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Birthing a slave child

Black mothers and white doctors

MARIE JENKINS SCHWARTZ

At the age of 13 or 14, Lulu Wilson was told by her Kentucky mistress that she "ought to marry". Arrangements were soon made to pair her with an enslaved man.

The mistress engaged a doctor to attend the bride. He "told me that less'n I had a baby, old as I was and married, I'd start in on spasms," the former slave recalled. "So it twan't long 'til I had a baby." Whether she meant she became sexually active, took measures to aid conception, or abandoned efforts to prevent pregnancy is not clear, but Wilson soon had a son.

These sketchy details of Wilson's childbearing history hint at an important aspect of slavery and medicine largely ignored by scholars: slaveholders expected, with the help of doctors, to appropriate and exploit the reproductive lives of enslaved women. Emboldened by law and custom, owners and their hired physicians felt entitled to intervene in even the most intimate aspects of slave life. Enslaved women's childbearing capacity was a commodity that could be claimed for profit, a means of ensuring the continuation of Southern slaveholding society, and a way of enhancing the professional and financial standing of doctors.

Southern slave owners paid increased attention to the birth of slave children as the USA expanded westward and cotton planting grew in importance. By the 1820s, planters were moving in large numbers to newly opened areas of settlement and growing the fibre for sale in European and New England markets tied to a burgeoning textile industry. The expanding 'cotton kingdom' required new labourers, but the US Congress had ended the nation's participation in the international slave trade as of 1808. Because planters could no longer import additional slaves from Africa or the West Indies, the only practical way of increasing the number of slave labourers was through human reproduction.

The idea that enslaved women would contribute to the economic success of a plantation not only through productive labour but also through procreation was powerful and seductive; it shaped the way women experienced slavery, the way owners thought about the future of Southern society, and the way doctors practised medicine. Bondwomen who did not achieve motherhood because they could not become pregnant or carry an infant to term came to be viewed as a 'problem' in need of correction.

The interest of slaveholders in slave women's ability to bear children was increasing as physicians were beginning to assert professional authority over childbearing. The two began to work together in an effort to increase the number of infants born in the slave quarter. As slaveholders called upon their services, doctors were increasingly drawn into the drama of slavery's perpetuation. Their involvement in the economics of slavery extended to offering opinions as to a woman's fertility at the point of sale and testifying in court cases brought to recoup the selling price of women who proved to be infertile. They attempted to achieve 'normalcy' in menstruating women in the belief that the regularity of monthly periods improved the chance that a woman would conceive.

Doctors also took measures that they hoped would stave off impending miscarriage and prevent or cure complications of childbirth that threatened the health of mother and child. They experimented

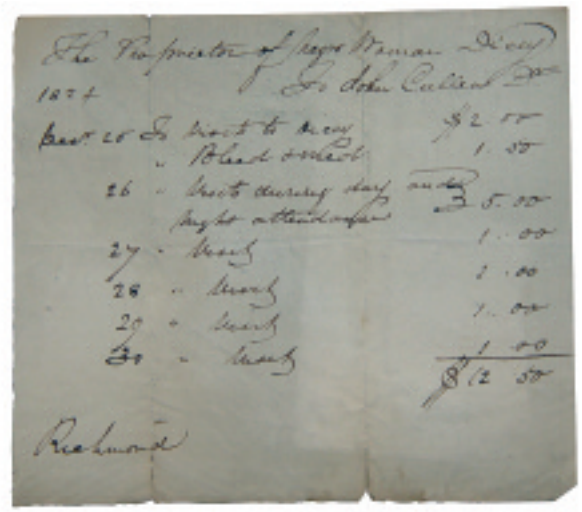
Above: Map showing free states (white), slave states (black) and unsettled territory (tinted).

Cover: 'Slave Mother and Child', © copyright John W Jones, artist and author of book and exhibition, *Confederate Currency: The Color of Money, Images of Slavery in Confederate and Southern States Currency.* www.colorsofmoney.com

with caesarian deliveries, repairs for vaginal tearing associated with prolonged childbirth, and the removal of breast and uterine cancers, for example.

Medicine played a critical role in the American slave system as doctors tried to manage in unprecedented ways the health of enslaved women from puberty through the reproductive years. Unfortunately, reproductive medicine was not so advanced that it assisted many patients. Worse, it sometimes produced horrific results. Southern physicians took an intrusive (termed 'heroic') approach to healing, which involved purging, puking, bleeding, blistering and drugging the patient.

In some instances, cutting occurred, as in the case of one woman called Mary. Many doctors believed that when a woman failed to menstruate, the discharge occurred vicariously through an outlet other than the vagina. When the enslaved Mary ceased having regular periods in early adulthood, J Boring, professor of obstetrics at the Atlanta Medical College, thought he detected menstrual blood oozing from her leg, which he amputated in an attempt to cure the condition. Alas, the procedure did not cure, and the stump reportedly bled each month when Mary's monthly menses should have appeared. Mary's situation was extreme, but she was not the only woman to suffer misguided treatment from doctors who sought remedies for conditions they poorly understood. Yet Southern doctors put themselves forward as scientific caregivers who were uniquely to be trusted with enslaved women's health.



Right:
Bill from Dr John Cullen to "The Proprietor of the Negro Woman Dicey", Richmond, Vrginia, 1824.
Photo courtesy of Alex Peck Medical Antiques

When doctors were called to the slave quarter to treat reproductive problems, they embraced the goal of their slaveholding clients to increase the number of infants born into bondage. They had financial incentives to do so. Not much money could be made in attending obstetric cases (which were frequently time-consuming), but any doctor who successfully treated obstetric complaints in the slave quarter would ingratiate himself with owners and earn a call back to the plantation for other reasons. In a region where the largest number of potential patients was enslaved, Southern doctors could ill afford to ignore slave women. But doctors' collaboration with slaveholders reflected a desire for professional status as well as financial security. Obstetric cases allowed physicians to participate in important medical debates about women's health that were occurring in Europe and in the USA generally. However much free and enslaved women might differ in status, their anatomy did not differ appreciably, which meant that medical procedures developed for one woman might be applied to all. In an era in which free women shied away from inexperienced doctors and untested medical practices, doctors looked to the slave quarter to gain valuable experience with women's bodies and to develop protocols for treating women's diseases. The needs of physicians thus meshed with the interests of slaveholders.

Southern physicians took an intrusive (termed 'heroic') approach to healing, which involved purging, puking, bleeding, blistering and drugging the patient.

Black women, for their part, found themselves struggling with white men in the most basic physical terms for control over fertility and childbearing and over health generally. They were distrustful of both slaveholders and their doctors and preferred their own healing traditions, which emphasised the power of roots and herbs and the critical roles of family and community. They placed faith in the wisdom of other women who administered teas and other preparations, invoked spiritual cures, pleaded for the amelioration of slavery's worst features (such as overwork and physical abuse), and trusted their own knowledge of the body to see them through pregnancy, childbirth and aftercare.

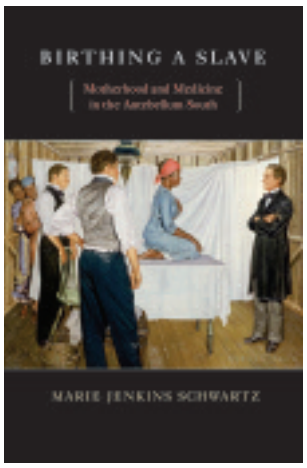
Childbirth in particular was a dangerous time for women. Women wanted attendants who understood their fears and who could give time-honoured advice about how to handle the chain of events leading to and beyond birth. When white doctors attended them, the women confronted men who appeared ignorant of practices important for ensuring the wellbeing of mother and infant and who were focused on identifying a physiological problem (diagnosis) and its therapeutic correction (cure). Only rarely did a doctor consider demanding work regiments and other conditions of slavery as possible sources of women's ailments.

Competing approaches to reproductive health evolved on plantations, as both black women and white men sought to enhance the health of enslaved mothers, although in different ways and for very different reasons. Although power relations in the South gave slaveholders and by extension their hired doctors authority to tend slaves as they wished, women

found ways to exclude them from the child and sick bed. At times, women hid from view medical conditions expressly to avoid the ministrations of a white doctor. A slaveholder might arrange to have a doctor attend a woman in childbirth, for example, but the physician would not know to come unless he was summoned by someone from the quarter. In addition, physicians objected to spending long periods of time in the slave quarter waiting for a birth and carrying out manual tasks associated with attendance at labour and illness. This left opportunities for enslaved healers to manage childbirth and women's diseases as they preferred. Even when doctors were in attendance, women secretly practised sequentially or simultaneously their own forms of healing.

Neither doctors nor slaves were able or willing to bridge the social and cultural gap that separated physician and patient. Each judged his or her own methods to be superior. Doctors claimed scientific sureness based on reason and knowledge acquired through literacy and professional associations. Enslaved women cited their own traditions wherein knowledge was gained through revelation, study of the natural environment and scrutiny of social relationships. Neither doctors nor slave women produced consistently positive outcomes, but both claimed cultural certainty about how women's health should be managed.

Encounters between black mothers and white doctors in the South during the decades leading up to the Civil War marked important new ways in which slavery and medicine were changing. The reach of slavery became more intrusive in the lives of enslaved women.



Simultaneously, medical practice became entwined with the cause of slavery's continuance, childbearing came to be seen increasingly as a medical problem, and doctors grew more conversant with matters of reproductive health as they gained experience in examining and manipulating women's bodies.

Marie Jenkins Schwartz PhD is professor of history at the University of Rhode Island, USA. She thanks the American Historical Association and the American College of Obstetricians and Gynecologists for financial support in completing this research. *Birthing a Slave: Motherhood and medicine in the antebellum South*, published in spring 2006 by Harvard University Press, is the first book to focus exclusively on the healthcare of enslaved women (above).

The local and beyond: the shifting terrains of unani tibb in India, *c*.1890–1930

GUY ATTEWELL

The names 'unani tibb' or 'unani medicine', as this medical tradition is known in South Asia, are at once suggestive of a history of great translocation in time and space.

Tibb has been embraced by peoples over the last thousand years in cultures stretching from the western Mediterranean to South-east Asia. But it is in the Indian subcontinent that tibb took strong roots, from the 14th century through to the present. These trajectories of translocation from West and Central to South Asia and beyond raise the fundamental questions of how to frame the relationship between the various streams of knowledge and practice at specific times and places within a broadly defined tradition of tibb, and how to identify the processes (political, social, economic, technological) that have either motivated or inhibited the elaboration of certain forms of knowledge.

My forthcoming book, *Refiguring Unani Tibb: Plural healing in late colonial India*, which is going to be part of Orient Longman's New Perspectives in South Asian History series, focuses on a particularly significant period in the formation of modernised tibb, although the delimiting dates of the study should only be understood as rough markers of what were clearly ongoing processes. During this period the first distinct unani institutions were formed, new modes of professional organisation initiated, and new means of communicating the concerns of unani physicians and the changing contours of their medical knowledge and practices consolidated and developed.

Tibb is commonly spoken of as a system of medicine – the seamless continuation of Galenic medicine and later West Asian elaborations. The very idea of it being a 'system' of medicine is itself a product of the new kinds of engagement that practitioners pursued in their efforts to demonstrate the cogency and viability of their selective interpretations of their own knowledge base and practice. The conceptual starting-point of my book is not to reify tibb as meaning 'such-and-such a body of knowledge and practice', but rather to examine, in a number of diverse scenarios, the different ways that unani knowledge has been constituted and the social or political conditions in which this has happened. The evolving tibbi profession was engaged in various forms of dialogue: with itself (evident in the articulation of the competing interests of its own practitioners), with healing traditions that adhered more closely to Islamic doctrines, with a variety of other medical practices (folk, private and state, Western and Ayurvedic), and most importantly with the public. The public were its patrons; practitioners of tibb sought to reach out to them, projecting in the process varied perspectives on authentic and legitimate unani knowledge and practice.

My book will show that the boundaries between humoral, moral, religious and biomedical ideas were porous and contested. It will highlight the tensions manifest in different spheres of unani practice as certain practitioners reconfigured their knowledge and practices though the prisms of nationalist and communitarian politics, changing social and moral norms, the expanding use of print, and colonially inspired models of legitimacy. These phenomena presented challenges to the authoritative practice of tibb as a local, family affair. Unani practitioners were forced to take stock of what they thought to be good, authentic and legitimate in order to represent this knowledge to the public on a vastly new scale – both to gain and maintain public trust and custom, and in order to represent the credibility of their practices in new, less personalised administrative, judicial and political domains. The thesis emphasises the importance of the market in the reform of tibb during this time, an area that is especially important in the context of the collapse of courtly patronage for elite unani practice in most parts of India during the 19th century.

The principal themes framed in my book will be: plague and unani reform; legitimacy in relation to institutional and family practice; the emergence of tibb as a 'national' enterprise; new engagements with women and change in the treatment of certain women's diseases; conceptualisations of male sexuality; and the role of the unani journal in the establishment of innovative practices and relationships with the public. Each one of these domains could be amplified as new materials from different regions in India – Bengal is an obvious omission – are researched, and there are, of course, other themes that could have been investigated. Notwithstanding these limitations, the structure of this book reflects the overarching ambition both to draw attention to diversity, complexity and contingency in early 20th-century tibb as well as to be able to point to the threads that link apparently diverse domains of theory and practice.

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New publication

Decentring Empire: Britain, India and the transcolonial world edited by Durba Ghosh and Dane Kennedy.

This volume charts a new direction in the study of British imperialism, its impact on India and other colonial territories, and its influence in propelling the forces of globalisation. Moving beyond the standard model of a bilateral circuit between imperial centre and colonial periphery, it highlights instead the web of transcolonial and transnational networks that spread across and beyond the empire, operating both on its behalf and against its interests. It suggests that these networks worked in effect to decentre empire, shaping the multidimensional contours of the global modernity we contend with today.

Decentring Empire brings together 13 original essays by some of the leading scholars of British imperialism, their contributions offered in honour of Thomas R Metcalf, the distinguished historian of colonial India. The essays range widely in scope, moving in time from the mid-18th to the mid-20th century, in space from India to Ireland, Australia and elsewhere across the imperial map, and in topic from economic, political and social to medical, legal and cultural concerns. Taken together, they demonstrate the analytical richness of current scholarship on British colonialism in India and elsewhere and give fresh insights into its role in the making of the modern world. This is history at the cutting edge, an important contribution to the ongoing debate about empire and its consequences.

Published in: New Perspectives in South Asian History, Orient Longman Private Ltd and Sangam Books UK, 2006 (ISBN OL 81-250-2982-6; Sangam Books 0-86311-871-2).

For purchases in the UK and Europe, contact Anthony de Souza (**E** sangambooksuk@gmail.com); for the rest of the world, contact Orient Longman Private Ltd (**E** info@orientlongman.com).

Disease, labour and habitation: the tea plantations of Darjeeling and Duars, 1860–1960

NANDINI BHATTACHARYA

My research is on health, habitation and settlement in northern Bengal in the 19th and 20th centuries.

The town of Darjeeling was primarily conceived of as a sanatorium for Europeans when it was established in the 19th century, after a survey conducted by the Government of India in 1839. Like most other hill stations in colonial India, it was originally intended as a retreat for Europeans weary of the hot and dusty Indian plains. As the current historiography of the discourses of disease in the tropical world contends, by the third decade of the 19th century, the acclimatisation theories were eclipsed and there were serious doubts about the survival of the Englishman in India over a few generations. The contrast between the disease-ridden, crowded, insanitary plains and the pure and healthy air of the 'hills' thus came to be a familiar trope of official as well as medical discourses in colonial India.

The commercial cultivation of tea in northern Bengal also began at the same time. After several years of research, collection and cultivation of tea plants in large nurseries such as the Botanical Garden at Sibpur near Calcutta (as well as in small experimental gardens in various parts of India), the first commercial tea company began producing tea in Assam in 1840. Within a couple of decades, the cultivation of tea on a commercial scale had extended to the northern Bengal frontier.

In 1856, it took off in Darjeeling. This was facilitated by the fact that the territory was mostly covered by forests and sparsely populated, and the Government gave large grants of land on lease at nominal rates to entrepreneurs. With the success of the tea industry in Darjeeling, tea plantations had been established in the territories at the foothills of the Himalayas. This was the Terai, the dreaded marshy, febrile territory that the English had to cross on their way to the more salubrious climate of Darjeeling. But they had not thought to linger there, much less settle down. By 1874, one of the entrepreneurial planters of Darjeeling had obtained a lease for a tea plantation at the western Duars, beyond the Terai. Duars, too, had a fearsome reputation for unhealthiness. In 1892, 20 years after the first lease granted and tea bushes staked out in the Duars, Arthur Story, a doctor who was employed by a group of tea plantations in the western Duars, wrote to his mother in Britain of his experience of medical practice: "Talk about darkest Africa, darkest Hindoostan is just as bad!"

The extension of tea cultivation, largely though not exclusively a European entrepreneurial activity in northern colonial Bengal, thus poses several intriguing questions. How did the discourses of disease and acclimatisation accommodate European settlement in febrile and unhealthy areas as much as in the 'healthy hill station'?

The production of tea was a labour-intensive industry; extending cultivation to sparsely populated regions involved importing hundreds of thousands of migrant labourers from the eastern Nepal as well as from some districts of Bihar. What were their experiences of disease in a strange land?

The historiography has emphasised that preventative medicine in colonial India was mostly initiated through government policies, and has generally stressed the enclavist nature of Western medicine in colonial India. Were the tea plantations then enclaves where the healthy and productive bodies of the labourers could represent the sites of the triumph of Western medicine (a privilege not accorded, owing to a variety of economic and political contingencies, to most of rural India)?

There were serious doubts about the survival of the Englishman in India over a few generations.

My research will explore these questions. The aim will be to study the practice of medicine within the plantations and examine the notion of the enclave – both the sanatorium/hill station of Darjeeling and the self-enclosed plantation in its various dimensions in colonial India. It will reexamine the question of the enclave in plantation economy, for there is a paradox here: the logic of a plantation is large-scale production for a worldwide market, the very opposite of inward-looking cultivation of the subsistence-level peasant economy. The technology used, the capital invested, and the entrepreneurs and labourers employed were all fluid in such a state; how did the practices and perceptions of preventative and curative medicine have a dialogue with the notion of the enclave? My research will explore some of the tensions in the paradox, and further examine the role of the colonial state and its successor, the newly emergent nation-state, in the policy and practice of medicine in the northern Bengal plantation economy.

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Modern medicine and the Sherpa of Khumbu: exploring the histories of Khunde Hospital 1966–98

SUSAN HEYDON

The celebrated Sherpa of Himalayan mountaineering, who lived in the rugged high-altitude environment of the Everest area of Nepal, lacked Western-style medical services until iconic New Zealander Sir Edmund Hillary, 'hero' of Everest, built them a small hospital in 1966, which he has continued to administer through the Himalayan Trust.

The history of Khunde Hospital, therefore, provides a case study for the introduction of modern medicine, as the Sherpa referred to Western biomedicine, and for the implementation of an overseas aid project. In Sherpa terms, Hillary was cast as a protector or sponsor who would help them succeed; such ideas fitted in well with those of Hillary, who liked to work in partnership with his Sherpa friends, responding to their requests for assistance.

Nepal had few trained medical staff in the 1960s, and the Nepalese Government gave Hillary permission to use medical volunteers from abroad. He began funding the training of a Sherpa doctor for Khunde hospital in the 1970s, but when we went there in the mid-1990s, it still had international volunteers in charge. The Everest area had changed considerably, with the rise of tourism fuelling economic development. Yet, when we left in 1998, after spending over two years at Khunde, our strongest impression was that while the Sherpa used the Hospital, increasingly this was done on Sherpa terms, within a framework of beliefs and practices that had revealed considerable continuity throughout the whole period.

What took place, therefore, when Western medicine met Sherpa beliefs and practices? The response was neither a one-way diffusion of Western medical practice nor a collision between the spirit-suffused system of the Sherpa and scientific biomedicine. People used the Hospital for some things but not others, based on their perception of whether it was the most effective, appropriate option. Over the years, the Hospital and community became used to each other in a relationship that was in practice a coexistence of difference. Each acknowledged and could incorporate aspects of the other's beliefs and practices when dealing with a person's sickness, but remained separate.

In my analysis, I have moved away from a binary, oppositional examination of a cross-cultural encounter and have situated Khunde Hospital in a conceptual device of 'worlds'. I argue that the Hospital existed and operated simultaneously within multiple separate yet interconnected worlds but do not privilege one discourse over another. If this idea is derived from an understanding of an underlying common set of assumptions in a 'world view', my use is broader. My worlds work beyond culture, encompassing institutions, political structures and knowledge communities, and were physical, social and intellectual spaces within which there were rules and norms of behaviour that structured action.

In order to explore the histories of Khunde Hospital, I set it within four distinct but overlapping worlds: those of Hillary, of the Sherpa, of Western medicine and of international aid. These are worlds that I have identified as being important for the questions I am looking at. My central discussion covers the ongoing encounter between Sherpa beliefs and practices about sickness and modern medicine, particularly looking at the individual patient's use and non-use of the Hospital and how staff there responded. Using the conceptual device of worlds, however, suggests the need for this example of the introduction and spread of Western medicine to be grounded in a consideration of Hillary's particular form of aid, the shifting discourse of international medical aid between the 1960s and the 1990s, and the unique world of the Sherpa. All of these worlds influenced the provision of healthcare at and from Khunde Hospital in different ways, sometimes separately but often simultaneously, and at some times and for some issues more than others.

Right:
The Khunde local ambulance.
S Heydon

While Hillary, his associates and the Sherpa were those directly involved in the encounter, other influences also had an impact. The medical world has its own culture, with its specialist practitioners and distinctive ideas about health, disease and treatment. Nepal, however, was not a wealthy developed country. The post-World War II period saw the rise of international medical aid programmes that operated within a framework containing particular

concepts and practices about what was appropriate. Nepal was a target for assistance and biomedicine was the main paradigm.

Hillary, the Sherpa, staff at the Hospital and international aid organisations all had their own views about health services and levels of involvement, and their own expectations about what could or should be done. Sometimes they coincided, such as in the belief about the need to provide services in rural areas. Sometimes they differed. In the 1970s, international medical aid discourse shifted away from a hospital-based model towards primary healthcare and community health services, but the people in rural areas wanted access to curative services rather than health education about prevention.

Providing healthcare at Khunde Hospital, therefore, revolves around many issues; people, location and relationships have often had as much influence as – and sometimes more than – the medicine. If the key to understanding Khunde Hospital is the relationship between the Sherpa and Hillary and the respect that began in a partnership on the mountains in the 1950s, then the multiple worlds of the Hospital reveal the complexities of implementing the Sherpa request to build a hospital in their rugged home near the world's highest mountain.

Susan Heydon was a volunteer at Khunde Hospital between 1996 and 1998, and is set to complete her doctoral thesis at the Department of History, University of Otago, New Zealand (**E** heydon.family@xtra.co.nz).
See also her feature article on Khunde in *Wellcome History* issue 27, page 2.

A phoenix rising: the social history of Baragwanath Hospital, Soweto, 1942–90

SIMONNE HORWITZ

Baragwanath Hospital, located on the outskirts of Soweto, one of South Africa's major black townships, was one of the largest hospitals serving South Africa's African population during the apartheid era.

Its sheer physical size, location and the nature of its patient body created particular problems in managing and delivering healthcare. At the same time, the Hospital also provided specific opportunities for research and clinical career development. It was a place where doctors and nurses could gain unparalleled experience. For many, the Hospital was a unique and special place.

Yet no sustained historical analysis has sought to explain this or to place it within a broader context. Accounts of the history of Baragwanath Hospital, and indeed of hospitals in South Africa more generally, have tended to be popular, personal or centennial records. This body of literature tends not to engage systematically with the broader literature on medical history or on the social history of South Africa. My study of Baragwanath starts to fill this historiographical gap through a detailed analysis of a single institution, using a range of historical sources.

Part of the reason for the paucity of academic studies on Baragwanath Hospital is the lack of easily available official source material. The major records pertaining to its administration were probably kept by the provincial Department of Hospital Services. However, these records were not available. The institutional records of the Hospital are also patchy; space was at a premium, and many administrative and patient records were destroyed. These factors shaped my research to a large extent.

Some official sources cover the establishment of Baragwanath as an Allied military hospital during World War II and its transition to civilian staus. These are located mainly in the South African National Archives and allow for a useful reconstruction of how debates around the establishment and transfer of the Hospital to civilian authorities were deeply intertwined with debates about urban African healthcare in an increasingly segregated South Africa.

The main source of documentation on the Hospital is in its Public Relations Department. The documents that make up this archive reveal what the Hospital's PR team and administration prioritised. Records at the University of the Witwatersrand (for which Baragwanath served as a teaching hospital) offered valuable sources not only on the University's interactions with the Hospital but also on conditions in the Hospital more generally. Other valuable sources of primary material were the private papers of a number of the doctors and departments. These official and non-official documents proved invaluable in reconstructing the history of the Hospital.

A significant portion of this thesis is based on oral interviews with doctors and nurses conducted both in the UK and during extended fieldwork at Baragwanath between 2003 and 2005. Interviews were in-depth semi-structured life histories that aimed to capture a range of qualitatively different perspectives.

The large number of interviews allowed me to develop a nuanced account of the way these two professional groups saw their role within the Hospital setting and how they shaped its ethos.

These sources led to a multilayered study of the place of Baragwanath in the healthcare system of Soweto and the way in which broader political, social and economic factors played out in shaping the Hospital and its services. My thesis argues that one of the central contradictions in the history of Baragwanath Hospital also illustrates one of the central themes in apartheid healthcare more generally. This is that while the system was clearly based on asymmetrical healthcare provision in which black hospitals were vastly under-resourced, those black hospitals that were teaching hospitals and that were used by the Government as showpieces of its apartheid policy did have centres of clinical excellence. Thus cutting-edge treatment, supported by internationally recognised research, existed at a hospital that was characterised by underfunding, overcrowding and in many cases the lack of basic care.

My study illustrates the factors that allowed this rapidly growing, underfunded, but surprisingly effective institution to find a niche that allowed it to exist, function and at times even flourish within the apartheid state. By doing so, I highlight new ways of looking at the history of medicine in South Africa and make a contribution to broader medical historiography by locating the Hospital in its social context.

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Conrad Gesner's correspondence: epistolary practices and medical knowledge in 16th-century Europe

CANDICE DELISLE

In the 16th century, letters came to occupy an important place in learned and lay European culture. New postal systems, traders and students carried letters throughout Europe; collections of letters from famous authors and manuals of correspondence, giving standard models of letters for any circumstance of life and business, met with a huge success and underwent innumerable reprints.

Right: Conrad Gesner by Tobias Shimmer. Published in *Libra*, 1952–53.

Medicine and natural history were not immune to this fashion. Letters circulated among physicians and naturalists, discussing ideas and experiments on new remedies, commenting on the latest publications and exchanging plants or pieces of animals. Patients wrote to their doctor full accounts of their sufferings, asking for epistolary advice. Learned physicians and the institutions employing them – courts or towns – negotiated the price of medical services, redefined the realm of each one's authority, or asked for patronage in exchange for a dedication in a book. Over the 16th century, a new medical genre, the 'medical letters', came into fashion; letters of 'great physicians' were collected and regarded as objects of knowledge.

At every stage of the process of creating knowledge, from the gathering of information and news to the formalisation of this knowledge in books, letters thus played a major, although up to now relatively unexplored, role. My research seeks to understand this role, and the reasons of the success of the epistolary form in early modern science and medicine.

Perhaps the main reason for this success was the fact that letters made it possible for early modern scholars to address the tensions they experienced in their practical and theoretical understanding of knowledge. Indeed, scholars interested in medicine or in natural history were confronted both with an important expansion of their world and with an increased need for local anchorage. The discovery of the New World, the rediscovery of ancient texts, the new travelling facilities and the advent of printing made suddenly

available an enormous amount of information. However, while earlier humanists had removed themselves from scholastic universities, scholars of the second half of the 16th century were deeply involved in their own local contexts through their positions as town or court physicians, or their teaching appointments at universities or high schools.

Conrad Gesner (1516–1565) is an excellent example of these tensions. A town physician in Zurich, he also taught at the local high school. These local roots were his main means of survival, but they kept him tied to the city. It was, however, crucial for him to break these local boundaries. Indeed, his many publications – such as a huge *Bibliotheca Universalis*, listing about 1800 authors and their books, and a four-volume *History of Animals* – and his last project, a history of plants for which he left more than 200 paintings, required access to plants and animals from all over the world. Faced with the realisation that any man's knowledge was localised, and with an ideal of universal knowledge, Gesner turned to scholars in other cities, equally anchored in their own local contexts and institutions.

Correspondence was thus an ideal medium for the exchange of natural samples and material for books. Indeed, it was supposed to be a substitute for face-to-face meeting with friends. This conversation had to keep going, while the debt of gratitude induced by the gift of a plant, a book or a remedy had to be repaid by a similar gift.

This scholarly obligation of sending something within a letter, however, was not always easy to fulfil: availability of books, animals and plants varied according to the season or the books fairs. Inserting news from their everyday lives in letters thus represented, for Gesner and his correspondents, a way to exchange something despite the scarcity of material objects. An outbreak of an epidemic, identification of a plant or a recent experiment made on a rare case, thus provided the correspondent with the expected food for thought.

However, these pieces of information had to be useful for others: sharing experience meant that Gesner and his correspondents had to transform their news into credible narratives. By insisting on the virtue of their witnesses, as well as by transforming their local news into general case narratives – in short by transforming their information into 'matters of facts' upon which they could agree – they fulfilled their scholarly obligation of giving something to think about to their conversation, thus ensuring the continuance of the exchange.

This stress put upon the exchange of 'matters of facts' profoundly changed the status of medical knowledge and natural history. Instead of being based on an endless research of primary causes, they became fields in which scholars were trying to explain how things worked, and how things were. Letters provided scholars with a common ground of discussion, one in which they could share not only gifts and patronage relationships, but also a collective understanding of the nature and practices of natural history or medicine.

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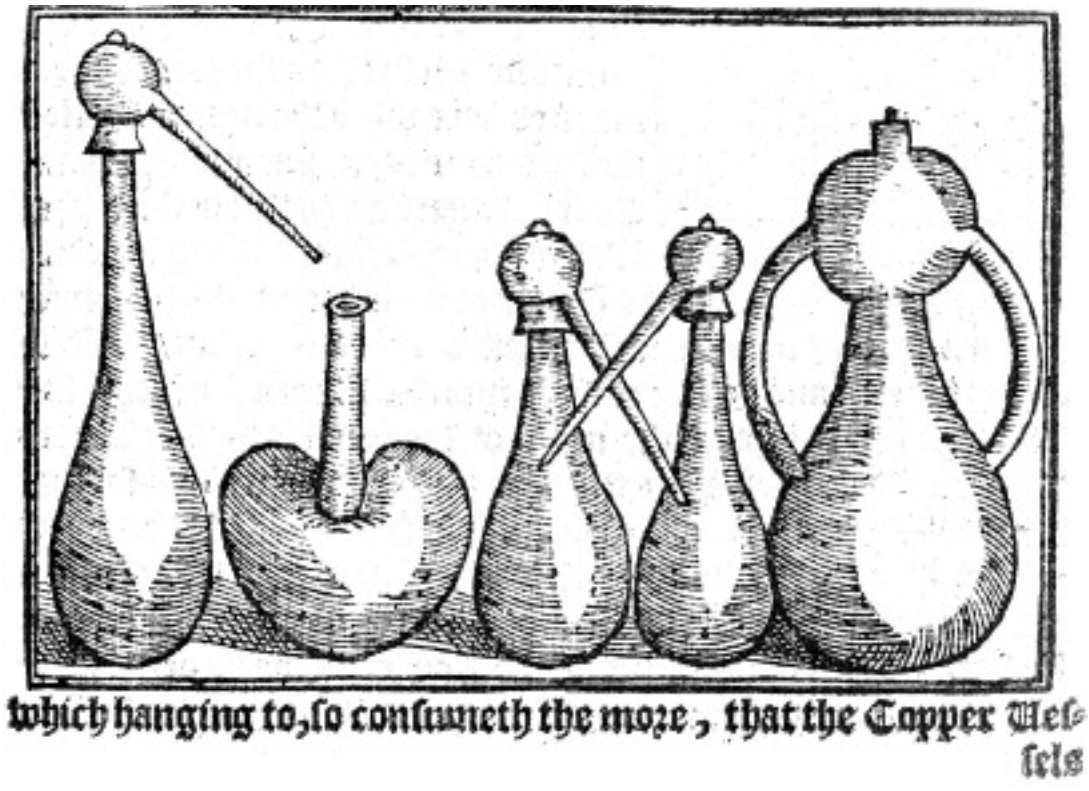

Right: Distillation apparatus, from Conrad Gesner's *The newe jewell of health*, 1576.

Everyday nature: knowledge of the natural world in colonial New York

SARA STIDSTONE GRONIM

In the 17th and into the 18th century, in the colony first called New Netherland and then New York, settlers lived in a common natural world. Their beliefs and practices were rooted in those found among Europeans of similarly modest social and economic standing.

Then in the 18th century, a host of innovations began to circulate in the Atlantic world, such as new crops, inoculation for smallpox, formal botanical studies, dramatic electrical demonstrations and assertions about everything from the physiology of the human body to the paths of comets. All of these came to New York, borne by both print and people. Some of these innovations were adopted readily, some were regarded with indifference and some roused vehement resistance. What accounts for the unevenness with which new knowledge was accepted?

The first part of my forthcoming book, *Everyday Nature: Knowledge of the natural world in colonial New York*, describes the beliefs about and practices in the natural world from *c*.1650 to *c*.1720. The people who settled first New Netherland and then New York brought with them a host of technologies – agricultural techniques and domesticated animals, mills and boats, contracts and maps – that translated relatively easily from the temperate climates from which they came to the environments in which they arrived. They did make some adaptations to local conditions, learning a modest amount from Indians who lived in and near the colony.

But these colonists had little interest in what Indians knew, for they had brought with them understandings of the natural world common among the literate but not learned of north-western Europe. They understood the cosmos as centred on Earth, with all heavenly bodies circling around it. As the moon moved against the background of the zodiac, and as the planets moved in and out of relationships with each other, they affected the flow of fluids within plants and animals, human and nonhuman. Health was the balance of humours in the body; healing, like agriculture and craftwork, was household work. Anomalies such as comets and outbreaks of epidemics were explained as instances of God's providence, in North America as in Europe. These settlers did not need to account for much that was locally idiosyncratic because they knew how the natural world worked, and believed that what they knew applied everywhere.

In the second part of *Everyday Nature*, I describe how practices and understandings that we now associate with the scientific revolution came to New York. But in the 18th century, science was not institutionalised in the ways with which we are now familiar. Rather, practices such as agricultural innovations, inventions and smallpox inoculation were hailed as part of general improvement. The practices of refinement, genteel comportment that signaled membership in the 'better sort', included such things as botanical classification, electrical demonstrations that showed mastery over previously terrifying phenomena, and the gentlemanly erudition of men with formal medical degrees. Reason was redefined, with anomalies such as witches pushed firmly outside its bounds and new practices in astronomy and natural philosophy affirming its reach. And new practices of cartography and explanations for human difference redefined landscapes both natural and human.

While New Yorkers by the 1770s had become familiar with all these innovations, they did not necessarily accept them or alter their practices and understandings accordingly. People in New York shared an orientation to the everyday and to the solidity of their own material experience. The economy of learning was such that the literate but not learned conceded very little authority to the erudite or the socially elevated. Moreover, New York was a particularly contentious colony, with multiple fractures caused by ethnic differences, religious disputes, political rivalries and economic competition. New Yorkers were particularly ready to see assertions of selfless devotion to truth as simply rhetoric that disguised self-interest.

For people in the early modern world, innovations in ideas about or practices in the natural world had implications beyond the practical. The natural world was simultaneously a realm of God, a model for human society, a theatre for the demonstration of social allegiances and a site for the exercise of political power. In colonial New York, as elsewhere, shifts in one realm threatened shifts in others. In watching New Yorkers grapple with new assertions that threatened to overturn their everyday knowledge, we can see how complicated, variegated and incomplete the transition to modernity was.

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Sports medicine: a tale of two halves

VANESSA HEGGIE AND NEIL CARTER

The aim of this project is to investigate the development, organisation and practice of sports medicine in the UK. This is a challenging area for medical researchers and practitioners.

Consisting of both preventative and restorative parts, sports medicine also raises questions of 'improvement' – performance enhancement. While drug taking and doping may appear to be obvious problems, sports medicine raises a multitude of ethical questions, requiring definitions of normal/abnormal bodies and maintaining equity in competition between individuals, nations, even races. Sports medicine may even challenge core notions of doctors' duties, requiring practitioners to prioritise short-term returns over long-term health outcomes.

A history of sports medicine is therefore illuminating not only in the history of medicine, where it follows changing attitudes and definitions of 'fitness' and 'health', but also adds richness to key themes in the history of sport, including commercialisation and the amateurism/voluntarism paradigm. Furthermore, since sports medicine has only recently (February 2005) been recognised as a speciality in the UK, it is also a useful 'case study' in speciality formation.

Despite these attractions, it is a significantly under-researched topic, generally approached through histories of gender, public health and school-based physical education. In 2004, the Wellcome Trust awarded a three-year project grant to the University of Manchester's Centre for the History of Science, Technology and Medicine and De Montfort University's International Centre for Sports History and Culture, to enable a historian of medicine and a historian of sport to examine the history of sports medicine in the Britain.

Writing about sports medicine in the first half of the 20th century has proved challenging, as most relevant British organisations were not formed until more recently: the British Association of Sport and Medicine (BASM) in 1953, the British Olympic Association's Medical Advisory Committee in 1959 and the Institute of Sports Medicine in 1965.

Yet the early decades of the century contained many medical practitioners and scientists who were interested in the bodies of sportsmen and athletes. Debates raged in the medical journals about the alleged pathology of 'athlete's heart'; Nobel Prize-winning physiologist A V Hill (1886–1977) concentrated on the muscular physiology and the biomechanics of athletic activity; Olympic athletes were screened and assessed, for both their own benefit and that of future researchers. In addition, the literate athlete or trainer had access to a plethora of articles and books on first aid, training regimes and dietaries.

The medical specialities that were later to contribute to sports medicine, notably physiology, physiotherapy, rehabilitation and orthopaedics, all gained increasing priority over the course of two world wars. In addition, the atmosphere of international tension post-1945, and the increasing frequency, diversity and significance of international sporting events, led to a sharper sense of competition within as well as between nations. Sports medicine was engaged not only to increase performance, but also to address issues of 'fairness'. It is significant that the International Olympic Committee's Medical Committee concentrated on doping, gender testing and the so-called 'altitude problem' until well into the 1970s. These were all issues that centred on questions of normality, and equity between individuals and nations.

It was therefore not until the 1970s that sports medicine took on the more formalised structure that we are familiar with today, with medical committees forming part of many national sporting organisations, and specialised 'sections' within medical organisations, including the many sports injuries clinics.

Sports medicine may even challenge core notions of doctors' duties, requiring practitioners to prioritise short-term returns over long-term health outcomes.

Our work is taking three sports as case studies: football, athletics and boxing. Each provides insights into the relationship between sport and medicine and into the wider social context. Moreover, they illustrate how sports medicine has been applied on a practical level.

Football, as the national sport, shows the impact of commercialisation on sports medicine. The game has had a long tradition of caring for the wellbeing of its players, and has moved from the trainer with the most basic first-aid skills to a full cohort of medical practitioners. The role of the practitioner has become increasingly important, given the demands on professional footballers and their rising market value. In addition, football was largely a working man's sport during the 20th century, and this has highlighted issues of social class in terms of the medical provision to athletes.

Conversely, track and field athletics was a predominantly amateur area for most of the 20th century. It was run by middle-class, gentleman-amateurs who resisted professionalism and were initially against coaching. Yet in many ways athletics was in the vanguard of developments in sports medicine: the two founder members of BASM, Sir Adolphe Abrahams and Sir Arthur Porritt, were not only doctors but also former track athletes.

Boxing perhaps has the closest relationship with medicine, but instead of medical support the main issue is control. The British Medical Association has campaigned for a number of years to abolish boxing on the grounds that injuries are a specific aim of the sport. This has given rise to high-profile incidents of medical intervention and the first agreement in British sport (1948) medically governing the fitness of an athlete to compete.

With just under two years completed, the sports medicine project will draw out the overarching 'story' and the changes and discontinuities in the history, discussing the major organisations and individuals involved, and examining the themes, practices, and shifting definitions of sports medicine.

Dr Vanessa Heggie is based at the Centre for the History of Science, Technology and Medicine, University of Manchester; Dr Neil Carter is at the International Centre for Sports History and Culture, De Montfort University.

Working with dust: health, dust and diseases in the history of occupational health

DEBBIE PALMER

This conference, held in April 2006 at the University of Exeter, attracted delegates from the USA, South Africa and Australia as well as the UK. Papers were organised thematically, with the focus of the first session on textiles and anthrax.

Tim Carter (University of Birmingham) explored attitudes to wool dust and its risk in the carpet-manufacturing town of Kidderminster between 1902 and 1909. Wool sorters and spinners, who lacked trade union organisation, remained either unaware or in denial of the dangers of anthrax. Farmers, at risk from 'shoddy' (wool industry waste) sold as fertiliser, formed a more articulate lobby. Mill owners often minimised risks, blaming workers' lack of cleanliness. Although it was recognised that disease was spread from spores highly concentrated in dust derived from the blood of infected sheep, dialogue continued about whether dust control or disinfection of high-risk imported wool was better.

In contrast, Rosemary Wall (Imperial College London) suggested that wool sorters in Bradford had a good understanding of bacteriology, gained from articles in the press, and were confident to apportion blame and responsibility – including striking for the introduction of safety precautions to prevent transmission of disease.

Janet Greenlees (University of Manchester and Glasgow Caledonian University) compared the mixed role the implementation of technology has played in the British and American cotton industry. Even though alternative technologies were available in both countries, a consensus of opinion in the USA not only connected the workplace with public health concerns about tuberculosis (and banned the practice of shuttle kissing much earlier than Britain) but also accepted scientific advice that steaming was unnecessary. American employers, willing to invest in more cost-efficient technology, unintentionally reduced deafness, whereas British employees failed to invest in new, quieter machinery.

Right: Coal dust pigment in a miner's hand.

Pamela Dale (Exeter) compared the different responses to hazards associated with shuttle kissing with that of the problem of mule spinners' cancer. Although early debates about mule spinners' epithelioma sought to attribute some blame for the problem to workers' lifestyles and clothes, the idea that oil, used to lubricate the mule, was carcinogenic received consensus among key actors by 1924. The response to shuttle kissing was much slower: debates among Medical Officers of Health frequently included discussion of workers' negligent behaviour and designs to remove women from the workplace rather than efforts to ensure best protection.

The second session opened with Jo Melling's (Exeter) discussion of how knowledge about silicosis was formed and diffused in Britain in the early part of the

20th century. Consensus that silica dust represented a threat to the workforce did not occur until after 1919. Such late recognition may be explained by limited use of the new technology of radiography and training of radiologists, the use of which depended on the political, professional and institution setting that had developed in regard to industrial health and injury compensation since the 1890s.

J C A Davies (University of Witwatersrand, Johannesburg) then introduced an international perspective, looking at silicosis and tuberculosis among South African miners in the 20th century. He suggested that a combination of silica dust, TB and HIV infection means that South Africa and the countries from which migrant labour has been drawn now face a massive public health problem. A series of studies and investigations identified the high incidence of TB among mine labourers but very little was done to tackle the problem.

Criena Fitzgerald (University of Western Australia) argued that despite the 1905 Royal Commission identification of TB as the main cause of ill-health among Western Australian gold miners, a lack of medical consensus delayed effective treatment. The establishment of a Mine Workers' Relief Fund in 1915 acted as a catalyst for change: as the Fund collapsed under the weight of claims, the Government introduced the Miner's Phthisis Act (1922), enforcing compulsory annual medical examination and the withdrawal of men with TB from underground. However, the size of the state and the cost of X-rays limited the Act's effectiveness.

Alfredo Menéndez-Navarro (University of Granada) identified the provision of preventative measures and healthcare facilities to treat silicosis in early 1930s Spain, as part of republican governments' strategy to eradicate labour tensions and assimilate the working class. Coal mining expanded rapidly between 1935 and 1958, but few miners received compensation owing to tight eligibility criteria and conflict concerning knowledge of silicosis. Employers' complaints about the economic burden of insurance forced the Government to take a more active role, although regular silica dust control measurements were not introduced until 1960.

Gerald Markowitz (City University of New York) discussed the long history of contention between industry and plaintiffs over the problem of silicosis. The argument that the issue of silicosis, a disease of the past, has been drummed up by 'shyster' lawyers has been given credence by a flood of lawsuits in Texas in which doctors who initially misdiagnosed large numbers of cases, perhaps motivated by fees given for positive findings, subsequently retracted their diagnoses. Industry continues to downplay, control and minimise the threat posed by the disease.

Andrew Perchard (University of the Highlands and Islands Millennium Institute) argued that attempts to tackle dust levels in Scottish pits, and their long-deleterious effect on the health of coal miners, were in part retarded by the shortcomings of mining education provision, which was offered to mining professionals and supervisory officials. Scottish coal owners were able to limit knowledge and understanding of occupational lung diseases through a tight control of mining education and research outputs.

Ronnie Johnston (Glasgow Caledonian) analysed the extent to which the National Coal Board, formed in 1947, adopted a different strategy towards the health of its employees from that of private enterprise. The Board's initial policy reflected a determination to neutralise the dust problem in the pits, marking an advance on the attitudes of private coal owners. However, economic imperatives in the difficult market environment from the mid-1950s made the balance between production and health difficult to achieve, with many attempts to reduce dust amounting to little more than tokenism. It was not until the mid-1970s that more statutory controls ended the prioritisation of production over workers' health.

Amarjit Kaur (University of New England, Australia) examined the health of migrant Chinese tin mine workers and southern Indian rubber plantation workers in British-governed Malaya in the 20th century. Colonial preconceptions and racial stereotyping meant that public health services were premised on the belief that these groups were ignorant and had unsanitary practices. Government devolved much of its legislative responsibility for health and sanitation to European and Asian planting interests.

Mark Jackson (Exeter) explored the transformation of the domestic environment from 19th-century sanctuary to 20th-century hazard within the context of shifting patterns of allergic diseases. As part of the post-war drive to return women to the home, many women were exposed to the new wave of consumer goods and products, presenting new risks to health. This trend can be linked to changing ideas on asthma: a model of causation that moved from a psychological condition to an environmental approach.

Christopher Sellers (Exeter) brought the event to a conclusion with a broad overview of 'New Frontiers in the History of Work and the Environment'. He extended analyses from the state of industry in the USA to the relationship between hazards in developed and developing countries. He contrasted the historical view of occupational health progress with historiography from the 1980s to the present day, which emphasises uneven economic development and narratives framed around what is internationally distinctive. An interesting round-table discussion followed, picking up themes raised by all papers. A follow-up meeting, organised by Chris Sellars and Jo Melling, will be held in the USA in 2007; interested parties may get in touch with Jo at j.l.melling@ex.ac.uk.

Debbie Palmer is a doctoral student at the Centre for Medical History at the University of Exeter.

Maternal health in the 20th century: international perspectives

ORNELLA MOSCUCCI

The emergence of an international maternal and infant welfare movement in the early 20th century provides a rich field for historians. Scholars have highlighted the great diversity in the timing of campaigns and in the approaches used by individuals, institutions and governments. High maternal and infant mortality stimulated local and national involvement, but motives and strategies differed widely from country to country, reflecting different political, cultural and economic factors.

The purpose of the afternoon workshop held at the London School of Hygiene and Tropical Medicine (LSHTM) on 10 May 2006 was to explore this diversity using examples from Britain, Scandinavia, New Zealand and the international maternal health arena. Organised by the Centre for History in Public Health, the workshop featured contributions from historians and public health experts working in the maternal health field. Four short presentations were followed by a discussion chaired by Dominique Béhague, a member of the Maternal Health Programme based in the LSHTM Infectious Diseases Epidemiology Unit.

The afternoon began with Ornella Moscucci (LSHTM) presenting a study that highlighted women's role in the construction of initiatives aimed at improving maternal health through the concern with cervical cancer. In the early 1900s, this was framed as a disease typically affecting poor, older women, many of whom were mothers of large families. Widely associated with obstetric injury and multiparity, it became an issue of special interest to feminist surgeons and gynaecologists after World War I in the context of anxieties about maternal mortality and morbidity. Women's contribution to the development of radiotherapy was examined in the light of professional struggles over the relative merits of surgery and radiotherapy. The establishment of a clinic for the purpose of investigating the radium treatment of cervical cancer, and its evolution into a hospital, the Marie Curie, were seen to have played a key role in establishing radiotherapy as an alternative to surgery in cancer of the cervix. Close analysis of this initiative revealed that medical women's interest in radiotherapy was prompted not only by long-standing traditions of service to other women, but also by the lure of new career opportunities in a rapidly developing speciality.

The need for a reappraisal of the role played by women's organisations in the maternal health field was the theme elaborated by Linda Bryder (University of Auckland). Her paper challenged two assumptions that have dominated the historiography of childbirth since the late 1970s. The first is the tendency to portray this history as the gradual domination of obstetrics by male doctors in a hospital setting, using ever-advancing technology. The second is the belief that only in the post-war period did women become more outspoken, voicing their demands through lay consumer groups. Focusing on New Zealand, the paper argued first that women themselves drove the movement towards hospitalised births with pain relief, allying themselves to modern obstetric science. Secondly, the move to 'natural childbirth' in the 1950s was driven as much by male obstetricians who wished to safeguard the newborn baby as by women who wished to experience the moment of birth. A complex picture thus emerged, in which the formation of alliances between providers and consumers of obstetric care was seen to have been critical to the development of services and practices in the sphere of maternity.

Right: Tanzanian midwife checking for fetal heartbeat.
N Durrell McKenna

Signild Vallgårda's (University of Copenhagen) presentation shifted the focus onto the function health promotion has played in the maternity field as a vehicle for the exercise of state power. Inspired by the work of Michel Foucault, she examined the governing programmes and practices through which transformations in mothers' behaviour and identity have been sought. Governing technologies have relied on distinctive vocabularies and procedures for the production of truth, used specific ways of acting and intervening, and deployed characteristic ways of forming persons and agents. During the 1930s, for example, the introduction of health examinations of women and children in Denmark and Sweden served to define standards of normal development for pregnant women and children, shaping women's health expectations and identifying groups in need of special state intervention. Health promotion material sought to change behaviour not only by means of prescriptive advice, but also by appealing to mothers'

autonomy, aspirations and sense of responsibility. These messages are still very much in evidence in contemporary Denmark and Sweden, although the governing ambitions have widened in the latter part of the 20th century to include the management of the family and of its social network.

The final session of the workshop drew on a project currently being developed within the ambit of the Maternal Health Programme at LSHTM. Katerini Storeng, Dominique Béhague and Oona Campbell's (LSHTM) paper examined the way in which history has been mobilised by players in the international maternal health arena since 1990. The study focused on two main domains in which certain 'lessons from history' are frequently cited: the contemporary use of historical analyses (e.g. of maternal mortality declines in 19th-century Sweden and other European countries) as a means of justifying the need for skilled midwives and medical interventions in childbirth; and the portrayal of the history of Safe Motherhood programmes commonly put forth by maternal health advocates themselves, which is often imbued with a sense of failure and struggle for identity and legitimacy. Players in the maternity field have drawn from the work of historians such as Irvine Loudon and Edward Shorter in order to legitimate an emphasis on the technical aspects of maternity care. What has not been widely appreciated is that the strategies that have worked for the West may not be appropriate to developing countries.

The workshop, which was well attended, stimulated a lively discussion of the uses of history in the maternal health field. Presenters and participants said they had found the workshop stimulating and useful for their own research.

Dr Ornella Moscucci is attached to the London School of Hygiene and Tropical Medicine.

Health and disease in Asia

GREGORY CLANCEY

In April 2006, the Wellcome Trust Centre for the History of Medicine at UCL and the Department of History at the National University of Singapore co-sponsored a one-day conference entitled 'Health and Disease in Asia: Historical perspectives and global linkages'. This was the first such event to bring together scholars working in the fields of the history and sociology of health and medicine from the UK and Singapore.

Three historians from the Wellcome Trust Centre and four historians and social scientists from NUS delivered short papers on current research, followed by questions from an academic audience. The venue was the Asia Research Centre at the NUS Kent Ridge campus, and the workshop was opened by Associate Professor Ian Gordon, Head of the Department of History.

The history of medicine is still a nascent field at NUS, though the sociology of medicine here is comparatively well developed. I am a historian of science and technology by training, but am currently doing some of my research in the history of health and medicine in Singapore and am supervising two PhD dissertations in this field. The Department has sent one graduate student to the Needham Institute at Cambridge (Fang Xiaoping), and Liew Kai Khiun, now at the Wellcome Trust Centre, is one of our former students. We were especially pleased to have him back for this workshop.

Sanjoy Bhattacharya (Wellcome Trust Centre) discussed his archival research among World Health Organization-related documents in India, and how it altered the story of the WHO's famous smallpox eradication campaign. Liew Kai Khiun described his research into how the global influenza epidemic of 1918 affected the British colonies of Malaya and the Straits Settlements (including Singapore). Andrew Wear (Wellcome Trust Centre) spoke about his current book project, which is based upon the extensive reading of 'settler literature' produced for Englishmen intent on emigrating to the colonies.

Mercedes Planta (NUS) delivered an illustrated presentation on a portion of her dissertation, still in progress, on the American public health regime in the late colonial Philippines. Rachel Safman (NUS) gave a provocative talk on the difficulties of coordinating efforts against avian flu across political borders. Chee Heng Leng (NUS) discussed the transition from a state-managed healthcare system to a semi-privatised one promoting 'health tourism' in Malaysia. Gregory Clancey (NUS) presented some preliminary research on Singapore's famous 'Public Health Campaigns' of the 1960s and early 1970s, and their political dynamics.

Although our topics initially seemed diverse in space, time and methodology, there was a surprising synergy among participants, and provocative exchanges in the question-and-answer sessions. The audience

varied in size throughout the day but all of the talks were well attended.Afterwards, the participants were treated to dinner at a local Indonesian restaurant hosted by the Dean of the Faculty of Arts and Social Sciences, Dr Tan Tai Yong. It was agreed that this workshop should be repeated at the venue of the Wellcome Trust in London, and that mutual workshops could form the cornerstone of a lasting relationship between our two institutions.

On a personal note I'd like to thank Sanjoy Bhattacharya for making this workshop possible through his interest, energy and commitment to the project. We were impressed by all three papers from the Wellcome Trust Centre participants, and were also grateful for their presentation to the Department describing the Centre and the opportunities there for graduate and postgraduate studies.

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The Fair Mile Hospital archive

KATE TYTE


THEATRE ROYAL,
BERKS COUNTY ASYLUM,
THE AREA BELLE,
BOX AND COX,

Berkshire Record Office in Reading houses a number of archive collections related to medical history, such as the records of several hospitals within the county and the Reading Dispensary.

Following the award of a grant under the Wellcome Trust's Research Resources in Medical History scheme in 2005, work has now been completed on a six-month project to comprehensively catalogue and conserve the 1870–1980 records of Berkshire's mental hospital, the Fair Mile Hospital, Cholsey, and to unlock the archive as a valuable resource for medical and local historians. The project involved cataloguing the records, writing a contextual introduction and carrying out extensive preservation and conservation work to save volumes that had been badly damaged by damp. The project has also enabled us to promote the collection to potential researchers through the creation of an online gallery containing images taken from the collection, and a brief history of the hospital.

Fair Mile Hospital opened in September 1870 and was the only hospital of its type in the county until it closed in 2003. The surviving records provide a picture of a typical county mental hospital, functioning as a large and almost self-sufficient community. Like other such institutions, Fair Mile initially treated its patients through the 'moral method', with plenty of food, exercise, entertainments and work on the farms and gardens, or in the kitchens and laundry. In 1948, the Hospital was incorporated into the NHS and became part of the Berkshire Mental Hospitals Group, which included a number of smaller units, children's homes and institutions for the 'mentally defective'. From this time onwards, Fair Mile began to use new methods of medical and non-medical treatment, including electro-convulsive therapy and psychological therapies.

Above: Poster for theatrical entertainment held at Fair Mile, 1872. *Berkshire Record Office*

The archive includes records related to administration, land and buildings, staff and patients. The highlight of the collection is an almost complete set of the statutory patient records from 1870 to 1944, including admission registers, records of medical treatment, casebooks and registers of discharges and deaths. The casebooks in particular offer a fascinating insight into the development of mental health care, showing how changing methods of classifying, understanding and treating mental illness were put into practice in the treatment of individuals.

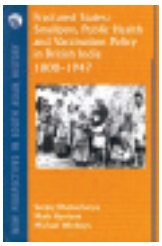
Following on from this project, Berkshire Record Office has been awarded a further grant from the Wellcome Trust to undertake a two-year project to catalogue and conserve the records of Broadmoor Hospital. That project is due to begin this summer.

Access to the Fair Mile catalogue, and to the archive itself, is now available at Berkshire Record Office; see **www.berkshirerecordoffice.org.uk/collections/fairmile.htm** for details. The catalogue will also be made available online through the National Archives Access to Archives website (**www.a2a.org.uk**).

More information about the Fair Mile collection, or any of the hospital archives held at Berkshire Record Office, can be obtained from Berkshire Record Office, 9 Coley Avenue, Reading, Berkshire RG1 6AF. **T** +44 (0)118 901 5132. **E** arch@reading.gov.uk.

Kate Tyte is Mental Health Project Archivist, Berkshire Record Office.

Fractured States: Smallpox, public health and vaccination policy in British India, 1800–1947



ANDREA RUSNOCK

In *Fractured States*, Sanjoy Bhattacharya, Mark Harrison and Michael Worboys analyse government efforts to control smallpox in British India from 1800 to 1947 and the enormous technical and administrative complexity surrounding the introduction and practice of smallpox vaccination in British India.

There were three primary means of controlling smallpox: variolation, Jennerian vaccination and isolation of diseased individuals. All three were employed, but by the first half of the 20th century vaccination had become the most important. Based on extensive archival research, the authors document the many obstacles that impeded the widespread adoption of vaccination. After reading this detailed account, one has an even greater admiration for the extent to which vaccination was successfully practised.

This book is part administrative history and part history of medical practice. One of its chief aims is to establish the complexity of public health policy and implementation in India under British rule in order to correct some of the assumptions other historians have made. Rather than adopting the framework that public health measures under British rule were forced on the Indian population, the authors seek to give Indians agency by documenting the variety of actions Indians took as administrators and medical officers. The authors also show that opposition to vaccination did not stem solely from religious concerns; on this point, the actual medical practice of vaccination becomes key.

During the Raj, there were four levels of government administration controlling smallpox policy: central, provincial, district and local. European bureaucrats had to rely on Indian officials, especially at the district and local levels, to implement smallpox policies, and these officials were often sympathetic to community concerns and opinions. These multiple levels of administration worked against any uniform policy, and the authors carefully document the variations in implementation that existed in different parts of India. Issues of funding and training of vaccinators, the maintenance of isolation hospitals, and the differences between rural and urban settings are all carefully discussed.

One of the most innovative aspects of this book is its focus on the technical details of vaccination. It was not a stable practice: there were many different types of vaccine and different methods of vaccination. The authors provide a fascinating account of how vaccinating serum was harvested (from humans or calves), how it was treated (with glycerine or lanoline to remove harmful microbes), where it was produced (newly created provincial vaccine institutes) and how it was stored (refrigerated or dried). Moreover, vaccinators used different techniques to insert the serum. Most often, they made a deep incision into the skin using a scalpel and inserted a large amount of vaccinating lymph. This technique frequently led to ulcerations and contributed to the unpopularity of vaccination. In the 1920s, efforts were made to introduce a less invasive technique in which a needle was used to make a series of scratches in the skin.

The variability of vaccination inevitably led to different results: some vaccines did not take; others created severe complications and, in some cases, death. The authors examine how opposition to vaccination was linked to its actual local practice. In particular, the difficulties of getting pure, effective vaccine to rural areas meant that Indians living in the country tended to have poorer experiences with vaccination and thus were not as willing to be vaccinated. Individuals weighed the risks and benefits of vaccination based on their and their neighbours' experiences, not just on religious principles. Again, the authors revise earlier histories that portrayed Indian resistance to vaccination as irrational.

This book is an important contribution to the history of public health policy, colonial medicine and smallpox control. The details provided by careful analysis of archival documents correct previous work and create a richer and more nuanced picture of the implementation of smallpox control policy in 19th- and 20th-century India.

Bhattacharya S, Harrison M, Worboys M. Fractured States: Smallpox, public health and vaccination policy in British India, 1800–1947. New Perspectives in South Asian History. India: Orient Longman; 2005.

Dr Andrea Rusnock is an associate professor of history at the University of Rhode Island, USA.

What is Medical History?

LIEW KAI KHIUN

Even among the more informed, medical history has been commonly misunderstood as part of the clinical study of medicine and health. New students or interested scholars coming from other disciplines, on the other hand, would have endured the rite of passage of acquainting themselves with the central issues of the overwhelmingly diverse fields of the discipline.

While several textbooks have been available to date, John Burnham's *What is Medical History?* represents the latest efforts in the area to make the study more concise and approachable. In terms of its physical size, his publication is one of the smallest, produced with minimal citations. The challenge for the author was hence to provide the general framework without falling into generalisations, and to deliver simplicity in style without sounding simplistic to his readers.

Burnham opens his narrative by discussing the genesis of medical history, from that of classical Greece to the more recent efforts by medical practitioners to write their own histories as of discovery and progress. This field subsequently attracted social historians, mostly from non-medical backgrounds, who platformed medical history into broader socio-historical perspectives. In the process, medicine became a medium for the critical interpretation of society and culture. In broad strokes, the author collapsed the expansive issues that social historians of medicine have discussed into the dichotomy of medicalisation against demedicalisation.

This binary becomes central to Burnham's chapters on 'The healer', 'The sick person', 'Diseases', 'Discovering and communicating knowledge', 'Medicine and health interacting with society' and 'Where medical history is going'. In historicising these issues, he seeks to demonstrate the fluid foundations and unstable social boundaries behind the development of the discourse of the medical sciences. The author ascribes the evolution from the ancient shaman to the modern physician as a result of the professionalisation of healing cultures, which eventually privileges the doctor as a heroic representation of science, enlightenment and progress. The maintenance of this status has also demanded correspondingly the exclusion of alternative medical traditions that fall outside the dominant framework, about which the label of quackery is deployed.

Moving to the patient, Burnham is also concerned that the issues of sickness should be recognised as historical constructions as much as clinical symptoms. With heightened emphasis towards excavation of the patient's account, social historians have explored the process in which society dictates and individuals react to the social roles of the sick. Beyond the doctor and patient was the mode in which the macro social body experiences illness or diseases. Although there are at present more than 120 categories of infectious and chronic disease, historians are more focused on uncovering the historical course in which these scourges have been framed and experienced in different periods. The articulation, organisation and transmission of medical knowledge are also major concerns in this publication. Rather than submitting to the linear trajectory from the crude to the refined in medical knowledge, Burnham argues that medical history should "ask the basic question on whether knowledge advances by proving or disproving an idea, and whether accepted knowledge changes by jumps or by slow steps". A final preoccupation of medical history lay in the realm of public health, which reflects not just the extent of mobilisation of society's resources for the purpose of healing, but also the underpinning social consensus or power relations. Such has in turn generated interest in issues from the roots of individual medical institutions and specialities to the formulation of state health policies and systems. Burnham opines that this exploration will engender multiple perspectives on how medical systems interacted with general historical trends in the search for a longer and healthier life.

In concluding his book, Burnham boldly predicts the continued relevance of history of medicine due to the sustained desire to "search for roots" to make sense of the seemingly rapid developments in the biomedical sphere. To him, as long as there are illnesses and healers, medical history will be needed to provide context for the efforts of humanity to deal with its suffering. The only difference lies in the manner in which the stories are being told: between those searching for a more simple and clear-minded perspective, and their counterparts seeking wisdom from more complex interactions.

As a textbook for students, *What is Medical History?* would be a vital introduction to this discipline. Without trivialising the conceptual themes involved or relying heavily on technical terminologies, Burnham has managed to express his thoughts in simple and plain prose. General readers do not need to be versed in the myriad forms of social theory to comprehend the Foucauldian concepts of medicalisation that Burnham has taken considerable efforts to simplify and summarise. For medical historians, this volume can also assume the role of bringing them back to reflect on the fundamentals of their scholarly pursuits.

Burnham JC. What is Medical History? Cambridge: Polity Press; 2005.

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Medicine, Public Health and the Qajar State: Patterns of medical modernization in 19th century Iran

SEEMA ALAVI

This book offers a fine English translation of a 19th-century Persian manuscript that provides copious details on military and civil hospitals in the period of the Iranian Qajar state. The relationship of the hospitals to the state and the extent of their importance in medical modernisation and fighting epidemics are discussed in a commentary that runs parallel to the translated text.

Hormoz Ebrahimnejad discusses the pre-19th-century 'medieval' hospitals in Iran. He argues that hospitals of the Galenic–Islamic medicine – like Jundishapur – flourished in the period of the early Islamic Caliphates. But they were few and their development slow. This was true even under the relatively stable government of the Safavids (1501–1722). The Islamic hospitals had a well-organised administration. Separate wards were assigned to different medical specialities: internal diseases, fevers, surgery, etc. Each hospital had a director who was assisted by two junior staffers: the superintendent (*moshref*) and the administrator (*qawam*). The hospital received no state funding, with support coming from a religious endowment (*waqf*).

In the mid-19th century the first state-run hospital was built in Iran under the patronage of the Qajar state. Unlike the European-styled hospitals of the Ottoman Empire, the Qajar hospital manufactured its 'modernity' within the framework of the 'medieval' Islamic hospitals. The author argues that the emergence of the 'modern' hospital in Qajar Iran is a noteworthy case study of 'modernity' outside the colonial framework. Since Iran was never colonised by any European power, the modernisation process was unique as it borrowed European concepts and grafted them on its own material, cultural and intellectual referents. This was as true of Western political ideas that were traced back to the Qur'an and Hadith to justify their incorporation in political movements, as it was for Western medical ideas that were located in the prevailing medical practices.

The author traces the emergence of this specific kind of Iranian modernity to the rise of the centralised Qajar state after years of civil war that marked the collapse of the Safavid Empire in the 18th century. The army was a central feature of Qajar state-building. And indeed, it was care and concern for the health of the military that prompted the expansionist Qajar ruling class to focus attention on issues of disease, epidemics and hospitals. This resulted in their investments in the funding of the hospital, the establishment of sanitary councils and the introduction of vaccination against smallpox.

In 1851 the Dar-al-Fonun, or the teaching academy, and the first public hospital (Marizkhaneh-ye-Dowlati) were set up. Both were geared primarily towards providing healthcare to soldiers and tangentially to the poor around Tehran. In other words, the state perhaps for the first time showed interest in 'public health'. Prince Abbas Mirza sponsored inoculation against smallpox in some districts of Azerbaijan. And he encouraged the Persian translations of English tracts on smallpox. The seed of reforms and rudimentary public health only grew in the years to come. The outbreak of cholera and smallpox epidemics later in the century only intensified the move towards public health concerns. And the influence of English merchants and settlers who doubled as translators and tutors of Western medical practice was unmistakable in the medical reforms of the period. By the late 19th century the Qajar state was reorganising city plans with an eye on public hygiene, professionalising medical practice with the objective of providing quality healthcare, and investing in education, which it saw as the pillar of public health sensitivity.

Later in the 19th century, Western physicians in Iran took forward the modernisation of the Qajar elite by reorganising sanitary councils and education institutes on formal and institutionalised Western models. They, however, did not disconnect them entirely from their traditional profile. Thus for instance, sanitary councils had both Iranian and Western doctors in the service of the state. And both traditional as well as Western ideas of medical theory and practice were experimented to control disease and provide public health. Again, in the Dar-al-Fonun both Galenic–Arabic as well as Western medicine was taught. And there was no contradiction in the *hakim* (practitioner of indigenous medicine) carrying also the title of the doctor. Thus argues Ebrahimnejad, 19th-century Iranian modernity as glimpsed from medical reforms and public health initiatives of the Qajar state went piggyback on Western models even while it retained its indigenous core.

This is a fascinating book. It is rich in detail, referencing and pioneering in charting a course for Iranian modernity through the initiatives of a state that reached out to Western models even as it remained outside the framework of colonialism. It is therefore not surprising that the chapters are laced with comparative references to India's brush with modernity that historians refer to as 'colonial

modernity'. India, because of its special place in the British Empire, had a different exposure to the Western medical practice. Ebrahimnejad suggests that the colonial framework made India's 'modernity' as glimpsed through medical reforms in the 19th century different from that of Iran.

But was there really that much of a difference? I can chart an almost similar narrative of medical modernity and public health going piggyback on Western models while retaining its indigenous core in the case of India as well. First, in the late 18th century, British medicine latched on to the 'scientistic' ideas of Graeco-Arabic medicine and its 'medical wisdom' in the 'new' medical scholarship that it introduced. British doctors learned Arabic and translated its texts into English. Second, in the early 19th century when European medical learning institutions were set up in Calcutta, this learning survived through indigenous communities of Urdu language and the medical knowledge that they sustained. Even the government printing press used to disseminate Western medical literature relied heavily on the Persian and Arabic scribes and medics of the earlier period. These men acted as interlocutors between the two systems.

Third, in the late 19th century, when medical reforms of the Graeco-Arabic medicine reached their apogee they did so in a vibrant public sphere, which was constituted by the active dialogue and discussion between the local practitioners and the Western doctor. In the late early 20th century, the *hakims* and doctors may have carved out independent professional identities but they both had cannibalised parts of each other's medical knowledge. Very much like the Iranian case, in India too the Western concepts of professionalisation and institutionalisation of medical practice were used not to abstract medicine from primordial networks, but merely to purge it of quacks (and, at least in the case of India, to reassert the hold of the families over medical knowledge). Indeed the old medical families may in some cases have joined the political anti-British chorus, but they were dependent on state support for their nascent institutions of learning, for placements in the public health programmes and for representation in the municipal and sanitary councils. Their medical reforms were implemented in consultation with, rather than in opposition to, those of the colonial state. How do we then begin to distinguish between the modernity of a colonial and a non-colonial society? Is this a valid exercise at all? Should we not instead think of larger issues of global capitalism in the late 19th century that influenced 'modernisation' and change in societies all over the world, irrespective of their relations to the metropolitan centres of power?

Ebrahimnejad H. Medicine, Public Health and the Qajar State: Patterns of medical modernization in 19th century Iran. Leiden: Brill; 2004.

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Witness Seminar programme 2007

Witness Seminars bring together key individuals to discuss major medical developments, capturing a unique insight into historical events.

6 February 2007
The Rise and Fall of Clinical Pharmacology in the UK, *c*.1950–2000
Adviser: Dr Jeffrey Aronson, Oxford University

24 April 2007
The Resurgence of Breast-feeding, 1975–2000
Adviser: Professor Lawrence Weaver, Glasgow University

22 May 2007
DNA Fingerprinting: From discovery to database
Adviser: Professor Doris Zallen, Virginia Tech, USA

10 July 2007
The Development of Sports Medicine in Twentieth-century Britain
Adviser: Dr Ian Burney, Manchester University

Witness Seminars are from 14.00 to 18.00 and will be held on the 6th floor of the Wellcome Trust, Gibbs Building, 215 Euston Road, London NW1 2BE.

Space is limited, so if you wish to attend, please contact Mrs Wendy Kutner, Wellcome Trust Centre for the History of Medicine at UCL, 210 Euston Road, London NW1 2BE.

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The discussions are transcribed, annotated and published in the Wellcome Witnesses to Twentieth Century Medicine series. These volumes are freely available to download. Hard copies at £6/US$10 plus postage can be ordered from Amazon and all good booksellers.

www.ucl.ac.uk/histmed/publications/wellcome-witnesses/

Medieval Chinese Medicine: The Dunhuang medical manuscripts

CHEN MING

More and more scholars of Chinese medical history are realising the importance of new sources of historical evidence. Western scholars of Sinology, Dunhuang studies and history of medicine, in Europe especially, have also become increasingly interested in the Dunhuang medical manuscripts.

The medical manuscripts in Chinese discovered at Dunhuang are of key importance for the study of medieval Chinese medicine. Formerly, scholars had at their disposal only those medical texts that have been handed down in print, such as Sun Simiao's *Beiji qianjin yaofang* and *Qianjin yifang*, or Wang Tao's *Waitai Miyao*. Published a century after the discovery of the Dunhuang Library Cave, *Medieval Chinese Medicine* is the first book to describe the abundant contents and great value of the Dunhuang manuscripts for the Western reader. The book contains 16 articles by scholars from seven countries as well as abstracts of the manuscripts.

As Susan Whitfield points out in the foreword, this book clearly illustrates the importance of international collaboration for the discussion of such fascinating material. The book showcases the scope and variety of current research on the Dunhuang manuscripts. The contributors discuss not only the evolution of medical techniques such as acupuncture, pulse diagnosis and even the art of the bedchamber, but also the development of medical doctrines and pharmacology, especially traditional *materia medica* and regimens. The transmission and transformation of Chinese medical traditions in the west of China are also covered.

Four of the contributors consider the ways in which the Dunhuang manuscripts reveal aspects of medieval Chinese medical thought and practice. They draw attention to the deep, complex relationships that connected religion, divination, iatromancy and *shushu* ('numbers-techniques') culture, as well as everyday activities and popular healing traditions, in Dunhuang. From this book, it is very easy for readers to identify sources relating to the influences on Chinese medicine of Buddhism and Taoism in their cultural context.

The most salient feature of the book is the especial importance it gives to the many Han bamboo-slip texts, medical records, manuscripts and illustrations or charts that have been discovered in various regions of China. The historical significance of these ancient materials is self-evident. Some contributors establish links between medical recipes on bamboo and silk from Mawangdui, medical records on bamboo from Wuwei, and the Dunhuang manuscripts. Through combination or comparison with classical medical works, they reveal the unique value of excavated texts for medical history.

By comparing and contrasting various ancient manuscript recensions of Tao Hongjing's *Bencao Jizhu* from Dunhuang, Turfan and the ruins of Fujiwara Villa in Japan, Mayanagi Makoto reaches some interesting conclusions about the exchange of medical knowledge between China and Japan. Resources such as the Dunhuang manuscripts overcome a tendency simply to rely on a limited repertoire of historical material, and certainly contribute to restoring or reconstructing the medieval Chinese medicinal scene. Non-specialist readers can gain from the book a more rounded knowledge of healthcare in medieval China.

This book chiefly uses the Dunhuang manuscripts in the British Library's Stein collection and the Pelliot collection at the Bibliothèque nationale de France. The manuscripts in the St Petersburg Institute of Oriental Studies of the Academy of Sciences of Russia have now also been published in China. In the future, when we can discuss all the medical manuscripts in Chinese and other languages along the Silk Road as a whole, we are sure to gain more insights into the complex picture of medieval Chinese medicine.

It can have been no easy task to translate so many passages from the Dunhuang medical manuscripts and classical Chinese medical texts into English. The reader will glimpse between the lines the hard work of the editors and translators. Notably, the editors consider that, because scholars hold different opinions regarding the terminology of Chinese medicine and the titles of the texts, it would be inappropriate to impose unified translations too rigidly. As a result, readers can compare different translations of the same term or title so as to form their own judgement.

The appendices mean that the book is simultaneously a work of reference, making it invaluable to Western readers who are not familiar with the rich complexity of the Dunhuang manuscripts. In sum, the wide scope of the study, as well as the range of rare primary sources, means that this book opens up new vistas for the study of medieval Chinese medicine.

Lo V, Cullen C (eds). Medieval Chinese Medicine: The Dunhuang medical manuscripts. London/New York: Routledge Curzon; 2005.

Dr Chen Ming is an Associate Professor at the Research Centre for Eastern Literature and the Department of Oriental Languages and Culture at Beijing University, China.

Conference: The World and Lady Mary – Gender, medicine and culture in the time of Lady Mary Wortley Montagu *c.*1690–1765

Centre for Eighteenth-Century Studies, University of York, April 2008

The Centre for Eighteenth-Century Studies is planning a conference with international speakers on this theme to be held in York in April 2008. Our intention is to revisit the political, medical and gender cultures of the 18th century, using the varied career and experiences of Lady Mary Wortley Montagu as a lens and point of reference.

Rather than taking a personalised biographical approach, we consider this life as in some sense indicative of many important developments in the society and culture of the period. The significance of foreign travel, the role of scientific innovation, and the tensions of class and gender in urban sexual, political and literary cultures are key interests for historians of medicine, empire, women writers and politics in the 18th century.

We seek expressions of interest from those wishing to offer papers in these areas as we start to plan the strands and sessions of the conference.

Suggestions and enquiries to Dr Joanna De Groot (**E** jcdg1@york.ac.uk).

Left:
Portrait of Lady Mary Wortley Montagu.

New smallpox history website

www.smallpoxhistory.ucl.ac.uk

Set up by Dr Sanjoy Bhattacharya, a lecturer at the Wellcome Trust Centre for the History of Medicine at UCL, this website showcases global histories of the experience, treatment, control and eradication of smallpox. It results from two Wellcome Trust-funded projects, one of which was started in October 2005 at the Wellcome Trust Centre. Dealing with the case study of smallpox control and eradication in East Pakistan/Bangladesh, it builds on a previous project that dealt with historical developments in India and resulted in several publications.

This website has several goals:

- It promotes the research findings of the Wellcome Trust-funded projects dealing with the global eradication of smallpox, with special reference to the South Asian region, to the widest possible audience. The website managers seek to interact with both academics and members of the public, in the hope that they can help to develop an active interest in international health history.
- It seeks to reach people who were involved in any capacity with smallpox control and eradication work in South Asia or elsewhere: those who took part in field operations, in financial and personnel management at international, federal and local government level, in vaccine research and deployment, in publicity work, in immunisation camps, etc.
- It also seeks to display short descriptions of academic work dealing with the history of smallpox in different national and regional contexts, in the hope that it becomes an important research resource and the focus of fruitful discussions among scholars.

Contact Dr Sanjoy Bhattacharya at smallpoxhistory@ucl.ac.uk.

Above:
Smallpox rash.

Calendar of events

TO ADD AN EVENT TO THE CALENDAR PAGE, PLEASE SEND DETAILS TO THE EDITOR, sanjoy.bhattacharya@ucl.ac.uk

NOVEMBER 2006

16 **Brainhood and the History of the Self**
Mind in Medicine Research Seminar with Dr Fernando Vidal (Max Planck Institute, Berlin), Wellcome Trust Centre
Contact: Carol Bowen (**E** c.bowen@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/

17–18 **Economic and Social History Society of Ireland Annual Conference: Medicine, Science and Society in Ireland**
Queen's University of Belfast
Contact: Marie Coleman (**E** m.coleman@qub.ac.uk)

23 **Doctors, Motherhood and Insanity of Childbirth in Victorian Britain**
Cambridge Wellcome Lecture in the History of Medicine by Professor Hilary Marland (University of Warwick)
Contact: hps-admin@lists.cam.ac.uk
www.hps.cam.ac.uk/medicine/wellcomelecture06.html

29 **AIDS Relief and Global Biomedicine Today: The re-emergence of a military–therapeutic complex in Africa?**
Public lecture by Dr Vinh-Kim Nguyen, (Clinique Médicale l'Actuel, Montréal), Wellcome Trust Centre
Contact: Carol Bowen (**E** c.bowen@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/

DECEMBER 2006

7 **Madness at Home: Domestic psychiatry and its limits in early Victorian England**
Mind in Medicine Research Seminar with Dr Akihito Suzuki (Keio University, Japan), Wellcome Trust Centre
Contact: Carol Bowen (**E** c.bowen@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/

JANUARY 2007

4–6 **British Society for the History of Science postgraduate conference**
Durham University
Contact: bshs.pg2007@durham.ac.uk
www.dur.ac.uk/bshs.pg2007/bshspg2007.html

FEBRUARY 2007

6 **The Rise and Fall of Clinical Pharmacology in the UK, *c*.1950–2000**
Witness Seminar with Dr Jeffrey Aronson (Oxford University), Wellcome Trust
Contact: Wendy Kutner (**E** w.kutner@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/

APRIL 2007

12–13 **Securing the Ultimate Victory**
Army Medical Services Museum, Mytchett, Surrey
Contact: armymedicalmuseum@btinternet.com

24 **The Resurgence of Breast-feeding, 1975–2000**
Witness Seminar with Professor Lawrence Weaver (Glasgow University), Wellcome Trust
Contact: Wendy Kutner (**E** w.kutner@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/

For a fuller listing of lectures, seminars, conferences and other events relating to the history of medicine, visit **http://medhist.ac.uk/events**.

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Contributor guidelines are available at **www.wellcome.ac.uk/wellcomehistory**

Contributions should preferably be pasted into an email and sent to the Editor (**E** sanjoy.bhattacharya@ucl.ac.uk).

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