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Abstracts

A1 Coverage Matters: Health Insurance, Medicine, and Society in East and Southeast Asia

1. John DiMoia, Seoul National University

National Health Insurance and the Politics of Health Reform in South Korea, 1967-1983

Following the initial wave of enthusiasm (February-early Fall 2020) during the COVID epidemic, a number of East Asian health systems received international praise for maintaining low case numbers. This paper seeks to return to this period by taking a critical look at South Korean national health insurance, which has received similar forms of praise for handling the pandemic conditions, providing the majority of Koreans with baseline care.

Started in 1963, Korean health insurance next expanded in 1977 to cover increasingly larger groups of workers, with additional measures coming in 1989. However, coverage for the self-employed and similar categories of workers excluded from the original scheme did not come until 2004, and then only with great contestation.

Rather than reading national health insurance as corresponding closely to the democratization process for South Korea, as is typical in much of the scholarship, I argue that its evolution has been incomplete, marked by gaps, and most importantly, deeply contested. Successive Korean governing forces have used insurance to legitimate their rule, both under authoritarian and democratic forms of rule.

1. To expose audience to comparative EA health systems
2. To challenge perceptions re COVID and Korean “success” story
3. To critique the relationships among national insurance, democratization, and civil society

3. Wayne Soon, University of Minnesota

Rethinking Taiwan’s Universal Healthcare: Global Actuarial Science and Chinese Authoritarianism

This presentation explores the history of the Chinese Nationalist Party (Kuomintang KMT) government’s expansion of health insurance in Taiwan from 1950 to the 2010s. I argue that the KMT party-state’s expansion of health insurance privileged government employees, who were the core supporters of the ruling party. By comparing the history of the insurance programs for government employees, the paper makes the case that KMT provided better coverage, lower premiums, and less medical gatekeeping for government employees who fled to Taiwan with the KMT than for ordinary laborers who identified more as Taiwanese. Such a discriminatory process was also buttressed by global actuarial science experts from the United Nation’s International Labor Organization. This China-centered approach towards universalizing

healthcare on the island became increasingly challenged by provincial legislators, labor activists, and the emerging political opposition that promoted local Taiwanese concerns on healthcare equity and access. This paper concludes that this dual process of KMT's population management and leveraging of United Nations actuarial expertise as the Republic of China became symbolic of the bio-geopolitics that animated the history and development of health insurance in Taiwan.

1. To expose audience to comparative East Asian health systems
2. To show the saliences of class and race in health insurance histories
3. To critique the relationships among national insurance, actuarial science, and civil society

3. Mohammad Khamsya Bin Khidzer, University of California, San Diego

Sickly, Idle and Risky Minorities: Race and Diabetes under Singapore's Emergent Insurantal Imaginary

How does healthcare financing as a technique of power engender emergent racialized meanings in public discourse? This paper considers the historical development of an insurantal imaginary, defined as a social context in which profitable, useful and necessary uses can be found for insurance technology, as a condition which gives rise to the articulation of the sickly, idle and risky minorities within Singapore's discourse on diabetes. I argue that the notion of sickly, idle and risky minority bodies could not have emerged in a system of national healthcare financing based on forced savings and government subsidy. The introduction of a universal national health insurance system and risk pooling in 2015 catalyzed a nascent insurantal imaginary that converges with postcolonial racial discourse in Singapore to enable a moralizing language of racialized responsibility and accountability for minority racial groups whose health woes are framed as burdensome to the nation. The findings from this research also represent a contribution to the broader theorizing of 'Asian biopolitics' through arguing the for the continued relevance of race ethnicity and nation in science and medicine in Asia, as well as the consideration of geopolitics in the shaping of the postcolonial Singapore body politic.

Develop Communicative Competency for Elected Representatives, Public Health and Healthcare Professionals.

Improve awareness of potential impact of public statements regarding health and race.

Highlight the dynamic history of race, health and medicine as well as the need for continued learning to maintain communicative competency.

A2 Animals

1. Bethany Johnson, University of South Carolina

Remember the Ground Squirrels: Public Health Physicians and Vector Narratives During the California Plague Outbreaks (1900-1925)

Although officials targeted rats as vectors of bubonic plague in San Francisco after 1900 and pneumonic plague in Los Angeles in the fall of 1924, a parallel infection narrative emerged in public health publications as early as 1908. Between 1908 and 1926, reports, case studies, and articles published by state and federal public health institutions targeted the ground squirrel as the primary vector of *Yersinia pestis* in California, infecting rats, fleas, and sometimes, humans. State and federal research on ground squirrel infestation, epizootic die-off, den migration, ectoparasite behavior, and the market for ground squirrel meat suggests that these rodents were (and remain) the primary vectors in the state. So, why did public health officials and municipal leaders focus primarily on rats? Since plague is not a human disease, institutional responses to plague outbreaks in early twentieth-century California are uniquely representative of the tensions that existed between public health officials, municipal leaders, and the media. Media sources (and some officials) targeted sanitation in immigrant communities (e.g., Chinese and Mexican) as the source of outbreaks. Destroying blighted housing and urban rat colonies or rat-proofing properties at the landlords' expense comprised the preferred approach by municipal leaders. Physicians working for public health institutions sought monetary support for long-term eradication plans, including permanent bacteriological labs and rodent capture. Rat eradication received enthusiastic funding during outbreaks, but civic support for continuing prevention programs eventually evaporated. Reconsidering the primary role of ground squirrels as plague vectors reveals that municipal resistance to ongoing prevention programs hobbled public health efforts and played a significant role in establishing long-term plague foci throughout the American west.

- 1) Develop knowledge and understanding of professional behaviors and values. This includes the sub-objectives: (A) develop the capacity for critical thinking about the nature, ends, and limits of medicine, (B) identify successes and failures in the history of medical professionalism, and (C) recognize the dynamic interrelationship between medicine and society through history. My addition to the "develop knowledge and understanding category" is: (D) recognize the dynamic, fluctuating connections between biotic and abiotic systems and epidemic disease.
- 2) Contribute to the improvement of patient care, including: (A) acquiring a historically nuanced understanding of the organization of the U.S. healthcare system

2. Tom Quick, Maastricht University

Flying Monkeys and the Polio Vaccine: A Logistical History of the Rhesus Macaque

This paper explores some of the wider environmental impacts of polio vaccine manufacture during the 1950s. Specifically, it examines the ways in which anti-polio campaigns relied on vastly increased use of Rhesus macaque in biomedicine, entangling them within then-emergent logistical networks. Demand for polio vaccination in the West facilitated the emergence of new trade routes for Rhesus, funnelling them from their native habitats in the newly independent nations of India and Pakistan and into the laboratories of pharmaceutical companies. Yet contemporary uncertainties regarding the geopolitical, moral and vital conditions under which these animals could be legitimately enrolled as resources in vaccine manufacture threatened to destabilize their status as tradeable scientific objects. The logistical requirements of polio vaccine manufacture helped motivate significant alterations in attitudes towards these animals

amongst governments (especially India, the UK and the US), animal advocate organizations (e.g. the RSPCA and affiliated organizations), and scientists themselves (e.g. at the UK's Laboratory Animals Bureau).

In addressing the contested status of Rhesus at this time, this paper will thereby show how the enrolment of animals within networks of biomedical practice challenged political and cultural as well as scientific assumptions regarding laboratory animals. It will thereby highlight the difficulties involved in disentangling the post-WWII history of laboratory animals from that of the contemporary emergence of logistics as a driving force of global economic change. It will place particular emphasis on ways in which the bulk air transportation of rhesus macaque helped constitute new sets of conditions through which they were conceived of and related to; both as resources for the creation and verification of biomedical material, and as beings with their own sets of needs, desires and interests.

Recognize the dynamic interrelationship between medicine, capitalism and society through history

Gain awareness of the reliance of contemporary biomedicine on global networks of exchange

Recognize ways in which biomedicine enrolls and transforms its surroundings, e.g. by alternating the conditions of animal life and death

3. Rebecca Kaplan, Oklahoma State University

Viral Space: Plum Island Laboratory, Animal Disease Research, and Rumor in the United States, 1955 – 2022

In the late 19th century, animal disease investigations increased at American universities and government institutions. Farmers, ranchers, animal health workers, and politicians viewed imported livestock illnesses as potential threats to the country's agriculture economies and non-human animals leading to this growth in laboratories, industry groups, and state and federal government agencies that researched these diseases. Despite the growth of veterinary medicine research, the Department of Agriculture barred private and public laboratories from working on certain causal organisms, such as the foot and mouth disease (FMD) virus. These policies prohibited the use of the virus in laboratories or research farms because the threat of an accidental laboratory release was considered too grave of a risk to American livestock. Instead, animal health practitioners sought knowledge about FMD in Europe and South America where the disease was enzootic.

Mid-20th century FMD outbreaks in Canada and Mexico led to changes in these policies including the development of a USDA laboratory on Plum Island, NY designed to house research on deadly animal diseases. Billed as the Alcatraz of germs, everything about the scientific space from the location to building design was created to prevent the uncontrolled release of organisms, micro and macro. The development of the laboratory and its operation as a secure facility with limited public access prevented accidental outbreaks but provided fertile ground for rumors. People accused Plum Island researchers of designing bioweapons, spreading Lyme disease, stealing people's dogs for experimentation, creating monstrous creatures and more

over the last 70 years. For parts of the public, Plum Island is home not just to viruses but also viral conspiracy theories. While these theories have been debunked, they raise questions about public access to governmental research and how to balance biosecurity and public knowledge.

Recognize the dynamic interrelationship between medicine and society through history
Acquire an historically informed understanding of how research practices and policies can shape popular narrative
Develop a historically nuanced understanding of the relationship between humans and non-human animals in medical research

A3 AIDS and Marginalization: When the past meets the present

1. Jeremy Lowe, University of California, San Francisco and University of Michigan
AIDS and Marginalization

The United States' Public Health Response to AIDS and the Aftermath in California, 1982-1988
In 1986, there was an attempt to pass CA Proposition 64 which would enact statewide mandatory HIV testing of suspected individuals at risk of spreading the disease and quarantine AIDS-infected persons based on the California Department of Public Health's guidelines to infectious and communicable diseases. Enacted in 1988, the California Health and Safety Code 120291 provided the framework to the ways in which state law defined HIV/AIDS criminal activities for Californians. Though such forms of public health measure and interventions sought to slow the spread of HIV/AIDS, this research paper will argue that the Reagan Administration's approach to being tough on crime contributed to the prevalence of HIV among vulnerable populations and to the incarceration of populations already heavily surveilled.

The spread of HIV/AIDS prompted policies to protect population health and drastic interventions of surveillance, policing, and incarceration. The clash between protecting the public's health and criminalizing disease raises the following questions: (1) Who were the major stakeholders in the implementation of the HIV-crime law? (2) What did the implementation of the US HIV-crime law demonstrate about the ways in which public health leaned on the criminal justice system as a means of intervention to protect the public's health? (3) How does the historiography of bioethics and reporting span concerns over state level public health measures? These questions help provide some foundation to historicizing the AIDS epidemic through the lens of American legal authority over public health.

Moreover, the research paper will amalgamate the various disciplines to historicize US government responses to the AIDS epidemic. The US governmental response to the early cases of AIDS helps historicize how the reporting of AIDS cases and the implementation of the 1988 HIV-crime law in California, though well intended, displayed poor public health intervention in the United States throughout the late 20th century.

Identify successes and failures in the history of public health measures
Recognize the dynamic interrelationship between public health and society through history
Develop the capacity for critical thinking about the nature, ends and limits of public health

2. John Carranza, University of Texas at Austin

HIV/AIDS as Disability: Bragdon v. Abbott, Respectability, and the Americans with Disabilities Act

This paper discusses the extent to which AIDS produced disability in individuals who were formerly considered to be able-bodied and how they won legal protections under the Americans with Disabilities Act of 1990 (ADA). Since HIV infection spread through stigmatized routes, people who became HIV-positive or were experiencing severe AIDS-related complications were exposed to discrimination in vital areas of life, such as healthcare and housing. By 1990, the passage of the Americans with Disabilities Act came to signal a critical response to discrimination based on disability status and extended legal protects to a large swath of the American population. However, HIV-positive and people with AIDS (PWAs) were still omitted from protection. Here, I examine the significance of the Bragdon v. Abbott (1998) Supreme Court decision and how "respectability" came to influence subsequent legal protections for HIV-positive people and PWAs under the ADA.

Contribute to the improvement of patient care

By: Thinking critically about how the law determines chronic illness as a disability; Who has access to healthcare and how misconceptions of disease curb or open that access; Consider the ethical implications of denying care to a patient with a chronic illness

3. Dalena Ngo, Yale University

HIV/AIDS Community-Based Partnerships between Universities and Correctional Facilities

Universities are anchor institutions, meaning that they are “are place-based, mission-driven entities such as hospitals, universities, and government agencies that leverage their economic power alongside their human and intellectual resources to improve the long-term health and social welfare of their communities.” Regarding this, community-based partnerships are important in delivering healthcare to marginalized folks, particularly HIV/AIDS care before and after release. The prevalence of HIV in incarcerated individuals is higher than in the general population and the overlapping epidemics of HIV and incarceration present a unique challenge that signify a complex array of determinants that can be delineated through community-based partnerships between academic medical centers and prison systems. This paper will examine the ways in which these community-based partnerships might produce continuity of care, but also work as functions of the neoliberal state, for example the University of Connecticut Health Center’s one hundred- and forty-million-dollar contract with the Connecticut Department of Corrections, to provide medical, dental, mental health, and pharmacy services at sixteen facilities. The provision of care is heavily intertwined through multiple apparatuses, and I seek to elucidate how universities work through prison systems to do engender their own agenda.

acquire a historically nuanced understanding of the organization of the U.S. healthcare system

A4 Teaching & Training

1. G. Jasper Conner, College of William and Mary

Race and the Failed Promise of Vocational Rehabilitation in the Segregated South

Following the passage of the Smith-Hughes Vocational Education Law in 1920, vocational rehabilitation for disabled civilians was organized and funded on a national scale. Though the rehabilitation of disabled veterans has received significant scholarly attention, vocational rehabilitation of ordinary workers remains understudied in histories of labor, disability, and medicine. While the project of vocational rehabilitation promised to render broken bodies productive, for most disabled people this prospect remained elusive. This was especially true for disabled African Americans living in the segregated South. Programs aimed at training disabled workers were administered by state agencies which reported to federal authorities, but remained largely independent in their approach to the work. Using the records of various Southern agencies involved with vocational rehabilitation, I argue that Southern states adopted an unstated policy of extending medical services and cash aid to disabled African Americans while largely reserving vocational education programs for white men. Vocational rehabilitation officials chose to mostly exclude Black workers from rehabilitation programs for two reasons. Prevailing notions about Black inferiority ensured that rehabilitationists underestimated the capabilities of potential trainees while many of the jobs for which they might be trained were customarily reserved for white workers in the Southern economy. I argue that this policy ensured that most Black disabled workers in the segregated South were forced to subsist from meager welfare payments, confining them to a position of dependence which reinforced white ideas about Black inferiority.

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

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.

Develop an historically informed sensitivity to the diversity of patients.

2. Mary Brazelton, University of Cambridge

Lyon in an Age of Uncertainty: Undisciplined Medical Students at the Sino-French Institute, 1921-45

This paper considers an unusual programme of medical education organised through the Lyon Sino-French Institute, which sponsored the postgraduate studies of over four hundred Chinese youths in France between 1921 and 1951. Forty of these students studied at the Faculty of Medicine in Lyon and affiliated organisations; examination of their French- and Chinese-language correspondence, publications, and medical theses provides an opportunity to learn what kinds of knowledge they valued, and why, amid radical epistemological uncertainty.

The men and women who arrived in Lyon had experienced unprecedented upheaval. The intellectual world into which they were born collapsed in 1905 with the dismantling of China's imperial examination system: a framework founded on a classical canon and cosmology that guided education, government, and politics. The Qing dynasty itself fell in 1911, to be replaced by a Republic. Amid intellectual and political uncertainty, what assumptions and ideals shaped the choices of Chinese youths to study medicine abroad? And why did some students go to France? As Bridie Andrews, David Luesink, and others have shown, many aspiring physicians of Western medicine preferred to study in Japan, or England and the United States.

I suggest that scientism and nationalism, as well as self-interest, drove Institute members to study medicine. Medical education held particular appeal because the tensions between practical training and textbook learning characteristic of French medical education in this period offered unusual independence and adaptability at a time when it was unclear what intellectual structures or disciplines might become important in the new Chinese Republic. Students ultimately benefited professionally from pursuing multiple, apparently disjointed courses of medical study, despite administrators' disapproval. The case of the Institute thus suggests that the French impact on medicine in China has been under-valued—and also that Chinese students themselves actively contributed to early-twentieth-century French medical practice and instruction.

In examining the Lyon Sino-French Institute as a case study of transnational exchange in medical education, this paper will help attendees (1) 'recognize the dynamic interrelationship between medicine and society through history.' The Institute's students often pursued medical courses and experience without prior approval, sometimes incurring disciplinary action as a result. Yet such autonomous tendencies often enabled students to become qualified physicians. This narrative thus adds nuance to the (2) 'identification of success and failure in the history of medical professionalism' and allows (3) 'critical appraisal of clinical management from a historical perspective.'

A5 Contesting Popular Knowledge

1. Molly Walker, Harvard University

Producing Medical Knowledge Amid Conflict: Malaria Intelligence, Information, and Propaganda in Early Soviet Georgia (1914-1945)

Invasion, annexation, and resistance amid a dangerous epidemic have, tragically, blighted the shores of the Black Sea before. On the heels of the Russian Revolution and civil war, and after years of world war, the Democratic Republic of Georgia won and lost its independence from Russia within just three years. When the Red Army invaded Georgia in February 1921, it stymied the country's ability to address public health crises. Malaria, already endemic to the region, grew epidemic. Contemporary reports listed pre-war morbidity due to malaria at 25,000 individuals per year, but in 1921, that rate increased twelve-fold to 300,000. That same year, one relief organization reported that out of a population of 6,000 in one Tbilisi neighborhood,

5,179 individuals were infected. Malaria control became one of the most urgent concerns of Soviet authorities hoping to pacify the new Georgian Soviet Socialist Republic. In this paper, I ask how competing actors negotiated malaria meanings and control policies during this period of conflict. I argue that, because malaria was of strategic significance to the military, secret police, and new party-state during rebellion and wars, ways of knowing the disease became entangled with intelligence and propaganda regimes. Just as conflict shaped the knowledge being produced about malaria and public health, so too did it influence the health information being reported to the public. During a 1923 malaria epidemic in which more than twelve million people throughout the entire Soviet Union were infected, authorities dramatically underreported case and mortality rates. I conclude that in response to a dearth of satisfying information about malaria, Georgians speculated and circulated rumors and even conspiracies about the disease, exacerbating already-strained tensions between Georgians and Soviet authorities. Despite heavy investments in a system of anti-malaria stations, the infectious disease nevertheless lingered, especially on the coast, during the 1924 uprising, and it reemerged in force during WWII. This case study will inform scholarly discussions of the production of medical knowledge during conflict, the circulation of health information, and global medical imperialism.

By the end of this activity, the learner will:

- recognize the dynamic interrelationship between medicine and society through history
- promote tolerance for ambiguity of theories and the nature of evidence

2. Kenneth Pinnow, Allegheny College

Bad Doctors, Bad Patients: Law, Ethics, and the Negotiation of Medical Authority in the Early Soviet Union

During the 1920s and 30s, doctors in the Soviet Union faced a newly empowered population that was making greater demands and had growing expectations about its care and treatment. Patients in turn faced what they perceived to be inept, callous, and recalcitrant doctors who resisted the new ways of Soviet socialism. Acts of violence against physicians, coupled with an uptick in criminal cases for medical malpractice, fed a climate of anxiety and mistrust. In response, the Soviet medical community increasingly turned to the law and the state for protection and to establish boundaries on expectations for doctors and patients alike. This paper explores the tensions between Soviet doctors and patients, including murders and assaults, as a window into the negotiation of medical authority. Using a comparative framework and focusing on the responses of doctors in their debates about medical ethics and malpractice, it argues that the reliance on external mechanisms like law and regulation speaks both to the redefinition of Soviet physicians as state employees and to the weaknesses of other sources of medical authority in an environment where tradition, self-governance, and respectability no longer held currency. Furthermore, this paper contends that the negotiation of medical authority in the USSR reflected a series of intersecting claims among doctors, patients, and the state that stemmed from the regime's class-based and collectivist vision of biological citizenship. Predicated on an extended process of acculturation and national development, this vision of

health and healthcare sought to make interactions between doctors and patients regular and normal. In the interim, however, Soviet physicians looked to more formal disciplinary powers as a means to solidify their position and limit threats from disgruntled patients and their angry relatives.

Given its focus on the historical construction of the doctor-patient relationship, including the importance of ideology, class, and socio-economic status, this presentation promotes the following learning objectives: 1) Recognize the dynamic interrelationship between medicine and society through history; 2) Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning; and 3) Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations).

3. Soile Ylivuori, University of Helsinki

Medical electricity, everyday vitalism, and 18th-century knowledge construction

This paper examines medical and popular depictions of eighteenth-century electrotherapies with the goal of teasing out the nature and popularity of the ontoepistemologies on which medical electricity was based. The 'electric fluid' was seen as the mediator between matter and spirit; it was depicted as the great 'vivifying principle' of nature and used in experiments to stimulate life in plants, animals, and humans. Accordingly, the paper argues that therapeutic explanations of electricity drew on vitalist understandings of matter, nature, and life, particularly influential in France among the 'Montpellier vitalists', who conceptualised matter as lively and active rather than immobile and passive. The paper will connect this tradition to new materialist ontologies of life and matter, most famously outlined by Jane Bennett. While recent scholarship has examined eighteenth-century vitalism mainly from the perspectives of scientific elites, this paper attempts to shed light on popular ontoepistemological understandings. Medical electricity as a practical manifestation of vitalism in everyday life provides an exceptional window into laypeople's ontoepistemological beliefs, allowing an investigation of how patients' understandings of their body's relationship to the world influenced their conceptualisations of the operating mechanisms and effectiveness of electrotherapies. The paper argues that a comparative analysis of expert and non-expert texts will yield new information of the popularity and heterogeneity of eighteenth-century ontoepistemological beliefs as well as the dynamics of two-way transfer of medical knowledge between experts and non-experts.

Developing the capacity for critical thinking about the nature, ends and limits of medicine; recognizing the dynamic interrelationship between medicine and society through history.

A6 Compromising Women's Health

1. Rachel Louise Moran, University of North Texas

"Not a Political Issue": Debating Postpartum and Post-Abortion Depressions, 1988-2010

Postpartum depression advocates have long argued that their cause is “not a political issue,” and must instead be understood as a non-partisan medical issue. The goal, though not always spoken, has often been to separate themselves from more divisive women’s health issues. By embracing languages of natural motherhood and frequent references to the health of the family, postpartum advocates have emphasized the nature of the problem separates it from controversial questions of abortion or birth control. When postpartum depression discussions were inevitably political, as with legislation and policies on screening, references to postpartum depression as a women’s disease were tempered with that second description of it as also a family disease and an infant’s disease.

These claims, especially claims of the non-partisan nature of postpartum depression, were challenged when postpartum depression activists tried to pass federal legislation on postpartum research. Its introducers framed the Melanie Blocker-Stokes Act, first proposed in 2001, as nonpartisan. The legislation was a small ask, \$3 million for research and programming. It consciously avoided a mandate on mental health screening, which had proven controversial when tried at the state level. But in response to the introduction of this legislation, Republican representatives introduced almost identical legislation on post-abortion depression. The project of framing post-abortion depression as a legitimate disease went back to anti-abortion activism of the 1980s. Then, anti-abortion activists and psychologists worked to establish abortion was a stressor or even a trauma for many women. Similar rhetorics of a women’s disease that was also a threat to the family connected the issues, even though the advocates for each were wholly different groups. Anti-abortion activists argued that more research into post-abortion mental health was needed, an argument they made before Congress in 1988. Once these consequences were proven, they reasoned, there would have to be policies of warning women about the risks of abortions.

Then, in the early 2000s, Republican representatives tried to tie post-abortion language to postpartum depression legislation. Joint hearings on the postpartum depression and post-abortion depression bills resulted. The fight led to the inclusion of some of the post-abortion language in the final version of the post-partum depression legislation as a compromise. The result was the bipartisan support postpartum depression advocates always claimed, but at a cost.

- Deepen understanding of illness and suffering
- Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
- Recognize the dynamic interrelationship between medicine and society through history

2. Udodiri Okwandu, Harvard University

Managing Misbehaving Mothers: Maternal Mental Illness and Postpartum Sterilization in North Carolina, 1934 - 1970

This paper explores how sterilization – as a treatment for maternal mental illnesses (i.e., psychoses related to pregnancy, childbirth, and childrearing) – served to reinforce normative gender and sex ideologies and manage racial and class hierarchies in North Carolina from 1934 to 1974. By the early twentieth century, obstetricians and psychiatrists recognized post-partum sterilization as treatment for certain women who suffered from maternal mental illnesses. This, in part, stemmed from the recognition that there was not a specific psychosis that impacted women during pregnancy, childbirth, and the postpartum period. Instead, any psychosis – from manic-depressive insanity to dementia praecox – could impact women during these periods. Given that different psychoses had varying prognoses, sterilization was recommended for women who were deemed likely to become psychotic again or harm herself or child following subsequent pregnancies. This practice was considered therapeutic sterilization, since it was intended to benefit the health of the patient. However, a close examination of the Proceedings of the Eugenics Board of North Carolina reveals that sterilization served both a therapeutic and eugenic purpose depending on the patient. In addition to considering a patient's prognosis, medical practitioners considered other factors, including their personality, family history, marital status, sexual history, and adherence to gender norms. For patients – often Black and/or low income – deemed pathological and transgressive, their sterilizations served the additional purpose of preventing the production of “defective” future generations. Thus, this paper illuminates how postpartum sterilization did more than simply manage “misbehaving mothers” who suffered from maternal mental illnesses, it also policed “deviant” subjects.

(1) Understand the dynamic history of medical ideas and practices and their implications on patients, (2) recognize the dynamic relationship between medicine and society through history, (3) understand how racial, class, and gender ideologies inform patients encounters with the healthcare system

3. Emily Seitz, Independent Scholar

“A crime in the sight of God”: Women Medical Students and Abortion in the Late Nineteenth-Century United States

In 1873 the Comstock Act made abortion illegal across the United States, and in the years immediately preceding the law six students at Woman's Medical College of Pennsylvania (WMC), the first medical college to train women in the United States, authored senior theses on abortion, feticide, and infanticide. Each of the authors abandoned the idea that abortion was permitted until the moment of quickening, or the point at which the mother could feel the movement of the fetal body. The doctrine of quickening governed the medical and legal communities through the early nineteenth century, but the students of WMC held a different view, believing instead that “that the foetus is from the very outset a living and distinct being, hence induced abortion is a crime second to none.” The boundaries of life had changed drastically in a span of only a few decades, and they were thoroughly policed by women physicians.

Women physicians spoke out against abortion because they were anxious to join the mainstream medical profession. The American Medical Association spearheaded the campaign

to criminalize abortion beginning in 1850 in an effort to discredit midwives, their main competition in a complex medical marketplace. The AMA's stance caused women physicians to adopt uncompromising views on abortion in an effort to distinguish themselves from practitioners of midwifery.

I argue instead that women physicians' dogmatic response to the procedure was both a result of their vulnerable position within the profession and a lack of consistent information about abortion in their education. This paper analyzes the clinical writings of women medical students and their medical school curriculum and finds no consensus concerning what constituted an abortion and when it was appropriate to perform the procedure. Further, the Comstock Act was defined in moral, not medical, language and provided a vague and unhelpful guide. Ultimately, the dogmatic response of women medical students and physicians makes sense when seen through the nexus of this inconsistent messaging. Students were legally and professionally vulnerable, and their uncertainty translated to public dogmatism and morality.

Identify successes and failures in the history of medical professionalism

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

Recognize the dynamic interrelationship between medicine and society through history

B1 Psychology, Knowledge & Power

1. Kellianne King, Pennsylvania State University

"Native Neurasthenia: An Examination of Nineteenth Century Medical Discourse and 'Nervous' Native Americans"

Keywords: psychiatry, Indigenous, 19th century United States

This paper adds to existing scholarship on health and Indigenous communities by shifting focus from physical ailments to discourses surrounding mental illness. It does so by considering the late nineteenth century phenomenon neurasthenia, a nervous disease white physicians believed afflicted mostly elite white men made ill by excessive ambition and intellect. Early neurologists pronounced neurasthenia a "disease of civilization," making the disease an ironic badge of honor. In constructing neurasthenia in their treatises, physicians insisted that Native Americans lacked the intellectual ability required to develop neurasthenia. I argue that examining the relationship between Native Americans and nervous disease sheds new light on the cultural myth of the "vanishing Indian." Physicians provided medical support to the myth by citing supposed unhygienic practices among Indigenous communities. At the same time, they argued that Indigenous bodies were inherently stronger than white bodies, an argument they also made regarding African-Americans. Nervous discourse helped resolve this apparent contradiction. As the supposed antithesis of "civilization" and "modernity," Indigenous groups were both immune from nervousness and facing certain extinction with the coming of a new "nervous" age. Physicians even made the argument that developing the disease would be a boon for Indigenous groups; it would indicate competency for citizenship and a place in

“modern” American life. Indian boarding schools reinforced this medical viewpoint. Schools that reported lack of nervousness both confirmed whites’ superiority complex and justified the boarding school mission. Indigenous groups did not passively accept whites’ diagnostic labeling, but they were aware of and responsive to nervous discourse. According to Indigenous newspapers, Native Americans were not immune but prone to nervousness, something that validated their intellect and affirmed their place in American life. Nervousness also harbored different meanings in an Indigenous context. To ensure their political survival, Indigenous leaders urged members to safeguard nervous health.

By the end of this presentation, the learner will:

- Recognize the longstanding ways medicine has been influenced by, created and perpetuated ideas about gender, race, and sexuality
- Develop a deeper understanding of multiple competing medical ideologies and practices
- Identify connections between medicine and historical political and social realities

2. Raphaël Tinguely, University of Lausanne

From Alpine Cretinism to Idiocy: Filming Mental Retardation in Switzerland (1920s-1950s)

From the 19th century onwards, the production and dissemination of still images (photographs, magic lantern plates, stereoscopic views) of Alpine cretinism made people, who were affected by this disorder, monstrous, folkloric, and pathological figures. Through these various media, geographers, mountaineering tourists, physicians, and alienists made Switzerland the main "ecological niche" (Ian Hacking, 1998) for this mental disease with physical symptoms (i.e., goiter). A century later, the moving image as well as the medicalization and especially the biologization of psychiatry reconfigured cretinism, which was then declined under different labels (fatuity, retardation, debility, imbecility, mental deficiency, or idiocy).

With this paper, I want to show how the film as a text participates in defining and redefining the endemic cretinism in the Alps. To identify the visual invariants and modifications along with the semantic shifts of this nosographic category, I will focus on three short films recently discovered in the archives. First, a film shot in the canton of Bern in the early 1920s by director Valentine de Kerven (1901-1991), who is the daughter of surgeon Fritz de Quervain (1869-1940).

Secondly, a film directed at the same time by the doctor Franchino Rusca (1884-1941) in the canton of Ticino. Finally, a short film from 1956 directed by the psychiatrist Giorgio Pilleri (1925-2018) under the supervision of the psychiatrist Ernst Grünthal (1894-1972) at the Waldau Psychiatric Hospital.

My hypothesis is that these films are not limited to being a tool for the dissemination of scientific knowledge (i.e., generalizing the use of iodine), but that they are also thought of as a medium whose potentialities (stage direction, camera movements, editing) authorize mental health specialists to put into narrative and even into show "madness" for non-expert audiences. In other words, these films are not only "useful films" (Charles R. Acland & Haidee Wasson, 2011), as they also contribute to setting conventions of representation and social scripts shared by many individuals from different backgrounds. I want to show that the aesthetic, material,

and contextual study of the film allows us to identify practical and epistemological issues that the history of medicine and the history of psychiatry tend to neglect.

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Identify successes and failures in the history of medical professionalism.

Recognize the dynamic interrelationship between medicine and society through history.

B2 Protest & Liberation /Activism

1. Vincenza Mazzeo, Johns Hopkins University

South Africa Under Apartheid: Histories of Struggle Against White Supremacy as Histories of Health, Medicine, Gender, and Freedom Making

In 1989, SPEAK magazine – a non-racial magazine produced by an organization called the SPEAK Collective in South Africa – printed a special volume it entitled “Health is Our Right: Union Women are Organising to Fight Cervical Cancer.” In the volume’s chief editorial piece, the SPEAK Collective interviewed Elizabeth Thabethe – a Hipak Plastics worker from Durban and a member of the Chemical Workers Industrial Union (CWIU) – in relation to the problem of cervical cancer and women’s fight against the “killer disease.” “Cancer of the cervix is a killer,” Thabethe said, “union women are fighting for the right to have good health... women are finding out about the campaign for PAP smears and organizing around it. They know that only through a united demand will we win the struggle against cervical cancer.”

Thabethe’s interview is striking for two reasons. First, it introduced the CWIU pap smear campaign – the first documented drive of its sort among black South African women – as a direct response to the rate at which black South African women were dying of cervical cancer. Second, Thabethe’s responses aligned women’s mobilization for pap smears in unionized factories with the logic and language of the anti-apartheid struggle in South Africa. The struggle, which sought to challenge the repressive and racist policies of South Africa’s National Party, deployed the rhetoric of “united demands” and “the struggle against” to foster mass mobilization. Spearheaded by Thabethe, the pap smear campaign mirrored this organizational tactic and drew on analogous language to articulate the “struggle against cervical cancer” as the struggle for women’s liberation and reproductive health. Despite the centrality of health to liberationist movements and vice versa, medical historians have yet to examine how African women’s health activism shaped the anti-apartheid struggle in South Africa and historians of Africa have undertheorized the relationship between health, medicine, and freedom in a post-colonial context.

This paper brings together histories of medicine, gender, and liberation to demonstrate that histories of struggle against white supremacy (or state-sanctioned racism) are also histories of health, medicine, and freedom making. In this paper, I argue that pap smear campaigns sought

not only to preserve life, but to reverse the deleterious conditions created by the apartheid state which expelled black South African women from state-sponsored medical care and limited their access to private care. Drawing upon *Speak Magazine* and interviews I conducted between 2015 and 2017 in Johannesburg, South Africa, I detail how ordinary women working in unionized factories organized around cervical cancer as a demand for the right to life against the backdrop of an unprecedented scale of state-sanctioned repression and violence. As a framework for examining women's organized demands for the right to life and the right to be free from death, I invoke Sharad Chari's conceptualization of counter-biopolitics (a political struggle against a system or state over the conditions of sustaining and reproducing life itself), Julie Livingston's theorization of cancer as a disease which "happens between people," and draw upon the institutional and cultural histories of medicine and medical training in South Africa, by Simmone Horowitz and Vanessa Noble, to demonstrate the centrality of struggles for freedom in histories of health, medicine, and medical activism. As a disease, cervical cancer was both gendered and racialized: for black South African women it was a leading cause of death by the 1980s, "a killer of mothers, daughters, and liberationist fighters." As a disease, cervical cancer happened between people and systems, and gave rise to a gendered struggle to not just survive cervical cancer, but to produce (freedom), reproduce (freedom fighters), and live with dignity in a time of white supremacy.

By the end of my paper, the audience will develop a capacity for critical thinking about medicine; understand how patients live with cancer; identify failures in medical professionalism in Africa; promote tolerance for ambiguity; and recognize that disease is social. This will contribute to patient care by helping clinicians to develop a historically informed perspective regarding their patients from different genders, races, backgrounds, cultures, places, and spaces; and it will help with patient advocacy.

2. Ryan Adams, University of Buffalo

"Estamos necesitados, no locos": Mental Health Care Activism in the Chicano Movement, 1970-1975

Race and culture are significant topics in the historiography of American psy professions, but the experiences of Mexican Americans as both professionals and patients are largely absent. In this presentation, I address this gap in the literature by discussing how Chicana/o activists inside and outside of the American mental health care system challenged the ideologies and practices of psy professionals in the early 1970s. They argued that Anglo psy professionals, who dominated their respective fields, promoted a culturally insensitive view of mental health that failed to meaningfully incorporate Chicana/os' sociocultural backgrounds into treatment plans. This model, when combined with an overall deficiency of mental health care services in Mexican American communities, resulted in few options for care for Chicana/os experiencing mental distress. This presentation uses *Salubridad Chicana, su Preservación y Mantenimiento: The Chicano Plan for Mental Health*, a report on mental health care generated by over 400 Chicana/o activists over a five-year period (1970-1975), to explore how Chicana/os defined mental health on their own terms. I argue that Chicana/os asserted that mental distress stemmed from living in a systemically racist society where Anglos actively sought to erase their

culture and force them to assimilate into the dominant society. Mental health, then, was the deconstruction of this racist system and the promotion of a Chicana/o identity as articulated through the concept of Chicanismo, which emphasized a person's connections to other Chicana/os and their shared cultural heritage as sources of strength and healing. The history of this activism is important because it demonstrates how activists in El Movimiento combined mental health care activism with the movement's broader critique of the oppression of Chicana/os in American society. In addition, their critiques illuminate how Anglo psy professionals, even those considered racially liberal, could marginalize and pathologize Mexican Americans within the therapeutic encounter.

Learning Objectives:

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

3. Joshua Doyle-Raso, University of Wisconsin-Madison

Latinx Public Health in Chicago: Activists, Scholars, and Doctors

In comparison to the predominance of men born and trained in Mexico as physicians that characterized Chicago's Latinx healthscape in the 1940s through 1960s, women's organizations, non-clinical researchers, and activist networks occupied more prominent roles from the 1970s onward. While earlier Latinx physicians' efforts to reach community members in the 1940s-1960s relied on integrating their outreach drives into pre-existing church and community festivals where they expected large crowds, new community-based and service-oriented organizations such as Mujeres Latinas en Acción and the Alivio Medical Center worked closely with research organizations like the Latino Institute to produce, disseminate, and act on original research and knowledge about Latinx public health concerns, particularly about issues relating to access and culturally competent treatment. Except for a brief moment, these emerging Latinx networks privileged biomedicine and other state-regulated practitioners, such as drug use counselors and childhood development experts—albeit bilingual and culturally competent practitioners—as the preferred model for healthcare in Chicago's growing but under-served Latinx communities, designated by the city as Healthcare Manpower Shortage Areas (HMSAs). Using a combination of oral history and archival sources, this paper situates the emergence of networks of doctors, activists, and scholars in 1970s and 1980s Latinx Chicago alongside a broader movement in US public health history which saw the proliferation of women's clinics and clinics led by and for members of other historically under-served or purposefully marginalized communities, such as African-Americans. In doing so, this paper extends the history of Mexican American and Latinx US public health history into the late twentieth century, linking that literature with the growing literature on clinics founded for and operated by women and/or African Americans in the late twentieth-century United States. Further, it expands the geographic scope of the extant literature about US-based Latinx history of medicine by including

the Latinx population of a Midwestern metropolis into a literature that is currently primarily focused on California, the Southwest, Texas, and Florida.

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

Understand that Latinx residents of the US have been and remain important actors in the history of medicine and public health in the United States--not just as advocates but also as practitioners and knowledge producers.

Recognize the dynamic interrelationship between medicine and society through history

B3 Medicine or Drugs?

1. Eva Ward, University of Strathclyde

"Rather accounted a good fellow than a bad one": Medical ethics and colonial drug laws in the American Philippines

In 1905, the United States colonial government of the Philippines prohibited all recreational sale and use of opiates and cocaine. The law took effect in 1908 and permitted continued distribution and consumption of narcotics and cocaine for medical purposes. Doctors' access to these controlled substances meant they were frequent points of contact in illicit as well as state-sanctioned distribution. This seemingly binary theoretical demarcation of legal-medicinal and illegal-recreational was not as straightforward in practice, however, as the case study of Dr. Dominador Gomez demonstrates. In 1924, the Filipino doctor Dr. Gomez was acquitted of illegal possession and distribution of opium, morphine and cocaine on grounds of lack of intent to violate the Opium Law. The trial court judge "held in substance that Doctor Gomez violated the Opium Law but that he probably did not realize that he was doing anything illegal; that he, consequently, did not act with criminal intent." The medical profession in the Philippines then took action against him, as the Board of Medical Examiners opened an administrative investigation against him for "his alleged medical treatment of morphine addicts." Following his death in 1932, an editorial in the Journal of the American Chamber of Commerce described Dr. Gomez as "rather accounted a good fellow than a bad one, he seemed unable to distinguish between right and wrong and was always thought to administer morphine to people habituated to its use, especially to Chinese whom it served in lieu of opium." The Chamber of Commerce did not consider that Gomez may have viewed the distribution of morphine "to people habituated to its use" as a legitimate medical practice regardless of its legality. The trial judge appears to have taken this into account given the acquittal, but the Board of Medical Examiners was less convinced. The case study of Dr. Gomez and the legal and professional response to his criminal charges illustrate the myriad ways of contesting colonial drug regulations in the American Philippines, the liminal nature of drug consumption for medicinal purposes and the plurality of the colonial state's response to violations of the Opium Law.

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

2. Mariana Broglia de Moura, Ecole des Hautes Etudes en Sciences Sociales

Confessions of some Brazilian Paperwork-Eaters: a material history of boundary-work between licit and illicit drugs through the health professionals control

The first international conventions on drugs during the 1920s established that drugs should only be sold and used to satisfy medical and scientific needs. In so doing, they built a drugs regulation system that granted the monopoly of the legitimate uses of drugs to health professionals and set new boundaries between licit and illicit uses of drugs. This system has often been studied either by emphasizing the role of some key actors for its establishment and development (in particular industrial countries such as the United States or European countries), or by focusing on international conventions and national laws that reinforced the division between licit and illicit uses and on their effects on illegal traffic and consumers. This paper proposes a double shift from these approaches by developing a material history of drug regulations in Brazil between the 1920s and 1950s focusing on the material effects of daily drug control on the medical and pharmaceutical professionals. On the one hand, I will analyse drug regulations from the point of view of a “peripheral” country that was not a producer or an industrialist of narcotics. I will focus on a set of governmental tools often neglected in the historiography, which had direct effects on the daily practices of doctors and pharmacists: administrative instructions, authorization forms, narcotics control books, official prescription forms and so on. On the other hand, I want to question the effects of these administrative tools on the daily negotiations concerning the divide between licit and illicit uses, in a more situated way, in order to propose new ways of thinking about the legality and illegality of drugs. I will not focus on laws or conventions but rather on the daily bureaucratic work that health professionals had to face and on how it defined the borders of licit and illicit uses. In order to escape the accusation of being the main cause for the development of drug addiction and illicit traffic, doctors and pharmacists had to demonstrate a strong capacity for paperwork and compliance to evolving administrative rules.

- 1.1) Understand the historical process by which drugs regulation have transformed the relationship between state and health professionals
- 1.2) Acquire a historically nuanced understanding of the distinction between drugs and medicines
- 1.3) Complexify power relationships between state, health professionals, layman
- 1.4) Understand the dynamic history of drug regulation in redefining health professional practices
- 1.5) Recognise other political, social and economic processes that have an impact on the work routine of health professionals
- 1.6) Understand how the focus on "war on drugs" has hidden the complexity of the divide between licit/illicit drugs and the problem of regulating health professional practices

3. Anne Kveim Lie, University of Oslo

Free dope or medical treatment? The coming into being of substitution treatment in the Scandinavian welfare states

During the last 30 years, substance dependency has increasingly become conceptualized in neurobiological terms as a biobehavioural disease residing at the molecular level, as part of a bid to transform this stigmatized phenomenon from moral defect into a chronic disease. As user organizations and other social movements now struggle with the challenge of questioning the biomedical model of addiction without falling back into the trap of moralization and criminalization, careful historical engagement is all the more important. In this paper, I will discuss how substitution treatment was introduced in Scandinavia in the long 1990s, with a particular focus on Norway. The Scandinavian welfare states all had a restrictive drug policy, relying on social work rather than medical approaches. Until the hiv epidemic, substitution treatment was severely opposed, and policy makers, politicians and clinicians saw substitution treatment as a way to disempower drug users and take away their “natural resilience”. Prescribing opioids outside of the hospital setting was strictly forbidden. The hiv epidemic introduced some to harm reduction approaches, but it should take another decade (until 1998) until a very small centralized state program with strict gatekeeping was introduced in Norway. It was designed with abstinence as a main long-term goal, and combined with social services and psychological assistance. Drawing on archival studies, oral history interviews as well as policy papers I will argue that during these crucial years, processes of (bio)medicalization and demedicalization were negotiated and borders were drawn, both diachronically and synchronically across different social subgroups. Physicians, nurses as well as patients pushing for pharmaceuticals as necessary survival tools were crucial in this process, but their respective roles changed over time. Social and psychological comprehensive support were still considered such an important part of the treatment program in the state system of opiod maintenance, that it caused centrally placed physicians in that system (who had previously been crucial in promoting opiod maintenance) to fiercely resist physician prescribing outside of the state system.

Develop the critical capacity for thinking about the nature, ends and limits of medicine
Recognize the dynamic interface between society and medicine through history
Respond to changes in medical practice guided by a historically informed professional responsibility and patient advocacy

B4 Being a Doctor

1. Caleb Prus, University of Rochester School of Medicine and Dentistry

John Tyryngham: A Fifteenth-Century Ordinary Medical Practitioner in MS Ashmole 1481 (I)

Despite the importance of “ordinary” medical practitioners to families and communities in medieval England, the identities of these healers and evidence of their methods have largely

been lost (Getz, 1998). To date, our best vignette of an ordinary practitioner is perhaps John Crophill, a bailiff from Essex, whose only evidence of medical practice is found in MS Harley 1735. This paper argues MS Ashmole 1481 (I) is a witness to the practice of another ordinary healer of the fifteenth-century, John Tyryngham. Though identified in legal documents as an esquire, his role as a healer is revealed through a constellation of textual and material evidence. A plague memorandum in his hand, for example, records what is likely one of the earliest case notes in English: a description of a suspected plague bubo. Indeed, unlike MS Harley 1735, Tyryngham's manuscript reveals that plague treatment and phlebotomy were dimensions of ordinary medical practice. The material evidence is similarly illuminating: folds show that his booklets were circulated unbound, and potential blood stains reflect his hands-on experience. One may even speculate that a list of names, scrawled on the facing page of the plague tract, are a record of his patients. What makes MS Ashmole 1481 (I) a particularly unique witness is Tyryngham's list of physicians and surgeons practicing in London. His record of several wards and masters of the London Barber's Company is significant, not least because of the guild's legal attempts to exclude outsiders from practicing phlebotomy. Tyryngham appears to have persisted in learning bloodletting despite their prohibitions, leaving his own list of "principals veynis" to demonstrate his experience. MS Ashmole 1481 (I) thus shows that ordinary practitioners not only learned phlebotomy but also acknowledged the expertise and authority of tradesmen, expanding the picture of "ordinary" medical practice in late medieval England.

1. Acknowledge the diverse identities of healers and the medical pluralism among patients throughout history
2. Recognize the changing nature of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
3. Understand the dynamic interrelationship between medicine and society

2. Steven Server, University of Chicago Pritzker School of Medicine

"Without caring about anything or anyone": Compassion, cruelty, and curanderismo in Cardenista Mexico

On November 23, 1936, at about 9am, just at the end of his second month performing rural service in Tanguancícuaro, Michoacán, medical student Miguel Segura Hernandez was called to the bedside of R.F., a 44-year-old woman complaining of abdominal pain. Segura evaluated R.F., and, concerned she had a simmering bowel obstruction, borrowed a local man's automobile to drive her to surgeons some twenty kilometers away. While he and the surgeons had done the best they could, R.F. had been discouraged from seeking care by a local unlicensed healer and had died on the operating table. Though Segura battled with a reasonable amount of "fear" at the weight of the responsibility, he felt he had done all he could. Segura argued that it had been the "black egotism...and lies" that had killed R.F., the product of "odious work of individuals without any sense of responsibility, morality, respect for human life, or...indispensable knowledge gained from the Clinic" who enriched themselves "at the expense of human pain without caring about anything or anyone."

Segura's lamentations on R.F.'s demise offer us unique insight into the dynamics of interprofessional conflict in Cardenista Mexico, in which allopathic medicine was a key element

in the State's long-standing modernizing enterprise as against the alleged agents of atavism that practiced empiric or folk healing away from urban centers. While scholars to date have emphasized the cognitive and rationalist dimensions of allopathic differentiation, in this paper, I highlight its emotional mechanics. As is evident in Segura's comments and the comments of many of his peers in their own theses, medical students' fledgling professional identities depended not merely upon assertions of the superiority of their ways of knowing, but also heavily upon avowals of their superior moral fiber and compassion relative to folk healers. In this paper, then, I hope to show that the construction of professional identity among allopathic physicians often depends upon the strategic use of feeling as much as—if not more so—than thinking.

- 1) Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations).
- 2) Develop a nuanced understanding of the complex, multifaceted sociological and political functions of empathy and compassion in medical practice.
- 3) Develop the capacity for critical thinking about the nature, ends and limits of medicine and medical education.

3. Doris Du, Vanderbilt University

Opportunities and Obligations: The First Women Physicians in People's Republic of China

The People's Republic of China was founded in 1949, but revolutions continued. How did women experience the critical juncture of the nation's reunification and transformation to the acclaimed socialist wonderland? During wars, many women joined the revolutions as military nurses, but their entry relied on an assumed association between women's nurturing "nature" and the professionalization of nurses. This paper is based on interviews I conducted with three retired women doctors who left nursing to the Sun Yat-sen Medical School, one of the nation's largest medical institutions, in 1954. I argue that the cadre identity heavily shaped the gendered experience of the nation's first women doctors by knitting them into an intricate web of the nation, gender, and profession. Cadres, literally "the main group" in Chinese, include not only state administrative personnel but, broadly, those who uphold the Communist ideology and act in the Party's directives.

In this paper, the women doctors' long careers spanned from the 1940s to the 1990s, making them indispensable agents in nation-building and public health campaigns. They worked with men, were politically involved as men, and cared for children much more than men. Building on Nicole Barnes' *Intimate Communities*, which studies military nurses' emotional labor that disciplined and connected illiterate populations, this paper focuses on their interaction with and understanding of the new party-state well into the post-war periods through their first-person retelling. It argues that the cadre identity continuously dictated their beliefs and behaviors as they navigated the transitions from the battlefield to state institutions, from school to marriage, from poverty to professionals, comprising the major cornerstones in national development and the medical system.

Drawing evidence from personal narratives and archives, this paper traces the dominance of the cadre awareness from the women's lived experiences as healers, mothers, and loyal members of the party-state. Oral history lets the women speak for themselves about their feelings, motivations, regrets, and legacy. In their voice, their stories resonate with so many unspoken compromises still shared by female professionals to this day.

keywords: women physicians, nation-building, oral history

- 1) Identify successes and failures of history of medical professionalism, especially the challenges presented to women in the field
- 2) Recognize the dynamic interrelationship between medicine and society through history
- 3) Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

B5 Cutting Us Softly: Surgical Approaches to "Women's Diseases"

1. Sharrona Pearl, Drexel University

"The Angelina Effect": Representations of Prophylactic Mastectomies in Popular Culture

On 14 May 2013, film actress and activist Angelina Jolie published an op-ed in The New York Times entitled "My Medical Choice." In this essay, Jolie chronicled her decision to have a double mastectomy following a positive genetic test for BRCA1, which raised her risk for breast cancer to 87%. Jolie who lost her mother, grandmother, and aunt to cancer framed her decision both in the context of her own health and her responsibility to her children. The op-ed focused both on medical details and destigmatization; Jolie was motivated to write the piece in order to encourage at-risk people to consider it, and to reassure them that even she – an icon of femininity and idealized female beauty – was no less of a woman for surgically removing and replacing her breasts. Following Jolie's op-ed, interest in the procedure rose significantly in the United States as determined by google searches. There is a rich scholarly literature on the influence of celebrity in medical decision-making in the market-driven environment of American health care; Jolie's attempt to destigmatize the procedure seems to have been effective in encouraging women and people with breasts to explore their options. In this presentation, I consider the recent history of increased representation of prophylactic mastectomies in popular culture following Jolie's intervention, while at the same time problematizing that categories of "prophylactic" and "therapeutic." I focus in particular on *The Bold Type*, a buzzy dramedy about women's media set in New York. *The Bold Type* gets pretty much everything wrong about working in women's media and the magazine industry. Listing all the mistakes after each episode became a genre in and of itself, a form of television criticism designed to flourish in the age of snark, particularly as it is written by those most affected by the gaps between TBT utopia and media reality. But it does get one very important thing right: the experience of prophylactic mastectomy. I consider the role of television in destigmatization, creating links between Jolie's op-ed, TBT representations, and the delicate balance between self-advocacy and market-drive health care in the US environment.

Develop knowledge and understanding of professional behaviors and values

By the end of this activity, the learner will:

- understand the dynamic history of medical ideas and practices, their implications for patients and healthcare providers, and the need for lifelong learning
- consider the role of patient advocacy in directing the development of medical practice
- recognize the dynamic interrelationship between medicine and society throughout history
- develop a grounded understanding for the stakes for listening to patient experience
- appreciate the importance of a feminist approach to considering the development of medical practice

2. Whitney Wood, Vancouver Island University

"I didn't know the stern end of a woman from the bow": Performing Gynecological Expertise in Mid-Twentieth Century Canada

Working as a third-year medical student in Bella Coola, British Columbia in the late 1940s, Adam Clayton Waldie, who would go on to earn an MD from the University of Alberta, recalled encountering his first gynecological patient: "She'd apparently had some gynecological surgery done down in Vancouver the year before, and wanted to know if it was still intact... At this time, I didn't know the stern end of a woman from the bow, and this was literally my first female examination." Taking up Waldie's account, where expressions of uncertainty regarding a lack of gynecological experience were twinned with anxieties surrounding the unfamiliar effects of new surgical procedures on the female anatomy, along with the reminiscences of other emerging and established general practitioners and specialists as a starting point, this paper explores the state of gynecological expertise in mid-twentieth century Canada. It focuses, in particular, on the ways in which physicians' encounters with an expanding range of pelvic floor surgeries – both in the operating room, and in post-operative spaces and routine gynecological appointments – demanded the (re)articulation of professional knowledge and authority. In the Canadian context, the postwar decades saw a shift away from the relative surgical conservatism that had characterized early-twentieth century gynecological practice, especially when it came to the treatment female patients past childbearing age. While treatment modalities ebbed and flowed over time and varied from practitioner to practitioner, with individual approaches shaped by experience, education, and region, the mid-twentieth century saw the development and growing popularity of surgeries including uterine suspension that were intended to treat pelvic organ prolapse, conditions that were often themselves linked to previous surgical interventions. Drawing on oral histories, medical journals, and popular discussions of gynecological surgery published in leading women's magazines including *Chatelaine*, this paper traces the transformation of pelvic floor surgery in postwar Canada, unpacking the ways in which a predominantly male group of practitioners made sense of the female body and constructed expertise in the evolving field of urogynecology.

By the end of this presentation, the learner will:

- 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);

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

3. Jaipreet Virdi, University of Delaware

Endo Existence within “An Epidemic Ignored”: Pain and the Power of Patient Activism

Endometriosis is a complex, debilitating disease that affects one in ten women worldwide. It is a health concern that is frequently misunderstood and misdiagnosed, taking an average of ten years for a patient to receive a diagnosis, thus severely reducing their quality of life. Though endometriosis patients regularly have their pain dismissed by medical experts, the disease is rooted in a long history of gender bias, misogyny, and sexism in reproductive healthcare. Though endometriosis can affect multiple organ systems and is not gender-specific, it is largely considered a “woman’s disease” that causes chronic pain and infertility. As 1970s feminist health activists transformed crucial aspects of healthcare and secured important patient rights, they also challenged conventional thinking about the female body and demanded access to information about their own health. Yet it took twenty years for activists to argue endometriosis needed to be recognized as an invisible and neglected disease, one that is a substantial health burden requiring state funding and support. Crucially, they pushed for endometriosis to be recognized primarily as a pain problem, not a fertility issue.

This paper presents a cultural study of patient activism, examining how popular representations encouraged people with endometriosis to demand better clinical diagnosis and treatment. By the 1980s, diagnoses of endometriosis grew rapidly such that what was once perceived as a “rare disease” became “an epidemic ignored” that affected up to 20% of people. Patient activists not only advocated for their own healthcare, but also shared their experiences publicly to transform the routine process by which the disease was understood, even collaborating with clinical researchers, policy makers, and surgical specialists for multi-million-dollar national action plans to improve endometriosis awareness and best practices.

CME Learning Objectives

1. Identify grassroots organizations for health activism.
2. Identify how community-based standards shape healthcare shape..
3. Think critically about scholarly intersections of disability, health, and pain.

C1 Contesting Disability

1. Nora O'Neill, Yale University

Fierce with Reality: Disability Rights, Feminism, and The Boston Project on Women and Disability, 1987-1995

American disability feminist activism gained traction in the 1980s, drawing on the strategies and ideologies of the disability rights and feminist health movements. However, little of this history has been explored by historians of these social movements. This paper analyzes the archives, publications, and oral histories of one group, the Project on Women and Disability (PWD), active

in Boston, MA (1987-95), to begin constructing the origins of this advocacy. PWD not only offered local consciousness-raising groups and therapy but also fostered a nationwide community of women with disabilities, through letters, publications, and the 1995 conference called “Fierce with Reality.” PWD’s story highlights the tensions between mainstream disability rights and feminist movements, most notably on issues of abortion and disabled motherhood. PWD articulated a pro-choice stance on abortion, while also advocating against what it called “eugenic” prenatal screening as part of its support for disabled babies and mothers. The history of PWD’s activism offers insight into the fraught relationship between abortion politics and disability rights, a much-needed history that provides context to today’s rapidly changing politics. At the forefront of disabled women’s activism, the group developed an image of the contemporary mainstream feminist to contrast PWD’s views on who could be a feminist. PWD rejected the idea of an independent, career-driven woman and instead urged mutual dependence and community-building. However, in the process of constructing a universal identity of the “disabled woman,” PWD ultimately excluded some disabled experiences, such as the compounding discrimination of racism and homophobia with ableism. Nevertheless, the group encouraged women to pursue autobiographical writing to find common connections. Beyond exploring the unwritten history of the origins of disability feminism, a history of PWD offers the historical underpinnings of both tensions and connections between disability rights and feminism that continue to shape activism and politics today.

1. Develop an understanding of the social and discriminatory factors that led to disability feminism activism historically and continue to fuel demands for healthcare that takes into account the intersections of historically marginalized identities
2. Acknowledge the necessity of including perspectives of disabled women in national debates on abortion in the United States
3. Recognize the power of autobiographical writing in both healing practices and community building

2. Stephen Mawdsley, University of Bristol

Jake Paralysis and Disability Activism in 1930s America

During America’s Great Depression, an estimated 50,000 to 100,000 Americans became paralyzed after consuming an adulterated patent medicine, known as Jamaica Ginger (Jake). Although it was marketed as a cure-all and was routinely prescribed by doctors, Jake was also favored as a drink during National Prohibition (1920-1933) due to its high alcohol content and low cost. For survivors of Jake Paralysis, the lasting disability and social stigma posed significant challenges. However, far from remaining in silence, survivors worked together to organize citizen action groups to seek justice and build supportive communities. Both the United Victims of Ginger Paralysis Association and the National Association of Jamaica Ginger Paralytics were pioneering organizations that collectively represented over 35,000 disabled people. Citizen action groups brought attention to the plight of survivors and sought legal recourse from manufacturers and the federal government. They raised money, organized marches, wrote to editors, formed special communities, and lobbied politicians. Drawing on a series of private papers, archived institutional records, and historical newspapers, this conference paper aims to

explore Jake survivor activism. As few historians have examined this outbreak, this paper will advance the historiography by offering an important case study of disability activism in America. It argues that while survivors were unable to achieve all of their core aims, they nevertheless demonstrated remarkable resilience, creativity, and resolve and at a time of severe economic hardship and uncertainty.

Deepen understanding of illness and suffering

Recognize the dynamic interrelationship between medicine and society through history

Elicit and write a patient's history worthy of an historian

3. Weiyue Kan, University of California, San Diego

Healing Disability: History of the Conceptualization of Physical Impairments in Qing China (1644-1912)

This paper examines disability from the perspective of traditional Chinese medicine, especially focusing on how physicians constructed, handled, and treated disability. By analyzing medical treatises, casebooks, recipe collections, and elite documentation, this paper first argues that the development of medical knowledge on women's bodies and new medical thought proposed fresh interpretations and alternative treatments for disability. Disability was not a single category in Chinese literate medicine. Physicians usually discussed disability in the following four curriculums: the curriculum of women (fuke, gynecology and childbirth), the curriculum of children (erke, pediatric medicine), the curriculum of external medicine (waike), and the curriculum of injuries (shangke). They understood disability as contagious and gendered, but also preventative and curable. Influenced by the scholarly modes of medical practice that began to expand after the Song dynasty, literate physicians attributed physical impairments to internal disorders or emotion imbalances. Their practices significantly preferred sophisticated treatments, such as pulse diagnosis, oral decoctions, and treatments with mild drugs based on herbs or minerals. The historical conceptualization of disability provides a concrete case of the construction of medical knowledge in late imperial China.

Furthermore, this paper contributes to the manual therapies versus learned medicine debates in Chinese medical thought and practice. I argue that the so-called "internal medicine-ization (neike hua) of external ailments (waike)" does not mean manual techniques were marginalized or neglected in healing disability. On the contrary, by analyzing the expansion of the curriculum of injuries, imperial trust in Mongolian doctors, and the development of martial arts medicine, this paper indicates that hands-on therapeutic techniques were essential in preventing and curing disability. Physicians used various hands-on therapies, such as acupuncture, bone setting, massage, pushing and pressing, and minor surgery to treat external injuries and prevent disabling.

Lastly, this paper provides a more nuanced way to understand the Chinese body. By examining medical perceptions on bones, limbs and organs, I argue that to heal disability, physicians not only held the knowledge of the functional body but also required the knowledge of a structural body.

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

C2 Medicalizing Deviance

1. Emine Evered, Kyle Evered, Michigan State University
Medicalized Alcoholism and the Making of Turkish Prohibition

In Europe and the United States, the concept of alcoholism as a disease was a novel one until the late eighteenth century when Dr. Benjamin Rush and others advanced ideas about addiction. Over the subsequent century, this view found receptive audiences amid the global rise of temperance. While Rush focused exclusively on spirits—and not beer or wine, his contention that alcoholism inflicted physical and psychological harms (e.g., fevers, jaundices, palsy, epilepsy, insanity, and others) became commonplace and was applied beyond just hard liquor. Amid the ascendancy of eugenics, concepts of “hereditary alcoholism” also advanced. For our paper, we draw from a history typically confined to narratives of Western medicine to analyze a vast but largely untapped body of Ottoman sources (e.g., medical treatises, books, journals, newspapers and magazines, public health and temperance pamphlets, posters, and propaganda). From our research, we interrogate how alcoholism’s medicalization diffused from the West to find fertile grounds in Ottoman public health, medical, and social reform projects. Western medicalized ideas thus coupled with parallel Ottoman concepts to invigorate a late-nineteenth century temperance agenda; a dynamic that precipitated the Turkish republic’s short-lived early-1920s prohibition. While the empire had a sizeable and diverse Muslim population with many definitions of Islam that banned alcohol and its consumption, we demonstrate how new, modernist, and reformist medicalized arguments combined with those of traditionalists and Islamists. All of this transpired amid imperial decline and collapse, European empires’ seizures of imperial alcohol interests and operations, and reported surges in beverage imports, domestic production, consumption, and public drunkenness. Overseeing the idealized “bone-dry” prohibition in both the Ottoman and republican parliaments were traditionalists and Islamists but the assemblies also included surprisingly high percentages of MPs who were physicians. As with America’s Prohibition, their commitment, dissemination of ideas to the wider public, and direct hand in the political process over the preceding decades proved vital in paving the way for the passage, by the very slightest of margins, Turkish Republic’s prohibition that began after but ended far sooner than America’s “noble experiment”. Through this examination, we also establish how medical professionals, pedestrian medicalized rhetoric, and a new secular civic morality combined with other cultural and religious interests to ensure that, though very briefly, Turkey yielded one of the first modern and medically informed prohibition of the non-Western world.

Our paper provides insight into physicians' involvement into temperance and prohibition activism in Ottoman Empire and one of its successor states, Turkish Republic. It sheds light on medicine and society relationship in a predominantly Muslim culture. In doing so, it provides a unique context to examine the history of addiction and its treatment through the lens of prohibition.

2. Christopher Rudeen, Harvard University

The Case of Mr. S.: Transvestism, Aesthetics, and Whiteness in the Early-Twentieth-Century United States

Much of the early medical writing on transvestism attempted to distinguish cross-dressing from homosexuality. The other relationship that interested observers, however, was between these individuals and clothing. When coining the term “transvestite” in 1910, German sexologist Magnus Hirschfeld made it clear that he considered clothes not “a dead thing” but instead “a form of expression of the inner personality” (Hirschfeld 1991 [1910]). Four years later, physician Bernard Talmey published five additional cases in a New York medical journal, including that of Mr. S. “Here we have a man,” the doctor wrote, “who in all other ways would belong to the superior class of men...Still this man attributes such a vast importance to feminine dress as is very rarely found, even among women themselves” (Talmey 1914). The present talk uses this case to explore questions of aesthetics and whiteness in medical understandings of transvestism. Transvestism became legible to the profession as an explanation of seemingly unusual relationships between people (namely men) and dress, granting individuals an (albeit limited) autonomy to speak on their identity through their clothes. This emerging trans subjectivity was thus integrally tied to fashion and a burgeoning understanding of its role in defining the self. Inextricable from this understanding were the otherwise normative characteristics of individuals such as Mr. S.—heterosexuality, morality, and whiteness. Reading this medical source against the grain, and in dialogue with work by Siobhan B. Somerville, C. Riley Snorton, and Matthew Frye Jacobson, this talk further articulates the role of clothes—as well as gender, sexuality, and race—in theorization about disorder and identity.

By the end of this presentation, the learner will be able to:

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)

3. Ben Maldonado, Harvard University

Perceiving Deviancy: Robert Latou Dickinson's Search for Autoerotic Sight, 1902-1950

This paper explores how New York gynecologist Robert Latou Dickinson (1861 - 1951) attempted to develop a method to identify and classify female and male masturbators through an examination of genitalia alone, a practice he utilized in his own clinical work. Influenced by physiognomists such as Cesare Lombroso, Dickinson contended that female genitalia could be read in the same manner as the face to reveal evidence of deviant behavior — and, thus, to extract Foucauldian confessions of the flesh. The act of masturbation, Dickinson believed, left

physiological evidence upon the body that only a skilled physician could recognize. Towards this end, Dickinson created images and sculptures of both normal and deviant genitalia as a mode of training physicians in this methodology. In his gynecological practice, he used this method of autoerotic sight to diagnose his women patients, trusting his own ability to read the body above the testimonies and denials of his women patients. While most work on Dickinson has focused on his studies of the female body, his search for physiological evidence of masturbation extended into male genitalia as well. I argue that Dickinson attempted to construct epistemic homologies between the sexes and insisted that male genitalia and female genitalia were similar enough in both form and development to warrant using the same mode of examination for both. While Dickinson's method of autoerotic sight was never widely used, it elucidates the landscape of gendered disbelief, the search for deviant bodies, and theories of sex differences in early twentieth century American gynecology and sexology.

Develop the capacity for critical thinking about the nature, ends and limits of medicine
Elucidate the complex history of sexism and homophobia in sex-related medicine and research
Develop an historically informed sensitivity to the diversity of patients (including appreciation of class, gender, socio-economic status, ethnicity, cultural, spiritual orientations)

C3 Plagues & Pandemics

1. David Korostyshevsky, Colorado State University

Genealogies of Addiction: Alcohol, Compulsion, and the Biopolitics of Temperance

A century before medical professionals articulated modern concepts of addiction, temperance reformers engaged in a biopolitical campaign to eradicate alcohol from American society. While most historians focus on the medicalization of addiction that began around the turn of the twentieth century, I work to uncover an earlier genealogy of addiction. In this paper, I explore how an overlapping set of nineteenth-century medical professionals, legal authorities, and temperance reformers pathologized compulsive drinking by constructing "habitual drunkenness." Unlike "intemperance," which only denoted excessive drinking, habitual drunkenness captured reformers' growing anxiety that alcohol, a discrete physical agent in all intoxicating drinks, destroyed the physical capacity for self-control. Operationalizing new scientific discoveries about alcohol, physicians involved in temperance reform defined habitual drunkenness as an artificial appetite, a morbid physiological condition. However, the pathologization of alcohol and compulsion did not lead to the medicalization of habitual drunkenness the way historians of alcoholism traditionally understand it. Configuring him as a mentally unsound person, medical and legal authorities worked to detect and discipline the habitual drunkard across a broad terrain of equity, chancery, and civil law, including adult guardianship proceedings, divorce cases, the contestation of contracts and wills, and litigation surrounding exclusionary life insurance practices. Legal consequences in these non-criminal contexts often involved the abridgment of property and contract rights central to full citizenship in the nineteenth-century United States. As judges and juries struggled to decide each case, they drew from a shared fund of knowledge about alcohol and its effects that had been

popularized by temperance reformers. I argue that these understudied modes of early American governance expose the exercise of biopower at the heart of early temperance reform. Authorities found ways to govern compulsive drinkers beyond public regulatory laws like alcohol prohibition, which remained politically unfeasible for most of the period. In the process, courts established habitual drunkenness as a serviceable—albeit contested, inchoate, and often ambiguous—medico-legal category of compulsion that shaped the later emergence of modern addiction concepts. As the ongoing opioid crisis generates new interest in harm reduction, destigmatizing and treating individuals suffering from substance use disorders will only succeed if we understand the pathologization of compulsion that predates “drugs” and “addiction” as problems altogether.

CME Learning Objectives. Attendees will:

1. Deepen understanding of early medical ideas about compulsion and addiction and their legal consequences beyond alcohol prohibition.
2. Recognize how complex entanglements between scientists, medical professionals, and legal authorities shape individuals’ rights and citizenship.
3. Apply theoretical frames like biopower and biopolitics to explain the persistence of historical contradictions in the treatment of substance use disorders.

2. Tom Ewing, Virginia Tech

Data Matters: Vital Statistics during the 1889-1892 Influenza Pandemic

Pandemics, by definition, are events measured in quantitative terms, as disease outbreaks that spread across the whole world. As demonstrated during the Covid-19 pandemic, methods used for measuring outcomes such as cases, hospitalizations, and deaths at global, national, regional, and even community levels are complicated and inconsistent. Accurate, timely, and consistent measurements are essential, however, for determining the scope and severity of a pandemic, particularly in situations where structural inequalities may be exacerbated by disease patterns. A case study of global data during the influenza pandemic of 1889-1892 (the so-called “Russian flu”) illustrates the importance of examining the practices of collecting statistics while also asking who makes decisions about what measurements matter. This paper focuses on three situations where structural inequalities were both documented in and obscured by vital statistics: first, in colonial systems, particularly in Africa and south Asia, where administrators processed data as part of the project of imperial rule; second, in independent states, including countries in Latin America and east Asia, where European and national medical staff reported on local and regional outcomes; and third, in racially segregated societies, such as the US south, where health departments documented stark disparities in outcomes. This paper integrates perspectives from global history, quantitative social science, and digital humanities to examine pandemics as historical topics with contemporary relevance.

Scholarly understanding of statistics during a pandemic

By the end of this paper, the learner will:

Recognize the complexity of researching statistics about pandemics

Understand how statistics reflect and reinforce structures of inequality

Integrate theories of data analytics into historical scholarship
Recognize connections between historical and contemporary pandemics

3. Alexis Bedolla, Universidad Nacional Autonoma de Mexico

Technology and security in the history of pandemic control: the case of global electronic disease surveillance

While scholars have extensively analyzed the history of modern pandemic control through the lens of international law, geopolitics and international development, less attention has been devoted to assessing the role of technology in the formation of this field. This paper aims at showing how technologies for conducting disease surveillance at a 'global scale' and in 'real-time' were not initially conceived strictly as public health tools. Rather, global electronic disease surveillance technologies were envisioned, during the late 1980s and early 1990s, as devices to defend the security of certain nations from threats like bioterrorism and biological weapons. The paper, in this respect, seeks to demonstrate how particular US national security interests gave rise to a distinct epidemiological problem-space in which the need to develop novel technologies for epidemic surveillance was first formulated.

To illustrate this argument, the paper shows how the creation of technological innovations like the Electronic Surveillance System for the Early Notification of Community-based Epidemics, and the Global Public Health Intelligence Network (among others) were the result of the emergence of this intertwining between epidemiology and national security. With this discussion, it is argued that pandemic surveillance – heavily influenced by national security – changed the object of intervention from local, known, and recurrent disease outbreaks to potential, unpredictable and non-specific global biological threats. This helped skewed pandemic control interventions to the problem of early identification, directing resources and political attention to problems of preparedness instead of cheaper and more effective ones based on better precaution or prevention.

1. Understand the history of the development of pandemic control through technology.
2. Recognise the importance of how US national security has affected the development of certain areas of epidemiological knowledge and practice.
3. Demonstrate that national security has been an important historical feature in the evolution of modern epidemic control

C4 Nationalist Medicine in China

1. Yating Li, University of Illinois at Urbana-Champaign

HEALTH, INDIVIDUALITY, AND NATIONALISM: FEMALE IMAGES IN CHINESE GYNECOLOGICAL MEDICINE ADVERTISEMENTS (1900S-1920S)

Ignited by a series of national crises, the newspaper industry flourished in early twentieth-century China. Through popularizing and materializing political and collective

imaginings into everyday life, they transformed Chinese people into national citizens. This study examines gynecological medicine advertisements from the 1900s to the 1920s, in which various models of new womanhood were constructed. By focusing on commercial advertisements, this study examines the relationship between women's health and the state while underlining conflict and tension between national demands and women's interests. Previous scholars have focused on women's reproductive duties highlighted in gynecological medical advertisements. Delineating the scope of new roles for women in society, this paper argues that these advertisements try to promote an image of healthy, modern, and patriotic female citizens. The discourse on nationalism, along with the women's emancipation movement and modernization, extended the role of women beyond reproductive duties: starting with producing healthy children, then expanding to cover new roles in the nuclear family, the consumer economy, and the construction of modern nation-state.

Recognize the dynamic interrelationship between medicine and society through history.

2. Liang Wan, University of Exeter

Military medicine and People's Legacy: Relocating Acupuncture-Moxibustion in the Nascent Socialist China 1945-1958

Chinese acupuncture-moxibustion has long been considered one of the most emblematic therapies in the Traditional Chinese Medicine (TCM) system around the world. However, the current popularity of this treatment is a result of active promotion as an integral part of "socialist medicine" by the Chinese Communist government during the second half of the twentieth century. This article explores the knowledge, usage and discourse of acupuncture by the Chinese Communist Party (CCP) through the period of the Chinese Communist Revolution and early years of the People's Republic of China (PRC) from 1945 to 1958. While acupuncture therapy continued to face a threat of abolition under the leadership of Nationalist Party (or Kuomintang), the CCP attempted this treatment zealously, primarily due to insufficiency of Western medicinal resources, in their rural Border Region and especially in the fight against diseases such as malaria when the Communist military marched south to attack the Kuomintang army from 1947 to 1949. After the founding of PRC in 1949, the military endorsement and Mao's criticism towards the "bourgeois administration" of the Ministry of Health in 1954 promoted acupuncture to be a symbol of "national, popular and scientific" therapy. Mass therapeutic practices and experimental trials of acupuncture were then implemented at hospitals, institutions and in rural areas. By tracing the way acupuncture-moxibustion ascended from an out-of-date practice to the crucial part of PRC's medical system, this article discusses what "socialist medicine" meant under the nascent regime, which involves both ideologically infused aims and ideas (Socialist by design), as well as contexts that did not necessarily related to particular political infrastructure (Socialist by default).

recognize the dynamic inter between medicine and society;

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

3. Harry Yi-Jui Wu, National Cheng Kung University

Mind control in the free port: historicizing brainwashing discourses in Hong Kong

The second half of the 20th century saw the idea of mind control becoming a contested topic worldwide as well as in East Asia. Narratives of mind-bending flourished in the Cold War, during which China and the United States were accusing each other regarding their roles in facilitating various forms of “brainwashing” projects. As a clinically unjustified technique, brainwashing is not relevant to the management of mental patients. However, this technique implies the condition of individuals who became victims of the two political camps that mobilized their psychiatric resources to rectify their ideologies. In the mid-1950s, reports on brainwashing proliferated in Hong Kong newspapers. For example, editorials of pro-Beijing newspapers continued to accuse the US and Japan for brainwashing the Japanese in the name of bushido. In the 1967 riot, the arrested left-wing students, stated in the Central Magistrate that his fellow classmates received enslaving education resembling brainwashing. During the Cultural Revolution, news began to appear around businessmen in Guangzhou receiving brainwashing. They were sent to attend political thought classes for re-education. Also stemming from the second half of the 1960s, educational psychology became an important discipline to monitor the unruly young minds as a colonial project. In the post-handover Hong Kong, the narratives of brainwashing still linger to illustrate efforts to edify citizens through school curricula. Intriguingly, while modern psychiatry was still too distempered to support residents’ mental health, the city was already filled with the language of brainwashing as a pseudo-science, heralding the illiberal future of the free port with shrinking freedom of expression and coercive thought policing.

Develop the capacity for critical thinking about the nature, ends and limits of psy sciences.
Understand the ways in which psychological languages were appropriated in the political context.

Recognize how psy sciences were anticipated as solutions of social problems over time.

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Develop the capacity for critical thinking about the nature, ends and limits of psy sciences.
Understand the ways in which psychological languages were appropriated in the political context.

Recognize how psy sciences were anticipated as solutions of social problems over time.

C6 What We Talk about When We Talk about Abortion

1. Shannon Withycombe, University of New Mexico

The 1907 Abortion Law: Statehood, Race, and Reproduction in New Mexico

In 1907 the territory of New Mexico passed its first anti-abortion law. Calling for the ban of the “willful killing [of] an unborn infant child,” with the exception to preserve the life of a mother, as advised by a physician, the territory joined in a national discussion about the role of abortion in shaping the country’s medical and social future. By 1907, the territory of New Mexico had been waging a campaign for statehood for over thirty years. After its first failed application to the federal government, Harper’s Weekly described the region: “at the last census [the population] was 111,000, nine-tenths are Mexicans, Indians, greasers, and other non-English speaking people... a community almost without the characteristic and indispensable qualities of an American State.” This talk will explore the connections between the 1907 anti-abortion law and New Mexico’s bid for statehood, and how both actions revolved around race and class. The U.S. Congress had repeatedly told the residents of New Mexico that they had no place in modern America, so the territory strived for modernity through the crafting of “American” medicine, which included reproductive control. Investigating the political and popular discussions within New Mexico in the dawn of the twentieth century, I will analyze how New Mexican lawmakers understood what it meant to be “American” and how reproduction fit within that image. Today,

New Mexico stands as one of the most liberal states for abortion services and the destination for thousands of pregnant people in the wake of the Dobbs decision, and these circumstances cannot be understood without proper historical contextualization.

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.

2. Jennifer Holland, University of Oklahoma

Fetus as Foil: How Anti-Abortion Politics Helped Denaturalize the Queer Body

At the end of the twentieth century, socially conservative activists envisioned abortion and homosexuality as the greatest threats to modern society, both touching off anxiety about those who failed to reproduce in traditional ways. But these were more than twin movements. Anti-gay activists relied on anti-abortion rhetoric and imagery about natural fetal bodies in order to denaturalize the gay body. From the late 1970s onward, conservatives were in a prolonged battle with queer activists over whether homosexuality was a perverse practice or an inborn trait. Social conservatives paired videos of Pride Parades with ex-gay narratives to prove that queerness was not biologically rooted or “natural.” Queer people did not deserve rights, only religious salvation, according to them. The “unborn” and anti-abortion imagery did essential work for social conservatives in this war. Fetal bodies became the physical embodiment of God-given and biologically ordained heterosexuality. They also signaled the dire threat to society if heterosexual reproduction was not protected by anti-abortion and anti-gay legislation. In this paper, I analyze representations and politics of fetal and queer bodies in the campaigns of the Oregon Citizens Alliance (OCA), an innovative socially conservative group, that waged anti-gay and anti-abortion referendum campaigns year after year in the 1990s. The OCA also inspired copycat campaigns across the American West. In these drives, I show how the fetal body often became a useful foil for the queer body.

Develop knowledge and understanding of professional behaviors and values

3. Charley Binkow, Boston University

“Compelled to Preach Catholic Doctrine”: Religious Consequences of Anti-Abortion Legislation in Nineteenth-Century America

In 1922, after sixty years of trying to criminalize abortion, Dr. Horatio Storer was proud his movement created an America where “Protestant pulpits were compelled to preach Catholic doctrines.” Between 1850 and 1880 nearly every state and territory enacted new abortion legislation. These laws targeted women as well as providers, made abortion a felony from conception, and changed how protestant Americans understood their souls. Religious leaders had spent generations emphasizing “new birth” but not until the 1860s did any church start stressing the sacredness of unborn life. Was this Catholic doctrine?

Anti-Catholicism fueled and defined the anti-abortion movement, packing complicated religious implications into a political agenda. White protestant birthrates were noticeably declining,

especially among upper-middle class families. Meanwhile Catholic immigration was accelerating. To nativists, these interlocking phenomena spelled racial and religious doom. Storer and his supporters believed the problem lay not in economics but in faith. White women were ostensibly the guardians of Christian virtue, but physicians believed these women were the most likely to terminate their pregnancies. American law and protestant institutions had failed these naïve women, misled them into believing early abortions were faultless. Both needed reforms. Storer himself began the campaign against abortion as a Unitarian, but he would finish as a Catholic.

When nineteenth-century Americans talked about abortion they were talking about religious, medical, and political authority. Opposed to Catholics, who used confession and superstition to surveil women, protestant men turned to the state and contemporary science. The epistemology was different, but the result was the same: white protestant Americans accepted a new theory for their immortal soul's origins and a higher tolerance for criminal intervention.

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

D1 Chronic Living & Paradigms of Embodiment

1. Lisa Haushofer, University of Zurich
The Chronic Abdomen

This paper examines the diagnostic category of the “chronic abdomen,” a gendered and racialized receptacle for abdominal symptoms that failed to align with certain biomedical diagnostic and therapeutic expectations in the 1910s and 1920s. By 1910, abdominal surgeons in Britain and the United States had successfully created the diagnosis of the “acute abdomen,” which bundled a multiplicity of conditions united not only by their localization but also by their potential to be resolved quickly through surgical intervention. Abdominal symptoms that failed to live up to this definition, by contrast, posed an ongoing diagnostic and therapeutic challenge. Through an analysis of scientific and medical literature as well as popular representations, the paper investigates the “chronic abdomen” as one response to this challenge. It examines how the chronic abdomen synthesized practitioners’ unease with chronicity, their concern about the relationship between mental and physical illness, their ambivalence towards novel theories and therapies (such as psychosurgery and autointoxication), and their gendered and racialized critiques of patients’ health-seeking behavior. The paper argues that what the ‘chronic abdomen’ captured was not so much a type of disease but a type of patient. While the diagnostic category itself did not outlast the 1980s, this legacy of a chronic abdomen patient persists, and continues to do harm, in today’s medical culture.

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

2. Kavita Sivaramakrishnan, Columbia University
Modernization, Citizens and Immunity 'at Work'

This paper traces how the post colonial Indian state, experts and industry articulated anxieties about the lack of flexibility, mobility and adaptability in an urban workforce; and discussed the challenges posed by chronic morbidities, risks and stress in urban populations. I am interested in understanding and comparing these ideas in South Asia with wider debates regarding bodies, stress and chronicity that were being voiced in international meetings and studies on chronic diseases and stress among 'productive' populations, that were adapted and echoed in India. By examining labor reports and social work studies, media and urban public responses during the decades between 1960s-80s to chronic diseases and conditions, I will trace how chronic suffering and debility was measured and marginalized, and exposures, work stress and absenteeism were attributed to a backward labor force. How could Indian bodies be adaptable, malleable, and defensive in an uneven transition to productive, modern lifestyles that promised immunity from malnutrition and development in the long term, but also involved exposing bodies to daily risks and infections? The Indian state and its social and biological experts, and an urban public began to set institutional 'standards', and new epidemic protocols to check infection and immunity, but expressed a narrow interpretation of risks and differences.

This paper will deepen understanding of illness and suffering among marginalized groups; it contributes to analyzing how medicine and health in society developed in dynamic ways; it suggests ways to critically appraise medical judgment and keeps in mind advocacy for patients

3. Lan Li, Johns Hopkins University
"Brain Damage: Code-Switching in Clinical Research"

This paper explores a generation of neo-traditionalist researchers in China publishing on neurodegenerative diseases following the Cultural Revolution (1966-1976). Specifically, they fixated on an old anatomical object known as sui hai 髓海 or The Ocean of Sui, which was a vital fluid that appeared in ancient, medieval, and early modern sources. These sources presented The Ocean of Sui as many things, which physicians of the "lost generation" took to further include bone marrow, hepatocytes, T cells that manifested as diseases in the spine, the blood, and the brain. I argue that as physician-researchers excavated these clinical manifestations of sui hai 髓海, they rendered it into an inclusive object that required researchers to code switch between cure and treatment, between certainty and uncertainty, between the timelessness and teleology of a fluid object that explained diseases of the brain. This growing interest in sui hai 髓海 presents crisis on two scales—first, at the scale of the body through chronic diseases related to bone atrophy, leukemia, Alzheimer's and dementia, and second, at the scale of the body politic following the social devastation of the Cultural Revolution. While scholars have tracked the emergence of barefoot doctors during the period—a politicized category of rural

practitioners placed in rural labor camps that reeducated militarized teenagers and blacklisted intellectuals—little focus has been placed on the burgeoning interest in classical textual medical analysis. What, if any, was the connection between emergent interest in mental health and neurodegeneration in the shadow of social destruction?

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

D2 Racial Medicine & Science in 19th C. US

1. Leslie Schwalm, University of Iowa Emeritus
Making Race in Civil War America

Leslie Schwalm's paper turns to the US Civil War. Although the war ultimately brought an end to slavery, northern white medical practitioners and scientists used the circumstances of the war—particularly Black enlistment and the crowding of refugees from slavery in contraband camps—to conduct medical and scientific research intended to advance the idea that race was an immutable biological designator of superiority and inferiority. That research extended from surveys and questionnaires to bodily measurements, dissection, and crania collections. Schwalm reveals the investigations conducted by agents of the US Sanitary Commission and Army personnel that, paired with the provision of substandard health care for Black Americans, fueled anti-Black racism, racist medical science, and health disparities during and after the war.

2. Christopher Willoughby, Schomburg Center For Research In Black Culture
Imperialism and Race in Nineteenth-Century U.S. Medical Schools

Christopher Willoughby's paper explores the creation and use of crania collections that medical and scientific students relied upon to learn to see and feel race in human bodies. In 1847, upon his retirement, Professor of Anatomy John Collins Warren gave his entire anatomical collection to Harvard's medical school, including a collection of 'national skulls' that grew to include more than 150 objects. Already, many US professors had begun developing a medical curriculum influenced by racial theories that naturalised enslavement and nascent imperialism.

3. Stephen Kenny, University of Liverpool
"he toiled steadfastly on despondency, privation and neglect:" the scale, shrouding, & significance of slave-ownership among physicians in the American South

This paper focuses on leading doctors under the system of slavery in the American South, for example, college faculty, those with private, college, or public hospital roles, and those who ran medical societies, or contributed to medical journals. The study complements and extends work by social and cultural historians who have provided accounts of the apprenticeships, educational journeys, and working lives of southern physicians (Stowe 2004 and Warner 2003), and scholars who have examined the commodification, objectification, racialization, and wholesale exploitation of the bodies and health of enslaved people (Berry 2017, Cooper Owens 2017, Hogarth 2017, Washington 2006).

The paper uncovers two new key features of doctors' intense relationship with slavery. First, the scale and significance of slave ownership by these leading doctors. Second, how the reputations acquired by these doctors concealed their investments in slavery and the exploitation of enslaved bodies. Using Federal census records for a sample state, South Carolina, the extent of key doctors' ownership of enslaved people will be revealed. Evidence on the direct ownership of enslaved people by doctors is important in terms of the convenience, profit, and status that ownership of human lives and labor brought. At the level of the medical encounter, of course, direct ownership of enslaved people meant that enslaver-physicians had immediate access to useful bodies and research subjects, who had few protections from persuasion, manipulation, coercion, and brute force.

To explore the extent to which the exploitation of enslaved bodies has been shrouded and concealed, the second part of the paper examines the reputations of these leading doctors, revealing that fundamental parts of their story have been willfully obscured by 'Great man' myths, deliberately hidden by terse and opaque biographical portraits, and disguised in celebratory narratives generated by peers, descendants and other accomplices with deep interests in maintaining hierarchical and unequal social systems.

Keywords: Slavery, medicine, history

1. To explore, through an extensive profile of slave ownership among southern doctors, the unjust enrichment of the region's medical profession.
2. To reveal how the profession's ties to the system of slavery were hidden, disguised, or otherwise played down.
3. To demonstrate a foundational dimension of the mutually constitutive relationship between medicine and the system of slavery, and its significance for more thoroughly decolonizing narratives of the profession.

D3 Making Disease Visible in Public Health History

1. Matthew Newsom Kerr, Santa Clara University

Beautiful Scars: The Medical Aesthetics of Smallpox Vaccination Marks in Nineteenth-Century England

The smallpox vaccine scar was the most visible bodily icon of 19th-century preventive medicine. From its introduction, the “Jennerian cicatrix” was both medicalized and romanticized as well as scrutinized and criticized. This paper focuses on the clinical aesthetics of the vaccination scar, primarily in England in the second half of the century, during which time practitioners and health officials navigated the increasingly contentious politics of the vaccinated body. I am interested in tracing the aestheticization of the vaccine scar within professional discourse and illustration. While vaccination itself was a matter of medical consensus, its necessary scarification was also a topic of great medical concern and debate. Doctors were mainly interested in how the scar could itself signify efficacy and duration of vaccine protection, as well as proper dosage and reliability of vaccine stock. The result was a belief that the scar needed to look just right. “When in doubt, look to the pock,” may well have been the slogan. Persons who bore “good scars” were almost invariably said to possess “beautiful arms.” The aesthetics of bodily marks guided a several-decades-long effort to define the ideal cicatrix and to establish best practices for imparting it. This involved elaborate schemes for inspecting, classifying, and standardizing vaccine scars, which also tended to reify a racialized set of assumptions about skin, complexions and scar presentation. It also included detailed attention to technique and instruments, underscoring the sense that good vaccinations were a matter of artistry and personal skill; the skin being a sort of canvas etched in an act of medical performance. Finally, it featured debates over professionalization and specialization in vaccination that recognized the conflict between preserving the rigorousness of the scar on the one hand and managing the public’s preference for a lighter touch on the other. Much like pockmarks resulting from smallpox, the vaccine cicatrix was never merely a natural sign of immunity; rather, it served in complex ways as an emblem signifying the medical marking of the body.

1. Develop knowledge and understanding of professional behaviors and values

- 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

2. Contribute to the improvement of patient care

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

2. Jacob Steere-Williams, College of Charleston

Mapping Endemicity: Visualizing the Colonial Roots of Global Health

Disease maps reveal—historians and practitioners of public health mostly agree here—spatial configurations of the epidemiological triangle of host, pathogen, and environment. They illuminate “shared realities,” in the words of Tom Koch, and transform individual pathologies into “public health events.” In the everyday practices of nineteenth century epidemiology disease maps were part of a visual toolkit early epidemiologists used to communicate

knowledge about the incidence, the origin, and the spread of disease. Most of the scholarly literature on disease maps has focused on epidemic and infectious diseases. But in the second half of the nineteenth century a new type of disease mapping emerged, mapping endemic diseases, meaning diseases localized to particular parts of the world. In this paper I explore this interesting category of disease maps. The study of the relationship between endemic and epidemic, and the complex reasons why some endemic diseases erupted as epidemics, was at the center of the rise of the modern field of epidemiology and global thinking about disease. Entangled with the rise of modern epidemiology, of framing diseases as endemic or epidemic was racial thinking rooted in colonialism. Endemic disease maps, I argue, were part of complex Western xenophobic ideas about the “origin” of certain diseases. Diseases framed as endemic to Europe, like typhoid, were easier to explain away when they erupted in epidemic form through environmentalist doctrine. But diseases such as cholera and plague, understood to be endemic to India, the Middle East, and Asia, required a different kind of logic. As John Macpherson, Inspector-General of Hospitals in Bengal, India, noted in 1867, “no question in medicine is more interesting than that of an endemic disease taking on the character of an epidemic, and of the behaviour of an endemic, when its own epidemic form reaches it.” By shifting our focus to think about endemicity and not epidemics, I reveal a different precursor to the twentieth century emergence of global health.

- 1: To understand the historical development of the epidemiological term "endemic" and how it was used by public health authorities.
- 2: To demonstrate the way in which disease maps in the past served to illustrate not only epidemic diseases, but diseases considered tied to people and places in the world.
- 3: To illuminate the radicalized politics of public health through the study of disease maps.

3. Emily Webster, Durham University

Mapping Imperial Epidemics: Medical Authority, Biopolitics, and Spatial Ecologies of Disease in the British Empire

This talk seeks to answer two different, but related, questions: first, how did the growing international practice of disease mapping in early twentieth century epidemiology translate to vastly different local circumstances, and to what effect? And second, what more could be learned about historical disease maps and epidemiological practices if historians of disease themselves engaged more widely in the practice of mapping? Taking epidemic maps and colonial public health reports from two major cities of the early twentieth century British Empire as reference points – plague in Bombay, India and typhoid in Dublin, Ireland –this presentation explores how the epidemiological practice of mapping constructed specific, place-based arguments about the culture and ecology of infectious disease. Placing these maps within the broader context of knowledge formation and biopolitical control in the Empire, it considers how the realities constructed by local disease maps could support, contradict, or actively resist contemporary epidemiological knowledge – and argues that the acceptance of this visual argument heavily depended on the colonial politics of medical authority. Turning a critical eye to the practice of mapping itself, I will then utilize a series of GIS maps constructed using historical geographic and public health data with varied temporal and spatial boundaries

to evaluate the underlying assumptions of primary source disease maps. Drawing on this comparison, I explore how spatial analysis, when combined with careful qualitative analysis, provides opportunities to read these sources against the grain. By combining historical frames which incorporate textured socioecological relationships with nuanced visualization and analysis of historical visual material, I argue, we can turn the colonial gaze on its head, allowing historians to see more clearly moments of power-driven ecological tension, minute relationships, and ways of living and being that themselves defy the hygienic gaze.

Participants in this panel (both presenters and audience) will:

1. Think critically about the nature of maps as a medical object and the situatedness of epidemiological knowledge in particular historical environments.
2. Learn some of the ways that the practice of mapping can, when combined with careful qualitative analysis, provides opportunities to read sources against the grain and reveal new aspects of medical knowledge formation.
3. Be able to assess the value of multidisciplinary methods for revealing historical patterns of disease and analyzing disease maps for the study of public health history.

D5 Miscarriage, Still-Birth, & Fetal Personhood

1. Kirsten Leng, University of Massachusetts Amherst

The Apparitional Stillbirth: Late-Stage Fetal Death and the History of Reproduction in the United States

“Stillbirth” as a category used to describe a particular pregnancy outcome has existed since at least the 17th century (Woods 2009, 16); however, its uses and meanings have varied across time and place.[1] Health care workers, medical researchers, statisticians, and public health administrators have deployed the term broadly and diversely, using it to characterize both intrauterine deaths after the point of fetal viability beyond the womb (a variable designation in and of itself) and to denote deaths that occur during delivery. The related classification of “stillborn” has been used to specify infants born dead as well as infants not breathing but with (often temporary) cardiac activity. Sometimes, stillbirth appears in health care literature and popular media as a variety of pregnancy loss; other times, it is discussed in relation to infant mortality. In times past, panicked parents invoked stillbirth to give cover to the desperate act of infanticide. Given its definitional capaciousness and its location on the precipice of existence and non-existence, stillbirth may be the ultimate liminal experience.

The historiography on stillbirth is thin on the ground and has focused mainly on the writings of famous obstetrician-gynecologists (Woods 2009), historical experiences of grief and practices of community memorialization (Thompson 2008, Parkin 2020, Simonds and Katz Rothman 1992; in anthropology, Layne 2003), and the implications of changing systems of birth and death registration (Davis 2009; Fordyce 2013).[2] The state of the literature is perhaps not surprising given the aforementioned categorical vagaries. Moreover, stillbirth itself rarely figures as the primary object of interest in the literatures comprising the history of reproduction, such as

medical texts, legislative proposals, popular pregnancy manuals, and public health studies. It is often mentioned almost as a limit or boundary on other objects of investigation.

Yet in this paper I argue that there is a lot to learn from investigating stillbirth's presence and deployment in discourses concerning reproduction. My method here is inspired by literary scholar Terry Castle's efforts to excavate the presence and meaning of lesbians in Western cultural history from their oftentimes marginal socio-cultural locations. Coining the concept of the "apparitional lesbian," Castle trains our attention on the figure of the lesbian, who, culturally, has been effaced and elided yet nonetheless remained ever-present. In so doing, she interrogates what this "absent presence" can teach us about cultural understandings and desiderata vis-a-vis the lesbian specifically, and sexuality generally.

Indebted to Castle's work, I titled this paper the "apparitional stillbirth" to signal my efforts to refocus an experience that has marginalized within histories of reproduction, yet whose very marginalization bespeaks considerable importance--and anxiety. Here I argue that tracing the place and function of stillbirth in two discursive realms—namely, infant mortality studies and prenatal care—over the course of the twentieth century helps reveal the limitations of American biomedicine as a praxis. That is to say, stillbirth reveals the limitations not only of biomedical interventions into pregnancy and birth, but also of the liberal ideology that underpins the profession and frames its research, which figures pregnancy as an individual event that proceeds smoothly save for "pathologies" and "ignorant" behavior and choices on the part pregnant person that can only be corrected via surveillance, education, submission to expert authority and technological applications. Furthermore, surveying invocations and analyses of stillbirth highlights the negative consequences of viewing pregnancy solely in utilitarian terms, i.e. as a means to an end, as opposed to an existential state and a moment in a person's lifetime with value in and of itself, as has recently been suggested by feminist philosophers (Browne 2022). Proceeding from this historical survey, this paper concludes by asking what it would take, in addition to yet beyond biomedicine, to create conditions of holistic care that would ensure better birth outcomes for all pregnant people.

[1] Here I am focused on Anglo-American history and historiography.

[2] There are, of course, parallel and at times intersecting literatures on the histories of miscarriage, abortion, infertility, childlessness, and the meaning of the fetus; see for example the work of Withycombe (2019); Freidenfelds (2019); Reagan (1996), Schoen (2015), May (1995), and Dubow (2010).

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My learning objectives fall squarely under the rubric, "Develop knowledge and understanding of professional behaviors and values." Specifically, my paper aims to:

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

2. Kathleen Crowther, University of Oklahoma

"Take a Secondine of a sound and health full body, and distill it": Averting miscarriage in early modern Europe

Early modern medical texts and family recipe books abound with drinks, powders, poultices, plasters, and baths intended to prevent miscarriages. These remedies utilize a dizzying array of ingredients, ranging from common herbs to expensive imported spices. In *The Midwives Book* (1671), Jane Sharp (c. 1641–1671) recommends a powder made of red coral, ivory shavings, mastic, and nutmeg to prevent miscarriage. In his handwritten recipe book, Thomas Sheppey (fl. 1675) advises distilling a placenta and drinking the resulting liquid in white wine and cinnamon water. Other miscarriage preventives involve rosemary, sage, tansy, as well as ingredients imported from Mexico and South America like cochineal, sarsaparilla, and guaiacum wood. But how do these remedies relate to early modern understandings of the causes of miscarriage? Medical writers since Antiquity explained that miscarriages happen because the fetus is only

loosely attached to the womb in the first two or three months after conception and is easily separated and expelled if the pregnant woman jumps up and down, dances, has sex, sneezes, coughs, lifts heavy objects, or gets too emotional. Yet the sheer array of ingredients suggests a more complicated understanding of the causes of miscarriage, one that does not always place the blame on the woman for carelessly or deliberately shaking the fetus out of the uterus. Some ingredients, like sage and tansy, had a variety of reproductive uses, including contraception, menstrual regulation, and abortion. Many, like rosemary, nutmeg, coral, and ivory had astringent properties and were used to stop and dry up fluxes of blood. Still others, like the placenta in Sheppey's recipe and eagle stones, operate by a kind of sympathetic magic. In this talk, I use remedies for miscarriage to tease out a more nuanced account of how women and their families understood and experienced miscarriages in early modern Europe.

Develop the capacity for critical thinking about the nature, ends and limits of medicine.
Deepen understanding of miscarriage as a cultural as well as a biological process.
Recognize the dynamic interrelationship between medicine and society through history.
Develop an historically informed sensitivity to the treatment of miscarriage and other reproductive health problems.

3. Rebecca Kluchin, California State University

Fetal Interests and Medical Decision-Making in America, 1960-2014

On June 24, 2022, the United States Supreme Court ruled overturned *Roe v Wade* (1973) and held that abortion is not a Constitutional right when it handed down *Dobbs v Jackson*. *Dobbs* returned abortion policy to the states, but many in the pro-life community are continuing efforts begun in the 1960s to outlaw abortion at the federal level through fetal personhood policies. Recently, journalists, politicians, and scholars have been debating the implications of these strategies, but few have focused on pregnant women in the past who had their medical decision-making capabilities rescinded by medical and legal experts seeking to protect the fetuses patients carried. Using three sets of case studies, this paper shows how doctors, hospital administrators, lawyers, judges, and lawmakers employed claims of fetal personhood to compel pregnant women to undergo treatment they refused on behalf of their fetus. The vast majority of patients profiled here are poor women of color, who lacked the status and resources to combat the white, male professionals who intervened in their care.

Centering patients' stories and using a reproductive justice framework to analyze them, this paper argues that the politics and practices of fetal personhood in America extend beyond abortion and into the realm of medical decision-making. It also argues that these experiences are part of a long history of medical racism and reproductive injustices in American medicine. The first set of case studies involves two pregnant Jehovah's Witnesses forced to undergo blood transfusions that violated their religious beliefs in 1962 and 1963. The second set of case studies involves nearly three dozen forced cesarean sections performed between 1979 and 1990. In these cases, when pregnant women refused their obstetricians' recommendation for surgery, physicians took their patients to court to compel their compliance. The final case study involves

two pregnant brain dead women kept alive so their fetuses could live in 1987 and 2014. In each instance, fetal interests were recognized and pregnant women's rights were diminished.

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
Develop a historically informed sensitivity to the diversity of patients

D6 Of "Medical Devices" & "Ingenious Inventions": Health, Technology & Print Since Early Modernity 1500-2000

1. Elaine Leong, University College London

George Hartman's Ingenious Engine: Medicine and Health Technologies in Early Modern England

In the early 1680s, the London chemical operator George Hartman debuted a design for an "ingenious engine" – a small tabletop stove which could warm houses, stew meats and, crucially, distil medicines. Descriptions of the engine, along with detailed schematics, were first included in his printed medical recipe collection titled *The True Preserver and Restorer of Health* (London, 1682) and later in *The Family Physician* (London, 1695). Several versions of the engine are described within the pages of these two books, enabling historians to reconstruct Hartman's design over time and examine the ways in which he tweaked the device to reflect customer preferences. This talk traces the history of the "ingenious engine" across a flurry of printed texts, and uses it to explore processes of design, production, and marketing of health technologies in late seventeenth-century England. I will show that "small technologies" such as Hartman's engine were designed to be multifunctional and multipurpose to attract the widest possible user-base. They were also dynamic objects continually modified to suit the needs and desires of potential users. Here, maker and user participated in an informal feedback loop to ensure that the device remained useful and relevant. Using the story of Hartman's device, I will demonstrate that everyday technologies of health played a key role in early modern health cultures, and that further explorations in their creation, production and use can illuminate our understanding of medical knowledge and practice. My adoption of analytical frameworks from histories of modern medicine and technology aims to foster conversations across the temporal boundaries. Finally, by shining light on simple home-based devices such as Hartman's engine, I hope to broaden the kinds of objects and devices which could be investigated under the umbrella term of medical technologies.

By the end of this activity, the learner will 1) acquire a historically nuanced understanding of histories of medical technologies; 2) further appreciative different medical cultures and perspectives of health and the body; 3) recognise the dynamic interrelationship between medicine, technology, and commerce.

2. Felix Rietmann, University of Fribourg

The Cradle and the Birthing Bed: Technology and Public Health in the late German Enlightenment

On Sunday, December 3, 1803, the *Journal of the Elegant World* published on its title page “news on inventions to the benefit of mankind,” made by the “court counselor” Dr. Bernhard Christoph Faust in Bückeburg. The news consisted in an announcement of four devices that Faust had designed to improve health in both medical and domestic settings. The devices included a machine to fix fractures of the leg, a birthing bed, a sick bed, and a cradle. These “inventions,” the enlightened readers were told, would “eradicate” some of the “most common ills of mankind” and provide “comfort, sleep, and refreshment” to both the “sick” and the “healthy.”

This paper discusses Faust’s “inventions” as a window on the role of health technologies in the German medical Enlightenment. Internationally renowned for his best-selling health catechism, Faust was both a prolific writer and a local reformer. As court physician, he initiated various regional and interregional educational and sanitary efforts that ranged from medical services for the poor to the distribution of leaflets and prints on personal hygiene and physical education. His devices figured within this broader ‘public health’ effort. The cradle was designed as an ‘everyday technology’ to improve infants’ “health and life” in the bourgeois household; the birthing bed as a portable device to regulate the practice of mid-wives. In this paper, I closely examine make-up, advertisement and distribution of Faust’s cradle and birthing bed. I argue that these “machines” not only intervened in relationships between patients and practitioners, citizens and doctors, and mid-wives and physicians, but also depended on new markets for industrial products and communication networks of artisans, producers, makers, and users. They thus provide an intriguing perspective on the intersecting worlds of commerce, medicine, and the public in the late Enlightenment.

Keywords: Medical Technology, Public Health, Enlightenment

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

3. Kirsten Moore-Sheeley, Cedars-Sinai Medical Center

Localizing Technologies and Markets in 20th-Century Global Health: The Case of Insecticide-Treated Nets

Insecticide-treated bed nets have become ubiquitous fixtures in households around malaria endemic areas of the global South. These “remarkably low-tech” devices—a combination of plastic mesh and mosquito-repelling insecticide—are just one of many health technologies disseminated through the circuitry of global health and development in the twentieth century. Like condoms, oral contraceptives, and oral rehydration therapy, they have helped stitch together conditions of survival in places lacking robust health care systems or infrastructure. All

these tools also figured centrally in social marketing projects, which built on the postwar boom in behavioral social sciences and extension of global commercial networks to sell health products and behaviors to at-risk populations.

However, the homogenizing influences of global capitalism and biomedicine, whose expansion underpinned the wide dissemination of these small technologies, were not entirely hegemonic. As the case of insecticide-treated nets reveals, users appropriated these devices in various ways (and sometimes not at all), in line with their own health needs, priorities, and medical epistemologies. This paper examines efforts to scale up insecticide-treated nets in East Africa through social marketing to show how such attempts at creating rational health consumers failed to discipline local technological definitions and practices. Posters, leaflets, and billboards advertising insecticide-treated nets to African populations—particularly pregnant women and mothers of young children—did not initially account for people’s understandings of malaria or bed nets. Nor did they reconfigure gendered landscapes of rural poverty, which inhibited intended users from accessing these devices. Thus, this paper argues, the accelerated globalization of health technology-commodities since the mid-twentieth century has led to the mass proliferation of material things but not necessarily in tandem with their original or intended medical purpose.

Keywords: Technology; Global Health; Marketing

1. Recognize the dynamic interrelationship between healthcare and society through history
2. Deepen understanding of the links between medical technology, health, and healing
3. Develop an historically informed sensitivity to the diversity of patients, including appreciation of class, gender, socio-economic status, and medical frameworks

E1 Colonial Medicine

1. Brad Bolman, University of Chicago
The Tropics of Medical Mycology: Skin, Empire, and Knowledge

The first department of medical mycology in the United States was at Columbia University, growing out of the university’s “Mycology Laboratory” founded in 1929 by J. Gardener Hopkins. Mycological research at Columbia is rightly celebrated for connections to the first antifungal medication for human diseases, Nystatin, and for influential work in developing pedagogical resources for medical mycology, but the relationship between mycology at Columbia and America’s overseas territories, especially Puerto Rico, has been significantly neglected. This paper places the growth of medical mycology at Columbia both within a broad international turn to the importance of fungal pathogens and within a faltering project of American imperial science, exemplified by Columbia’s short-lived School of Tropical Medicine. The paper focuses on two Puerto Rican researchers, Arturo L. Carrión and Margarita Silva-Hutner, whose intertwined career trajectories reveal the structural challenges for citizens of the territories to

participate in American medicine and science as well as how “skin” became rearticulated as a site of fungal illness in the twentieth century.

The presentation will acquaint listeners with the history of an under-appreciated and under-studied branch of medical research (medical mycology) and a key piece of the story of its development. Listeners will better understand the dynamic history of medical ideas and practices, and their implications for patients and health care providers. They will also learn to recognize the dynamic interrelationship between medicine and society through history.

2. Rachael Hill, Californiat State Polytechnic University, Pomona

Harming and Healing: British Colonialism and African Prophetic Responses to Social Suffering in Western Kenya

This paper will focus on two popular prophetic movements, Dini ya Masambwa (DyM) and Mumboism, that captured the attention of British colonial officials in western Kenya during the first half of the twentieth century. I argue that both anti-colonial prophetic movements aimed to heal the damage wrought by colonial land and labor policies. Both movements sought to usher in a new era in which Europeans would be purged from the land and Africans would restore health and prosperity to their communities. While prophetic movements have been largely ignored by historians of health and healing in Africa, I argue that Mumboism and DyM were rooted in pre-colonial healing practices documented throughout the African Great Lakes region. Primarily framing Mumboism and DyM as “political” or “religious” obscures their connection to deep and enduring ideas about health and healing in the region. These movements appear in the colonial archive alongside reports of famines, severe soil erosion, drought, and epidemics that devastated human and cattle populations. I argue that prophetic movements emerged as a response to collective misfortune experienced as a series of public health crises created by British colonial policy. These movements expressed an etiological rationale that connected a decline in the collective health of their communities to the spiritual and moral failings of the colonial order.

Deepen understanding of illness and suffering across cultures

Understand the dynamic history of medical ideas and practices in African societies

Recognize the dynamic interrelationship between medicine and society through history

Develop a historically informed sensitivity to the diversity of ideas about health, healing, and social suffering

3. Thomas Parkinson, University of Cambridge

Colonial Aphasia: A Material History

Language impairments have figured prominently as metaphors in postcolonial analysis. Ann Laura Stoler’s notion of ‘colonial aphasia’, for instance, turns a rare speech-impairing neurological disorder into a metaphor for France’s inability to reconcile with its colonial past. The concept of ‘colonial aphasia’, which has gained a wide currency across the humanities, is defined as ‘an occlusion of knowledge’ and ‘a difficulty generating a vocabulary that associates

appropriate words and concepts with appropriate things'. Hence, better than 'forgetting' or 'amnesia', the term more accurately captures the cultural and intellectual mechanisms by which imperial history has been obscured or silenced. This paper challenges the accuracy and utility of that concept by taking recourse to the history of medicine. It locates a material history of aphasia in nineteenth-century India, and it demonstrates how a commonly invoked postcolonial concept had a colonial history of its own. During the 1860s, physicians at the Calcutta Medical College discovered a new form of language loss that they believed to be caused by overwork in the hot, insalubrious climate of tropical Asia. The papers of Bengal's most senior colonial doctors show a sustained interest in the idea that a person could be silenced by their Indian locale. They supposed that white, European officials and bureaucrats were uniquely vulnerable to neurological failure and its sequelae, speechlessness. And their 'colonial aphasia' was marked by the ideologies of race, empire, and environmental determinism. Unlike its figurative namesake, causation was the definable feature of this highly localised and historically constituted medical condition. Thus, disordered language and speech therapeutics are linked more fundamentally with colonialism than our contemporary abstractions would suggest. Blending theoretical criticism with a history of science and empire, this paper centres 'aphasia' to make a broad critique of scholars' usage of disability as metaphor.

1. cultivate a better awareness of the ways that concepts of disorder and disease relate to colonialism 2. to understand how the profession of medicine was formed by interactions between a diverse roster of doctors and patients in and outside of Europe 3. to be receptive to new, critical histories of medicine that situate disability as a historically contingent category of being.

E2 Medicine & Social Stability

1. Po-Hsun Chen, University of Manchester

Treating Environmental Toxicants and Social Instability by Chinese Medicine in Taiwan in the 1980s.

Polychlorinated biphenyls (PCBs) are environmental toxicants and incurable chemical compounds. PCBs related toxicants caused environmental pollution in the U.S. and food poisoning in Japan in the 1970s. In the 1980s, the leaking of PCBs into edible oils also triggered tragic poisonings of blind children in Taiwan. This article demonstrates and argues that Chinese medicine was not only a medical method for treating PCBs poisoning but also a political tool for building cultural identity in post-war Taiwan.

During the Taiwan martial law period, Kuomintang (KMT) government encountered difficult political situations at home and abroad. Thus, KMT implemented the Chinese Cultural Renaissance Movement to build Chinese cultural identity and reinforce KMT's governance. During the outbreak of PCBs poisonings, Senior KMT member Li-Fu Chen, a mining engineer trained in the U.S., promoted the integration of Chinese medicine into PCBs therapy. Interdisciplinary teams also conducted animal experiments and clinical trials to prove the efficacy of Chinese medicine. Although Chinese medicine treatment's long-term outcome was

not satisfactory in the end, Chinese medicine had already served KMT's political goals to alleviate the societal panic.

Keywords: Chinese medicine, cultural identity, environmental toxicants, polychlorinated biphenyls (PCBs), post-war Taiwan.

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

2. Andrea Ens, Purdue University

"Far from Being Degenerates": Conversion Therapy and Social Privilege in Early Twentieth-Century America

In 1913, American psychiatrist A. A. Brill wrote that his experiences studying and treating same-gender attracted patients convinced him "that a great injustice is done to a large class of human being, most of whom are far from being the degenerates they are commonly believed to be." Conversion therapy practitioners in early-twentieth-century America frequently insisted that their patients, rather than being malicious, criminal, immoral deviants, suffered from a curable, observable medical condition with biological roots. This was, however, an exclusive category, limited to a "high type" of patient, according to Brill, "for those are the ones we should reclaim."

This presentation examines how practitioners like Brill understood, described, and attempted to "cure" non-heteronormative people in early-twentieth century America. I argue that seeing queerness as a biological malady with behavioral manifestations allowed conversion therapists from 1910 to 1940 to "rescue" socially privileged patients from gender transing and same-gender attraction's negative connotations during this historical period. Conversion therapists argued that this class of patients did not deserve punishment and scorn against the backdrop of complex legal and medical structures that criminalized, pathologized, and surveilled non-heteronormative desires and identities. Their medical journal articles describe white, affluent, and native-born conversion therapy patients as respectable, morally-upstanding individuals, not "sexual deviants" (who were largely imagined as immigrants, people of color, and members of the working class). Such diverging characterizations of queer bodies reveal how American conversion therapists focused their efforts on people who possessed racial, economic, and social statuses already deemed worthy of sympathy and preservation. This history has strong implications for our present-day understanding of conversion therapy in America as well as the ways race and class create mental health disparities between LGBTQ+ populations over time.

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

3. Paul Lombardo, George State University

Pro-Life eugenics: What the leaders of the American eugenics movement thought about abortion

It has become common to hear politicians, pundits and even U.S Supreme Court justices assert that there is a linear relationship between the rise of eugenics early in the 20th century, the early birth control movement, and more recent social and political successes of those who champion reproductive autonomy, including access to abortion.

But there is no evidence that early leaders of the eugenics movement supported women who wished to terminate pregnancies, either as part of the movement for birth control, or for any other reasons. It is more accurate to describe those leaders as anti-abortion, and most of their followers as people who condemned abortion for moral, legal, and medical reasons.

This presentation will focus on statements about abortion from the recognized leaders in American eugenics, as well as other prominent voices in the eugenics movement from 1904 to the demise of many eugenic organizations after World War II. Among those whose public positions reflected this antipathy toward abortion were Scottish physician Caleb Saleeby, disciple of Francis Galton and author of the first monograph on eugenics, who said: “when a new human life is conceived our duty is to preserve it,” Charles Davenport, Director of the Eugenics Record Office (ERO), who agreed that “no eugenicist could support destruction of the unfit either before or after birth,” and Harry H. Laughlin, the most successful eugenic propagandist from the ERO, and recipient of an honorary medical degree from the Nazis, who proclaimed “Preventing the procreation of defectives rather than destroying them before birth, or in infancy, or in the later periods of life, must be the aim of modern eugenics.”

While there was a wide variety of opinion among those who endorsed eugenics concerning the value of birth control, there was virtually no support among its leaders—either those for or against birth control—in favor of abortion. Most in the early eugenics movement were as fully opposed to abortion as a modern “right to life” partisan. This opposition was captured in many documents, including the 1935 manifesto that took the place of the earlier Eugenics Catechism.

- 1) Participants will appreciate the distinction between birth control and abortion made by leaders in the U.S. eugenics movement.
- 2) Participants will recognize the near universal rejection of abortion by leaders in US eugenics.
- 3) Participants will develop a nuanced understanding of how U.S. eugenicists supported measures such as coercive sterilization while simultaneously rejecting abortion.

E3 Race, Gender, and Repair in Postwar US

1. Andrew Hogan, Creighton University

Markers of Prestige and Barriers to Inclusion in Postwar US Health Professions

In recent years, health professions have sought to address their longstanding lack of racial/ethnic diversity. However, few have considered the successes and barriers of previous initiatives. In this talk, I examine how occupational therapy (OT) and physical therapy's (PT) efforts to enhance minority recruitment have been impacted by other professional priorities. Specifically, I look to education programs as key sites of inclusion initiatives and exclusionary policies. Most late-20th century OT and PT students were trained in baccalaureate programs, even as prominent figures in both fields pushed for a shift to graduate entry-level degrees. Highlighting other health professions, many OTs and PTs argued that they were falling behind in respect, autonomy, and skill. Others were more hesitant. Some noted that transitioning to the graduate entry-level would inhibit minority recruitment, by increasing cost and completion time.

Ultimately, both fields moved to graduate programs in the 2000s. One major result was heavier reliance on GRE and undergraduate science GPA in admissions decisions. Especially in PT—where most education programs required one year of biology, chemistry, and physics—pre-requisites were onerous to obtain and greatly privileged performance in basic science courses. By the 2010s, research showed that minority students, as a population, were strongly disadvantaged by PT programs' emphasis on GRE and science GPA in admissions decisions—due to well-established structural disparities in educational background and opportunities by race.

Historians of medicine have done little to examine post-WWII non-medical health professions, aside from nursing. This presentation draws on a unique set of newsletters, archives, and oral histories to examine justifications for increasing OT and PT entry-level degrees and explores how this shift impacted minority recruitment initiatives. I argue that OT and PT leaders privileged efforts to enhance their field's prestige, in the view of physicians, while overlooking the impacts of their policies on minority recruitment. As I explore, other health fields—such as respiratory therapy and nursing, which have much higher levels of racial/ethnic diversity—offer alternate pathways for achieving more robust minority recruitment. These include the availability of multiple on-ramps for professional education, such as at the associate's and bachelor's level.

By the end of this activity, the learner will: 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.

2. Adrien Gau, University of Pennsylvania

Normalizing Surgery Beyond Intersex: The Case of Funnel Chest

Pectus excavatum, colloquially known as funnel chest for its sunken-in sternum, is perhaps the most common chest wall deformity; its incidence rate is comparable to, if not more than, that of intersexuality. Also similar to intersex, the standard treatment protocol for funnel chest is surgical "correction" in early childhood, even though the benefits for physical health are unclear, as the majority of adults who retain their funnel chest show few debilitating symptoms.

While it may seem that the case of intersex is more morally charged, and therefore more fruitful for study, this paper demonstrates that the relative lack of controversy in the history of funnel chest allows us to better see how the shifting conversations surrounding perceived anatomical deviations ostensibly unrelated to sex reflect changing priorities and anxieties around bodies and their place in society.

This paper traces the changing conception of funnel chest in American medicine from 1930 to 1960. In just these few decades, funnel chest transformed from an incurable but mostly inconsequential physical deformity, to a prophylactically treated birth defect that otherwise threatened children's budding psyches in the form of a future "social handicap." To prevent future psychological harm, parents and physicians opted for these children to undergo a surgery perfected throughout the 1950s called the Ravitch procedure. While the medical community generally acknowledged that the Ravitch procedure did not bring about much measurable change in physical health, they did see it as an important (deeply gendered) cosmetic improvement, which was enough to justify the risks of pediatric surgery.

Also important to this history is the way in which the future risk of a citizenship limited by both physical and social debility defined this condition. Here, fear of disability drove medical intervention. As such, disability is not simply an ad hoc establishment of difference, but an evolving imaginary that attempts to stabilize a future vision in order to make meaningful decisions in the present.

1) Shed light on the history of treating funnel chest, which has not yet been studied extensively in the history of medicine or disability studies; 2) Propose adjustments to theoretical frameworks such as medicalization and the binary of the medical-social models of disability, to enrich our understanding of the relationship between patient and practitioner; 3) Make connections within the changing medical landscape of the USA post-WWII, such as the professionalization of cosmetic surgery and psychology

3. Bess Williamson, School of the Art Institute of Chicago

Handicapped Homemakers and Occupational Therapists: Gender, Race, and Disability in post-World War II Rehabilitation

After World War II, U.S. medical practice significantly expanded in the area of "rehabilitation," the medical and social services aimed at integrating disabled people into work and home lives. While vocational rehabilitation had largely focused on male veterans and industrial workers, new strategies of rehabilitation were distinctively feminine in terms of both practitioner and patient. This paper explores "Handicapped Homemaker" projects of the 1940s-60s in which occupational therapists and other mostly-female professionals aimed to address the particular needs of disabled women in the home. It examines the intersecting and overlapping identities of therapists and patients as predominantly white, nondisabled women intervened in the home and family lives of a more diverse array of women patients.

In the context of mid-century views of the home, Handicapped Homemaker projects were at once wildly ambitious and strictly normative. In proposing a thorough redesign of the American kitchen to accommodate a disabled body, therapists took on one of the most hegemonic socio-technical spaces of the twentieth century. Yet their approach also reinforced racist and sexist views of homemaking, marriage, and caregiving. Ultimately, they produced the idea of a Handicapped Homemaker firmly rooted in the norms of white, middle-class parenting and marriage that was more likely to describe the therapists than their clients. A particular focus on design as a means of change – listing and photographing hundreds of gadgets and small construction fixes – aligned with what architectural historian Dianne Harris has analyzed as the whiteness of postwar home design in a period of widespread housing segregation and discrimination.

This paper observes that Handicapped Homemaker projects asserted a role for medicine in changing the social and material world beyond the hospital. But it also asks how these women professionals reinforced restrictive views of gender, race, and disability in the home and family. These biases, moreover, still influence contemporary iterations of occupational therapy and the possibilities available to disabled clients.

Develop knowledge of the history of occupational therapy practice in the United States
Think critically about the meaning of "home" and "occupation" for women of diverse racial, economic, and family statuses in this period
Deepen understanding of the practice of occupational therapy in using everyday spaces and technologies

E4 Tools & Teaching in Early Modern Medicine

1. Walton Schalick, University of Wisconsin
Sanguisuga aura: Leeches, Markets and Medieval Medicine

Alexander Neckam, a 12th-century intellectual, recounted a plague descending upon Naples. Unlike prior pestilences, this was almost biblical in nature, a deadly infestation of leeches. Evading conventional remedies, the leeches succumbed only when the populace appealed to a legendary necromancer, Virgil. He recommended they fashion a golden leech, placing it in a well. Later, the citizens forgot this event; cleaning the well, they discovered the leech and removed it; the living leeches returned. Replacing the golden leech again saved the city. Similar tales were repeated by Gervase of Tilbury, Vincent of Beauvais, and others, through the thirteenth century.

Human ‘memory’ of leeches, like that of the Neapolitans, is both short and long, primal and innovative. In the Middle Ages, leeches were intimately associated with medicine, as well as blood and greed. So pervasive was the leech in this medical ‘vein’ that Old English homonymously labelled a healer ‘læce.’ As wider use of lancets arrived, they were called

'bdellometers' (Greek βδέλλα, 'leech'/'lamprey'). In the enveloping matrix of analogies, the læce could also be seen as avaricious and a 'blood-sucker.'

Despite the widespread link between doctors and leeches, medieval leeching remains remarkably unstudied by modern historians. In this paper we begin to fill that lacuna by examining the seminal role leeches played in medieval practice, theory, language, and 'marketing' of medieval medicine. It is posited that while leeches were less important than modern imagery suggests, they were nevertheless polyvalent in their interpretative role by and of doctors, for disease, and for their relationships with patients.

Using an array of sources in Latin and vernacular, in manuscript and print, by elite and lay, from academics and artists, through word and image, this paper frames leechcraft from acquisition to disposal. In it, we find that leeches were not only important in therapeutics, but also in diagnosis, prognosis, and regulation.

Through this reading, leeches demonstrated their power, changing Virgil into a magician, transforming disease into health, and securing medicine in its protoprofessional status. Beyond merely a means of exsanguination, the leech's locus in medieval medicine was that of a cultural philosopher's stone.

1. By the end of this paper, the attendees will have a greater appreciation of premodern uses of leeches.
2. By the end of this paper, the attendees will have a greater appreciation of social structure impacting health and disease.
3. By the end of this paper, the attendees will have a greater appreciation the interaction of cultural elements impacting medicine and the medical profession.

2. Edoardo Pierini, University of Geneva

The Early Modern Narcotic Outbreak: Opiates and Sleep in Thomas Willis' Pharmaceuticae Rationalis

Since Antiquity, Physicians used to know the medical properties of the opium poppy, whose derivatives were considered powerful but very dangerous drugs that should be used only in desperate cases. This attitude lasted in Britain until the seventeenth century, when the medical use of opium started to be gradually considered less dangerous and consequently prescribed much more frequently.

The reason for this increase could be traced by the praise of this medicament by important English physicians such as Thomas Sydenham (1624-1689) and especially Thomas Willis (1621-1675), a highly influential member of the Royal Society. In his celebrated work *Pharmaceuticae Rationalis* (1674), Willis dedicated an entire chapter to "Opiate Medicines or Causing Sleep", where he gave a detailed account of "the nature, manner of working, subjects, and limits or Sphere of Activity of Opiates". In this context, Willis describes the importance of sleep "to the preserving the health of the Body, and to the furnishing of the gifts of the Mind", as well as the necessary "remedies" to achieve a right balance between wake and sleep. The

opiates were indeed considered the best way to get a good sleep, and therefore people got the opportunity to take them almost daily, as shown in some cases reported by Willis himself. Also, Willis considered narcotics as formidable anodynes and invaluable medicaments against very common issues such as cough and stomach problems, so that it is impossible for the modern reader to not foreshadowing possible problems with addiction to this substance. In this paper, I show why opiates and sleep were intrinsically bounded in Willis' neurological theory and why the following hints of the emergence of opium addiction in the British society at the time were almost unnoticed.

- 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
- Critically appraise clinical management from a historical perspective

E5 Care & Coercion

1. Richard McKay, University of Cambridge

"The goat in the trouble": syphilis, sodomy, and race from university to prison in early-twentieth-century New York

Jennifer Jones highlights the archival gaps and silences running through black queer historical scholarship in the United States, and notes that challenging the "presumed whiteness of LGBTQ subjectivities" has been one of the field's key interventions.¹ Such archival silences pose particularly acute challenges in researching the history of same-sex transmission of venereal disease (VD). Women are seldom mentioned. Few records detailing disease transmission between men survive from before the penicillin era, and those that do privilege the experiences of white sufferers.

It is important, therefore, to spotlight queer instances of VD transmission where race appeared salient to contemporaries. This presentation does so by examining an undated anecdote circulated in 1932 by William Munson, a New York public health official.² His article extolling the virtues of contact tracing for syphilis described an outbreak among thirteen male students attending an unnamed university in his state. Each student reported an anal chancre—highly suggestive of same-sex transmission. Several weeks of sustained, "almost third degree" interrogation eventually led to the identification of a "colored" male chef as the individual suspected of infecting the white students. According to Munson's account, the chef was arrested, handed an indefinite prison sentence, then transferred to a state hospital for the criminally insane.

My presentation will expand upon this single published report by analyzing newly uncovered archival prison records, psychological assessments, and correspondence. In contextualizing a hushed-up university sex scandal and one man's daunting journey through the carceral system, it offers a case study of how eugenics and racism permeated medical views of homosexuality

and syphilis in the early twentieth century. The presentation will emphasize the chef's resilience in his interactions with university and religious leaders, state health and law enforcement officers, and prison doctors, as they deliberated the prospects of his moral and physical rehabilitation and cure.

1Jennifer Dominique Jones, "Finding Home: Black Queer Historical Scholarship in the United States Part I," *History Compass* 17/5 (2019), <https://doi.org/10.1111/hic3.12532>

2William L. Munson, "Practicability of Epidemiological Methods in the Control of Syphilis," *American Journal of Public Health and the Nation's Health*, 22/2 (1932), pp. 134-40.

By the end of this activity, the learner will:

Develop a historically informed sensitivity to the diversity of patients

Develop an understanding of the influence of eugenics and racism on medical practice

Acquire a historically nuanced understanding of patient experiences of syphilis

2. Laura Earls, University of Delaware

"a Woman chain'd down upon a Table:" Anatomical Models and Gendered Obstetric Knowledge in the British Atlantic World

A woman frantically strains against the chains that bind her to a dissection table as paying onlookers leer over a surgeon who slices into her womb for their amusement. Dr. Abraham Chovet sculpted this morbid wax model of a painful vivisection scene to demonstrate the circulation of blood between mother and fetus for his public lectures in eighteenth-century London. He likely continued to make and exhibit wax anatomical models during his time in Barbados and Jamaica before he settled in Philadelphia in the 1770s. This paper uses anatomical models made by Chovet and his contemporaries William Smellie and William Hunter to assess the role of objects in gendered and racialized negotiations of obstetric authority and knowledge in the British Atlantic world. The literature on the intrusion of man-midwives into traditionally women-only childbirth spaces centers white practitioners in Europe, and this paper intervenes by elucidating Atlantic connections between childbirth practices and anatomical models as teaching tools in England as well as the Caribbean and North American colonies. European man-midwives built their legacies upon the pain and deaths of pregnant women in their case studies, and anatomical models, whether made of wax, wood, or copperplate engravings, are often the only traces of these women left in the archive. This paper reads anatomical models across media for continuities in ideas about maternity and the maternal body in the British Atlantic world, and it asks how to find women, especially enslaved women in the Caribbean, in objects used to advance obstetric knowledge and praxis.

-Deepen understanding of illness and suffering.

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

E6 Politics of Reproduction

1. Ava Purkiss, University of Michigan

“Our Women”: Racial Patienthood and Medical Value(s) in Gynecology, 1890-1920s

In 1897, Dr. James Read Chadwick, a founding member and then-president of the American Gynecological Society, delivered an impassioned speech about reproductive organ removal to his colleagues. In admonishing fellow gynecological surgeons about their eagerness to perform hysterectomy and oophorectomy, he stated, “No one can deny that for the race it is an unmixed evil to have a large percentage of our women, still in the childbearing age, rendered suddenly sterile beyond recall (emphasis added).” What did Chadwick mean by “our women,” and who did he consider “the race?” Throughout his speech, Chadwick used implicit racial language to advocate for more minimally invasive gynecological surgery for white female patients. As the field of gynecology began to professionalize at the turn of the twentieth century, white male doctors established new treatment modalities, sanitation standards, guidelines on bedside manner, and guiding principles for the profession with white, middle-class women in mind. This paper will explore how racial norms and assumptions shaped the field of gynecology and concepts of patienthood. While this presentation will examine the historical tendency to normalize a “typical” white patient, it will also chronicle how African American women, who as enslaved women played critical roles in the medical innovations of gynecology in the nineteenth century, continued to bear gynecological burdens in the twentieth century as both practitioners and patients. For instance, as practitioners, black women helped white women avoid embarrassing interactions with white medical men by treating them for sexually transmitted infections. As “patients,” African American women served as research subjects for a profession that both needed them and disregarded them. These practices contributed greatly to racialized ideas about medical value(s) and customs in the gynecological profession. Using medical journals, gynecology textbooks, physician correspondence, women’s diaries, and black health newspaper columns, this paper will demonstrate the inextricable relationship between race and gynecology in the twentieth century.

1. Deepen understanding of the historical interplay between racialization, racism, and medicine
2. Develop the capacity for critical thinking about the nature, ends, and limits of medicine
3. Identify successes and failures in the history of medical professionalism
4. Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning

2. Ogechukwu Williams, Creighton University

The “Abortion Row” in Nigeria and the Politics of Women’s Reproduction

In June 2022, the Lagos State government of Nigeria published a document outlining its guidelines for safe termination of pregnancy. By the following month, it suspended this document due to a deluge of criticism from religious organizations and citizens who felt that any laws that appeared to endorse the termination of pregnancy was morally reprehensible and against “tradition.” This was not the first time, however, that the question of abortion, termed globally as the “abortion row,” had caused such fervor and public debate in Nigeria. In the 1970s, the federal government of Nigeria appeared to favor the legalization of abortion but

switched gears in 1981 when lawmakers voted, without room for debate, to bury the abortion bill that had been proposed in the House of Assembly. Drawing from archival records, newspaper publications, and oral histories, this paper examines Nigeria's place in the global "abortion row" that overtook most regions of the world throughout the 1970s and 1980s. It explores how legislation regarding the termination of pregnancy was shaped by age-old cultural taboos, patriarchal practices, and religious sentiments. While most discourses on abortion in Nigeria focuses on contemporary challenges, I situate these struggles within a historical paradigm that stretches back to the colonial era and underlines the patterns that have shaped contemporary public responses to legislation on pregnancy termination.

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

3. Pietra Diwan, Maria Lucia Boarini, Universidade Estadual ed Maringa
Six million silenced voices: understanding the "consensual" sterilization of women in Brazil (1960s-1990s)

For the original thinkers of largely disseminated eugenics, control over birth was essential to prevent nationality from degeneration. After 1945, with the public opinion's discredit of eugenics and its association with Nazism, another topics of concern arose: the worldwide poverty and the population problem. International community – actually, only the major countries in the UN council – discussed and decided that underdeveloped countries should put a break on birth to mitigate poverty and increase quality of life. This presentation focus on the results of a post-doctoral research about the "consensual" sterilization of almost six million women in Brazil in the context of the "humanitarian help" efforts after 1950s.

We consider this process as being part of the legacy of eugenics – if not eugenics itself – transformed and implemented in the second half of the 20th century. Under arguments of women having low intelligence level to make their own decisions about their bodies; policy makers and physicians making these decisions were predominantly men. On top of that, were the influence and impact of several international organizations giving funding, equipment and medical education to practitioners. Among some of the questions raised, where these women deciding for a permanent contraception in their bodies with enough information? According with the conditions of the way the tubal ligation were practiced and its dynamics – mostly, during cesarean section – where these sterilizations made in the mother's or doctor's interest? In which measure it is legitime to ask if the moment of consent is valid or made under doctor's intimidation? Most of these records are not available for two main reasons: a nationally disseminated and intentional medical practice of not producing records to avoid future legal prosecution and the active destruction of remaining files.

In a combination of an alleged population problem, the belief in a neo-Malthusianism, and the positive eugenics drafted by Julian Sorell Huxley in *Eugenics and Society* (1936), and later by The

Geneticist Manifesto (1939), the practices of controlling birth were largely disseminated worldwide in the following years. Not only in Brazil, women from many other countries were affected by these policies (United States, Japan and India) impacting the population dynamics of who can or can't be born (Stern, 2005; Bashford, 2014). An apparent "choice over the reproductive capacity via permanent contraception" is actually seen as "control over reproduction power" as defined by Schoen (2005).

Among some of the sources used are the Planned Parenthood records; Julian Huxley Papers (Rice University); memorandum "Some Implications of Population Trends in Poor Countries (CIA, 1970); Report NSSM 200 or Kissinger Report (1974); Brazilian Report Anticoncepção: 1986 [Contraception: 1986]; and the Relatório Final da Comissão Parlamentar de Inquérito destinada a examinar a "incidência de esterilização em massa de mulheres no Brasil" (1993) [Report from National Commission to Investigate "the incidence of women's mass sterilization in Brazil]; besides several bibliographical and biographical primary and secondary sources connecting the main representatives of these agreements and practices, the Brazilian researchers-gynecologists Elsimar Coutinho and Helio Aguinaga.

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

F1 Communities & Community Health

1. Katherine Sorrels, University of Cincinnati

Guru's Orders: Medical Paternalism in Alternative Disability Care

Medical paternalism—the assumption that health-care professionals can know what is best for disabled people without soliciting their preferences about their own health—is a central concern of disability scholars and activists. And for good reason. Without a clear understanding of medical paternalism, we cannot explain the history of institutionalization. Nor, for that matter, can we understand the activism behind deinstitutionalization or more recent opposition to post-institutional "congregate care" (nursing homes and larger group homes). The premise of such activism is that congregate care is necessarily dehumanizing, because it groups together disabled people, apart from the broader community, and thus denies them a sense of belonging in the community.

But what if a congregate care facility were, itself, a community? And what if its mission were to cultivate a sense of belonging for all its members? This paper looks at medical care in one such community: Camphill Village, founded in 1961 in New York State. Camphill doesn't have staff, but instead long-term volunteers who also call the facility home. Members live together in extended-family-style households, where the non-disabled people provide care for their

disabled household members, and resources are pooled to support everyone's needs. As a congregate care facility founded just as deinstitutionalization began, Camphill had a strained relationship with state overseers and policy makers. The fact that it also practiced alternative medicine exacerbated tensions, but also supported Camphill's effort to position itself as an alternative, even as an anti-institution, when institutions were being shuttered.

This paper takes Camphill—at the height of its hostility toward the state and medical establishment (1970s and 1980s)—as an example through which to examine the relationship between medical paternalism and belonging. I look specifically at medical care provided to disabled people by the community's primary care physician, Dr. Philip Incao (1941-2022), and arranged by the "house parents" in the disabled people's households. My sources are oral histories, Incao's publications, and Camphill records. I find not only that medical paternalism was pervasive, but that house parents often added a layer of in loco parentis paternalism. And yet, there is also evidence that these same households sometimes fostered mutually transformative relationships between disabled and non-disabled people. The very relationships that promote belonging.

I conclude by discussing the questions this case raises for disability scholarship in light of theoretical work on belonging. Namely, does a climate of belonging necessarily imply full citizenship and justice? Is belonging always or necessarily a warm or positive feeling? And if not, what qualities should we measure and promote, both in contexts where belonging exists without adequate respect for personhood, and where respect for rights and fairness fall short of promoting belonging.

1. Recognize the role of medical paternalism in congregate care for people with disabilities.
2. Describe the main obstacles to belonging for people with disabilities in congregate care settings.
3. Analyze the relationship between medical paternalism and belonging in the context of disability.

2. Dominique Tobbell, University of Virginia

"Moms and Tots": Nursing and the Politics of Community Health in 1960s' Detroit

During the 1960s, Detroit was in the midst of an "urban crisis" marked by profound racial inequities in access to health care services. In 1965, public health nurse, Nancy Milio, established a community-based maternal and child health center in a predominantly low-income Black neighborhood in Detroit. With funding from the federal Office of Economic Opportunity and administrative support from the Detroit Visiting Nurses Association, the Moms and Tots Neighborhood Center was staffed by community members and established to serve the needs of the community as identified by the community. The center offered prenatal care, family planning, and health and sex education, and reduced structural barriers to care by providing free childcare and transportation, and low-cost services. Using the center's archival records, Milio's diaries, newspaper articles, government papers, and oral histories, this paper analyzes the different meanings the Moms and Tots Neighborhood Center held for the women

who staffed the center, the clinicians who provided care, and the community members it served during the turbulent years of the late 1960s.

As a case study of a nurse-led clinic, this paper contributes new perspectives to the historiography of community health centers, which to date has largely focused on those established by academic medical centers and led by physicians, as well as the historiography of community health activism. It provides insights into the entangled policies and politics of community health provision, whereby efforts to increase health services to low-income Black women confronted the race, gender, and class biases of clinicians, administrators, and politicians. These health politics – and the broader political economy of urban health care – contributed to the liminal status of the Moms and Tots Center, reflecting the contested status of community health centers themselves and the low value placed on the health and social wellbeing of the patients they served.

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

3. Camden Elliott, Harvard University

Wabanaki Ethnogenesis: Smallpox and the Reordering of Communities in the 17th Century Northeast

In this paper I recast the origins of the Wabanaki Confederacy—and Indigenous conglomeration encompassing the modern Abenaki, Penobscot, Passamaquoddy, Maliseet, and Mi'kmaq tribes—by looking at the history of health and disease. Ever since the anthropologist Frank Speck “identified” the Confederacy historians have been unable to agree on when it formed, what it meant, or even who all was in it. The constituent nations of the Wabanaki Confederacy, like many Indigenous peoples across North America, were devastated by epidemics of smallpox that began with contact but made substantial progress and wreaked so much havoc during the 1630s. But rather than casting epidemic disease as a destroyer of communities—a la Crosby and his ‘virgin soil’ hypothesis—my work rethinks what new communities and kinds of communities emerged in the wake of these epidemics. The crux of this came during King Philip’s War when an epidemic of smallpox afflicted both settler colonists and Native communities. As Wampanoag and other Algonquian peoples fled as part of what historians now call the Algonquian diaspora, they spread the disease into Wabanaki communities, allowing for further integration into kin groups and finally the creation of new practices around disease. With the experience of this mortality event still fresh, the Wabanaki—pulled together in opposition to the English and by thinned ranks from English diseases—adopted novel disease mitigation strategies that were incredibly effective. These successes stand in stark contrast to the repeatedly introduced epidemics that devastated colonial populations and colonial armies. Smallpox and the history of disease offers a window into retelling and reimagining Native and colonial histories of early America.

Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
Deepen understanding of illness and suffering
Recognize the dynamic interrelationship between medicine and society through history

F2 Children

1. Heather Reel, Rutgers University

A Spoonful of sugar helps the medicine go down: The Dionne Quintuplets and the depression-era medical child

In interwar America, reformers turned to children as conduits for disseminating messages about public health. Leveraging sentimental notions of childhood, and the jazz age appeal of storytelling, pageants and parades, reformers engaged audiences who might have otherwise found health lectures and demonstrations boring or overly didactic. Though these efforts petered out by the early 1930s, the Canadian-born Dionne quintuplets, continued this tradition for a uniquely depression-era audience. As the first known surviving set of quintuplets in the world, the Dionnes were the most recognizable children in America, and the story of their birth, initial precarity and ultimate survival was deemed its own “modern medical fairy tale” framed much like the plays that could be purchased and performed by children to add “zest” to health teaching. As the quints grew, they were cast as committed medical enthusiasts who were complicit in their own care and excited about rituals of health maintenance and visits to the doctor. They supposedly played active roles in “gleefully” receiving their diphtheria vaccinations and even welcomed the dental drill with curiosity rather than fear.

This paper will explore the Dionne quintuplets' role as emissaries of a purported child-driven interest in medicine, and a vision of “child-friendly” health provision, in the depression-era United States. Drawing upon national articles about the quintuplets in the American popular press, I argue that readers, who seemed to have a voracious appetite for the carefully curated cuteness of the Dionnes, believed that the quints had special access to, familiarity with, and reverence for medicine. This belief was leveraged to promote an imagined “medical child” who willingly participated in and welcomed medical intervention and care. This paper contributes to a broader exploration of how children have been configured, materially and symbolically, within twentieth century practices of health and medicine and the medical imaginary.

- 1) recognize the dynamic relationship between medicine and society throughout history
- 2) understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning
- 3) develop an historically informed sensitivity to the importance of age as an organizing category in public health education and medical practice

2. Mia Levenson, Tufts University

Scientific Rearing and the Proper Care of Preemies: Race, Eugenics, and the Incubator Baby Show

From 1898 to 1943, Americans were more likely to find the emerging technology of the infant incubator at a place of public amusement than in a pediatric hospital. Across the country, these popular exhibitions followed a similar stratagem. Inside the glass and metal enclosure, attendees would find a small, but very much live baby. Organizers insisted that these shows educated their audience on the need for neonatal healthcare, a field that was only just gaining ground within the medical institution at the turn of the century. Regardless of their supposedly instructive objective, for over forty years the incubator baby show captured the US imagination, finding their way into books and stage shows that enacted both the fascination with the technology's capabilities as well as the concern over the implications it held over the relationship between humans and machines.

The common historical narrative surrounding the incubator baby shows, most recently retold in Dawn Raffel's *The Strange Case of Dr. Couney: How a Mysterious European Showman Saved Thousands of American Babies* (2018), is one of utopic multiculturalism: Martin Couney, an immigrant physician, came to the United States with a novel technology and used the exhibitions as an opportunity to help all infants regardless of race or nationality as well as educate the public on the necessities of this sophisticated apparatus. However, incubator baby shows were found at major world's fairs alongside enfreaked bodies, ethnological villages, and eugenics exhibitions, presenting a racialized history that belies the "immigrants-get-stuff-done" narrative. This paper will explore how incubator baby shows at world's fairs were shaped by the eugenics discourse imbued in the fairs' construction. Tracing the history of the infant incubator and the development of the incubator baby show, this paper will interrogate how the shows were presented in the language of animal husbandry and scientific approaches to reproduction. The incubator baby show's performance of technologically-assisted childrearing considered alongside the advent of eugenicists' dominance over reproductive discourse during this era asks several key questions that I intend to examine. How did incubator technology serve as a metaphor for scientific breeding and the intimate relationship between humans and medical machinery? How were the incubator baby shows shaped by their location at massive public attractions like world's fairs? How did the incubators' melting pot of a cast engage with early twentieth century understandings of race and immigration in the US?

- Recognize the dynamic interrelationship between medicine, society, and popular culture through history
- Develop the capacity for critical thinking about the nature, ends, and limits of medicine
- Examine the role of race and racialized discourse in the development and proliferation of medical technology

3. Mical Raz, University of Rochester

How Anti-Abortion Activists Shaped Our Child Welfare System - A Political History of the Adoption and Safe Families Act

“Instead of yelling at one another about abortion, we should spend our energy making adoptions easier,” wrote former first lady Hilary Clinton in 1995. In the mid-1990s, conservative and Evangelical adoption advocates worked to create a bipartisan coalition to advance adoptions. Many Democrats viewed adoption as an attractive, low-risk policy field that could help support children in need. Ultimately this bipartisan coalition helped pass numerous pro-adoption laws, including the 1996 Adoption and Safe Families Act (ASFA), which was championed and supported by a range of figures from both major political parties. ASFA is a mainstay of current child welfare policy. Crafted as a response to concerns over rising numbers of children in foster care, as well to concerns over children hurt in their homes despite child welfare interventions, ASFA shifted the child welfare pendulum away from family preservation and towards coercive intervention. ASFA relaxed existing legal protections against child removal, and lowered the bar for termination of parental rights, resulting in more children removed from their homes of origin, and permanently placed in new homes. As legal scholar Dorothy Roberts has argued, these measures exploited the perceived failures of family preservation, to justify the permanent separation of families, disproportionately Black and poor.

While many scholars have studied and critiqued ASFA’s policy impacts, they have not excavated the origins of the law. In this presentation I will highlight how pro-adoption, anti-abortion activists agitated for and shaped legislation that separated children from their parents. ASFA requires states to pursue termination of parental rights after children have spent 15 out of the past 22 months in substitute care, regardless of whether child abuse or neglect even occurred, thus “freeing” up children for adoption, even when they may have parents who are yearning to care for them. Furthermore, the specter of coerced removal into closed, state-mandated adoptions helped convince some struggling mothers to relinquish their children to open, private adoptions, in order to maintain some connection with their child.

Relying on oral histories, archival papers of bipartisan senators who cosponsored ASFA as well as of William Pierce, adoption advocate, anti-choice activist and President of the National Council for Adoption, this talk reveals how a bipartisan coalition prioritized adoption as the response to struggling families, while capitulating to anti-choice activists. ASFA is one of the enduring legacies of the Clinton-era, in which Democrats supported bills that furthered key conservative priorities and often hurt Democratic constituents.

In the post-Roe era, as current SCOTUS opinions reference the “domestic supply of infants,” this study helps elucidate the origins of our current child welfare legislation. Shedding light on the anti-abortion roots of ASFA and its legacy today helps enhance our understanding of this act as well as map out priorities for reform.

1- Understand current child welfare policies from historical perspective

- at the end of the presentation learners will be familiar with the goals of the Adoption and Safe Families Act (ASFA)

- Learners will be able to identify key impacts of ASFA, highlighting in particular racial disparities.
- 2 - Identify health risks of coercive child welfare interventions
- learners will be able to identify how child intervention and removal may adversely impact pediatric health outcomes
- learners will be able to identify how state mandated termination of parental rights and adoption may cause trauma to families and children

F3 Pharmaceuticals, Expertise, & Risk

1. Gabriel Carter, Lucas Richert, University of Wisconsin-Madison

"What is the Soft Drug Problem?": Gatekeeping, Pharmacist Authority, and the Pharmaceutical Industry, 1950-1975

In light of contemporary court cases about the legal and ethical responsibility of pharmaceutical companies and pharmacy chains to protect patients and consumers from psychoactive and intoxicating substances, this paper highlights the internal debates between pharmacists about their need to balance profits with public health concerns related to so-called "dangerous drugs" and "magic bullets." More specifically, this paper will present archival documents from approximately 1950 to 1975 in the United States, including a collection of posters by Frank Pinchak, documents from the American Pharmaceutical Association regarding the 1962 Remington Honor Medal that was given to Harry Anslinger, and a 1974 consumer manual on "Soft Drugs" that was published by the Pharmacists' Society of Milwaukee County. Utilizing such primary documents, this paper covers the discussions between pharmacists about the construction of their authority in the medical marketplace, the gatekeeping efforts of the pharmacist as part of the pharmaceutical industry, and the marketing of drugs that cross between medicinal and recreational contexts, such as opium and various opiates. These topics and concerns, put simply, grapple with the role of pharmacists and the pharmaceutical industry in harm reduction (broadly construed). While harm reduction, as a political movement and public health policy, did not begin to take shape until the late twentieth century, the debates between pharmacists throughout the early- and mid-twentieth century in the United States showcase a concern about the commodification, franchising, and profit-motives of the pharmaceutical industry. The aim of this paper, then, is to elucidate these debates to better understand the role of pharmacists in early harm reduction activities and idea-formation and connect these to current debates related to the prescription and use of pharmaceuticals.

(1) Identify the dynamic history of medical/pharmacy ideas and practices around gatekeeping of "dangerous" drugs, their implications for patients and health care providers, and the need for lifelong learning; (2) assess primary documents and ephemera that speak to pharmacist authority related to pharmaceutical products; (3) recognize the dynamic interrelationship between medicine, substances, and society through history.

2. Yang Li, Princeton University

Building HuaPharm: Antibiotics, Expertise, and Health Care System in the People's Republic of China

In the 1950s, as antibiotics and the therapeutic revolution were spreading globally, for the newly established People's Republic of China, to care for the people's health meant to be able to provide cheap biomedical drugs. Less developed in pharmaceutical technology, China relied on technology transfer from the Soviet Union. From 1953 to 1958, the construction of Soviet-aid HuaPharm, allegedly the largest antibiotic factory in Asia at the time, became a high-profile state project written into China's First Five-Year Plan. But as the Nobel Laureate Ernst Boris Chain observed, HuaPharm was basically a Soviet factory.

To domesticate HuaPharm and make sure it fit socialist ideologies, the communist state adopted a series of management strategies. A new generation of ideologically correct factory scientists were cultivated, and a new group of technological party cadres rose to prominence. Scientific and technological expertise was nationalized through the new system, which paved the way for the practice of socialist mass science and the Cultural Revolution. Soon after HuaPharm demonstrated its success, it further brought antibiotic technologies to other regions in China and abroad, including Mongolia, North Korea, Vietnam, Romania, and Mali.

The state-sponsored construction of pharmaceutical factories also contributed to the nationalization of the pharmaceutical marketplace. By the time the Ministry of Health launched the barefoot doctor program for rural regions under Chairman Mao's calling, the new system of science and technology had ensured abundant supply of antibiotics as a material benefit of the socialist state. Barefoot doctors' reputation and authority relied heavily on their power to access and distribute antibiotics, which served as the material agent of biomedicine and therapeutic revolution. Such therapeutic modernity further spread in the Third World through the impact of the barefoot doctor model, medical aids, as well as the transfer of pharmaceutical technology.

To understand the material foundation of the barefoot doctor program, and of barefoot doctors as a particular kind of medical professionals in history.

To ground the history of medicine in its dynamic interrelationship with technology, industrialization, and political conditions in developing countries.

To identify the key characters of pharmaceutical industry and medicine in a socialist society.

3. Erin Paterson, University de Strasbourg

A Persistent Lobby: Interest Groups and Their Impact on Antibiotics on the WHO's Essential Medicines List (1977-2010)

The World Health Organization's bi-annual publication of the Selection of Essential Drugs (later renamed List of Essential Medicines and hereafter shortened to EML) was first released in 1977. This publication helped shape the global context of which drugs should be accessed first and

considered necessary to have in hospital formularies. As early as 1979 these changes were evident as the EML became a list that ostensibly was meant primarily for use in low to middle income countries alone. Starting with pharmaceutical industries, the main lobbying efforts were seen as a way to control the EML's access, but by the late 1980s private and public interest groups began to lobby the WHO to broaden the EML's impact and scale. This paper analyzes the additions, deletions, and alterations of antibiotics presented on the EML since its inception and the outside pressures and influences that led to each change.

There have been many historical analyses of the EML, however this paper focuses exclusively on the antibacterial section of the list, and how the WHO's reaction and response to antimicrobial resistance (AMR) can be tracked and monitored through the EML's changes over time. Revisions to the EML reflect cultural, socio-political, and global financial challenges (such as the TRIPS Agreement). In essence, the EML provides a linear narrative of global concerns, industry pressure, interest group lobbying, and regulations of antibiotics and AMR, while also identifying key issues in the drying of the antibiotic pipeline. The circumstances exhibited on the EML illuminate the discrepancies within the institutional enforcement of global antibiotic management and production, while simultaneously highlighting community pressure the WHO has received with each successive publication. This paper draws on the text of the EMLs, WHO publications (such as the Essential Drug Monitor), interviews with individuals of those directly responsible for the production and dissemination of the EML, reports from interest groups who lobbied EML development, and national reports on the implementation and use of the EML as a policy measure.

Key Words: World Health Organization, Public Health, International Policy

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

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

F4 Medicine & Markets

1. Sabrina Datto, Hamilton College

Mediating Medical Authority: Commercial Affects of South Asian Medical Periodicals c. 1880-1930

This paper brings together work in affect theory and political economy to trace the multiple forms of medical authority expressed within South Asian medical periodicals. In the last decade, historians of medicine in colonial India have used vernacular language archives to historicize the formation of Indian medical discourses – to document how the institutions, practices, and concepts of ayurveda, yunani, and siddha were refigured in the political context of colonial society. This research has clarified the limits of a “systems” approach and demonstrated that

these discursive traditions were historically contingent and internally differentiated by class, urban-rural divides, and competing claims to traditional authority. Much of this work illuminated how mass publishing enabled new political commitments and new readerships for medical writing. Work on Urdu language material has helpfully distinguished the early-modern habitus of the gentry-physician from the new kind of practitioner that emerged in the late nineteenth century. However, the contrast between professional personae circulated in print and their aristocratic antecedents elides the complexity of the Urdu medical publishing landscape, which was highly variegated both synchronically and diachronically. This paper foregrounds the institutional diversity of Urdu medical publishers and explores how these institutions mediated the medical authority of physician-editors in periodicals published between 1880 and 1930. I argue that the self-definition of late-colonial Avicennian physicians in India was conditioned less by an oppositional stance to western medicine than by the social forms through which these men disseminated medical knowledge: the family firm; the state dispensary; the vernacular commercial press. Moreover, the published personae of these physician-editors reveal a topography of commercial affects that range from the shame prompted by quotidian racism to the gentry values of honor and service that persist despite the pecuniary constraints of commercial publishing. Ultimately, this study of the breadth of Urdu medical periodical publishing explains how the internal differentiation of indigenous medical cultures is connected to global processes and demonstrates the significant limits of thinking through medicine in South Asia through cultural binaries, of east and west, or Hindu and Muslim.

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
Identify successes and failures in the history of medical professionalism

2. Julia Cummiskey, University of Tennessee at Chattanooga
Social Marketing for Health: Selling Healthy Choices in Late 20th-Century and Early 21st-Century East Africa

As historians have documented, in the late 20th and early 21st century, new entities such as the World Bank began to take a larger role in global health. This paper explores the concomitant change in the arena of health communication, with increasing reliance on public-private partnerships for the purposes of “demand creation”. In the 1980s and 1990s, a new field of “social marketing for health” grew in influence and significance in global health. Combining strategies from traditional commercial marketing with techniques from health education this field encompasses print media, audio and video content, and experiential campaigns designed to shape the choices people make about health products, behaviors, and services. In this talk, I will explore the rise of social marketing for health campaigns in East Africa in the context of the HIV/AIDS epidemic. Using data collected from oral history interviews in Uganda; the digital

Clearinghouse on Male Circumcision for HIV Prevention; resources published by FHi360; and other social media campaigns, I will argue that social marketing for health has further relocated responsibility for global health from medical experts into the hands of people and institutions associated with finance and economic priorities. As health becomes increasingly commodified and people targeted by social marketing for health campaigns are approached as consumers, the line between reliable health information and misleading health misinformation has become blurry in new ways. Moreover, the materials produced by these campaigns reflect and reproduce longstanding ideas about race, gender, sexuality, class, and modernity. These campaigns frame health behaviors as choices made by individuals and disregard the structural factors that shape risk for HIV risk as well as risk of other infectious and chronic diseases in modern East Africa.

Develop the capacity for critical thinking about the nature, ends and limits of public health
Recognize the dynamic interrelationship between medicine, public health, and society through history

3. Lauren Ruhrold, University of Minnesota

Human Repair Shops: Business Practices, Professional Ethics, and Medical Devices at Midcentury

In 1947, the Surgical Instrument Shop at Duke University opened for business. Located in the basement of the Medical Sciences Research Building, the shop was created to be a living laboratory by Dr. Julian Deryl Hart, chairman of the Department of Surgery. Commercially available devices, instruments, and tools had failed to meet the faculty's rapidly evolving clinical and research needs. Through the shop, physicians and surgeons could present half-baked ideas and rough sketches to a small team of skilled craftsmen, who would "turn all sorts of metals and plastics into instruments and machines to facilitate doctors' work." Hart hired mechanic George Newton as foreman. He filled the shop with \$15,000 worth of second-hand machine tools brought to Durham from New York. "You just tried to give them the best quality instrument you could," Newton later reflected. By 1955, the shop proved itself a major success. It facilitated the creation of more than 10,000 specialty devices, ranging from rotating tables to endobronchial balloons. The shop had also turned university employees into patent holders, royalty earners, investors, and entrepreneurs.

Drawing on institutional records and oral history interviews, this paper uses the Surgical Instrument Shop at Duke University as a window into the business for medical devices at midcentury. It explores how new institutional arrangements and shifting professional ethics placed physicians at the center of an unstable and decentralized industry. That reconfiguration ultimately altered the device industry's organizational boundaries, commercial priorities, and power dynamics. This paper places this case study in context by locating similar developments at other American universities. It also contributes to existing efforts to increase crosstalk between the history of medicine and business history, bringing university instrument shops into existing discussions about the process by which medicine transformed into big business during the twentieth century.

1. Recognize the dynamic interrelationship between medicine and society through history
2. Identify successes and failures in the history of medical professionalism
3. Acquire a historically nuanced understanding of the organization of the U.S. healthcare system, and of other national health care systems

G1 Sex, Medicine, & Racial Normality

1. Beans Velocci, University of Pennsylvania

Sex Without Bodies: Making Womanhood Out of White Sexual Aberrance

In the early decades of the 20th century, gynecologist and sexologist Robert Latou Dickinson held two truths simultaneously: sex was a spectrum upon which bodies routinely fell out of binary categories and into an intermediate zone, and all of his white women patients were definitely women no matter what kinds of bodies they had. This paper examines the racial logics that undergirded Dickinson's recapturing of non-normative bodies back into the normative category of womanhood. A staunch eugenicist, Dickinson saw both his writings on sex and gynecological practice as part of a mission to improve "the race" (i.e., whiteness) through sexual health. This paper shows how Dickinson, along with his research associate and co-author Lura Beam, supported an image of the perfect sexual dimorphism of whiteness by recapturing into pure femaleness white women patients who underwent hysterectomies and ovariectomies and mastectomies, who never menstruated, who were sterile, and who were born without a uterus or a vagina. Even those women who, in Dickinson's theory, exhibited enlargement or shrinkage of the labia and clitoris as a result of queer sexual behavior, could be welcomed back into normative womanhood. This paper, then, tells the story of how the pathological was not kicked out of the normal, but instead brought back into it, and how rather than constricting, the definition of what constituted bodily womanhood expanded in the service of eugenic goals.

develop understanding about the social construction of sex, develop understanding of the relationship between sex and race, recognize the productive presence of ambiguity in medical thinking

2. Nic John Ramos, Drexel University

Psychoanalysis's Afterlives: Racial Normality, Normal Homosexuality, and the Problem of Modern Sexualities

This paper examines the psychoanalytic methods and research findings of homophile psychologist Evelyn Hooker and Black nationalist psychiatrist J. Alfred Cannon as two exemplary responses to the racist, homophobic, and transphobic underpinnings of psychoanalytic thinking. Looking to psychoanalysis's rise as a response to colonialism's and psychiatry's overreliance on behavioral therapy in the late nineteenth and twentieth centuries, the paper argues white homophile and Black nationalist mental health professionals in the 1960s and 1970s each respectively proposed certain white gender-conforming gay and lesbian subjects, certain white trans subjects, and certain Black heterosexual subjects as equally normal and "modern" as the

white heterosexual subjects that psychoanalysis first posited as exclusively endowed with psychic “interiority” a century prior. Instead of attain a universal humanism through psychiatry as imagined, the paper reveals these proposals about the supposedly modern sexualities of gay and Black subjects ultimately made queer and trans subjects of color more deeply vulnerable to psychiatric racism, homophobia, and transphobia. This paper then, highlights how increasingly popular ascriptions of modern sexuality are deeply indebted to the colonial underpinnings of scientific racism and how attempts to achieve psychiatric universalism continue to elide a wide range of sexual activity and psychic interiority.

Develop an understanding of the social construction of modern sexualities; develop a deeper understanding of scientific racism and its continuing legacy, recognize the shortcomings of psychiatric thinking in regards to the intersections of race, gender, sex, and sexuality

3. Emmett Harsin Drager, University of Missouri

Racing for an Etiology: Transsexuality, Gender Clinics, and the Pathologization of the Racialized Family

This paper examines the university-based gender clinics of the 1960s and 1970s and their aim to pinpoint an etiology of transsexuality in order to treat and prevent so-called gender deviance. First, using gender clinic demographic data and case histories, this paper argues that in the early days of the university-based gender clinics, clinicians and researchers often recruited patients from state psychiatric hospitals and/or the criminal justice system. These patients, many of whom were patients of color, were foundational to studies into the cause of transsexuality. Next, focusing on UCLA psychiatry professor and gender clinic researcher Robert J. Stoller and his theory of “too much mother,” this paper argues that transsexuality was understood as a multi-generational process and problem, requiring that treatment extend beyond the individual and into the family structure and culture more broadly. Stoller’s theory of “too much mother” attributed the cause of transsexuality to the mother, or more specifically, many generations of bad mothering. Examining Stoller’s etiological theory alongside Daniel Patrick Moynihan’s “The Negro Family: The Case for National Action,” the paper highlights the shared genealogy of trans medicine and U.S. racial science through the rise of family therapy in the mid-twentieth century and the pathologization of the racialized family.

Develop understanding of early trans medicine, develop understanding of the relationship between theories of transsexual etiology and theories of racial pathology, recognize the racial legacies of trans medicine

G2 Health & the Corporation

1. Dana Landress, University of Wisconsin-Madison

The Cost of Niacin: Corporate Nutrition and the Politics of Hunger in Birmingham

In 1936, Harvard-trained nutritionist Dr. Thomas “Tom” Spies arrived to Birmingham, Alabama to investigate pellagra, a nutritional deficiency disease, among patients at Hillman Hospital. For the next two decades, Spies would operate a nutrition clinic at the academic teaching hospital, but outside of the formal confines of the university system. The Spies Clinic financed itself solely through contributions from major industrial donors across Alabama and the nation. Spies contended that malnutrition posed a major threat to the industrial prosperity of the South and he assured prospective corporate donors that his clinic could provide a cheap and effective cure for pellagra patients that would restore them to productive members of the southern labor force. Within a few years, the racially segregated clinic had cured thousands of Black and white pellagra patients across Birmingham. By 1940, the Spies Clinic oversaw a one-million-dollar operating budget and many of the patients received referrals from company physicians at steel mills that had financed the clinic. Spies believed that even without any external symptoms, patients could experience “chemical starvation” and that such a phenomenon was the source of a widespread “hidden hunger” among impoverished, working-class people. The Spies Clinic continued a long tradition of private capital funding public health work in the U.S. South. By providing patients with synthetic Vitamin B3 (niacin), Spies contended that changing the diets of steel workers in Birmingham was not necessary to cure them of pellagra. Despite corporate interest in identifying a nutritional magic bullet to save workers from pellagra, this paper will reveal how the politics of “nutritional enrichment” still left most southern workers poor and malnourished.

- 1) Develop the capacity for critical thinking about the nature, ends, and limits of private capital in financing public health work
- 2) Critically engage in conversations about the structural determinants of illness and the capacity and limitations of clinical practice to address diseases of poverty
- 3) Critically appraise clinical management from a historical perspective

2. David Courtwright, University of North Florida

"The Pain Mafia": Key Opinion Leaders and the Origins of the Prescription Opioid Crisis

The opioid crisis is usually dated to the 1996 introduction of OxyContin. The misleading promotion of it and competing opioid analgesics, together with distributors' and pharmacies' failures to prevent diversion, triggered a national prescription-opioid addiction and overdose epidemic that, over two decades, morphed into a national heroin and fentanyl catastrophe. This story is true but incomplete. The opioid crisis dates to 1980, when Dr. Kathleen Foley of Memorial Sloan Kettering challenged the established belief that long-term opioid therapy was inadvisable for chronic nonmalignant pain (CNP). Though poorly supported by evidence, her revisionist view was ideal for opioid manufacturers seeking to crack the large CNP market. The publications of Dr. Foley and other early revisionists revived the medical debate over opioids in CNP. Both sides fielded advocates from respected institutions. Opioid manufacturers ignored or disdained the conservatives, whose advice discouraged wider use of narcotics. They lavished attention and money on their opponents, whose views encouraged wider use of narcotics at higher doses. The weed sprouts got the water and fertilizer, not the established plants.

Revisionism flowered in the late 1980s, 1990s, and early 2000s as Purdue and other manufacturers identified, cultivated, subsidized, and deployed reform-minded KOLs to reshape professional opinion and loosen opioid regulations. Their efforts were augmented by thousands of lesser-known advocates, medical and pharmaceutical professionals trained in retreat meetings at resort locations. KOLs nonetheless remained indispensable. The most important reason doctors changed prescribing behavior was peer influence, which ran from KOLs to specialists, and from specialists to primary care doctors. Atop this pyramid of influence sat a small number of KOLs paid by multiple manufacturers. Insiders dubbed them "the Pain Mafia." The Pain Mafia performed many roles. It was critical to the success of new product launches. It helped shape drug development, product positioning, brand development, life-cycle management, and prescribing practices, all of which translated into profits. From their perches in academic medicine, KOLs influenced opinion in multiple ways, from their own publications and lectures to gatekeeping functions like journal editorships and service on pharmaceutical and therapeutics committees. Some KOLs offered confidential strategic advice to manufacturers and served as paid expert witnesses on behalf of pill-mill doctors on trial for killing their patients.

For all of this, few KOLs acted from purely mercenary motives. The views of the early revisionists, however weakly supported, were earnest. One of their number, Dr. Steven Passik, has described the early movement as based less on evidence and more on zealous determination to alleviate patients' suffering. "It had all the makings of a religious movement at the time," he said in 2012. "It had that kind of spirit to it."

Hope proved a poor substitute for evidence in that it led revisionists into a familiar cognitive trap. When a health initiative succeeds, the passage of time makes it easy to forget the significance of what has not happened. What had not happened when revisionism was first gaining adherents was the recrudescence of widespread medical opioid addiction. The benefits of the older tradition--narcotic conservatism--were invisible. The burdens were all too visible, particularly for health care providers who daily confronted chronic pain and who imagined a better future for their patients if taboos were cast aside and the power of opioids unleashed.

By the end of this activity, the learner will:

Understand the background, academic origins, and chronology of the U.S. opioid crisis.

Better understand the multiple roles that KOLs played, and continue to play, in pharmaceutical promotions and marketing.

Understand why KOL cooptation, and involvement in, the controversy over long-term opioid analgesia for chronic noncancer pain had serious public health consequences.

G3 Research & Experimentation

1. Emma Wathen, University of Wisconsin-Madison

"Fresh Specimens": Obstetrical Experimentation in the United States, 1910–1940

“Up to comparatively recent times little advancement has been made in obstetrics,” Detroit physician Walter E. Welz remarked in 1913 as he ushered in an era of “more perfect control.” Between 1910 and 1940, with the transition from home birth to hospital birth, physicians’ increasing level of control over women’s childbirth experiences expanded their opportunities for obstetrical research and provided, in the words of Chicago obstetrician J. P. Greenhill, “fresh specimens.” A survey of articles published in the American Journal of Obstetrics and Gynecology (AJOG) during this period reveals a robust collection of experiments on pregnant and newborn subjects—studies where researchers performed cistern and lumbar punctures; injected subjects with hormones and serums; recorded fetal heart rates and bleeding and coagulation times; tested pharmaceuticals and anesthetics; and induced labor and infectious diseases. Using the AJOG as a source base, this paper quantitatively evaluates trends in obstetrical experimentation, looking at changes in the number of obstetrical experiments over time, the affiliations of authors who conducted these experiments, and the topics that captured researchers’ interests. It investigates the ways in which pregnant subjects cooperated—or refused to cooperate—with medical researchers and emphasizes the ways in which institutional structures, as well as the race, class, gender, and age of the subjects, impacted their ability to refuse or cooperate. Finally, it analyzes the language researchers used, particularly the rhetorical strategy of minimizing the perceived risk and harm, as it considers what risks pregnant and infant subjects were (or were not) subjected to and what the consequences of those risks were. Ultimately, this paper attempts to illuminate these nameless “fresh specimens” who, knowingly or unknowingly, participated in obstetrical knowledge-making.

By the end of this activity, the learner will:

Appreciate the socio-cultural contexts of obstetrical research

Illuminate the role of experimental subjects in obstetrical knowledge-making

Identify successes and failures in the history of medical professionalism

2. Nicole Nelson, University of Wisconsin-Madison

Historicizing the “reproducibility crisis”: Evidence-based medicine and contemporary preclinical reform

Over the past decade, the US National Institutes of Health has made a series of reforms aimed at increasing the rigor and reproducibility of the research it funds. These changes happened with surprising speed—the NIH Office of the Director announced its plans for reforms in 2014, and by early 2016 these changes had been rolled out across all institutes and centers. This talk will examine the historical circumstances that laid the groundwork for these rapid policy changes, linking the history of preclinical research reform to the history of evidence-based medicine (thereby linking the history of science to the history of medicine). I show how the techniques that EBM researchers developed in the 1990s to evaluate the quality of clinical trials were adopted and adapted by translational researchers, generating a body of evidence about the quality of rodent studies that was later mobilized by reformers within the NIH. Assessments of the number of authors reporting that their studies had been masked and randomized, for example, allowed reformers to argue that preclinical research was substandard because

relatively few practitioners used the specific types of bias-reducing techniques that are common in clinical research. This moment in history is part of a broader story of how ideas of “quality” that have developed within the clinical trials ecosystem are being taken up in new institutions and research fields.

Recognize the dynamic interrelationship between medicine and biomedical research throughout history.

Understand how what counts as good knowledge or good care depends on historical and institutional contexts.

3. Alen Agaronov, New York University Grossman School of Medicine

The Mediterranean Way of Research: A Performance Historiography of the Discovery of The Mediterranean Diet in the Seven Countries Study

The scientist’s body plays a crucial role in determining what and how discoveries are made. However, the study of landmark investigations through two-dimensional archives may offer little insight into the lived experience of scientists and how they ascribe meaning to experiences. The discovery of The Mediterranean Diet in the Seven Countries Study (SCS) is an exemplar case of a scientific breakthrough inseparable from investigators’ fieldwork in the Mediterranean basin region in the late 1950’s to early 1960’s. Yet, as I demonstrate in this paper, SCS investigators distance themselves from “the Romantic Period of cardiovascular disease (CVD) epidemiology,” or how they refer to, and downplay, early fieldwork as documented in memoirs, home movies, and photographs. In this paper, I describe a video-documented performance historiography for an embodied study of the relationship between the SCS fieldwork and the meaning attributed to The Mediterranean Diet. Using secondary narrative interviews with SCS investigators, multimedia records of the SCS, and my own medical records, I describe a series of analytical performances, including an ‘immersive (green screen) archival analysis’ of SCS home movies, a 24-hour re-enactment of fieldwork rituals in the Mediterranean (documented on Super 8), a poster presentation and a webinar at Harvard University, and more. Building on scholarship by Hilgartner (1990), Daston & Galison (2007), and Möllers (2016) on stage-management, professionalism and entrepreneurship in the sciences, I discuss how this performance historiography shed light on the tension between SCS investigators’ efforts to simultaneously communicate their work to the public, find pleasure in it, and pioneer a new field in a hostile climate. I conclude that The Mediterranean Diet and the SCS are one and the same, and describe an embodied approach to the history of medicine – something analgesic, pleasurable, taxing, imaginary, rigorous, and physically accommodating – The Mediterranean Way of Research.

Keywords. Performance historiography; Research excellence; Seven Countries Study

By the end of this activity, the learner will:

- 1) Elicit and write a patient’s history worthy of an historian;
- 2) Understand the dynamic history of medical ideas and practices, their implications for patients and health care providers, and the need for lifelong learning; and

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

G4 Public Health

1. Kristin Brig-Ortiz, Johns Hopkins University

Deviancy and Disease: Water Management, Public Health, and Non-Normative Behaviors in South African Ports, 1830-1900

“What am I to do?” wrote Thomas Janson of Port Elizabeth in May 1876. “It is a great injustice that I should be constantly fined for throwing dirty water in the streets, when [I cannot] find any other place where it can be put.” Janson struggled with what many of his fellow residents also found wanting: proper water infrastructure to adhere to the municipality’s basic sanitary laws. As Port Elizabeth, Cape Town, and Durban gradually built waterworks and drainage connections, their residents contested how the municipalities legislated the “proper” ways to employ and manage that infrastructure and the water it held and policed. Building on histories of water, public health, and social normativity, I argue that the use of water and its infrastructure created a fractured relationship between municipal officials and urban residents built on a set of expectations that dictated how these cities built, used, and managed water infrastructure, especially in relation to the spread of disease. While scholars has addressed the creation of water infrastructure as part of British colonial power, few have discussed how urban residents’ daily interactions with different kinds of water shaped local views and uses of that infrastructure, destabilizing that colonial power and its sanitary pretensions. People at all levels of port society defied city regulations as they strove to maintain disease-free bodies, households, and businesses: they washed clothes at wells, drank water from unwashed tanks and holes in the ground, dumped waste waters into public streets and drains, and tampered with taps and pipes to access more water during scarce seasons. By virtue of its everydayness, this mundane deviancy blurred the lines between normative sanitary actions and pathological behaviour, influencing how South Africa’s ports responded to disease outbreaks and other imminent public health threats emerging from their wells, pipes, and drains.

Deepen understandings of illness and suffering, particularly their relationship to the environment.

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

Recognize the dynamic interrelationship between medicine, the environment, and society through history.

2. Timothy Sim, University of Cambridge

Finding the public in public health: Complaints as public engagement with mosquito control in Singapore, 1965 – 1985.

In 1986, the World Health Organization lauded Singapore as a “case study on the successful control” of dengue fever, a viral disease spread by the *Aedes aegypti* mosquito. Between 1965 and 1985, public health officials employed educational campaigns and mandatory home inspections to convince citizens to guard against mosquito breeding at home. These efforts dramatically reduced mosquito breeding and the incidence of dengue fever. Although this story appears to recapitulate standard narratives of top-down progress in Singapore, the significant role of the public in this episode of public health has been overlooked. Using state archives, newspaper articles, and parliamentary reports, this paper shows that the public exerted enormous influence on official policy by complaining directly to the Ministry and indirectly via the press or parliamentary representatives. In their frequent complaints, citizens mobilized the state’s own discourse on the dangers of mosquitoes to expand the reach of public health. The more the Ministry emphasized personal responsibility in preventing mosquito breeding at home, the more the public pointed to broader problems that required state action, such as clogged drains, unsanitary public housing, or apparently unhealthy neighbours. Because the Ministry actively responded to these complaints, the scope of what counted as a public health issue widened. This paper thus draws attention to the dual meaning of the term “public” in public health. While historians such as Miriam Gross, Alex Mold, and Marcos Cueto have pointed to the variegated reception of health interventions amongst different “publics”, it is still often assumed that the state drives public health. This paper goes further by demonstrating that the public can actively request for, extract, and modify health governance from the state. Instead of an autonomous state transforming the health of an independent public, we see a coevolution of the state and the public in performing public health.

The paper shows that public health interventions should not be imagined as the simple imposition of state power or professional expertise onto a docile or resistant public, but should involve feedback and reciprocity. Anti-mosquito efforts in Singapore succeeded not despite public complaints, but because complaints were taken seriously by state actors and led to recognizable changes in official measures. This responsiveness was crucial to maintaining public support for public health.

This corresponds to the following suggested objectives:

1. Recognize the dynamic interrelationship between medicine and society through history
2. Acquire a historically nuanced understanding of other (non-US) health care systems

3. Nancy Tomes, Stony Brook University

Panic as a public health problem: critical reflections on risk communication in the 1970s-1980s U.S.

Due to COVID-19, sharing too much information and/or presenting it the “wrong” way have gained new attention as critical public health problems. But as historians well know, those concerns are hardly new. This paper explores one particularly important time period and place of their articulation: the 1970s and 1980s U.S. During those years, the ways that public health experts and government officials interacted with “the media” (including TV, radio, and print journalism) during public health crises became a focus of debate. Struggling with problematic

legacies from the second Red Scare and “nuclear fear,” experts sought to develop ways to share essential information without producing states they variously referred to as fear, panic, and hysteria. At the same time, the public health-media nexus was being transformed: on the science side, by big data, computer modeling of epidemics, along with psychological and neuroscientific conceptions of “rational” decision making; on the social side, by the growing pressures for scientific transparency and accountability and media interest in providing more “man on the street” perspectives. This paper explores the framing of those concepts: who got to decide what was healthy versus unhealthy fear and how were those mindsets associated with “good” versus “bad” information? It is drawn from a bigger project looking at how 20th c. pandemics, real and threatened, have generated efforts to deploy information as an antidote to panic, making information “management” an increasingly essential—but problematic—aspect of public health responses to disease crises. The paper builds on histories of public health (Colgrove and Fairchild, Honigsbaum, Humphreys), media and journalism (Ostherr, Tufekci), and risk assessment (King, Lakoff) and uses primary sources from the early field of risk communication; a particularly important source is the 20th c. Fund’s 1984 study *Science in the Streets*.

By the end of this activity, the learner will:

Have a better understanding of the challenges involved in risk communication during public health crises

Have a deeper appreciation of the long term media dynamics that influence the work of risk communication

Be more aware of the complexities involved in public health efforts to distinguish between "healthy" and "unhealthy" fear.