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Wellcome History



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Occupational health in Singapore



Better sick than hungry?

The historical context of occupational health and safety in Singapore

*"When stomachs are empty, safety standards and occupational health take a back seat. Unemployment is a disease worse than industrial dermatitis or noise-induced deafness, or even cancer of the lung from prolonged exposure to asbestos. Factory workers will risk health hazards if the alternative is an empty rice bowl. Better sick than hungry. Industrial workers will not squeal one decibel even if required to work in a deafening environment of 60 to 70 decibels."*¹
Singapore's Health Minister Goh Chok Tong in 1982.

"The Committee (on the Spyros disaster) will eventually establish that guilt and responsibility be directed at a few or many, at one or several organizations. Whatever the findings, we all share the guilt and responsibility. We all chose to accept the need and presence of these industries in our midst, the economic advantages of employment, and with it the hazards (that come along with it)." A reader's response to the press on the Spyros tragedy, Singapore's worst industrial accident² (30 October 1978).

Attritions from the harsh working conditions existing in the docks and the plantations had been a familiar and accepted part of the transient immigrant communities in the colonial port city of Singapore. Work-related afflictions rose significantly with the rapid industrialization of the economy by the post-colonial government from the 1960s arising from the new environments in the factories, shipyards and worksites. In turn, a safety culture was being established to provide safer and healthier work environments, criminalize negligence and set in place a structure of compensation for injured workers. Although, the situation was stabilized by the 1990s, less discussion has been focused in retrospect on the external and social cost of the price of industrialization and the social profile of those who are made to pay for it.

Occupational hazards are no longer seen as a merely inevitable part of work that people have to suffer. This is directly attributable to the development of the concept of Occupational Health and Safety (OHS). The search for the major causes of occupational accidents has moved to concentrate on the systemic and organizational aspects of work rather than on immediate circumstances and behaviours that lead up to each individual accident.³ This concept goes beyond the more institutionalized parameters of measuring and work-related diseases and accidents and the establishment of occupational medicine as a separate field of medical sciences. In their attempts to move from the micro-causality of disease-bacteria and toxic substance focus by science that is unable to consider macro-causality like the power relations in society, Williams and Thorpe called for the study of OHS.⁴

Their approaches are based mainly on the key premise of Navarro, who summed up the central to production values, which dominate human values in capitalist society. In this, health is sold and disease is compensated.⁵ The post-war East Asian economies had embarked on breakneck industrialization gaining the status of 'economic miracles' within one generation. The price paid by the workers in terms of occupational injuries and diseases was also drastically increased. The International Labour Organization estimated that during an expected working life of 35 years, 186 000 annual fatal occupational injuries (amounting to a loss of 6.5 million lives) and 140 million non-fatal injuries occurred in every working generation in Asia.⁶ The voices of these victims have however remained under researched and documented. Accounting for the "deep silence," Koji Taira argued that the "climate (of glorification and hegemonization of the countries economic success) discourages a critical examination of events and problems..."⁷ It is in this light, rather than the statistical rates of occupational accidents and diseases or celebratory labour legislation that we should examine the legacy of OHS in Singapore.

The colonial experience

In its less scientific form, OHS took root in Singapore as early as the 19th century when hospitals were established for the large numbers of sick seamen stranded at the port. As the demand for labour grew for the tin mines and the rubber plantations to fuel industrial development in Europe, accidents soared among migrant workers opening up new lands in the tiger- and malaria-infested tropical jungles and coolies walking on narrow planks with heavy sacks mounted on their backs.

The establishment of the international labour laws, following the founding of the International Labour Organization, caused OHS legislation to be passed and the development of monitoring agencies like the Factory Inspectorate of the colonial Labour Department. Nonetheless, although the working of the Inspectorate provides some interesting insights, the influence of its supervisory staff remained relatively insignificant until the 1960s. While oral accounts of such working conditions are available, little documentary research has been conducted about the extent of the occupational injuries and deaths incurred by these migrant workers.



Above: Singaporean fishermen at work. Watercolour by JTaylor 1879.



After independence

The local government succeeding the British Colonial administrators embarked on an industrialization programme in the 1960s as a means of modernizing the economy and providing jobs for a growing population. Large numbers of people were thrust into working in huge shop floors, handling increasingly sophisticated machinery and coordinating within complex work structures. By the 1970s, the media was screaming with the headlines of an average of “10 killed and 30 injured a month”⁸. These ‘immediate accidents’⁹ were generally categorized under ergonomic and chemical factors.¹⁰ While no estimates have been made on the total figures since the industrialization process, the accident rates during the 1990s were already considered high in spite of the various improvements made. For a population of three million, an average of 80 fatalities, 120 permanent disablement and 4200 non-disablement cases occurred a year.¹¹ The longer-term occupational diseases that plagued the republic’s workers are generally related to noise-induced deafness, industrial dermatitis, occupational lung diseases, poisonings/excessive chemical absorption and gassings. The confirmed cases of occupational diseases have also remained high at about 550 cases or 2.7 per 10 000 employed, although the rates have fallen significantly from the 1970s to 1980s.¹² The industries with the highest rates of afflictions were and still are the factories, shipyards and construction worksites.

The victims have been predominantly blue collar workers with the highest number of incidents coming ironically both from the highly skilled workers, who have to undertake higher risks, and the untrained or casual labourers. Thus, while trained technicians were usually the first victims of explosions and radiations, temporary foreign contract workers with no knowledge of the local work cultures and procedures made up the bulk of the industrial mishaps, especially from the 1980s when the republic was increasingly reliant on foreign labour. As for age and gender, a large proportion of the wounded were younger males who not only dominated the shipyards and the construction sites. Women workers make up most of the numbers of those hurt in the factories and the manufacturing sectors, as these concerns are staffed mainly by females. The accident rates were not confined to Singapore citizens. On the contrary, the large proportion of the cases came from foreign contract labourers with little familiarity the work system due to language and cultural barriers. Perhaps the worst accident that marked the darker legacy of industrialization was the Spyros tragedy in 1978 in which a workman accidentally sparked off an explosion on a Greek tanker killing about 76 workers and injuring 69 others. The disaster exposed not just the ‘carelessness’ of the worker who followed the industry habit of loosening on oil pipes with blowtorches, but the poor safety procedures at the shipyard as well as inadequate regulations from the part of the government.

Comprehensive measures have been established in place to address the rates of industrial accidents and diseases in Singapore. A more thorough assessment of the social price of the rapid pace of industrialization is, however, lacking. The current literature on the subject concerns itself with more micro-medical and institutional factors rather than macro causes and trends. Little attempts have been made by social scientists to estimate the external cost of these accidents, compensation structures, the social perceptions of occupational medicine and therapy, safety cultures on the shop floor, as well as the actual attitudes by the state and industry beyond official pronouncements. The archival sources on OHS since the 1960s have remained inaccessible for ‘reasons of confidentiality’. Hence, what is commonly remembered is the story of contemporary Singapore’s unqualified march towards industrialization,



which has, in many ways, reinforced the belief that issues concerning OHS remain a peripheral issue to the issue of economic growth. A similar march towards industrialization in East Asia and the rather belated introduction of OHS as a concept of labour rights, intended to protect the health of workers, have belatedly begun changing the way in which workers are relating to the social structures in this new environment. Asians, however, continue to see industrial diseases and accidents more as personal ill fortune or the inadequacies of institutional safety procedures, rather than the more subtle workings of the power relations existing in the capitalist social structures. This aspect of the social history of medicine can be fruitfully studied by scholars not only in respect to Singapore, but also with regards to all the industrializing economies. The wealth of data that is provided by OHS networks can be used to reconstruct important trends and to bring out subjugated voices of the injured victims of Asian history. Only then would we be able to find out whether it is “better to be sick than hungry”.

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- 2 *The Straits Times*. 30 October 1978.
- 3 Feyer A-M, Williamson A (eds) (1998) *Occupation Injury: Risk, prevention and Intervention*. London: Taylor and Francis, p. 118.
- 4 Williams C, Thorpe, B (1992) *Beyond Industrial Sociology: The work of men and women*. Australia: Allen and Unwin, p. 142.
- 5 *Ibid.* p. 141.
- 6 Takala, J (2000) Indicators of death, disability and diseases at work. *Asia Pacific Newsletter on Disease and Work* 7(1). www.occuphealth.fi/e/info/asian/ap100/indicators02.htm
- 7 Taken from Turner C L (1995) *Japanese Workers in Protest: An ethnography of consciousness and experience*. University of California Press, p. 9.
- 8 *The Straits Times*. 3 August 1970
- 9 *Ibid.* 12 August 1990.
- 10 The ergonomic factors are: falls and slips, being struck by objects or caught between objects and contact with hot substances. The chemical factors are: fires/explosions and radiation. www.gov.sg/mom/menubar/aboutmom/abmom.htm
- 11 ‘Industrial accidents by degree of incapacity and industry, 1992–2001’. *Ibid.*
- 12 ‘Total number of occupational diseases, 1986–2000’. *Ibid.*

Psychiatry and primary care in 20th-century Britain

Since World War II, mental health issues have begun to assume a dominant position within the general practitioner's caseload. As the World Health Organization noted in 2001, the number of consultations in primary care for mental disorders is second only to respiratory infections. Patients look to their family physicians not simply for the relief of physical suffering but for psychotherapeutic and pharmaceutical solutions to the psychological complexities of contemporary life. This shift from the healing of physical illness to ministering to mental distress represents a profound transformation in our experience and expectations of primary care. Current ideas of the doctor's role have much in common with those of the 18th century. Nonetheless, it is facile to equate our contemporary medical expectations with the hopes and anxieties that patients brought to their doctors 200 years ago. We live in an era in which psychological and psychiatric categories provide the fundamental vocabulary through which people make sense of their place in the world. Commonplace feelings of anxiety or sadness are now often pathologized as unacceptable signs of psychological ill health. There is a widespread equation of mental health with personal happiness rather than the old Victorian ideal of self-control. These days we expect our general practitioners to guarantee us lives of fulfilment and joy. Such hopes can lead to deep disappointments for both doctors and patients.

Tracing the relationship between psychiatry and general practice in 20th-century Britain is a complex task. For this reason I have chosen to concentrate on four discrete topics, each of which encapsulates a distinct and important aspect of their general history. These are: the impact of psychological theories on the doctor's understanding of patient testimony in the inter-war period; the psychologization of the doctor-patient relationship during and after World War II; the role of general practitioner research in the development of psychiatric epidemiology during the early years of the NHS; and finally, the importance of GPs as frontline psychiatrists and prescribers of antidepressants.

Effects of World War II

Many doctors became committed to psychological models of the patient in the years immediately following World War I. Radicalized by their experiences working with shellshock victims and pensions administration, practitioners began to recognize the need for a psychological interrogation of patient testimony. Rival schools of psychodynamic and psychiatric practitioners developed new approaches to patient testimony which interpreted the individual's 'bodily complaint' through reference to personal history, economic motivations and emotional health. These groups included the Freudians gathered around David Forsyth and Millais Culpin; the Adlerians led by elite physicians such as Walter Langdon Brown and Francis Crookshank of the Medical Society for Individual Psychology; and professional psychiatrists such as R D Gillespie at Guy's and Aubrey Lewis at the Maudsley. All argued for the reform of medical education, urging the incorporation of psychological training within the medical curriculum. Their insistence on the connection of bodily symptoms to the patient's situation and emotional history was rooted in wider political and scientific changes. At one level, as Christopher Lawrence has noted, the new attention paid to individual factors in



Aubrey Lewis helped develop British social medicine after the war, promoting new attention to the domestic and environmental context of the patient.

medicine could be seen as part of a patrician reaction to the routinization of modern medical diagnosis. However, these interpretative connections also reflected contemporary developments in neurology and psychophysiology, where new models of the conditioned response, the stress reaction and the body schema had further emphasized the complexity of individual diagnosis.

World War II and after

World War II saw the expansion of psychology's role in general practice. It moved from being an aid to diagnosis to become the basis for a GP-centred psychotherapy. The work of physicians such as Arthur Watts of Ibstock provided a model of the therapeutic encounter which was popularized through discussions in the *Practitioner* magazine and later formalized in the Tavistock seminars led by Michael Balint. Belief in the efficacy of GP-centred psychotherapy was predicated upon a psychosomatic model of illness which had developed in the physiological investigations of W B Cannon, Hans Selye, and Franz Alexander. It was also supported by the wartime development of British social medicine and social psychiatry (in the work of John Ryle and Aubrey Lewis, for example) which promoted new attention to the domestic and environmental context of the patient. These theoretical developments provided an invaluable resource for GPs renegotiating their medical roles and professional authority within the emergent NHS. They suggested that the family doctor retained key insights into individual cases of mental and psychosomatic illness by virtue of his or her knowledge of the patient's personal circumstances and history. I aim to analyse the relationship between the psychotherapeutic model of the patient and changes in the professional organization and identity of general practice.

The growth of primary-care psychotherapy was accompanied by related developments in general practice research. In the late 1930s, James Halliday began studies of the incidence of psychoneuroses among Scottish National Insurance claimants. Halliday's aim was to underline the necessity of the



Sir Allen Daley commented in 'The Health of the Nation' that psychoses and psychosomatic illness contributed the greatest single group of sources of national unhappiness and inefficiency.

psychosomatic approach by demonstrating the prevalence of cases of mental distress and anxiety among patients presenting rheumatic disease. This close connection between general practice research and the promotion of GP psychotherapy continued into the postwar period with progressive doctors providing useful estimates of the nature and extent of psychiatric morbidity within their general practice populations. By 1952, Sir Allen Daley could comment in 'The Health of the Nation', that psychoses and psychosomatic illness constituted the greatest single group of sources of national unhappiness and inefficiency.

Thus, by the 1950s the political significance of general practice psychiatry had been transformed. It moved from being a diagnostic and therapeutic tool within the doctor–patient encounter to provide positive epidemiological knowledge upon which wider psychiatric policies could be based. The foundation of the MRC General Practice Research Group under the direction of Michael Shepherd is a good example of an attempt to think through the difficulties of primary-care

research while remaining committed to the possibility of using epidemiological knowledge to shape the direction of government policy. As Shepherd recognized, the shift towards primary-care research led to a reconceptualization of psychiatric morbidity as a much broader and more inclusive category. The data generated in primary-care research in turn provided the basis for campaigns by pressure groups such as MIND and the Mental Health Research Foundation, which called for the reorganization of the mental health services.

The widely felt need for a general practitioner psychiatry service was made manifest in the Ministry of Health's 1962 'Report on the Part of the Family Doctor in the Mental Health Service' and the Gillie Report of 1963 on 'The Field of Work of the Family Doctor'. The growth of primary-care psychiatry in the 1960s coincided with the rapid increase of antidepressant prescription in general practice and the development of new epidemiological approaches to psychiatric morbidity. To a large extent, these developments were mutually reinforcing, with the therapeutic effectiveness of new drugs underlining the legitimacy of psychopathological diagnoses. Yet they were also intimately connected to wider policy transformations, most notably, the government experiment in community care.

In tracing the history of general practice psychiatry through to the advent of community care, I want to complement the recent work on the history of the asylum which has been pursued so successfully by groups in Exeter, Leicester, Oxford and Bangor. Through their work we are developing a fine historical understanding of the long trajectory of the mental patient 'in and out of the asylum'. I hope to add to this by showing how the concept of mental illness itself was refined outside the walls of the asylum, in the everyday medical work of Britain's general practitioners.

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The Great War and the Great Flu Pandemic of 1918

Despite its considerable human toll and unenviable reputation as the modern era's greatest scourge, the Spanish influenza pandemic of 1918 remains one of the most elusive and least understood of epidemiological phenomena. Though its three waves claimed an estimated 80 million lives worldwide between April 1918 and April 1919, there has been surprisingly little written about this H1N1 virus that does not focus on a North American or former British Commonwealth context, or on



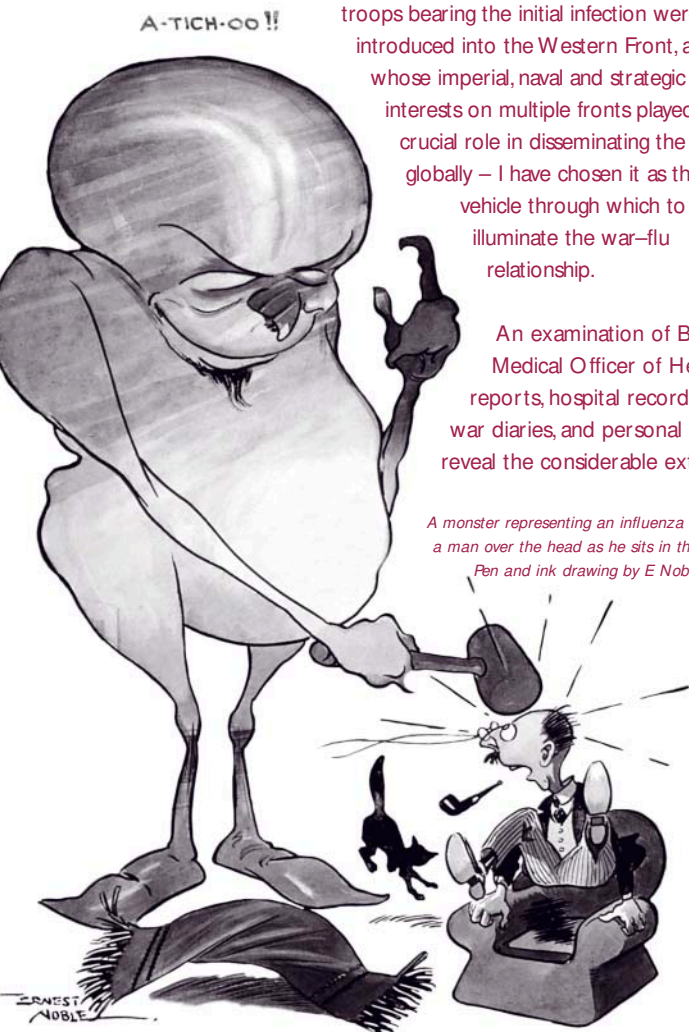
A typical hospital ward for military patients. Note the close proximity of the beds – an ideal setting for the virus to propagate. The scene is in King George Hospital, Stamford Street, London, c. 1915–18.

current efforts to recover period tissue samples and reconstruct its genetic code. To date, there had been no systematic study of the aetiology and impact of the pandemic at its very epicentre, in Europe. Europe was the crucible not only of the Great War but also of the Spanish flu, and it was here that the new virus developed its unique virulence and acquired the means with which to circumnavigate the globe. The virus struck ferociously upon a European society prematurely made confident by the bacteriological revolution against the threat of epidemic disease, and exacted a level of mortality (180 000 in France, 225 000 in Britain, 550 000 in Germany and 800 000 in Italy) that no outbreak of Victorian cholera, smallpox or measles could rival. The comparative neglect of the pandemic's European context is all the more curious when one considers the wartime situation into which it was introduced. When the first wave appeared in the summer of 1918, the European combatants were approaching the end of their fourth, final year of 'total war,' with unprecedented numbers of physically exhausted, under-nourished and susceptible people crowding into home-based industries and frontline trench systems, or engaging in new levels of frequent and rapid movement. While there has been a tendency to treat World War I and the 1918 influenza pandemic as concurrent but unconnected events, three years of research has convinced me that some compelling causal links exist between them. Rather than working in isolation, the war and the disease fused symbiotically into a dangerous partnership, whose combined ravages made 1918 the costliest year of the war. Given Britain's unique position among the European combatants –

— serving as an intermediary through which US troops bearing the initial infection were introduced into the Western Front, and whose imperial, naval and strategic interests on multiple fronts played a crucial role in disseminating the virus globally – I have chosen it as the vehicle through which to illuminate the war–flu relationship.

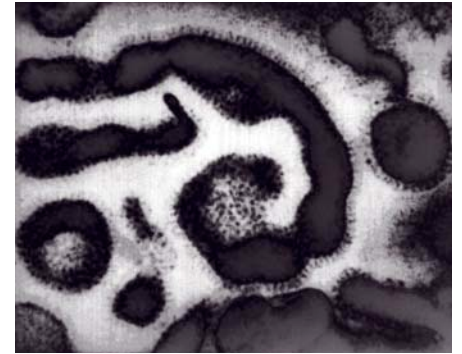
An examination of British Medical Officer of Health reports, hospital records, official war diaries, and personal letters reveal the considerable extent to

A monster representing an influenza virus hitting a man over the head as he sits in the armchair. Pen and ink drawing by E Noble, c. 1918.



GOOD EVENING I'M THE NEW INFLUENZA!!

which, both at home and abroad, wartime conditions (overcrowding, food and fuel shortages, unparalleled demographic movement, overburdened medical resources, physical strain, and mental stress) were instrumental in creating



An influenza virus.

an ideal environment for the disease to flourish and attain pandemic proportions, while impeding the best efforts of the medical profession and government authorities to combat it. At the same time (completing a vicious circle), the worsening flu situation magnified wartime suffering and rendered it increasingly difficult to maintain an effective war effort. The comparative ease with which the invisible enemy could strike behind the lines, on the home front, and claim the most productive and militarily-necessary segment of the population (young adults), seemed more sinister than marauding zeppelins. Skyrocketing rates of absenteeism and death in vital munitions factories, in mines and among essential public services, had a menacing effect on the domestic war economy. In the various operational theatres abroad (France, Italy, Macedonia and Mesopotamia) the pandemic's rapid depletion of Britain's fighting ranks (and those of her enemies) played a not insignificant role in determining the character and outcome of the decisive actions that occurred there in the final year of the war.

The pre-operational movement and congregation of vast forces on the Asiago Plateau and on the Plave in Italy and at Lake Doiran in Macedonia, provided fertile ground for nurturing and disseminating the disease, which, in turn, ultimately contributed to a string of military postponements and close-calls. Similarly, the summer flu wave weakened the British forces in France just as they were confronting the last major German offensive of the war, and then reappeared again in Sept–Oct during the crucial assault on the Hindenburg Line. On the high seas, operations were disrupted by epidemic outbreaks on overcomplemented, ill-ventilated and medically-understaffed Royal Naval vessels, and post-influenzal complications buried far more seamen in 1918 than enemy sinkings. In November 1918, negotiations for an Armistice coincided with a peak in pandemic mortality in London (2500 deaths in one week alone) and other belligerent centres. While volumes have been written about the influence of technological, material and decision-making factors on the course of World War I, the role of disease has been largely overlooked. Though commonly heralded as a medical watershed, in fact the Great War witnessed only a partial triumph over sickness-related wastage, and on all fronts, non-battle casualties (of which disease, particularly influenza, figured most prominently) continued to outnumber wounds received in combat. The fact that admission records were imprecisely kept during active operations, and that influenza was routinely misdiagnosed or confused with other febrile diseases, has meant that actual morbidity and mortality was even higher than has hitherto been recognized. Using a wide range of medical sources, I have undertaken a major upward revision of influenza figures in every theatre in which British personnel were engaged.

It would appear that disease has also been omitted from our understanding of Europe's 'Lost Generation.' While this phenomenon has traditionally been conceived in terms of combat-related deaths (the decimation of the promising young male officer corps), the fact that influenza was most destructive of 18–35 year olds of all classes and occupations would seem to suggest a broader, less military and elitist definition was in order. Given the disease's tendency to strike women in roughly the same proportion as men, and the indelible imprint it left on the lives of Vera Brittain, Edith Wharton and innumerable female war workers, we might need to divest the myth of its heavily gendered quality too. The nurse's story looms large in my work, especially given that in the pre-antibiotic era, the survival of an influenza case (especially if complicated with pneumonia) often depended on the selfless attention of a VAD or Red Cross nursing sister. An attempt is made to highlight the sufferings of another marginalized group, the Indian,

British West Indian and Chinese contingents who rendered vital service to the British forces, but received substandard medical care during the pandemic and often perished in disproportionately higher numbers than their European counterparts.

The 1918 pandemic has more than historical interest. Given the ever-mutating nature of the virus and the certainty with which many of today's virologists and epidemiologists regard a new outbreak (possibly worse than 1918), any study of the aetiology, dynamics and impact of the Spanish flu will help illuminate a lingering threat to our own society.

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Yogic practices in the Bon tradition

Tibetan traditions have employed *rtsa rlung 'phrul 'khor* (TK), 'Magical Movements of the Channels and Vital Breath,' as part of their spiritual training since at least the eighth century. These yogic practices are referred to as 'mind-body' techniques in the Western field of complementary and integrative medicine (CIM).

Based on the TK text from the Bon Dzogchen or 'Great Completeness cycle of the Listening Transmission of Zhang Zhung' (*rDzogs pa chen po zhang zhung snyan rgyud*), and its commentary by the famous meditator and scholar Shardza Tashi Gyaltsen (d. 1934), I have been focusing on TK's application in the modern world, giving particular attention to the

possible benefits of using these mind-body techniques as part of a CIM treatment for people with cancer.

Namkhai Norbu Rinpoche, one of the very few to ever write on this topic, states that TK is the equivalent for the Sanskrit Yantra yoga, where the meaning of yantra is not only 'magical' but also, 'machine'. Norbu

Below left: Miniature of Padmasambhava sitting in meditation posture.



persuasively describes body as a machine or a tool, which one can utilize to understand one's own nature more clearly.¹

Although there are as yet no published scholarly works on TK in general, and certainly nothing within the Bon tradition, Western societies' interest in this more physical kind of Tibetan practice has been growing.²

One's physical body, speech or energy, and mind are known in the Bon Great Completeness teachings as the three doors through which one can practice and eventually realize enlightenment. The energetic body, represented by the vital breath (*rlung*) and the channels (*rtsa*), is said to be the link between the mind and physical body. In fact the TK practices assume, explicitly or implicitly, that the practitioner is familiar with the 'channels and vital breath' (*rtsa rlung, TL*) practices. In other words, *rtsa*



rlung practices are crucial in the training and harmonizing of the vital breath, which is the basis of TK.

TK involves a coordination of physical movement that guides the vital breath, which in turn carries the mind. When practiced by the Bon lay community as well as monasteries such as Menri in India and Tritan Norbutse in Nepal, it is primarily used to develop one's meditation practice. However, the movements are also traditionally held to strengthen one's physical health and emotional stability as a secondary benefit. Together with colleagues at the University of Texas MD Anderson Cancer Center of Houston,³ a randomized controlled clinical trial was conducted to determine the feasibility, acceptability, and initial efficacy of TK with cancer patients. For this pilot study we designed a seven-session programme that included *rtsa rlung* practices from the 'Mother Tantra' (*Ma rgyud*) and the foundational (*sngon 'gro*) TK set from the 'Listening Transmission of Zhang Zhung'.

Importantly, the yoga programme was associated with a significant reduction in sleep disturbances, improved sleep quality, reduced sleep latency, increased sleep duration, and decreased use of sleep medications. Improving sleep quality in a cancer population may be particularly salient as fatigue and sleep disturbances are common problems for patients with cancer.

These are encouraging signs of the positive effect that TK might have in cancer patients, and that could also extend to other cancer or medical populations. In fact, a second ongoing part of this study is examining the benefits of the Tibetan yoga program on both psychological and physiological (immune and hormone function) outcomes in women with breast cancer. These pilot programs are among the few studies of yoga in a cancer patient population and the only scientific study of Tibetan yoga in any population.

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(E-mail: alec@rice.edu).

Notes

- 1 Namkhai N (1986) *The Crystal and the Way of Light*, edited by John Shane. New York and London: Routledge and Kegan Paul, 1986.
- 2 During the last three years the *Yoga Journal* published two articles related to Tibetan yoga, and *Show Lion* newsletter included two articles of my own on TK.
- 3 Lorenzo Cohen, Carla Warneke, Rachel Fouladi, and M AI

BOOK REVIEW

Bodhisattva Kar

Bacchic Medicine

Wine and Alcohol Therapies from Napoleon to the French Paradox

In *Bacchic Medicine* Harry W Paul illustrates how the medicinal uses of wine and alcohol came to be variously negotiated within the increasingly professionalized world of Western scientific medicine over the past two centuries. Without reducing the professional discourse to a mere function of dominant economic interests or cultural prejudices, the author attempts to chase the related debates and discussions through their multiple social contexts. The book contains 11 chapters clustered into five parts.

Paul begins by interrogating the boundary between the professional and the popular. Instead of conceptualizing the two as surgically separated, unchanging and uncontaminated domains, he chooses to see how on the question of wine therapies popular medicine responded to the bureaucracy-backed 'onslaught of official scientific medicine' by gradually forging 'a sort of symbiosis' with its powerful contestant. Suitably sensitized to anthropological insights, this chapter indicates how the dissociation of the 'purely medicinal' functions from a complex whole of nutritional requirements, scatological rites, religious performances and cosmetic uses eventually contributed to the therapeutic devaluation of alcohol and wine in the long term. During the first wave of professionalization in the early 19th century, however, such a dissociation

became crucial for the Brunonians who attempted to contain the popular therapeutic traditions within the explanatory grids of contemporary clinical discourse. Through a detailed discussion of the "first complete medical manual on the therapeutic role of wine" composed by Professor Eduard Loebenstein-Loebel in 1816, Paul describes an early 19th-century hierarchization of different varieties of wine and the concomitant classification of their diverse functions.

Part II of the book examines how, in the successive theorizations over the 19th-century, wine and alcohol therapies came to lose their panacean halos, though the process was far less linear than this statement might suggest. Till the middle of the century, physicians like Robert B Todd in Britain could successfully defend the continuation of therapeutic uses of alcohol on the basis of contemporary physiological doctrines, variously

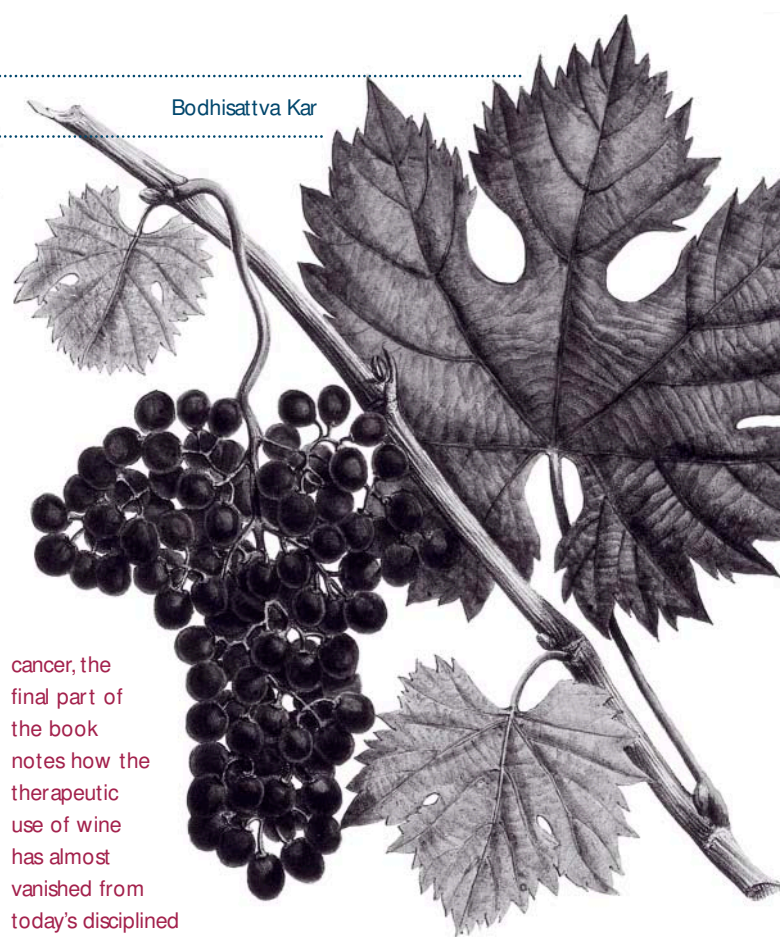


emphasizing its nutritional value and antiseptic, stimulating or antipyretic properties. But new findings in the specialized discipline of chemistry soon began to “radically [change] the structure and content of scientific knowledge about alcohol”, often cruelly disclosing the “internal inconsistencies in the paradigm of alcohol therapy”. The growing elite concern over ‘alcoholism’ in industrial societies unmistakably crossed these scholastic squabbles to produce an initially differentiated but increasingly negative image of alcohol amidst the professionals. The growing pharmaceutical industry also severely circumscribed the therapeutic uses of alcohol, and by the end of the 1880s, “[t]he medical view seemed to have shifted heavily in the direction of seeing alcohol chiefly as a sometimes useful poison”. If alcohol was given to bear the cross of increasing evils and ailments in the industrial age, it was also the time of the emergence of, what Paul calls, the ‘French central drinking dogma’ that wine is different from all other alcoholic drinks. Claiming a differential role for wine within the discourse of modern medicine was, Paul convincingly argues, based more on cultural preference and local commitments than on methodological breakthroughs.

In one of the most interesting chapters of the book, Paul relocates ‘The Debate over the Pathogenic Nature of Plastered Wine’ in a broader context of patronage and propaganda. Trapped within the classic 19th-century dilemma of improving public health without displeasing the major economic interest groups, the post-Revolution French state increasingly demanded a conclusive dictum from the medical profession on the scientificity of the widespread practice of using calcined gypsum as a wine additive. Paul’s focused account of the ensuing debate not only delineates the ways in which the winemakers from the Midi mobilized a respectable medical opinion in defence of this commercially crucial practice, but also demonstrates how the scientific idiom of the anti-plasterers could operate only within a territory of commercial viability. That the histories of producing medical truths are necessarily situated within and constrained by the larger economic, cultural and political considerations can also be seen in the chapter ‘Debates over Wine Alcohol, Prussian Blue, and Sulphur Dioxide’. As contestations over the use of these clarifying or preserving chemicals indicated, the relative failure of organized medicine to move beyond a helplessly empirical methodology – in spite of considerable help from chemistry – kept spaces within medical theories open to re-inscription of the fiction of ‘natural’ wine.

In the horizon of promotional claims the natural could easily dissolve into the national. Paul’s argument here seems to be one of crossmapping of the cultural and therapeutic repertoires: “the mythic status” of wine as the French national drink both strengthened and was reinforced by many French physicians’ claim that wine had little or no role to play in the aetiology of alcoholism. His discussion of the early 20th-century defences of wine therapy in part IV continues to gesture at the multiple connections between the professional rhetoric and the social world of the French bourgeoisie. Examining how “[d]iscussions about wine consumption provided an excellent occasion to denounce dull, brutal, beer-drinking Germans” or how the seemingly ‘exclusively male monopoly’ over wine therapy came to be seriously challenged in the 1930s, Paul admirably saves his narrative of medical debates from collapsing into a linear account of disciplinary evolutionism.

Situating the more contemporary specialist discussions about the role of wine in clinical defences against bacterial attack, heart diseases and



cancer, the final part of the book notes how the therapeutic use of wine has almost vanished from today’s disciplined medical knowledge. “They have more solid and specific physiological and biochemical evidence that moderate consumption of wine is good preventive medicine.” Since this otherwise enjoyable book does not contain a comprehensive discussion of how contesting definitions of ‘moderate consumption’ were produced and circulated within the medical community, one is left with the suspicion that the unity and cohesion of ‘pro-wine doctors’ is somewhat overplayed in Paul’s narrative. The same might be said about the representation of medical opposition to wine. While it would be absolutely unfair to accuse *Bacchic Medicine* of having glossed over the complexities of the medical discourse, it is indeed true that many of the indicated tensions have not been fully fleshed out in the book. A more serious criticism might emerge from a postcolonial reading. In spite of a few scattered observations on the unmistakably colonial character of the French economy (“French wine producers were the victims of an all too successful colonialism in Algeria, which produced twenty-two million hectolitres of wine in 1934 to add to France’s seventy-eight million”), the volume seems to suffer from an almost calculated erasure of the troubled but crucial role of coloniality in the making of the French self-imagination. When wine was being defended in the metropolitan medical circle as a major site of civilizational values, France was also holding a large empire across the globe in the name of the same civilization. It is hard to believe that a traffic, even if clandestine and unrecognized, between the colonial experience and the metropolitan theorizations did not exist.

Paul H W (2001) *Bacchic Medicine: Wine and alcohol therapies from Napoleon to the French Paradox*. Amsterdam and New York, NY: Rodopi.

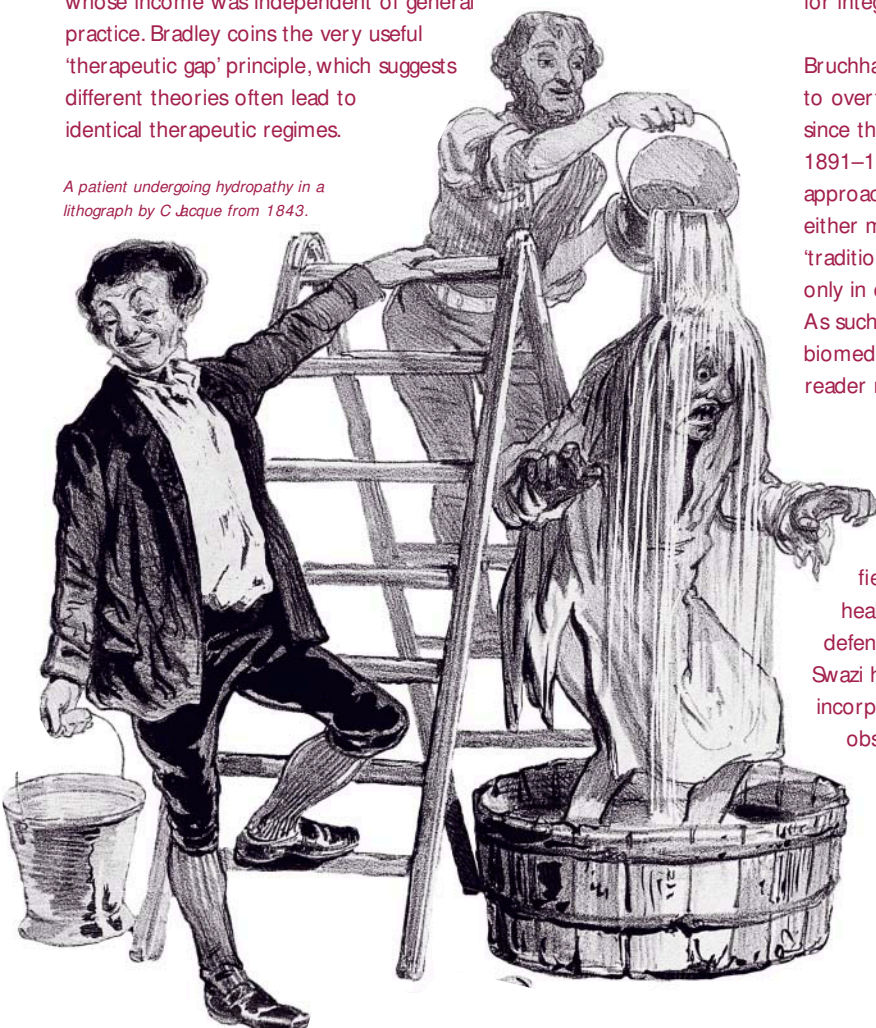
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Plural Medicine, Tradition and Modernity, 1800–2000

Ernst's volume is characterized by the refreshing acknowledgement of the need to dispense with monoisms, dualisms, dichotomies and residual categories and the courageous notion that 'folk' or 'alternative' medicine may in fact be epistemologically and therapeutically superior to biomedicine, though this proves harder in practice than in theory to deliver. The misconception that medical systems with ancient roots should not be seen as static and homogenous but rather as made up of diverse strands adapting to changing and local conditions is also challenged. Plural medicine is seen here as a multi-dimensional phenomenon with permeable boundaries.

James Bradley analyses hydropathy in Britain from 1840–60. Bradley, while disliking the orthodox/alternative dichotomy, struggles to escape it primarily due to his conceptual pre-figuration of the historical field as constituting only 'orthodoxy' and 'hydropathy'. While hydropathy never institutionalized, some 'orthodox' practitioners embraced the water cure, others villifying it at the theoretical and epistemological levels. Rejection/acceptance was dependent upon the social/political outlook of practitioners rather than their pathological/physiological principles – acceptance came easier to medical elites whose income was independent of general practice. Bradley coins the very useful 'therapeutic gap' principle, which suggests different theories often lead to identical therapeutic regimes.

A patient undergoing hydropathy in a lithograph by C. Jacque from 1843.

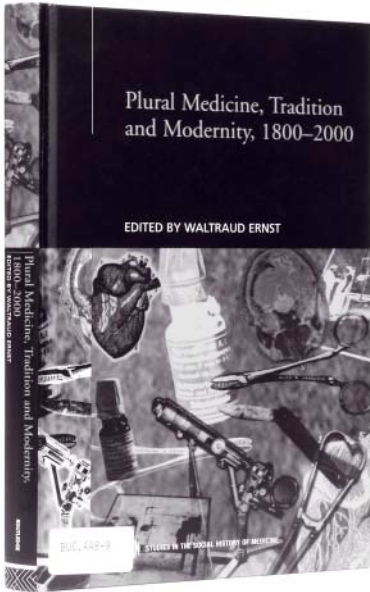


David Arnold and Sumit Sarkar counter Surinder Bhardwaj's assertion that homoeopathy was seen as a Western medical system in early 19th-century India which became naturalized and harmonized with Hinduism and Ayurvedic medicine. Rather, Arnold and Sarkar claim homeopathy spread through practitioners from countries disconnected with colonial governance. Seen as Western but not colonial, homeopathy's rapid and successful assimilation as indigenous was facilitated through early translation of its works into the vernacular, its cheapness and the resonance of homeopathy's 'self-medication' ethic with Indian culture. Interestingly, homeopathy was not considered 'alternative' but the 'new orthodoxy'.

Claudia Liebeskind analyses Indian Unani tibb's (Unani is Greco-Islamic medicine) defence of its own scientificity in the face of biomedicine's influence between 1900 and 1950. Tibb practitioners (*hakims*) argued for an Aristotelian definition of science claiming tibb anticipated biomedical discoveries, was more suited to the Indian climate and temperament while appealing to *prisca sapientia* for legitimacy. No 'therapeutic gap' here: drugs were not regarded as free standing but firmly rooted in medical philosophy. Revivalist strategies led to calls for integrating tibb and biomedicine or purification of tibb from within.

Bruchhausen and Roelcke are particularly challenged in their attempt to overturn the Eurocentricism implicit in accounts of African medicine since they only have German discourse as a research tool for the period 1891–1916. Interestingly, Bruchhausen and Roelcke conclude no single approach toward African medicine can be discerned on the part of either missionaries or the colonial government of the period, while 'traditional medicine' as a clearly bounded category emerged only in colonial times due to Western discourse and preoccupations. As such traditional medicine remains potentially exploitable as far as biomedicine and pharmaceutical companies are concerned. The cautious reader may decide this is a Eurocentric conclusion after all.

Ria Reis tests the Unschuld hypothesis – that medical legitimation depends on correspondence between treatment practices and social crisis management – in the context of traditional Swaziland treatment of epilepsy observed during field work from 1985 to 1988. Reis links the resilience of Swazi healing with wider sociopolitical power struggles, particularly those defending sacred kinship. The progressively eclectic transformation of Swazi healers demonstrates for Reis 'integration' as traditional medicine incorporating biomedicine rather than vice versa. However, Reis's dual observation that patients' treatment choice depends on perceived aetiology and decision makers' family position in turn needs integrating.



Anne Digby and Helen Sweet consider nurses as culture brokers between Western and traditional South African medicine during the 20th century. While recognizing biomedicine did not supplant traditional medicine, Digby and Sweet imply the universality of Western biomedicine by attributing biomedicine's South African adoption to its 'efficacy'. Likewise, whereas no African concept of 'germs' and 'infection' exists, inadequate linguistic skills explained the difficulty of translating African symptoms into Western

nosology. Local nurses cognizant with indigenous beliefs and operating within local power structures made the 'best patient advocates'. Fascinatingly nurses and occasionally doctors, adopted indigenous vocabulary and conceptualization in their medical practice.

Volker Scheid, by a heady mix of complexity, (diachronic) actor-network theory and ethnography illustrates how 'modern' and 'traditional', while separated in thought, align effortlessly in the 20th-century practice of Chinese medicine. Plurality, as a natural condition of social practice, manifests itself in the coexistence of 'discipleship' and 'studentship', standardized learning but individualized practice, and the integration of family lineage into the university structure. Guanxi personal networks, cited by Scheid as illustrative of the contingent emergence of the modern and traditional, sounds suspiciously like any postgraduate student's experience though and could evidence more modern hegemony that Scheid is willing to acknowledge.

Scheid's blend of traditional and modern is echoed in Patricia Laing's study on medical pluralism in 20th-century New Zealand. Analysing pluralism in the context of her own breast cancer treatment, Laing shows how seemingly contradictory medical ideas become juxtapositioned in healing narratives, such being constructed out of 'multiple worlds'. Like Liebeskind's Indian tibb Laing found notions of indigenous illness only curable by indigenous healers and like Bradley's hydropathists Maori healers were demarcated by colonialists and anthropologists. Laing advocates a redirection of analysis of health systems to emphasize the actor as central to the healing process and the site of reconnecting the material and spiritual.

Permeability of boundaries is a theme continued by Kate Reed in her investigation of the global and local in health product consumption among South Asian women living in Leicester, UK, since the 1960s. Within local networks of Asian diaspora women obtained most Asian products, being proud of their knowledge regarding them, what Reed refers to as 'diaspora discourse'. Reed found a transcultural flow of health products between Asia and the UK underpinning a distinctly 'British Asian' identity, as well as a pragmatic and global approach to health services. Thus the women drew on diverse discourses in various locations and circumstances illustrating for Reed the global dynamism of pluralism.

Keeping with healthcare markets, Maarten Bode looks at the transformation of indigenous Indian medicine in the marketing of traditional remedies by the pharmaceutical industry. Companies through various media legitimate self-help remedies through a fusion of traditional culture, modern science and holistic medicine combining 'modernity' with a 'naturalness' moral discourse. Science and technology imagery alongside historical and religious motifs legitimate traditional products from a glorious Indian past. The simultaneous critiquing of Western lifestyles alongside the retention of the Indian conception of the life force demonstrate powerfully that 'tradition' and 'modernity' are not mutually exclusive.

Medical marketing is a focus for the contributions of Michael Hardey and Ned Vankevich who deal with the influence of the Internet in the consumption and production of medical knowledge and resulting changes in sociomedical relations. Whereas Hardey claims his website analysis shows the Internet is promoting Giddens's vision of the transformation of the 'sick role' to that of active health consumer, Vankevich focuses on the increasing antiquack rhetoric aimed at 'alternative' medical systems over the web.

Personal websites recounting illness experiences represent for Hardey a paradoxical blend of oral history and evidence-based medicine as well as a blurring of boundaries between producers and consumers of health. Hardey occasionally slips into technological determinist mode though, overlooking the possibility of equifinality – that the Internet may simply be information by other means.

Vankevich goes further than Hardey in explaining the Western critique of biomedicine and subsequent interest in alternatives as stemming from not just allopathic malpractice and *E. coli* cover-ups but from the shortcomings of biomedicine itself in addressing the complexity of human illness in both objective and subjective terms. Current antiquack rhetoric, with its 19th-century ancestry, overlooks such alternative medical contributions.

I got a great deal from this volume. It demonstrated to me both the desirability of dispensing with ideologically loaded dichotomies and Eurocentric categories and the difficulty in doing so. At the risk of sounding monistic, I suggest a crucial problem for the historian highlighted by this volume is the need to categorize the historical field reflexively; for example, why talk about 'alternative medicine'? Is it useful to talk about 'alternative medicine' at all? How else may we categorize the components of plural medicine? This, with a move towards looking at medical practice as well as medical beliefs will challenge the universality and homogeneity of biomedicine, such as is mentioned in the Laing and Reed articles, and further challenge assumptions surrounding marginalized medical systems.

Ernst W (ed) (2002) *Plural Medicine, Tradition and Modernity, 1800–2000*. Routledge Studies in the Social History of Medicine Series: London.

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The Haldane archives



JB S Haldane in Indian clothes, in Monaco in 1961.

JS Haldane was born on November 5, 1892, into an illustrious Scottish family with a recorded ancestry in the male line dating back 700 years (he said he had a 'historically labelled Y chromosome'). He is acknowledged as one of the founders of modern evolutionary theory, especially population genetics. What is not as well known is that he and his wife Helen Spurway (a distinguished student of genetics and behaviour in her own right) spent their last years in India. Thanks to this, a substantial portion of their huge collection of books and scientific reprints is now located there, in the city of Hyderabad.

Once in a lifetime, we find ourselves in a situation with a dream like quality to it. I experienced a feeling not far from it, when recently I had the opportunity to browse through JB S Haldane and Helen Spurway's personal library of books at the Centre for Cellular and Molecular Biology in Hyderabad (CCMB). I learnt from Dr Pushpa M Bhargava, Founder-Director of CCMB, that after the death of Helen Spurway in 1978, Haldane's sister Naomi Mitchison had gifted the entire Haldane collection of books and papers to him and his wife, Manorama; and they in turn bequeathed it to the Regional Research Laboratory (RRL), where CCMB was initially housed.

Even as I took a first glimpse at the books my mind boggled at their diversity. In spite of knowing that Haldane was a polymath with a depth and breadth of knowledge in varied fields, it made a deep impression on me. The collection has many first editions of well-known literary and scientific works, including a book signed by Charles Darwin – possibly originally in the possession of Haldane's father, a famous physiologist. There were at least a hundred books authored by members of the Haldane family. The subjects varied from science to literature and philosophy, and covered an impressive range: Western classics, religion, Marxist theory, politics, Hindu philosophy, Indian epics, poetry, economics, art and architecture, novels and almost every aspect of science. Apart from English, there were books in French, Italian, German, Spanish, Greek, Sanskrit, Hindi, Urdu and Bengali. I am still to find out how many of these were languages that Haldane or Spurway knew and which books were solely her choices. The collection includes the lectures of William Harvey, a complete series of Charles Darwin's works, *Hereditary Genius* by Francis Galton, August Weissmann's *Essays on Heredity* and books written by G J Romanes, Albert Einstein, Oparin, Hans Driesch and Ernst Haeckel. Haldane's personal library was initially housed in England and moved with him to India. It first went to Calcutta where he took up an assignment at the Indian Statistical Institute (ISI) in 1957. Haldane's

relationship with ISI soured eventually and a move was unavoidable. On being invited to the state of Orissa by the Chief Minister, Biju Patnaik, Haldane and Spurway set up a genetics and biometry laboratory in Bhubaneswar in 1962. Manjari Ghosh, a neighbour of the Haldanes in Bhubaneswar, has said: "In his department at the agricultural university Professor Haldane installed his personal library of some 60 000 volumes. Besides scientific books and journals, the library contained books on a wide range of subjects. He was very pleased when anyone made use of it." Haldane made the collection accessible to anyone who was interested. As a result he lost many books but was not unduly worried by it. According to A B Gupta (an associate at ISI), Haldane's reaction to losing a book was to say "The utility of a book lies in the dissemination of its contents and not in its proud possession". Haldane and Spurway appear to have enjoyed their stay in scenic Bhubaneswar, known for its temple architecture.

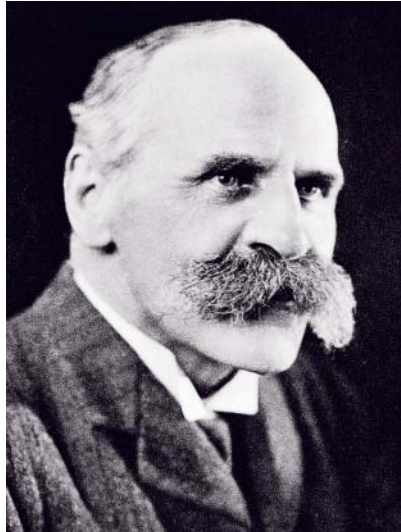
The pleasant time ended when Haldane succumbed to cancer in 1964. After his death Helen Spurway shifted to Hyderabad on the advice of friends. P M Bhargava says: "The first we heard of her was not by name but by the description given by the Mirzas of an eccentric woman who kept all kinds of pets from chicken and jackal, to deer and tortoises. She was described to us as cranky, rude and altogether strange. It did not take us long to figure out that it was Helen that the Mirzas had for a neighbour." From then on P M and Manorama Bhargava essentially acted as her local guardians. About the books P M Bhargava says "Her collection of books, manuscripts and letters was invaluable... One morning Manorama went in to find a big bonfire in one of the outhouses. Helen took her to the bonfire and asked her to be a witness to the burning of a suitcase full of valuable but white-ant-eaten papers, books and manuscripts, saying "I want you to be a witness that these were eaten by white ants and, therefore, burnt by me. I received these as dowry from my husband's family and they might accuse me of selling them".

From 1965 onwards, Helen Spurway lived in Hyderabad together with the books and her menagerie. In 1978 she developed tetanus – possibly due to the bites of her pet jackal – and passed away on 15 February 1978. A decision regarding her personal possessions was taken jointly by Haldane's relative Graeme Mitchison and the Bhargavas. According to P M Bhargava, "Naomi Mitchison, sister of JB S Haldane, came a little later and eventually gifted the entire Haldane collection of books and papers to us which we passed on to our laboratory library". The Haldane collection was used by scholars, among them K Dronamraju, a student of Haldane who has written extensively about his mentor and guide. In the latter half of 2002 it was brought to the Centre for Cellular and Molecular Biology where it is currently housed.

While going through the books I could not help wondering whether there might have been reasons for Haldane's moving to India apart from those already discussed by others. The earliest 'Indian' connection Haldane had was when as a small boy he went to a fancy dress party dressed as a Sikh soldier, the elaborate turban tied with the help of a relative who had been in India. Once while reminiscing about his father John Scott Haldane, JB S spoke of the times when there was severe plague in India and measures had to be advocated for killing rats in ships arriving from there. The French government was experimenting with an apparatus using sulphur dioxide and JS Haldane was requested to give his opinion. JB S accompanied his parents by sea from Tilbury to Dunkirk. The crew of the ship was mainly made of Indians. JB S struck up a

friendship with them and started sharing their meals. To quote him: "The ship was guarded by a very fat *gendarme* with a sword. I eluded him and got down a dry dock. He stood on the edge saying '*Ventre du diable*'. These were the first words of French, which I heard on French soil. I have liked the French and Indians ever since."

During World War I, Haldane was a bombing officer. In 1915 he was wounded in Mesopotamia and was sent to Simla, a hill station in north India, to recuperate. Later he spent a year in central India directing a bombing school in Mhow. While there his old enchantment with the country appeared to return. He was impressed by Indian ways of facing life and death. It appears that he had made up his mind even then to return to stay in India: "I determined to come back as soon as I could associate with Indians on a footing of equality". Because of his concern for all living beings he found some aspects of Hinduism attractive and sensible. He had a good knowledge of the Hindu epics and said, "I find many of the virtues and vices of the heroes of Indian epics quite intelligible and even sympathetic. The second [actually, first] word of the Gita, Dharmakshetre, gives an exact description of my feelings when I went to the trenches for the first time in 1915". He went on to add, "India has made many contributions to world culture, perhaps the greatest is the ideal of non-violence... Gandhi realized that if non-violence to human beings is to be effective it requires both courage and intelligence. He had plenty of both".



John Scott Haldane, father of JBS and a renowned physiologist.

Even though Haldane had fought for Britain in World War I and went on record to say that he had enjoyed it, he had a deep aversion for the British establishment and imperialism. Around this time Haldane was drawn increasingly towards India, the country of Mahatma Gandhi. He was also attracted by Nehruvian socialism and his efforts to make India a secular state. It looks as if he was feeling uncomfortable and unhappy in his country by this time. In 1954, before moving finally to India, he said, "Where in the world as it is at present should I find the greatest amount of freedom of this kind? I am not sure of the answer, but I suspect that the answer is in India." By this time Haldane had already visited India couple of times.

As I carry on with my research on his stay and contribution to developing science in India,

I hope to get better acquainted with JB S Haldane the man and scientist.

Acknowledgements

I would like to thank Dr Laji Singh, Director, CCMB, for granting permission to study the Haldane's collection. I would also like to thank Dr Somdatta Sinha and Mr P Divakar of CCMB for their help.

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PUBLIC ENGAGEMENT RESOURCE

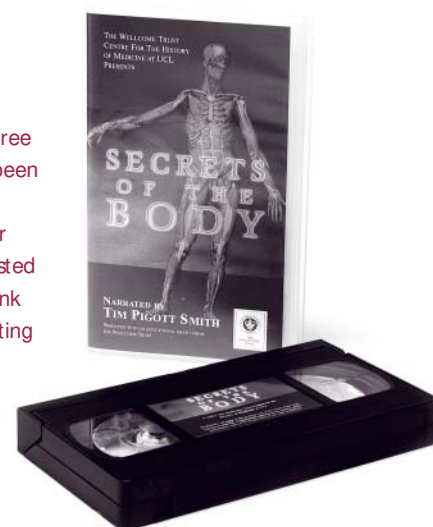
Carole Reeves

Secrets of the Body

"Action", called the director softly, and the camera on its focus track and dolly moved slowly past a curved iron staircase to reveal historian, Dr Fay Bound, turning the pages of an 18-century volume of ecclesiastical court records. A shaft of winter sun through a stained-glass window, and the flickering light of six altar candles, appeared to be the only sources of illumination whereas, in reality, the set was surrounded by lights and reflectors which had taken more than an hour to rig. The scene was the neoclassical church of St Pancras on London's Euston Road, one of the locations chosen to film an outreach video produced by the Wellcome Trust Centre for the History of Medicine at UCL. *Secrets of the Body* transports viewers across two millennia, exploring ideas about the body from ancient Greece to the Human Genome Project, and features the work of three of the Centre's research fellows: Dr Fay Bound, Dr Hormoz Ebrahimnejad and Dr Paddy Ricard.

The ten-minute video was the brainchild of Alan Shiel, the Centre's creative administrator who is an enthusiastic proponent of public

engagement. Confronted with three research fellows who had each been awarded a sum of money for outreach projects as part of their Wellcome Trust grants, he suggested that they pool resources and 'think big'. A detailed proposal and costing for the video was prepared by Carole Reeves, a medical historian and media producer, and submitted to the Trust for additional funding. With the enthusiastic support of Dr Tony Woods and the History of Medicine Grants Office, *Secrets of the Body* went into production in November 2002. In addition to the live action which was shot in three London locations, and the costume drama sequences, the video includes archive



Right: Filming *Secrets of the Body* at St Pancras Church, London.



Far right: Dr Fay Bound.



film footage sourced from the Wellcome Trust Film and Audio Collections and iconographic images from the Trust's Medical Photographic Library. Music for the video was written by composer and musician David Holmes, and the narrator was actor Tim Pigott Smith, who expressed delight at being asked to contribute to the programme. Alan Shiel acted as executive producer and the writer/director was Carole Reeves. Since the objective of producing this video is to place it in areas of public access such as museums, libraries, medical and community centres, it is also being formatted for use with a PC and interactive touch screen within a secure kiosk. The Wellcome Trust Centre is also producing two leaflets, one giving information about history of medicine at the Centre, and the other promoting the Wellcome Library as a public resource. The video will remain in selected locations for two or three weeks before being moved on and may also be tape-streamed from the Centre's website.

The art of creating a successful short movie for a public audience is to keep it exciting and fast moving. Furthermore, if viewers are captivated within the first minute, there is every likelihood that they will watch the entire programme. All television producers know this which is why title sequences are slick (and expensive to produce) and title music is memorable. For 60 per cent of *EastEnders* fans, the distinctive title music is the prompt to make a cuppa before settling down to watch the soap! *Secrets of the Body* has a 30-second title sequence which contains over 40 still and moving images interwoven with animated graphics. It took a week to build and cost one-fifth of the total budget. This is not extravagant given that the viewer will be activating the start/stop button.

In order to keep the action moving, there are no 'talking heads'. Interviews were conducted off-camera and each participant had only 90 seconds in which to tell a story based on his/her research, relating it to the concept of 'body secrets'. The interviews were then dubbed over live action. Do the following extracts intrigue you enough to want to know more?

"In 1720, Elizabeth Brooke asked the church courts for a separation from her husband John, who she believed was trying to murder her. Witnesses couldn't agree on the cause of Elizabeth's distress. Her vicar believed she was spiritually tortured; female friends blamed the psychological distress of an unhappy marriage; Elizabeth's physician said she suffered from nervous debility and 'the vapours', while her husband claimed Elizabeth was melancholic and had driven herself insane through alcoholism. This shows how complex ideas about emotion were in 18th-century culture, with new beliefs about nervous disease sitting alongside traditional concerns about humours and the soul."

Dr Fay Bound (E-mail: f.bound@ucl.ac.uk)

"Modern medicine was integrated in 19th-century Iran as a result of two processes. Firstly, discovering the reasons for the outbreak of plague and cholera forced traditional physicians to reinterpret their classical theories and this made them open to new ideas. Secondly, the Qajar princes sponsored both traditional and European physicians. This institutional cohabitation furthered the permeation of modern ideas into traditional medical beliefs. As a result, traditional medicine shifted its gaze from symptoms of diseases on the body's surface to the inner body and admitted the necessity of dissection as a method of medical instruction."

Dr Hormoz Ebrahimnejad (E-mail: h.ebrahimnejad@ucl.ac.uk)

"Phenylketonuria (PKU) was discovered in 1934 in an institution for the mentally handicapped by a Norwegian biochemist, Asbjørn Følling. It soon appeared that this was a genetic disorder and affects about one in eleven thousand. Very early on researchers suggested that the mental retardation might be prevented if children could be given a diet with low levels of the damaging amino acid, phenylalanine. By the end of the 1950s most local health authorities were screening newborn babies for the disease. This was the first postnatal screening in the UK and it ignited everyone's imagination. It was very inspiring to think that you're not carrying your genes like a time bomb."

Dr Paddy Ricard (E-mail: p.ricard@ucl.ac.uk)

We would be pleased to hear from anybody wishing to obtain a copy of *Secrets of the Body* or who would be interested in showing it at a meeting or to an outreach audience. Please contact Alan Shiel. E-mail: ashiel@ucl.ac.uk

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Symposium on International Health Programmes in South Asia – a reappraisal

7 March 2003

The symposium began with an introduction by the organizer, Dr Sanjoy Bhattacharya (Wellcome Trust Centre for the History of Medicine at UCL), who pointed out that although studies on the medical history of South Asia were increasingly attaining significance, the role of international donor organizations in the region remained under-researched. The symposium was an effort to bring together several scholars who have researched on the theme, to understand the role played by international donor organizations in the history of public health and medicine in South Asia.



Lantern slide of plague epidemiology, Bombay, 2nd Koliwada Lane; types of living quarters, goats and other animals tied in front of the house.

The first paper was by Professor Michael Worboys (Wellcome Unit for the History of Medicine, Manchester), titled 'The Rockefeller Foundation and the Hospital System in Bombay Presidency, 1915–47'. He argued that hospitals were objects of historical narrative in their own right. In the 1920s, there were several hospitals in the Bombay Presidency, which were generally municipal or charitable ones. They assessed that there was not much need to prioritize laboratory-related medical education in India. The Rockefeller's funding therefore did not intervene directly in the public health system of India but invested in medical education, nurses' training, public hygiene, and health. They focused particularly on rural health, to which end they directed their financial and technical resources in the American Mission Hospital at Miraj, which was deemed to be the only hospital worthy of assistance. Professor Worboys quoted May Byrd's report, which emphasized the

lowly position of nurses in Indian society; the occupation being taken up generally by Christian converts. In 1941 the establishment of a central nursing school was recommended whose aim was to train up to 20 000 nurses and promote rural visits. By 1945 it was possible to initiate rural visits by trained nurses. He concluded that the Rockefeller Foundation played an important role in promoting Western medicine at the basic level in the interwar years.

The second paper of the session was presented by Dr Sanjoy Bhattacharya, titled, 'Allies at War? Rockefeller initiatives and British colonialism in South Asia, 1920–50'. He described the Rockefeller initiatives in India in disease control, particularly of hookworm and malaria. Their primary thrust was towards public health and better organization of sewage management, immunization, nursing, and public health education. Initially there had been a provision for the selection of a few individuals to be trained in North America, which was later abandoned. Dr Bhattacharya argued that in India the responses to the RF initiatives were essentially varied. It received better attention in the Princely States than it did in British India. The responses to the RF varied from perceiving it as a humanitarian organization to denouncing it as an imperialist force. Dr Bhattacharya concluded by raising the question: whether the negative reaction towards the RF should be seen as an outcome of the fear of global spread of disease or as a consequence of identifying the RF as essentially an imperialist agent.

The first paper of the second session was by Dr Niels Brimnes (Aarhus University, Denmark) titled, 'Scandinavian Aid Programmes and TB Control in South Asia, 1920–50'. He traced the origins of the campaign to the general feeling, post-World War II, that some kind of restitution had to be made for the fact that anti-German resistance had been lukewarm in Denmark. The TB immunization programme was chosen for its visibility and for the ease with which it could be conducted – Denmark being a leading producer of the BCG vaccine. Initially the programme was to have been undertaken in Eastern Europe. The campaign was jointly undertaken by the Danish Red Cross, the Swedish Red Cross and Norwegian organizations, and was later funded by the UNICEF.

With a US\$2 million grant from UNICEF, a joint enterprise was formed with the UNICEF and Scandinavian non-governmental organization, the International Tuberculosis Campaign (ITC). India was the first country to come to an agreement with the ITC in 1948, whereby its operations were to be extended to India. However, the donors were not particularly willing to extend the BCG campaign outside Europe, for logistic and other reasons. The campaign was begun in 1949 but soon it was concluded that the estimates of the project had been unrealistic because there was a severe lack of qualified Indian personnel. In 1950 Dr Usnedts was convinced that the work done so far had been beneficial. In 1951 Holm in his second visit concluded India was ready for mass vaccination. In July 1951 the campaign came to an end.

Discussing the nature of the project, Dr. Brimnes stressed that it was particularly marked with adjustments: primarily from one developed for Europe to be then used for India. Secondly, there would have to be a reformulation of strategies from the short term to a long-term perspective. Further, the enormity of the task changed the concept of 'demonstration' into a 'mass campaign'. The project was also plagued by a lack of support from the Indian government and resistances from places like Madras, particularly where female patients were concerned. This was largely due to the fact that there was a severe shortage of trained female personnel to undertake the campaigns Dr Brimnes summed up by stressing the need to explore these resistances in terms of the larger issues like Indian nationalism and its relationships with western medicine.

The next paper in the session was by Ms Sunniva Engh (Wellcome Unit for the History of Medicine, Oxford) entitled, 'Scandinavian Aid to Indian Family Planning Programme'. The paper focused on the 1970–96 Post Partum Project, 1972–80 Indian Population Project, and on women's rights with respect to their choices regarding contraception. She explained the reasons behind the aid to family planning in terms of moral, ethical and religious views, as well by the need to promote international solidarity in the context of the Cold War. She stressed the fact that Sweden did not convert aid into a political strategy. The interest was in family planning, particularly the use of contraceptives, population growth being seen as ultimately a threat to world peace. Family planning was viewed as a basic human right. By 1978, after initial controversies, the choice for abortion was left to women. She concluded by outlining the outcome of the project, which included improved hospital facilities, increases in staff, and also the problems with the sterilization process during the Emergency.

The first paper in the third and concluding session was by Professor Kalinga Tudor Silva (University of Peradeniya, Sri Lanka) entitled 'Health and Social Welfare in British Ceylon: The role of external interventions'. Professor Silva explored the role the state played in public health and examined the colonial aspect of Sri Lanka as a model welfare state. His narrative extended from the Donoughmore period (1931–47) during

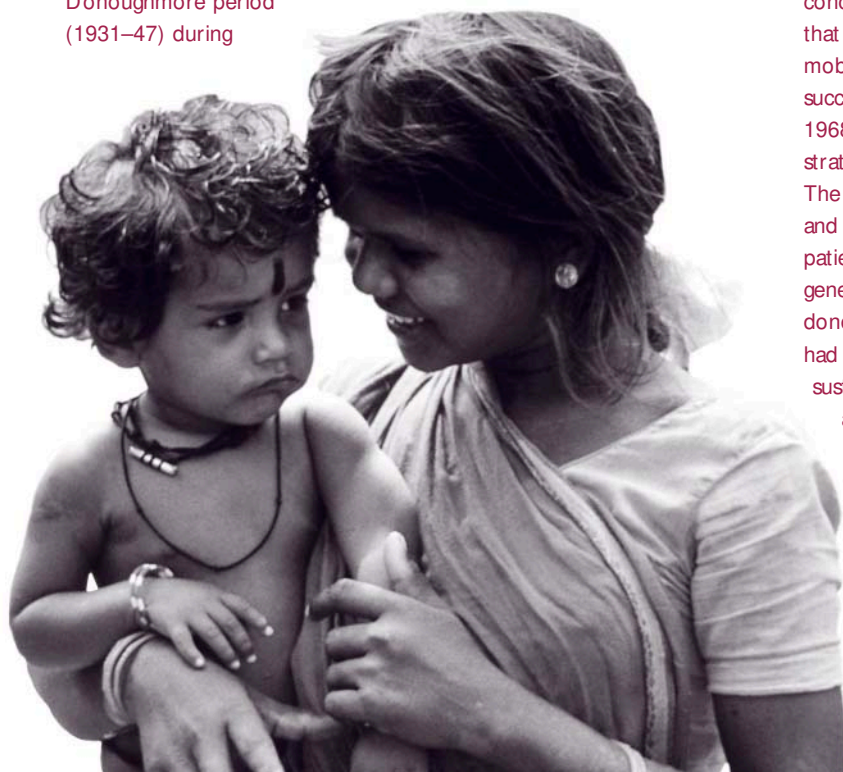
which Sri Lanka had semi-autonomy and universal suffrage was introduced, to the post-Independence period, 1948 onwards. He traced three major trends in policy making – the first between 1931 and 1948, when the welfare state was in the formative 'embryo' state, to the period of consolidation between 1956 and 1970, and the policy changes in context of the interventions of the World Bank, the IMF and the compulsions of liberalization. Finally he discussed how the concept of the welfare state in Sri Lanka was thus shaped by debates among the British, the Nationalists, the Liberals and the Leftists.

The second paper in the session was presented by Professor Pieter Streefland (University of Amsterdam), entitled, 'The Emergence of Routinized High-Coverage Vaccination Programme in Bangladesh'. He stated that the need for large-scale compulsory vaccination, particularly for smallpox and cholera was emphasized by the Border Committee in 1947 as part of attempts to effect postwar changes. Immediately after 1947 the vaccination programmes in East Pakistan had been restricted to the BCG for TB and the cholera vaccines. The problems were magnified because the massive post-Partition migrations were held to have spread the diseases. In 1968 East Pakistan was part of the global campaign for the eradication of smallpox. By 1975 smallpox was reported to have been eradicated from Bangladesh. He argued that international development discourse reflected concern about the fast-growing population. Studies in the 1980s have concluded that public health services have largely been ineffective in Bangladesh. The Expanded Immunization Programme in Bangladesh was launched in 1979, but required large-scale coverage and continuity, which were dependent on logistic and data support. The programme accelerated only after it was supported by international agencies and private initiatives.

The final paper of the session and the symposium was by Professor Paul Greenough (University of Iowa, USA), 'The Smallpox Eradication Programme in South Asia, 1970–77'. He argued that the strategy of 'surveillance and containment' was deemed to be a better strategy than mass vaccination in South Asia in eradicating smallpox. A review in 1968 concluded that the incidences of smallpox were rising in South Asia and that up to 90 per cent of the cases were not recorded. During 1968–72 mobile vaccination teams operated (with freeze-dried vaccines). The success of the intensified Smallpox Eradication Programme between 1968 and 1972 in both India and Bangladesh had depended upon the strategies of surveillance and containment on a village-to-village basis. The entire operation had called to measure a great degree of coercion and intimidation, which included house-to-house searches for smallpox patients and forced vaccination. The high degree of coercion was generally directed not so much by the state as by the international donor agencies which had participated in the programme. The policy had also been characterized by meticulous record keeping and had sustained itself through the collaboration of several South Asians who appear to have been dedicated to the cause of smallpox eradication by any means.

Nandini S Bhattacharya, Doctoral Student, Wellcome Trust Centre for the History of Medicine at UCL
(E-mail: nandini_hills@rediffmail.com).

Image courtesy of the Wellcome Trust's International Health Image Collection



Anatomical Knowledge in the Ancient World

From prehistory to late antiquity

University of Birmingham Medical School (UK), 16–19 June 2004

The Society for Ancient Medicine is holding its first European meeting outside the USA on 16–19 June 2004, when it is teaming up with the Centre for the History of Medicine of the University of Birmingham Medical School to hold the conference. The initiative is supported by the Institute of Pathology, Bogenhausen Academic Hospital, Munich (Germany) and the Institute of Ancient History and Culture, University of Salzburg.

This international conference aims to bring together for the first time a gathering of classicists, ancient historians, medical historians, medical practitioners, archaeologists and biological anthropologists to explore our understanding of the body in ancient medicine and philosophy. The conference will look at all aspects of anatomy and anatomical knowledge from prehistory to late antiquity, with special reference to the Classical world (and its predecessors), Europe, Egypt, the Near East, the Indian Subcontinent and China.

The multidisciplinary programme will include papers (or posters) on the following general themes:

- anatomy and disease;
- anatomy and the philosophy of the body;
- anatomy and medical practice;



Two Greek soldiers, one binding the other's arm.

- anatomy and gender;
- anatomy and medical education;
- anatomy in ancient art;
- anatomy and sport.

The conference will be held in the University's Conference Park, located nearby the main campus and the Medical School. It will be accompanied by a social programme, reflecting the multi-ethnic culture of Birmingham, together with a conference dinner. The languages of the conference will be English, French and German. Already we have had offered 43 papers from scholars from 15 countries.

For further details contact:

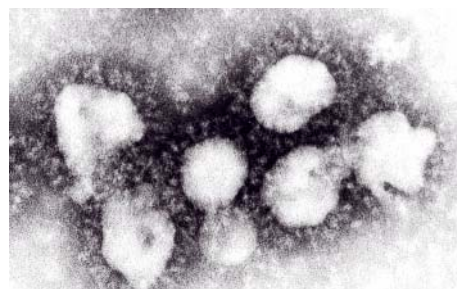
Robert Arnott
Centre for the History of Medicine
The Medical School, University of Birmingham
Birmingham B15 2TT (UK)
E-mail: R.G.Arnott@bham.ac.uk

Medicine at the Border

The history, culture and politics of global health

An international conference, Sydney, Australia, 1–3 July 2004

- SARS and its precedents
- Foreign-ness, diaspora and contagion
- Travel, migration and quarantine
- Disinfecting mail, from leprosy to anthrax
- Colonialism and hygiene
- Vaccination and histories of nations
- Race, immigration and medico-legal border control
- Frontiers, medicine and cultures of aid
- History of international health and hygiene
- Detention, dangerousness and risk
- Medical history and epidemiology
- Genealogies of geography and population



SARS virus showing the distinctive corona.
Hazel Appleton, HPA

Sponsored by the Departments of History and Medical Humanities,
University of Sydney

Call for papers: 300-word abstract and CV in hard copy
by 1 December 2003 to:

Dr Alison Bashford
Department of History
University of Sydney, NSW
Australia 2006

E-mail: alison.bashford@history.usyd.edu.au

Web: www.arts.usyd.edu.au/departments/history/conferences.shtml

New Open University course in the History of Medicine

In February 2004, the Open University will offer its first ever course in the history of medicine. For the last three years a small course team – Peter Elmer, Deborah Brunton, Silvia De Renzi and Ole Grell – with the assistance of a large number of consultant authors have been planning and preparing materials for *Medicine and Society in Europe, 1500–1930*. This is a chronological survey course in the social history of medicine, which explores development in theory and practice through studies of specific topics. These aim to reflect the current state of scholarship in the field, and include areas of well-established scholarship such as hospitals and public health as well as newer fields, including colonial medicine, the medical environment, and medicine and war.

Medicine and Society has a number of distinctive features. It covers Europe and its colonies, using comparisons between different countries to highlight the social, political and cultural factors shaping medical thought and practice. The course also has a strong emphasis on the use of visual sources. The course team have used the OU's long experience in producing audiovisual material to prepare eight short videos on topics from the early modern hospital to medicine in World War I. In addition, there is a CD-ROM, which aims to teach students basic visual literacy, then provides interactive exercises on over 200 images, most from the Wellcome's extensive collections.

These are complemented by a virtual museum of around 90 medical objects. *Medicine and Society* is also one of the first courses in the history of medicine designed for distance learning, and thus promises to open up the subject to many students who might not otherwise be able to study it.

The course is based around two books of specially commissioned essays – *The Healing Arts: Health, disease and society in Europe, 1500–1800* and *Medicine Transformed, Health, Disease and Society in Europe, 1800–1930*. The authors are all established scholars in the field and include Roger Cooter, Andrew Wear, Stephen Jacyna and Hilary Marland. Each essay contains exercises based on extracts from

Left: Image from William Cheselden's Osteographia, which features on the OU course CD-ROM.

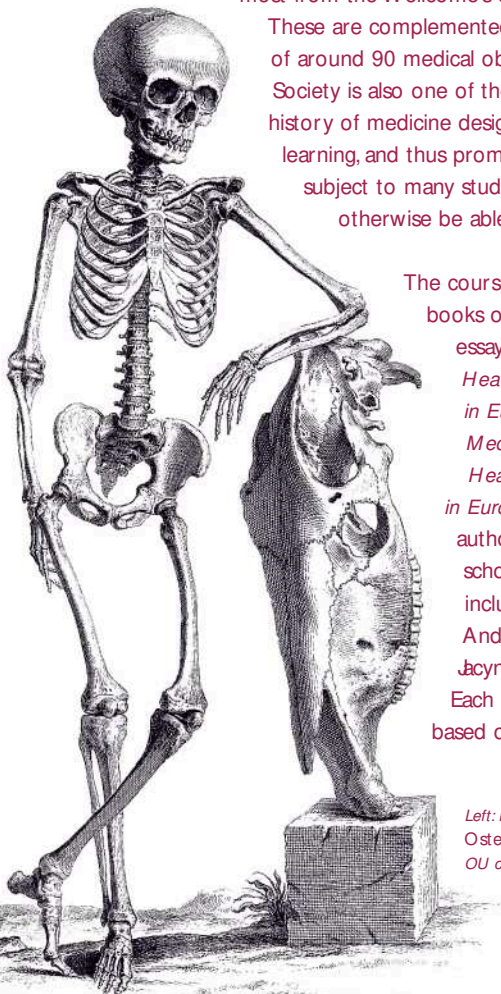


A surgeon binding up a woman's arm after bloodletting. Oil painting by Jacob Toorenvliet, 1666. This image appears on the cover of the first course book.

primary and secondary sources, published in the accompanying source books, *Health, Disease and Society in Europe, 1500–1800: A source book* and *Health, Disease and Society in Europe, 1800–1930: A source book*. Although written primarily for OU students, they are designed to be used in any other teaching context. All four texts will be published by Manchester University Press in 2004 and we hope they will prove popular – particularly the source books which offer a unique mix of materials.

Students are already signing up for *Medicine and Society in Europe*, and early indications are that the course will be popular. This presents the course team with a problem – we need to recruit tutors! Anyone interested in the course can find more details on the website: www.open.ac.uk/arts/a218. Potential tutors can also look up www3.open.ac.uk/employment/associate-lecturers or contact their local OU regional office.

Dr Deborah Brunton
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The Tyranny of Treatment

Dr Samuel Johnson, his friends and late Georgian medicine

Opened 18 September 2003

Opening on the birthday of Dr Samuel Johnson (1709–1784), author of the famous English dictionary, this new exhibition is a very personal exploration of how a wide range of medical conditions were treated in the 18th century.

The exhibition takes place in the historic garret of Dr Johnson's House, the very room where the dictionary was compiled between 1747 and 1755. The displays examine the health of Dr Johnson and five of his closest friends, including Sir Joshua Reynolds, James Boswell, Mrs Thrale, Fanny Burney and Anna Williams. It explores the treatments they used for conditions still common today such as blindness, hearing problems, asthma, depression, venereal disease and breast cancer.

The six friends' stories are illustrated with displays showing typical surgical instruments of the period such as a couching needle used for cataract operations, syringes and various blood-letting implements. There are first person accounts by Fanny Burney describing her mastectomy in 1811, and by Hester Lynch Thrale covering a lifetime of pregnancy, miscarriage and the loss of eight out of 12 children in infancy.

Exhibition highlights will be the rare chance to see Samuel Johnson's death mask, which shows the scars of childhood scrofula, his original autopsy report, and an 18th-century skull with signs of syphilis.

The exhibition is a snapshot of medical understanding in the late Georgian period. It illustrates a time in which the limitations of medicine meant that some conditions, and some treatments, were far more



Above: Dr Samuel Johnson.

dangerous than they are today but that people shared many of the health concerns we continue to live with.

For more information on lunchtime events and evening lectures or to book a private view please contact:
Natasha McEnroe, Curator,
or Rachel Kennedy, Education Officer, on 020 7353 3745 or by e-mail on curator@drjohnsonshouse.org. Web: www.drjohnsonshouse.org
The exhibition will be open to the public until Saturday 31 January 2004.

Museum opening hours are Monday to Saturday 11.00–17.00. Nearest Underground stations are Blackfriars and Chancery Lane. The house is well signposted from Fetter Lane, Shoe Lane and Fleet Street.

There is an admission fee.

Dr Johnson's House
17 Gough Square
London EC4A

ANNOUNCEMENT

Rose Prize

This prize commemorates William Rose, Apothecary of London, whose court case of 1701–04 established the legal foundation of general practice in England and Fraser Rose, a co-founder of the Royal College of General Practitioners. The Worshipful Society of Apothecaries of London and the Royal College of General Practitioners are pleased to announce the Rose Prize for original work in the history of British general practice will be awarded for the first time in spring 2005.

Submissions are invited from all non-professional historians either as individuals or as a group who are, or who have been, involved in primary healthcare. The work should be original and previously unpublished, with demonstrable emphasis on primary source material, and it should have been undertaken in the previous two years. It should be appropriately

illustrated. Any topic on the history of British general practice may be chosen. Typescript entries should not exceed 8000 words, but submissions in other media will be accepted provided that they are of comparable intellectual rigour. Publication will be encouraged.

For further details and entry forms contact:
Ms Kate Messent
Awards Administrator
The Royal College of General Practitioners
14 Princes Gate
London SW7 1PU
Tel: 020 7581 3232
E-mail: cmessent@rcgp.org.uk

European Psychiatry on the Eve of War

Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s

In 1937, at the instigation of the Rockefeller Foundation, Aubrey Lewis, clinical director of the Maudsley Hospital, made a tour of key psychiatric institutions in Europe. The report he wrote on his return is published here for the first time. It opens up a number of new perspectives on the European medical world in the years immediately before the World War II: a time when psychiatry was in flux and there was a wide debate about how it should be defined. Appointed as professor of psychiatry at the University of London in 1946, Lewis was one of the most influential psychiatrists in second half of the 20th-century in the UK. The editors analyse the issues raised by his report and look at the history of the Maudsley Hospital from its opening in 1923. They also study the role played by the Rockefeller Foundation in the development of the Maudsley and, more widely, the nature and status of psychiatry itself at a key period in the history of the specialism.

About the editors

Katherine Angel is working on her PhD thesis on contemporary medical discourse about psychological and multiple causes at Cambridge; Edgar

Jones is Reader in the History of Medicine and Psychiatry at the Institute of Psychiatry and Guy's, King's and St Thomas' School of Medicine, Denmark Hill, London; Michael Neve is Senior Lecturer in the History of Medicine at the Wellcome Trust Centre for the History of Medicine at University College London.

Angel K, Jones E and Neve M (eds) *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital and the Rockefeller Foundation in the 1930s*. Medical History, Supplement No. 22, 2003, pp. vi, 189, illus., ISBN 0 85484 092 3, hardback, £32, US\$50.

Orders to:

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Wellcome Library
The Wellcome Trust
183 Euston Road
London NW 1 2BE, UK
E-mail: t.tillotson@wellcome.ac.uk

Pearls of the Orient

Asian treasures from the Wellcome Library

This lavishly illustrated book conveys the richness and diversity of the Wellcome Library's Asian collections in a series of studies contributed by experts from the UK, Germany and Russia.

Each chapter reflects a different region of Asia, its peoples and culture, in which something of the variety of the Wellcome Asian collections can be appreciated. The different languages and their scripts, the various materials used for writing, the multiplicity of cultural and religious backgrounds and their antiquity are exemplified in the Asian collections. They constitute a major resource for study and research of Asia's cultural and social history so beautifully illustrated in this publication.

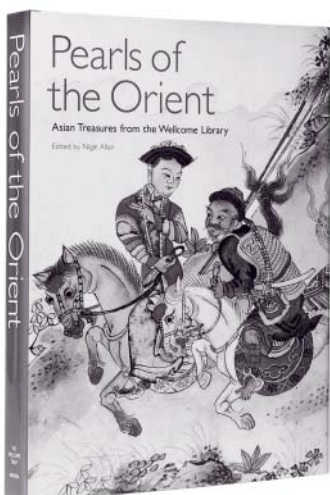
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Henry Wellcome and the Asian collections – Nigel Allan
Marriage Hebrew style – Nigel Allan
The nature of image veneration in Armenia – Vrej Nersessian
Between meaning and image: Islamic calligraphy – Nikolaj Serikoff
Astrological image in two Persian manuscripts – Sergei Tourkin
The love of Krnsa in poems and paintings – Dominik Wujastyk
'Reading' Indian manuscript paintings from Punjab – Jeevan Singh Deol
Illustrations from the life of the Buddha – William Pruitt and Peter Nyunt
A monk travels to heaven and hell – Henry Ginsburg
A rare series of Tibetan banners – Gyurme Dorje
Illustrations of ethnic groups in southwestern China – Hartmut Walravens
Japanese medical books and illustrations – Peter F Kornicki

Price £30 (US\$50); delivery is free.

Pearls of the Orient is published by Serindia Publications (www.serindia.com) and is distributed in the UK, Western Europe and rest of the world (excl. USA, Canada, Thailand and India) by Thames & Hudson (www.thamesandhudson.com).

Allan N (ed.) (2003) *Pearls of the Orient: Asian treasures from the Wellcome Library*. Chicago: Serindia Publications. 216pp. ISBN 0 906026 60 1



The century of the transformed cell

Researchers at the Manchester

Wellcome Unit study the recent history of cancer research and cancer services



is in many ways paradigmatic of 20th-century medicine. In the second half of the century, only cardiovascular disease loomed larger in death and disability statistics. Cancer, however, played a much more central role in public imagination – as the leading edge of biomedical research, a major target for pharmaceutical innovation, a key object of public health concerns and the chief focus of popular medical charity. From laboratory science to philanthropy and from high technology to hospices, the history of cancer offers an ideal window onto the dynamics of modern medicine.

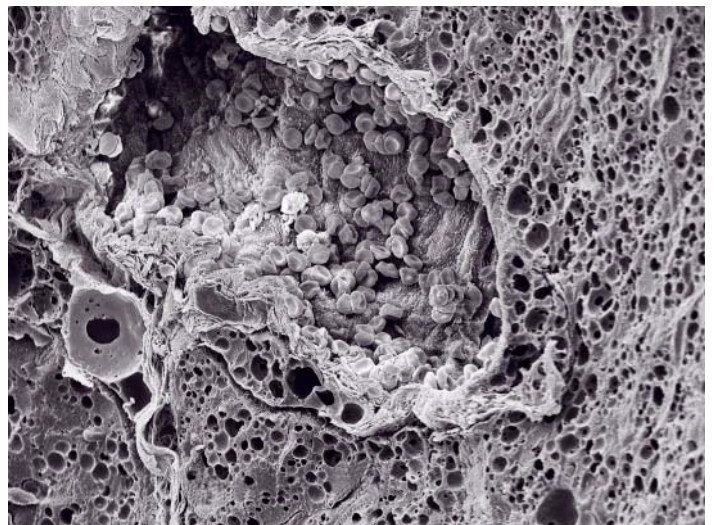
Professor John Pickstone at the University of Manchester has been awarded a Wellcome Trust Programme Grant to research the history of cancer research and cancer services in the UK. Work on the project 'Constructing Cancers, 1945–2000' has now started. For the project, Pickstone has assembled a team of three postdoctoral researchers. Helen Valier completed a PhD in Manchester on the history of clinical research programmes before and after the launch of the National Health Service. She has since taught history of medicine and technology at Leeds and researched the history of diabetes services in postwar Britain. Elizabeth Toon's University of Pennsylvania PhD dealt with health education programmes in Detroit. Elizabeth taught at Cornell University's Science and Technology Studies Department and assisted Robert Aronowitz with his research on the history of breast cancer in the USA. Carsten Timmermann, the third researcher who also assists Pickstone with the coordination of the project, gained his PhD in Manchester for a study on the history of German interwar medicine, after which he worked on the postwar history of cardiovascular research in the UK and Germany.

The Manchester researchers are focusing on the history of three cancers which they believe to be key to a better understanding of the links between changing notions of disease, and biomedical research programmes and clinical services. The history of blood and lymph cancers, for which the first effective methods of chemotherapy became available in the 1960s, is one of the success stories of postwar biomedical science. In the UK, this development gave rise to the discipline of medical oncology. Breast cancer features highly on the public agenda, and the history of breast cancer services has been shaped significantly by patient activism and gender identity. Lung cancer, finally, is in many ways a recalcitrant disease and has enjoyed little interest from biomedical researchers since the link with smoking was established by epidemiologists in the 1950s and 60s.

Pickstone and his colleagues are planning to compare the histories of these three types of cancer in the context of postwar society and politics, and explore how, while having been invested with their own

identities, they represented facets of the same disease group. They will be researching the relations of research and therapy, looking at patient expectations and experiences regarding risk, diagnosis, treatment and palliation, and they will be studying the role of professional and institutional configurations as determinants of patient management.

Manchester is an ideal place to undertake such a project. Not only have the Wellcome Unit and its host institution, the Centre for the History of Science, Technology and Medicine in the past years been able to establish a solid reputation for good scholarship on the recent history of these fields. The city is also home to one of the most important cancer hospitals and research institutes in the UK, the Christie Cancer Hospital and the Cancer Research UK's Paterson Institute.



Above: Scanning electron micrograph of a blood vessel in a melanoma.

The Manchester team are aiming for strong international links with historians of medicine, but they are equally interested to establish a dialogue with practitioners and patients, and with a larger public. They will be creating a substantial project website with sources, summaries and brief publications, providing an infrastructure for productive collaborations with researchers on related topics elsewhere in the world, and with opportunities for an active communication with their different audiences. Thereby they are hoping to add a historical dimension to the public awareness of cancer research and services.

For more information, please visit the website of the Manchester Centre: www.chstm.man.ac.uk/; or contact Professor John Pickstone, Wellcome Unit for the History of Medicine, University of Manchester, Mathematics Building, Oxford Road, Manchester M13 9PL. E-mail: john.pickstone@man.ac.uk.

Wellcome Trust Centre at UCL

In the autumn of 2002, the Wellcome Trust Centre for the History of Medicine at UCL was delighted to welcome several members of the former Unit at UEA, who have further strengthened the profile of our group in London.

Roger Cooter has come aboard as a Wellcome Professorial Fellow. Roger's reputation as one of the world's leading social historians of ideas in science and medicine from the 18th to the 20th century is well known. A prolific author, he is perhaps best known for his work on the history and historiography of alternative medicine, medical ethics, the popularization of science, phrenology, orthopaedics, child health, accidents, and war and medicine, but he has also written on a number of other subjects. With John Pickstone, he recently edited and contributed to *Medicine in the 20th Century* (Routledge, 2003), which has been hailed as an historiographical accomplishment of lasting value. His diverse research interests are reflected in forthcoming publications on, among other things, doctors in Parliament in inter-war medicine, for the *Bulletin of the History of Medicine*; the idea of war and epidemics, for *Social History of Medicine*; the mixed traffic in Victorian bodies, for *Victorian Studies*, and the demise of the social history of medicine for a forthcoming edited volume. Recently invited by the National Library of Medicine, at Bethesda, to explore their iconographical collection, Roger returns there in October to present his findings to a conference on 'Visual Culture and Public Health'.

However, his main foci of attention over the next few years will be on a political history of medical ethics, and a study of the question of the



Left: Professor Hal Cook, Director of the Wellcome Trust Centre at UCL.

militarization of medicine from the mid-18th to mid-20th century. Roger regularly reviews for historical and medical journals, and is one of the editors of the Manchester University Press monograph series, 'Encounters: Cultural histories'. No stranger to seminars and symposia, he will be able to contribute

significantly to the Centre's ongoing scholarly programmes and to consult with students, fellows and visitors.

Roger was accompanied to the Centre by two Wellcome Trust postdoctoral fellows, Rhodri Hayward and Louise Gray, together with four full-time PhD students. To them the Centre also extends its warmest welcome.

Rhodri took up his fellowship in October 2002 to work on the historical relationship between psychiatry and general practice in 20th-century Britain. His work involves examining the uptake of psychological models in general practice, the psychologization of the doctor-patient relationship and the rise of GP psychotherapy after World War II, and the role of primary-care physicians in the development of psychiatric epidemiology. The study moves from the political use of illness models in face-to-face doctor-patient encounters in the interwar period to the modern use of large-scale assessments of psychiatric risk and morbidity in the formation of contemporary social policy. Thus attending to key points of contact between medical practice and political power, Rhodri's work at the Centre echoes some of Cooter's in its approach. No doubt it will be as significant in its impact.

Since arriving at the Centre, Rhodri has completed an article on religion and neurology for the *Bulletin of the History of Medicine*, contributed a chapter on the history of the Maudsley Hospital for Volker Roelcke's and Paul Weindling's forthcoming volume on *British-American-German Relations in the History of Psychiatry, c.1870-1945*, and written on 'medicine and self' for *Wellcome History*. He has also contributed papers on medical technology and human identity for the 'Psyche de Schrift Workshop' at the University of Weimar, and on epilepsy and holism for the Anglo-Dutch-German meeting at the University of Warwick. He is currently coorganizing for the Centre a conference on the modern history of sleep and dreams, and with Roger Cooter supervises four of our PhD students.

Louise Gray obtained her PhD from UCL in 2001 after studying at the Centre. Her dissertation on health provision for the rural inhabitants of early modern Hesse, Germany, was supervised by Professor Nutton.

Visitors

Visitors to the Wellcome Trust Centre during September, and at the Centre at the time of publication, included:

Dr Eugen Ciurtin (University of Bucharest)

Dr John Martin Honigberger and a comparison of the 'appropriate moment' in Hippocratic writings and ancient Indian medicine.

Dr Constance Putnam (Concord, USA)

Writing a book (and papers) on Semmelweis and Oliver Wendell Holmes.

Dr Moyra Smith (College of Medicine, University of California)

The history of human genetics, with special emphasis on the morbidity of specific birth defects.

Sally Bragg

Visitor and Programmes Administrator

(with apologies to those of our visitors whose plans were not finalized at the time of providing copy.)

Her Wellcome Trust Postdoctoral Fellowship builds on her doctoral study, pursuing the effects of the Reformation and Counter-Reformation on health and welfare policies in 16th-century Hesse. 'Bottom-up' as much as 'top-down' in approach, Louise's work fundamentally challenges the separation of religion from medicine found in most historical studies. Louise has already begun to publish, with a chapter on the experiences of old age in the narratives of the rural poor in early modern Germany for a volume entitled *Old Age in the Pre-Industrial Past*. She also has various reviews in press. More central to her life just now, however, is the recent arrival of her first child. Louise will therefore be intermitting her fellowship for a year. We wish her and her family well, and look forward to her return to the Centre in due course.

Of the four PhD students who came to the Centre with Roger, Peter Skelton, is now in the second year of his study of the scientist and science popularizer, John Tyndall; Jonathan Toms is completing a critical study of the transformation in the status of mental patients in Britain

during the second half of the 20th century; Ben Mayhew, on AHRB funding, is undertaking a contextual study of John Bowlby's theories on child development; and Rob Kirk, also on AHRB funding, is finishing a study of the problematization of the experimental animal in laboratory medicine from the 1930s to the mid-1960s.

I would like to express my thanks to the staff of the Centre, most especially to Alan Shiel, and to those at Trust and UCL, who helped to make the transition of our new colleagues possible. We look forward to moving on to even greater accomplishments thanks in part to the additional vigour of our new colleagues.

Professor Hal Cook
Director
The Wellcome Trust Centre for the History of Medicine
University College London
E-mail: h.cook@ucl.ac.uk

Roy Porter Memorial Studentship

The Centre is delighted to announce that the Wellcome Trust has approved its nomination for the first Roy Porter Memorial Studentship. The successful candidate for this most prestigious studentship in the history of medicine is an outstanding young Indian scholar, Nandini Bhattacharya.

Nandini has an MPhil and MA from the Jawaharlal Nehru University and a BA with first class honours in history from the University of Baroda. At the Centre, Nandini will work on a study of 'Disease, Labour, and Habitation: Understanding health and sanitation in the tea plantations of Darjeeling and Duars, 1860–1980'. The study will attempt to understand health among the plantation workers in terms of ecology, habitation, and life style, and the role of the state with particular reference to malaria and tuberculosis. Her work will be supervised by her namesake (but no relation!), Sanjoy Bhattacharya.

Competition for the studentship was fierce, with applicants from across Europe, North America and the Far East. Nandini was eventually selected above other outstanding candidates for her passion and commitment to her studies and the subject matter. The selection panel, which included Professor Lisa Jardine from Queen Mary and Westfield College, felt that she was a worthy candidate to hold the honour and responsibility of being the first scholar to be awarded the studentship named after such an eminent historian of medicine, and that Roy himself

would have approved of the selection of someone so energetic and so determined to make a contribution to our understanding of the subject.



Nandini Bhattacharya.

Announcing the award, the Centre Director, Professor Hal Cook, expressed himself delighted with the appointment. "Nandini Bhattacharya is an exceptional young scholar whom we are proud to have join us. Her work will provide a fascinating insight in the life of plantation workers from the days of the Raj to post independence India. It is exciting that she will help us further develop our international perspective and in particular underpin the work which is being done in the Centre by a group of scholars working in the area of Asian Medicine."

In accepting the award Nandini described herself as thrilled and honoured. She will begin her studies in September. The award is for three years and will therefore be advertised again in late 2005.

Alan Shiel
Administrator
The Wellcome Trust Centre for the History of Medicine at UCL
E-mail: a.shiel@ucl.ac.uk

CALENDAR OF EVENTS

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

October 2003

22 Hospital Contributory Schemes to Health Cash Plans:
A twentieth-century history of a British institution
Institute of Historical Research, London
Contact: Martin Gorsky (E-mail: m.gorsky@mlv.ac.uk)

30 Anglo-Spanish Colloquium on Rural Health
in 19th-century Europe
School of History, University of East Anglia, Norwich
Contact: Steve Cherry (E-mail: s.cherry@uea.ac.uk)
or Rowena Burgess (E-mail: rowena.burgess@uea.ac.uk)
[Colloquium concludes on 1 November]

November 2003

4–8 Asian Society for the History of Medicine, Taipei, Taiwan
Contact: ashm@pluto.ihp.sinica.edu.tw

14 History of Paediatric Gastroenterology Conference
Apothecaries Hall, London
Contact: Professor John Walker-Smith
(E-mail: johnwalker_smith@hotmail.com)

March 2004

3 Alice Stewart: A life in epidemiology
Friends Meeting House, London
Contact: Robert Arnott (E-mail: R.G.Arnott@bham.ac.uk)

June 2004

16–19 Anatomical Knowledge in the Ancient World: From prehistory
to antiquity (Society for Ancient Medicine Conference)
University of Birmingham Medical School
Contact: R.G.Arnott@bham.ac.uk

July 2004

1–3 Medicine at the Border: The history, culture and politics of
global health
University of Sydney, Australia
Contact: alison.bashford@history.usyd.edu.au

August 2004

5–7 Fifth British-North American Joint Meeting of the BSHS,
CSHPS and HSS
Halifax, Nova Scotia, Canada
Contact: info@hssonline.org

November 2004

History of Cancer
National Library of Medicine (NLM), Bethesda, Maryland, USA
Contact: David Cantor (E-mail: cantord@mail.nih.gov)

Submissions to *Wellcome History*

The next issue of *Wellcome History* is due out in spring 2004. Please send your contributions to Sanjoy Bhattacharya at the address shown. Preferably, contributions should be pasted into an e-mail and sent to the Editor (sanjoy.bhattacharya@ucl.ac.uk). Alternatively send the Editor a disk with a paper copy of the article. For more detailed instructions, visit the *Wellcome History* web pages at www.wellcome.ac.uk/wellcomehistory.

DEADLINE FOR SUBMISSIONS: 15 NOVEMBER 2003

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