St. Follow Chapel two and one-half blocks, crossing College and High Streets. The Yale Art Gallery is on the right hand side.

Medical Historical Library at the Medical School (333 Cedar St.)

Exit Omni Hotel, go left along Temple St to first corner, turn right on Crown St and proceed one block to College. Turn left on College St, and walk 4 blocks on College (over the highway overpass). College ends at the intersection with Congress Ave which intersects Cedar St. in one-half block. Turn right on Cedar St. and proceed one-half block to the entrance to the School of Medicine.

Yale Campus Tour (Meeting place: Yale Visitor Center, 149 Elm St.)

Exit Omni Hotel, go right along Temple St, cross Chapel St and continue on Temple across the New Haven Green. Elm St crosses Temple at far end of The Green. Turn left on Elm. 149 Elm is 2nd building on right.

Corrections and Modifications to the Program

Buses to Yale Commons for AAHM 90th Birthday Party:
Saturday, 2 May, starting from the Omni at 6:15 pm.

Concurrent Session G3: International Narcotics Control

Addition:

Noël K. Wolfe, *Fordham University, Bronx, NY*: *Bronx Community Activists: Crafting a "Community" Response to Crack Cocaine. (Abstract, below)*

Concurrent Session H5: Pre-modern Pharmacy in Eurasia

Deletion:

Stacey Van Vleet, *Columbia University, New York, NY*: *The Medicine Buddha's Alchemy: History, Purity and Precious Pills in Tibetan Buddhist Medical Rituals (17th-Early 20th Centuries).*

Noël K. Wolfe, *Fordham University, Bronx, NY*: *Bronx Community Activists: Crafting a "Community" Response to Crack Cocaine.*

There is general consensus among drug policy scholars that the modern drug war in the United States is not only a failure but has had a detrimental impact on American society, particularly on minority communities. Lost in the scholarly condemnation of the War on Drugs are the voices of black and Latino activists who literally fought with drug sellers in their community, demanded a punitive response to crack by police and politicians, and described their own actions using the rhetoric of war. My paper examines faith-based community activism against crack cocaine in the Bronx from 1983 through 1990. It shows that an impetus for the draconian response to crack came not only from law and order politicians but also from multiracial communities besieged by crack and crack-related violence. While activists from the Northwest Bronx Community & Clergy Coalition and South Bronx Churches outlined a broader anti-drug strategy that addressed education and rehabilitation, their earliest and most sustained demands were for a criminal justice response to crack cocaine in their neighborhoods. These demands were made several years before the passage of federal anti-drug laws that ushered in a new age of racially discriminatory sentencing and mass incarceration. Utilizing the Coalition and SBC's organizational papers, oral histories and New York City newspapers, my research uncovers how the social, cultural and political climate influenced and constrained Bronx anti-drug activism.

Learning Objectives

Examine the social, cultural and political factors that reinforced a punitive rather than a treatment-based approach to crack cocaine

Consider the constraints on urban community activism in response to drug crises

Discuss how Bronx anti-drug activism expands our understanding of the War on Drugs
