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Florence Nightingale

The need for a reappraisal

KEITH WILLIAMS

Revisionism has hardly touched Florence Nightingale, and she remains one of the great icons of the Victorian Age. Despite some hostile comment, in particular that in F B Smith's relatively recent book, the popular image of her remains that of the 'Angel of Scutari', and the 'genius' behind much medical reform and the development of nursing.

However, an examination of primary sources reveals that much of this reputation is based on myth, the problem being that historians generally have not undertaken the breadth of primary research necessary to arrive at an objective re-evaluation of her work, her achievements, and her role in the movement for medical reform in the 19th century. This is particularly true in regard to military medicine, and it may fairly be argued that Nightingale, far from guiding the reform and development of military medicine, actually impeded its progress as a result of her class-based hostility to military doctors.

It is often forgotten, or overlooked, that Nightingale was born into a very wealthy and well-connected family. Indeed, at a time when influence was often determined by social standing, the Nightingales could exercise considerable influence. Palmerston, who was Prime Minister during much of the Crimean War period, was a close friend of the Nightingale family, his estate in Hampshire adjoining theirs. Such contacts were easily extended, and when in her 20s, Florence was to form a close friendship with Sidney Herbert, who was to become her most important political patron. As a member of the gentry class Nightingale was well versed in the philosophy of *noblesse oblige*, hence her sincere and deeply felt care for the common soldier entering her hospitals in Scutari. But she also was undoubtedly a snob, displaying considerable resentment towards those, the Crimean doctors in particular, who had dared to rise above their station. Here it has to be appreciated that at the time of the Crimea some 72 per cent of military doctors were Scottish or Irish, many coming from fairly modest or poor backgrounds, and tended to be despised by the aristocratic or upper-class English line officers. It was therefore easy for the likes of Lord Raglan, the Commander-in-Chief in the Crimea, to blame, as he often did, the medical officers for problems caused by his own staff when under attack by politicians in London. Such class consciousness and social prejudice was fairly widespread, as illustrated by the postwar statement by Palmerston that the greatest deficiencies in the Crimea had been caused not by people of his own social class but "where there were persons belonging to other classes of the community – in the Medical Department, the Commissariat Department, the Transport Service, which have not been filled by the aristocracy or gentry".

What Nightingale achieved at the hospitals at Scutari has been subject to some debate, and there is much evidence to suggest that she did more harm than good

Nightingale seemed to have no hesitation in participating in the attacks on the Crimea army doctors, and on the Army Medical Department in general. Indeed, she became noted for her exaggerated statements and vituperative asides in relation to the senior medical staff. She had a particular animus toward Dr Andrew Smith, who overcame a lowly background

Above: Nightingale with staff and patient at Scutari. By T Packer, *c.*1855.

Cover: Oil painting of Nightingale.

(his father being a poor Border shepherd) to rise to the position of Director-General of the Army Medical Department, and to Dr John Hall, the Principal Medical Officer in the Crimea. The former she referred to as "that old smoke-dried Dr Andrew Smith", while when Hall was awarded a KCB for his work in the Crimea, she scathingly remarked that in his case the letters stood for "Knight of the Crimean Burial-grounds". She also promoted the damaging assertion that Hall had no adequate medical qualification, when in fact he was an FRCS, by examination, and had an MD from St Andrews. Hall regarded her as a spy for the politicians in London, and it is certainly true that she did send Sidney Herbert (now Secretary at War) lengthy observations on the Scutari doctors, wielding to advantage the power that political patronage had accorded her. The full extent of her vilification of those to whom she took a dislike, or the extent to which she promoted the cause of her few favourites, can never be known since many of her papers and letters relating to the Crimea period she herself destroyed, or had destroyed, around 1861.

While the Crimean War provided Nightingale with fame and influence, it was the actions of the press that resulted in her involvement in the first place, and that brought her to such prominence. British troops did suffer hardships in the Crimea, but there can be little dispute that the extent of the problems of army maladministration and of the suffering of the troops during the first year of the war was greatly exaggerated, and often distorted, by a press seeking to extend its power, influence and readership. No previous war had been so extensively covered by the press, or in such a way, with sensationalist and scandalous stories fanning the flames of mass hysteria in Britain. It was this that provided the stimulus to action, and to obfuscation, both by a government that sought to placate its critics and assuage the public outcry, and by individual politicians anxious to protect their own reputations and careers. The recruitment of Nightingale and her nurses by Herbert was merely one aspect of consequent government action, but was a highly visible exercise that was to provide more in terms of public relations benefit than practical help. This is amply demonstrated by the statistics, for Nightingale took only 38 nurses to Scutari where there were some 3200 patients, each nurse thus having a charge of 84 patients. Given this, it is inconceivable that more than a few patients could be accorded adequate attention by each nurse. Within a few months the number of patients had risen to over 5000, but the number of nurses remained unchanged.

What Nightingale achieved at the hospitals at Scutari has been subject to some debate, and there is much evidence to suggest that she did more harm than good. However, the self-serving press created the 'Angel of Scutari' myth that has dominated the popular view of her, and in this sense Nightingale may justly be heralded as the first media-created celebrity, with all the accompanying trappings, including a devoted fan club as evidenced by the large number of fawning letters written to her at Scutari. Sentiments such as those expressed in a letter by 'CR', who confessed to be "one among the many who truly admires, thinks, dreams, and prays for your welfare", cannot have failed to inflate her own ego, and form the basis for her remark in 1856 that "the War Office cannot turn me out because the country is with me".

From such a base it was but a short step to Nightingale setting herself up as an authority on, and major protagonist in, the reform of military medicine. But many of her accredited achievements in this area do not bear close scrutiny, and much of the historiography here requires reappraisal. Unfortunately, many writers on Nightingale have contented themselves with merely repeating the myths about her created out of self-interest by both the press and by various contemporary politicians, and perpetuated thereafter in biographies of her that are little more than hagiographies. As is often the case, many of these myths have been repeated so often that they have attained the status of fact, but are myths that are easily exploded by reference to archival material, particularly the reports of the various parliamentary committees and Royal Commissions of the time.

Right: Sidney Herbert, Secretary at War during the Crimea and Nightingale's political patron. By W Hall after G Richmond.

The evidence shows that many of the reforms in military medicine attributed to Nightingale's influence had been long-standing proposals, or had been mooted previously by others. One highly significant development was the establishment of the Medical Staff Corps in June 1855 as a direct response to the problems caused by the orderlies in the Scutari hospitals. Although the idea for this has been attributed to Nightingale, in a letter to Herbert in January 1855, it had, in fact, been proposed earlier by Andrew Smith, and agreed by the War Office the previous month. Again, Nightingale has been reported to have regarded the establishment of a medical statistical branch as one of her most important proposals adopted by the Royal Commission in 1857. But Smith, in fact, had proposed to the War Office in December 1855 that a board for medical statistics be established formally within his

office, a function that was already being performed at that time. Nightingale has been credited also with the idea of the need for an army medical school, but this is something that had been first proposed over 50 years previously, although she did have some influence on the running of the School once it was established. It is also of note that, contrary to popular belief, British military hospitals had employed female nurses long before Nightingale went to Scutari.

While such myths are easily exposed, the limits of Nightingale's influence at this time may be gauged more directly from her recorded failures, notably her attempts to stop the building of the new army hospital at Netley, near Southampton, a scheme that had been instigated by Smith, her bête noire. The scheme was approved in January 1856, despite opposition from Nightingale and her supporters, who argued that the site was unsafe on sanitary grounds. An attempt was made by the Nightingale faction in 1858, while Netley was in the process of construction, to have it "finished as a barrack", but this again proved futile, and Netley became a highly successful hospital, eventually closing in 1958. With the death of Herbert in 1861, Nightingale's influence with the War Office waned, and henceforth she would focus her attention on sanitary reform.

This article is based in part on material in the Royal Army Medical Corps Muniment Collection in the Wellcome Library.

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The modern image of the Unani and Ayurvedic industry, *c.*1980–2000

MAARTEN BODE

"Packing is everything," I was told when I started my research on the Ayurvedic and Unani manufacturing industry in 1996.

The owner of the medium-sized Bombay manufacturer Sandu meant not only modern packing and dosage forms such as tablets and capsules, but also the importance of modern marketing techniques and practices such as branding to create an image around a product and its manufacturer. Although for over a century Ayurvedic and Unani manufacturers have played a crucial role in the modernisation of Indian medicine and influenced the way Indians look upon their medical traditions, this fact has been largely ignored by social scientists and historians working on Indian medicine.

My forthcoming book, *Taking Traditional Knowledge to the Market*, which is going to be part of Orient Longman's New Perspectives in South Asian History series, looks through the lens of the industry and its medical products, and highlights Indian medicine as a commercial activity. This describes and analyses in what ways the logic of the market has shaped, constrained and transformed two Indian medical traditions, Ayurvedic and Unani Tibb. What kind of indigenous medicines dominate the Indian market? To whom and how are these marketed and what are the images used by the industry to promote its products? How do large manufacturers construct the 'Indian-ness' of their commodities? The theoretical perspective of the paper draws on work of Arjun Appadurai in which he makes us aware that meanings attached to material objects such as medicines depend upon the social–cultural context in which these substances operate. My work analyses Ayurvedic and Unani medicines as objects of trade and as material things shaped by commercial social relations.

Right: Ayurvedic herbs on display in Mumbai. *Mark de Fraeye*

Based upon ethnographic research relating to large Ayurvedic and Unani manufacturers in India during the period 1996–2002, data were generated from open-ended and semi-structured interviews, conversations, observations, and company publications such as popular, semi-popular and professional periodicals. Promotional materials and research reports were also used, as well as popular writings on Indian medicine such as articles in general newspapers and magazines. What media and which messages do large Ayurvedic and Unani manufacturers use to 'convince'

the Indian consumer to buy their products? How have they adapted their medical products to middle-class urban buyers, which during the 1990s have become their most important customers? In their marketing discourse manufacturers emphasise the Indian character of their products. What are the notions of Indian identity on which they capitalise? Modern science and technology are used by large manufacturers to create a competitive edge and distance themselves from the image of backwardness that also sticks to Indian medical traditions. How can we explain that the usage of these 'Western things' does not undermine the Indian-ness of Ayurvedic and Unani medicines?

My book starts with setting apart three categories of Ayurvedic and Unani formula and shows that branded products sold as over-the-counter consumer goods dominate the market and make up over 80 per cent of the sales of Ayurvedic and Unani medicines – which grew from US$7.5 million in 1980 to US$1 billion in 2005. The turnover of Ayurvedic medical products is around 15 times bigger than that of their Unani counterparts. This difference in size is also reflected in the number of manufacturers: approximately 7400 Ayurvedic manufacturers against 400 Unani ones. The concentration rate in the industry is substantial: ten large manufacturers produce 60 per cent of all Ayurvedic commodities; one single firm is responsible for 70 per cent of the turnover of Unani products. This Unani firm and four of the biggest Ayurvedic firms (together accounting for 40 per cent of Ayurvedic sales) provide the context for my study of Indian medicine as a commercial undertaking. Large manufacturers thrive on selling branded medical products – classified as 'fast moving consumer goods' – to middle- and upper-middle-class urban consumers. Apart from offering 'natural' and 'authentic' solutions for managing chronic conditions such as diabetes, arthritis and high blood pressure, these products are sold as solutions for the iatrogenic effects of environmental pollution and hectic lifestyles marked by fast food, alcohol consumption and synthetic (Western) medicines.

In the arena of the marketplace, India's medical traditions have become commercialised and its healing substances have been commodified. Within the logic of commerce, I further discuss: the making of brands from substances mentioned in Ayurvedic and Unani canons and recipe books; the linking of medicines to Indian popular and traditional culture; Indian popular discourse on health and identity; the framing of Indian medicines by logical-positivistic research; the representation of Ayurvedic and Unani medical products in professional and popular media; humoral pharmacology as a scholarly humoral and hermeneutic undertaking; and the construction of Indian medicine as a 'value' associated with wholesomeness, naturalness and Indian-ness. In short, my book discusses how the paradox of being traditional and modern at the same time is managed in the marketing discourse of the five largest Ayurvedic and Unani manufacturers.

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The impact of Western Medicine on Hyderabad and its Unani

OMAR QURESHI

It is reported that, in 1841, Nasir-ud-doula, the fourth Nizam of Hyderabad, suffered from 'burning micturation', which persisted despite the best efforts of his hakims.

He was advised by the British resident at the time, General Fraser, to be seen by Dr William Maclean (an 'allopathic' doctor) and was subsequently cured, albeit using dietary alterations akin to Unani methods of treatment. The Nizam later granted the opening of an allopathic medical school and hospital and established the medical department in 1846, as he wished that the Hyderabadi public should also benefit from new allopathic treatments.

Hyderabad, under a great deal of British influence, borrowed much from the administration systems of British India: "almost every department of the British Administration was represented in the state and worked with creditable efficiency". This "creditable efficiency" provided allopathic medicine with a great many advancements in Hyderabad. In particular were the major new hospitals of Afzalgunj, and later the very grand building of Osmania General, which drew comparisons to the best hospitals in London. Allopathic institutions grew very rapidly with the introduction of the latest technologies. X-rays, chemical laboratories and ambulance services were all employed within the city. Modern medicine was a symbol of progression and the Nizams were always keen to show off these hospitals; they received numerous high-profile visits. The foundation stone of Victoria Zenana Hospital for women was laid by the Princess of Wales, no less. Nizam Mahboob Ali Pasha is even credited for his "liberality and public spirit" in the *Lancet* of 1891 for facilitating Edward Lawrie's two Chloroform Commissions of 1888 and 1889, which were held at Afzalgunj Hospital, aiming to convince the global medical community

of the safety of chloroform as an anaesthetic. The use of chloroform remained a contentious issue and the Commissions catapulted Hyderabad to the centre of a heated medical row. Hyderabad was again associated with discovery when, in 1897, Ronald Ross discovered malarial parasites in a dissected *Anopheles* mosquito at a makeshift laboratory in Hyderabad.

Some Hyderabadis saw the rapid rise of allopathic 'British' medicine in the state as manifestation of British control

Despite its many successes, allopathy did not replace the indigenous forms of medicine in Hyderabad. Ironically, it was the introduction of Western medicine that spurred a Unani revival. The British presence, and growing influence over political matters, was a cause of concern to some Hyderabadis, who saw the rapid rise of allopathic 'British' medicine in the state as manifestation of British control. Indeed, after Macaulay's Minutes of 1835 asserting that "European knowledge is true and best," indigenous forms of medicine, while still receiving funding through local government, did not receive the same level of state endorsement that was the case in Hyderabad, or other independently administered states such as Bhopal. So, within the subtle interplay of politics, to strengthen Unani was to strengthen the frontiers. Although not through direct competition, since the two systems coexisted, the use of medical philosophies contributed to maintaining a level of parity such that allopathy (and hence the British) should not be considered superior.

The seventh Nizam of the Asif Jahi dynasty, Osman Ali Khan (r. 1911–48), was personally involved in this ideological tug and implemented many changes designed to give isonomy to both medical systems. Although retaining his official support for allopathy in funding the hospitals built in this period, his belief lay in Unani. It is said that the only time a stethoscope, an icon of allopathy, touched his own body was to check whether he was dead. Funding of Unani had initially been on a much smaller scale when compared with allopathic medicine, and his investments addressed this. However, much more than merely funding the Unani advances in Hyderabad, his enthusiasm and personal involvement inspired a climate that would foster a modernised Unani, enabling it not only to survive, but to flourish alongside its allopathic counterpart.

Upon viewing the construction of the magnificent Osmania hospital building, he felt the need for an equally grand edifice as the centrepiece of Unani medicine. And so by 1930 a new hospital, the Sadrshifa-Khana-e-Nizamia ('chief house of cure of the Nizams'), was being built. His hakims pointed out the common origin of both in Greek medicine, and that Unani could be preferred since it treated the patient holistically, rather than just addressing the bacterial cause. The Unani School was established in 1891, and the Unani Medical College in 1939, with the length of a Hakim's training being increased to five years – the same length as an allopathic medical school. Thus, graduates from either could be considered equally well qualified.

In order to legitimately be compared to a modern allopathy, Unani too needed to be seen as progressive. The Nizam therefore set out to raise the profile and reputation of Unani medicine, and he did this by several methods. He initiated a new emphasis on research and built new institutions for this. Showing his support, he often attended the opening ceremonies personally and said at one of them that "the field of research in this science is necessary for its survival...Because no science or art can flourish in the condition of stagnation." He encouraged the study of Unani through scholarships to attract the most gifted students, and rewards and honorary titles for physicians who published books and articles. He also established a separate department within the Medical Administration, which aimed specifically at improving Unani services. To this end, in 1935, the government even paid for a delegation of the best Unani physicians from all over India to report on how to reorganise Unani. To be seen as 'modern', the ancient Unani art had to adapt and as part of his promotion of Unani, the Nizam's government gave official permission to physicians in the dominions to practise it alongside allopathy. Of course progress facilitating Unani's survival was being made in other states also and even in British-administered states it did not disappear, with funding coming from other sources, but this official endorsement from the highest level of government in Hyderabad is an important divergence from situations elsewhere.

Right:
Nizamia General Hospital in Hyderabad, now in its eighth decade.
Mark de Fraeye

Nizam Osman Ali Khan's various reforms had the desired effect and there was indeed a renaissance of Unani medicine in this period, which is apparent in the hospital attendances: "In addition to the above [allopathic] institutions, medical relief was administered by Unani and Ayurvedic dispensaries to an equally large number of people". This feat is even more remarkable when you consider there were far fewer Unani hospitals and dispensaries

than allopathic ones. Perhaps this is evidence of underlying public confidence in Unani, it having been the main system of medicine in Hyderabad for centuries. Certainly Unani's great tradition in Hyderabad facilitated its modern survival.

Today Unani is still practised widely throughout India, and has official status alongside 'Western' medicine – a model first implemented in the Nizam's Hyderabad whose efforts in reviving the art to achieve parity with allopathy helped to ensure its role in an independent India. A tool of colonisation for the British, medicine for the Asif Jahi Nizams was a tool of defence. Their adoption of allopathy showed Hyderabad to be a progressive state, and the rejuvenation of Unani medicine never allowed the British to assert the superiority of knowledge they claimed in Macaulay's Minutes.

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The rise and fall of the Feingold diet for hyperactivity

MATTHEW SMITH

My research, funded by the Wellcome Trust, investigates the history of the Feingold diet, an alternative approach to explaining and treating hyperactivity in children.

In 1974, paediatrician and allergist Ben F Feingold of San Francisco published the bestselling manual *Why Your Child is Hyperactive*. Therein Feingold made the provocative claim that rising rates of hyperactivity – then, as now, the most commonly diagnosed childhood psychiatric disorder in North America – were not due to genetic dysfunction or brain trauma, as most physicians believed, but instead caused by the consumption of food additives. According to Feingold, hyperactivity could be not just treated but cured by the adoption of a diet that eliminated such substances, a diet subsequently nicknamed the Feingold diet. Feingold's theory gained significant attention during the 1970s from the media, the general public and the medical community. While the media made a minor celebrity out of the septuagenarian physician via numerous television and radio appearances, his supporters established Feingold Associations throughout North America to promote the diet. The medical community, however, was less impressed. Suspicious of Feingold's clinical observations, his motives and the efficacy of his diet, they designed dozens of trials to test his hypothesis during the 1970s and early 1980s. The prevailing opinion that emerged out of these trials was that Feingold's theory was untenable; following his death in 1982, medical and media interest in the diet withered away.

Most physicians treating hyperactive children today would argue that this concluded Feingold's story; scientific testing proved that food additives did not cause hyperactivity and that the Feingold diet was a useless imposition on families with hyperactive children. Examination of the broader context within which Feingold's theory developed and was

Right:
The Feingold diet blamed food additives for hyperactivity.
Olivier Blondeau/iStockphoto

evaluated and dismissed, however, suggests that these conclusions were premature. Indeed, assessing the trials designed to test Feingold's hypothesis reveals that most produced mixed results. Moreover, trials that did claim to yield definitively negative, or positive, results tended to be riddled with design flaws that rendered such conclusions suspect. Perhaps the most telling indication that the trials designed to test Feingold's theory were inconclusive is the fact that nearly all investigators conceded that, regardless of their own trials' results, Feingold's theory deserved additional study. Unfortunately, following Feingold's death, such investigations rarely occurred and garnered little attention.

What explains the spectacular rise and fall of the Feingold diet? Why do some novel medical ideas and therapeutic strategies find lasting and widespread legitimacy, while others linger on the fringes of medical practice? How do physicians evaluate new theories and what impacts most on their decisions? Finally, what role do patients and their families have in determining the fate of medical theories? In addressing these

questions, my research will involve a comprehensive analysis of the origins of the Feingold diet and how it fit into the contemporary context of allergy, psychiatry and nutrition research and clinical practice. I will also investigate the strategies employed by Feingold to disseminate his theory among the medical community and the general public and evaluate which factors shaped the reception of the diet by both physicians and patients. In order to develop a deeper sense of how and why decisions about the Feingold diet were made, my project will rely on documentary and oral history evidence. The documentary sources employed will include articles, letters and commentary from medical journals, as well as contemporary newspapers and magazines, the newsletters of the Feingold Association and Feingold's own writings. My oral sources will encompass a mix of physicians, patients, parents and activists, including both Feingold's supporters and detractors. I hope that such an approach will reveal not only the factors that affected how patients and physicians assessed the Feingold diet, but also the impact of Feingold's theory on how physicians and patients regarded other aspects of alternative medicine.

Although mainstream interest in the Feingold diet ebbed in the 1980s, recent debates about food, its adulteration and its impact on health have renewed interest in additive-free food and the link between nutrition and behaviour. Concerns about the safety of the food supply, precipitated by the spread of mad cow disease, the organic food movement and the rise in childhood obesity, to name but a few

Right:
There has been a resurgence of interest in the link between child behaviour and nutrition.
Maartje van Caspel/iStockphoto

developments, have brought many of the questions Feingold asked about additives and hyperactivity back into the public arena. One of the best examples of this resurgence is Jamie Oliver's school dinners campaign, one of the tenets of which is that healthy, additive-free food improves children's ability to behave and learn. Moreover, the internet has allowed the Feingold Association and similar groups to spread their message about food additives and fomented debate about the effects of additives on children's behaviour. As these developments continue apace, it would not be surprising if mainstream medical interest in the Feingold diet re-emerges as well.

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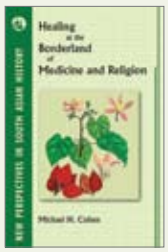
New publication



Healing at the Borderland of Medicine and Religion by Michael H Cohen.

One of the transformations facing healthcare in the 21st century is the safe, effective and appropriate integration of conventional, or biomedical, care with complementary and alternative medical (CAM) therapies, such as acupuncture, chiropractic, massage therapy, herbal medicine and spiritual healing. In *Healing at the Borderland of Medicine and Religion*, Michael H Cohen discusses the need for establishing rules and standards to facilitate appropriate integration of conventional and CAM therapies.

The kind of integrated healthcare many patients seek dwells in a borderland between the physical and the spiritual, between the quantifiable and the immeasurable, Cohen observes. But this mix of care fails to present clear rules for clinicians regarding which therapies to recommend, accept or discourage, and how to discuss patient requests regarding inclusion of such therapies. Focusing on the social, intellectual and spiritual dimensions of integrative care and grounding his analysis in the attendant legal, regulatory and institutional changes, Cohen provides a multidisciplinary examination of the shift to a more fluid, pluralistic healthcare environment.

Michael H Cohen holds a joint appointment as assistant clinical professor of medicine at Harvard Medical School and assistant professor in the Department of Health Policy and Management at Harvard School of Public Health. He is also senior lecturer at the University of the Bahamas, president of the Institute for Integrative and Energy Medicine, and principal in the Law Offices of Michael H Cohen. He is author of five books, including *Complementary and Alternative Medicine: Legal boundaries and regulatory perspectives*.

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New WHO history seminar series

THOMSON PRENTICE

One of the most successful features of the World Health Organization's ambitious Global Health Histories (GHH) project, launched in late 2004, has been the series of lunchtime seminars held at WHO headquarters in Geneva (pictured). The first of these was held in January 2005, when the guest speaker was Dr Halfdan Mahler, former Director-General of the WHO, an iconic figure who will always be seen as leading the primary healthcare movement at the historic international conference at Alma Ata 30 years ago.

His contribution to the inaugural seminar was enthusiastically received by an audience of more than 150 current or former staff members. This was the first real evidence that the WHO has a deep and abiding interest in the history not just of its own work but of global health in general, and it was a strong endorsement of the GHH initiative.

There have been 17 more successful lunchtime seminars under the GHH banner since then. The speakers have included leading historians from many countries. They have covered a wealth of subjects ranging from child health in Uruguay and cholera in Egypt to tuberculosis in India, HIV/AIDS in Africa, and health and social change in Russia and Sweden. The topics have been both profound and picturesque – such as the lecture on evolutionary biology, and the most recent meeting, which contained a colourful presentation of public health posters from around the world.

Now, the seminar initiative receives a tremendous boost with a new series of lectures in 2008, which, apart from the inherent value of each presentation, will also be a significant addition to the high-profile activities that are being arranged to mark the WHO's 60th anniversary. The new series has been made possible by generous support from the Wellcome Trust and the Wellcome Trust Centre for the History of Medicine at UCL. Through Director Hal Cook and Reader Sanjoy Bhattacharya, the Centre has developed a very fruitful professional relationship with GHH since the project's earliest days, and is at the forefront in the GHH international network of contacts.

Altogether there will be ten presentations – twice the number of seminars held in 2007. Speakers will include: Dr Jessica Reinisch (Birkbeck, University of London); Prof. James Fairhead (University of Sussex); Prof. Mark Jackson (University of Exeter); Prof. Paul Weindling (Oxford Brookes University); Prof. Daniel Pick (Birkbeck, University of London); Dr Sonu Shamdasani, (Wellcome Trust Centre for the History of Medicine at UCL); Prof. Anne Crowther (University of Glasgow); Dr Sanjoy Bhattacharya (Wellcome Trust Centre for the History of Medicine at UCL); Dr Sally Sheard (University of Liverpool); and Dr Lynette Schumaker (University of Manchester) and Dr Virginia Bond (London School of Hygiene and Tropical Medicine and the ZAMBART Project, University of Zambia).

All the seminars will be held in the WHO Library's main meeting room (12.30–14.00). Dr Barbara Aronson, head of the Library, said: "It's a wonderful list of lectures. I can't wait to hear them all. It is an honour for the Library to host this programme." Dr Bhattacharya said: "This series of lectures deals with some of the most important elements of international and global public health. Apart from dealing with the origins of the WHO and some of the early challenges faced by it over time in national and international contexts, these lectures also delve into the history of the development of different disciplines and specialisms within a multifaceted organisation with a goal of providing universal healthcare in the broadest possible way. It is also fitting that a series of historical lectures intended to celebrate the WHO's 60th anniversary accommodates presentations dealing with its celebrated role in global smallpox eradication and its continued battles against damaging infectious diseases like AIDS and TB."

WHO/P Virot

The new seminars will ensure the Global Health Histories initiative maintains a high profile during 2008, while its work on other aspects continues. These include two books aimed for publication this year. The first is a history of the third decade of the WHO, covering the years 1968–77, written by Socrates Litsios, historian and former WHO senior scientist. The second is a special collection of 'public health classics' – landmark health, medical and scientific papers from leading journals across the ages that have been reprinted with modern commentaries in the *Bulletin of the World Health Organization*.

www.who.int/global_health_histories/en/

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History of medicine at the Wellcome Trust Centre, UCL

HAROLD J COOK

The Wellcome Trust Centre for the History of Medicine at University College London is proud to be widely regarded as the premier institution for the study of our field. Our goal is to work collaboratively in order to further the core knowledge of our subject area while also supporting the work of others who have an interest in the field and initiating outreach projects to bring the history of medicine to new audiences.

As we do this, we are reminded of Sir Henry Wellcome's vision of the history of medicine as a field through which the whole of the human condition can be explored: the history of medicine provides both challenges and comforts as our own generations feel our way into the future.

The Centre has 'gone global' in recent years. This is not to reject the great strengths that our field has developed through the study of medicine in 'the West', particularly in Britain and North America. But it is to build on those strengths while also challenging some of our assumptions about the causes of historical change by adding new information and points of view to our investigations. During the last two or three decades, the history of medicine (like other fields) has learned much from, and contributed much to, the study of culture, including ideas and practices; this has often been accomplished by careful study of local developments and 'microhistory'-like case studies. At the same time, however, we often speak about how we live – or our ancestors lived – in a global age, in which medical ideas and commodities flow from group to group, city to city, nation to nation, region to region, and around the world. Exploring the ways in which medical people, practices and ideas move about can therefore help us comprehend the connections between different locales, and the transformations wrought by these exchanges. Perhaps even more importantly, unexpected results are likely to come from investigations in little-known libraries and archives. Expanding our vision, or at least our reading, can in turn have effects on how we understand our own lives and subjects. New information and ideas will undoubtedly create friction when rubbing up against current views, and sometimes as much or more heat than light can result. But the new energies produced will also stimulate transformations in our field.

As will be self-evident, no single institution can undertake anything like the scope of investigation implied by going global. The Centre therefore has currently focused its attention on continuing to develop a historical understanding of medicine in Europe from antiquity to the late 20th century while broadening its remit to examine other places in Eurasia. It has therefore been a special pleasure to welcome new permanent members to the academic staff who study China, South Asia and the Indian Ocean littoral. I have also used research funds to appoint Alisher Latypov to explore the history of medicine in Central Asia. Nevertheless, no serious progress can be made in furthering our understanding of the historical situation of medicine in the world without collaboration with many others. The Centre's academic strategy, therefore, is not only for internal guidance but also for reminding us that to the greatest extent possible our resources in London are to enable the studies of others as well. And this in turn would not be possible without a first-rate administrative staff who support not only the work of the regular academics but our much-valued long-term affiliates, visitors, and guests: since 2001 we have had over 200 self-funded visitors spending six weeks or more studying at the Centre, plus many postdoctoral and other kinds of fellows. (People who would like to join us can find out more information on our website.)

Since spring 2007, we have relocated to the refurbished old Wellcome Building at 183 Euston Road, where we are again next to the superb Wellcome Library and also the new Wellcome Collection galleries and facilities. Our location brings us next door to UCL, and with the many libraries and archives in the Bloomsbury section of London – not least the British Library – the members of the Centre, both permanent and visiting, are perfectly positioned to carry out research in breadth and detail.

The Centre is not only a research institute, however: we continue to develop an active teaching programme.

The academic and administrative staff also support our vigorous programme of events, from work-in-progress seminars and one-day workshops and colloquia to named evening lectures and major international conferences, all of which are often organised collaboratively. The Centre's academic and editorial staff are also responsible for a number of important publications in our field: *Medical History*, Wellcome Witnesses to Twentieth Century Medicine, Clio Medica: The Wellcome Series in the History of Medicine, and the Sir Henry Wellcome Asian Series; in addition, academic staff members edit this newsletter and the journal *Asian Medicine*, and co-edit the book series New Perspectives in South Asian History. The Centre is also now engaged in various online publishing projects. Moreover, for the past year and a bit we have also had an Outreach Historian working with us (Carole Reeves), whose remit is to further public understanding of medicine and its past and to encourage those who would like to be more

involved with the practice of the history of medicine. Through her efforts, we hope not only to expand an interest in our subject but also to learn from the experience in ways that will sharpen our own research.

The Centre is not only a research institute, however: we continue to develop an active teaching programme. The Centre continues to teach a longstanding, varied and quite successful intercalated BSc course for over two dozen medical students per year, many of the options of which also attract students from elsewhere in the university. For the past four years we have offered an MA course in the History of Medicine, which has had about a dozen students per year from a variety of backgrounds, many from abroad. Members of the Centre also participate in the London Centre's MSc in the history of science, medicine and technology. They also teach on the courses offered by the Society of Apothecaries, which holds many of its sessions at the Centre. Our PhD programme has become particularly strong in recent years, with over half of the students coming to us from abroad. Together with Stephen King of Oxford Brookes, our Deputy Director, Anne Hardy, and our Postgraduate Tutor, Helga Satzinger, have also organised a training course for PhD students from around the UK who are studying the history of medicine, which also meets on our site four Saturdays per year.

All these and other successes have been due to the work and commitment of a first-rate team of permanent academic members. The group is now quite different from the staff who transferred from the former Academic Unit of the Wellcome Institute to UCL in 2000. At its inaugural, the new Centre had a new Administrator (Alan Shiel) and Director (Harold Cook) appointed to lead the group, and two new academic staff positions (Sanjoy Bhattacharya and Vivienne Lo) were filled in 2001. A third new post (held by Sonu Shamdasani) was created owing to the philanthropic generosity of the Philemon Foundation in the USA. A fourth (William Fleming MacLehose) was awarded to us by UCL in 2007. Following the retirements of Bill Bynum and Chris Lawrence, and the departure of Janet Browne for Harvard, we have welcomed Helga Satzinger, Guy Attewell and Emma Spary. A vacancy caused by Andrew Wear's recent retirement will be filled next year.

Only through collaborations with many partners and the continuing support of the Wellcome Trust and UCL have the recent transformations of the Centre been possible. With the help of all our partners and colleagues, we can help bring a reinvigorated knowledge of medicine's past into the future. For further information, please see www.ucl.ac.uk/histmed.

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Genetics in Germany, 1900–50

HELGA SATZINGER

I joined the Centre in 2005 as Reader in the History of 20th-century Biomedicine. I was previously at the Centre for Interdisciplinary Studies on Women and Gender at the Technical University of Berlin, where I worked as a historian of science, combining historical gender and science studies. My doctoral degree was from the Technical University of Braunschweig; it investigated the work of the Franco-German medical couple Cécile and Oskar Vogt, who, in the first half of the 20th century, pioneered 'brain research' by localising mental functions in certain areas of the brain.

Right: Participants at a 1935 'Congress on the Standardisation of Sex Hormones', including Adolf Butenandt.

The history of genetics is currently my main field of research. My book, which is forthcoming this year, investigates genetics and hormone research in the first 50 years of the 20th century. Its goal is to ask how the social and symbolic gender order shaped the biological sciences that have become the scientific basis of modern medicine and medical research. The book looks at three case studies and research groups, which were searching for the genetic material and using the theme of inheritance and determination of sex difference as the paradigmatic example in genetics and hormone research. The first case study deals with the establishment of the chromosome theory of heredity in the first decade of the 20th century by Marcella and Theodor Bovery. They identified chromosomes as the material basis of inheritance; they also investigated the relevance of the cytoplasm as being of utmost importance for development.

The second case study covers a theory of the gene developed by Richard Goldschmidt in the 1920s, while studying the problem of sex determination. Highly influential in German genetics at that time, this theory was an alternative to the dominant theory of the gene, advocated by the American Thomas H Morgan and his school. The fascinating – and disquieting – aspect of Goldschmidt's theory is that it became part of the debates on racial purity and gender identity in Weimar Germany. Different gene concepts, and differing gendered and racial concepts of social order, were closely linked. On the one hand there was Goldschmidt's model for sex determination, according to which every higher organism integrated both male and female factors in a particular balance, and genes were not absolutely stable. On the other, there was the ideal of a clear binary, discontinuous gender order; here every ambiguity was a sign of degeneration, and had to be prevented by racial purity.

The final case study deals with Adolf Butenandt's work on sex hormones, which started in the late 1920s, supported by his fiancée Erika von Ziegner in crystallising the 'female hormone'. Butenandt became a leading figure in West German biomedical research after 1945. He believed in a strict binary gender order, so his concept of sex hormones could not accommodate the controversial findings that men and women both have 'male' and 'female' hormones. He transferred his concept of the hormone as the active principle to the concept of the gene, thus creating new tasks and new limitations for biochemistry in the field of genetics in the period after World War II. Covering three eras of German history – Imperial, Weimar and Nazi Germany – the book shows how political convictions and particular gender concepts were integral to scientific concepts of the gene and sex hormones. It also seeks to show how these considerations hindered the scope of scientific hypotheses and conclusions. The book traces the careers of women scientists working in these research groups; it begins with the pioneering women who fought for access to university education and academic careers around 1900, and continues with the first generation of independent female scientists during the Weimar Republic. It ends with a description of exclusionary practices against women in the scientific communities dominating after 1933.

My current research focuses on the history of medical genetics, while continuing to investigate the history of women in biomedical science and medicine. I am involved in cooperative international research projects to investigate the globalisation of *Drosophila* genetics in the 20th century, and, with the Max Planck Institute for the History of Science in Berlin, in work on the role of gender studies in the history of science and medicine.

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Food as a medical object in Paris, 1675–1815

EMMA SPARY

My current project began in February 2006 when I started a Research Fellowship at the Centre, and has been carried over into my new post as Lecturer in the History of Eighteenth-century Medicine.

From the start, it was framed as an attempt to examine how medical and scientific knowledge claims fared in public settings outside the safe confines of the institution. For these reasons, it is oriented towards archival and primary printed materials that have hitherto received little attention either from historians of medicine or from historians of food and cuisine. My account begins at a time when the first shops selling prepared food goods appeared on the streets of Paris, and ends with the demise of the First Empire. I explore a variety of different issues from the intervening period.

Beginning with the politics and theology of dietary recommendations by the Paris medical faculty in the 1710s, I move onto an extended study of coffee as a global good that became 'domesticated' in France by being cultivated in the colonies and integrated into the city's networks of knowledge and consumption. Coffee became a mental fuel for one generation of men of letters who frequented the café. I then move on to explore the models of habituation and the cultivation of taste that were central to the mid-18th-century culinary and philosophical world and that, I argue, created the moral controversy upon which our modern narratives of addiction are still founded today. The conflict provoked by the debates over cuisine was an opposition between reason and appetite; until 1750 many authors remained confident that the use of reason would allow indulgence in moderate pleasures, but thereafter one finds increasing pessimism among medical and philosophical writers alike, exemplified in the writings of Jean-Jacques Rousseau and Samuel-André Tissot.

These debates also played out in the marketplace. I look in detail at the production and sales of distilled liqueurs and show that until the 1760s, there was nothing corresponding to our modern notion of 'alcohol' in chemical or public discourse. Within Paris, distillers and pharmacists clashed over who had the right to define proper distillatory procedure, with the latter turning increasingly towards quantitative and non-

Right: Japanese funeral costumes. Watercolour, c.1880.

Right:
A woman in France offering food to children. By J G Wille after Dietricy.

corporeal standards of liqueur and brandy quality. In another chapter, I explore the market for health foods in Paris from the 1770s onwards. Such foods were only used when consumers accepted the health claims attached to the product in question, so that eating a health food became a way of swallowing someone else's authority over one's own body. I have also carried out a series of studies concerning the fate of the nutritive principle, considered to be unitary in the period.

In the work of Antoine-Augustin Parmentier and his close collaborator Antoine-Alexis Cadet de Vaux on bread and potatoes, one can trace the political allegiances of their programme for improving bread-making and identifying and implementing wheat substitutes from the late Old Regime into the First Empire, culminating in a study of poor soup as an industrial, chemical and philanthropic programme in early 19th-century Paris. I also look at the ways in which medical interest in broth as the principal medicinal vehicle transmuted into attempts to calibrate broth's nutritive powers, then into efforts to relate nutritive intake to weight and to produce and market pure nutrition in the form of bone gelatine. I then return to cuisine, showing how gastronomic writings should in many ways be seen as direct responses to the issues raised by the previous generation of politically active alimentary chemists, who had sought to overturn many established notions about nourishment and necessary foods. The project ends with a chapter on the development of the sugar beet industry in the French Empire, a programme promoted by Napoleon himself in the wake of the Continental Blockade. Here the issues raised earlier regarding the authoritative status of medico-scientific experts in the public sphere, the political role of surrogate foodstuffs, the problem of habituation and the legitimacy of chemical definitions of the nature of foods play out in interesting ways, involving ministers, medical and scientific practitioners, philanthropists, industrialists, critics and consumers. I think of it as the lost history of French food – a fascinating parallel to the well-known *gastrohistoire* genre, which at last pays attention to the many scientific, medical and political interventions in making and defining food and drink.

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'Islamic' medicine as transregional medicine

GUY ATTEWELL

The more I study Tibb ('Islamic' medicine, as a term of convenience), first through examining Iberian encounters with Arabic-derived texts and Asian medicinals in the 15th and 16th centuries, and then through more sustained research on Indian contexts in the colonial period, two things have become clear to me that I think have been little problematised or deeply investigated to date.

First, the need to conceptualise Tibb, from the outset, as a transregional phenomenon; second, to destabilise the notion of Tibb as a uniform set of practices that could be taken from one place and implanted in another. Both of these issues as matters of concern arise from numerous constraints in the way Tibb has been approached. The creation of pristine histories of medical traditions, and their labelling in corporate, culturalist, religious or civilisational terms (Greek, Chinese, Hindu, Islamic, for example) is a reifying process worth studying itself. Additionally, perhaps transregionalism gains currency as part of an academic interest in globalism in consonance with the movement of capital and goods of our so-called globalising world. If that is the case, then studying Tibb offers an opportunity not to celebrate cosmopolitanism and globalisation unreflectively, but, on the contrary, to engage with the entangledness, the connectedness and the disconnectedness of peoples, materials, texts, thoughts and practices across times and places.

The project that I am embarking on is a social history of drugs and their trade: how drugs have travelled, how people have used them and how drugs have maintained, lost or gained medical, social, cultural and economic significance. I am particularly interested in those drugs that became important in healing traditions in Islamic milieux and that circulated across the Indian Ocean.

Medicinals of diverse origins provide a glimpse of the varied material foundations of Tibbi practice and its

connections to transregional trade. We can illustrate this further with reference to myrobalans (fruits of the trees *Emblica officinalis* or amla) and several trees belonging to the *Terminalia* genus (chebulic and beleric myrobalans). Myrobalans have a long, illustrious and even sacred history in India, Tibet and central Asia as medicinals. Combined together they constitute triphala, a widely known remedy in textual and oral healing traditions in India. Rendered into Arabic as *itrifal*, its constituents and therapeutic benefits are described in Arabic works on materia medica of an early date, such as in the work of Ibn Sina. That their use was widespread in western Asia from the tenth century, and not just of theoretical interest, can be inferred from the excellent work of Efraim Lev and Zohar Amar on documents deposited at a synagogue in Cairo, mainly during 900–1300 CE. According to the relative number of citations, they find that myrobalans were by far the most popularly used drug – local or exotic – in actual medical practice among a Jewish community in an Islamic milieu. The myrobalans were no doubt traded from India, although the chebulic variety was also cultivated in parts of central Asia, and may have come from there. Right from the beginning, then, of what we take to be originary moments in the formation of a medical tradition, which comes to be seen as 'Muslim' or labelled as 'Greek' (Unani), are so many signifiers of exchange and crossovers between peoples and places.

The movement of medicinal substances across great distances raises questions about whether and how medical knowledge travelled. It is interesting to note that humoral theories based on air, water, fire, earth – the four elements of Galenic medical theory – manifest themselves in local healing traditions across the Indian Ocean, while one of the names for physicians in Malay, Swahili, Persian and Urdu is based on the word for physician in Arabic, *tabib*. Clearly there has been a tremendous diffusion of diagnostic and therapeutic knowledge, which is directly linked to the networks of trade and migration within the Islamic world, broadly conceived. But how do we understand the processes of transmission, diffusion and localisation of medical knowledge? How have political, social and economic factors motivated certain forms of knowledge, while inhibiting others?

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Medieval concepts of the child

WILLIAM MACLEHOSE

My research currently focuses on the interaction of medicine and religion in Western Europe during the middle ages. I study the ideology of the family, especially concepts of the child in embryological and paediatric writings of the 12th and 13th centuries in France and Italy, as a locus of concern and contact between medical, social and spiritual understandings of the world.

I have chosen the history of childhood as my focus, because ideas of pregnancy, birth and early childcare reveal much about the hopes and fears of each society. Medieval medical, philosophical and religious writers singled out the fetus and child as physically and morally vulnerable creatures. The history of medieval childhood presents a subject whose body and soul were common preoccupations in medical and religious thought: the young were considered to be particularly prone to corruption and disease, both corporeal and spiritual. As such, medieval concepts of the child provide a unique vantage point in the correlations between medical and theological knowledge.

My earlier work has identified an increasing interest in the fetus and child over the course of the high middle ages, particularly surrounding the ever-present danger of infant mortality. My book, *A Tender Age: Cultural anxieties over the child in the twelfth and thirteenth centuries* (Columbia University Press, 2006), argues that a concern over the child's wellbeing played an important role in distinguishing and even demonising problematic social groups and phenomena in the medieval Christian world. Embryological and paediatric writers were disquieted by women's bodily fluids as sources of nutrition for fetus and newborn. Orthodox polemicists defended infant baptism and condemned heretics by invoking the fear of an unbaptised infant's corporeal death and spiritual punishment. Chroniclers who discussed the so-called Children's Crusade pondered the psychological nature of the child and the process of physical and mental maturation. Each discourse invoked the transience and fragility inherent to childhood in order to expose the seriousness of a perceived threat to the child and to society as a whole.

Orthodox polemicists defended infant baptism and condemned heretics by invoking the fear of an unbaptised infant's corporeal death and spiritual punishment.

My new project more directly studies the connections between religious and medical thought and experience in the central and later middle ages. From the 12th century onward, Christian belief centred increasingly on the corporeality of the divine as manifested in the

Right: Woodcut of medieval nursing. By S E Hieronymus, 1497. Detail.

incarnation and particularly in the early moments of Jesus's life. Devotion to the Christ Child allowed the West to imagine the birth and infancy in a variety of arenas. Learned theologians debated with Jews and Muslims about the nature and possibility of a virgin birth, and invoked Aristotelian models of generation and paediatric materials to defend their faith. At the same time, cults of the Child's relics, sermons and poems destined for a more popular audience, plays connected to the liturgy, and visions beheld by Christian mystics, all ruminated on and even revelled in the care of the Holy Child. Beneath all of this was a strong desire not simply to re-imagine but to re-create the events in very real terms as a contemporary birth and infancy. In this sense, the sources can provide important information about the roles of midwives, wet nurses, and other caregivers often overlooked in contemporary medical treatises. Throughout all of this material, we encounter a close interplay between the medical and the religious, the theoretical and the experiential, the popular and the learned.

My work, present and future, seeks to broaden the scope of the history of medieval medicine, and particularly to uncover links between medico-scientific knowledge of the body and religious, political and other intellectual discourses. Understandings of physiology, health, maternity and childcare appear throughout the medieval sources as important means by which people understood their relations to God and to their communities. The sources also underscore the ways in which Latin writers understood themselves in relation to the ancient Greek past and to the medical traditions of the Arabic world. To this end, I am studying the connections between the Muslim and Christian worlds as I edit the first known Western paediatric writing, a Latin treatise on the diseases of children attributed to the Persian physician Rhazes (al-Rasi). Throughout the treatise, the delicate temperament of the child reveals much about the importance of hygiene and the limits of pharmacology. With the treatise, which has no known Arabic original despite the attribution to Rhazes, we witness the process of Western assimilation and transformation of the Graeco-Arabic medical tradition. This practical work is the first example of a new Western medical genre dealing exclusively with the diagnosis and treatment of children's diseases and reflects the desire for classification of knowledge in the scholastic world.

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Finding the lost children of Craig-y-nos

CAROLE REEVES

Craig-y-nos Castle (the name means 'Rock of the Night') lays claim to be the most haunted castle in Wales.

Perched on the edge of the Brecon Beacons National Park, it was the estate of Adelina Patti, the world-famous opera singer, from 1878 until her death in 1919. Within the castle grounds, Patti built an ornate theatre where she sang for audiences of up to 150, including British and European royalty. The Patti Theatre is now a grade I listed opera house and headquarters of The Opera School Wales. On Patti's death, her third husband, Baron Rolf Cederstrom, sold the estate to the King Edward VII Welsh National Memorial Association, established in 1910 to combat tuberculosis in Wales. As the Adelina Patti Hospital, it served for 40 years as a sanatorium for children and young women, at a time when the incidence and death rates of TB in the industrial areas of South Wales were higher than anywhere else in Britain. TB claimed the lives of 12 young men and 17 young women a year in every Welsh community of 6000 people.

Ann Shaw, an artist and writer now living in Scotland, was a patient in Craig-y-nos from the ages of nine to 13 (1950–54), during which time she kept a diary and took photographs on a Kodak 'Box Brownie' camera. On a nostalgic visit to Craig-y-nos Castle (now a hotel) at the end of 2006, she was amazed to discover that many of the original wards, although dilapidated, were still intact. All hospital records, however, had been destroyed. So began the search for the 'lost children of Craig-y-nos' and the construction of an archive that will result in the first ever collective account

Right:
Boys on the balcony with teacher Mrs Thomas, *c*.1951.
Children of Craig-y-nos

by patients and staff of life inside a TB sanatorium. Advertisements in local papers, on the BBC Mid-Wales community history website, and Ann's daily blog (**www.craig-y-nos.blogspot.com**) brought forth a deluge of correspondence and memorabilia from around the world. By October 2007, the project had collected over 1000 photographs, most of which were taken by the children themselves recording such things as bed baths, wards, buildings and staff, improvised fancy dress, pets, concerts and visiting celebrities, streptomycin injections, feeding wild birds from the balconies, and illicitly riding ponies owned by the medical superintendent's daughters, using dressing-gown belts as halters. Photographic exhibitions have been held in the heart of the community at Ystradgynlais in the Swansea Valley and at Brecon. An online exhibition is at **www.childrenofcraigynos.com**. A reunion held at the Castle on Sunday 9 September 2007 was attended by 120 ex-patients, staff and their families.

In addition, over 70 oral histories had been recorded and transcribed from ex-patients and staff aged 58 to 99. These cover not only the entire 40-year period of the sanatorium's existence but also Patti's last decade as resident of the Castle. Many people had never spoken of their experiences until interviewed for the project and it is clear that the Craig-y-nos story is extremely complex, with both positive and negative long-term consequences for survivors. Deprived of family life (visiting was only once a month and a number of children were abandoned by their parents), the children looked to each other for emotional support through months of bed rest, traumatic procedures such as artificial pneumothorax and gastric lavages (to retrieve TB bacilli from swallowed sputum), and the deaths of close friends. Ann Shaw recalls: "It was Dorothy [another child] who explained to me that I had TB. I remember her saying, 'You've got a hole in the lung and you have got to keep very still. If you move, that hole will grow bigger and you'll die'. After receiving that piece of information I lay very still. For 15 months."

Deprived of family life, the children looked to each other for emotional support through months of bed rest, traumatic procedures and the deaths of close friends

The Craig-y-nos project is now well established in the community and has received considerable support from the English and Welsh media. Some of the 'children' themselves, now parents and grandparents, are passing on their experiences to schools and local interest groups as well as collecting further interviews and memorabilia. TB was one of the most feared diseases of the 20th century, particularly in Wales, so it's perhaps not surprising that Craig-y-nos Castle buried its 40-year history as a sanatorium. Its survivors, the Children of Craig-y-nos, are central to a unique new resource for social, medical and family historians, and in the process are helping to lay their own ghosts.

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Public enemy no. 1: TB since 1800

ANNA CROZIER

In September 2007 the Centre for the Social History of Health and Healthcare, Glasgow, was pleased to host a conference on the history of tuberculosis – partly inspired by the 50th anniversary of Glasgow's own, highly successful, TB mass radiography campaign.

From the outset the conference organisers had hoped to make the event cross-disciplinary and it was gratifying to see these efforts rewarded with a range of perspectives presented. The forum brought together scholars from medical history, social and cultural history, archaeology and geography with TB practitioners and policy makers to explore personal, community and national experiences of the disease.

The proceedings kicked off with a fascinating keynote from Professor Linda Bryder (University of Auckland), entitled 'TB and the Medical Historian'. She traced the developments within the historiography of TB. She recounted how, when she became interested in the topic, very little of substance had been written historically, and described the way the historiography subsequently evolved into the thriving scholarship that exists today.

The rest of the day saw nine more papers organised around three thematic sessions. Dr Charlotte Roberts (University of Durham) gave insightful background to the bioarchaeology of tuberculosis, explaining what early evidence of TB might suggest about its modern virulence and location. Professor John Grange (University College London) then gave a medical perspective on the way the chemotherapy of TB had developed, with its many false starts and instances of premature optimism. Dr Flurin Condrau (University of Manchester) rounded off the first session with a richly contextual talk about the rise and fall of Davos as an iconic TB sanatorium, reminding the audience of the importance of place in understandings of the wider constructions of TB as a disease.

Above right: Tram-car advertising for the 1957 Glasgow TB campaign.

Right: Badgers: blamed for the spread of bovine TB. *Valerie Crafter/iStockphoto*

The second session saw lively contributions from Dr Stephanie Kirby (University of the West of England) on TB nursing, Professor Arthur McIvor (University of Strathclyde) and Dr Ronnie Johnston (Glasgow Caledonian University) on the history of TB within the context of occupational health, and Dr Peter Atkins (University of Durham) on bovine tuberculosis in relation to the human bacillus and the much-debated role of badgers in its spread.

The last panel compared various international approaches to TB management, with papers presenting strategies for TB control drawn from the Norwegian, New Zealand and Australian experiences. Dr Teemu Ryymin (University of Bergen), Ms Debbie Dunsford (University of Auckland) and Dr Criena Fitzgerald (University of Western Australia) presented in this session, which resulted in some absorbing questions from the floor, particularly over the points of comparison between these campaigns.

Day two commenced with another keynote, this time from Professor Ian Levitt (University of Central Lancashire), which framed the morning's papers, all of which were to examine Scottish experiences of TB. Professor Levitt focused upon the 1957 Glasgow mass radiography campaign, providing some original insights into the political shenanigans that formed the little-talked-about background of this movement in social medicine.

Next spoke Ms Amy Farnbach (Arizona State University) on Scottish diagnoses and treatments of TB during the 19th century. Her talk neatly laid out some background to the two papers that followed, which both returned to events in 1957 Glasgow. First we heard Dr Patricia Barton's (University of Strathclyde) personal account of the campaign – not only had her aunt and mother been volunteers in 1957, but she herself had contracted TB (although some time later). As such, it provided a rich and moving description of postwar Glasgow and situated the public enthusiasm for the mass X-ray against a wider socio-demographic history. This point was expanded by Dr Irene Maver (University of Glasgow), who contextualised events from her perspective as an urban historian. By understanding

Above: Stannington Sanatorium for children with TB, Northumberland.

events in terms of a 'civic crusade', she argued that issues of civic and local political identity were vital in instilling public cohesion and motivation.

The final session started with an intriguing analysis of TB in film by Dr Christian Bonah (Université Louis Pasteur) and Dr Vincent Lowy (Université Marc Bloch). This highlighted recurrent tropes within TB health education films and showed their chronological development. This was followed by a stimulating presentation on the Rhondda Fach survey of 1950 in South Wales (Dr Pamela Michael, University of Bangor) and, finally, a closing talk by Professor Thomas Daniel (Case Western Reserve University) on how TB had deeply affected the experiences and writings of the Brontës.

Of particular note was the attendance of Sir John Crofton, formerly Professor of Respiratory Diseases and Tuberculosis, University of Edinburgh and President of the Royal College of Physicians of Edinburgh, and lifelong researcher and campaigner in the treatment of TB. Still sharp as a tack in his 96th year, Sir John had much to contribute to the discussions. It was a great honour to have him attend.

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History of health at Glasgow

Historians of medicine at Glasgow Caledonian University and the University of Strathclyde joined together in September 2005 to form the Centre for the Social History of Health and Healthcare (CSHHH).

This derived from a growing sense of mutual interests; the establishment of the Centre has been supported by both institutions, not least through the creation of new posts. The research interests of CSHHH members, individually and collectively, embrace a broad range of historical topics – for instance the history of occupational health, the colonial medical service in East Africa, rituals of death and dying, and the history of drugs and addiction. Recent publications from those attached to the CSHHH include: the collection edited by James Mills and Patricia Barton, *Drugs and Empires: Essays in modern imperialism and intoxication* (Palgrave, 2007); Arthur McIvor and Ronnie Johnston's *Miners' Lung: A social history of coal dust disease in the UK* (Ashgate, 2007); and the article by Janet Greenlees on tuberculosis and occupational health that appeared in *Urban History* in 2005. Centre members also have extensive links with colleagues abroad, and various international and collaborative projects – for instance on the history of child guidance – are currently underway or at advanced stages of planning.

The CSHHH has also organised a number of seminar series, workshops, and conferences. In the autumn of 2007, the Centre hosted a conference based around the 50th anniversary of Glasgow's mass radiography campaign against tuberculosis (see above), and seminars with the theme 'Religion, Health and Welfare in Europe from the Eighteenth to the Twentieth Centuries' took place. Both of these events received financial support from the Wellcome Trust. In 2008, meanwhile, the CSHHH, in conjunction with the Centre for the History of Medicine at the University of Glasgow, will host the annual conference of the Society for the Social History of Medicine. Also in 2008, an MSc programme in Health History will be inaugurated, again drawing on staff at Glasgow Caledonian and Strathclyde Universities. This is part of a broader, ongoing, institutional commitment to the history of medicine by both universities, which was also recently manifested by, for example, two dedicated PhD studentships on the history of occupational health located at Glasgow Caledonian.

Further details on these and other activities and on Centre members and their research interests can be found at **www.caledonian.ac.uk/historyofhealth/**. Enquiries about the Centre from colleagues in the field are very welcome.

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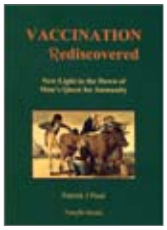
Vaccination Rediscovered



CHRIS PAPADOPOULOS

"I do not wish well to discoveries, for I am always afraid they will end in conquest and robbery," commented Samuel Johnson; he should have added "controversy". From its title, Patrick Pead's concise book *Vaccination Rediscovered* fuels the debate that has surrounded this subject since Lady Mary Montagu's support for the ungodly practice of inoculation.

The author's primary thesis for this book is indeed controversial: "the first investigative review of the origins of vaccination and a narrative with a radical perspective". Patrick Pead shares the oft-quoted view that history was written by those who prevailed over others, thereby denying credit where it is due. In the case of vaccination – the deliberate transfer of cowpox virus to make a person immune to smallpox infection – we should all become aware of the entrenched attitudes and resistance of the male learned fraternity to this new idea, pay due honour to the unrecognised genius of the 'first vaccinator', Benjamin Jesty, and reassess Dr Edward Jenner's contribution to humanity.

In his evaluation of the material, the author starts with a synopsis of most of the known facts concerning smallpox. In the section that follows, he brings to light a great deal of new information on the Dorset farmer Benjamin Jesty, revealing his origins, the incident surrounding the vaccination of his family in 1774 and his subsequent official recognition as the first vaccinator with cowpox by the Original Vaccine Pock Institution in 1805. However, when the analysis turns onto Jenner, drawn by the passionate exposition of Jesty's unrecognised genius, the author's impartiality is called into question. Two of the chapters are concerned with 'The enigmatic Dr Jenner' and 'Did Jenner know?' Typically, Pead asserts that "there is now a growing acceptance amongst medical historians that Jenner's priority is a falsehood". Yet Benjamin Jesty's prior claim to vaccination with cowpox has been generally known and documented by, among others, Thomas McCrae and F D Hart. Perhaps more should have been written about the Dorset case but, for many historians, Jesty could do no more than his circumstances decided.

More significant, however, the author would like the reader to share his conviction that "it is very unlikely that Jenner was ignorant of Jesty", that he has been "careful to base this on sound reasoning from historical evidence" and that in the absence of documentation "his conclusion must remain a proposition". Importantly, he fails to mention that many of Jenner's strongest critics included some prior collaborators and those who advanced claims of pre-Jenner vaccination pioneers. At no time were they able to produce evidence charging him with *prior knowledge* of Jesty's case. While the author is keen to stress Jenner's contribution, his analysis makes a conspicuously biased evaluation of evidence and imputation of Jenner's character.

His sources are very extensive, reflecting the 25 years of researching this subject. However, a key weakness of this book lies in the absence of references to support most of the citations presented in the text. Such lack of references and the book's disputatious writing style undermine further the sense of objectivity necessary in a work of this kind.

If the book's claim for a "radical perspective" alludes to Jenner's part in hiding Jesty's prior attempt at vaccination, it has failed to establish this. Similarly, the information preceding Jesty's vaccination and including the material on Mary Montagu is well known, and many of the conclusions arrived at by the author are familiar to historians with an interest in the subject. But, perhaps, the book is intended for the general public rather than the specialist reader.

We should all become aware of the entrenched attitudes and resistance of the male learned fraternity to this new idea

To the credit of Patrick Pead, that tenacious research led to the discovery of Jesty's portrait and its acquisition by the Wellcome Library. One empathises with his depiction of Benjamin Jesty as much as despairs by the lack of scientific interest shown in this episode by the physician Dr Trowbridge, who attended Jesty's wife. But, as Neil Hallows points out, "genius is not just a rare thing but also very fragile".

On balance, the key strength of this work lies with its useful range of bibliography and account of the events surrounding the Jesty vaccination case. A more dispassionate and balanced approach to the appraisal of the material would have made this book a more worthy addition to the genre.

Pead PJ. Vaccination Rediscovered. Chichester: Timefile; 2006.

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Arabic Medical Manuscripts of the Wellcome Library

GUY ATTEWELL

Usually all one might expect of a manuscript catalogue is that it identifies manuscripts in a given collection, provides the shelfmark, and skeletally details authorship, title and general subject matter. Enabling the act of retrieval is at the core of a conventional manuscript catalogue.

The catalogue under review breaks significantly from this model to show how a catalogue can be a tool for research, while also greatly facilitating retrieval. It is the first of three volumes that aim to provide a comprehensive and meticulously detailed description of the Arabic medical manuscripts in the Wellcome Library collection.

Before the publication of this first volume, by Nikolaj Serikoff, researchers intending to consult the Wellcome Library's extensive Arabic medical manuscript collection had to rely solely on the catalogue compiled by Albert Zaki Iskandar, published in 1967. Iskandar's catalogue may have met the requirements of the time, but neither did he catalogue all the material available to him in the collection (omitting fragments and defective copies), nor have the Wellcome holdings of Arabic manuscripts remained static. The most important addition was the purchase at auction during the 1980s of the collection of Sami Ibrahim Haddad, a Lebanese physician, collector and historian of medicine.

There are significant differences between the core collection (as catalogued by Iskandar) and that of Haddad and the two succeeding volumes, as also between the methodologies that Iskandar and Serikoff adopted for their cataloguing of the material. The collection catalogued by Iskandar, gathered primarily by Sir Henry Wellcome's agents in West Asia in the early 20th century, comprises many fine canonical works, and these are celebrated in Iskandar's introduction. By contrast, Haddad's collection can be seen, as Serikoff argues in his introduction, to reflect the more everyday concerns of physicians who wrote in Arabic. Many of the works are anonymous and defective in some respects, but rather than being omitted or relegated to the end of the catalogue, they are accorded equal weight and the same scrupulous scrutiny as the ones that can be attributed to authors. Further, the 87 manuscripts collected by Haddad and catalogued here date from the 13th century right up to the 20th, with many from the 17th and 18th centuries. This is important for research in Arabic-language healing traditions, which for complex reasons have until recently been skewed in favour of the study of formative texts roughly of the Abbasid era (754–1258).

The catalogue under review envisages textual production from a wide angle. Beyond authorship (where known), the catalogue includes information that does justice to the collective enterprise that such production often entailed, such as on the scribe or copyist, the binder, artist and illuminator, as well as details of ownership. Of great use for researchers, the description of content goes beyond a standard summary and incipits and explicits (the words that begin and end the manuscript) to give the first line (of the Arabic text) for each subsection within the work. This information appears in the section 'Detailed content', which is provided for each manuscript. The researcher is thus able to have a more focused understanding of the manuscript and its contents prior to visiting the Wellcome Library. This will help enormously those who have to travel distance to reach the Library.

The writing styles found in Arabic texts have been conventionally described according to the designation of script (e.g. *naskh*, *nastaliq*). Serikoff goes one step further in attending to the nature of the script by developing the novel parameter termed 'pace' in order to describe the actual distribution and form of the Arabic characters on the page. This is a useful research aid, especially for anonymous works. Handwriting styles of different manuscripts can be more effectively correlated with one another to aid identification and provenance, while those manuscripts not written by professional scribes (which would rarely conform to generic script styles) can be faithfully described.

The scope, content, structure and codicological devices in this catalogue open the history of Arabic medicine and medical manuscripts in the Wellcome Library to a broad spectrum of scholarship. The volume includes several detailed indices to aid searches and it is accompanied by a CD with digitised images of the manuscripts and their bindings, which means that ample and accessible visual presentation is possible without making the cost of the publication exorbitant. That said the cost of the work is high (from £112 new with Amazon) and this may be prohibitive for individuals, although for a quality reference work that provides such detail it should fall within the budget of libraries and research institutes, at which it is primarily targeted.

Serikoff N. Arabic Medical Manuscripts of the Wellcome Library: A descriptive catalogue of the Haddad Collection. Leiden, Boston: Brill; 2005.

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Devices and Designs: Medical technologies in historical perspective

JANE SEYMOUR

As the editors of this volume readily declare, historians have long been interested in medical technology. Previous work has provided a well-stocked "methodological tool shed" from which to borrow, although one approach that informs nearly all the papers here is an understanding that technologies, like scientific knowledge, are socially constructed. Of course, technological tools are limited by, and may also impose, material constraints.

This is a particularly successful and cohesive example of a volume arising from a conference. After an introductory essay, the editors have convincingly grouped the papers into three sections. The first of these deals with technical innovations in the emerging economies of modern medicine. John Pickstone's opening chapter works five case histories together, constructing a larger narrative from "thick descriptions" of orthopaedic practice in the North West of England. He tells of development from the bonesetter's craft of the early 19th century to the "technoscience" of modern hip replacement surgery, a linear unfolding that nevertheless remains concerned with illuminating specific historical context. Jonathan Reinarz's chapter discusses factors determining the adoption of new equipment and methods in Birmingham's voluntary hospitals in the 19th century. He shows how the "diffusion of medical artefacts" was contingent upon factors, particularly financial ones, not under the control of doctors or even patients.

Staying in the 19th century, Christopher Crenner's account of the use of private laboratories by Boston physicians tells an alternative story to that of the laboratory as instrument of modern bureaucratic efficiency, highlighting rather its role as underpinning individualised practice. The importance of understanding local context as well as overarching narratives is thereby emphasised. Moving into the 20th century, Peter Twohig's treatment of the innovations of the X-ray and the laboratory in Canadian hospitals demonstrates how technologies can disrupt notions of occupational groupings into health professionals, allied health professionals and support staff, offering insight into the complexity of workers' roles and the fluidity of work boundaries. These papers are thoughtful and engaging analyses of some of the ways in which technologies have shaped, or been resisted in, the emergence of modern medicine.

The second section is again concerned with illuminating context and contingency, but does so by relating the histories of particular technologies. Neil Handley discusses false eyes, both as cosmetic devices and as carefully crafted, and later engineered, ophthalmic prostheses designed in consideration of comfort and hygiene as well as appearance. Patrick Hidefjäll's paper on cardiac rhythm management devices focuses on the challenges posed in this industry by the technology, the market and its regulation. The moral of this story is that innovation by itself is no guarantee of success. Takahiro Ueyama and Christophe Lécuyer deal with clarity with the technically complex story of the development of the Stanford Medical Linear Accelerator and how this process, which incorporated interdisciplinary clinical and research work, introduced a new paradigm of science-based medicine that ultimately transformed Stanford Medical School. Carsten Timmermann's chapter on the transition of ganglion-blocking drugs from an experimental tool in the laboratory to a therapeutic agent in the clinic tells how this coincided with the transformation of hypertension into a treatable disease. Julie Anderson returns to the theme of orthopaedic surgery, and to some of the same actors cited by Pickstone, in her account of the combatting of problems of infection control in hip replacement surgery.

The third and final section is concerned with expectations of technology and its outcomes and endpoints. Robert Bud's essay shows that antibiotic resistance was recognised as a serious danger by the medical profession well before the public perceived a threat, an awareness that developed in the lay sphere only after the reporting of science had become less unquestioningly positive and more critical. Gerald Kutcher discusses clinical trials of cancer treatments as a practice in standardisation and shows local resistance to the transfer of knowledge embedded in treatment protocols developed through trials and consensus conferences. The last two essays treat firmly of the contemporary. Sally Wyatt and Flis Henwood relate patients' ambivalent responses to risk discourses in hormone replacement therapy, while Stuart Blume traces the relations between evidence-based medicine and political considerations to discuss who makes decisions about available, worthwhile treatments and on what basis.

This is a rich collection with many satisfying and thought-provoking articles that should engage not just historians interested in technology but anyone concerned with modern medicine, its origins and implications.

Timmerman C, Anderson J (eds). Devices and Designs: Medical technologies in historical perspective. Basingstoke: Palgrave Macmillan; 2006.

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Rome or Death

ALAN SHIEL

General Giuseppe Garibaldi had no problems with the 'vision thing'. He was a man who only dealt in big ideas, ideas so big that lesser men and women could scarcely envisage their fulfilment. Therein lay the problem.

He battled, literally, for many years for the unification of Italy, a project opposed by many – particularly Rome, which rightly foresaw the loss of temporal and political power over the Papal States. His achievement in securing unification was the greater, not just for overcoming the forces of reaction that opposed him but also the lack of vision, commitment and organisation of those who broadly supported him and his project. We can follow this problem again as he moved from creating a unified Italy to his next major project, rebuilding Rome.

Daniel Pick recounts here how, exhausted and battled-scared from the struggle for Italian unity, Garibaldi retired to an island retreat in the Mediterranean. But for a man of such restless energy and vision a quiet retirement to tend his garden and spend more time with his family was never likely, and indeed proved impossible.

The condition of Rome, the city so full of cultural and historical meaning, which Garibaldi foresaw as the future capital of the world, troubled many observers. "One hour of our life in Rome is worth a century of life elsewhere," he had written to his wife in 1849. But it was a city utterly polluted by the Tiber, which flooded the city and surrounding plains, and is described by Pick as a foul and squalid sewer "generating untold human infections, a sorry fate for a river which in ancient times had been renowned for its purity".

Pick provides a lively and informative account of 'Roman fever'; it is interesting to observe that as late as the mid-19th century similar medical conditions were named after locations where they were believed to be caused by unique local circumstances, rather than identified as a common problem (Roman fever eventually became recognised as malaria). Baedeker guides advised visitors that goggles made of grey glass would be an efficient form of protection from the fever, as would blue veils for ladies. For the Church, the cause of the fever was simple: moral decadence. It is difficult to resist making the admittedly less than perfect comparison to South Africa's official policy towards AIDS, a condition that can apparently be cured by garlic and beetroot.

The thrust of the book is an account of Garibaldi's emergence from his somewhat listless retirement to campaign for a huge programme of public works, including the diversion of the Tiber and the building of a system of canals. There were a series of plans, including one to completely build over the Tiber and create a city of boulevards in the style of Haussmann's Paris. Garibaldi's fights with politicians, bureaucrats, planners and bankers are vividly recounted, but however much one is attracted towards Garibaldi's vision, it is difficult not to have some sympathy for the gainsayers, faced with a man whose attention to detail or understanding of public finances must have made him quite infuriating to deal with. He was, as throughout his life, a man so driven by a huge project that technical or financial objections could not be entertained.

Overlaying the political battles, Pick gives us an insight into the man, a colossus apparently with feet of clay when it came to his private life. Pick refers to Garibaldi's "less than conventional domestic circumstances, his children out of wedlock, mistresses and petitions for divorce". He married his first wife, Anita, aged 35 (a marriage that might have been bigamous, since there was no evidence that her previous husband, a violent and abusive drunk, had indeed been killed, as she claimed). It was a marriage that only lasted for seven years, ending in her death in 1849 as they fled from Austrian troops, who with the French had suppressed the Roman Republic. Her death is described as the defining tragedy of Garibaldi's life. Thereafter he appeared to be constantly seeking the perfect partner to replace her, and dealing harshly with a series of women, discarding them as they failed to match up to his perhaps increasingly over-romanticised recollections of Anita.

I have always regarded Garibaldi with a degree of suspicion. His apparent ability to "walk with Kings, nor lose the common touch" has always struck me as a convenient conceit from a man of undoubted vision and energy but unconvincing modesty. This book does nothing to undermine my prejudice.

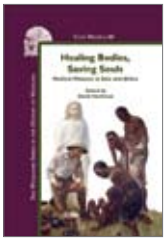
Where the two major strands in the story meet is that Anita was, in all probability, killed by malaria; this might provide the key to Garibaldi's obsession with the state of Rome and his determination to rid it of fever.

This is an excellent book, elegantly written, with some helpful maps and illustrations. The chronology at the start is greatly greatly helpful; the index less so. Overall, it brings together the strands of a great story, the many strands that make *Rome or Death* impossible to pigeonhole. Whether a biography, a social or political history, a medical or environmental history or a psychological study of a Great Man, this is a splendid piece of history that scholars and students will both benefit from and enjoy reading.

Pick D. Rome or Death. Pimlico Press; 2006.

Alan Shiel is the Administrator at the Wellcome Trust Centre for the History of Medicine at UCL (**E** a.shiel@ucl.ac.uk).

Healing Bodies, Saving Souls



THEA VIDNES

"In the Congo…it was commonly believed that autopsies were a form of butchery by whites, who then canned and ate the bodies". Meanwhile in India, suspicion of some missionaries' motives prompted fears that they "were in the habit of performing human sacrifices to ensure the success of various projects".

Beneath the slightly racist sensationalism, both these extracts from *Healing Bodies, Saving Souls* highlight tensions between the biomedical and evangelical facets of Christian medical work overseas – a subject at the heart of several essays in this collection. The outcome of 'Medical Missions in Asia and Africa', an interdisciplinary conference held at the University of Warwick in 2002, the book's aim, through presentation of the papers discussed, is to augment and challenge existing understandings in order to "define the place of missionary medicine within the overall history of medicine".

Each of the ten chapters that follow the introduction – arranged by region (China, India and sub-Saharan Africa) and then chronologically – is a case study, making often extensive use of mission archives to emphasise a certain feature of missionary medicine. Subjects covered include the function of eye surgery in the introduction of Christianity to the Cantonese, the pivotal influence of secular (Rockefeller Foundation) funding in the ascendancy of medical over evangelical emphases in mission work in rural China, and maternal and child healthcare in Tanganyika as a significant way of "getting principles of western biomedicine accepted as a viable option in the African plural medical tradition".

A feature evident in many of the essays, most explicitly presented in Uoldelul Chelati Dirar's study of Capuchin missionary strategy among Eritrean lepers, was indigenous communities' exploitation of missionary medical services. Interaction was frequently at a technical level only: based on principles of effectiveness, mission medicine could be preferred to local therapy if it was cheaper and more available, yet any accompanying religious and proselytising dimensions were generally rejected.

Linda Beer Kumwenda's chapter on African medical personnel in the Universities Mission to Central Africa and Shobana Shankar's on work done by American missionaries among young Muslims in colonial Northern Nigeria are particularly appealing for their inclusion of the local patients' and practitioners' comments and responses. This informs and enlivens the authors' discussions to a degree that is perhaps lacking in some of the book's other papers. Another eye-catching entry is James H Mills's argument that the outcome of the Indian Hemp Drugs Commission of 1893–94, informed by missionaries' medical ideas and images, can be shown to have shaped metropolitan ideas sufficiently to force political debate that remains ongoing. Mills thus offers the episode as an example, positing a wider claim for the impact of missionary medical knowledge – apart from institutions – on Western discourse and power relations.

Aside from the highly specific nature of each paper, the historical, anthropological and sociological backgrounds and perspectives of the various authors require from the editor a comprehensive introduction if any sense of cohesion is to be established in the reader's mind. David Hardiman's first chapter is a fine attempt at this: following an overview of the historiography of medical missions, eschewing summary of each contribution, he adopts a thematic approach instead. In so doing, he is able to refer to the individual essays where they are relevant within the eight themes he identifies: attitudes of different Christian denominations to such work, the theory and practice of Christian medicine, women medical missionaries, leprosy, the local politics of mission medicine, the place of mission medicine in the history of medicine, transitions to indigenous practice, and the ethos of service in medical mission.

The broad range of subjects and expertise included makes informed criticism of this anthology problematic; nonetheless, given the evident richness of the sources, greater use of images (frequently employed in the introduction but scant throughout the rest of the book) would have aided presentation in many other chapters. Furthermore, a marked absence of sub-headings in John Manton's essay made an interesting discussion about Irish Catholic missions' dominance over 1930s–60s leprosy work in Nigeria hard to follow.

With detailed historiography in several of the chapters and its full introduction, the book functions best as a source of reference and resource. It will be especially valuable to scholars of the specific regions discussed, yet also to students and anyone seeking an indication of the breadth of missionary medicine's influence in the 19th and 20th centuries. While I remain unsure that this (or any) text could be judged to have comprehensively delineated the missionary's role within the *overall* history of medicine, certainly it constitutes a noteworthy contribution to the field.

Hardiman D (ed.). Healing Bodies, Saving Souls: Medical missions in Asia and Africa. Clio Medica 80. Amsterdam, New York: Rodopi; 2006.

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Calendar of events

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

APRIL 2008

14 **The Origins of the NHS**
Lecture by Professor Virginia Berridge
Gresham College, London
Contact: enquiries@gresham.ac.uk

15 **The Pursuit of Disease: Trinidad Regional Virus Laboratory, 1953–61**
Seminar led by Debbie McCollin
University of Manchester
Contact: Melissa Smith (**E** melissa.smith-2@postgrad.manchester.ac.uk)

18 **'Mortal Coil': Science, medicine and the prolongation of human life**
Lecture by Dr David Boyd Haycock
Royal Society Library, London
Contact: http://royalsociety.org/contactus.asp

23 **History of Women's Health Conference**
Pennsylvania Hospital, Philadelphia, Pennsylvania, USA
Contact: Stacey C Peeples (**E** peepless@pahosp.com)

MAY 2008

13 **History of Cervical Cancer and the Role of the Human Papillomavirus over the Last 25 Years**
Witness Seminar with Professor David Jenkins
Wellcome Trust, London
Contact: Wendy Kutner (**E** w.kutner@ucl.ac.uk)

21 **Cremation and the Work of the Dead**
The Roy Porter Lecture, by Professor Thomas W Laqueur
Darwin Lecture Theatre, Gower Street, London
Contact: Carol Bowen (**E** c.bowen@ucl.ac.uk)

JULY 2008

4–5 **Who Cared? Oral history, caring, health and illness**
Oral History Society Annual Conference, in association with the Centre for the History of Medicine, University of Birmingham Medical School
Contact: R.G.Arnott@bham.ac.uk

14–18 **12th International Conference on the History of Science in East Asia**
John Hopkins University, Baltimore, Maryland, USA
www.hopkinsmedicine.org/histmed/images/ICHSEA.html.doc

AUGUST 2008

8–9 **Reading and Writing Recipe Books *c*.1600–1800**
Conference at the University of Warwick
www.warwick.ac.uk/fac/arts/english/events/recipebooks

SEPTEMBER 2008

3–5 **History and the Healthy Population: Society, government, health and medicine**
Centre for the Social History of Health and Healthcare, Glasgow
Contact: lmarshall@arts.gla.ac.uk

See also page 9 for details of the WHO Global Health Histories seminars for 2008.

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

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

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