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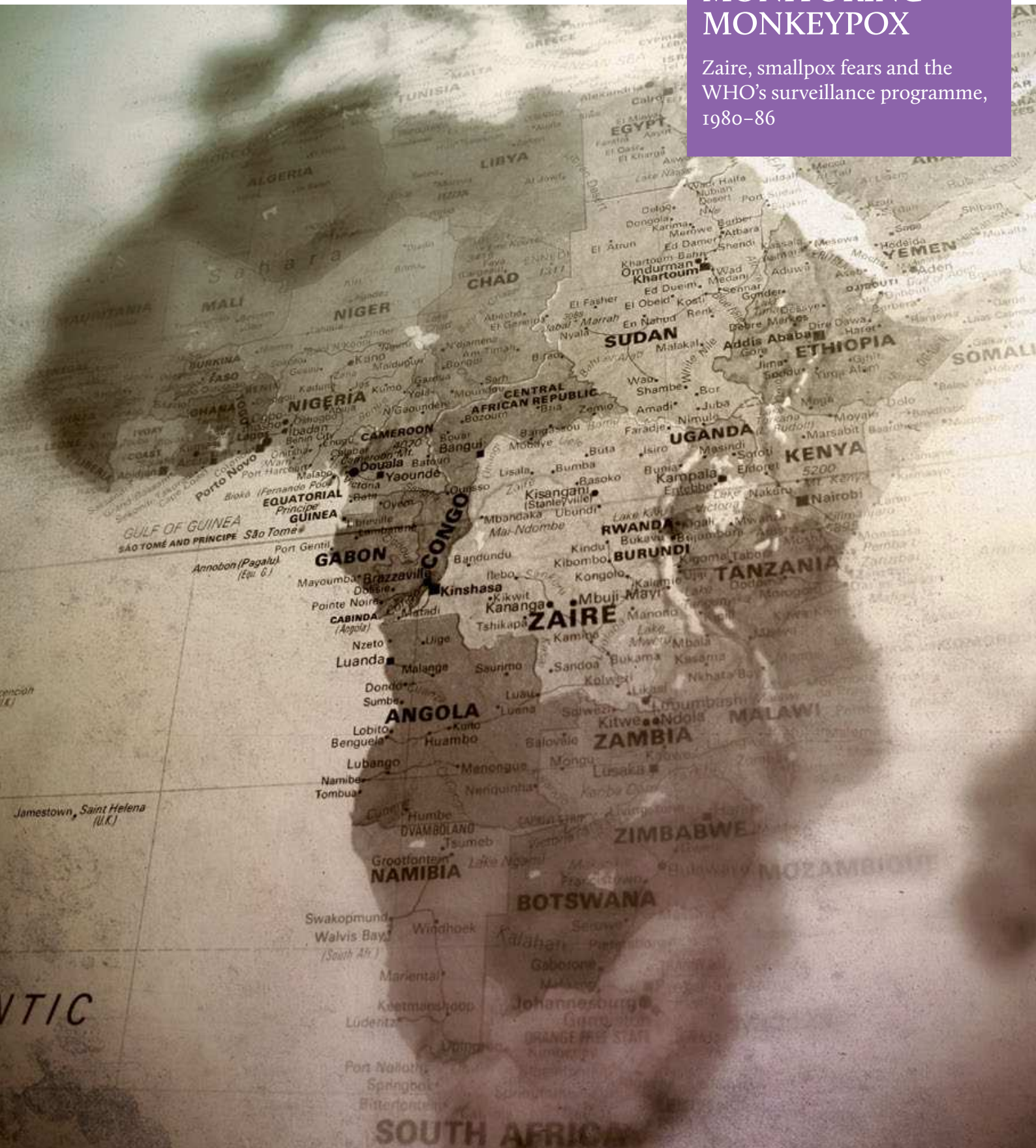
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Wellcome HISTORY

MONITORING MONKEYPOX

Zaire, smallpox fears and the WHO's surveillance programme, 1980-86



An ‘insurance policy’ for smallpox eradication

Feature: The World Health Organization’s monkeypox surveillance programme, 1980–86

Robin Fawcett



WHO headquarters in Geneva. Wellcome Library

In May 1980, the WHO certified the global eradication of smallpox. In recent years, historians have examined more closely the difference between the public and private, published and unpublished, accounts of the eradication, and the discrepancies can be revealing.

Beneath the triumphant language of the historic declaration lies evidence of considerable scientific uncertainty and fear that variola virus might yet lurk in some remote corner of the globe, or that a closely related virus – monkeypox – might mutate into the very scourge the WHO had struggled to eliminate. With this in mind, the WHO Smallpox Eradication Unit conducted a broad and intensive monkeypox surveillance programme in central and western Africa from 1980 to 1986. An examination of unpublished papers in the WHO smallpox eradication programme archives in Geneva suggests that the WHO’s motives with regard to the monkeypox programme were more complex than generally acknowledged.

Years before the intensive monkeypox research programme, WHO researchers had acknowledged repeatedly that monkeypox virus, in and of itself, was unlikely ever to become a major public health threat. Instead, the WHO’s commitment to the research was a result of the virus’s clinical and laboratory similarities to variola virus; the interest in monkeypox naturally intensified as the smallpox eradication programme drew to a close.

Monkeypox virus and variola are both members of the genus orthopoxvirus, although their epidemiological features differ; it was generally accepted that, unlike smallpox, monkeypox had an animal (not human) reservoir. In humans, monkeypox was virtually indistinguishable from smallpox infection, with a similar clinical course of fever and pustular rash. And in the 1970s, Soviet scientists even suggested that a variant of monkeypox, dubbed ‘whitepox’, was identical to variola.

In contrast to the optimistic language of the smallpox eradication

announcement, WHO scientific working papers from 1978–79 reveal fears that smallpox might return, from either an animal reservoir or the mutation of monkeypox. Just months before the 1980 declaration, the Global Commission for the Certification of Smallpox Eradication recommended that the WHO give urgent priority to the Soviet whitepox findings. This and the subsequent research and surveillance activities demonstrate the fears that monkeypox was a threat to the success of smallpox eradication. The need for an ‘insurance policy’ against unexpected poxvirus would be a familiar theme in WHO plans for a dedicated programme of monkeypox surveillance and research.

In 1979, the Smallpox Eradication Unit proposed monkeypox surveillance and research activities notable for their extraordinary depth and breadth. Objectives included: a more precise definition of human monkeypox frequency, transmissibility and geographic distribution; determination of the monkeypox virus reservoir and ecology; and ascertainment of whitepox virus prevalence as well as other animal orthopoxviruses that might cause human disease in west and central Africa. The proposed target countries included Zaire (as was), Nigeria, Cameroon, Ivory Coast, Liberia, Sudan and Malaysia.

The scope of the monkeypox programme attracted private criticism from smallpox eradication veterans, including Dr Donald A Henderson, who was director of the smallpox eradication programme during the crucial years 1966–77. Medical and scientific researchers with experience in central Africa had reservations, too, about the complex technical and logistical challenges inherent

in the proposed field activities. The participation of local health authorities, particularly in Zaire, was questioned, as was the conservative estimate of costs. Furthermore, an immense backlog of sera at the US CDC from suspected smallpox cases would mean long delays for the processing of animal sera and tissue samples from monkeypox ecological surveys, and the monkeypox-specific antibody testing available at that time was unreliable. Nevertheless, by May 1980, the monkeypox surveillance programme was well underway.

Operational complexities abounded, and there was conflict between Geneva and teams in the field

The monkeypox programme occupied an important place in the WHO agenda for more than five years, led by some of the Smallpox Eradication Unit's most experienced officers. The activities covered a large swathe of territory, with a population of more than 5 million people. Nearly 300 cases of human monkeypox were detected, mostly in Zaire, where the programme was most active. Surveillance there was mainly hospital-based, targeted in rainforest regions. Serological surveillance was also conducted in Zaire in areas with the highest incidence of human monkeypox, mostly by collecting sera from children who had not received smallpox vaccine. These field studies, in combination with serological analysis and epidemiological research, were conducted at great length and expense, despite considerable administrative, logistical and political challenges. The campaign itself was characterised by frequent changes in research priorities and tactics, as the efficacy of particular strategies, and their implementation in different localities, was much debated.

The response of Zaire's citizens, local health officials and government officers to the growing WHO presence is not well documented in the Geneva archives. The WHO did make an effort in 1980–81 to personalise the country-specific surveillance programmes in western Africa. In Zaire, however, in keeping with the WHO system established in the days of smallpox eradication, the leadership and organisation of

the monkeypox programme were kept separate from the Zairian public health programmes that provided both financial and personnel support. This caused operational challenges. The WHO surveillance protocols were criticised by the Zaire public health service, for example, because they were incompatible with long-established national health maintenance systems and contained highly technical language unsuitable for the Zairian nursing staff to whom the protocol was distributed.

Operational complexities in Zaire abounded, and there was conflict at times between WHO administrators in Geneva and the research teams in the field. Cooperation from villagers and hunters was essential for the animal serology surveys, but the Zairian currency frequently experienced massive devaluation and was therefore not useful for compensation. By 1985, WHO field teams had adopted a form of currency that was both practical and highly effective: they paid villagers with shotgun cartridges. As correspondence between the field teams and WHO headquarters reveals, administrators were shocked and disturbed to discover their researchers dealing in such controversial material. The WHO field officers were immediately instructed to use only local currency, much to the dismay of the research team.

While field research in central and west Africa struggled to get underway, scientific fears about whitepox virus were being laid to rest. In late 1982, a breakthrough paper by Dr Keith Dumbell, a British authority on variola virus, discredited the Soviet whitepox research. Dumbell compared key biological markers of variola strains and demonstrated that cross-contamination of variola isolates in the Soviet lab had been responsible for the controversial findings. WHO scientists have more recently suggested that Soviet interest in variola virus and monkeypox research may have been prompted in part by Soviet efforts to weaponise orthopoxviruses, and the whitepox findings may have been deliberately fabricated.

Dumbell's conclusions and the scientific community's subsequent dismissal of the whitepox threat mark a major turning-point in the language used by the WHO to justify the monkeypox surveillance programme's activities. By 1983, WHO committee

working papers referred not to the threat of smallpox recurrence but to helping African nations manage outbreaks of human monkeypox. Tragically, it would be a different viral infection that would cause Africa's next public health crisis. In 1986, the WHO Committee on Orthopoxvirus Infections decided that the human monkeypox programme should be discontinued in light of the new research priority in central and west Africa: HIV/AIDS.

Sporadic cases of human monkeypox infection continued in central and west Africa after the

What is monkeypox?

- First discovered in 1958 in monkeys (hence the name), but more common in rodents.
- Part of the orthopoxvirus genus, like smallpox – the two have similar symptoms in humans.
- Commonest in central and west Africa, but never a major killer.

conclusion of the active surveillance programme. Significant outbreaks occurred in Zaire in 1996–97 and again in 2001; extended inter-human transmission was noted in an outbreak in the Republic of the Congo in 2005. A cluster of monkeypox infections occurred in the midwestern USA in 2003, associated with exposure to infected prairie dogs; the outbreak was traced to the importation of small mammals from Africa. Today, many epidemiologists and scientists consider monkeypox a potential bioterrorism threat.

The six-year mandate granted to the WHO monkeypox surveillance programme following the global eradication of smallpox provides a basis on which the confident rhetoric of the eradication declaration can – and should – be questioned. Three decades later, as we celebrate this monumental achievement, the medical world remains wary of smallpox, both as a disease and as a weapon. The history of smallpox eradication, and its research politics and methods, remains contemporary and relevant.

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Following Agnodike and Phaethousa

Work in progress

Helen King



Agnodike, by Alois Delacoux, 1834. Wellcome Library

I am completing a book (with an Arts and Humanities Research Council Fellowship) examining the fortunes of two ancient stories from the 16th century onwards. These are the Hippocratic case history of Phaethousa, who grew a beard when her husband left her, and Hyginus's Latin story of Agnodike, the 'first midwife'.

Both went through multiple transformations as they were used for different purposes by medical and other writers. For example, in late 17th- or early 18th-century London, a woman wanted to produce a handbill to advertise her skills in healing skin conditions, as well as providing cosmetic services such as facial makeovers in which she reshaped eyebrows to make the forehead look higher. Searching around for a professional name, she chose to call herself 'Agnodice: The Woman Practitioner', which suggests that the name would encourage clients to buy her services. In contrast, in 1851, when challenges were being made to women's traditional exclusion from the medical profession, the American physician Augustus Gardner gave a lecture on the history of midwifery in which he argued that women should not be allowed to practise obstetrics, owing to "the past inefficiency and present natural

incapacity of females" in this area. This dual appeal to history – the 'past' – and science – what women are 'naturally' able to do – was designed to deflect all possible dissent. He compared Agnodike to the infamous abortionists of his own day. A name that had evoked healing had completely changed its meaning.

The story of Agnodike is known from only one ancient source, the elusive Latin writer Hyginus (*Fabula* 274), who cannot be tied to any firm dates within the period of the Roman Empire. It re-entered the Western tradition in 1535 and was popularised through the work of Tiraqueau and Estienne in the 1550s and 1560s. The bare details – Agnodike disguises herself as a man in order to learn medicine, but then reveals her true sex to women in labour, until she is taken to court – were fleshed out in many different ways by writers from 1600 onwards who enlisted her as a classical ally to fight their contemporary battles: men trying to enter midwifery, women trying to prevent them, midwives seeking to raise the status of their profession, women struggling to enter other areas of the medical profession, and men endeavouring to keep them out. It featured in debates about Caesarean section and abortion, despite neither even being mentioned in the original Latin text. Studying the extraordinary range of variations in how this story was told provides a window on to the medical debates of the early modern and modern periods, and illustrates how a story from even a very marginal Latin writer could be seen as powerful enough to support various positions in professional and gender politics.

As for Phaethousa, she features as late as the 19th century, in a reference in James Young Simpson's treatise on hermaphrodites. In contrast to Agnodike, she comes with the authority of the 'Father of Medicine'. But she was not only used in discussions of sex change. In the 17th and 18th centuries she was used to illustrate theories about the role of emotion: either lust, the symptoms only developing because her husband was not available to satisfy her, or sorrow, with her 'female testicles'

drying up because she missed him so much. She also featured as evidence of the power of the imagination; by thinking of her husband, she came to resemble him. Furthermore, the story was also used as an example of various physical disorders, such as menstrual suppression and uterine prolapse.

A name that had evoked healing had completely changed its meaning

My book uses the stories of the virgin Agnodike and the mother Phaethousa to discuss the nature of femininity and the role of different parts of the body – beard, voice, womb, external genitalia – in establishing it. Agnodike can pass as a man without difficulty, but her femininity is not affected by her disguise. Phaethousa's femininity is a fragile condition, easily disrupted by the departure of her husband, but although her internal organs no longer function properly, and her external appearance changes, she remains a woman – a conclusion not, however, followed by all versions of her story.

These women were both so fundamental that, from the late 16th century onwards, the reader simply expected to find them in histories of midwifery or in discussions of sex change. The book therefore explores how classical texts were used to provide authority in medicine: how and why did their authority continue into the modern period? How far could the texts provide continuity, being read in different ways so that they could be accommodated into new explanatory frameworks? A close reading of the uses of Agnodike and Phaethousa also challenges Thomas Laqueur's still-influential model of a shift from a one-sex to a two-sex model in the 18th century (*Making Sex*, 1990), looking at sex and gender beyond the genital organs, and revealing a more complex interaction between different models of the body.

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Urbanising cholera

Work in progress

Rajib Dasgupta



A slum area of Delhi, where cholera has been a major risk. *Wellcome Images*

Most accounts of the epidemiology of communicable diseases characterise the man (and on occasion the woman) of medicine and science as the single dominant hero – to borrow Dostoevsky’s expression, “a positively good man”.

The germ, on the other hand, is quite certainly the villain of the piece, to be cracked (in the laboratory) and controlled (through vaccines and antibiotics). Accounts of greater social sensitivity (by historians and anthropologists) deal with a wider range of social nuances that affect common women and men in myriad ways. Coming from a public health officer this is an insider-practitioner’s view that places common concerns centre stage. My work is constructing a social epidemiological account of cholera, taking a public-health perspective, with a focus on the urban poor. Detailed analyses of social determinants of a single disease are not common; indeed, the social determinants literature has largely developed in the context

of non-communicable diseases in Western/industrialised societies.

Societal distributions and determinants of disease need to take into account political economy and political ecology; thus “power – both power over and power to do” is crucial for exposure to health hazards. While levels in real-life situations exist simultaneously (not sequentially), the proximal/distal framework may disjoin levels rather than connecting them. Examination of the problem of cholera as an urban health issue requires this sensitivity and therefore an adequate breadth of canvas. This account brings to the fore the transformation of cholera from an ‘Old World’, highly fatal epidemic to a milder disease, an endemic entity (with a propensity for focal outbreaks) of contemporary megacities, clustered in locales where the urban poor reside. The social determinants of this acute communicable disease operate at multiple levels, mired in local economics and politics.

Cholera is one of the classic diseases in the history of epidemiology.

John Snow’s seminal work on cholera epidemics in London (1820s–50s) marked a paradigm shift in epidemiological thinking for several reasons: a rational approach to the social determinants, inductive logic based on detailed and accurate descriptive data, and the right action for the right reasons (in contrast to sanitary physicians and miasmatic theories that were right in terms of action, for the wrong reasons). With subsequent shifts in analytical approaches, fuelled in part by epidemiological transition, a far more statistical approach has established itself as the gold standard of evidence-based medicine, focused on individual determinants (popularly, ‘risk factors’).

My work takes an eco-social approach in examining the social determinants of cholera and deals with different aspects of the problem. It argues for a social epidemiological approach to develop a contextual understanding of diseases. Social determinants of health, a wide and complex field of enquiry, encompasses social class, caste, gender, ethnicity,

education, infrastructure and access to public health services – to name a few. Social action needs to be based on a variety of evidence, including the historical. The emphasis is to identify the ‘causes of the causes’. That is what my work sets out to do for cholera in the context of a megacity (Delhi) where a large proportion of the population are ‘urban poor’, living and working in conditions of deprivation.

The pandemics of cholera are traced in the context of northern India, including the Punjab and Delhi, demonstrating that the region was repeatedly affected by successive epidemics, largely on account of importation through trade routes. This has been traced to the current (seventh) pandemic with a detailed analysis of time trends including the threat of a potential eighth pandemic attributed to the emergence of a new strain (*Vibrio cholerae* O139) in 1993–94.

Detailed description of the process of planning for public health in Delhi links the city’s post-independence rapid growth and social inequities to access to water and sanitation services, therefore highlighting the emergence of cholera as an endemic urban health problem. The analysis of spatial distribution of cholera cases within Delhi illustrates the value of ‘area effects’ as an epidemiological approach. Detailed mapping and eco-social

characteristics of colonies (vulnerable to cholera and other waterborne infections) mark a significant addition to existing knowledge.

A deconstruction of Delhi’s 1988 cholera epidemic, one of the most politically sensitive contemporary public health events, is an important contribution. The formal academic literature available focuses exclusively on microbiological aspects, while NGO literature does cover some of the social determinants. The uniqueness of this analysis is in the additional access to and analyses of official documents and collation of a wide range of information – into a cogent story demonstrating that social inequities adversely affected populations condemned by legal biases of urban planning and infrastructure.

A primary inquiry has been analysed to foreground the social determinants. An in-depth study of 300 households (100 each from three infrastructurally disadvantaged settlements) examined the role of behavioural factors. It is generally agreed that pathways of transmission of waterborne diseases are complexly intertwined. It is increasingly being argued by powerful players of international health that interventions based on ‘secondary routes’ (i.e. behavioural determinants including storage and hygienic issues) are effective in significantly reducing transmission of diarrhoeal

diseases. Based on statistical analysis of household-level incidence data and behavioural determinants, I conclude that behavioural issues lose their significance when pitted against stronger infrastructural determinants, access to which is a function largely of planned provision.

The Report of the WHO Commission on Social Determinants of Health is a concerted public health effort towards evolving a “new global agenda”. A remarkable and bold initiative, it has been received with both optimism and scepticism. The Commission cannot be faulted for not recognising that the momentum and nature of contemporary urbanisation is detrimental to the health and wellbeing in particular of the urban poor. It calls for urgent improvement of living conditions in slums and considers that most countries wish to be self-sufficient in resources. Upfront, it sees a clear role for local governments in housing and basic services, and as a prerequisite to that political recognition of illegal settlements and regularisation of tenureship. It is hoped that a work of this nature will strengthen the new agenda.

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A pathological misunderstanding

Work in progress

Stephen Lewis

Giovanni Battista Morgagni (1682–1771) is often described as the father of modern pathology. However, the image presented through continued reference to him and the bearing this has upon our modern understanding of the concept of disease may be in need of some clarification.

Published in 1761, Morgagni’s *De Sedibus et Causis Morborum per Anatomem Indagatis* equates post-mortem anatomical findings with observations made of the same individuals during life. As a result, it established the idea that there could be something tangible and

localised associated with disease. In so doing, Morgagni provided a material basis for the nosology, promulgated by Thomas Sydenham (1624–1689) and subsequently others, that diseases were specific entities that could be systematically classified in much the same way that species came to be classified by the Swedish botanist Linnaeus (1707–1778). (Indeed, Linnaeus presented his own classification of disease in his 1763 *Genera Morborum*.)

The century following Morgagni’s death saw a significant shift in medical thinking and in the relationship

between patient and physician. The previous person-oriented medical cosmology gave way to an object-oriented one: a move from bed chamber to hospital, and ultimately laboratory, as the source of medical knowledge and choice of treatment was effected. The focus of medical attention progressively shifted away from the suffering individual to the source of that suffering. The logic was simple: remove the source of the suffering and the patient will be made well again.

The work of Marie François Xavier Bichat (1771–1802) in *Traité sur les Membranes* (1800) helped shift

attention deeper, to the level of the body's tissues, while Rudolf Virchow (1821–1902) took this deeper still, to the cellular level, in *Die Cellularpathologie* (1859). At the same time, a shift in the notion of disease seems to have begun to take place. Where there was once a diseased person, the idea that there could be diseased organs, diseased tissues and even diseased cells emerged. Indeed, the words 'pathology' and 'disease' have now come to be so closely associated that they are in some contexts interchangeable.

The pathology to which Morgagni is progenitor is literally the study of suffering

However, an impasse has been reached in this reductionist trend that ran from Morgagni through Bichat to Virchow. During the 20th century, the search for causes of disease reached the level of the non-living, chemical components of the body. But on crossing the boundary between living and non-living substance, one reaches a point where one cannot reasonably speak of 'diseased genes', and to speak

of 'diseased body chemistry' would be nonsensical. The word 'disease', it seems, is reserved for only those components of the body that might be said to be 'alive' in some sense.

Originally, the word 'disease' literally meant an experience of 'dis-ease' – that is, 'un-ease' – and described what is now more often implied by the word 'illness'. In English, the earliest use of the word 'disease' dates from the early 14th century and simply meant 'discomfort', having been derived from the old French '*desaise*', which meant much the same. By the late 14th century, however, it had already come to be used in the sense of being unwell or ailing, but its literal sense of general discomfort seems to have continued until the early 17th century. Thus, a word that began by referring to how an individual felt in their entirety has now come to be applied also to component body parts.

This reification of 'dis-ease' has, at times, been perpetuated by a misunderstanding that has appeared in some influential texts on the history of medicine. The title *De Sedibus et Causis Morborum per Anatomem Indagatis* properly translates as 'On the Seats and Causes of Diseases, Investigated by Anatomy'. But it has sometimes been mistranslated as 'On the Sites

and Causes...' – with 'sites' erroneously substituted for 'seats'. Had Morgagni really meant 'sites' he would surely have chosen to use the more appropriate Latin word '*situs*'. Instead, he seems to have deliberately chosen 'seat'. Coupling 'seat' with 'cause' implies that he regarded the post-mortem lesions observed to be sources of disease – which we may reasonably understand here to mean an experience of 'un-ease' – rather than as disease entities *per se*.

While Virchow described himself as a thoroughgoing ontologist in that he held that diseases were discrete entities, the same should not be assumed of Morgagni. Morgagni showed that an individual's experience of un-ease had a seat from which it might be said to emanate – not a site where it should be assumed to exist. In this sense, the pathology to which Morgagni is progenitor is literally the study of suffering (from the Greek '*pathos*', meaning 'feeling' or 'suffering') rather than merely the study of altered anatomical structures. It should be understood as the study of the suffering individual in the fullest sense.

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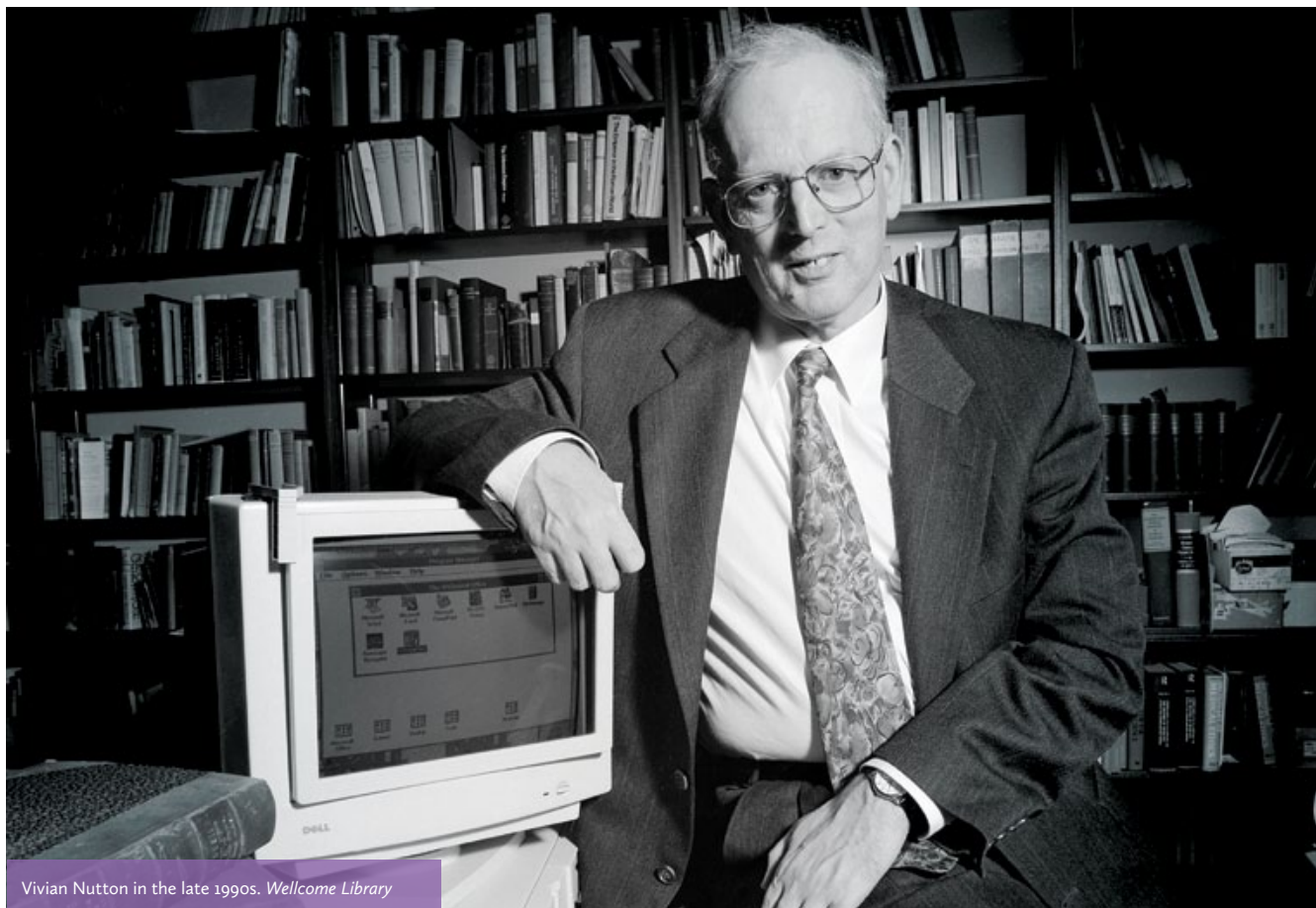


Giovanni Battista Morgagni, by Nathaniel Dance-Holland. Wellcome Library

Looking to the future

Professor Vivian Nutton is a world authority on Galen and has greatly influenced the study of ancient medicine. To mark his retirement, he reflects on how the field has developed and on changes yet to come. In the following pages, colleagues share their assessments of the man and his work.

Vivian Nutton



Vivian Nutton in the late 1990s. Wellcome Library

In 1962, in my first undergraduate essay, I declared that, except for papyri, new discoveries of classical texts were now unlikely. My supervisor, Geoffrey Lloyd, commented in the margin: “except for medicine”.

Like most students, I suspect, I took little notice of that correction – until I came across it again when clearing out some old papers 30 years later. Nor did I realise that my supervisor was at the very forefront of new developments in the study of ancient science that would radically alter classicists’ perceptions of an area that long continued to be regarded as eccentric. Even in 1979, when I organised the first ever conference on Galen, those

present – who included almost anyone from anywhere in the world with an interest in him – could easily fit into a smallish lecture room. Today, all this has changed, and one can hardly keep up with the variety of essays and books being produced on the subject, and texts forgotten for centuries are being made available for almost the first time since they were written.

One catalyst was the realisation by philosophers that ancient writers of medicine and science had valuable things to say, and that those who came after Hippocrates and Aristotle, and especially Galen, were independent thinkers of considerable merit. Feminists also discovered ancient

medicine, particularly Hippocratic gynaecology and the much later Soranus. Metrodora, whoever she (or he) was, and Mustio enjoyed a reputation that had not been theirs for centuries. Historians, of whom I was one, took a little longer to appreciate the abundance of information in ancient medicine texts; demographers were to the fore. Doctors, too, started to see that Galen was neither the fool nor the obstacle to progress that traditional judgements had suggested.

Experts on Greek and Latin also began to hold regular conferences to discuss the problems of editing authors whose writings, even if printed, had never been properly edited. When in

1979 I published my first edition of a Galenic text, I made many errors, simply because this was pioneer work, clearing the way for others to follow. Hippocratic editors, too, were still establishing the guidelines that today's editors now take almost for granted. Latinists also discovered that the Latin of surviving medical texts, many written after 300 CE, was far from being as barbaric as had once been claimed, and that it revealed a vibrant intellectual world that had been previously unsuspected by those whose concerns for purity of language had restricted their gaze to a few earlier centuries.

New texts have been constantly turning up from libraries far and wide, some in Greek (including a spectacular find in Thessalonica), some in the original Latin, but more often in a variety of translations into Syriac, Arabic, Hebrew and medieval Latin. They include Galen's medico-philosophical autobiography, first edited in part from translations but recently revealed entire in its original Greek, and his complete bibliographical treatises, forgotten medical handbooks and even a missing sentence from the Hippocratic Oath (although few now believe it to be by Hippocrates himself). The recently retrieved *Avoiding Distress* is not just a major contribution to ancient medicine and to Galen's biography, but the most important work on culture in Rome to have been published since the

Renaissance. This proliferation of new texts has revealed two things: first, the great variety of medical ideas and practices in Antiquity, and secondly, the continuation of learned debates and discussions well down into what had been considered the Dark Ages or the scholastic Middle Ages.

All this is now discussed in conferences worldwide, by young students as well as by greybeards, and by scholars whose interests range from texts to archaeology, and from demonstrative logic to animal dissection. We now know more than we did even ten years ago about Hellenistic medicine and about the ways in which Galen's personal experimentalism developed in Late Antiquity into a more didactic Galenism. With so much new material, ancient medicine seems likely to flourish for a few years yet.

But there are clouds forming. The growing interest in Arabic and the opening up of major Arabic collections will certainly provide new texts in translation, but it may not balance a decline in a competent knowledge of Greek and Latin, particularly at school and university, which is already having its effect. This is being felt most strongly in medieval and Renaissance studies, where few can now read with ease the high academic Latin that was for centuries the European lingua franca, and where attention is thus overwhelmingly focused on material in translation or in the vernacular original. Once-familiar names such as

Bernard of Gordon or Matteo Corti are now forgotten because their works exist only in Latin, and, what is worse, sometimes only in manuscript.

Instead, we are going to rely more and more on translations into English. (Non-English studies, including even the excellent French translations in the Budé series, remain largely unread on the shelves of Anglophone libraries, to the detriment of Anglophone scholarship.) Some of my concerns will be addressed in a new Cambridge series of English translations, sponsored initially by the Wellcome Trust, which from 2011 will include many works by Galen never previously translated into any European language. It is debatable whether this will entirely replace the hard editorial and manuscript work that, over the last two decades, has produced so much fruit, but it is likely to attract others with different skills who will lead the study of ancient medicine in new and fascinating directions.

As the architectural historian Nikolaus Pevsner said on the completion of his *The Buildings of England*, readers should not just concentrate on what has been achieved: they should look forward eagerly to its revision.

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Reading lists, limericks and lunches

Celebrating Vivian Nutton

Helen King

I encountered Vivian for the first time when I was at UCL as a student, gravitating towards ancient medicine. I was told that I had to meet Dr Nutton, and it was clear that it was a rite of passage into this academic field. I made the appointment; I had no choice.

It was a terrifying experience, not least because he recommended me to read a long list of works in German, and I was too busy to do much speaking myself as I tried to work out how to spell the authors' names while he ran through these at very high speed! That

was my introduction to one aspect of Vivian's role in the history of medicine that nobody else comes near filling: the provider of bibliography on pretty well everything, in a range of languages. An hour with Vivian is always much better value than a day searching library catalogues or databases. I am not sure how we moved from this to regular lunch meetings, at the Wellcome Institute for the History of Medicine, with Vivian always respecting the impoverishment of students and paying for my meal. At some point, we

progressed from this to each paying for our own food, and I was aware that a subtle transition had occurred: I was now a colleague, not a student.

In a further shift in our professional relationship, he asked me to read the whole of his *Ancient Medicine* in draft, and it was an odd experience for me to be in the position of telling him what was wrong with his writing, after he had performed this service for me several times. Coming at the manuscript as a whole, I was able to see repetitions and non sequiturs

that were not clear to Vivian, but I also learned a lot about the aspects of a topic that I have not studied for myself. In many ways, I was delighted that the publication of this monograph meant that there was at last a book that I could recommend to students as a one-stop shop, but I soon realised that it was a mixed blessing, as students felt that there was nothing they could add to this encyclopedic, learned, but also enjoyable book.

Vivian has established ancient medicine as a field in the UK, not least as an undergraduate subject. In his research, he manages to be both a philologist, happy with the minutiae of texts and translations, and a social historian of medicine, never forgetting that texts were written in a context – and often used in many different contexts. His range, from the ancient world to the Renaissance, is unrivalled, and his delight in the rare materials he has encountered on the way is infectious. Andrew Cunningham once wrote that “Vesalius as vivisectionist was simply

Galen restored to life”; hearing and reading Vivian, I have sometimes wondered if he was channeling Galen. I have always been impressed by his accessibility: he is happy to talk to school groups and undergraduate societies as well as being an enthusiastic university lecturer. His writing skills include limericks; after I told him about my experiences teaching about early dissection, he sent me the following, which is above my desk as I write now:

*Alexandrian medical men
Preferred vivisection, but then
For reasons obscure
It lost its allure
And never was heard of again.*

In other ways too, he is a man of hidden talents. Many of us know about his bell-ringing and his singing, but I suspect fewer have seen his Russian dancing; I was witness to this when, with one of his children, we escaped from a series of deadly boring welcomes to a Berlin conference

given by various dignitaries, and for reasons that are not at all clear, Vivian crouched down and started to dance.

Vivian has supported initiatives such as the regular colloquia on ancient medicine originally set up by Philip van der Eijk and me as a forum for those in many disciplines working with ancient medical texts. His assistance here has ranged from giving his acerbic and unfailingly accurate advice on which proposals for papers to accept, to being present at many of the events themselves. He manages to be genuinely welcoming to newcomers to the field, while never suffering fools gladly. He is one of those academics who will never retire; he has taught me just how many projects it is possible to work on at the same time. While it is good that he can spend more time with Christine, his children and the rest of his family, it is also good to know that he will continue to be a defining presence in ancient medicine.

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Recollections of a fellow bookend

Celebrating Vivian Nutton

Tilli Tansley



Vivian Nutton and Tilli Tansley. Wellcome Library

For many years, Vivian Nutton and I were the bookends of the academic unit of the Wellcome Institute for the History of Medicine (later the Wellcome Trust Centre) at UCL. At one end, Vivian presided over the centuries from

Antiquity to the Renaissance, while I upheld the other end, specialising in 20th-century medical science.

We largely occupied very different academic worlds, and it might be assumed that we had very little in common. However, for many years we

had adjacent offices, which ensured practically daily conversation, and over the years we have found ourselves on numerous committees, seminar programmes, working parties etc. of organisations such as the Society of Apothecaries, the Royal Society of Medicine and the Friends of the Wellcome Institute, all involved in creating and maintaining bridges between medical practitioners and scientists on the one hand and medical historians on the other. As a former medical scientist, I obviously found these activities important, and it was always impressive that Vivian also saw the maintenance of such links as part of his professional responsibilities at a time when few of our colleagues agreed with us.

We were once almost co-authors of a paper, when I was invited to write a short review on the origin of the concept of the synapse for

Brain Research Bulletin. In addition to reviewing the scientific material, I wanted to check the widely accepted and repeated account of the derivation of the word, and took the relevant materials to Vivian, who immediately cleared up a longstanding misinterpretation of Charles Sherrington's idiosyncratic Greek, for which I was extremely grateful. I prepared a draft manuscript and suggested co-authorship. This Vivian declined, saying his contribution was merely that of a colleague, although he did point out two typos, a split infinitive and an inadequate footnote in my draft.

His silver wedding anniversary demonstrated the loyalty and affection he inspires

It is not within my expertise, nor I think is it necessary, to comment in detail on Vivian's academic achievements and accomplishments. The national and international honours and reputation he has garnered speak for themselves, although many friends were saddened that his election as a Fellow of the British Academy in 2008

went largely unacknowledged in the Centre, unlike Roy Porter's election in 1994, which was celebrated in style with a party. Vivian's other talents, especially the musical, often came to the fore: a keen campanologist, he played the handbells, and often also the xylophone, keyboards or the piano at numerous Christmas concerts. He rehearsed and conducted several scratch choirs (and I use the word 'scratch' advisedly) within the Wellcome Institute and the Wellcome Trust, and also contributed to several other choirs, including those of the British Medical Association and St Bartholomew's Hospital.

The most revealing side of Vivian's character, however, comes from his friends and family. For several years he had to look after his wife, Christine, who was severely incapacitated after major back surgery, while also coping practically single-handedly to maintain a home for them and their three children. He did so calmly and efficiently, and indeed many colleagues and students never realised the immense domestic burden he was carrying. His and Christine's silver wedding anniversary celebrations demonstrated in particular the loyalty and affection he inspires, with professional

colleagues and family mixing with old friends from Yorkshire, some going as far back as primary school.

Vivian's retirement, plus the closure of the Wellcome Trust Centre at UCL, truly brings to an end a glorious episode in Wellcome history, and in the history of the history of medicine. Vivian was one of the first members of the Wellcome Institute, appointed when the pharmaceutical company the Wellcome Foundation formally employed the Library and academic staff on commercial contracts, such that Vivian held the unique academic position of Historian (Ancient)/Plant Manager Grade 1. His utter reliability and rectitude contributed to the outstanding international reputation that the Institute gained, and he has provided a model of academic excellence for generations of students, and also for colleagues. The continuing invitations to lecture around the world, as well as visits to children and grandchildren in the UK and abroad, will no doubt keep Vivian and Christine busy. His keyboard will continue to be in heavy use, and I suspect we have not heard the last of his beloved Galen.

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An intellectual comrade

Celebrating Vivian Nutton

Liba Taub

Vivian Nutton is well known as an immensely impressive presence in the history of medicine and the wider scholarly world. His reputation is formidable, based on his breadth of knowledge, his original and penetrating work as a historian, and his command of the literature, both primary and secondary. As is often the case with eminent scholars in any field, younger scholars are sometimes intimidated in situations in which they are faced with such august figures.

Nutton was one of the participants in a one-day colloquium on 'Science and Empire in the Roman World' held at St Andrews University in 2004. Of course, his reputation preceded him, and a number of younger attendees

commented that he was much less fierce in person than they had feared. In fact, his close engagement with all of the contributors, no matter how junior or senior, and his willingness to share ideas, information and bibliography, was most helpful and generous.

Inspired by the success and bonhomie of that colloquium, I have, with Aude Doody, organised a one-day workshop on 'Scientific, Medical and Technical Writing in Ancient Greece and Rome' annually since 2006 (several of these have kindly received funding from the Wellcome Trust). We invited Nutton to chair at our first, because of his stature in the field but primarily trusting his ability to do what was required. His

involvement in these annual workshops has been crucial to their success.

Nutton was remarkably helpful from the beginning in establishing the tone that has been a hallmark of these workshops, in which very senior scholars with international reputations give papers in the same sessions with younger academics and promising postgraduate students. This has enabled us to focus on shared interests in technical texts that, in many cases, have not been much studied. Nutton led the way from the very first of our workshops, in treating everyone seriously, with attention and courtesy.

His chapter in the volume *Authorial Voices in Greco-Roman Technical Writing* (2009, based on

papers given in 2007) is indicative of his interaction with and contribution to the group dynamic. At that workshop, held in Dublin, Harry Hine presented a paper on Roman authors in which he explored the different means by which authors writing in Latin present themselves to their readers, looking, for example, at the implications of authors' choice between first-, second- and third-person linguistic forms. These choices produce different impressions of subjectivity and objectivity, from the autobiographical to the hidden author, which subtly shape readers' expectations for uses of the text. Hine offers a valuable methodology to be used as tool for thinking about the ways in which linguistic forms can signal different relationships between author, text and reader.

Nutton was very intrigued, even inspired, by Hine's approach, which he then applied in the chapter he

contributed to the published volume, 'Galen's authorial voice: a preliminary enquiry'. Here, Nutton examines the *Peritōn porōn kinēseōn* (*De motibus dubiis: De motibus liquidis; On problematical movements*), a text that has been considered spurious and has been largely neglected. (At the time of writing his paper, Nutton was producing a new edition, with Gerrit Bos, of the work, due for publication in July 2011.) Nutton presented his chapter as a test case, applying Hine's methodology to this text, comparing Galen's use of self-referential language there with those of a number of other medical authors, including Rufus of Ephesus and Aretaeus. Nutton concludes that Galen adopts the personal more frequently than other writers, who tend to use more neutral language. Galen has a reputation for being notoriously egocentric; Nutton's linguistic analysis confirms this appraisal.

Within our workshops, Nutton's straightforward and collegial engagement with others has repeatedly (and reliably) provided an inspiring example, on many levels. His intellectual comradeship and contributions have added enormously to our meetings, and to our publications. In his chapter mentioned above, he noted that "the style of an ancient medical text is almost as important as its content in conveying the overall message of the writer". I think that I speak for all of the workshop participants over the years in saying that Nutton's style of scholarly engagement has been, for our intellectual community, intellectually stimulating, unusually sharing and greatly welcome – in short, his style, as well as his content, has been much appreciated.

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Vivian Nutton and the Renaissance

Celebrating Vivian Nutton

Nancy G Siraisi

Others are more qualified than I to write of Vivian Nutton as a classicist and a historian of ancient medicine whose contributions range from editions (with accompanying translation and commentary) of texts of Galen in the *Corpus Medicorum Graecorum*, through interpretive articles on aspects of Galen's medical teaching, to the comprehensive monograph *Ancient Medicine*, in which Nutton draws on sources of many kinds to trace what can be known of medical ideas and practice in the ancient Mediterranean world over many centuries.

My own knowledge of Nutton and his work has been primarily through his numerous contributions to the history of Renaissance and early modern medicine. From an early stage in his career, Nutton has, in addition to his studies of Galen and of ancient medicine, simultaneously turned his attention to the subsequent development of medicine in western Europe. The focus of his interest in this area has been the 15th and 16th centuries, when expanded knowledge

of Greek philosophical, scientific and medical texts had a powerful impact on medical education and ideas. Nutton's monograph *John Caius and the manuscripts of Galen* and numerous of his articles rest on deep knowledge of manuscripts and early printed editions of Renaissance medical writings. Yet with Renaissance and early modern (as with ancient) medicine, Nutton's work is far from being narrowly textual. His is a remarkable and unusual combination of expertise in both ancient and Renaissance/early modern studies and in both philological and historical scholarship.

On a more personal note, I first met him some time in the early 1980s, though I can no longer remember the date or occasion. At that time, although my training was as a medievalist, my interests were coming more and more to centre on the history of medicine in the Renaissance and, especially, the 16th century. A few years later, when Michael McVaugh and I were given the opportunity to edit a volume of essays on the history of medicine for the History of

Science Society's annual *Osiris*, we sought to bridge the late Middle Ages and the 16th century. Thus, we were especially pleased when Nutton, whose work continued to open up new areas of medical history to me, agreed to contribute an article. Shortly thereafter, he was able to participate in person in a workshop on 'Renaissance Natural Philosophy and the Disciplines', at the Dibner Institute for the History of Science and Technology (then at MIT), organised by Anthony Grafton and me. And from throughout the 1980s and 1990s, when I travelled to Europe for research or conferences, I recall many discussions with Nutton at the Wellcome Institute about research topics of mutual interest. I know that I was only one of many visitors from abroad who benefited from his learning, his encouragement and his commitment to pre-modern medical history as an international field of scholarship.

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“When you can’t write, write.”

Celebrating Vivian Nutton

Laurence Totelin



Portrait of Galen, 17th century. Wellcome Library

A few weeks ago, I contacted Vivian with a question on Galen’s attitude towards poetry. He sent me his reply within 24 hours (actually a rather slow response by Vivian’s standards); it was, as usual, full of information on Galen himself and on the modern scholarship on the issue.

Anyone who has heard Vivian lecture, or who has read any of his numerous works, will have been struck by his encyclopedic knowledge of the history of medicine from Hippocrates (fifth century BCE) to William Harvey (17th century CE) and beyond; but not everyone will be aware of his amazing

intellectual generosity. Vivian takes the duty of sharing and transmitting knowledge very seriously indeed, and takes pleasure in witnessing the expansion in the field of medical history. At a recent conference in Oslo, he expressed his joy at seeing new faces in the room, the faces of young scholars (some at the very beginning of their PhD studies) who will approach ancient medicine in new ways and develop innovative methods.

It is in order to help this new generation – a generation who may not have his familiarity with the Greek language – that Vivian has decided to take part in the ‘Translating Galen’ project (directed by Philip van der Eijk). The first volume will include a translation of a recently rediscovered text by Galen, *On the Avoidance of Grief* – a treatise in which Galen exposes for his reader the philosophical means by which he avoided sadness in the face of loss (written after many of his precious possessions had been destroyed by a great fire that swept Rome in 192 CE). Like Galen, Vivian has recently experienced loss with the announced closure of the Wellcome Trust Centre for the History of Medicine at UCL, but he is not allowing disappointment to overwhelm him, and is working in positive ways to help those affected.

I met Vivian, as my potential PhD supervisor, nine years ago. At one point during the interview, he asked me to translate a random passage of Galen. I did very badly, but must have kept my calm, as I soon received an offer to study under his supervision (and a generous grant from the Wellcome Trust Centre). I must confess I found Vivian’s way of bringing everything back to Galen (my PhD thesis was on the recipes contained in the Hippocratic Corpus) slightly disconcerting, and I have never mastered the palaeography skills required to decipher his handwriting, but his supervising style suited me perfectly. Vivian was always available to help me with a translation or a missing reference: he lent me

numerous books and off-prints and informed me about conferences I should attend, but he let me work in my own way and develop my own approach. We had a limited number of formal supervision meetings, but we often chatted over coffee (prepared by wonderful Joan) in the common room at the Centre. I have been allowed to learn from my mistakes and to manage my own time. Today I find myself repeating his advice to students suffering from writer’s block: “When you can’t write, write.”

Vivian must have followed his own advice on a regular basis, if one may judge by the vast number of his publications. My personal favourite is a short article entitled ‘The drug trade in antiquity’ (J R Soc Med 1985;78:138–45). It describes vividly, with humour, and with a wealth of detail the market competition between various actors in the field of ancient pharmacology: the learned medical author such as Galen, the rootcutter, the travelling drug-sellers, etc. It is intended for an audience of non-specialists in ancient medicine, but the specialist will learn much from it. Like Galen, who wrote treatises for medical students, practising physicians and interested laymen, Vivian has the ability to speak to varied audiences. This desire to address a range of publics he has instilled in me, and I have enjoyed teaching both ancient history and medical students.

I have drawn several parallels between Vivian and Galen, to whom Vivian devoted most of his career, and I know that Vivian himself likes the comparison. Of course Galen appears at times to be rather over-competitive and boastful, but beyond the façade, one finds generosity, concern for friends and for the future of the profession. These qualities define Vivian; may his legacy be as long-lasting as that of the illustrious physician from Pergamum!

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Manuscripts, signatures and shelfmarks (and macros)

Celebrating Vivian Nutton

Barbara Zipser



Vivian Nutton with an edition from 1500 of Galen's *Therapeutica/Therapeutica ad Glauconem*. Wellcome Library

My first contact with Vivian Nutton was through his book *John Caius and the Manuscripts of Galen*.

I was then a first-year PhD student in Heidelberg working on a late antique text on ophthalmology. For my environment, a very old-fashioned Classics department, this was an unusual topic. The reason for this was not the date of the text, which was certainly post-classical (my PhD supervisor specialised in the reception of classical thought); it was register and content. Even though our libraries held all the relevant literature, medical texts were rarely read. Hippocrates seemed to be the only exception. Lowbrow texts were not part of the curriculum.

Thus, it may not be too surprising that I first came across the text by coincidence, when I mistyped a

shelfmark while ordering textbooks on the library online catalogue two weeks before my finals. A stash of books arrived, but one of these was not what I thought I had ordered. Annoyed, I returned the book, just to order it again after a few days. Subsequently, I sought and received permission to turn it into a thesis. A few weeks later I first got in touch with Vivian to inquire whether there was anybody else working on the topic at the moment. His book on the manuscripts of Caius was on top of my reading list for the new project, and after all I had heard he was the person who would know what was going on in the world of medical history. A colleague, who had corresponded with him about entries for an encyclopedia, proofread my rather formal email, and we also had it double-checked by a native speaker of English. After some minutes I received a very informal and enthusiastic reply telling me to go ahead and also providing me with some additional resources. I was now in touch with the community.

The Caius book is a fascinating read. It is an in-depth study of Galen manuscripts associated with a British physician and scholar of the 16th century. At this point, some medical texts from antiquity were already available in printed form, but most were just based on one or two manuscripts. Handwritten medical books were still important sources; they were compared with the existing printed editions and sometimes even passed around between scholars. The notes and drafts that resulted from these projects are of interest not only because they reflect the intellectual discourse at the time: they also cover material that is today lost.

After the completion of my PhD I moved to London for a three-year Wellcome Trust fellowship, working on a manuscript held by the Wellcome Library, which Vivian had pointed out to me because he “thought it was interesting”, without going into

any more detail. After a few hours’ work with the original I came to the conclusion that it contained an unedited medical manual, one of the first texts written in the precursor of contemporary Greek. Other than most other medical texts, and in fact most texts in general, it was not written for the educated elite of the time. The vernacular was spoken, but not used in writing over the following centuries. It finally became the official language of Greece in the second half of the 20th century.

My fellowship project was complex, to say the least, and since I always was interested in computing, I decided to switch to a more versatile software solution. After a few weeks, having seen some first drafts of my text, Vivian asked me whether I could install the software on his machine as well, as he was working on a similar task: a book containing, among other things, a number of different translations of a Galenic treatise that is lost in the Greek original. So I did, and after a brief introduction to the system he used ledmac, a complex LaTeX package for critical editions. Being an avid DOS user he got to grips with it very rapidly and switched to the new system for his book.

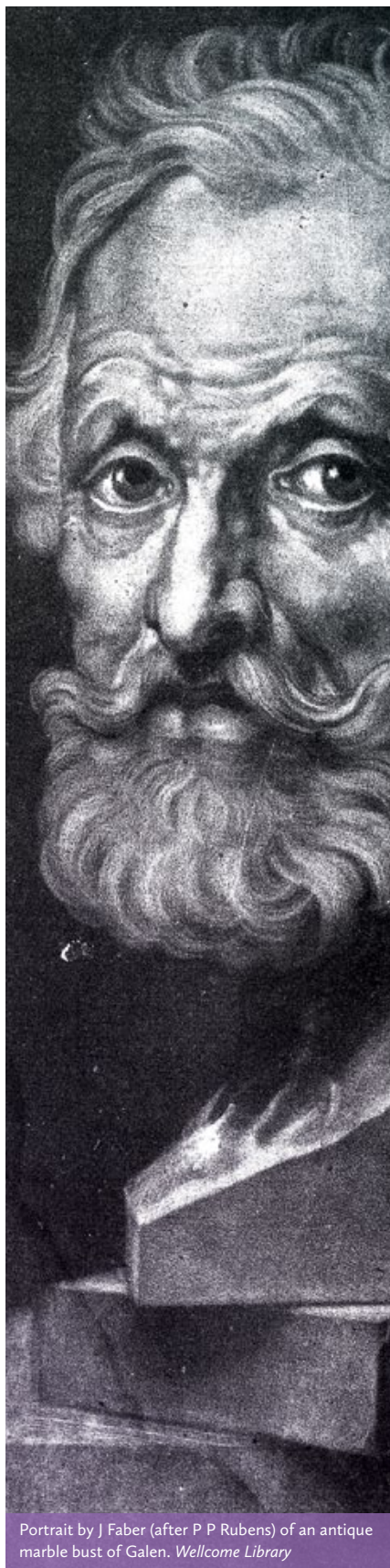
Vivian is a member of a choir, run by a retired heart surgeon at St Bart’s Hospital. Most of the singers and the orchestra are in some way linked to London hospitals. After I had been in London a few weeks, Vivian invited me along. We have been walking to rehearsal every Friday since, for the past seven years, discussing strange manuscripts and computer software on our way. We have sung at a variety of venues, including a concert in a church at the Barbican for the Royal College of Surgeons to commemorate Nelson’s death. Our next concert is going to be the Mozart Requiem.

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Mr Galen

Celebrating Vivian Nutton

Philip van der Eijk



Portrait by J Faber (after P P Rubens) of an antique marble bust of Galen. Wellcome Library

My first meeting with Vivian Nutton was when he gave a lecture at Leiden University some time in the late 1980s.

At the time, I was working on my PhD on Aristotle's theory of sleep and dreams, and since there is a medical background to Aristotle's ideas, I was beginning to develop an interest in ancient medicine, especially Hippocrates and Diocles. Yet the name of Galen – the topic of Vivian's talk – did not mean very much to me; and during the lecture, Galen's figure remained shadowy in the literal sense, for the technology was letting us down and the slide projector did not manage to produce the famous picture of him we were all waiting for. Yet that was more than compensated for by Vivian's vivid lecture style and his entertaining table talk at the dinner afterwards. It was the beginning of a long collegial friendship and collaboration.

A few years after this meeting, at the Leiden conference on 'Ancient Medicine in its Socio-Cultural Context' (1992), Vivian served on the academic committee and delivered the keynote lecture on one of his favourite topics, 'the medical meeting place'. The first sentence of that lecture, reproduced in the conference volume of 1995, ran as follows: "The loneliness of the ancient physician would make for a splendid title for a book on ancient medicine." Again, Galen's figure loomed large in the background. No less unforgettable was the table speech in Latin that Vivian produced at the conference dinner.

Ironically, that Leiden conference, attended by more than 150 delegates, marked the beginning of a remarkable surge in interest in Graeco-Roman medicine – a development that has continued ever since and that has led to the establishment of ancient medicine as a popular subject within classics and ancient history degree programmes at British universities. Vivian sometimes rehearsed the anecdote of a London taxi ride in the early 1980s together with Geoffrey Lloyd and James

Longrigg: after narrowly surviving a number of dangerous moves by the driver, they said to each other that this had nearly been the end of ancient medicine in the UK. That would have been close to the truth at the time, but no longer so ten years later, when ancient medicine had begun to gain territory as a panel in the annual meetings of the Classical Association and the American Philological Association – not to mention similar meetings in other European countries. It is a development to which Vivian made major contributions, not least through his fine survey *Ancient Medicine*, published in 2004.

The loneliness of the ancient physician would make for a splendid title for a book on ancient medicine

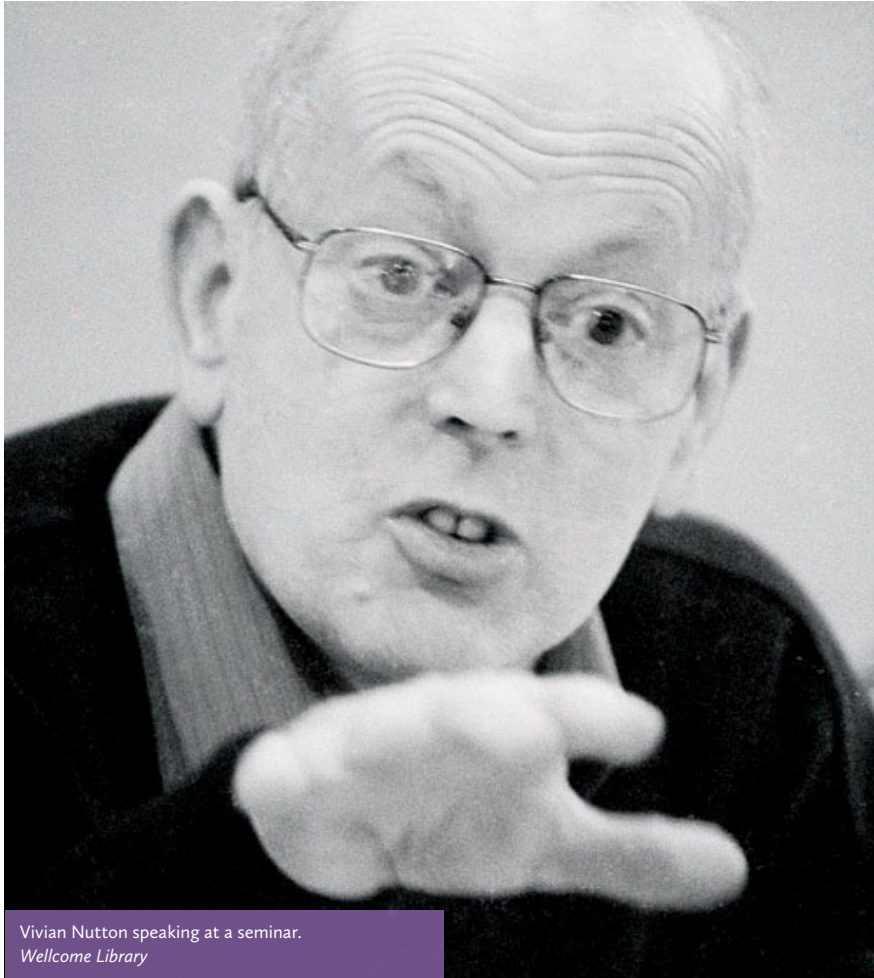
What applies to ancient medicine in general applies to Galen in particular, for here, too, we owe a great deal to Vivian. It is no exaggeration to say that he pioneered the study of Galen long before it became fashionable, both philologically and from the point of view of medical, social and cultural history. His critical editions of Galen's *On Prognosis* and *On My Own Opinions* for the Berlin Corpus Medicorum Graecorum, and his forthcoming edition of Galen's *On Problematic Movements* for CUP, are landmarks in Galenic scholarship. And I am very pleased to announce that they will soon be followed by his translation and commentary of the newly discovered Galenic work *On Avoidance of Distress*, to be published in the new series Cambridge Galen Translations, to which he will continue to contribute both on the advisory board and as a co-translator.

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What would Vivian Nutton say?

Celebrating Vivian Nutton

Ann Hanson



Vivian Nutton speaking at a seminar.
Wellcome Library

I have wondered why Galen was so poorly represented in the fragmentary papyri and parchments containing works from his hand — when compared, for example, to the number of papyri with texts known in our *Hippocratic Corpus*.

Counting the number of papyrus copies of a work or an author surviving to modern times has seemed to give an indication not only of readership in the ancient schools but also of a more general popularity among adult readers. Thus, the fact that Homer's *Iliad* surpasses all other literary works in Greek in the number of copies represented by fragments on papyrus and/or parchment underscores the notion that it was being read by many in the Roman province of Egypt, schoolchildren and grown-ups alike. The *Iliad* papyri make plausible a relationship between

number of discrete fragments and size of readership (these days the number of *Iliad* fragments is perhaps representing nearly 1000 copies).

A similar imbalance favouring the *Hippocratic Corpus* over Galen seems also to exist in the collection of medical texts excavated from late antique Antinoupolis. The lists in Diels's *Die Handschriften der antiken Ärzte. Griechische Abteilung* are not strictly comparable, for while the list of manuscript copies for treatises in the *Hippocratic Corpus* is concise and occupies pages 3–57, the list for Galen is complicated in part by the evidence Diels assembled for Latin translations; he followed the Kühn edition for his pages 58–115, but continued on with Greek titles not in Kühn, while pages 136–50 list items known only in Latin translation. It is instructive to compare Diels's information in 1906

on the manuscript evidence for *On his own Opinions/De propriis placitis*, page 119, with what Vivian assembled for his 1999 edition of the treatise for *Corpus Medicorum Graecorum*, V 3.2, pages 14–45. That same year Vivian hosted a symposium that resulted in 2002 in the collection of essays he edited as *The Unknown Galen*.

Insofar as papyrus fragments are concerned, the timespan might seem to favour the *Hippocratic Corpus* in that its earliest copy from *Epidemics II* was assigned a date in the first century BCE, while the earliest date assigned to a copy of Galen's *De placitis Hipp. et Plat.* is the first half of the third century CE, thus copied either during the very last years of Galen's life or in the decades shortly after his death. Galen himself claimed that his writings were read from one end of the Roman Empire to the other and that he carried on vigorous correspondences with provincials from many areas. He reported the remarks he made to Peitholaus, the Emperor's chamberlain, that Marcus Aurelius was always saying about him that he was the first among physicians and unique among philosophers.

Galen's contemporary Athenaeus of Naucratis, who, like Galen, immigrated to Rome, turned him into a character at the party he once hosted (*Sophists at Dinner*, or *Deipno-sophistae*). The characteristics Athenaeus attributed to Galen are certainly plausible: Athenaeus's Galen wrote more treatises on philosophy and medicine than all those who preceded him, and lectured guests on Italian wines and on medical opinions on the nourishing properties in breads and cakes. But it is essentially only Galen's self-portraits that present him as a lion in Roman society. Photius, patriarch of Constantinople in the ninth century CE, claimed in his *Bibliotheca* to enjoy reading Galen's *De sectis*, certainly one of Galen's more popular treatises (and a commentary to it among preserved papyri from late antiquity); but Photius went on to criticise Galen more generally as someone who "burdened

his treatises with irrelevancies, digressions, and lengthy periods, and these, in turn, confused and obscured the meaning of his texts...breaking up their structures; his verbosity rendered readers indifferent". The enthusiasm Photius's contemporary Hunayn ibn 'Ishaq showed for Galen's treatises makes it clear, however, that Photius represented neither a majority opinion in his own time nor in earlier centuries. Perhaps the forthcoming volume of medical texts from Oxyrhynchus will somehow rebalance the papyri and texts of Galen will come to equal, or even outnumber, those from the *Hippocratic Corpus*.

Despite the fact that Galen has a long way to go in order to catch up, I am loath to concede that there were more Romans and more late antique readers for the *Hippocratic Corpus* than there were for Galen. Those who were reading papyrus copies of Hippocrates from the first century BCE to the fifth and sixth centuries CE concentrated

on a relatively small number of texts, the majority of which also figured in the canon of the Alexandria medical schools: *Aphorisms*, *Epidemics*, the pseudepigraphic *Letters*, treatises in gynaecology or orthopaedic surgery. I wonder, then, whether one could not read the evidence from the papyri a bit differently, blaming not Galen and his prolixity but rather ourselves: we are the ones who cannot find Galen in a morass of papyri. For one thing, our electronic *Hilfsmittel* fails us: we may search Galen's vast output of texts electronically, but our database limits us for the most part to the Greek text as it appeared in Kühn. Translations of Galen into other languages have to be identified in the old-fashioned way by reading and carrying contents in one's head. If the weaknesses are ours, are there schemes that might overcome the difficulties in locating Galen among our fragments? And, more important, is this the story the imbalance among papyri of Hippocrates and Galen is trying to tell?

I had advice from Vivian back when joining the Berlin fragment of *De placitis Hippocratis et Platonis* to the fragment in Munich, and again when trying to make sense of Melchior Goldast's creation of the correspondence he confected among Cleopatra, Marc Anthony and Soranus. I had every intention of asking Vivian about the imbalance in the papyrus fragments during the Oslo Conference 'Texts of the Medical Profession in Antiquity: Genres and purposes', in September 2010, and his paper, 'Private and Public in the Writings of Galen of Pergamum', seemed almost to invite the question of how best to construe the paltry offering of papyri from the hand of Galen. But time slipped away in Oslo to other matters. So I ask now: What would Vivian Nutton say?

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A tireless champion

Celebrating Vivian Nutton

Diana E Manuel

Professor Vivian Nutton is a classicist of considerable renown, both at home and abroad. He enjoys a reputation as a first-class scholar and, notably, as an authority on the Greek physician Galen of Pergamon, Asia Minor (present-day Turkey). Galen (129–216/7 CE) is the most prolific medical writer whose works survive from the ancient world.

Nutton has, over the years, received honours in recognition of his work from a number of prestigious institutions, spanning in North America and Europe as well as in his own country. He is particularly proud of his *Médaille d'honneur* from the University of Tours in 1987 for his work on Renaissance medicine. In 2008 he was elected a Fellow of the British Academy.

Having graduated in classics and taught in Cambridge (where he was a Research Fellow and is now an Honorary Fellow of his alma mater, Selwyn College), he moved to London in 1977. Here he joined the Wellcome Institute for the History of Medicine, which

eventually became the Wellcome Trust Centre for the History of Medicine; he thus became a member of the sub-department – later a full academic department – within University College London. He was promoted to Professor in 1993, thus joining two illustrious historians of medicine: Professor William Bynum, who did so much to create the international reputation of the department during his long period of leadership, and Professor Roy Porter.

Alongside Bynum and Porter, Nutton worked tirelessly to promote and enhance the wide scope and international status of history of medicine as a discipline. He, like them, has always been a very keen and highly esteemed teacher of the subject. He is regularly invited to contribute to a wide range of conferences; being an excellent linguist, he sometimes delivers his contributions in the language of the country. In addition to his undergraduate teaching, Nutton has been highly valued as a postgraduate research mentor and

supervisor. Indeed, he has quite a cadre of past students who occupy prestigious teaching posts in history of medicine both at home and abroad.

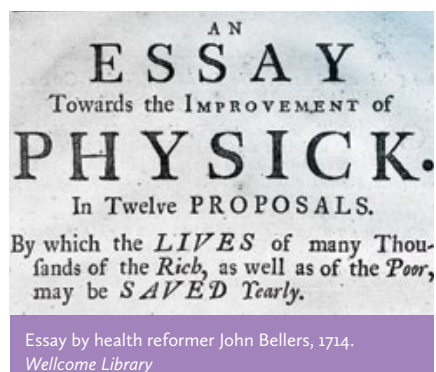
Yet alongside his academic career, Nutton has also maintained a vigorous non-academic strand to his activities. His family has always been central to his life, and in his earlier days he magnificently looked after his three children when his wife, Christine, an important professional helpmate, was coping with a stubborn and debilitating back problem. Alongside this, he has always been an enthusiastic and regular member of a number of singing groups and choirs. He is also an accomplished campanologist. The department currently displays a beautiful picture of Nutton in a bell tower with three others – all men alas! – all smiling and wearing colourful jumpers, holding their ropes and ready to pull.

Dr Diana E Manuel is Honorary Senior Research Associate and Fellow of UCL (E d.manuel@ucl.ac.uk).

Charity and the City: Medieval to Early Modern

Workshop report

Elma Brenner



This workshop for postgraduate students and early career researchers was held at Hughes Hall, University of Cambridge, in September 2010.

It was one of a series of workshops on aspects of voluntary action organised by the New Researchers Committee of the Voluntary Action History Society and financially supported by the Economic History Society.

The imperative for Christians to practise charity in order to ensure their future salvation stimulated the development of hospitals, medicine and public welfare initiatives in medieval and early modern Europe. The workshop aimed to address change and continuity in institutions, practices and ideas associated with urban charity between the medieval and the early modern periods. Six papers were presented by researchers from the UK, France, Germany and Portugal in sessions chaired by Jane Stevens Crawshaw (Oxford Brookes University), William MacLehose (Wellcome Trust Centre for the History of Medicine at UCL) and David Adams (Cambridge). The workshop was introduced by Sarah Squire (President of Hughes Hall), and John Henderson (Birkbeck, University of London) led a roundtable discussion at the end of the day.

A particular focus was on hospitals in their broader urban context. Papers by Elena Taddia (independent scholar, Paris) and Lisbeth Rodrigues

(University of Minho, Portugal) highlighted the important economic role of hospitals, as both recipients and distributors of funds in the city. Taddia discussed the two major hospitals in the early modern Republic of Genoa, the Pammatone hospital and the Albergo dei Poveri, both of which were financed by wealthy Genoese citizens. Unusually, the hospital of Nossa Senhora do Pópulo in early modern Portugal, Rodrigues's case study, preceded the town that later sprang up around it. The hospital created job opportunities and stimulated commercial life in the area. Both papers also illustrated how medical, religious and welfare functions were combined in early modern (and medieval) hospitals. In Genoa, charitable initiatives stimulated medical developments: the Pammatone hospital had its own pharmacy and medical school. Nossa Senhora do Pópulo had a specialised medical function as the first thermal hospital in the world, but also sheltered pilgrims and provided outdoor relief to the poor.

Laura Crombie (University of Glasgow) discussed a hospital established in late medieval Ghent by a local guild of crossbowmen. She highlighted the important role of women in the care of the sick: by the mid-15th century, the hospital was being run by guild sisters. Her paper also highlighted the fact that it is often very difficult to find evidence about medical treatment in medieval hospitals. The Ghent hospital's inventories list many liturgical objects, but only mention a few items that were used for medical purposes.

Gustavs Strenga (Queen Mary, University of London, and Albert-Ludwigs Universität Freiburg) examined the link between charity and commemoration in the late medieval towns of Riga and Reval (Tallinn), the present-day capitals of Latvia and Estonia respectively. Wealthy benefactors viewed the commemorative prayers of the poor on

their behalf as highly effective towards ensuring their future salvation, and the poor thus played an important role in the 'economy of charity'. However, as Laura Crombie also showed, it is very difficult to identify 'the poor' in the Middle Ages. Nonetheless, in Riga and Reval, as elsewhere in Europe, benefactors clearly distinguished between those they considered deserving or undeserving of assistance.

The ideas and attitudes that shaped urban charity were addressed by Steve Ridge (Wellcome Trust Centre for the History of Medicine at UCL) and Lars Kjaer (Cambridge). Ridge discussed the philosophical ideas of the Quaker John Bellers (1654–1725), who proposed that healthcare should be viewed as a branch of politics and that there should be a centrally administered system of hospitals for the poor. He thus argued that the Commonwealth should take full responsibility for the care of the poor – a very different model from the earlier religious model of charity. Kjaer examined the practice of almsgiving at aristocratic feasts in central medieval England. He revealed that luxury and charity were closely connected. In order to compensate morally for the excessiveness of their feasts, aristocrats abstained from consuming all the food provided, conserving some to be distributed to the poor. This created a connection between the wealthy and the poor, since both groups consumed the same food. The paper drew attention to the importance of food in medieval charity: giving food to the hungry was a Biblical work of mercy, and much charity involved gifts of food.

In the roundtable discussion, John Henderson commented on the themes that had emerged during the day. He noted that many more sources survive for the early modern period than the medieval period, which inevitably influences our picture of the differences between them. In addition, we have few sources about informal charity in the family and the local community,

which must have been widespread. The papers had underlined the moral dimension of charity: hospitals were religious institutions, where great emphasis was placed on healing the soul as well as the body. The economic importance of hospitals, and the role of women in charity, had also been

demonstrated. The final discussion considered whether or not, given the medieval understanding of charity as a Christian duty and the emergence of notions of state responsibility for the poor in the early modern period, urban charity can truly be considered to have been 'voluntary'.

Dr Elma Brenner is a Wellcome Trust Research Fellow associated to the Department of History and Philosophy of Science at the University of Cambridge (E ehobz@hermes.cam.ac.uk).

Migration, Mental Illness and the Management of Asylum Populations

Workshop report

Sarah York

This one-day workshop in September 2010 was hosted by the Centre for the History of Medicine at the University of Warwick, co-organised by Hilary Marland (Warwick), Catherine Cox (University College Dublin) and me, and was generously supported by the Wellcome Trust. The workshop was designed to bring early-career and established scholars together to focus on the relationship between migration, mental illness and the management of asylum populations. A range of papers, concentrating on the 19th- and 20th-century asylum, contributed to debates on admission and discharge processes, the complexities of asylum management, and the management of particular patient groups within the asylum.

Following opening remarks by the organisers, the first speaker of the morning session was Rebecca Wynter (University of Birmingham). Her paper considered micro-migration and spatial integrity in the early 19th-century asylum, exploring the boundaries and borders associated with asylum therapeutics and structures and economics. I followed with a focus on the management of suicidal lunatics and the prevention of self-destruction, demonstrating how the desirability of prevention permeated all aspects of institutional life, influencing the conduct of treatment methods and approaches to patient management.

In the second session, Louise Hide (Birkbeck, University of London) discussed the lived experiences of male

patients within two LCC asylums: Claybury and Bexley. She explored the ways in which men adapted to methods of management and treatment, within an environment that was by definition contrived and artificial, and apparently running counter to notions of masculinity. Jonathan Andrews's (Newcastle University) paper examined the management, meaning and conduct of post-mortem examinations at the Victorian asylum, concentrating primarily on the Royal Edinburgh Asylum, Morningside.

He considered the development of the dead house from a marginal sector of asylum activity to a linchpin of laboratory medicine. The third session began with Carole Reeves's (Wellcome Trust Centre for the History of Medicine at UCL) paper on Jewish immigrants to Colney Hatch Asylum. This paper compared the Jewish immigration experience with that of the indigenous East Enders. Reeves illustrated that the ways in which asylum patients were perceived along lines of ethnicity influenced their management and prospects for discharge. Pamela Michael's (University of Bangor) paper considered migration and insanity in north Wales. This paper explored the possibilities offered by asylum records, including admission data and case histories, for investigating patterns of migration by asylum patients between communities and institutions.

The workshop's final session featured a presentation by Catherine Cox, Hilary Marland and me. This

paper presented our initial findings from the Wellcome Trust-funded project 'Madness, Migration and the Irish in Lancashire, c.1850–1921', exploring the migratory patterns of Irish patients through the Lancashire asylum system. It addressed the impact of Irish admissions on the four Lancashire asylums and the Poor Law system, demonstrating the extreme pressures placed on asylum managers and Poor Law authorities and exploring some of the solutions put forward. The workshop concluded with Nicole Baur and Joseph Melling's (University of Exeter) paper on mental health patients and readmission to mental hospitals in southern England. Focusing on the mid-20th century, their presentation offered some preliminary thoughts on the role of the geographic and social origins of patients, their period of hospitalisation and the pattern of their return to hospital as readmissions.

This was the first of two events to be organised in association with our Lancashire project; a second event will be held in Dublin in 2011. The workshop was intended to restart what was formerly a very active and productive history of psychiatry workshop series. The workshop concluded with several offers to host future events within this broad framework.

Sarah York is based at the Centre for the History of Medicine, University of Warwick and University College Dublin.

WHO Global Health Histories

New seminars and initiatives for 2011

Thomson Prentice

A series of lunchtime seminars in 2011 marks the continuing expansion and development of the WHO Global Health Histories project (GHH), with ongoing support from the Wellcome Trust and the University of York.

The new series follows the successful conclusion of the 2010 seminars, which focused on a wide range of issues of emerging public health importance. They most often drew capacity audiences at the venues in WHO headquarters, as well as being broadcast as webinars on the internet. Almost 50 history seminars have now been held under the GHH banner in the last six years.

An innovation for 2011 is that the seminars in the first half of the year are providing background and potential input for the next *World Health Report*, due to be published in 2012, which will be on the theme of 'research for health'. Although the *Report* has invariably drawn on history in its coverage of global health issues since its launch in 1995, this is the first time it will have a formal link with GHH. Subjects covered include infant growth and nutrition, antenatal care, health promotion, tobacco control, maternal care, childhood immunisation and food security. In the second half of the year, the theme of the seminars will be environmental health, with presentations on asbestos pollution and environmental law.

GHH was established in late 2004 and is located within the WHO Department of Knowledge Management and Sharing. Its mission is based on the principle that understanding the history of health, especially during the last 60 years, helps the global public health community to respond to the challenges of today and contribute to a healthier future for everyone, especially those most in need.

Through the seminars, publications and other initiatives, GHH promotes closer links and exchanges between health policy makers and decision takers, historians, researchers, scientists, academics, students and

the general public. In the last few years, GHH has been building an international network of health historians with expertise in a wide variety of areas. The network now extends to all of the WHO's six regional offices and boasts many of the best-known names in health history. Expertise represented here ranges from the postwar origins of the WHO itself, the influences on health of the Cold War and the end of the colonial era in several continents, to the failure of the global malaria eradication campaign in the 1960s and the successful eradication of smallpox.

Understanding the history of health helps the global public health community to respond to the challenges of today

GHH is led by WHO press coordinator Dr Hooman Momen, who introduces the seminars and oversees the development of the project. He said: "There is no doubt the seminars are very popular inside WHO and far beyond. Last year was an eventful one for GHH in several other ways. Work began on the official history of the fourth decade of WHO, 1978–1987, to complement the three previous volumes on previous decades." Publication is expected by the end of 2011.

Dr Momen added: "In 2010 we also held a witness seminar to help mark the fifth anniversary of the signing of the Framework Convention for Tobacco Control. This seminar was also sponsored by the Wellcome Trust and served as pilot to measure the interest in holding more such events at WHO. The outcome was considered a success by participants. A further witness seminar is being planned in 2011 on the antimalaria drug artemisinin." Also planned for 2011 is a book on some of the public health achievements of the WHO, and this will be targeted towards a youth audience.

The Wellcome Trust continues to enthusiastically support the GHH seminars. This support has been personified by Dr Sanjoy Bhattacharya, recently appointed Reader in the History of Medicine at the University of York. He has been a key figure in helping the development of GHH since its earliest days, and has been involved in the overall organisation and support of the lunchtime seminars since 2008, initially with the Wellcome Trust Centre for the History of Medicine at UCL.

He said: "The Department of History at the University of York is delighted, with the generous backing of the Wellcome Trust, to support the continued success and expansion of the Global Health Histories initiative. The seminars held in 2010 have taken the interactions between policy and academia to a new level, encouraging conversations that have had an impact on the work on both groups of speakers. They have also pointed to the great potential of stoking further interchanges of ideas between academic researchers and policy managers, both during the design and implementation of policy."

Professor Thomas Baldwin, of the University of York, was one of the 2010 speakers, with a presentation on obesity and public health. Of the seminars in general he said: "In my experience these were very stimulating occasions with excellent discussion. The range of expertise from all around the world makes these meetings unique and provided me with a broader understanding of the issues than I have encountered at similar occasions in the UK."

Thomson Prentice is former managing editor of the *World Health Report* and has helped organise the seminars since their inception. He is a freelance editor and writer (E thomsonprentice@wanadoo.fr).

For details of the 2011 seminars, visit www.who.int/global_health_histories.

Ward No. 5, KEM

Book review

Manjiri N Kamat



Ward No. 5, KEM is an elegantly written book by a distinguished surgeon, Dr Ravi Bapat.

He is Professor Emeritus, Department of Surgical Gastroenterology at the Seth G S Medical College and the King Edward Memorial (KEM) Hospital in Mumbai. He was formerly Vice-Chancellor of the Maharashtra University

of Health Sciences, Nashik.

The blurb states: “*Ward No. 5, KEM* is not an autobiography. Nor is it a doctor’s case-book of the landmark medical cases he has handled over the years. Instead it is a simple straightforward narration of the experiences of a dedicated doctor who has spent long hours in the ward of a noted public hospital.” Bapat’s experiences at the KEM Hospital span a period of almost 40 years from about 1966 to 2003, first as a student, then as a surgeon, teacher and Head of the Department of General Surgery and Gastroenterology Surgical Services. He was awarded the Agostino Trapani International Prize for his work on immunomodulation in surgical jaundice.

In popular perception there is a certain mystery attached to a hospital. There is a gulf that separates the medical professional from the patients as well as society at large. The book demystifies a surgeon’s life and medical practice in an effort to present a humane picture of the day-to-day experiences of a surgeon in a hospital ward. In doing so it bridges the gulf that separates the medical professional from the society he or she is committed to serve.

The ethos of the book is eloquently captured by Bapat’s foreword: “My long years of medical practice have taught me that to see a patient in a scientific way one has to consider, along with the physical examination, his state of mind, his temperament, his environment, his occupation, his routine, his relationships at home and more. It is necessary to converse with him, to understand his persona before one decides on the line of treatment. Although medicine is a science, it’s not a precise one like mathematics or physics.”

The book is divided into six chapters. The first deals with the history of KEM and Seth G S Medical College, and Bapat’s association with these institutions. The following three chapters present a vivid picture of his experiences in Ward No. 5, where he treated innumerable patients across a wide spectrum including journalists, writers, actors, politicians, and his family and friends. The penultimate chapter is an engaging account of his extracurricular activities and documents his experience of illness when he was himself admitted as a patient in the hospital where he had treated thousands over the years. The last chapter is a reflection on the state of medical education and public health, general hospitals

and social consciousness, and raises pertinent questions about the medical profession in contemporary India.

The KEM Hospital and the Seth G S Medical College were established by the Bombay Municipal Corporation (BMC) in 1926. They were located in the working-class area of Parel in Mumbai. The donors from the Moolji Jetha family had insisted that Indian doctors were to be recruited. This was because preference had been given to British medical personnel when it came to senior positions in the Indian Medical Service. It was Dr K N Bahadurji who had approached Sir Pherozeshah Mehta to urge the BMC to build and manage its own medical college and hospital. KEM soon acquired the reputation of being one of the finest teaching hospitals in Asia.

Bapat studied at the Medical College and specialised in surgical gastroenterology with the guidance of Dr Vasant Sheth. He learned to do certain rare procedures on the oesophagus, the gall bladder, the bile duct, the pancreas and the colon. He developed a new method to enlarge narrowed oesophaguses, which was called ‘endless string’ procedure. Surgical gastroenterology thus became his chosen specialism and KEM became the benchmark for such new techniques in the field.

The book raises many important issues about public health in contemporary India. Since India’s independence, not a single government hospital has been set up in Mumbai. A large part of the responsibility for addressing the health needs of the poor rests with the municipal hospitals; there is pressure to privatise these. In such a scenario, who will provide healthcare for the poor? The super specialist hospitals in Mumbai are outside the reach of these sections of society. The government and municipal hospitals are geared to deal with natural and man-made disasters. If general hospitals are privatised, who will deal with the victims of such calamities? Bapat laments the eclipse of the ‘family doctor’ and expresses concern about the increasing commercialisation of medical practice.

The book will be of immense value to doctors and non-specialists alike. It will help to build up a dialogue between social scientists, medical professionals and policy makers as well as to create public awareness about the state of healthcare in contemporary India. Above all, books in this vein will open a window to refreshing insights into the history of medicine.

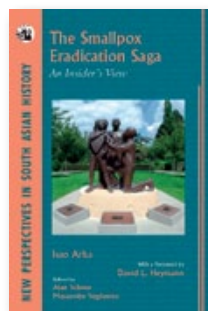
Dr Manjiri N Kamat is Associate Professor at the Department of History, University of Mumbai, India ([E mnkamat@yahoo.com](mailto:Emnkamat@yahoo.com)).

Bapat R (transl. S Jaywant). *Ward No. 5, KEM*. Mumbai: Eminence Designs Pvt. Ltd; 2008.

The Smallpox Eradication Saga: An insider's view

Book review

Vivek Neelakantan



It is said that science does not advance without doubt. This is particularly true of *The Smallpox Eradication Saga*. Isao Arita chronicles the smallpox eradication programme as it unfolded under disparate circumstances from 1962 to 1980 through an insider's perspective in countries such as Brazil, Indonesia, India, Bangladesh, Ethiopia, Somalia, and West African nations such as Nigeria, where the World Health

Organization (WHO) implemented the smallpox eradication programme. These country-level experiences serve as crucibles to examine the evolution of eradication strategies from mass vaccination to surveillance and containment.

Pivotal to the global campaign to eradicate smallpox in 1966 were West African nations that had received US bilateral aid. West Africa revealed that smallpox transmission was slow and required close contact; it could be interrupted if the chain between the smallpox-susceptibles and contacts was broken. The vaccination of only a proportion of the population in the villages where the smallpox cases were occurring – using jet injectors – not only helped conserve vaccine but also proved that mass vaccination was less effective than surveillance and containment.

Indonesia demonstrated remarkable flexibility of strategy when the WHO launched the intensified programme of smallpox eradication in South-east Asia in 1967. Initially oriented towards mass vaccination of the entire population, the programme in Indonesia shifted towards vaccination of susceptible children. However, detection of outbreaks in Indonesia was weak. Therefore the national smallpox programme officer introduced smallpox recognition cards for effective surveillance, which the WHO then introduced worldwide. The Indonesian programme thus forced WHO policy makers to rethink the efficacy of strategies such as mass vaccination and searching for unvaccinated people. Containment – focusing on discovering smallpox outbreaks, vaccinating the villagers of the affected areas and contacts of the patient – was in fact the strong arm of the Indonesian programme.

By 1973, eradicating smallpox from India and South Asia was critical: these countries made up 95 per cent of the 135 000 cases worldwide. Arita and Vladimir Zigmund, a Czechoslovakian WHO medical officer, had envisioned active searches for smallpox cases, but these did not materialise as patients with chickenpox were mistakenly admitted into smallpox wards, contracted the disease and spread the virus. Containment was thus a weak ingredient in the Indian programme.

The Horn of Africa proved to be the world's last reservoir of naturally occurring smallpox after the disease was eradicated from India in 1975. Efforts were hampered by conflict between the governments of Somalia, Ethiopia and Kenya. Arita attributes the 1977 success of eradication there to the collaboration and dedication of the programme staff in these countries, although the dense narrative of chapter 14 reveals that Somalia and Ethiopia differed on the source of the original outbreak.

Soon after countries became free of smallpox, the WHO adopted a range of innovative approaches ranging from pock surveys in West Africa to analysing varicella cases in the laboratory in Pakistan. Yet no further cases were reported. On 8 May 1980, the World Health Assembly concluded that the world had been freed of smallpox.

Country-level experiences serve as crucibles to examine the evolution of strategies from mass vaccination to surveillance and containment

The book concludes by noting that the eradication programme succeeded despite delays caused by Cold War upheavals and that officials had in some cases needed to circumvent the WHO's hierarchy in order to execute certain aspects of the programme, such as investigating outbreaks. Arita also briefly discusses the security threat posed by smallpox in the context of bioterrorism.

A number of points escape his attention, such as poor surveillance and the non-disclosure of patients in Indonesia, India and West Africa. Was this non-disclosure an expression of subaltern popular resistance (considering that chickenpox cases were mistakenly diagnosed as smallpox) by WHO officials and national health authorities? Arita's investigation of Liberia highlights the presence of smallpox in villages and the Minister of Health's suppression of epidemiological data. However, the book ascribes success to the WHO leadership without questioning *why* there were occasional differences between health ministries in Liberia and elsewhere and the WHO headquarters in Geneva.

Arita's insider's perspective and narrative style unearth the shortcomings of the WHO in the Indian state of West Bengal, where a WHO officer had misdiagnosed chickenpox cases as smallpox, causing much embarrassment. An important aspect of *The Smallpox Eradication Saga* is Arita's ability to draw valuable lessons from the history of public health programmes such as the Expanded Programme of Immunization, development of new vaccines and surveillance against infectious diseases. The book is a valuable supplement to the existing historiographies of smallpox by relating the past experience of smallpox eradication to current public health programmes.

Vivek Neelakantan is pursuing his PhD at the Unit for the History and Philosophy of Science, University of Sydney (E vivekneelakantanster@gmail.com).

Arita I. *The Smallpox Eradication Saga: An insider's view*. Orient Longman; 2010.

New history of medicine book series

The Society for the Social History of Medicine (SSHM) has a new book series. *Studies for the Society for the Social History of Medicine* published its first two volumes in 2010: *Meat, Medicine and Human Health in the Twentieth Century* (edited by David Cantor, Christian Bonah and Matthias Dörries) and *Locating Health: Historical and anthropological investigations of place and health* (edited by Erika Dyck and Christopher Fletcher). More edited and single-author volumes will appear in 2011, and the series is looking for more manuscripts, from established and early-career academics working in the field.

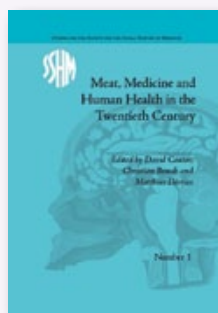
The SSHM has a long history of book publishing. Its first ventures into this field were *Health Care and Popular Medicine in Nineteenth Century England* (Croom Helm, 1977) and *The Social History of Occupational Health* (Croom Helm, 1985). These were followed by the book series *Studies in the Social History of Medicine*, a collaboration with Tavistock (later Routledge). Established in 1989, the series published 37 books by the time it ended in 2009. *Studies for the Society for the Social History of Medicine* is the successor, published by Pickering and Chatto.

The new series has a broad remit. Its concern is with all aspects of health, illness and medicine, from antiquity to the present, in all parts of the globe. Its interests include the circumstances that promote health or illness, the ways in which people experience and explain such conditions, and what they do about them. Practitioners of medicine, nursing, psychiatry, pharmacy, biomedical science and vernacular healing come within its ambit, as do hospitals, asylums, hospices and other medical institutions, patients and politicians, priests and pill-pushers, wise-women and witches, and all concerned with medicine, illness, health and healing. Methodologically, the series welcomes approaches derived from social history, as well as relevant studies in economic, cultural and intellectual history. It also seeks to encourage historical work that employs the insights of related disciplines such as sociology, anthropology, demography and epidemiology, as well as literary, science and policy studies.

The editors welcome both formal proposals and informal enquiries about the suitability of a project for the series. Formal proposals should set out the intellectual rationale for the volume: its main claims to novelty and how it engages with the secondary literature in the field. The proposal should also provide the basics of the book: title, word length, chapter headings, number of illustrations, potential readership and when you expect to submit the completed manuscript. The proposal package should also include at least two sample chapters. The series has a two-stage review process: a review of the proposal (which aims to set out whether the series should offer a contract, and what conditions, if any, should be attached) and a review of the entire manuscript (which aims to determine whether it is suitable for publication, and/or what needs to be done to make it publishable). Books are

only published after they have satisfactorily passed this second review. Note that Pickering and Chatto generally publishes books of 80 000–100 000 words in length.

For more information on the series and how to submit, go to the Society's website (www.sshm.org) or contact the series editors: Dr David Cantor (cantord@mail.nih.gov) for edited volumes or Dr Keir Waddington (WaddingtonK@cardiff.ac.uk) for single-authored monographs.



Meat, Medicine and Human Health in the Twentieth Century

Edited by David Cantor, Christian Bonah and Matthias Dörries
London: Pickering and Chatto, 2010

This collection of ten historical essays explores some of the complex relations between meat and human health in 20th-century North America and Europe. Its

subjects include the relations between the meat and the pharmaceutical industries, the slaughterhouse and the rise of endocrinology, the therapeutic benefits of meat extracts and the short-lived fate of liver ice cream in the treatment of pernicious anaemia. Other articles examine responses to BSE and bovine tuberculosis, cancer and meat consumption, DES in cattle, American-style meat in Mexico and Nazi attitudes towards meat eating. Together these papers highlight a complicated array of often-contradictory attitudes towards meat and human health. They illuminate how meat came to be regarded as a central part of a modern healthy diet. And they trace a diversity of critiques of meat, meat eating and the meat industry.



Locating Health: Historical and anthropological investigations of place and health

Edited by Erika Dyck and Christopher Fletcher
London: Pickering and Chatto, 2010

The ten essays in this book are concerned with the dynamic relationship between health and place. They explore a selection of

historical and cultural instances in which the multiple meanings of health and place intersect. Some of these are rooted in materialist or physical interpretations; others preface the role of sentiment and affect in place attachment and illness experience; and others still delve into ontological and subjective engagements that aim to understand how health and place connect with aspects of identity, authenticity and sovereignty.

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