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Men with a mission

Early physicians in British East Africa

THOMAS P OFCANSKY AND BRITT L EHRHARDT

Beginning in the mid-19th century, a small number of British physicians arrived in East Africa. These physicians imported a medical practice, trained Africans in the skills and traditions of this practice, and established institutions that persist to this day. Working under challenging conditions, they also engaged in investigations of diseases such as cholera that advanced health throughout the British sphere of influence in Africa. Some of the more important personalities of this period included James Christie, Albert Cook, John Arthur and John Gilks.

James Christie, who received his medical degree at the University of Glasgow in 1860, began his career by working in mental hospitals in Britain for several years. In 1865, he arrived in Zanzibar and became attending physician to Sultan Majid bin Said. Christie's choice to serve overseas was not unusual for newly minted medical doctors of his era. At least one-fifth of British-trained general practitioners worked overseas at the time, with Scottish and Irish physicians particularly likely to serve in Africa because of their inability to break into London's lucrative private market.

Arriving in Africa, Christie befriended Bishop George William Tozer, who belonged to the Universities Mission to Central Africa, and Captain M A Fraser, an ex-British Navy officer who managed a sugar plantation. The three became politically active, publishing a pamphlet entitled *The East African Slave Trade and the Measures Proposed for its Abolition*.

Above: Group of missionaries at Mombasa, Kenya. From the papers of Albert Cook, 1896.

Cover: A medical missionary in Africa. Oil painting by Harold Copping, 1930.

In 1870, Dr J Netten Ratcliffe, President of the Epidemiological Society of London, asked Tozer for current epidemiological information about conditions in East Africa. Tozer passed the request to Christie, who wrote several reports on cholera and on dengue fever. Christie then began a more systematic study of the origin and nature of East Africa's major cholera epidemics, which occurred in 1821, 1836–37, 1858–59 and 1869–70. Indeed, Christie's most important contribution concerned these investigations. Many observers believed that cholera spread by being blown across the Indian Ocean to East Africa but Christie proved that the disease had been carried over land. In 1874, Christie departed Zanzibar and returned to Glasgow the following year. Two years later, he published a study entitled *Cholera Epidemics in East Africa*, which remains a classic and provides a thorough assessment of his medical investigations in the region.

A second influential physician, Sir Albert Ruskin Cook, was born in London and attended St Paul's School of London and Trinity College, Cambridge. In 1893, he received a Shuter scholarship from St Bartholomew's Hospital and subsequently qualified as a physician. Shortly afterwards, he joined the Church Missionary Society. In 1897, Cook arrived in Uganda and, within a month, he was treating 50 to 80 patients daily. He opened Mengo Hospital, which, by the 1930s, had become East Africa's premier medical facility.

During his tenure in Uganda, Cook and his brother Jack diagnosed the first cases of sleeping sickness, a disease that is believed to have claimed the lives of some 200 000 Ugandans in the Lake Victoria region. His other activities included missionary work, including establishment of the mission schools in Acholi and in

Bor, Sudan. After World War I, Cook focused on improving child welfare and the quality of maternity care in Uganda. He sought to reduce the number of venereal disease cases in Uganda by supporting the colonial government's Social Purity Campaign. Cook and his wife also solicited donations to establish the Lady Coryndon Maternity Training School. By the early 1930s, his career was drawing to an end. In May 1930, his wife died of malaria. Four years later (having received a knighthood), he retired but continued to work as a consultant to Mengo Hospital. Sadly, he turned to morphine, reportedly because he suffered from insomnia and because he desperately missed his wife. In 1951, Cook died at his home outside Kampala.

John William Arthur was born and educated in Glasgow. He decided to undertake a medical career in East Africa, arriving in 1906 as a medical missionary to the Kikuyu mission with the Church of Scotland. For Arthur, the choice of Kenya was a fortuitous one, as he worked enthusiastically to build the mission and, later, to advocate for government reforms. In 1911, Arthur succeeded Henry E Scott as head of mission. In this capacity, he supervised the construction in 1914 of its first hospital. From this eight-bed building, the mission grew into a training centre: between 1919 and 1922, the mission trained 60 African hospital assistants. Education was an important focus of the mission beyond its training programme, and luminaries including future President of Kenya Jomo Kenyatta studied there.

Ordained in 1915, Arthur shifted his focus from medicine to education and evangelism. However, his advocacy of public health for African communities and medical training for Africans continued. Arthur was a complex figure: his humanitarian and pro-African attitudes at times conflicted with his opposition to the Kikuyu Central Association political movement. Some of Arthur's most notable work focused on female circumcision, a practice he opposed. This position repeatedly led him into disagreements with pro-circumcision parishioners, who deserted the church in great numbers, and with colonial officials, who preferred not to raise the contentious issue. J Pease, a senior commissioner of Kikuyu Province in 1929, opined: "I consider the general policy of government towards female circumcision should be one of masterly inactivity" – a position Arthur argued was abhorrent. Arthur was the first European to represent African interests as an unofficial member of the Legislative Council, an activity that many European officials and colonists opposed. He was an avid mountaineer, and held the presidency of the Mountain Club of East Africa for some time. He married in 1921, and the couple returned to Britain in 1937, where Arthur held several posts in Fife and Edinburgh until his death in 1952.

John L Gilks, "one of the least-liked but perhaps most efficient colonial officials" (Malowany, 1997), served as Principal Medical Officer of Kenya from its establishment as a Crown Colony in 1920 to the transfer of the responsibility to Albert Rutherford Paterson in 1932. Gilks built the colony's medical administration, including overseeing the establishment and publication of the *Monthly Journal of the Kenya Medical Service* (later the *East African Medical Journal*). Gilks also increased the number of medical officers and negotiated, usually unsuccessfully, for improved salary and benefits for his staff. By 1924, the department had 33 British medical officers. Gilks's wife was particularly influential in the distribution of staff. Anyone who incurred her

displeasure or that of her friends "was liable to find himself on transfer at short notice to one of the less desirable up-country stations" (Carman, 1976).

During his tenure, Gilks strove to bring medical practice in mission facilities under government control, which led to clashes with mission leadership. His feuds included the Kikuyu mission run by Arthur. Gilks also oversaw the establishment of a Medical Training Depot at the Native Hospital in 1929, where Africans were trained as hospital, laboratory and pharmacy assistants. He and Lord Boyd Orr, of the Rowett Institute, frequently collaborated on nutritional issues. After the 1927 publication of their first paper, the Colonial Office established a research plan for investigating problems of nutrition among Africans in the colony.

Gilks had a reputation as a poor administrator but an extremely competent clinician. He personally diagnosed the first case of *kala-azar* in Kenya, a diagnosis that had eluded the medical officers caring for the patient. However, his heavy-handed style increased tensions between his medical officers, medical missionaries and other members of Kenya's European community.

The activities of Christie, Cook, Arthur, Gilks and others shaped the future practice of medicine in East Africa and around the world. Their epidemiological investigations of cholera, sleeping sickness, *kala-azar* and other conditions influenced tropical medicine throughout the British East Africa. The facilities, administration systems and institutions established by these men continue to underpin medical activities in East Africa.

Above:
Albert Cook. By Peters Kampala, *c.*1930.

Thomas P Ofcansky is attached to the US Department of State and Britt L Ehrhardt is attached to the Johns Hopkins School of Public Health, USA.

New publication

State of Vaccination: The fight against smallpox in colonial Burma by Atsuko Naono

Researched in both London and Burma (Myanmar), *State of Vaccination* examines how a colonial medical establishment attempted to cope with the neglect that came from being on the periphery of British India. In Burma, local medical officers often doubled up as field officers, laboratory scientists, veterinarians and teachers to compensate for the weak reach of the colonial state and the chronic shortages of funding and staff. More autonomy was surrendered to local colonial medical officers and the success of the vaccination effort was more vulnerable than in the presidencies to the limitations of transportation, preservation and legislation, on the one hand, and the challenges of large-scale immigration, local inoculation and indigenous resistance, on the other.

By emphasising the importance of the colonial medical sub-terrain on the periphery of British India, Atsuko Naono profiles the civil surgeon and his interactions with the local landscape. This book makes an important contribution to our understanding of the history of colonial medicine in Asia.

This study begins in the 19th century, when Burma came under British rule after three successive wars, and ends with the constitutional separation from India in 1937. Compared with other areas that were a part of British India, Burma rarely figures in studies of colonial health in the British Empire. As a useful countervailing example of medicine under the Raj, incongruities between the colonial medicine practiced on the subcontinent and its periphery in Burma are highlighted.

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See **www.orientblackswan.com**.

Spotlight on the history of medicine at the University of Exeter

JOSEPH MELLING

The Centre for Medical History at the University of Exeter has been established for more than a decade and is currently in receipt of a second Strategic Award from the Wellcome Trust (2008–13), entitled 'Environments, expertise and experience'.

This Award enables us to bring together four distinct strands of research, which are covered in the contributions below. The role of medicine and healing in the classical period is well represented at Exeter's Centre in the research of Christopher Gill, Julius Rocca (a Wellcome Trust grantholder) and John Wilkins on various aspects of Galen's writings and the dissemination of his ideas throughout the classical world. There is also a link here with the developing research of Kate Fisher and Rebecca Langlands on sexuality and eroticism in the Roman Empire, and its transmission in modern tourist consumption of images in places such as Pompeii. This work is also reflected in the piece on Henry Wellcome's personal collection of erotica, which is likely to contribute to the exhibitions associated with the London Olympics.

The second strand in the Strategic Award is concerned, therefore, with the role of sexuality and the body in the progress of medicine and healing since the medieval period. This area includes the continuing and expanding research of Sarah Toulalan (a former Trust grantholder) on the early modern period, as well as the interests of new colleagues such as Catherine Rider and Alexandra Walsham, whose research includes an examination of the use of water, touch, precious stones and artefacts in the healing of the sick in medieval and early modern times.

Connecting with each of these themes is the third strand in Exeter's research strategy, the transmission of knowledge and more particularly 'expertise' since ancient times. This forms an obvious focus for the work on Galen and other classical writers but also underlies Staffan Muller-Wille's new project on Linnaeus's system of classification, in which he will collaborate with our new colleague Isabelle Charmantier. In common with other research at Exeter, this research is explicitly European and international in its scope and concerns. The theme of knowledge and dissemination of scientific and lay understanding also informs the major programme research on modern stress as a contested field of expertise and practice, led by Mark Jackson and Joseph Melling in collaboration with Edward Ramsden and Pamela Dale. The puzzle of knowledge dissemination informs a raft of doctoral work including that of Ali Haggett, Sarah Hayes and Matthew Smith (the last on the Finegold diet). Centre members in Cornwall are working on the related area of scientific expertise and knowledge dissemination in regard to the Porthcurno telegraph station, research linked to the Cornish Museum and funded in a major grant to Richard Noakes. A distinctive contribution to our discussions of the creation, storage and distribution of expertise has been undertaken by Joseph Melling and Nicole Baur in their work with John Draisey of the Devon Record Office on a Trust-funded archival project on modern mental health records and their usage by different medical and lay practitioners.

The final theme in Exeter's developing research brief is that of environments and impacts of climatic, landscape and interior environments on the health of historical subjects and the progress of earlier medical knowledge and technologies. The contribution of the environment to past and present wellbeing is evident in Mark Jackson's work with Maddy Morgan at the national Meteorological Office (based in Exeter) on flu outbreaks in the late 19th century, and in Melling's developing work on sunlight and health using similar materials. The Strategic Award specified future work on interiors or 'sick buildings', and it is intended that this research will contribute to both the stress programme and the wider research culture at Exeter. Centre members based in Cornwall include Tim Cooper, whose successful Trust-sponsored conference on 'Visions of Eden' attracted international speakers as well as providing a forum for his research on waste management and environmental health in the long term.

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The items on Exeter research in this issue of *Wellcome History* provides only a sketch of current and developing research at the Centre and anyone interested in these and other areas of work is warmly encouraged to contact us for further information.

Professor Joseph Melling is Director of the Centre for Medical History at the University of Exeter (centres.exeter.ac.uk/medhist).

Historical erotica in Wellcome's collection

KATE FISHER AND REBECCA LANGLANDS

It is not generally realised that Sir Henry Wellcome and his team made a deliberate and systematic collection of historical erotica and objects related to sex for his Wellcome Historical Medical Museum. Their aim was to use this material to develop an understanding of the diversity of human sexual practices and attitudes, but how did they interpret these objects and what sort of evidence did they think they provided about sex?

Our research – in collaboration with Jenny Grove – suggests that the Wellcome Institute was developing new models for thinking about human sexuality within a non-teleological view of human cultures, rejecting the models provided both by 19th-century categories of morality and civilisation, and by the new concepts of sexual pathologies emerging in European sexology.

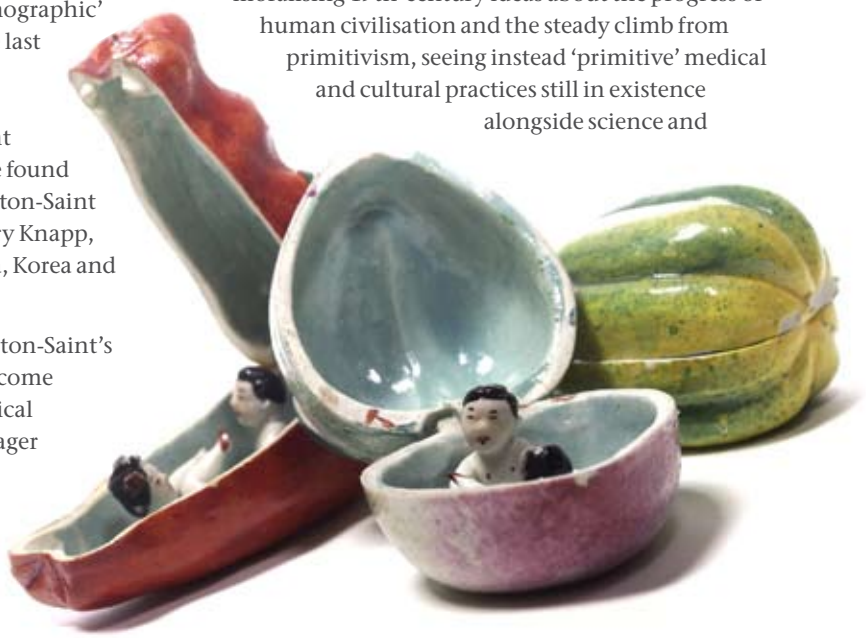
In London, Wellcome Collection's *Medicine Man* exhibition offers "a cross-section of extraordinary objects from [Henry Wellcome's] forgotten museum, ranging from diagnostic dolls to Japanese sex aids, and from Napoleon's toothbrush to George III's hair". Erotic objects, such as the Chinese porcelain fruit containing erotic scenes (pictured below) or the silver-bound hinged cowrie shell containing a painting of a man unlocking the chastity belt of a reclining woman are seen as evidence of the "bewildering variety of oddities" that Wellcome collected, and the incoherence of his project.

What is not generally realised is that these objects represent just a fraction of the erotica in his collection, which contains over 800 such items, and that they did not find their way there as part of an indiscriminate acquisition of objects or as part of job lots. On the contrary, from the beginning, Wellcome and his team of collectors made a point of seeking out erotica and sexually themed objects from all over the world, categorised by Wellcome staff as 'pornographic' or 'phallic' or sometimes 'priaps' – the last a favourite term of roving collector Captain Peter Johnston-Saint, Wellcome's 'Foreign Secretary'. Insight into this determined collecting can be found in the correspondence between Johnston-Saint and Surgeon-Captain Montague Henry Knapp, during Knapp's travels through China, Korea and Japan in 1935.

It is clear that a central aspect of Johnston-Saint's commission as purchaser for the Wellcome Museum was the acquisition of historical erotica. Johnston-Saint was initially eager that Knapp should purchase various contemporary sex aids from the Japanese company Arita on his visit to Kobe, and sent him a marked-up catalogue as a guide: "Re your letter of 24th June and our subsequent conversation on telephone about the things you asked me to get from the Wellcome Museum in Japan (Special Section), I will get the things you mentioned in your letter from the Drug Co. in Kobe." But Knapp wrote that he had also seen "various interesting ivories that look Chinese and Japanese from time to time" and it was not long before, with Johnston-Saint's encouragement, he was pursuing a quest for erotic treasures throughout Asia: "I hear there are probably some things of the kind you want to be found in China." As he writes to Johnston-Saint from Hong Kong on Christmas Day 1935, "it has been interesting collecting them, and I hope you will be pleased with them., some are distinctly old & good...Others are cheap and pornographic stuff but all of interest I think."

Back at the Institute, staff underlined in red pen those items identified as destined for what Knapp calls the "Special Collection" or the "Special Section", often labelling objects with the abbreviation "S.S." Johnston-Saint's own travel notes and journals also attest to an ongoing interest in collecting such material; in Rome he finds "a most remarkable and valuable collection of 18th century pornographic plates beautifully mounted" and "twenty three casts of Greek gems, all medical or pornographic" and writes: "after lunch again to the bazaar. This time I had a real good find – two black phallic groups which must be at least 3000 years old."

The Wellcome Institute was by no means alone in collecting historical erotica, and as well as private collections, 'secret museums' full of such material were famously to be found in the British Museum and at the Royal Archaeological Museum at Naples. However the Wellcome approach to interpreting and displaying the material was an unusual one, reflecting the Institute's broader attitudes to human cultures and history, among them a resistance to the idea of the progress of civilisation. Its ethos was one that challenged moralising 19th-century ideas about the progress of human civilisation and the steady climb from primitivism, seeing instead 'primitive' medical and cultural practices still in existence alongside science and



Right: Chinese porcelain fruit, containing representations of a couple engaged in foreplay.

modernity: "The belief in the occult effect of certain objects...is found not only among the most barbaric tribes, but also among the highest civilized peoples of today" ('Wellcome Museum Handbook', 1920). The Institute sought, through the acquisition of a wide range of sexually themed material from across the globe and throughout human history, to gain an understanding of the diversity of human sexual practices and beliefs without being overtly judgemental about those practices.

Despite the creation of a Special Section, the Wellcome Institute also rejected the established museological model, which saw sexual material hidden away in secret chambers with restricted access. On 24 April 1943, Gayer Anderson wrote to the Museum offering a selection of "pornographic Greco-Roman pieces" of "good workmanship". He urged the purchase of the objects as they were "of very considerable anthropological interest" and, assuming that these items were "naturally difficult to place", enquired whether the Museum had "a private room for such objects". The Director, S H Daukes, eagerly accepted the collection but rejected the need for a private display room: "This will be added to our collection of similar material, which will ultimately find a place in our Section dealing with psychology." His response reflects the conception of the Museum as a place for specialist research rather than a public attraction, for the use of those in the medical and related professions. However, the range of permitted visitors was broad and included, for example, the London and Country Ramblers' Association in 1920 and students from Priory Grove Girls' School in 1930.

One might assume that Wellcome was influenced by the emerging discipline of sexology, and by the intellectual agenda of collections of contemporaries such as Magnus Hirschfeld at his Institute for Sexual Research in Berlin. Hirschfeld's collection did indeed contain a similarly diverse range of objects, statues and amulets from all over the globe. However, the Wellcome Institute did not employ the language or concepts of sexology, which tended to categorise sexual practices into different pathologies. Despite the medical context of their collection, and their interest in such matters as diseases that deform the penis, the Wellcome team were interested in the somatic rather than the psychological when it came to sex.

As part of the 'Sexual Knowledge, Sexual History' project, researchers from the University of Exeter's Centre for Medical History have been rooting around in the storerooms of the Science Museum, where much of the material from Wellcome's original Historical Medical Museum is now housed, and digging in the archives to find out more about this material and what it meant to the Wellcome team who went to such lengths to acquire it. Some of these fascinating historical objects will be displayed in a major exhibition network throughout the South-west of England as part of the 2012 Cultural Olympiad, and be accompanied by exploratory workshops with teenagers and young people, and other community groups, artists and sex education experts.

Dr Kate Fisher and Dr Rebecca Langlands are Senior Lecturers attached to the Exeter Centre.

A study of anxiety and depression

ALI HAGGETT

My work explores anxiety and depression in postwar Britain. It focuses specifically on the claim, made by feminist historians, that middle-class housewives developed symptoms of neurosis as a result of the lack of opportunities available to them and the banality inherent in the domestic role.

My research also addresses the charge that, as a consequence, pharmaceutical companies deliberately targeted women in the advertising of psychotropic medications. I suggest that previous accounts have overemphasised the links between the housewife's role and mental illness, underplaying alternative contributory factors.

Through the examination of articles, case studies, clinical trials and letters in the medical press, my thesis investigates contemporary ideas about the classification, diagnosis and treatment of minor mental disorders. It also examines the personal recollections of women who experienced domestic life during the 1950s and 1960s.

Finally, the study provides an analysis of promotional material produced from pharmaceutical companies that manufactured psychotropic drugs and over-the-counter remedies for 'nerves'. Utilising this broad base of sources, I suggest that the causes of anxiety and depression in married women were more complex than has previously been suggested. Many women settled with ease into marriage and domesticity; although there were arguably a number of inherent challenges, by and large they assessed their role as worthwhile. Those that endured anxiety or depression did not identify the cause as related to their role as homemakers. A number of alternative factors appeared to have influenced the onset of illness, including marital breakdown, trauma during childhood or adolescence, and a familial predisposition to mental illness. The research thus refines previous feminist accounts of domesticity, and builds upon recent research from scholars such as Penny Summerfield and Judy Giles, who have begun to explore the complexity of attitudes revealed by women during the postwar period.

Ali Haggett is a Research Fellow at the Exeter Centre.

The medicalisation of maladjustment

SARAH HAYES

My research explores the conceptualisation and establishment of the term 'maladjusted' as a recognised medical condition needing professional psychiatric or psychological intervention, and the ways in which this term was applied specifically to children in the first half of the 20th century.

Above: Infant with a bottle. From *Sunday Illustrated*, 1922.

Examination of the process by which maladjustment was established as a medical category highlights the complex interplay between psychiatric, psychological, psychoanalytical, sociological, educational and judicial theories and practices relating to child development. My work shows how a shifting emphasis on moral, intellectual and emotional development was reflected in the changing nature of theories relating to the behaviour of children. This process is explored from the introduction of psychological notions of mental and emotional adjustment in the 1890s, through the establishment of management strategies (including child guidance) in Britain in the interwar period and the recognition of maladjustment as a statutory handicap under the 1944 Education Act, and, finally, to the publication of the Report of the (Underwood) Committee on Maladjusted Children in 1955.

Focus on models of maladjustment illustrates the processes by which social factors, such as individual behaviour and parenting, became the subject of medical attention, highlighting issues surrounding increased intervention by the state and medical profession into the private domestic sphere. Professional emphasis on the mental and emotional wellbeing of children came to dominate many key areas of policy making throughout this period. Established accounts of work in this field have previously emphasised a Whiggish 'pioneer' approach, of medical teams working in harmony towards the greater understanding of children. However, I challenge the assumption that increased professional understanding of the aetiology of maladjustment automatically resulted in improvement in the lives of maladjusted children. The interplay of medical, social and educational theories and agendas was substantially more complex than has previously been acknowledged and, rather than improving the lives of maladjusted children, in many ways served to reinforce their marginalisation within society.

Sarah Hayes is a doctoral student attached to the Exeter Centre.

New publication

History of the Social Determinants of Health: Global histories, contemporary debates, edited by Harold J Cook, Sanjoy Bhattacharya and Anne Hardy

Every subject has its history, including the social determinants of health. It is a subject that investigates differences in human health that occur because of social life, from income and class to family life and neighbourhood. Social determinants can have very large effects on longevity, just as do other factors, such as the provision of medical care or clean drinking water. A commission to study the social determinants of health and to propose ways of improving health based upon their analysis was therefore established under the auspices of the World Health Organization and chaired by Professor Sir Michael Marmot.

In support of the commission's work, a large international meeting was organised in London with several eminent historians to discuss the historical experience of people from around the globe. Because historians are among those who have tried to assess how social relationships have affected health, they can point to some determinants of health that others might miss, while historical investigations can in turn benefit from knowing what other analysts consider to be the most important social determinants of health. The resultant knowledge is of importance to us all, and many of the arguments and evidence from the meeting are brought together in this book.

Published in: New Perspectives in South Asian History. Hyderabad: Orient Blackswan; 2008. ISBN 978 81 250 3508 4. See **www.orientblackswan.com**.

The history of stress: medical research and contested knowledge in the 20th century

JOSEPH MELLING

Stress has acquired the proportions of an epidemic or even pandemic since the closing decades of the 20th century. Not only does stress appear to have prevailed in many different areas of working life, emotional relationships and social engagement, but it also seems to have pervaded both public pronouncements and private conversations. Stress seems, quite literally, to be everywhere.

Above: Nowadays, stress seems to be everywhere.

Yet the conception and language of stress is a relatively new phenomenon and as a way of signifying a general condition of life it belongs to the later 20th century. The discovery of specific and generalised forms of stress a relatively recent phenomenon, and the analysis of the meaning of stress remains a contested field for scientific observers as well as practitioners. Numerous bodies, from the UK Health and Safety Executive to the World Health Organization, appear to agree that stress is a serious and very expensive problem, but there is much less consensus on the origins and expression of stress. Nor has there been much serious research on the historical conditions in which stress can be said to have emerged and been identified.

This was the purpose of the application by the Centre for Medical History to investigate the subject. The award of a Wellcome Trust programme grant to Mark Jackson and me was followed by the appointment of Edward Ramsden and Pamela Dale as collaborative researchers in 2007. Each member of the research team is investigating a related area of stress. Jackson's extensive work on Hans Selye from the 1930s has progressed in tandem with Ramsden's research into animal behaviour, crowding and the urban design experiments of the 1950s–70s. I have been particularly involved in models of work organisation and management design that emerged in the early decades of the 20th century, influenced by the military and civilian mobilisation of the two World Wars. The Cambridge 'memory' and efficiency studies have figured in both that work and the research undertaken by Dale, which has concentrated on the recorded experience of stress in British and American nursing during the middle decades of the 20th century.

An integral part of the programme research has been the organisation of workshops and seminar series at which different themes in the research project are developed by external speakers alongside Exeter researchers. In November 2008, Allan Young of McGill University, Canada, spoke to us about post-traumatic stress and in spring 2009 Cary Cooper addressed us on the dilemmas of stress.

Professor Joseph Melling is Director of the Exeter Centre.

Conference announcement

Shrines, Substances and Medicine in Africa: Archaeological, anthropological and historical perspectives

Friday 18 September 2009, 09.30–17.30
Wellcome Trust, Euston Road, London

Confirmed speakers include Laurence Douny, Timothy Insoll, Benjamin Kankpeyeng, Murray Last, John Mack, John Parker, Mike Rowlands and Roger Sansi Roca

(see **www.insoll.org/conference.html** for the full conference programme).

The registration fee including refreshments and lunch is £15. Email tim.insoll@manchester.ac.uk for BACS transfer details or send a cheque payable to 'Timothy Insoll' to the conference organiser: Tim Insoll, Archaeology, School of Arts, Histories & Cultures, Mansfield Cooper Building, University of Manchester, Oxford Road, Manchester M13 9PL.

Rewriting the system of nature: Linnaeus's use of writing technologies

STAFFAN MULLER-WILLE

As a consequence of overseas discoveries, early modern European scientists were faced with what has been termed the 'first bio-information crisis'. The sheer amount of exotic, hitherto-unknown species that reached the shores of Europe forced scientists to reconsider the ways in which they wrote and thought about the natural world.

Paper technologies had to be developed that allowed the processing of large amounts of new information, and these technologies in turn allowed early modern naturalists and physicians to think in new ways about the 'order of nature'. A Wellcome Trust-funded project has allowed an exploration into these processes, through a detailed reconstruction of the ways in which the naturalist Carl Linnaeus (1707–1778) assembled, filed and cross-referenced information about plants and their medicinal virtues. Linnaeus has been described as a 'pioneer in information retrieval'; in particular, he was one of the first to suggest that 'natural' plant genera and families share similar pharmaceutical virtues, and that herbal drugs might be sought out on that basis. His manuscripts, held at the Linnean Society in London, provide an excellent opportunity to understand how information-processing practices determine such ideas.

While the project focuses on the corpus of manuscripts and publications of a single scientist, it will serve as a pilot to develop both a terminology and a methodology that is attentive to the materiality of writing, and will have ramifications for how the history of science and medicine is done in general. Isabelle Charmantier joined as Research Assistant in spring 2009.

Above: Carl Linnaeus. Oil painting after Martin Hoffmann.

Dr Staffan Muller-Wille is a Research Fellow attached to the Exeter Centre.

Sex, health and medicine in early modern England, c.1540–1725

SARAH TOULALAN

This project explores how early modern medical knowledge informed ideas about sexual and reproductive health and fertility, and hence about the appropriate nature and incidence of sexual activity at different stages of the life cycle. The research examines a range of issues to do with bodies and sex in relation to ideas about health and medicine in the period, but one major extended area of study is to do with children and sexual activity in childhood.

Beginning with a consideration of ideas about 'children' and the time of life considered as 'childhood', I then move on to look at contemporary medical understandings of the body and what these might mean for how early modern people thought about the young and sexual feelings, and hence about sexual activities in which children were involved. The legal age for marriage at this time was 12 for girls and 14 for boys and although the average age of marriage was much higher (mid-to-late 20s), marriages of older men to young girls did take place. Samuel Pepys married Elizabeth before she turned 15 years old and Simonds d'Ewes's bride was 13. Those who married as young as the legal age of consent to marry were not always allowed to cohabit and hence to consummate the marriage, though others did so immediately, with some brides bearing children at the age of 13. Procreation was held to be the first aim of marriage and sermons preached by Protestant ministers on marriage suggest that reproductive capability might have been a major consideration in this decision. William Gouge, for example, stated unequivocally in his *Of Domesticall Duties* (1622) that "Ripenesse of yeares is

absolutely necessary for consummating a just and lawfull mariage".

A key question, though, is whether or not the concepts of 'child sexual abuse' or 'paedophilia' had any

contemporary currency. 'Abuse' and 'abusing' were terms that were routinely used in cases of assault, including sexual assault and rape, but were not terms that were restricted to victims of a particular age.

Whether or not these ideas were in play at this time, cases of sexual assault and rape of children suggest that there was a sense of the particular heinousness of such behaviour, and that it should be prevented and punished, whatever damage prosecution might do to a child's 'reputation' and future marriage prospects. It does seem, though, that it was not a particular concern for the corruption of the 'innocence' or 'moral sanctity' of childhood that was at stake then, as seems to be the case today in attitudes towards sexual activity directed towards children, but rather the ruination of the child's (and the family's) reputation that required redress, and the punishment of the perpetrator of physical harm. Ideas about the boundaries of the victims' culpability are also explored: adultery and fornication were prosecuted and punished, and such prosecutions and punishments could be – and, in some cases, were – applied to children below the age of consent. In what circumstances could a child be held responsible for its sexual behaviour, and at what age (and why) was a child considered to be responsible for such behaviour? The answers to such questions are to be found not only in the religious and social structures of early modern society but also in contemporary medical theory and knowledge about the body at this stage of life.

Dr Sarah Toulalan is a Wellcome Lecturer in Medical History and has been working on this project since 2005, supported initially by a small research grant from the British Academy.

Hippocratic lessons for modern health

JOHN WILKINS

In the minds of many, Hippocratic medicine may appear to have little to teach us beyond the Oath. A doctor must have an ethical relationship with his or her patients and colleagues, whether or not the form of words underpinning that commitment is the Oath itself.

In recent years, however, some students at the Peninsula Medical School in Exeter have managed to leave to one side their scientific problem with four elements and four humours and have pursued a short Special Study Unit on Hippocratic medicine with a different emphasis. They have discovered two key areas of Greek medicine that underline their own training, particularly if they plan to work in the community as GPs. The first is a focus on the patient as an individual who may present symptoms slightly different from the textbook nosology and cure. "The constitutions of patients differ," observes the author of *Regimen* 3.67.

Above:
Samuel Pepys.
Colour reproduction
of oil painting.

The second is to consider the patient as a natural and social being, as an organism that needs to be understood in its own environmental and social terms before a diagnosis can be safely reached. A Hippocratic doctor would be likely to consider climate (including temperature and wind direction) and water supply more than a modern counterpart because the ancient ability to control the human environment was less than ours, but modern concerns might be with levels of heat and dampness in the home and the patient's access to essential resources. In a developing-country context, there would be additional concerns about sanitation and access to clean water. Modern concerns might also be with the planet's environment, the human contribution to the degradation of the atmosphere and seas, and possible questions concerning physical and mental health that arise from earlier assumptions that the human body is a mechanism that can be adjusted to suit a natural world that human beings can control as they wish.

In *Airs, Waters, Places*, a Hippocratic doctor writes: "Whoever wishes to pursue properly the science of medicine must proceed thus. First he ought to consider what effects each season of the year can produce; for the seasons are not all alike, but differ widely both in

Above: Hippocratic therapy and modern medicine both stress the importance of exercise to health. *Anne-Katrin Purkiss*

themselves and in their changes. The next point is the hot winds and the cold, especially those that are universal, but also those that are peculiar to each particular region. He must also consider the properties of the waters; for as these differ in taste and weight, so the property of each is far different from that of any other."

In Exeter we are now exploring another promising approach in Hippocratic thought, namely a strong emphasis on a proper regime to maintain the individual in good health. The balanced regime of diet, exercise and bathing formed a major division of Hippocratic therapy, the place at which to start before the doctor moved to the more drastic divisions of pharmacology and surgery. The patient needed to balance nutritional intake and the expenditure of energy. Individual needs would vary according to the style of life: a rich patient would not need the same regime as a labourer or sailor, an old person's needs would differ from a child's, and so on. The natural environment would continue to play an important part, for like the plants and animals that they consume, human beings are subject to seasonal changes (*Regimen* 3.68) and to the topography and climate in which they normally live.

This is a system that locates the patient (in both sickness and health) in the world in which he or she lives, that integrates health with lifestyle and helps to ensure that the patient will need to visit the doctor less often – or at least to see the doctor and allied health services as a guide to health and not only as a cure for sickness. In this model, the patient maintains good health, with implications for persistent and chronic conditions, and only needs urgent intervention for major infections and emergencies. Such a model implies the integration of nutrition, exercise and swimming into mainstream medicine.

Nearly 2500 years after Hippocrates, diet and exercise remain central to public health. Despite increasingly sophisticated and expensive technologies to identify those at risk of future disease and to treat various stages of existing disease, diet and exercise remain important for both the prevention and self-management of many contemporary chronic conditions. The success of scientific medicine and the power of its main pharmacological and surgical tools have perhaps diverted attention from the relatively humble interventions that lay people can do for themselves. However, appropriate diet and sufficient exercise are central strategies for the prevention of cancer, diabetes and cardiovascular problems, to name a few. Thus those at risk of hypercholesterolaemia may be reducing the fat content of their diets in order to lower their overall cholesterol levels, those at risk of hypertension may be reducing the salt content of their diets, and those struggling with low mood might try to increase the amount of exercise in their daily routines to head off a diagnosis of depression.

In spite, or even because, of the spectacular successes of biomedicine, many people have criticised what they perceive as its narrow and reductionist focus, and its neglect of the human aspects of healing. One aspect of this critique is the comparative neglect of prevention rather than cure, a common complaint being that biomedicine may cure the symptom but not its underlying cause; another aspect is the focus on pharmaceutical treatments. Some people desire more advice about the prevention of future ill-health than they usually receive from their doctors, and for this reason may consult complementary therapists. Some people are critical of what they see as the over-reliance on pharmaceutical treatments and the comparative neglect of non-pharmacological treatments. Globally, much more money is spent on pharmaceutical research than on research into non-pharmacological treatments or preventative measures. The data to support evidence-based practice and medical education is thus much more oriented towards pharmaceutical treatments than towards other interventions. While we may know that, in general, the key to good health lies in diet and exercise, there are many specific questions – for example, about individual nutrients, exercise regimes and people's willingness to change their lifestyles – that remain to be answered.

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For patients, this is also an issue about responsibility: relying on the doctor is a way of relinquishing responsibility. Those choosing to optimise their own diet and exercise regimens are, in the process, taking responsibility for their own health.

Professor John Wilkins specialises in the history of food and medicine in Graeco-Roman culture at the Exeter Centre.

Fracturing Colonial Medicine

ANNA CROZIER

This two-day workshop at the Centre for the Social History of Health and Healthcare, Glasgow, in April 2009, discussed some of the dilemmas faced by historians researching the colonial elites.

In contrast to critiques presented from within subaltern studies, and via explorations of local medical pluralism, there seemed to be rather less historiographical awareness of the diversity of the colonists' experiences – with colonial doctors often characterised as uniformly symbolic of state and, after 1880, biomedicine. With this in mind, this workshop aimed to explore the diversity within, and between, different colonial groups and also to problematise (though not necessarily to resolve) the utility of 'colonial medicine' as a label.

Professor David Arnold (University of Warwick), got the event off to a vigorous start with an engaging keynote, 'Is There (Still) a Colonial Medicine?' He considered the different ways that 'fracturing' colonial medicine might be helpful to contribute to a more nuanced understanding of the subdiscipline, but ultimately argued for the indispensability of the notion to guide future research. The subsequent papers exposed the subtle ways that different agents of colonial medicine embodied differing priorities. Teemu Ryymin (University of Bergen) contrasted how church and state both attempted to civilise the indigenous Sámi of northern Norway in the early 20th century; Atsuko Naono (University of Warwick) dissected the priorities of nongovernmental and governmental organisations in Burma; Letizia Gramaglia (Warwick) related how the drive and ambition of Robert Grieve in British Guiana revolutionised institutional care of the insane far beyond British government initiatives. Jorge Varanda Ferreira (Social and Anthropology Research Centre, Lisbon) then presented on the health services of the Diamang Diamond Company of Angola. It was intriguing how this company failed to interact with the Portuguese authorities, and rather preferred to import its medical ideas from other colonial contexts.

Above: Participants at the workshop.

The following session examined the fractured nature of colonial knowledge. Ryan Johnson (University of Oxford) argued for a gulf between ideology and practice in tropical medical experiences in West Africa and Markku Hokkanen (University of Jyväskyä, Finland) described the dissimilar ways colonial doctors conceived of, and reacted to, 'fevers' in early colonial south central Africa, showing that there was no necessary synthesis between those ostensibly united behind the same medical orthodoxy. Finally, Liesbeth Hesselink (independent researcher) spoke on the way the colonial government of the Dutch East Indies fought over midwifery provision.

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Day two started with a fascinating keynote by Professor Frances Gouda (University of Amsterdam). This comprised a comparative account of government health policies in Dutch colonial Java and the American Philippines. Although geographically close, the visions and methods of the Dutch versus the American colonialists could not have been further apart. Thus Gouda underscored the difficulties of conceiving of a single colonial medical programme. The next session

included papers from Sandeep Sinha (University of Calcutta), Leonard Smith (University of Birmingham) and Sherry Gad Elrab (University of Exeter), all of whom presented on the difficulties of translating Western medicine to colonial contexts. In each case colonial medicine was mediated by local circumstances, sometimes with surprising consequences. Rod Edmond (University of Kent) presented on the complex responses to leprosy in Hawaii to commence a session on leprosy control. By comparing the reactions of Protestant missionary Charles McEwan Hyde with those of writer and traveller Robert Louis Stevenson, Edmond argued just how nuanced, and even contradictory, Western reactions to leprosy could be. Furthermore, these reactions were moulded by agendas outside the medical sphere. This theme was elucidated – in quite a different context – by John Manton (King's College London), who showed how the burgeoning development of international health rhetoric reconfigured the role of missionary medical practice after 1945 in Nigeria. The session was rounded off by Onaiwu Ogbomo (Western Michigan University) on colonial Nigeria, particularly highlighting the way missions capitalised on leprosy as a medical niche to define themselves against the colonial state.

The final session considered colonial officialdom, revealing the 'fractures' to be found among prominent symbols of Western medical imperialism. Sabine Clarke (University of Oxford) discussed the foundation of the Colonial Research Service and highlighted the temporal differences of colonial emphases as well as the geographic and personal ones. Rosemary Wall (King's College) then gave a paper on the Colonial Nursing Association, elucidating how recruitment incentives differed significantly from those of colonial doctors. Hines Mabika (University of Basel, Switzerland) followed this by presenting on the different strategies of two famous medical missionaries, Albert Schweitzer and Georges Liengme, showing the rifts that could exist between contemporaries. Finally, Noémi Tousignant (London School of Hygiene and Topical Medicine) gave a lively closing paper on the pharmaceutical circuits in Senegal as sites of both local and international cooperation and conflict.

The Western embodiment of colonial medicine was exposed as diverse – even in some instances disharmonious. With so many temporal and geographical differences, were historians justified in calling on the discursive notion of 'colonial medicine' at all? Many participants thought so and, as such, this workshop provided an important forum for debate.

Dr Anna Crozier is based at the University of Strathclyde, Glasgow.

Making history at the WHO

THOMSON PRENTICE

As 2008 drew to a close, history at the World Health Organization in Geneva ended on a high note. December saw the final seminar in the Global Health Histories series organised by the WHO and the Wellcome Trust Centre for the History of Medicine at UCL, and the completion of a unique and remarkably successful initiative. The series has been seen as one of the most significant contributions to the WHO's 60th anniversary activities – and it was also the longest running.

It began in March 2008, with a lecture examining the significance of the public health initiatives of the UN Relief and Rehabilitation Administration (UNRRA) – a predecessor to the WHO – in the aftermath of World War II. Dr Jessica Reinisch (Birkbeck, University of London) discussed how public health emerged as a fundamental component of the survival and recovery of populations across Europe after 1945.

In April, the focus switched from the political climate in Europe to the natural climate in West and Central Africa. In his paper 'Climate Change, Health and Disease in the Forests of Africa', Professor James Fairhead (University of Sussex) suggested that the effects of climate change on forests there have been underestimated, and discussed the implications, particularly the risk of epidemic diseases linked to vegetation.

From that exotic environment the switch in May was to the exotic world of Marcel Proust in *fin-de-siècle* France. In a vivid presentation, 'Marcel Proust and the Global History of Asthma', Professor Mark Jackson (University of Essex) described how Proust (1871–1922) was plagued by asthma from childhood. His ill-health reinforced contemporary beliefs that asthma was an 'aristocratic disease', largely confined to the elite. But Professor Jackson went on to show that asthma today is a disease of poverty and social deprivation.

A sunny June in Geneva felt the chill of Cold War politics. Professor Paul Weindling (Oxford Brookes University) sought to reveal why in 1951 the Rockefeller Foundation abruptly closed down its International Health Division, which for almost 40 years had worked against malaria, yellow fever and other diseases. The political background and mutual suspicion of the superpowers raised wider health issues in the Cold War era.

Postwar research also featured in July, when Professor Daniel Pick (Birkbeck) presented 'In Pursuit of the Nazi Mind: Psychology, psychoanalysis and politics 1940–1950'. He discussed how 'denazification' became linked with questions of individual and collective mental

health, referring to case studies of Hitler, Hess and other leading Nazis. Also in July, Dr Sonu Shamdasani (Wellcome Trust Centre at UCL) reconstructed the rise of psychotherapy in medicine, neurology and psychology from the 19th century onwards.

September saw another outstanding presentation on a British perspective on international nursing organisation in the 20th century. Professor Anne Crowther (University of Glasgow) and Susan McGann (Royal College of Nursing Archive, Glasgow) explored the history of nursing from the days of Florence Nightingale to the College's relations with bodies such as the International Council of Nurses, UNRRA and the WHO.

In a stimulating and very thought-provoking lecture in October, Dr Sanjoy Bhattacharya (Wellcome Trust Centre) focused on the smallpox eradication projects in the South Asian subcontinent in the 1960s and 1970s. His presentation also considered lessons stemming from the history of smallpox eradication that could be of benefit to contemporary global health projects, particularly polio eradication.

November brought fascinating insights into the life and times of global health consultant Brian Abel-Smith (1926–1996) and his work with the WHO. Dr Sally Sheard (University of Liverpool and visiting professor at the London School of Economics), produced a detailed profile of the man who pioneered international comparisons on health services finance for the WHO, visiting over 80 countries on behalf of the Organization. Abel-Smith was also senior adviser for several years to WHO Director-General Halfdan Mahler on the economic strategy of the 'Health for All' programme.

The seminar series ended with a powerful presentation by Dr Edmund Ramsden (University of Exeter) that examined population density and social pathology based on groundbreaking experiments with laboratory rats in the 1960s. It raised issues related to the problems facing humanity in an increasingly overpopulated and urbanised world.

From start to finish, the series won a lot of praise both within the WHO and outside. The seminars were invariably well-attended, in some cases with standing space only in the meeting room, which could accommodate 50–60 people. The lectures were very popular among staff, from senior professionals to young interns, and among visiting historians, researchers and students. A common view among staff was that the series provided meaningful intellectual refreshment, offered insights into a wide variety of unfamiliar topics and brought together colleagues who otherwise might not have met.

Among both the Wellcome Trust leadership and the speakers themselves, there were also plaudits at the end of the series. Dr Tony Woods, Head of Medicine, Society and History Grants at the Trust, attended the final seminar and told the audience: "I think this has been an extremely valuable and successful initiative and I would like to see it go forward with our enthusiastic support in 2009." Mark Jackson said: "The Global Health Histories seminar series constitutes an exemplary initiative in the history of modern medicine. In particular it engages with, and constructively develops, two critical challenges facing historians of medicine: firstly, the need to develop a more sophisticated global history that is not only sensitive to regional differences but is also transnational and comparative in its approach; and secondly, the drive to write a history of medicine that speaks more directly to scientists, clinicians, policy makers and the public. The collaboration between the Wellcome Trust and WHO through this series of seminars delivers on both counts, drawing together academics from different disciplines and encouraging genuine intellectual cross-fertilisation. Sanjoy Bhattacharya and Thomson Prentice are to be congratulated. I am deeply committed intellectually and politically to the kinds of initiatives that they have developed."

Professor Hal Cook (Director of the Wellcome Trust Centre) also attended the series and expressed his support for it. "History matters, as we all know from the news each day," he said. "Many aspects of the WHO take on significance only when its past aspirations, and its successes and failures, are compared to other developments."

Sanjoy Bhattacharya, who co-organised the series and attended every seminar, said: "Historical and other social science studies are all about identifying the complex political, economic and social contexts underlying the preparation of policy goals and the implementation of projects. They, therefore, awaken us to the existence of variations in official and civilian attitudes and actions. When studied carefully, these can provide important insights into the many ways in which health programmes are interpreted by field workers and the people among whom they work. The history lectures at the WHO were important precisely because they stimulated us to consider many such complexities, providing information that can be of interest and use to those involved today in running public projects."

Daniel Pick, whose seminar was in July, said: "I was very glad to have the opportunity to contribute to this new collaboration between WHO and the Wellcome Trust. The series was carefully organised, well thought-out and smoothly run. I felt it was an enjoyable and facilitating context in which to present my work. I also found the responses of the audience interesting and helpful for my own continuing research on the topic I spoke about. I hope there will be similar occasions at which I can participate in future."

Sally Sheard, who presented her work in November, said: "I reflect on the helpful diversity of comments from the audience at my seminar, and I gather from others. It was good to present to an audience that was not purely academic or historical, as it encouraged me to rethink the context of the material I delivered. I found the experience very useful. Talking to individuals afterwards, it seems also that WHO benefits from having a greater historical 'presence' – something for which Thomson and Sanjoy share the credit."

WHO historian Socrates Litsios, author of the recently published *Third Ten Years of the World Health Organization*, said: "To achieve its goals, WHO promotes change on many fronts, all of which have long and complex histories. To be unaware of these histories is to risk being unaware of the major obstacles that have prevented change in the past. Mere repetition of what is desirable is not enough; strategies for change are needed that clearly reflect knowledge both of the factors in the past that have impeded progress and those efforts that have worked best to overcome those obstacles. The current interest within WHO and internationally in primary healthcare is not merely a celebration of 30 years since the Declaration of Alma-Ata, it is also a recognition that what was accomplished in the 1970s is still valid despite the widely different social and economic context of today. The history seminar series was an extremely valuable contribution to the history of global public health, as well as the history of the Organization itself."

The Wellcome Trust is supporting a new Global Health Histories seminar series in 2009 at the WHO (see back cover). Co-organised again with the Wellcome Trust Centre, this thematic series on the history of tropical diseases and their social, economic and political backgrounds is underway. A year-long programme of seminars is on offer, with each event hosting two speakers – a disease expert and an historian.

Presentations from the 2008 seminars can be found at **www.who.int/global_health_histories/seminars/2008/en/**.

Thomson Prentice is the Coordinator of the WHO's Global Health Histories project and was until recently the Managing Editor of the *World Health Report*.

The Museum of the Royal Pharmaceutical Society

BRIONY HUDSON

The Royal Pharmaceutical Society of Great Britain has had museum collections since 1842. The Museum was established as a *materia medica* collection to support teaching in the Society's new School of Pharmacy.

Above: A room in the Museum in the 1880s.

Starting from an empty room, within a year an appeal to members of the new body resulted in gifts of around 850 specimens, including a collection of all of the British plants in the first London Pharmacopoeia (in 1618). At its height, the Museum encompassed around 20 000 animal, vegetable and mineral specimens.

However, by the mid-20th century, pharmacognosy had lost its place at the centre of pharmacy teaching, and the Society's School of Pharmacy had become part of the University of London. As a result the collection is now cared for at the Centre for Economic Botany at Kew, where it forms part of their extensive collections. The 45 000 items currently in the Museum's holdings originate from a new initiative started in the 1930s, when pharmacists were encouraged to donate historical items to the Society to establish a collection that represented the story of British pharmacy.

One of the Museum's many highlights is English delftware drug jars, dating from the 1640s to the late 1700s. The Museum also holds an extensive range of medicines, from the earliest proprietary products in the 18th century to 21st-century examples. Alongside these sit equipment used by pharmacists to make medicines, advertisements, photographs, and caricatures satirising the pharmacy profession and their products. A smaller collection represents the history of the Royal Pharmaceutical Society itself, and the Museum also works closely with the Society's Library and its impressive collection of historical books.

Jacob Bell, the Society's founder, described the Museum's collections as "an heirloom to be handed down", and the staff use their expertise to ensure that this resource is cared for appropriately and added to for use by future generations. These collections also provide the foundation for all of the Museum's work today. The current Museum team consists of four full-time staff and five part-time voluntary staff, three of whom are non-practising pharmacists.

What can the RPSGB Museum do for you?

- **Answer your questions about pharmacy history**. We act as a national point of contact for information about the history of British pharmacy. Whether your

question is 'what was used to treat asthma in the 1930s?' or 'when was the pill machine invented?', we will do our best to provide you with an answer.

- **Give you a tour of our displays at the Society's headquarters**. The Museum's reception display area is open Monday to Friday, 09.00 to 17.00. We run individual and group guided tours by appointment. Researchers can also request a research visit to see stored items.
- **Support your history-related activities**. Our outreach work includes lending display material for events, providing images and information for talks or publications, and getting involved in open days or giving off-site talks.
- **Help you with historical material**. Our remit includes identifying mystery objects, and advising on health and safety issues related to historical medicines. We can also provide advice about donating items to a museum, or finding a buyer for your collectables.
- **Provide you with a gift inspired by the history of pharmacy**. We sell merchandise based on the Museum's collections. This includes seven replica jars, three book titles, our *How Medicines Were Made* DVD, mouse mats, and sets of greetings card and postcards.
- **Educate, entertain and inform you online**. The Museum's website (**www.rpsgb.org/museum**) contains: four online exhibitions; 35 illustrated information sheets, from pill-making to women in pharmacy; and information about visiting us, our services and our collections.

With over 131 000 hits every year, the website provides information to people who can't get to us in person, whether in the UK or the large number of international enquirers we help each year. Last year, the Museum, working with the British Society for the History of Pharmacy, launched a new online resource, 'The evolution of pharmacy', with illustrated information sheets aimed specifically at pharmacy lecturers and students (**www.rpsgb.org/informationresources/museum/resources/evolution.htm**). We plan to continue to increase significantly our online collections information, including catalogue information about the collections themselves, and an online guide to research in pharmacy history.

However, the Museum does not just provide enquiry services, displays and guided tours. We also support other institutions in presenting British pharmacy history accurately, whether by lending objects to other museums for their own exhibitions or by advising media researchers to ensure an accurate portrayal of pharmacy history.

For many years, Museum staff have provided some services for schools, adult visitors and schools of pharmacy. With a grant from the Heritage Lottery Fund, we are currently running an 18-month audience development programme to build on this work. Initiatives include pharmacy debates for secondary school students prompted by our Pharmacy Debate Packs resources for teachers, and The Great Pharmacy Debate competition that we ran with the English Speaking Union in March 2009. Our plans to get London-based adults involved include a series of 'Behind the Scenes' handling sessions, and a pharmacy-themed walk around Lambeth launched in September 2008. We have also just finished a pilot project to create two loans boxes for schools focusing on medicines safety, past and present.

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Briony Hudson is Keeper of the Museum Collections at the RPSGB.

American foundations in Europe

JOHN STEWART

A one-day workshop on the impact of US foundations on 20th-century European welfare and social science was held at the University of Copenhagen on 20 March 2009.

This event was jointly sponsored by NCoE Nordwel, a Scandinavian research network focusing on historical and contemporary dimensions of social welfare, and the Centre for the Social History of Health and Healthcare (CSHHH) based at Glasgow Caledonian and Strathclyde Universities and supported by a Wellcome Trust Enhancement Award. Contributors were drawn from the UK, Sweden, Finland, Norway and Denmark.

Contributions included Dr Erik Ingebrigtsen (University of Trondheim) on the Rockefeller Foundation and nursing in interwar Hungary and my own presentation on the Commonwealth Fund and child health in Austria in the 1920s. An edited volume of papers, to be published by University of Helsinki Press, is being put together by the organisers, Professor Klaus Petersen (University of Southern Denmark) and me. It is anticipated that this workshop will be the first of a number of collaborative ventures between NCoE Nordwel and the CSHHH.

Professor John Stewart is Director of the Centre for the Social History of Health and Healthcare, Glasgow.

Diabetes Stories – an oral history website

HELEN LLOYD

The Diabetes Stories website (www.diabetes-stories.com) is based at the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) and was funded by two Wellcome Trust history of medicine grants. When it was launched in 2005, it contained 50 audio interviews with people diagnosed with diabetes, and it won the University of Oxford's IT in Teaching and Learning Award. This year saw the addition of 50 more audio interviews, with those who cared for people with diabetes, including family members and healthcare professionals.

Above: One of the project interviewees as a child (back), 1953.

The idea for recording an oral history of diabetes in the 20th century came from David Matthews, Professor of Diabetes Medicine at Oxford. His older patients had talked to him about past experiences of large syringes, blunt needles, strict diets and urine testing over the kitchen stove, and he felt that there should be a permanent record of such memories. A Wellcome grant funded the recording of 50 interviews, lasting around one to two hours each, with people diagnosed with diabetes between 1927 and 1997. These covered a crucial period in the history of diabetes, with some older interviewees recalling stories of diabetic relatives who died before the advent of insulin in 1923 and some younger interviewees looking forward to a possible cure. In between came the gradual realisation that insulin was less miraculous than had been thought: it did indeed save lives, but many of those lives would eventually be blighted by complications such as blindness, amputation or kidney failure. Also, at the end of the 20th century, there was a dramatic rise in the number of people with diabetes.

Many interviewees said they "could not have survived" without the help of family members, referring in some cases to rescue from unconsciousness and in others to – perhaps equally important – support with diet or exercise. It became clear that the role of the family should be covered by our website and that the experiences of healthcare professionals should also be included, since the website was rapidly becoming a first port of call for those interested in the history of diabetes care. We applied to the Wellcome Trust for a grant to record 50 'carers', of whom half would be doctors, nurses, dietitians and podiatrists and half family members (the term 'carers' was rapidly abandoned as several family members rejected it). These new interviews were added to the website in March 2009 and CD copies of all the interviews were deposited in the British Library Sound Archive and at OCDEM.

Only the most dedicated researcher will listen to 100 interviews, so in addition to the unedited audio recordings, we provide short audio samples, written summaries, full transcripts, an interactive database, and facilities to search for words and phrases. There are also contemporary and historical photos of the interviewees and of artefacts and documents that they have lent or donated. There is a section describing our working methods and a section listing 40 topics that proved important to the interviewees, with links to the relevant parts of the interviews. Topics range from 'Costs before the NHS was created in 1948' to the more subjective 'Attitudes to diabetes among ethnic minorities'. Some are deliberately vague, such as 'Negative experiences of nurses', to provide leads for widely differing future research interests.

One website user wrote that it is "addictive" to listen to people talking reflectively and movingly about their daily lives. In 2008 alone, the website received over 900 000 hits from around the world. The hope is that it will be an enduring resource for anyone interested in the human aspects of health systems, for historians, healthcare professionals, people with diabetes and their families, and for all those interested in the ways that people remember and make sense of their lives.

Helen Lloyd joined the staff of OCDEM to undertake these projects, recording all the interviews. She runs her own consultancy (**www.oralhistoryconsultancy.co.uk**).

Medicine-by-post: The changing voice of illness in eighteenth-century British consultation letters and literature

KEITH WILLIAMS

Wayne Wild's book is, as its title proclaims, about the practice of postal consultation and treatment, whereby a sick person would write to a physician, usually of some eminence, describing his medical history and current symptoms.The physician would reply with a diagnosis, directions for a regimen, and a prescription to be made up by a local apothecary.

According to the author, such practice was common in 18th-century England, but alas this is a statement that it is impossible to quantify in any meaningful way, leaving its veracity open to doubt. Indeed, Wild appears satisfied here merely to refer his reader to the section on the subject in the Porters' work *Patient's Progress: Doctors and doctoring in eighteenth-century England*. Unfortunately, the Porters had given no quantification or great detail either, appearing content to provide some examples of such correspondence as support for their claim that postal treatment was "popular".

However, as Wild's study demonstrates, the degree of usage of postal consultation had very obvious limitations, not least being those of patient literacy and money, the typical fee for a consultation being a guinea, a not inconsiderable sum in the Georgian period. It is hardly surprising, therefore, to discover that postal patients came from the upper middle classes and the aristocracy, and it is problematic as to whether a study of a limited sample of correspondence between these social elites and their elitist medical advisers can cast much light on the relationship overall between the medical profession and society in general. Obviously, Wild thinks it does – or at least sees it as a good starting-point.

Although the first and final chapters provide an appreciation of some of the common themes of medicine by post during the period, and of the interpretation of how contemporary novelists represented the experience of disease and the doctor–patient encounter, the focus is on specific doctor–patient correspondence. Indeed, over two-thirds of the book is devoted to describing and analysing the private correspondence between three eminent physicians and their patients, taken from different decades of the 18th century, and that therefore are put forward as representing the predominant medical theory and rhetorics of their time. Each is accorded a separate chapter, and a comparison of the three usefully demonstrates the evolution of medical thought in response to changes in scientific discovery and in society over the century as a whole, but such an analysis is not always presented in the most straightforward manner.

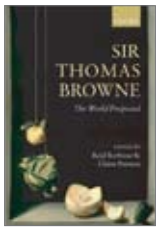
The first physician discussed, James Jurin, was secretary to the Royal Society in 1721–27, and perhaps unsurprisingly therefore was a Newtonian and an advocate of the iatromechanical theory (which attempted to apply Newtonian mathematics and physics to human physiology) that influenced much medical thought in the first three decades of the century. The second subject, the prolific George Cheyne, is probably best known as the author of *The English Malady* (1733), and as a result of his correspondence with the likes of the Duchess of Huntingdon. In contrast to Justin, Cheyne embraced the new nerve physiology that started to pervade medical thought in the third and fourth decades of the century, thus making communication with his patients considerably easier. The third study mainly deals with the Scottish Enlightenment physician William Cullen in the second half of the century, but also offers useful insights into medical education in Scotland, and into the impact of the Scottish Enlightenment on medical practice. Of particular note is the emphasis given to the influence of physical climate and social environment on the nervous system, thus requiring sensibility and sympathy in relating to patients – in contrast to Cheyne, who had viewed such requirements as being medical liabilities.

Wild asserts that this work is an interdisciplinary study aimed at readers who are mainly interested in the social history of medicine and 18th-century literary criticism. To some extent this is true, but there is an obvious leaning towards the literature aspects, with considerable attention given to analysing the rhetoric utilised by the physicians whose correspondence is reviewed. Admittedly, the copious notes provided, defining terms and expanding on points made in the text, as well as providing bibliographic references, are very welcome, but, even so, it is difficult to appreciate what particular added value this work brings for students of medical history *per se* other than providing greater illustration of aspects of 18th-century medicine already covered in other works. No doubt a reviewer approaching this study from a literary perspective would adopt a more positive stance.

Wild W. Medicine-by-post: The changing voice of illness in eighteenth-century British consultation letters and literature. The Wellcome Series in the History of Medicine. Amsterdam/New York: Rodopi; 2006.

Keith Williams is a doctoral student at the Wellcome Trust Centre for the History of Medicine at UCL.

Sir Thomas Browne: The world proposed



HAROLD J COOK

The Norfolk physician Sir Thomas Browne is still legendary as one of the greatest medical humanists accessible in English, and one of the few authors of the language whose work has been available in current editions more or less from the publication of the first unauthorised edition of his *Religio Medici* in 1642.

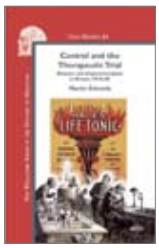
He is almost as famous for his attack on popular errors, *Pseudodoxia Epidemica* (1646), and for his meditations on antiquity and funerary customs, *Hydriotaphia, or Urne-Buriall* (1658), as for his reflections on religion and the world. His fame depends not so much what he wrote – although that is quite interesting – as the manner of his expression, which earned him the reputation of one of the greatest stylists of the language. For centuries, he was an example to all physicians of the importance of wide-ranging learning and discriminating judgement, and some of them, most notably Sir Geoffrey Keynes, contributed fundamentally to the scholarly literature on Browne.

Given the difficulties modern readers have with early modern English, and the pressing demands on today's medical students and professionals, one wonders whether Browne is much read any more by those in medicine. But ironically, perhaps, never has there been such excellent work on him as currently. In 2005, the 400th anniversary of his birth was therefore commemorated by several events at which his life and work were subjected to scrutiny once more. Reid Barbour and Claire Preston have edited the papers from one of them, amounting to a clear and careful guide to his writing authored by a wide-ranging group of academics almost entirely associated with English literature and its history. Medical historians will probably mostly be interested in the essays by Brent Nelson (on the collecting habits of Browne and his son Edward, also a physician), Debora Shuger (on his Laudian sympathies in religion), Victoria Silver (on the trial of the Lowestoft witches and Browne's testimony in favour of their conviction), William N West (on the *Pseudodoxia Epidemica*), and especially Barbour (on Browne's interest in human skin as organ and hieroglyph). As Barbour says, Browne cared about the anatomy, healthy function and diseases of skin, including smallpox, but "he also explored its artistic, moral, theological, and social-cum-racial implications". In exploring such details, the impressive breadth of reading, careful observational skills, exacting memory and probing intelligence of Browne come to life. Browne's works still repay the effort of reading, and for anyone who wishes to learn more after an initial go, the guidebook assembled by Barbour and Reid will be invaluable.

Barbour R, Preston C (eds). Sir Thomas Browne: The world proposed. New York: Oxford University Press; 2008.

Professor Harold J Cook is Director of the Wellcome Trust Centre for the History of Medicine at University College London.

Control and the Therapeutic Trial: Rhetoric and experimentation in Britain, 1918–1948



SHINJINI DAS

How do doctors decide upon the most effective drug for a particular disease? This apparently simple query opens up a highly interesting and rich history. The history of 'drug standardisation' in the first half of the 20th century involves a complex process of interaction and negotiation between physicians of different orders.

Martin Edwards's *Control and the Therapeutic Trial* explores this story in Britain. How the randomised controlled trial (RCT) became the only accepted norm for determining therapeutic efficacy of drugs is the focus of this empirically rich and lucidly written book. The author has also developed another parallel theme running throughout the book, namely the power of 'rhetoric' – the ambiguity in meaning in certain words and the implication of their deployment in 'scientific endeavours'. Edwards systematically exposes how the UK Medical Research Council (MRC) continually played around and exploited the word 'controlled' to help to establish its own 'controlled trials' as the most appropriate standard for therapeutic evaluation.

In the process, the MRC managed also to establish itself as the sole proper arbiter of therapeutic efficacy in Britain. Implicit in this story is the gradual marginalisation of the authority of the bedside practitioners and minute clinical observation. The advent and triumph of laboratory-based physicians and practices in the first half of the 20th century, the clash between empiricism and so-called 'scientific rationale', form an important strand of the book.

How the randomised controlled trial became the only accepted norm for determining therapeutic efficacy of drugs is the focus of this empirically rich and lucidly written book

Chapter one is a detailed historiographic discussion of the therapeutic trial prior to 1948. The longish sections dealing with the various connotations and uses of 'rhetoric' as well as the myriad meanings of 'control' in early 20th-century Britain are revealing. Each of the next four chapters discusses the MRC's clever exploitation of the various meanings of 'control' in the context of different diseases. This is elucidated with detailed discussions of the debates concerning efficacy of four different drug treatments: the debates around raw pancreas therapy (1920s), light therapy (1920s), serum therapy (1929–34) and immunisation trials for pneumonia (1940s). Chapter six focuses on the contrasting views and strategies of the two leading men within the MRC, Almroth Wright and Bradford Hill. Focusing on the life stories of the two men, this microhistory of a chapter gives interesting insight into the importance of language and the use of appropriate nomenclature in establishing scientific 'truths'.

However, one cannot but comment on the structural planning of the book. Dealing with a specialised, almost technical subject such as the RCT, it would have done well to clarify certain points at the onset. The meanings of 'therapeutic trial', 'controlled trial' and especially 'randomised control trial' as it came to be established by 1948, involving comparison groups, are somewhat unclear. Factual details concerning these are there throughout the book, yet it would have helped to have a clearer perspective of their evolution towards the beginning. Non-specialist readers with insufficient knowledge of the idea of therapeutic trial may find the beginning, especially the introduction, confusing.

Besides, Edwards refrains from grounding his story in the social and political context of the time. He gives a meticulous account of the internal history of the MRC – the clash of ideas and interests of different lobbies and officials within, the formation of the different committees (such as the Therapeutic Trial Committee or the Committee on the Biological Actions of Light) and their contexts. Yet the book fails to situate the MRC's ascendancy within the broader British political and social currents and tensions of the period. In other words, how the MRC managed to become the sole arbiter of drug efficacy – the background of its material negotiations with physicians, laboratory scientists, government, pharmaceutical industry and the public – is conspicuous by its absence. This complex process is nonetheless hinted at in the section on historiography, where the author discusses works of Toth, Alan Yoshioka and others. The reader almost expects Edwards at some point to reflect on these issues, to integrate his detailed research on the development of the RCT and the MRC's shifting role in it with the wider political developments. In the absence of that, the book often appears to be too focused, too specialised – a fascinating yet insular account of the development of the RCT.

The volume also leaves the issue of the trial subjects mostly unexplored. An account of drug trials invariably involves people on whom they were conducted. Edwards mentions such subjects only incidentally – for instance, the large-scale trials of inoculation against pneumonia upon Africans in the 1940s, of typhoid vaccine in India in 1898–99, and of influenza vaccine on prisoners of war and camps of displaced persons in the 1940s. He also makes a brief yet intriguing association of 'controlled' with regulated and ordered populations. However, the atrocity of the process, the politics and power dynamics involved, and the role of colonialism, if any, are completely ignored.

Narrating a history of the scientific phenomenon of the trial, Edwards exposes the malleability and flexibility inherent in ideas constituting scientific truths

These gaps apart, the book is indeed an impressive attempt. Its politics is clear and in the reader's face. *Control and the Therapeutic Trial* successfully questions the solemn rigidity of a contemporary scientific truth. Narrating a history of the scientific phenomenon of the RCT, Edwards exposes the malleability and flexibility inherent in ideas constituting scientific truths. In a fitting conclusion, he dwells on the current connotation of the RCT. He hints at how the rhetorical power of 'control' clings on in the 21st century and is still exploited today. The book is a welcome addition to the scholarship dealing with social construction of truths. The content, along with the easy style of writing, should ideally attract readers of diverse interest: historians of medicine and science, practising physicians as also non-specialist readers.

Edwards M. Control and the Therapeutic Trial: Rhetoric and experimentation in Britain, 1918–1948. Amsterdam and New York: Rodopi; 2007.

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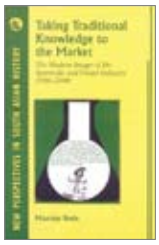
Taking Traditional Knowledge to the Market: The modern image of the Ayurvedic and Unani industry 1980–2000



MARGARET JONES

The manufacture of Ayurvedic and Unani medical products is now a multimillion-dollar industry in India, with estimated turnovers in 1998, for example, of $625 million and $42.5m respectively. Increasing urbanisation and the rise of an affluent Indian middle class has created a market for ready-made Ayurvedic and Unani formulas and largely replaced traditional preparation methods.

Maarten Bode's *Taking Traditional Knowledge to the Market* explores the paradox at the heart of this industry, which has to present indigenous medical products as both modern and traditional, both professional and common.

Recent historical studies have paid attention to the experience of indigenous medicinal systems under the impact of biomedicine: see for example G Attewell's *Refiguring Unani Tibb: Plural healing in late colonial India* (2007) or H Ebrahimnejad's *The Development of Modern Medicine in Non-Western Countries* (2009). However, Bode's volume breaks new ground in its analysis of the ways in which Ayurveda and Unani medicines have been refigured for the market. He explores a number of vital questions in relation to this commoditisation: to whom and for which ailments are these medicines marketed? What role has been played by government regulation in shaping them? What makes commodities indigenous and how are they marketed? How are biomedical notions and practices applied to frame the identity, quality and efficacy of Indian indigenous products? What is classical pharmacology and how does it inform their compilation and deployment? The axis of this study centres on his structural analysis of advertisements in the public media. His overriding purpose, he says, is however to explore how, by enclosing within it the traditional, the refiguring of Ayurvedic and Unani medicine has contributed to the shaping of a modern Indian identity.

Bode explores these issues primarily through an ethnographic examination of five representative Indian manufacturing firms of Ayurvedic and Unani medical products. This research included interviewing directors, marketing managers and scientists, visiting company clinics and laboratories, viewing publications, undergoing treatments, and sharing meals and celebrations. It was not only, as he says, beneficial to his health but it undoubtedly resulted in a close encounter with those who research, produce and market the products. To counterbalance the closeness of this encounter he also spoke with other stakeholders in the field such as NGOs, research and medical personnel at government institutes, and organisations involved in research, regulation and distribution, such as the Pharmacopoeial Laboratory of Indian Medicine and the Central Council for Research in Indian Medicine and Homeopathy. However, there is little discussion here of the limitations inherent in this method of research.

Bode identifies three types of indigenous medicine: branded, prescription and traditional. The first of these accounts for 75 per cent of the market, and the most fascinating element of the book is the discussion on how these traditional Ayurvedic and Unani formulas have been re-imagined, repackaged and marketed for the consumer – who Bode argues is now largely the urban middle class. These branded products are expensive in comparison with the more traditionally produced Indian medicines and with the biomedical over-the-counter drugs. Thus they can no longer be purchased by the poor, an inversion of the situation at the turn of the previous century. They are marketed to be modern; advertisements feature pictures of modern production units and laboratories but, tellingly, they also reference the classical Ayurvedic or Unani origins of the product. The result, Bode argues, is a problematic and unconvincing attempt to unite classical concepts of health and disease and how the medicines work into the idiom of biomedicine and modern pharmacology. In effect, he concludes, "Ayurvedic and Unani manufacturers assert that their medicines make people effectively modern by extracting the 'poisons' of Westernisation".

This volume offers some vital insights into how these manufacturers view and sell their products. Bode acknowledges that his narrative is wholly from the perspective of the producers; he makes no claims to do more than this and it is all too easy to highlight the sins of omission. However, therein does lie a problem, because although he sets out to trace the 'social lives' of Ayurvedic and Unani medicines in their various roles, the lack of a consumer perspective weakens his overall argument about their contribution to the construction of a modern Indian identity. It is to be hoped that he, or someone else, takes up the challenge and investigates how these medicines are perceived by those who purchase and use them.

Bode M. Taking Traditional Knowledge to the Market: The modern image of the Ayurvedic and Unani industry 1980–2000. Hyderabad: Orient Longman; 2008.

Dr Margaret Jones is based at the Wellcome Unit for the History of Medicine, University of Oxford.

Healing at the Borderland of Medicine and Religion

AMNA KHALID

In his most recent book, Michael Cohen studies the interface between alternative therapies and conventional biomedical treatments. He elucidates the various challenges – intellectual, psychological, cultural, ethical and legal – posed by the integration of complementary and alternative medicine (CAM) with conventional medicine.

Cohen begins by noting how biomedicine acquired a position of legally sanctioned dominance in the USA in the 19th century and marginalised other forms of healing. He examines the differences and schisms between conventional medicine and CAM therapies, and then investigates the rise of the notion of holistic healthcare in the USA in the 1960s. He goes on to consider the difficulties of integrating CAM therapies and conventional care, proposing negotiation theory and liability analysis as an effective means to develop a healthcare system in which treatments that are 'not biologically plausible' can be integrated and assimilated into conventional approaches to healthcare. Furthermore, Cohen demonstrates how negotiation theory can facilitate not only a useful and effective dialogue between conventional medicine and CAM, but also between patients and practitioners and their differing expectations of one another. He makes the astute observation that patients and physicians are not the only agents playing a role in the negotiation of treatments. Other groups, such as CAM providers, allied health providers (nurses and psychologists), policy makers, regulators, consumer groups, industry, scientists and insurers, are also involved in the process. He goes on to show how negotiation theory and liability analysis can open up ways for more effective agreement between these various agents to see how different systems of healing can work together.

In the second chapter, Cohen reviews the argument made in *The Role of Complementary and Alternative Medicine: Accommodating pluralism*, edited by Daniel Callahan, whom he commends for stressing the need to engage in a multidisciplinary dialogue and analysing epistemological assumptions of biomedical critiques of CAM therapies. Cohen notes this work opens the possibility of negotiation and exchange between partners by moving towards a scenario that promotes tolerance and respect and recognises the worth and usefulness of pluralism.

Cohen then goes on to look at the particular case of epilepsy and examines the various difficulties in integrating CAM approaches into conventional care. In this clear and useful chapter he attends to the legal and regulatory issues. He suggests ways in which this borderland between biomedicine and spiritual healing can be navigated ethically while at the same time delivering 'integrative care' where the concept of healing addresses not only the patient's physical and mental condition and needs but incorporates their spiritual and emotional wellbeing as well.

Further on in the book, Cohen considers expanding definitions of 'health' beyond mechanistic understandings of life to explore the role of spirituality and intentionality in the process of healing. In so doing he highlights the holistic and 'vitalistic worldview' that underpins CAM therapies and places healing in the broader context of the outer environment.

Cohen argues that while many of these spiritual healing practices have increasingly been secularised, they are not necessarily to be equated with religion; however, spiritual healing does penetrate the boundary between medicine and religion as it is based on faith in certain healing practices. This then clarifies why Cohen uses the word 'Religion' in the title of his book instead of 'Spirituality' or 'Alternative Healing'.

In the final chapter, Cohen examines how spiritual healing is legally regulated in the USA and evaluates the effectiveness of this regulation. He analyses the constitutional clash between individual freedom and autonomy, and the state's right to regulate healthcare practices, problematising the very definitions of 'medicine' and 'healing' to question divisions between physical, mental, emotional and spiritual wellbeing. Through this analysis he highlights the need to seriously rethink legislation based on 19th-century legal principles favouring biomedical doctors. He makes a strong and convincing argument for a new legal language and range of concepts to effectively facilitate and regulate 'New Health Care' allowing for an 'integrative' and pluralistic approach to health and healing.

While the chapters in this book at times seem disconnected and read like reviews of books and academic debates, Cohen makes an important contribution by proposing strategies for navigating around the intellectual and practical problems and difficulties posed by the integration of CAM and conventional treatments. This book is an interesting read and will be useful for not only academics but also healthcare professionals, policy makers and students of medicine.

Cohen MH. Healing at the Borderland of Medicine and Religion. Hyderabad: Orient Longman; 2007.

Dr Amna Khalid is a Senior Lecturer at the University of Cape Town and a Research Associate at the Wellcome Unit for the History of Medicine at Oxford.

WHO Global Health Histories seminars 2009

This seminar series, 'Tropical Diseases: Lessons from history', is being organised by the Global Health Histories project run by the Knowledge Management and Sharing/ Information, Evidence and Research department within the World Health Organization in Geneva.

It is being run with the support of the Wellcome Trust, the Wellcome Trust Centre for the History of Medicine at UCL and the Wellcome Unit for the History of Medicine at the University of Oxford, together with the Special Programme for Research and Training in Tropical Diseases and the Department of Control of Neglected Tropical Diseases at the WHO.

The format is quite distinctive: each seminar will involve two speakers and invite audience discussion. Speakers will include established historians of international and global health, as well as internationally recognised scientific experts who have had long careers in the treatment and control of specific tropical diseases. These events will offer lessons learned from history and implications for current health policy making; for the historians, this is an invaluable opportunity to learn about the great complexity of multifaceted public health programmes, as well as the many staff and approaches involved in running them. All talks will provide perspectives on evidence relating to the treatment, control or elimination of tropical diseases; speakers will also discuss successes and failures of policy, and assess how political, economic, cultural and social issues played an important role in each case.

The talks, which are open to all, have previously attracted very enthusiastic audiences, with significant representation from within the WHO and other UN agencies. The WHO has, in addition, arranged for 'webinars' of all of these events, allowing the talks to go out live globally. People outside the WHO can access the events online, as well as accessing the speakers' PowerPoint presentations and asking questions via email – and thus be part of general discussions. However, people wishing to join these webinars need to register at a WHO site before each lecture; invitations for registration will be posted on the TDR website (**apps.who.int/tdr**) and can also be collected from the seminar organisers.

There have already been four series of lectures, which have dealt with leprosy, guinea worm, sleeping sickness and onchocerciasis. The details of the themes to be covered – and the historians who will be involved – are as follows:

- **Malaria: Professor Peter Brown, Emory University, USA**
  23 September 2009
- **Chagas' disease: Dr Simone Kropf, Fiocruz, Brazil**
  7 October 2009
- ***Kala-azar*: Prof. Achintya Kumar Dutta, Burdwan University, India**
  21 October 2009
- **Tropical disease vectors – identification and control: Prof. Randall Packard, Johns Hopkins University, USA**
  4 November 2009
- **Pharmaceuticals and vaccines: Dr Jeremy Greene, Harvard University, USA**
  2 December 2009

Further information is available at **www.who.int/global_health_histories/seminars/2009/en/** and from Sanjoy Bhattacharya (joygeeta@hotmail.com), Thomson Prentice (thomsonprentice@wanadoo.fr) or Gael Kernen (kerneng@who.int).

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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:

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