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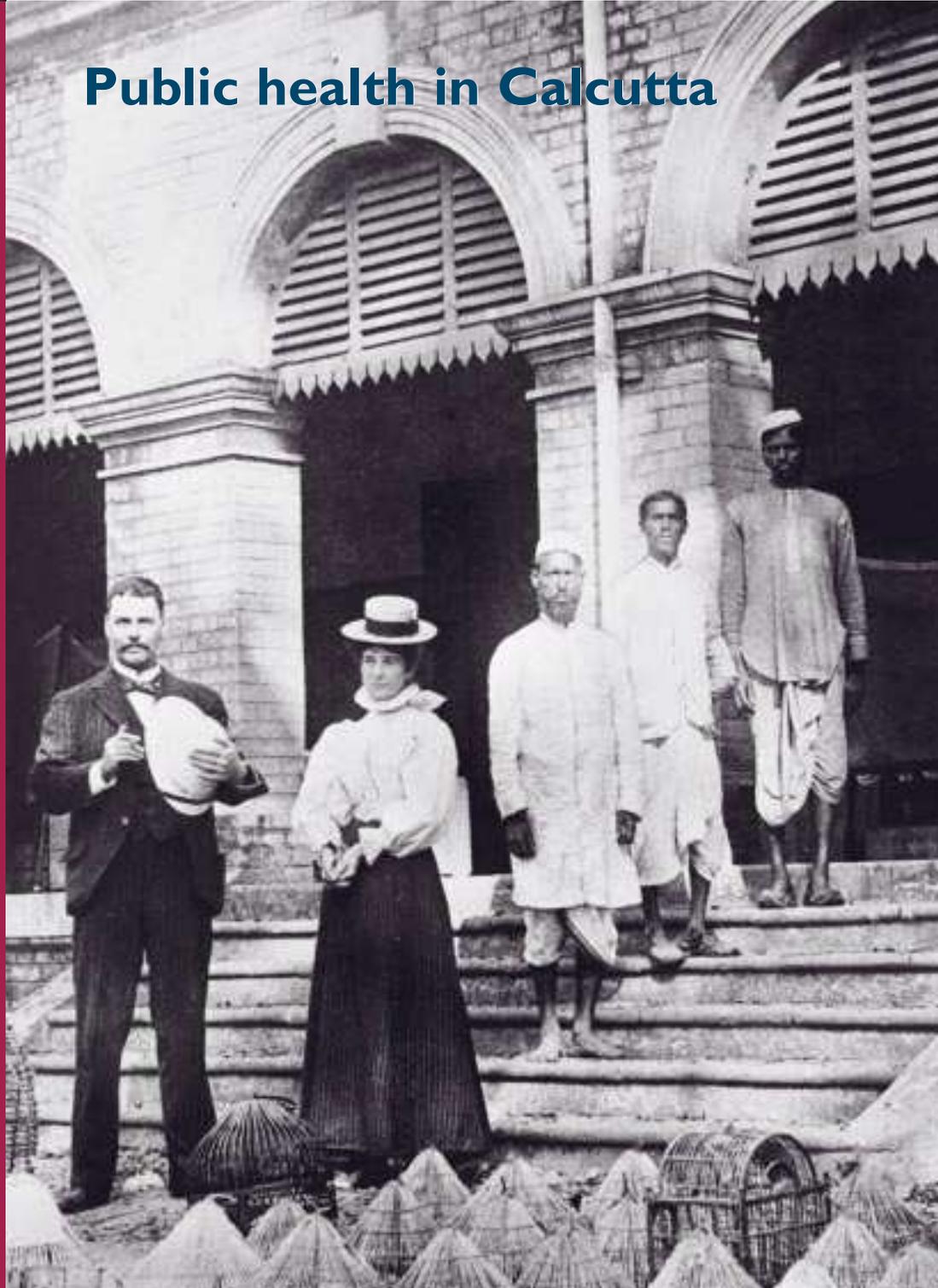
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Wellcome History

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Public health in Calcutta



Town planning and public health in Calcutta in the 18th and 19th centuries

Modern town planning in Calcutta has a long history. Calcutta, a cluster of villages, owes its existence as a trading settlement to the English East India Company. In the 18th century the Company built a fort on the Hooghly river for commercial and strategic reasons. But this proved vulnerable. The local king, Siraj-ud-daula of Bengal, disapproved of the fortifications and in 1756 he attacked Calcutta. Changing political alignments however proved beneficial to the English traders in the subsequent months. With the help of Indian notables the Company decisively defeated Siraj in the Battle of Plassey [1757] and effectively laid siege to his territory. Subsequently, a better fort was built south of the original site and an open space was demarcated around it to facilitate a clear line of fire. At the edge of this empty ground the merchants and officials built their houses, confident that the fort would suffice for their defence. Thus the nucleus of English settlement in Calcutta slowly took shape.

To the north of this township grew the Indian habitation peopled by middlemen, scribes and traders whose collaboration was essential to the perpetuation of alien rule in Bengal. Within a few decades the port town of Calcutta eclipsed the older capital of Bengal, Murshidabad, and became the hub of commerce and administration. As a port and centre of government it also attracted a large inflow of population from the surrounding countryside and provinces. Largely consisting of the poor, these people trekked long distances to Calcutta in search of work as unskilled labour and for better pay and living conditions. Their material circumstances did not drastically improve but there was plenty of work to be found. In many ways they changed the way the new colonial town was developing and in turn they were shaped by the economic and administrative policies of the English East India Company.

Town planning in Calcutta had intimate connections with the threat of disease and epidemics. Indeed the passage of the Company merchants to India in the early years was marked by the inevitability of death. The common illnesses reported were dysentery and various fevers, treated summarily by Company physicians with doses of brandy, mercury or bleeding. The hot, humid weather of India was a constant threat. The ferocious monsoons and flooding were also feared. Eighteenth-century English sources mention the melancholy meeting of Company merchants at the end of the rainy season to count the survivors among themselves. One famous account talks quaintly about the Company hospital in Calcutta where “many undergo the penance of physic, but few come out to give an account of its operation”. The unfamiliar, abundant and exotic foliage was also viewed with suspicion as the generator of unknown illnesses. Another constant preoccupation was the threat of noxious vapours or miasma. The low-lying swamps to the east of the settlement – the salt-water lakes – the repository of rotting vegetable and animal matter during the summer months were seen as the source of dangerous and fatal emanations. The settlement thus grew away from the east hugging the higher ground in the west towards the river. The lack of proper roads meant that the river became the most efficient means of transport. But it also served as a source for drinking water as well as the great drain for the newly formed settlement.

Front cover image: Laboratory at Calcutta. Surgeon-Major Ross, Mrs Ross, Mahoned Bux and laboratory assistants, 1898.



The pattern of buildings reflected some of these concerns. Houses were built on platforms or only the upper floors were used as a place of residence to escape the vapours arising from the ground. A great deal of attention was given to empty space around the house to facilitate the circulation of air. Vegetation was ruthlessly exterminated and low-lying tanks filled up. A functional demarcation between place of work and residence slowly became the norm. This was, however, not true of the habitations to the north where the closely built mixture of permanent buildings and temporary huts reflected the traditional ecology of Indian urban settlements and the presence of a bazaar economy.

The architectural historian Norma Evenson pointed out that the growth of colonial towns in 18th-century India coincided with the golden age of British urban design. Town planning needed a long-term investment in the future that the merchants in Calcutta, mere birds of passage from England, were unwilling to make. Yet this situation changed in the 19th century. The acquisition of territory and authority gradually placed new imperatives before the rulers. From arbitrary and short-term strategies, a full-fledged plan of governance was now worked out. Town planning became part of a larger scheme to press down the grid of modern administration on a colonial society.

The earliest and most articulate expression of this view was exemplified in the career of Lord Wellesley, the Governor-General of India [1798–1805]. His advent marked a decisive change of attitude in Company administration. The top posts in the Company had been gradually shifting to aristocrats from the mere merchant adventurers. This had an important impact in the way the Company functioned in India. Wellesley began by ordering that a proper residence commensurate to the status of the Governor-General be built. Government House, the enormous Palladian pile in the middle of Calcutta, came to signify the growing power of the Company and subsequently became the official seat of the Viceroys of India. The English now saw themselves as permanent residents and as modern empire builders, not unlike Napoleon in Europe. The Company

in London was however not happy with Wellesley's extravagance, but his new notions of governance were also dictated by practical considerations.

Calcutta had become the capital of the British, the most important *entrepôt* in Eastern India, but its rapid growth without adequate planning had played havoc with civic services. Most of the roads were unpaved and also unsafe. Stinking drains had no proper outlets. The river was a crowded confusion of commercial and civic establishments. Even as Wellesley sat down to write his famous *Minute on Calcutta* [1803], half the town was submerged due to rains. Realizing that the development of Calcutta was crucial to the commercial fortunes of the Company, he made an attempt to order the haphazard and *ad hoc* development of the town and give its growth a certain direction and shape. Wellesley declared in his *Minute* that:

The appearance and beauty of the town are inseparably connected with the health, safety and convenience of the inhabitants, and every improvement which shall introduce a great degree of order, symmetry and magnificence in the streets, roads, ghats, and wharfs, public edifices and private habitations, will tend to meliorate the climate, and to secure and promote every object of a just and salutary system of police.

The significance of this confident statement lies in its early articulation of urban reform, particularly if we remember that the Company was still fighting imperialist wars and its hold over large parts of India was still tenuous. It demonstrated how seriously the Company was committed to stake its future in India. The ideological thrust of the *Minute* certainly laid an important precedent for municipal policy in the future. That this was not intended as mere cosmetic change is evident from Wellesley's design for the large-scale restructuring of the town as a whole. He set up numerous committees and his vision was to be effected not just through grand public buildings but by road construction. The inauguration of rectilinear planning in Calcutta signalled the beginning of the modern city plan in India. The underlying assumptions though were still neo-Hippocratic, for road building with its thrust at clearing obstructive vegetation and crowded human settlements for easy circulation of air was seen as a panacea for healthy living. The historian Dipesh Chakrabarty has hinted that historically this phase brought about the marriage of cleanliness with notions of beauty, a norm that underlines all modern attempts at civic reform throughout the 19th century. Roads also implied better communications, increased policing and importantly new ways of access to the population.

Although Wellesley was to leave India in 1805, in later years the vehicle for his ideas was the Lottery Committee [1817–1837] that actually put into practice some of his proposals for change. The Lottery Committee – so called, since the profit from public lotteries helped finance its activities – has left its permanent mark on Calcutta in the shape it gave to the city's urban profile. The work of the Committee acquired a particular urgency as epidemic cholera had started spreading from lower Bengal in 1817. Simultaneously the cartographer J A Schalch was commissioned, and his great map, which came out in 1825, made a careful survey of buildings and the topography of the town. He conclusively proved that Calcutta sloped west to east, i.e. from the river to the salt-water lakes, thereby laying the scientific foundations for a practical drainage system for the town. The Committee began its work by embanking the river, and systematically clearing it of encroachments. The Strand Road was the result of this effort. Besides, the Committee pioneered slum clearance by formulating a plan for driving a grid of straight roads through densely built-up hutments in the central and northern areas, i.e. the Indian areas of the town. Casual labourers were hard hit by these moves and forced to re-settle away from the centre

of the town to the periphery further east, next to the marshy and unhealthy salt-water lakes, to their own peril.

But perhaps the most enduring achievement of the Committee was to create a broad south to north axis [Wellington–College–Cornwallis streets], parallel to the narrow, over-used and crowded pilgrim route Chitpur Road in north Calcutta. The new thoroughfare also fulfilled a long-felt strategic need of connecting the cantonment Dum Dum in the north with the town proper. The new axis also demonstrated the resolve of the authorities to rid the town of its unhealthy atmosphere since it was aligned along the flow of the natural air current [south to north]. Broken by squares, the new street became a modular example for change that was a contrast and challenge to the pattern of organic development found in Indian Calcutta. The Committee thus set the agenda for future town planning in two important ways. The embanking of the river showed that commercial imperatives were always at a premium. Tackling the prevalence of disease through slum clearance in primarily Indian Calcutta followed closely and set another important precedent for the future.

The investigations of the Committee had created a great bank of knowledge that was tapped by doctors like J Randal Martin of the Bengal Medical Service. Neo-Hippocratic theories and climatological imperatives intermeshed with the threat of epidemics to produce the rhetoric of his *Medical Topography of Calcutta* [1837]. As one of the first 'histories' of the city in English, its scope was wide-ranging and included not only medical precepts but also commentary on local customs and native architecture. Martin's world-view, as Mark Harrison has pointed out, was influenced by ideas like utilitarianism, then popular in England. This effectively meant asserting power; marking out cultural differences between the rulers



and ruled, where the latter were seen as inferior; a change from the recent past that had at least made some attempts to come to terms with traditional Indian knowledges and customs. But essential to this way of thinking was also the ideology of 'improvement'. Ranajit Guha has recently argued that improvement was a political strategy that made imperial rule acceptable, even desirable to the Indian elite. Martin's plea for improvement took the novel form of public health. Indeed the notion of the 'public' was crucially important in the way the state justified its intervention in this sphere, as also in the arena of private domestic arrangements. Martin's proposals thus set new and important norms for urban space.

The most substantial evidence of this way of thinking can be found in the multi-volume reports of the Fever Hospital Committee [1835–1842] which in many ways marked not only the gradual acceptance of modern axioms about sanitation but also with the establishment of Medical College Hospital the institutionalization of Western medicine in India. This was most dramatically borne out by the conversion of educated upper-class Indians to this form of Western modernity. Martin's book, despite his condescending views on Bengali society, had been enthusiastically received by reformist Bengalis. Rustomjee Cowasjee and Dwarkanath Tagore, influential merchants in Calcutta, were appreciative of such sanitary efforts. Additional support came from Modusoodun Gupto, one of Calcutta's eminent medical practitioners who had trained in both traditional Indian and modern Western medicine. He declared categorically before the Fever Committee a preference for the Lottery Committee-built Cornwallis Street in the north because he found it more healthy than Indian areas like Colootola and Barrabazar. Institutions that were to play an important part in the cultural life of Bengalis like Presidency College, Sanskrit College, Medical College and the social reformist Brahma Samaj were established along this axis. By the last few decades of the 19th century, this area had turned into a quintessentially Bengali enclave of residence. In a sense it could be taken as the first successful example of modern town planning. The investigations of the Fever Hospital Committee set the trend for enumeration, a necessary adjunct to efficient governance and control.

A proliferation of vital statistics, censuses and municipal returns was the direct outcome of policies from this era. In 1837 thatched huts were banned due to the threat of fire. Sanitary policy however took a new turn with increasing focus on cantonments after the Indian Mutiny [1857] as the loss of soldiers through disease far outstripped deaths in battle. Cantonments being in close proximity to towns had an inevitable impact on the way the latter came to be reconfigured in the minds of colonial administrators. In Calcutta the combined effort of these changes together with the overweening presence of Western medical institutions meant that urban space came to be medicalized. The white ruling classes effectively removed themselves from daily contact with the Indians by evolving a social life around exclusive residential areas, clubs and race-courses. A great wave of secular change after the 1850s confirmed Calcutta's premier position as imperial outpost, the 'London of the East'. The engine of growth however still remained commerce. The confidence of the colonial state in this era of high imperialism can be seen in the way the centre of town, the Dalhousie Square area, was given a face-lift as was the famous Writer's Building, the hub of colonial administration, which got its gothic façade in this era. But Calcutta's image was affected by international censure about poor sanitary conditions and the spread of epidemics from Bengal, especially cholera. The threat of quarantine galvanized the colonial government to take active measures. Increasing

costs had forced the Government to raise local taxes, delegating in return more municipal responsibility to Indians. The latter proved unpopular on racial grounds with the European community, some of whom demanded instead more control of the town, stringent action and increased government spending to meet the threat of epidemics.

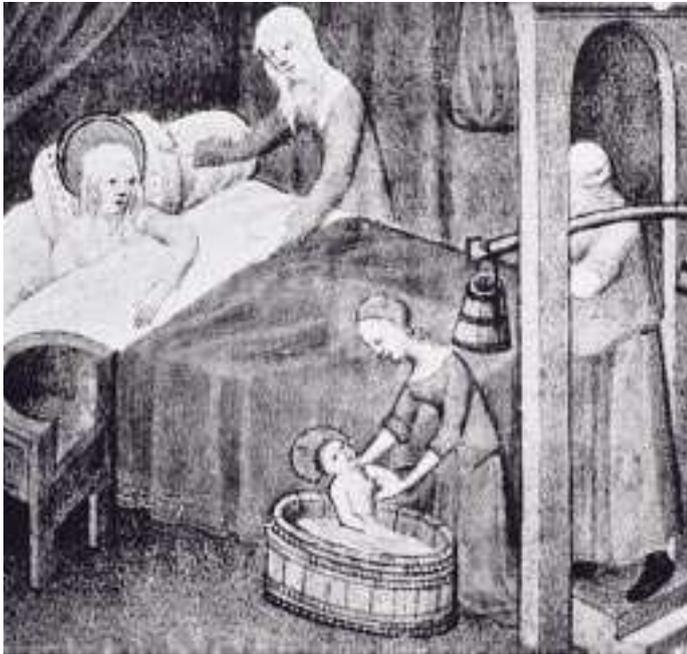
However, government intervention, when not occasioned by alarmist outcries, was usually tentative, confused and piecemeal. Between the threat of cholera in the 1830s and plague in the last decades of the 19th century, Calcutta saw many attempts at sanitary and urban reform. Its varied success was dictated by numerous factors which included the state of medical knowledge, personal idiosyncrasies of the presiding Health Officer [a post created only in the 1860s], lack of government funding and reluctance of Indian landlords, who owned most of the residential land, to make any improvements.

It was far easier instead to tackle insanitary settlements of the urban poor that dotted the city. Punitive sanitary measures thus came to be directed determinedly at *bustis* [temporary hutments], pilgrimage sites like Kalighat within the city which attracted a large floating population, and areas of commercial work like the docks. The outright demolition of unhygienic settlements lent a procrustean character to the Government's *busti* policy in Calcutta. But the character of *bustis* had been changing through the century. Thatched huts had been gradually replaced by tiled ones and these in turn by hastily built brick structures. In the eyes of the high-strung colonial administrators facing the threat of epidemics, this had the effect of confusing temporary shelter with more established upper-class housing. With time, racial attitudes and orientalism coalesced into condemning all of Indian Calcutta as a 'slum'.

Various schemes had been proposed from the 1830s onwards, some of them visionary, that fantasized the demolition of large parts of north Calcutta. The plague prompted one government report in 1898 to recommend razing to the ground the most important business district Barrabazar [in central Calcutta] on sanitary grounds and building the railway station in its place! What gave these proposals teeth was the impact of Chadwickian ideas, especially the practical possibilities of engineering remedies. Calcutta's water supply system and drainage were completed by the 1870s but even here the benefits of modernization were not immediately noticeable. Since the city's water supply had been put in place first without adequate provisions for drainage, waterlogging led to malaria and other diseases. In 1885 the outlying suburbs to the south that had a majority of European residents were formally amalgamated with the city proper. The northern suburbs were left out, provoking angry dissent from Indians. The battle lines were now drawn and the conflict became sharper as incipient nationalist feelings were aroused with the Viceroyalty of Lord Curzon [1899–1905]. Curzon was intransigent, imperious and fancied himself as a latter-day Wellesley. Predictably his lofty ideas had little place for Indian participation. It was during his tenure that the seeds were sown for 'Hausmannizing' the city especially north Calcutta through the application of a full-fledged plan. The Calcutta Improvement Trust, a major landmark in town planning, came into being only in 1911, a culmination of sanitary imperatives that had shown remarkable continuities throughout the 19th century.

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The Hebrew production on women's healthcare in the Mediterranean West at the end of the Middle Ages



Above: Miniature (c. 15th century) showing the bedside care of a woman who has just given birth.

This research was initiated by my personal and academic interest in two different aspects of Western culture: the textual production in Hebrew during the Middle Ages, and the historical experience of women. I have based my study of Jewish women's practices and knowledge related to healthcare – and the beauty of their bodies – through written texts available to us in a combination of concepts, categories and methods developed by different disciplines – Hebrew philology, women's studies and history of medicine.

Traditionally, Hebrew scholars have not shown great interest in Hebrew medical texts dealing with women's health. In the last few years, however, some publications in this field have been produced. Most notable in this regard is the edition and translation of gynaecological texts provided by the historian Ron Barkai (*A History of Jewish Gynaecological Texts in the Middle Ages*, Leiden: Brill, 1998). Nevertheless, in my view these recent studies have failed to appreciate the comprehensive nature of the content of the medical texts that have been studied, and have overlooked the magical component of some of the recipes described, as well as other sections on women's cosmetics and adornment. This kind of analysis has had the effect of reducing women's healthcare to gynaecology while, on the contrary, texts often offer an all-encompassing approach to the care and beauty of the female body and the matters relating to hygiene, cosmetics and the genital organs. At the same time, they have not analysed in depth the implications these practical treatises have *vis-à-vis* the understanding of women's historical experience.

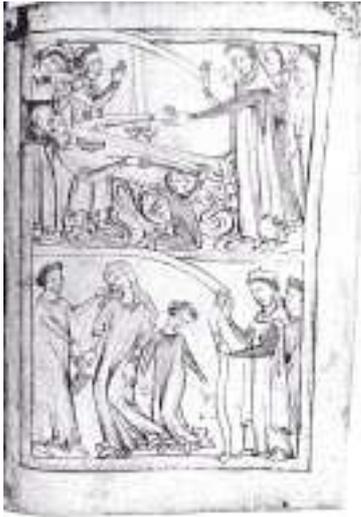
Some 19 texts on the subject have recently been identified, which were produced and/or circulated in Western Europe (at least 25 manuscripts

of them are preserved). But whereas scholars have described most of these works, only a small part of them has been edited and analysed systematically. The large number of preserved manuscripts suggests that this type of literature was valued and quite widely disseminated among Jewish communities during the Middle Ages. These manuscripts also reflect another important trend – the shift within Jewish intellectual circles towards a Latin cultural model.

Ron Barkai notes that while the 13th-century texts originating in Salerno displaced the older gynaecological ideas of Soranus of Ephesus in Western Europe, Hebrew gynaecological literature barely showed signs of this change. This is because the Latin adaptations of Soranus constituted the main current on which Jewish treatises specializing in gynaecology were based between the 12th and 15th centuries. Nevertheless, given the present state of research on Hebrew literature on women's healthcare, a study of the available data provides us with a more complex overall picture. It reveals that a large part of the known texts show, albeit in differing measures, influences of ideas taken from the Graeco-Arabic medical tradition, which reached the treatises through various routes. These included Hebrew translations of original Arabic texts or Arabic works translated from Greek, works written at Salerno or under the influence of Salernitan authors which circulated both in Latin and in a number of vernacular languages, as well as some local traditions.

That said, the number of manuscripts that have been edited and studied thus far is small. In my view, the identification and study of new works, fragments of works or recipes on matters related to the ailments and healthcare of the female body, together with the edition and analysis of those already identified, would help prepare a more complete picture of Hebrew medical literature on women. My own research has been centred until now on the study of some medieval Hebrew manuscripts relating to healthcare and its relationship with women, both as providers and as recipients of care. My doctoral thesis edited, translated and studied a 15th-century manuscript entitled *Sefer ahavat nashim* (Book of women's love). In my view, this is the only extant copy of a large compilation, probably written in the 13th century in the north of Spain or south of France, which deals with magic, sexuality, cosmetics, gynaecology and obstetrics. I have subsequently found and read other manuscripts whose contents are related, in whole or in part, to these themes and focus on the preservation and care of health, especially of women's bodies. After analysing these, I observe that they are somehow linked to some literature dealing with women's healthcare written in Latin and in several vernacular languages, particularly Catalan and French. This has also been noted by Montserrat Cabré ('From a Master to a Laywoman: a Feminine Manual of Self-help', *Dynamis* 20, 2000, pp. 371–393).

This tradition is connected to texts on women's health produced in Salerno, whose study has successfully been undertaken by Monica Green (*The Trotula. A Medieval Compendium of Women's Medicine*. Philadelphia: University of Pennsylvania Press, 2001). The possible connections between the above-mentioned tradition and the Trotula



Above: Physician attempting to revive a fainting woman.

texts with Hebrew production will allow me to examine the relationship of Jewish medical practitioners and learned physicians with their Christian contemporaries, as well as the interaction of people of different communities with similar practical experiences. Many of the remedies and therapeutical procedures found in these texts are based, as documented in the records, on experience and living practice, and were intended to be applied. It is, however, not always clear by whom.

As stated earlier, one of the routes by which ideas from the

Graeco-Arabic medical tradition reached Hebrew tracts is through the translations into Hebrew of original Arabic texts or of those previously translated from Greek into Arabic. The study of these translations from Arabic might not only enlighten us about the process of transmission of notions and theories from Arabic sources, but also inform us about how these intertwined with those emanating from the Latin medical tradition. In the light of this goal, I have translated into Spanish the section, 'On childbirth', Book IV, Fen XXII, Tract II, chapters I–X, of the Hebrew translation of Avicenna's *Canon* (*Avicena, Canon medicinae: estudio y edición facsímil del ms. 2197 de la Biblioteca Universitaria de Bolonia*. Madrid: AyN Ediciones, 2002).

I have been awarded a Wellcome Research Fellowship to edit, translate and comment on the Hebrew text entitled *Sha'ar ha-nashim* ("Women's chapter"), London, British Library, MS Or. 10396/3, ff. 85r–88v.

This apparently unique manuscript, written in the 15th–16th centuries, is a short gynaecological treatise that offers remedies for diseases of the breasts, for pain and other ailments of the womb and those that occur after giving birth, for promoting conception and its reverse, and for procuring an abortion or expelling the dead foetus. This mainly practical text offers a wide range of therapeutical measures for women's healthcare such as baths, fumigations, electuaries, poultices and pessaries.

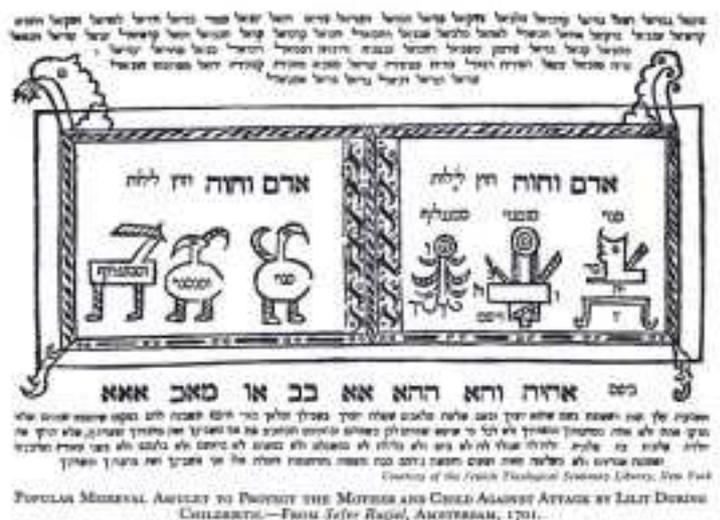
The *Sha'ar ha-nashim*, despite its brevity, is a precious example of this confluence of Graeco-Arabic views and local traditions on women's physiology and health. It shares Galen's theories, such as his humoral pathology and the centrality of abnormal menstruation in women's disease, with other treatises composed by Arab authors and afterwards translated into Latin. At the same time, the text shows a particular preoccupation with women's health, which manifests itself through therapeutic measures. A careful analysis of this text would prove a valuable means of understanding of the complex mixture of medical traditions that formed the medical Hebrew literature on women, and its relationship with other works on women's healthcare, that were disseminated throughout Europe from the end of the 12th century onwards.

In due course, I intend to prepare a list of recipes and pieces of knowledge attributed to females in these medical treatises.

Though it seems that not many women were linked directly and individually to the production of texts during the Middle Ages, the existing literature shows that women's original contributions were acknowledged. Often medieval texts on healthcare – especially on women's healthcare, but not exclusively so – refer to anonymous women, generally in a collective way, as the origin of a recipe or medical practice. These attributions of 'diffuse authorship', as they have been referred to by some historians, do not identify women by their names, even though they mark out their sex clearly (Montserrat Cabré, "Autoras sin nombre, autoridad femenina, siglo XIII", in María del Mar Graña, *Las sabias mujeres II*. Madrid: Al-Mudayna, 1995, 59-73). As Hebrew written tracts reveal the same pattern, the importance of producing a list of female attributions does not reside in the 'quantification' of women's contribution to medieval science, but in highlighting the symbolic significance of a historically undervalued experience. This would also help, in my opinion, restore the broken chain of female genealogy.

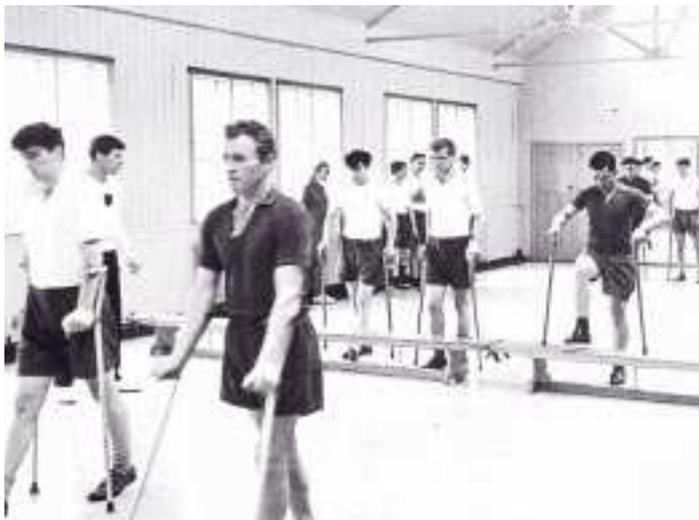
To conclude, therefore, the aim of my research is to contribute to the understanding of Jewish women's healthcare at the end of the Middle Ages in the Mediterranean West, paying attention to both medical notions and the women's experience. On the one hand, the analysis and comparison of Hebrew texts with those written in various vernacular languages and Latin will enable us to learn about the possible links established between Hebrew medical literature on women and other medical currents developed in Western Europe at the time (the Arabic influence will, of course, not be overlooked). On the other hand, the combination of concepts and methods developed by medical and women's historians will allow us to uncover the historical significance of these texts dealing with women's healthcare for the understanding of women's historical experience. Moreover, this research will help to elucidate the position of women in the development and transmission of knowledge and practices related closely to the care of their bodies.

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Above: Amulets related to childbirth were popular in the Middle Ages.

The Soul of a Nation



Walking re-education, Army Medical Rehabilitation Unit, 1956–68.

Rehabilitation, denoting a holistic approach to the process of recovery, became a highly popularized term during the Second World War. However, more basic medical techniques of rehabilitation had been used much earlier. For instance, physicians had been practising rehabilitation in the form of exercises to reduce the effects of fracture, during the First World War period. Rehabilitative techniques concerned with the psychological health of the patient, such as occupational therapy, had an even longer history. The book resulting from this research, *The Soul of a Nation*, will argue that, despite this long history, it was during and after the Second World War that rehabilitation became an all-encompassing process. It was not only concerned with the medical stabilization and recovery of the patient, but was expanded to include the long-term process of rehabilitation into society. The whole was underpinned by an active collaboration between government departments, the armed services, voluntary services and the medical profession.

The study will take the period 1939, the start of the Second World War, to 1956, the Percy Report on rehabilitation, as its focus.

The opening section will deal with the rise in popularity of rehabilitation among the medical profession in the years before the war, and its rapid adoption as a response to the numbers of people injured in the early years of the war. Compared with the First World War, the numbers of deaths and casualties were not as numerous. The new military technologies of weapons and warfare ensured that there were still significant and serious casualties, while new medical technologies ensured that many of those injured survived. Drugs such as penicillin and sulpha served to reduce the numbers who died from infection, while developments in the field of blood transfusion lessened the number of deaths by shock. With the increased number of survivors the field of rehabilitation became highly important.

The rehabilitation regimes of all of the three armed services will be examined in the book, and an assessment will be made of the reasons behind their ready adoption of rehabilitation. The RAF had a particularly strong rehabilitation ethos, to the extent that they ran their own rehabilitation hospitals. For the RAF rehabilitation was seen as important

because it was so difficult to train new recruits to the intricacies of the job. The Army and Navy, however, generally used the Emergency Medical Service hospitals. During and after the period of hospitalization special physical training instructors trained the patients from these services. The job of the physical training instructors was to attempt, through exercise and competitive recreation, to restore the injured servicemen to full mobility and fighting fitness. For some patients, recovery from injury was complete and they were able to return to active service. For others, their injuries were so severe that they were left permanently disabled. Even for these servicemen, rehabilitation became a central part of their life. They were not discharged immediately from their service; instead rehabilitation was carried out in the services and some with minor disabilities were retained. For those severely disabled discharge followed eventually and they were transferred to the care of various government agencies with a long-term rehabilitation remit.

Through the physical training instructors, games and exercise became an important part of rehabilitation. However, a central measurement of the complete process of rehabilitation came when the disabled person found a job. While fitness and occupational therapy were important, the ultimate aim of rehabilitation was employment. The book has at its heart a discussion of how the rehabilitative process worked, and why it was geared to the final goal of employment for permanently disabled ex-servicemen.

The book will focus on several case studies, on institutions established during the war and others that have a longer history. The regime at Stoke Mandeville Hospital in Aylesbury will be examined, as it was one of the most innovative and best-known centres for rehabilitation. Within this hospital a Spinal Unit was set up in 1944, which treated those disabled ex-service people who had received a spinal injury and as a result were paralysed. Those with spinal injuries survived the Second World War in a way previously unseen as they benefited from new developments in drug therapy and the treatment of shock, and this ensured their return from the battlefield for rehabilitative treatment. Paralysed ex-service persons were one of the last groups to benefit from rehabilitative therapies, but the results were some of the most rewarding. As well as the usual rounds of physical therapy, the head of the Spinal Unit, Ludwig Guttmann, and his patients devised new types of sports that disabled people in wheelchairs could play as part of their rehabilitation. Other institutions that used rehabilitative therapies are featured in the book, such as St Dunstan's, which was a home for blinded ex-servicemen, and the Star and Garter Home.

Although these homes were ostensibly for ex-servicemen, and in smaller numbers women, some civilians who had become disabled due to enemy bombing were also offered treatment in these rehabilitation units. While certainly not on the same scale as those fighting men and supporting women, civilians were an important segment of those exposed to rehabilitative techniques, and their experiences are also covered in the book.

The role of rehabilitation continued to be important after the war. Government had involved itself directly with the process of rehabilitation during the war; and in the context of the development of the welfare state and the National Health Service, this role was set to continue. A parliamentary committee in 1943, headed by George

Tomlinson, examined the role that rehabilitation would play when the fighting ended. This early report paved the way for the Disabled Persons Employment Act of 1944, which purported to assist all disabled people in finding suitable employment, although this actually favoured ex-servicemen and women above others. There were three reports emanating from the standing committee established by Tomlinson's report of 1943. The final report of this period, the Piercy Report, was presented to Parliament in 1956.

In its entirety the book will offer a new and refreshing assessment of the lives of wounded and disabled servicemen and women in the Second World War. Of particular interest is the acknowledgement of a new regime of treatments and approaches under the generic name of rehabilitation. This brought together a coalition of new medical technology, the welfare concerns of the armed services, charitable hospitals and organisations, and the interventionist approach of the wartime and post-war governments. The experience of the men and women at the heart of this book will illustrate the effect of rehabilitation of the individual, while also exploring the sea change in attitudes towards disability across government, in the medical profession and in society as a whole.



Therapy for arm amputees, Army medical Rehabilitation Unit, 1956–68.

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Hospital institutions and political power

The origin of the hospital has been a thorny question. Some historians such as Foucault and Ackerknecht have linked the rise of modern hospitals in the 19th century to the development of clinical medicine. Previously, Sigerist maintained that only in the second half of the 19th century did hospitals become anything more than shelters for the desperately poor and evolved into centres of scientific medical treatments. Other historians, however, have observed that the features characterizing modern hospitals in Europe appeared much earlier, from antiquity to the late Middle Ages.

During the first half of the 20th century, when studies on Islamic medicine developed, some historians indicated that the first hospitals with medical and scientific purposes initially appeared after the establishment of the Islamic caliphate in the 8th century. Alexandre Philipsborn, who studied the medical and scientific characteristics of hospitals in the East Roman Empire, believed that the Pantokrator hospital, set up in Constantinople in the 12th century, adopted some features from *bīmāristāns* (houses for the sick) in Islamic countries.¹

The Iranian historian, Najmabadi, on the other hand, tried to show that Persian physicians and/or princes initiated the creation of hospitals under the caliphate.² Alternatively, the Turkish historian, Sayili, argued that the Turkish emirs and sultans played a major role in the construction of the first hospitals under the caliphate.³ Finally, Timothy Miller, in his famous book *The Birth of the Hospital in the Byzantine Empire* (published

in 1985), challenged all these theories by contending that xenons in the Byzantine empire developed between the 6th and 12th centuries were endowed with proper medical staff and hierarchical administration. Such an argument implied that the *bīmāristāns* in medieval Islam – as well as the modern hospitals in Europe – were modelled on Byzantine xenons.⁴

My interest in reassessing the question of the origin of hospitals was sparked by a Persian manuscript that proposed guidelines for the first public hospital in 19th-century Iran. The anonymous author of this manuscript lamented the absence of hospitals in Iran, while, according to him, the Iranian kings were the first architects of hospitals since the ancient times. As proof of this claim, he indicated the universal use, during the medieval period, of the Persian term *bīmāristān* to designate hospitals. This argument did certainly not lack a nationalistic and political bias. Nineteenth-century Iran witnessed a nationalistic movement, which expressed itself in various ways, including the production of a particular kind of historiography of pre-Islamic Persian kings. Seen from this perspective, the author was representing the establishment of hospitals in the 19th century as a sign of the revival of Persian civilization and custom which had been abandoned since the Arab invasion: "...during the Arab domination, although the standards of the Kings of Iran were completely abandoned, the [Persian] custom of the hospital was still, in many parts of the country, respected and practiced."⁵ What is referred to as the 'Islamic hospital' was, therefore, according to this author a Persian institution and not an Islamic one.

One could bridge the gap between these conflicting accounts on the origin of the hospital by identifying historical, social and cultural continuities between hospitals in Ancient Iran, the Byzantine Empire and medieval Islamic territories. There is no fixed fundamental nature of the



Dr Mirza Ali Mo'tamed al-atebba teaching modern medicine at the polytechnic School of Dar al-fonun, Tehran, c. 1880.

hospital deriving from one nation, religion or philosophy. Foucault, Ackerknecht and Sigerist were right to maintain that the hospital in 19th-century Europe was a new phenomenon with no equivalent either in the past or in other countries. Hospitals in ancient Persia, in the medieval Latin world or in medieval Islamic lands did not have the same structure or function, because they had been developed and maintained within different social and political environments. The hospital of Jundishapur, for instance, which was constructed, according to one Syriac source, on the advice of Nestorian Christians, could not be the same as the xenon of the Byzantine Empire. Hospital institutions were sometimes inspired by each other but, given the different socio-historical conditions in which they evolved, did not develop or decline in the same way.

Historical research often misleadingly focuses primarily on the birthplace of hospitals whilst studying their antecedents and function. Finding the birthplace of the hospital, no more than searching for the birthplace of science, cannot explain the particular process of development of hospital or medical knowledge in different countries and at different epochs. The concept of the hospital existed in various civilizations at

different times and with different connotations. For instance, one can surmise that the idea of hospitals in Iran could have been derived from the very old institution of *caravanserai* (inn for travellers), just as the idea of hospitals in the Byzantine Empire was taken from *xenodocheon*, which was also an inn for travellers. The *bîmâristâns*, developed during medieval Islam, might, thus, have been modelled on either Persian *caravanserai* or Byzantine xenons. But though origin seeking is of historical interest, it does not explain sufficiently how hospitals in medieval Islam were constructed and how they evolved.

Another issue of disagreement on the origin of hospitals comes from the fact that hospitals have usually been associated with development of medical knowledge. They are identified according to whether or not – and to what extent – they provided medical treatment. And yet, patients in the ancient and medieval periods, in both the West and the East, gave more importance to the shelter and comfort they could find in the hospital compound than the inefficient medical treatments provided (cautering, bloodletting, etc.). The construction and maintenance of hospitals, as in the case of other buildings of public interest such as mosques, *madrasas* (schools) and *caravanserai* depended on the might of political power and not on the level of medical knowledge.

A cursory review of hospitals in Byzantium and Sasanian Empires in pre-Islamic Iran, as well as in Islamic lands from the caliphate until modern times, indicates that their construction was directly linked to socio-political conditions. They flourished when a socio-political stability was secured and the economy flourished. Princes or emperors funded them sometimes directly from their own treasury and sometimes from charity revenues. And significantly, in Islamic countries charitable resources were usually raised and controlled by secular powers. The number of Islamic hospitals multiplied in Damascus, Cairo and Baghdad, respectively the capitals of the Umayyad (661–750), Tulunid (868–905), Fatimid (909–1171) and Abbasid caliphs (750–1258). The same pattern of hospital construction occurred in Iran: we see them in cities such as Marw (8–9th century), Rayy (10th century), Ispahan (10th century), Neishabur (11th century), Shiraz (13th century) and Tabriz (early 14th century) under powerful local princes and nobilities.⁶

In light of all these considerations, my forthcoming book delves into social and political history in an effort to examine – and present a more nuanced study of – the history of hospitals and medicine in Iran.

¹ Alexandre Philipsborn "Der Fortschritt in der Entwicklung des byzantinischen Krankenhauswesens" in: *Byzantinische Zeitschrift*, 1961, vol. 54, pp. 338-65.
² M. Najmabadi, *Târîkh i tibb dar Iran pas az Islam* (History of medicine in Iran after Islam), Tehran, 2nd edition, 1366/ 1986.
³ A. Sayili, "The emergence of the prototype of the modern hospital in medieval Islam", *Studies in history of medicine*, (New Delhi), vol. 4 (1980), pp. 112-118.
⁴ Timothy Miller, *The Birth of the Hospital in the Byzantine Empire*, Baltimore and London, 1985, p. 4.
⁵ Mss 505, Library of Majles (Parliament), Tehran, p. 5.
⁶ Ahmed Isa, *Târîkh al-bimâristânât f'il Islam*, Bayrut, 1981, pp. 266 ff.

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Cultures of Neurasthenia: From Beard to the First World War

In 1869 the American neurologist Beard 'invented' a new disease, a disease of modernity, an American disease. Under pressure of brainwork and the wear and tear of modern life, nerves could become overstrained, which could lead to a whole range of symptoms such as tiredness and anxiety. Beard called his new illness neurasthenia.

Jointly edited by Marijke Gijswijt-Hofstra and the late Roy Porter, the book *Cultures of Neurasthenia* emerged out of a seminar on 'Neurasthenia and Society', held in Amsterdam in June 2000, where a group of international historians presented their research. They tried to understand how this American concept fitted into a European setting; how the ideas of Beard were received in England, Germany, Holland and France. They asked questions about diagnoses and treatment and wanted to know how neurasthenia was experienced by patients and further received by the broader society.

In her introduction Gijswijt-Hofstra describes neurasthenia as "a fascinating topic because of its protean character; its floating diversity in the course of time, in different regions and in different groups" (p. 2). The disorder is indeed a relevant topic for historical analysis, because its meaning has changed so considerably over time. After the term appeared in the late 1860's in America, it was taken up in Europe where it was used in the last decades of the 19th century and gradually disappeared again a few decades later. But, as Roy Porter argues in his contribution, the condition of extreme nerve exhaustion was already diagnosed in 18th-century British upper-class gentlemen. Furthermore, the disappearance of the term neurasthenia at the beginning of the 20th century did not mean the disorder had ceased to exist. The subtitle of the book limits the cultures of neurasthenia from Beard to the First World War, but many contributors continue their story until well into the 20th century. In the East, neurasthenia is even today a widely used and valued diagnosis. And could not what is today called 'Chronic Fatigue Syndrome' be seen as a contemporary version of neurasthenia?

In the process of trying to unravel the changes in meaning historically, the contributors to this volume reveal that a straightforward history of a disorder such as neurasthenia does not exist. Its content does not only change over time and space, but shows itself always and everywhere ambiguous. The term was ambivalent and multifaceted and how it was to be understood was constantly negotiated and redefined. During this

process, the disorder constantly crossed cultural borders, thereby establishing essential differences.

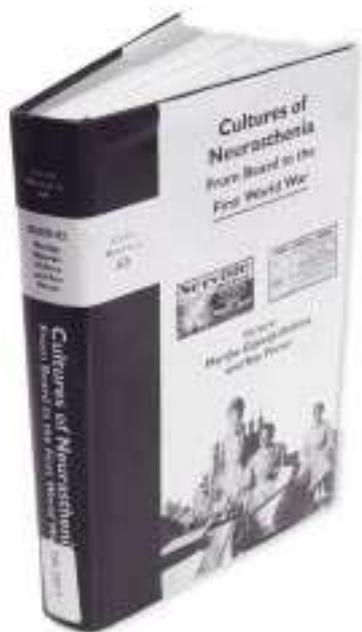
In this manner, it trespassed the boundaries of class. Beard had initially established neurasthenia as an upper-class problem, as its sufferers were mainly brainworkers. But this volume shows that, in Europe, it could equally become an ailment of the so-called 'degenerated' working classes. For example, British neurologists insisted that it could be a working-class disorder; and that is also how Charcot in France reinterpreted it. The contributors conclude, however, that neurasthenia essentially attacked the middle and upper classes. Having arrived at the right time at the right place, neurasthenia seemed to justify the sufferings of the better-off: their tiredness, nervousness, sleeplessness and more, without associating these symptoms with insanity, thus avoiding the stigma of mental illness and the asylum.

The gender aspect of the hazy concept of neurasthenia proves equally confusing. Easily seen as the male and therefore 'respectable' form of hysteria, it could be interpreted nevertheless as quite the opposite: an essentially female disorder [see Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980*, London, 1987]. The people writing this volume, constantly confronted with contradictory evidence, understand that gender was indeed an important category within the making of neurasthenia and conclude that, although it was diagnosed in women, it seemed to trouble men more. Apart from class and gender, age group could similarly become a category linked with the concept of neurasthenia, as, for example, it was 're-invented' within Dutch educational discourse in child-rearing advice.

The editors have organized the articles by country and in a thematic order; separating the professional, the patient's and the public's view. This division is somewhat problematic since it remains impossible to grasp to what extent the texts of neurasthenia were authored respectively by culture and society, by sufferers or by influential medical men. Moreover, its construction took place precisely at the crossroads where these views met as a result of constant negotiation between patient, doctor and surrounding society.

Neurasthenia dwelled at the border of soma and psyche. Initially seen as a physical problem of nerves, it slipped into the realm of psychiatry around the turn of the century. It helped the upcoming specialization of psychiatry to break away from the medical speciality of neurology. The concept of neurasthenia, immediately taken up in Germany, led to a controversy within the medical world between different disciplines. Although less readily accepted as diagnosis in Britain, it became similarly significant for the affirmation of medical identities. As a result of this debate in Holland a new domain for treatment outside the asylum came into existence. Neurasthenia became a business and private sanatoria that provided cures for the disorder proved profitable all over Europe. As varied as the symptoms could be, as diverse were the cures, ranging from electricity, hydrotherapy and rest to a wholesome diet.

The influence of medical professionals was crucial to the making of diagnoses and the establishing of a cure. Men such as the gynaecologist Playfair in Britain and neurologist Jelgersma in Holland delineated the meaning of the term by defining causes, symptoms and therapies. Jelgersma and to a much greater extent Kraepelin in Germany, linked the idea to concepts of sexuality and degeneration. In France, neurasthenia



was made current by Charcot, and also taken up by Janet, who called it psychosthenia. But, argues Shamdasani, it was because of Janet's lack of students, publications and influence in general that this concept did not become 'fashionable' as neurasthenia had done.

While plenty of medical tracts are available to the historian who researches the medical point of view, the outlook of the patient proves more difficult to track down. For that purpose, Joachim Radkau excavated numerous German patient registers and Marijke Gijswijt-Hofstra has analysed diaries and correspondence of some prominent sufferers in order to write her very fine article. Their approach leads to elaborate micro-history writing: especially revealing when placed back within a wider social background and framework.

Advertisements for all kinds of patent medicines and cures for nervousness in contemporary publications proved an intriguing source for understanding the resonance the concept of neurasthenia had within wider society. Ambiguous yet again, while representing the public view on neurasthenia, these ads also helped to construct that view. The reader had to recognize the problems addressed in the ad in order to buy the remedies for over-stressed nerves it promised. By giving a name to the ensemble of implied problems – by "baptising [it] with a diagnosis" (Sonu Shamdasani, 'Claire, Lise, Jean, Nadia and Gisèle. Preliminary notes towards a Characterisation of Pierre Janet's Psychasthenia', 374) – advertisements in widely read periodicals were used to sell both neurasthenia itself and its treatment. Because of the purpose of the ads – to promote a cure – they did not represent nervousness as a hereditary and thus predetermined problem, even though ideas of degeneration and fears of decline of the race became central elsewhere in the discourse on neurasthenia.

This was clearly so when it became a tool of political propaganda, as happened in France. During the Dreyfuss affair, Jews and intellectuals were portrayed by the anti-Dreyfussards as weak and degenerated as opposed to strong and virile Frenchmen. Degeneration and neurasthenia furthermore featured in literature, and naturalist novelists invented characters whose nervous behaviour was influenced by predisposed factors. Evidently these characters were created in the mind of the author; within the scope of the period, and thus literature offers an excellent opportunity to explore neurasthenia's cultural meanings, especially when it associates ideas of degeneration and nervousness with additional contemporary issues, such as feminism for example.

The various stories of neurasthenia are diverse, and often conflicting. The lack of unity, the disagreements, ambiguity and ambivalence within this collection is, however, appropriate for a cultural history of this kind. The well-chosen title explains that the disorder is approached as a cultural notion, that there are many narratives and that one can expect to find writings that introduce us to the cultures in which neurasthenia was adopted and adapted.

There have been histories of nervousness, depression and neurasthenia in the past but it is the acceptance that "apparently there is more than one simple story of neurasthenia" (Radkau, 'The Neurasthenic Experience...', 215) and the attempt at a comparative study that make this collection a worthwhile project. A comparative approach such as this is much needed. Particularities within an individual society can only become clear when, like here, comparison has first exposed similarities

and differences. However, the authors have not always collaborated sufficiently and similar ideas and conclusions are retold in different settings with few references to fellow contributors.

This collection is uneven in many other respects, as tends to be the case with many multi-authored edited volumes. Some articles are very interesting, while others are less so. The best ask challenging questions of a relevant selection of source material and are written in a clear language. Each contribution reflects the interests of the writer and, coming from different cultural backgrounds, diverse historiographical traditions are embedded in the respective essays.

The editor questions in the introduction the way in which the dissimilar approaches show a "divergent historiographical use of the term [neurasthenia]" (p. 21). Whereas the American and the English contributors have used the term in a "strictly particular sense", the Germans and Dutch have interpreted neurasthenia more as a wide "umbrella term" for nervous disorders. She wonders if this reflects actual historical use. One should not forget, however, that by undertaking a comparative work historians deal with different languages. Neurasthenia, literally meaning nerve-weakness, was – although derived from a Greek root – essentially invented as an English term, and it is not necessarily readily translatable into Dutch, German or French. Language plays an essential role, since it is such an integral tool of cultural analysis, which seems to be easily forgotten.

The collection appears focused towards a British readership. It is taken for granted that the reader is familiar with the political, social and cultural situation in Britain. Contributors from other countries, though, especially the Dutch, have felt the need to introduce their country's cultural, social and even political background. Therefore these contributions are more descriptive with unfortunately less space left for historical analysis. This unevenness is evidently also related to the differences in breadth and depth of literature and research already undertaken on the subject in different countries.

Cultures of Neurasthenia is a welcome contribution, not only to the history of medicine but also to broader social and cultural history in general. The book suggests how disease has a history as representation, how a concept travels across geographical and social borders. Influenced by and at the same time shaping surrounding society, narratives of disease become cultural histories, giving us a window into a certain social organization particular to British, German, Dutch and French culture. The comparative approach is particularly revealing. This collection is an inspiring invitation to medical and social historians to join forces and embark on more comparative work.

Marijke Gijswijt-Hofstra and Roy Porter (eds) (2001) *Cultures of Neurasthenia: From Beard to the First World War*. Amsterdam: Rodopi. ISBN 9 042009 314, 407pp.

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Hippocrates in Context 27–31 August 2002



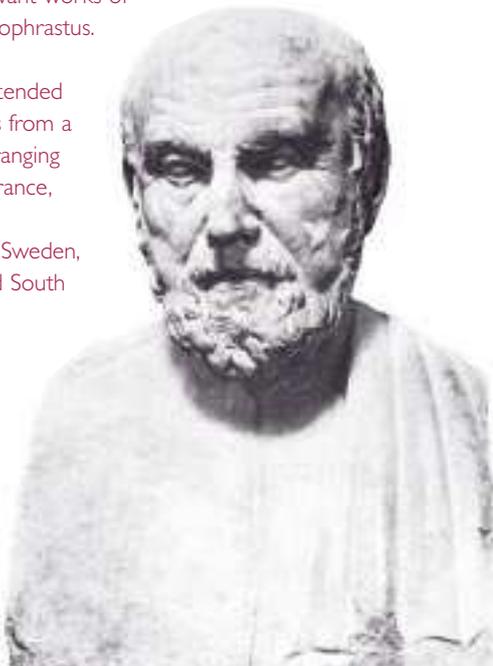
Hippocrates lecturing to his students under the plane tree on the island of Cos.

This conference, held at the University of Newcastle upon Tyne, 27–31 August, was the 11th in the prestigious international series, 'Colloque International Hippocratique', and the first one in the series to take place in the UK (and indeed in the English-speaking world). It was hosted by the Newcastle Classics Department and organized by Professor Philip van der Eijk.

The purpose of the conference was to broaden the appeal of Hippocratic studies by focusing on the historical context in which the Hippocratic writings were written and on the impact they had on ancient society, culture, mentality and morality, language, literature and thought. 'Context' here was not restricted to the Greek world, but also included the medical thought and practice of other civilizations in the Mediterranean, such as Persian, Babylonian, Egyptian and Indian medicine.

A further point of interest was the relationship between the Hippocratic writings and non-Hippocratic medical authors of the 5th and 4th century BCE, such as Diocles of Carystus, Praxagoras of Cos, as well as the relevant works of Plato, Aristotle and Theophrastus.

The conference was attended by about 100 delegates from a variety of nationalities ranging from the UK, the US, France, Italy, Spain, Greece, the Netherlands, Germany, Sweden, Switzerland, and indeed South Korea. The proportion male/female was about 50/50; and there was a significant number of younger people, research students and postdoctoral fellows. The conference fully achieved one of its goals – to open up



Hippocratic studies to scholars who are not specialists in the field but whose research touches on ancient medicine. Participants included ancient historians, (bio) archaeologists, historians of philosophy and science, social historians of medicine, medical anthropologists, specialists in Near Eastern and Egyptian medicine, students of Greek language and literature and members of the medical profession to whose research, teaching or practice the Hippocratic writings are relevant.

The conference programme featured over 40 speakers, including the world's leading experts in the field of Hippocratic studies, such as Jacques Jouanna (Sorbonne), Heinrich von Staden (IAS Princeton), Amneris Roselli (Istituto Orientale, Naples), Daniela Manetti (University of Florence) and Armelle Debru (Université de Paris VII). Among the speakers, too, there were a significant number of younger scholars and research students, for many of whom this was the first opportunity to present and discuss their views with senior scholars in the field.

The academic quality of the papers and the discussions was on the whole very high, and overall the conference can be said to have broken new ground in the field of Hippocratic studies. Without abandoning the traditional philological approach, Hippocratic medicine was viewed more explicitly in relation to other ancient medical traditions and to the intellectual, cultural and social background of the classical world. The input from British and American scholars in what was traditionally a predominantly Mediterranean colloquium was also refreshing.

The conference took place on the Newcastle University Campus, and many delegates expressed their appreciation for what they felt was the smooth, efficient and careful organization of the event. Apart from the academic meetings, there were receptions hosted by the University and by the City of Newcastle upon Tyne, and visits to the University's Shefton Museum of Greek Art and Museum of Roman Antiquities. The conference dinner was held in Trinity House on the Newcastle Quayside, and the excursion went to Craggside House and gardens in the Northumberland countryside.

The Conference was sponsored by the Wellcome Trust, the British Academy, the Catherine Cookson Foundation, the City of Newcastle upon Tyne, the Classical Association, Newcastle University's Faculty of Medicine and Newcastle's Faculty of Humanities and Social Sciences.

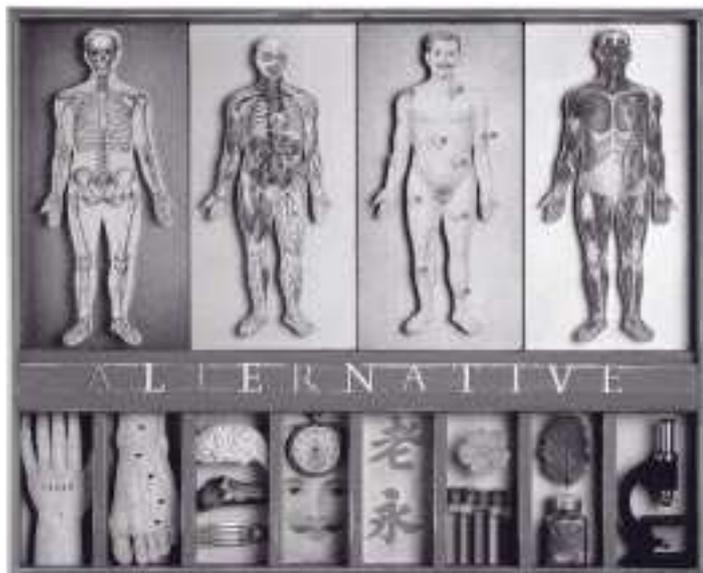
A selection of papers will be considered for publication in the conference volume, to be published by Brill Press (Leiden, Netherlands).

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CAMs Conference

23 July 2002, De Montfort University Campus



Hosted by the School of Health and Social Welfare of the Open University, the aim of the conference was to discuss recent and prospective developments in Complementary and Alternative Medicines (CAMs) on the themes of change, integration and research.

Julie Stone, author of the recent 'An Ethical Framework for Complementary and Alternative Therapies', began by asking which should come first: change, research or integration? This dynamic, she claimed, is little understood. Assuming integration of CAMs can only occur into the dominant paradigm Stone suggested regulations of orthodoxy may be inappropriate for CAMs due to the latter's being, for example, less invasive, and fostering a close therapeutic relationship. Stone noted the general shift to greater professionalization (defined as education, training and external validation) and statutory self-regulation (SSR), but concluded CAMs need not professionalize or come under one umbrella body in order to gain wider acceptance since public demand will facilitate integration, with cost effectiveness rather than efficacy attracting a cash-starved NHS. Failing that, Stone predicted, CAMs will continue to thrive underground, unregulated.

Dr Richenda Power, Osteopath and Medical Sociologist, spoke on regulation and integration of osteopathy since 1998, which has led to increasing referrals of 'difficult' patients by GPs to osteopaths, that is, those patients GPs are unable to deal with. Drawing on her experience of working with 'emotionally damaged' children in the school environment Power claimed osteopathy is crossing boundaries which have become closed to other healthcare professionals, viz touching children. Power claimed this was immensely beneficial to the children and improved their classroom behaviour. The questions of whether this is osteopathy as social control or whether osteopathy had changed since such integration was not touched upon.

Dr Sarah Oerton, University of Glamorgan, detailed the boundary-setting behaviour of therapeutic masseurs used to distinguish their

therapy from sex work in the public arena since prostitution is often advertised under the banner of 'massage'. Oerton found such boundary setting was achieved in massage literature, advertisements and prospectuses by three motifs: the masseur as 'angel' in the white clinical coat, as custodian of tradition, and as the benign, godly and uncontaminated healer. Formal protection of masseurs by regulation is hampered by the general acceptance in the profession of common sense being an adequate safeguard, and by the difficulty of defining a practice as diverse as 'massage'.

Mike Saks discussed recent developments in CAMs and asked whether we are going 'back to the future'. Highlighting CAMs' political nature by defining as 'everything not orthodox', Saks began by claiming whereas the 19th-century medical playing field was market-led and homogeneous in relation to training and philosophy between various medical groups, the current situation is dominated by the role of the state with heterogeneous training programmes. Further, the recent House of Lords select committee recommended the referral of patients to CAMs practitioners via the traditional medical gatekeepers – GPs, perpetuating an uneven playing field. What to do?

Saks concluded a greater flow of knowledge between orthodox and CAMs should occur. Incorporation could be achieved via the Council of Regulators of Health Professionals along with research funding at the national level. To me, this all sounded worryingly easy and raised the alarm that CAMs practitioners are not fully aware of the lessons of history regarding integration, some of which were outlined by Phil Nicholls in his paper 'Writing the History of Homoeopathy'.

Nicholls suggests an elective affinity of allopathy with the interests of practitioners to make a living. Historically, therefore, rationalism (aka orthodoxy) has dominated, with empiricism (aka homoeopathy) acting as an intermittent reality check. Though not made explicit by Nicholls, the implications for CAMs are for practitioners to speed up their treatments and increase their 'turnover'. Nicholls claimed the consultation ban enforced by the British Medical Association (forbidding allopathic physicians to consult with homoeopaths and other 'quacks') was a major factor in homoeopathy's 19th-century success in that it crystallized homoeopathy's distinctiveness. Unfortunately, Nicholls did not confirm whether homoeopathy's demise corresponded with the revoking of the consultation ban, an historical point of importance to current CAMs practitioners since here may be an historical precedent for resisting integration.

Finally, **Ms Margaret Coates**, Registrar of the General Chiropractic Council, outlined the trauma of implementing statutory self-regulation among osteopaths and chiropractors in recent years, recalling the anger she was met with by practitioners who objected to the registration procedures and cost (and fee of £1250 plus retention fee of £1000



per annum!) believing they were entitled to registration according to the 'grandfather principle'. Balancing the needs of chiropractors to be registered (after the deadline it was illegal to practise as such without registration) with the needs for protection of the public, to date 1874 had registered, with 80 withdrawing their applications and 40 being refused registration.

With the increased use of CAMs this conference highlighted some of the issues facing CAMs practitioners in the years ahead: codes of ethics, quality benchmarks, the perils of statutory self-regulation and the kind of relationship they desire to forge with mainstream medicine. Integration was generally assumed to be desirable (even inevitable) but perhaps this was because of the strong representation by chiropractors and osteopaths – 'the orthodox alternative' as one speaker put it.

Speakers from across the CAMs spectrum may have brought into sharp relief the point of their commonality, namely their marginal status. Such heterogeneity makes future political posturing problematic and perhaps explains why it is by no means clear exactly what CAMs practitioners want. Even if this agenda were set would it be 'all for one and one for all' or would individual practices allow themselves to be 'picked off' by mainstream medicine? Would integration lead to change beyond recognition? In this respect CAMs studies need a strong historical basis to draw lessons from the past in order to direct future policy.

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Congress of the International Economic History Association

The Congress of the International Economic History Association was held at the Hilton Hotel Buenos Aires, Argentina on 22–26 July 2002. About 80 sessions were organized during the course of the congress. The session, 'Disease, Development and Medicine in Modern Asia: South Asia and East Asia', was held on 25 July and consisted of two parts. The first part concerned the problem of development. **Kohei Wakimura** (Osaka City University, Japan) opened the meeting with a paper dealing with the demographic impact of epidemic malaria in British India. This paper focused upon the causal relationship between colonial developmental activities (railway and canal irrigation) and epidemic malaria during the period from the middle of the 19th century to the First World War. This was followed by a paper dealing with health conditions and healthcare systems in India since independence. **K B Das** (Utkal University, India) analyzed the long-term change of demographic and health indicators, emphasizing insufficient development of healthcare systems, particularly in rural India after independence. Although **Liu Shiyung** (Institute of Taiwan History, Academia Sinica, Taiwan) could not participate in the session due to administrative problems, his paper was read and dealt with anthropometric studies on Taiwan during the Japanese colonial period. Using average adult height data, he showed the existence of significant health and welfare improvement during the 1920s and 1930s.

The second part of the session mainly concerned the institutional aspects of medicine and public health. The introduction of Western

medicine and public health measures was often influenced by the onset and nature of colonialism in modern Asia. **Robert Perrins** (Acadia University, Canada) spoke about the development of Dairen (the Guandong leasehold) during the Japanese colonial period (1905–1945), focusing upon the role of public health measures in its urban development. Colonial medicine played a very important role in the sense that it was believed to show an evidence of Dairen's modernity. **Wataru Iijima's** (Yokohama National University, Japan) paper examined the eradication process of malaria in the Ryukyu-Okinawa islands during the 20th century. Interestingly, the approach of malaria changed from the Japanese-Taiwan model (blood test and quinine prophylaxis) to the American model (DDT spraying) after 1957. Lastly, **Mark Harrison** (Oxford University, UK) presented a well-researched paper, arising from a book project being completed by Sanjoy Bhattacharya, Michael Worboys and himself, dealing with smallpox vaccination in British India. The paper made it clear that the failure to extend vaccination coverage to the population in rural areas was often not due to a deliberate colonial policy or cultural objections arising from within Indian society, but due to the weaknesses of vaccine technology.

It was proposed that this session would be the first step toward the collaborative research project that will highlight the uses of having a comparative study on the history of disease and medicine in modern Asia. If you are interested, please contact:

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Stephen Jay Gould



No one who reads a newspaper will have missed the news of Stephen Jay Gould's death. Gould, Professor of Zoology at Harvard University and 60 years old, died on 20 May 2002 of lung cancer:

Gould was both prolific and very successful as a writer. Few scientists can have attained the level of public popularity that he did. Because of his chatty style, readers were able to vouch for a degree of familiarity with what they admired. His output was prodigious. He churned out approximately 300 longish essays for the magazine *Natural History*. The essays were collected and published in a number of best-selling books.

With rare exceptions he wrote about the same thing, namely evolution and its implications. What he had to say was set off against the background of the Darwinian picture of evolution. That picture, known as natural selection, sees evolution as a continual incorporation of favourable variations in the hereditary material. The variations themselves are believed to occur randomly and with no regard for whether they are beneficial or harmful. The outcome of natural selection is adaptation, the appearance that organisms give of being exquisitely designed to suit their environments.

Gould was a confirmed evolutionist, but he was not happy with the air of seeming inevitability of evolutionary explanations based on natural selection. For him evolution was a fact, a wonder; built on a series of historical contingencies and erratic in its course. It was what Darwin had said it was, but it was much more too – a melange resulting from accidents, chance events and constraints. The study of evolution was an essential part of human culture.

As a *popularizer* of evolutionary ideas he was arguably without a peer in our time. Richard Dawkins, the other well-known *popularizer* of evolutionary theory, may have been (and is) a better purveyor of scientific ideas, but Dawkins's best prose comes packaged in a spare style that does not make for the same level of mass appeal.

Besides these popular pieces, Gould's output included more specialized books. *The Mismeasure of Man* is a passionately written, meticulous dissection of the absurdities and horrors that the concept of the intelligence quotient (IQ) has given rise to. *Wonderful Life* is an almost lyrical account of the bizarre-looking, 530 million year-old fossil

invertebrates discovered in the Burgess Shale deposits in the Canadian Rockies. In *Ontogeny and Phylogeny*, Gould attempted to resurrect the study, championed forcefully by Darwin, of embryonic development as a fundamental clue to evolutionary relationships. And in *Rocks of Ages: Science and Religion in the Fullness of Life*, Gould got on the wrong side of both rationalists and the religious-minded by saying that the domains of science and religion did not overlap; you could have your cake and eat it too. His last book, *The Structure of Evolutionary Theory*, came out just before his death. Its quality and impact remain to be assessed.

Gould the writer was a huge success. His essays are immensely readable and laced liberally with quotations and allusions; baseball lore and the Bible were favourites. However, he was not modest about displaying his breadth of knowledge or the astonishingly wide range of information he had acquired. The numerous digressions he employed could be mildly irritating – especially if you knew where he was heading and were impatient for him to get there. Ironically, enormously successful as he was, Gould's stature as a popular writer was limited by the fact that much of what he wrote was in order to advocate his own way of looking at evolution, a way that was not generally accepted. This is a second point of difference between Dawkins and Gould.

What about Gould the professional evolutionary biologist? His area was palaeontology – the study of fossils – and his speciality a group of land snails. The work was well acclaimed; in 1975 he received an award for excellence in palaeontological research – impressive for a scientist under 40. But, though this is said with hardly any first-hand acquaintance with his published contributions to the field, the impression one gets is that they were not extraordinary. It is as an evolutionary thinker that Gould lays claim to our attention.

There were three big ideas that he was (in part) responsible for and tried to push hard. The best-known of these was embodied in the phrase, one might even say slogan, 'punctuated equilibrium'. This referred to the hypothesis proposed by Eldredge and Gould in which they said, roughly speaking, that nothing happened in evolution for most of the time: species did not generally change except for geologically brief episodes during which ancestral forms were 'suddenly' replaced by their quite distinct descendants.

The second of Gould's noteworthy hypotheses was put forward in a paper written jointly with his Harvard colleague Richard Lewontin. The ornate title contained the message: "The spandrels of San Marco and the Panglossian paradigm: a critique of the adaptationist program". Gould and Lewontin claimed that many features of living forms existed, not because they aided survival or reproduction, but because of the sheer profligacy of nature. Unlike what a strict Darwinian interpretation would demand, the reason for their being was not in any way related to the use to which they were put. The analogy was to the decorations found in spandrels, empty spaces between the perimeter of a dome and a pair of adjacent arches. The spandrels were by-products of erecting a dome that was supported by arches, not elements of design in their own right. The point, said Gould and Lewontin, is that the spandrels are made use of because they happen to be there; they are not designed with an architectural requirement in mind.

This attack on so-called pan-adaptationism or 'Darwinian fundamentalism' was in line with Gould's constant flailing at what he

thought was narrow-minded evolutionary orthodoxy. The spandrel argument was later used in a modified form by Gould and Vrba. The special word this time was 'exaptation', meaning a structure whose evolution served a function quite unrelated to what it was subsequently used for. (To take Dr Pangloss's own outrageous example, the human nose was ideally suited to hold up spectacles, but obviously it could not have evolved for that purpose.)

Gould's third big engagement with conventional Darwinism was to stress that the large-scale features of evolution had more to do with accidents and constraints than with a steady and unbroken chain of cause-and-effect links. For example, the famous asteroid impact that pushed the dinosaurs on their way to extinction opened up the field for us mammals, but the diversification of mammalian lineages was in no way a logical consequence of the age of the dinosaurs. Historical contingency, rather than physical determinism, seemed to him the true hallmark of evolution.

Still, on all three issues Gould gave an impression of wavering. He started off usually by saying that he was dethroning an essential aspect of Darwinian orthodoxy. Next (sometimes simultaneously) he stated that he was only restoring the pluralistic nature of original Darwinian thinking which had been hijacked by extremists. As the years passed, Gould increasingly tended to adopt an attitude as of one vindicated. This came through most clearly in his writings on punctuated equilibrium. On the other hand, the scientific community reacted rather differently. Punctuated equilibrium aroused the most heat, with some biologists embracing it wholeheartedly and others pointing out that Eldredge and Gould were not saying anything new. The more mathematically minded were roused to produce models which demonstrated that punctuated equilibrium was actually a necessity. Members of the other camp pointed out that the fossil record was long known to be full of extended periods of stasis, as it were, interspersed with brief episodes of activity. In other words, the rate of evolution had always been erratic. Indeed, Gould's own mentor, G G Simpson, had drawn attention to the absence of any sense of smoothness in the history of evolutionary change.

Gould's response to these criticisms was to say that they were beside the point: what he wanted biologists to address was his contention that the long periods of evolutionary stasis hid an important message. That message was that evolution was a severely constrained process, therefore on the whole conservative. The implication was that changes had to be rare affairs; so that when they occurred at all, they had to be substantial changes. In the matter of spandrels, the opposition came from those who asserted that he was underestimating the power of natural selection. Besides, his own thesis would seem to demand that (to persist with the metaphor) accidental changes, in themselves neither advantageous nor disadvantageous, could lead to complex structures being formed within the space provided by the spandrels. This is a proposition that is hard to swallow. Similarly, on the question of the relative importance of natural selection *vis-à-vis* other forces in determining (or not determining) the broad course of evolution, the reaction was mixed. Regarding the Burgess Shale fossils, to which Gould had drawn attention in order to point out how poorly they functioned as signposts of what was to come, one of the people who had made his name by working on the fossils themselves, Conway Morris, said that he had got it all wrong.

The general public's response to Gould verged on the adulatory. Some went so far as to call him a second Darwin; others have said that "just like Darwin" he was an organizer and synthesizer more than an original worker. The first statement is ridiculous and the second verges on the fatuous. Instead one can try to compare him, purely as a popular writer, with J B S Haldane. But even here, there is no question that he comes off second-best – which, by the way, is not meant to be a negative comment. He lacked the range, insight, originality and forcefulness that are the hallmarks of Haldane at his best. Still, he may have been the more entertaining writer.

In striking contrast to the more or less unmixed praise of the general public, he elicited a decidedly mixed bag of reactions from his peers. Probably part of the reason for this was the assertion that his favourite ideas were fundamentally new. As I have said, Gould mounted three major campaigns. The first was in support of long epochs of evolutionary stasis punctuated by brief periods of change, the second against adaptation as a universal explanation for the diversity of life and the third in favour of contingencies and constraints as significant factors in evolution. In none of the three cases was an entrenched and dogmatic establishment ranged against him, as he tended to suggest. Rather, he was calling attention to aspects of evolution that were already recognized but were not accorded the prominence that he gave them (for good reasons, the others would rejoin).

His sustained attacks provoked people to sit up and re-examine their own picture of evolution, which was all to the good. He constantly hammered away at the idea that the course of embryonic development is difficult to tinker with, that developmental constraints act as important checks on the potentially open-ended character of natural selection. The importance of keeping this in mind cannot be over-stressed.

Two other features of his forays into evolutionary biology deserve to be applauded. Firstly, it is a fact that for many, Darwinism meant adaptation and adaptation alone. Here he performed the immense service of making people go back to the original literature and appreciate the breadth of the picture that Darwin had sketched. Secondly, as with any aspect of science, the study of evolution often descends into arcane detail.

Many scientists either do not see, or do not have time for, the big picture. Gould was a prominent exception. The questions he asked touched on nothing less than the grand sweep of evolution. Most of all though, Gould wrote in a manner that made people see that science could be fun. He will be long remembered for this.

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Conjugal Love in India

Rati'sastra and Ratiramana: Text, Translation, and Notes

The purpose of Rati'sastra was to provide instruction and advice to young Hindu couples before and after they cohabit as a couple. The desired outcome of lovemaking has always been, according to Hindu law and custom, the production of male issues. Conjugal love or "Rati'sastra" is the means to assure that auspicious result.

Kenneth Zysk's *Conjugal Love in India* is a study of traditional Hindu ideas about love in the domestic abode, and deals with the two principal Sanskrit treatises on the subject, Rati'sastra and Ratiramana. These two works, leaving no stone unturned, cover every aspect of conjugal life, from the finding and selection of a suitable pair to procreation. With an introduction that situates the doctrine of conjugal love (rati'sastra) and the texts that explain it in the history of brahminic scholasticism, this work helps to elucidate aspects of Indian history and culture in the medieval and modern periods, and provides a good basis for comparative studies with similar themes in other cultures.

Kenneth G Zysk (PhD), University of Oslo and Australian National University, is Associate Professor and Head of the Department of Indology at Copenhagen University. He has been Senior Fulbright Fellow to India, and a Wellcome Fellow in the History of Medicine in London, and has served as Director of Dharam Hinduja Center's Indic Traditions of Healthcare project at Columbia University and taught at New York University. He has published two books and numerous articles on the themes pertaining to the history and practice of Indian medicine and Ayurveda, both inside and outside of India, is co-editor of a series on Traditional Indian Medicine, and is managing editor of the Critical Pali Dictionary.



This is the first volume in the new Henry Wellcome Asian Series.
Kenneth G Zysk (2002)
Conjugal Love in India
ISBN 90 04 12598 1

"Medicine on a Grand Scale": Rudolf Virchow, Liberalism, and the Public Health

"Medicine on a Grand Scale" explores the connections between classical liberalism and public health policy through the career of Rudolf Virchow. Virchow was the founder of modern pathology, the architect of Berlin's sewerage system, a pistol-wielding revolutionary and a liberal politician whose concurrent service to three German parliaments totalled 96 years.

His many-faceted activities offer a unique opportunity to situate the growth of social medicine within the matrix of liberal ideology. This book's three main chapters discuss Virchow's medical reform activities in the 1848 Revolution (starting with his famous report on the Upper Silesian typhus epidemic), his role in the canalization of Berlin and his parliamentary activity in public health legislation and the politics of the German medical profession under the Second Empire. Its conclusion assesses Virchow's legacy to German, and broader European, social liberalism. A short study written in a robust, accessible prose, this monograph is intended not



only for scholarly consumption but also for interested laypeople in the medical and public health communities.

Ian F McNeely is Assistant Professor of History at the University of Oregon. A specialist in European history during the ages of Enlightenment and Revolution, he is also the author of *The Emancipation of Writing: German Civil Society in the Making, 1790s–1820s* (Berkeley, 2003).

Ian F McNeely (2002) "*Medicine on a Grand Scale*": *Rudolf Virchow, Liberalism, and the Public Health* Occasional Publication, No. 1, 97 pages. ISBN 0 854840 82 6. £10/US\$15 (+ p&p £1 for UK; £2 for Europe; £3.50 for the rest of the world).

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Prevention and Cure: The London School of Hygiene and Tropical Medicine

In 1999, on the eve of the 21st century, the London School of Hygiene and Tropical Medicine (LSHTM) celebrated its centenary. In historical perspective, the date of 1899, when it opened as the London School of Tropical Medicine (LSTM), is crucial to the decisive role it has played in the development of preventative medicine in the 20th century. Its long and complex history falls into two distinct parts: for an initial quarter of a century the School's teaching and research facilities were devoted exclusively to tropical medicine; from the early 1920s it began a period of development into an institution concerned with research and teaching of public health in general and of preventative medicine and hygiene on a global scale, including all latitudes and climates, tropical and temperate alike.

Written to mark the centenary of the LSHTM, this detailed history, which includes original illustrations from the School's archives, tells the story of this world-famous institution through an analysis of the major academic disciplines which have been, and remain, its particular areas of interest and expertise. The story of the institution is interwoven with

the accounts of the many remarkable individuals who have contributed to its work through the development of their particular disciplines within the School and beyond it, in research and in teaching. Well researched and highly readable, this account brings to life a century that has been measured by achievements that changed the world. *Prevention and Cure: The London School of Hygiene and Tropical Medicine* will become a classic text in the field of medical history.

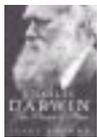
Lise Wilkinson and
Anne Hardy (2002)

Prevention and Cure: The London School of Hygiene and Tropical Medicine
Kegan Paul International. ISBN 0 710306 24 5, £75.00.



NEW PUBLICATIONS

Sharon Messenger



Charles Darwin: The Power of Place



Janet Browne's first volume of her biography of Charles Darwin, *Voyaging*, received considerable critical acclaim. This concluding volume covers Darwin's publication of *On the Origin of Species* in 1859, the impact it had on Victorian society, and, in return, its effect on his own life. It sees Darwin attempting to adjust to his new role as a controversial and much-debated figure. Always a private man by nature, Darwin suddenly found himself seen as a divisive figure, reviewed and discussed in circles that stretched far beyond the boundaries of

Victorian science, one of the leading thinkers of the 19th century, both reviled and admired.

The second half of Darwin's life was inextricably interwoven with the story of *The Origin of Species*, and this biography looks closely at the wider publishing world of Victorian England and the different audiences that responded to his ideas. Darwin relied heavily on his friends and family, his publishing contacts, his correspondence network and the expanding geographical and economic horizons of Victorian Britain to distribute his views to the furthest corners of the Empire. Much of his achievement rested on the domestic 'factory' that he created at his home in the Kent countryside from where he despatched thousands of letters enlisting supporters, thanking reviewers and discussing tactics with friends. His house was also a refuge, where he could indulge his mysterious illnesses. This biography also shows what it was like to become a scientific celebrity. It describes the ways in which new forms of knowledge could be distributed and ultimately made acceptable in Victorian Britain.

Janet Browne (2002)
Charles Darwin: The Power of Place
Jonathan Cape, London
ISBN 0 224042 12 2, £25.00.

Leprosy archives on UNESCO's world heritage list

Readers of *Wellcome History*, Issue no. 19, February 2002, read about the Global Project on the History of Leprosy with its base at the University of Oxford. The project website has links to major Internet sites featuring leprosy. What was not mentioned, and we think may be of interest to many readers, is that the Norwegian leprosy archives in Bergen have now been placed on UNESCO's 'Memory of the World Register'.

The register was established in 1997 with the aim of increasing awareness among UNESCO member countries of their documentary heritage. This heritage is often described as the world's 'common memory'. The register is a parallel to the better-known UNESCO list of world heritage sites.

At a meeting in South Korea in June 2001, the Memory of the World Register was extended to include 21 new archives or collections. Among these were the manuscript of Beethoven's 9th Symphony, James Cook's diary and two Norwegian nominations, the leprosy archives in Bergen and the original manuscript of Ibsen's *A Doll's House*. Today the register includes 69 archives or collections from 33 countries.

The Bergen leprosy archives

The leprosy archives in Bergen are spread among four institutions in the city: The Regional State Archives of Bergen, The City Archives of Bergen, The Medical History Collection in Bergen and the Leprosy Museum. Together they document unique medical history, which includes the scientific breakthrough by Bergen doctors (including Gerhard Armauer Hansen) in microbiology and epidemiology, as well as documenting the widespread history of leprosy in Norway.

Norway was one of the two western European countries with the largest number of leprosy patients. There were, for example, over 3000 patients in 1850, in a country with a population around 1.4 million. The last leprosy wing in a Norwegian health institution was closed as late as the 1970s. The city of Bergen has two major leprosy hospitals preserved, and one of them, St Jørgens, has been a hospital since the Middle Ages.

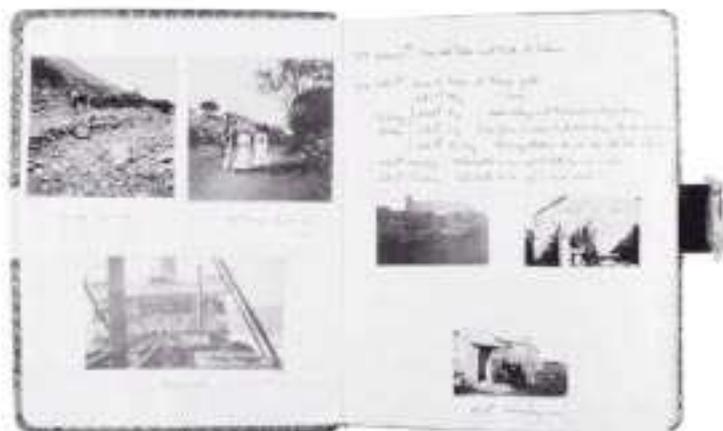
A great deal of information about the leprosy archives in Bergen, including illustrations, catalogues and databases, has been made available on the Internet since the summer of 2001. It is a major website made by the four institutions mentioned as well as the co-operating partner, The Digital Archives in Norway. It is available in English and Norwegian at <http://digitalarkivet.uib.no/lepra>

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Above: Illustrations from the leprosy archives in Bergen.

First impressions: the archives of the London School of Hygiene and Tropical Medicine



Above and overleaf: Pages from the joint diary of Geoffrey Douglas Hale Carpenter, Entomologist, and his wife, Amy Frances Carpenter, from their travels in Uganda.

An archivist can consider herself very fortunate when she is the first professional to work in an institution that has archives that need organizing. The opportunity to uncover hidden treasures and make these accessible to the institution and the research community far outweighs the daunting task of dealing with the dirt, dust and mould that have accumulated on the material over the years. I began this challenge at the start of July 2002 and have, so far, enjoyed every day.

One of my first impressions of the London School was of the interesting and diverse material in its archives. The oldest school of public health and tropical medicine in the world, it was established by Sir Patrick Manson as the London School of Tropical Medicine in 1899 and following the 1921 Athlone Report, which recommended the setting up of an institute of state medicine, became Britain's national school of public health, assuming its current name in 1924. Among its collections are the papers of Sir Ronald Ross, awarded the Nobel Prize for Medicine in 1902 for his proof of the mosquito transmission of malaria; plans and correspondence relating to the design and construction of the School in Keppel Street which was opened by The Prince of Wales in July 1929; the notebooks of Timothy Richards Lewis (1841–1886), Surgeon and Pathologist; correspondence and scripts for the BBC programme *Doctor in the House* and an extensive photograph collection including staff and students, the

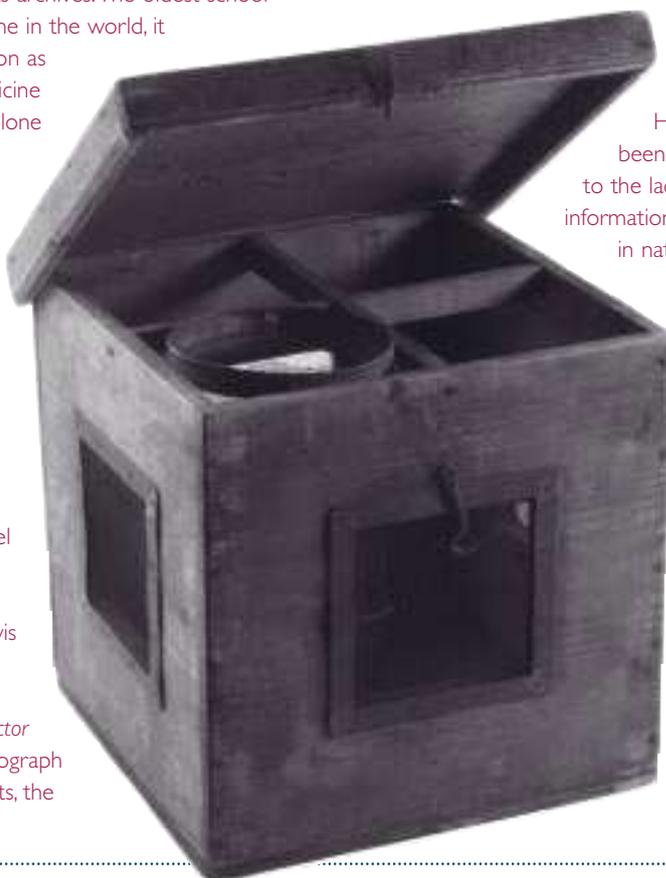
building and people suffering from tropical diseases. One of my favourite discoveries is the joint diary of Geoffrey Douglas Hale Carpenter, Entomologist and his wife, Amy Frances Carpenter, recording their experiences including trips to Uganda for his research on sleeping sickness between 1913 and 1930. As well as diary entries documenting their day-to-day activities, there are photos, pressed flowers, press cuttings, concert programmes and their wedding invitation. Some of the artefacts in the collections include a microscope used by Sir Ronald Ross, the wooden box designed by Louis Westenra Sambon in 1900 for the transport of mosquitoes between Rome and London and a mallet used by Neville Chamberlain to lay the foundation stone of the school in 1923.

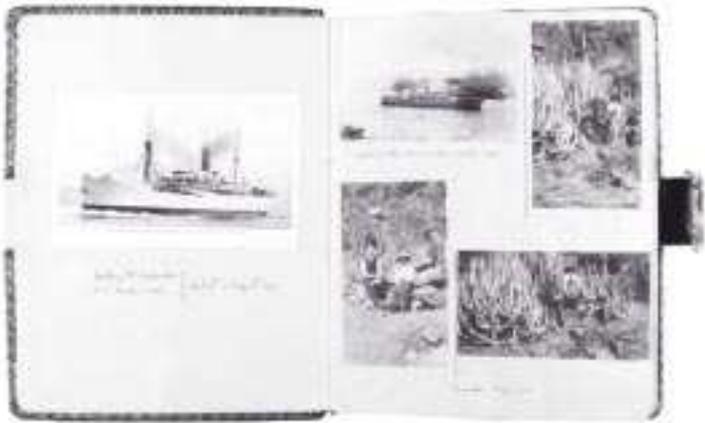
Some of the material has previously been listed on a card catalogue, indexed by name, while the Ross archive was catalogued to item level in 1983 and is stored on microfiche. This is searchable by author, title, form and subject. These systems allow the user to find material if they already know the name of the person they are researching, but becomes problematic for more general searching. For example, a recent researcher found using the Ross catalogue especially time-consuming when looking for material relating to Ross and the anti-malaria campaign in Greece and Cyprus. A number of collections have been described at collection level, according to the General International Standard of Archival Description (2000), and appear on the AIM25 website. AIM25 is a major project to provide electronic access to collection-level

descriptions of the archives of over 50 higher education institutions and learned societies within the Greater London area (<http://www.aim25.ac.uk>).

However, much of the archive material has been inaccessible to the research community due to the lack of an accessible catalogue, the absence of information about the archives of the School included in national finding aids such as the National Register of Archives and the unsuitable facilities available for researchers to study the material. To enhance accessibility, the School has purchased CALM 2000 and hopes to make the archive catalogue available to the research community in spring 2003. A brief list of the contents of the archives is available on the School website as well as information on how to access the archives and a chronology of the School which should answer

Box designed by Louis Westenra Sambon, in which malaria-infected mosquitoes were sent from Rome to London for Sir Patrick Manson's malaria experiment, 1900.





some basic questions that researchers may have on the history of the School (<http://www.lshtm.ac.uk/library>).

As well as sorting, appraising and cataloguing material that the archives already hold, I will be surveying the holdings of the rest of the School to ensure that relevant records transfer to the archives. There is a wealth of information being generated by the individual projects and departments, especially data sets, which need to be recorded and stored for the benefit of the School and future scholars. The successful bid to fund the post of Archivist through the School Initiative Fund was formulated jointly by the Professor of History and the Librarian & Director of Information Services. It is encouraging for an

archivist to work in an organization which values history. I have been invited to be part of the School's History Group and am working with the Professor of History on a number of initiatives to increase access to the archives, including students on the MSc Public Health course using archive material for their work in the History and Health Study Unit.

The opportunity to be the first archivist to work on a collection is one that is new to me but has proved to be an exciting and enjoyable experience. Being the sole archivist in an organization can have its drawbacks but former colleagues can always be asked for their professional opinions and the School is part of the University of London, which has a number of archivists working for the various colleges and schools. Plans for the future are to investigate the possibility of new storage facilities, develop funding proposals to ensure the continued preservation of the archives, consider the establishment of a records management service for the School and create online exhibitions to promote this fascinating collection to the wider world. If you are interested in finding out more about the archives of the London School of Hygiene and Tropical Medicine or have information on material that would contribute to the history of the institution, please contact:

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WEB RESOURCES

Sharon Messenger



Peace and Economics. Each field has its own separate and easily navigable section. The site contains information on all 736 Prize winners to date, the Nobel Organization, Alfred Nobel, and Nobel events, as well as educational material and games. It consists of more than 9000 static documents, several databases and a number of multimedia productions with Nobel Prize connections.

The website is a great resource for the historian of science and medicine as it contains a searchable archive of material back to the inception of the Nobel Prize in 1901. The search function allows both simple and advanced searches and allows you to create lists of laureates. It is an excellent and speedy way to check individual details about Nobel laureates. Information about laureates includes press releases, biographies, Nobel Prize presentation speeches and interviews. The site also contains information about Nobel himself, including a complete transcript of his will. <http://www.nobel.se/>

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The Nobel e-museum is the official website of the Nobel Foundation. Founded in 1995, it is maintained by the Nobel e-Museum Group at the Nobel Foundation in Stockholm. The site contains both detailed and accurate information on Nobel Prize winners in Physics, Chemistry, Physiology or Medicine, Literature,

'Innovation, Assessment and the Hip Prosthesis': an ESRC project at the Manchester Unit

Hip replacement is one of the most successfully performed elective surgical procedures of the 20th century, and the artificial hip is recognized as one of the major benefits of post-war medicine. Currently the NHS undertakes over 40 000 every year, as well as a significant number performed by surgeons in private hospitals. In many ways, the hip replacement waiting list has become a way of measuring the performance of the NHS in the pages of the popular media. From the late Queen Mother through the social order, hip replacement surgery is nowadays seen as an everyday occurrence.

Although the hip replacement is, and has been since the early 1960s, a common type of elective surgery, it has received little attention in the annals of the social history of medicine. To correct this imbalance, since May 2001 a project funded by the Economic and Social Research Council (ESRC) has been working on the history of the artificial hip. The research group, headed by Professor John Pickstone, forms part of the ESRC's Innovative Health Technologies programme. Two Research Associates, Julie Anderson and Francis Neary, were appointed. The project is based at the Centre for History, Science, Technology and Medicine at the University of Manchester; and seeks advice on specialist aspects of the research from David Cantor at NHI Washington and James Raftery at University of Birmingham. Manchester is an ideal base for the research project as nearby Wrightington Hospital in Wigan is extremely important in the history of hip replacement as it is where John Charnley did much of his work on the research and development of the artificial hip. Later Charnley's biographer left his papers, which have been instrumental in the hip prosthesis project, to the University of Manchester.

The three-year research project, formally titled 'Innovation, Assessment and the Hip Prosthesis', aims to increase the historical awareness of the research and development process which contributes to a medical

innovation such as the artificial hip. This is being done through a close examination of work carried out in hospitals and by surgical implant and device manufacturers. The programme of research will conclude with a wide-ranging oral history of those patients who have experienced the surgical procedure. In essence, the research will add to our knowledge of the history of medical technology, and provide a detailed case study of that area.

In the first year of the research programme the investigators were concerned primarily with archival research including the Charnley archive, and the various industry-related holdings of the Thackray Museum in Leeds. Those surgeons who had worked with Charnley at Wrightington, many who have recently retired and also those currently practising, have been interviewed. In the next two years, Julie Anderson will visit the US and Europe to conduct comparative research. She will also begin interviewing patients who have had artificial hips implanted. Francis Neary has since left the project, and has moved to Wrightington Hospital. He is carrying out complementary work establishing a database of hip and knee replacements, and is also working on the establishment of a Joint Replacement Museum which will be opened at Wrightington Hospital in the next two years.

If anyone has any further queries about the research, or if you would like to contribute to the project, please contact Julie Anderson at: julie.anderson@man.ac.uk or call 0161 275 5947.



Above top: Julie Anderson, John Pickstone and Francis Neary examining hip replacements and catalogues.



Above: Photograph of a Charnley prosthesis cup, femoral component and cement restrictor circa 1976 manufactured by Thackray which has since been taken over by DePuy.

NEWS

Sally Bragg

The Wellcome Trust Centre for the History of Medicine at UCL



The Centre regularly attracts scholars from all over the world, working at varying levels on a wide variety of topics. Some of those based at the Centre between September 2002 and March 2003 include: **Adam Bencard** (University of Copenhagen), *Corporeal matters: historiographies of the body*; ***Ms Jo Castle** (independent scholar), *Books of Secrets and the relationship between these and surgeons' writings*; **Dr Genevieve Dumas** (McGill University), *The informal curriculum of medieval doctors*; **Dr Niki Ellis** (Director, Health Risk Management, PricewaterhouseCoopers, Sydney), *An historical analysis of gun control within the public health paradigm*; **Dr John Fisher** (Newcastle University, NSW), *The evolution of slaughter programmes against infectious diseases of livestock*; ***Professor Stanley Gelbier** (Professor of Dental Public Health at King's College, University of London), *The development of specialized dental services for people with disabilities between 1900 and 2000 and how the establishment of specialist societies interacted with such developments*; ***Professor Mitch Glickstein** (Dept of Anatomy, UCL), *The emergence*



of modern neuroscience; ***Dr Jordan Goodman** (UMIST), *Detailing the making of scientific knowledge on the voyage of 'HMS Rattlesnake' between 1846 and 1850*. Jordan is funded by The Royal Society and The British Academy; ***Dr Andrew Hull** (Glasgow University), *Science and specialization before the National Health Service: the academicization of hospital medicine in Glasgow and Liverpool c1900–c1948*. Andrew is a Wellcome Trust Research Fellow, based at Glasgow; ***Ki-Heung** (Science Studies Unit, University of Edinburgh), *A social history of the mad cow*; **Dr Susanne Klausen** (University of Victoria, BC), *The Birth Control International Information Centre and the development of contraceptive services in the British Colonial Empire, 1930–1950*; **Professor Brian Nance** (Coastal Carolina University), *Renaissance medical narratives: practice, patients, and the rise of the Renaissance Observatio*; **Dr Mariko Ogawa** (Mie University, Japan), *Sanitation and water in relation to the cholera epidemics of the 19th century*; **Professor Kim Pelis** (Uniformed Services University, Bethesda), *The physiological conceptions and clinical treatments of shock (1815–1880)*; **Professor Elena Rabinovitch** (St Petersburg Jewish University), *The way death was presented in the works of ancient Greek and Roman writers*; **Professor Tudor Kalinga Silva** (University of Peradeniya, Sri Lanka), *The history of malaria control in colonial Ceylon*, via a British Academy Visiting Professorship. Tudor returns in March to speak at our Symposium on International Health Programmes in S Asia (7 March), and to give a Public Lecture (12 March); **Dr Paula Viterbo** (The George Washington University, Washington, DC), *The teaching of gynaecology in Britain and America during the 20th century*; **Dr Fabiola Zurlini** (The Public Library of Fermo), *The physician Romolo Spezioli (Fermo, 1642–Roma, 1723) and his personal library*.

(NOTE: Those marked * are at the Centre at the time of publication.)

Fellows

Dr Alex McKay (SOAS) was awarded a three-year WT Fellowship to work on *Frontier Encounters: Western biomedicine in Himalayan South Asia, 1900–1950*; **Professor Roger Cooter** has joined us as a Wellcome Professorial Fellow. The Fellowship is for five years and his subject is *war and medicine*; **Dr Louise Gray** has been awarded a three-year WT Fellowship to work on *Reformed medicine? Politics, religion and healthcare provision in 16th- and 17th-century Hesse*; **Dr Rhodri Hayward** has been awarded a three-year WT Fellowship to work on *Psychiatry and General Practice c1925–c1973*.

Students

Ms Leela Sami (India) has been awarded a WT Centre Studentship to work on *Famine, Disease and Women's Health in Madras (1871–1960)*, under Sanjoy Bhattacharya's supervision; **Ms Laurence Totelin** (Belgium) has been awarded a WT Centre PhD Studentship to work on *Hippocratic Recipes*, under Vivian Nutton's supervision; and **Ms Helga Powell** (UK) has been awarded a WT Centre Studentship to work on *Eugenics and the female body in medicine, art and popular culture in Britain, 1895–1940*, under Janet Browne's supervision.

Other new students include **Mr Robert Kirk**, who is conducting research into *the relationship between ethology and laboratory animal practice in 20th century Britain*; **Mr Peter Skelton** is working on *John Tyndall and problems of scientific biography*; **Mr Jonathan Toms** is working on *the history of ideas of citizenship and the mental health charity, MIND*; and **Mr Ben Mayhew**, who is working on *ethology and psychology in the work of John Bowlby*.

Sally Bragg (with apologies to those of our visitors whose plans were not finalized in time for inclusion at the time of writing)

Visitor and Programmes Administrator

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John Pickstone steps down as Director of the Manchester Unit

John Pickstone stood down as Director of the Wellcome Unit at the University of Manchester in August 2002, with Michael Worboys taking over the role. John was the founding Director of the Unit in 1986, having played a leading role in the energetic and persuasive representations that led the Wellcome Trust to grant 'Unit' status to what was then a group of six staff who had just moved from UMIST. The Unit is located within the Centre for the History of Science, Technology and Medicine (CHSTM), a full department within the Faculty of Science and Engineering (www.chstm.man.ac.uk). In 2002–03, the Centre will have nine permanent staff and another eight employed on research grants. While the majority of the Centre's activity is in the history of medicine, staff also work on the history of the physical and biological sciences and the history of technology. The Centre is also the home of the National Archive for the History of Computing.

For the last 16 years John has played a leading role in shaping the direction of the Manchester Unit, which has increasingly focused on

medical sciences and technologies since 1850. That said, Unit staff work on medicine before 1800, medical environmentalism and the biological sciences, and the public understanding of STM, especially through museums. One of the reasons for the successful development of the Unit is that John has worked, and continues to work, across all of these areas and his synthetic approach to the discipline has made for an inclusive research culture. Over the years the Manchester Unit has attracted high-quality staff, many of whom have been moved on to important posts in the history of medicine. Former Manchester staff hold University Awards at Lancaster (Paolo Palladino) and Edinburgh (Steve Sturdy), and Mark Jackson heads the history of medicine group at Exeter. Other alumni include: Mary Fissell (Johns Hopkins), Mark Jenner (York), Keith Vernon (Central Lancashire),



CHSTM staff in 1986.

Back row: Tony Parkinson, Roger Cooter, Colin Dival, John Pickstone. Front row: David Edgerton, Jean Raymond, Joan Mottram, Jonathon Harwood.

David Edgerton (Imperial College, London), and Colin Divall (NRM, York). However, arguably John's most impressive achievement was the way in which he seized the Trust's change of policy on Units in the late 1990s, mobilizing support from across the institution to establish six full-time permanent posts in the history of medicine at the University. This record of growth has few, if any, parallels in the discipline and creates a splendid platform for further developments.

Professor Pickstone is now occupying a Research Chair, concentrating on his personal research, writing, editing and research promotion. He will continue to supervise the ESRC-funded project on artificial hips and work on the development of Manchester Medical Archives. John is editing the Biomedical and Earth Sciences volume for the Cambridge

History of Science series with Peter Bowler and is writing a number of papers on 'medical knowledges'. A significant part of his time will be taken up supervising a major new Trust Programme Grant for a study of the medical history of cancer in Britain since 1945 that begins in 2003.

Michael Worboys is not devoting all of his time to managerial matters. He is maintaining his work on colonial medicine, tuberculosis and germs, although he is starting a Trust-funded project that develops themes provided in his book *Spreading Germs* (CUP 2000). The new study is on bacteriology and laboratory medicine in Britain in the period 1890–1920, based in the first instance around an analysis of three laboratories: the Lister Institute in London, the Public Health Laboratory in Manchester and the Bacteriology Department at Guy's Hospital, London.

CALENDAR OF EVENTS

To add an event to the calendar page, please send details to the Editor (sanjoy.bhattacharya@ucl.ac.uk).

March 2003

- 7 International Health Programmes in South Asia: A reappraisal
Wellcome Trust Centre for the History of Medicine at UCL
Contact: sbhattacharya@ucl.ac.uk
- 12 Public lecture: The Medicalization of Social Problems in Sri Lanka: The British colonial experience (given by Prof. K T Silva)
Wellcome Trust Centre for the History of Medicine at UCL
Contact: sbragg@ucl.ac.uk

April 2003

- 24–26 Body Modification: Changing bodies, changing selves
Macquarie University, Sydney, Australia
Contact: bodmod@scmp.mq.edu.au;
www.ccs.mq.edu.au/bodmod

May 2003

- 16–17 The 'Freudian Century'? The impact of psychoanalysis on intellectual life in Britain
British Psychoanalytical Society, London
Contact: bulletin@compuserve.com

June 2003

- 19–21 Form and Function: The hospital (Third International Network for the History of Hospitals Conference)
McGill University, Montreal, Canada
Contact: waddingtonk@cardiff.ac.uk or aadams4@po-box.mcgill.ca

July 2003

- 11–13 Innovating Medicine: Medical technologies in historical perspective (Society for the Social History of Medicine Summer Conference)
University of Manchester
Contact: julie.anderson@man.ac.uk or
carsten.timmermann@man.ac.uk

September 2003

- 4–7 20th Congress of the British Society for the History of Medicine
Whiteknights Hall, University of Reading
Contact: Dermot@ouvip.com

SUBMISSIONS TO *WELLCOME HISTORY*

The next issue of *Wellcome History* is due out in summer 2003. Please send your contributions to Sanjoy Bhattacharya at the address shown. Preferably, contributions should be pasted into an e-mail and sent to the Editor (sanjoy.bhattacharya@ucl.ac.uk). Alternatively send the Editor a disk with a paper copy of the article. For more detailed instructions, visit the *Wellcome History* web pages at www.wellcome.ac.uk/wellcomehistory.

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