This is a repository copy of Swami Laxmi Ram's ayurvedic pharmacy in Jaipur, India.

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Calendar of events

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DETAILS TO THE EDITOR, sanjoy.bhattacharya@ucl.ac.uk

APRIL 2007
25 A Miracle Happened There: The West and central African smallpox eradication programme and its impact
Lecture by Dr Joel G Breiman, Baner Scientific Advisor; Fogarty International Center, National Institutes of Health, USA, Wellcome Collection, 183 Euston Road, London NW1 2BE
www.ucl.ac.uk/histmed/events/smallpox.html
25 Peter Ritchie Calder and the Public Culture of 20th-century Science
Seminar, LSE
Contact: Jane Gregory (E jane.gregory@ucl.ac.uk)

MAY 2007
2 The Last Challenge: The Horn of Africa
Lecture by Dr Cin A de Quadros (President and CEO, and Director of International Programs, Albert B Sabin Vaccine Institute, Washington, DC, USA), Wellcome Collection, 183 Euston Road, London NW1 2BE
www.ucl.ac.uk/histmed/events/smallpox.html
9 Epidemiology and the Science of Detection, 1890–1960
Lecture by Professor Anna Hardy (Wellcome Trust Centre for the History of Medicine at UCL, Roberts Building, Torrington Place, London Contact: Carol Brown (E c.brown@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/
9 Pain and Laughter: A preliminary history of sentience in southern Africa
Seminar by Julie Livingston (Rutgers University), Goldsmiths University of London
Contact: Rebecca Lao (E r.gold@gold.ac.uk)
www.goldsmiths.ac.uk/departments/history/news-events/
cultural-history-medicine.php
23 The Asiatic Enlightenments of British Astronomy
Roy Porter Lecture by Professor Simon Schaffer (University of Cambridge), Cruciform Building, Gower Street, London
Contact: Carol Brown (E c.brown@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/
30 The Global Eradication of Smallpox: Historical perspectives and future prospects
Lecture by Professor Donald A Henderson (Professor of Medicine and Public Health, University of Pittsburgh; and Resident Scholar, Center for Security, University of Pittsburgh Medical Center, USA), Wellcome Collection, 183 Euston Road, London NW1 2BE
www.ucl.ac.uk/histmed/events/smallpox.html

JUNE 2007
28-1/7 British Society for the History of Science Annual Conference
University of Manchester
Contact: Executive Secretary (E bhahs@bhhs.org.uk)
www.bhahs.org.uk/bhahs/conferences/annual_conference/2007/manchester/

JULY 2007
25-29 Biennial Meeting of the International Society for the History, Philosophy and Social Studies of Biology
University of Exeter
Contact: egross@ex.ac.uk
www.centres.ex.ac.uk/egross/events/lshpssb/
For a fuller listing of lectures, seminars, conferences and other events relating to the history of medicine, visit http://medhist.ac.uk/events.
Preparing medicines in Jaipur, India

Ayurvedic pharmacy

Swami Laxmi Ram’s to be refined into ayurvedic pills.

© Theresia Hofer

Right: Making ayurvedic herbal pills. © Theresia Hofer

Dr Govardhan, an alumnus of the Institute, had also been a disciple of Professor Ram Prakash, a renowned practitioner in the region. Both had been linked to the ‘pharmacy’ we were about to visit.

No sign announced that we had arrived at the ‘pharmacy’ – which, as Dr Govardhan explained, was owing to the organisation’s ideal of not advertising itself. Through a large gate, we entered the building and immediately experienced an air of nostalgia.

This place has a fascinating history about which nothing has so far been written by academics. This article, thus, aims to make readers – and future researchers of this – aware of this important urban centre, an interesting site to study the past as well as contemporary ayurvedic practice in Jaipur.

I was shown around the neighbourhood by Dr Govardhan, an ayurvedic doctor originally from Andhra Pradesh, and one of his friends, who is a student of ayurveda in London. Dr Govardhan, who has taught at Thames Valley University and the Manipal Ayurvedic University of Europe in London, had kindly made it his mission to introduce us to the unique ayurvedic practice in Jaipur. We had already spent a few days at his various clinics, which included the state government’s Bambiwalka Ayurvedic Hospital near the old Ajmeri Gate and the unit attached to the massive National Institute of Ayurveda (with 600 students studying ayurveda at different levels).

The managing director, Bhajan Das Swami, then introduced us to his history, while we sat in a cool consultation room. The pharmacy was founded by Vaidya Laxmi Ram, who had studied ayurveda at the Maharaja Sanskrit College in 1865. Built according to the rules of Indian architecture as laid down in the Vaastu Shastra (the Indian science of proportion and architecture), it is not only well designed, but also built with careful attention to detail.

His residence, which is known as Laxmi Ram’s Bagicha (‘Laxmi Ram’s Park’), had been a site for meetings with leaders of the Indian independence movement, not least with Jawaharlal Nehru, India’s first Prime Minister. As one of the black-and-white photos displayed there indicated, Nehru stayed at this residence in 1942 – a momentous year that saw the launch of the Congress-led Quit India Movement, which brought forth a ferocious response from the colonial government as it was seen to threaten the already-flagging Allied war effort in Asia. Guru Golwalkar, one of the early leaders of the Hindu nationalistic party Rashtriya Swayamsevak Sangh (RSS), had also stayed at this residence, highlighting the breadth of the organisation’s political patronage. Ram Prakash Swami, another important head of the pharmacy, had cordial relations with the Congress and other political party members and personalities, such as Gazi Zail Singh (India’s first Sikh President), Indira Gandhi (Nehru’s daughter and ex-Prime Minister), Atal Bihari Vajpayee (ex-Prime Minister associated with the Bharatiya Janata Party) and Jai Prakash Narayan (a prominent parliamentary socialist who had also played an important role in the independence movement).

Dr Govardhan was a devoted disciple of Ram Prakash Swami and had studied under him for 23 years. Currently, he, his designated successor (a 25-year-old called Jagdish Sharma) and some other members of staff live in the Laxmi Ram pharmacy, which is also popularly known as the Bavaji ki Dawakhana (‘the old man’s medicine place’).

The medicines are prepared here by hand, in line with the rules prescribed in the Siddhha Bhesaja Manimala, a book written by Shri Krishnamara (1848/49–1897). A room full of jars and bottles testifies to the large range of formulations produced and prescribed – among them preparations with gold and other precious metals. The advantage of such a small-scale pharmacy and clinic is that one can tailor certain medicines to the physical/mental constitution and the special needs of particular patients. In some cases, medicines produced here are even sent after by patients who have received a consultation in one of the government hospitals.

The pharmacy is an inspiring example of how people engage themselves in preserving ayurveda under circumstances of increasing standardisation and commercialisation. I also believe that this place would prove to be very rewarding for historians and anthropologists interested in conducting research into the early institutionalisation of ayurveda in Jaipur and western India, as well the complex relationship this medical tradition has with religion and politics at a local, national and global level.

While the ayurvedic industry is growing in India and abroad, it is not the aim of this small institute to expand. “We want quality and this institute is not here for doing business,” Bhajan Das Swami informed us. His interest is to preserve the ‘purity of ayurveda,’ which is an ethos that restrains the institute from advertising itself commercially. An understanding of an ayurvedic tradition that diverges from what one might call ‘quick-fix ayurveda’ also emerged in another conversation with this 75-year-old man. Asked about the role of ayurveda for the contemporary world, he said: “Ayurveda is not about medicines. It is the science of life, how to live, when to wake, what to eat, morality etc. And what is most important is how to be satisfied. Satisfaction equals peace of mind, and peace of mind governs the body.” Such statements, together with the fact that the term Swami (‘Reverent’), instead of Vaidya (‘doctor’), the word usually used for an ayurvedic practitioner, is used for all members of his lineage, contributes to a feeling that this place retains aspects of a religious community to it. Only men live there, and as with certain religious groups in India, no garlic or onions are used in the kitchen – situated in the open air on the roof of the house. Also, all foods prepared there are sattvic foods (considered to be calming for the mind).

Therasia Hofer

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Rethinking therapeutic efficacy: environment and medical development in colonial Punjab

LAUREN NAUTA MINSKY

Understanding how faith in healers was produced is a complex topic for historical inquiry and one that is surprisingly little explored in the context of colonial South Asia.

Many scholars implicitly assume that faith in the efficacy of particular healers or healing institutions was exclusively contingent upon such qualities as their knowledge, technical skills, medicines, charisma and affiliated medical tradition (such as ayurveda, unani, folk or biomedicine). Other historians instead assume that attenders of healers, especially those patronised and promoted by the colonial state, did not act out of faith in their efficacy at all, rather, they were directly or indirectly coerced by European and Indian healers, elites and government officials to submit to medical treatment. In either case, the role of ‘ordinary’ social groups – including peasants, nomadic pastoralists and migrant labourers among others – in the creative making of effective healers and healing institutions is confined to a position of response: acceptance of, resistance to, or picking and choosing between medical alternatives made available to them ‘from above’.

My work seeks to interrogate these assumptions by developing an understanding of the making of therapeutic efficacy in colonial South Asia. Adopting an approach that combines aspects of agrarian and environmental history with the history of medicine, I explore the process of medical development in the Punjab plains region during the late 19th and early 20th centuries. In particular, I show how ‘ordinary’ social groups actively fashioned effective healers, healing institutions and healing practices in a manner that confounds both assumptions of elite- and healer-driven cultural change, and conventional understandings of medical traditions and therapeutic pluralism in colonial South Asia.

To begin my study, I reconstruct the semi-ard disease environment in which people fell sick and struggled to get well in colonial Punjab. In so doing, I draw attention to the ways in which seasonal hunger, labour demands, migration and commodity shaped different social groups’ lived experience of the region’s disease environment. I also illustrate how changing social relations and activities of production during a period of agricultural expansion, intensification and commercialisation shaped the seasonal basis of sickness, sub-regional variations in disease incidence, and the distribution of morbidity and mortality among social classes and age groups.

In turn, I use my understanding of the region’s disease environment to historicise the development of effective healers and healing institutions during the colonial period. Breaking down conventional boundaries between medical ‘traditions’, I demonstrate that all healers and healing institutions in colonial Punjab acquired characteristic specialisations along seasonal, disease, class, gender and species lines through an ongoing process of negotiation with sick attenders and their kin. As a result, healers in colonial Punjab were not so much seen as representing one or another medical tradition as they were seen as distinctly specialised. For instance, both rawals and the staff of hospitals and dispensaries were best known not as folk and biomedical healers respectively, but as specialists in curing blindness and diseases of the eye.

An understanding of healing specialisation necessarily alters how we conceptualise the role of ‘ordinary’ social groups in the working of therapeutic pluralism in colonial South Asia. For one thing, patients’ determination and selection of appropriately specialised healers was crucial to ensuring that therapy proved effective. Second, patients did not attend just any (or every) similarly specialised healer; rather, they made decisions between healers and labourers to mobilise the resources necessary to ensure that treatment from a chosen healer would result in a cure. As I show, patients’ definitions of efficacy were highly dependent upon the resources exchanged between healers and patients, including offerings, fees, taxes, advice, food, medicine, accommodation, bedding, transportation and nursing care. As such, the efficacy in practice of similarly specialised healers varied greatly, and was always defined by patients and their kin in relation to, and in combination with, other similarly specialised healers.

Patients’ evaluations of efficacy also clearly underwent significant changes throughout the colonial period, as political struggles affected the availability and distribution of resources for healing. Building upon these findings, I conclude my study with an analysis of the making of effective healing practices during the spring and autumn harvest seasons when the vast majority of deaths in colonial Punjab occurred each year. In particular, I illustrate how patients and their kin both shaped the substance of, and selectively combined, the expertise and resources of similarly specialised healers and institutions to craft altogether novel, and regionally distinctive, seasonal cultures of healing. For instance, when quinine was first introduced into Punjab by Europeans, the efficacy of this ‘fever-tree’ medicine among poor and malnourished labouring groups was greatly limited by its ‘heating’ properties (as evident in disabling side-effects such as headaches, vomiting and nosebleeds), the duration of treatment, and the specificity of the drug’s efficacy for malaria (as opposed to autumnal fevers more broadly). When faced with rising rates of malaria, however, rural social groups made quinine into an effective part of their existing autumnal fever therapy by consuming it in high doses with ‘cooling’ dairy offerings and additional fever medicines such as opium and neem. By taking quinine in this way, peasants and labourers dramatically mitigated the drug’s side-effects, reduced the length and cost of treatment, and bolstered their resistance to autumnal fevers more broadly.

Thus, instead of thinking about therapeutic pluralism in South Asia as a potpourri of medical ‘traditions’ and alternatives offered up by healers and elites, there have been and (continue to be) additional logics and forms of agency at work. Glimpsing such logic and agency suggests that the history of medicine in South Asia is complicated in ways that merit greater attention to the active and creative role played by ‘ordinary’ social groups.

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In this research I am exploring how we can move away from the idea that costs can only be measured in dollars or pounds and to look at what the loss of a parent – or AIDS in terms of money values, but from the idea that costs can only be measured in dollars and not have an AIDS angle, whether we think of livelihood analysis, gender studies, macroeconomic and trade policy, intellectual property rights issues, cultural analysis of change, policy development or myriad other areas. One reason why the medium- and long-term effects of HIV/AIDS are not well understood is that the current prevalence of HIV positivity (seroprevalence) is still very high, in some countries, suggesting that the epidemic is still in its early stages. This means that the social and economic costs and other impacts of the high levels of current prevalence (now in the 25–40 per cent range in central and southern Africa, above 1 per cent in Russia, Ukraine and Estonia, and approaching 10 per cent in some Indian states) will not be seen for some years to come. But the epidemic has already had devastating effects in many areas of sub-Saharan Africa. Medical services are at breaking point and there is large-scale orphaning and destitution. Food security is under threat because of the loss of agricultural workers and industrial production is also at risk, particularly in Botswana, where seroprevalence has exceeded 35 per cent in some companies. However, in a relatively rich country where antiretroviral therapy is free or very nearly free, this challenge is being met. This is not the case in many other countries.

But this research is showing how the greatest costs are those borne by families, communities and whole nations as the relations and links of trust that make markets and politics possible break down. Losses in the informal and ‘trust’ economies are probably of even greater import than losses to production and productivity in the formal economy. What is the effect on national life of loss of local politicians who die prematurely, resulting in more frequent elections with consequent choice of less and less experienced incumbents?

The project will make particular reference to Russia and Africa, which are at very different stages of the epidemic. Although supported by some fieldwork, in this the main this work draws on existing data from a range of academic disciplines, and questions accepted concepts such as ‘cost’, ‘responsibility’ and ‘impact’. It is essentially a theoretical project, but some fieldwork has been done in South Africa, Uganda, the USA and Russia.

Military hospitals and the development of modern medicine in 19th-century Iran

HORMOZ EBRAMHINNEJAD

Military hospitals in 19th-century Iran played a considerable role in the improvement of what was termed ‘manual medicine’, which had long been neglected by Galenico-Islamic medicine and relegated to unskilled practitioners.

When modern medicine was introduced through court-employed Western physicians, the medical community was roughly divided into two groups. On the one hand, the ‘empirics’, including surgeons-barbers and rank-and-file doctors that statistically dominated medical practice in both urban and rural areas; on the other hand, the medical elite that consented to learned physicians trained in Galenico-Avicennian medicine. It was this latter group that, due to its social position and intellectual interests, first came into contact with modern medicine in the 19th century. Not immediately ready to accept modern ideas, as they were imbibed by the Islamised Greek cosmology that included Galenism.

It is instructive to contrast learned medicine and surgery within the old medical system. The literary and scholarly knowledge provided learned physicians with a social prestige and respect within the medical community. Although comparatively small in number throughout the country, learned physicians represented the ideal image of the medical profession. The surgeons, though, were far from enjoying the same esteem, not only because they were not educated or learned (and they did not need to be), but also because their craft, dealing with blood, was considered unclean.

Nonetheless, the situation changed throughout the 19th century, mainly due to the increasing need for surgeons in the expanding and modernising army. Iran, during the 19th century (except for the two wars with Russia in the Caucasus in 1801–13 and 1826–28), sustained no major military conflict. However, the nature of the Qajar government, and the way it administered the country and levied taxes, required a quasi-permanent military mobilisation. With the expansion of the troops, field as well as base hospitals were created to deal with various diseases multiplied through the agglomeration of soldiers in caserns.

In my work, I argue that state medical institutions, particularly military hospitals, provided the major impetus for the development of modern medicine in 19th-century Iran in two ways: first by accelerating the process of medical professionalisation, and second by the development of clinical and anatomical medicine, inasmuch as military modernisation caused surgery and hospital practice to gain momentum.

The modern military and state administration transformed medical organisation, at least at the state level, by the introduction of a more regular and formal system of remuneration. Not only did the establishment of a regular salary by the state have a financial aspect, but also the state salary (baqqa-e divân) confirmed by royal signature, conferred social legitimacy and legal sanction to the activity of the physicians. This strengthened their social and professional status and distinguished them from rank-and-file doctors.

Unlike contemporary Europe, 19th-century Iran did not experience any noticeable economic, social and political transformation that could result in fundamental change to the medical system. The modernisation of the army, although limited to its being provided with discipline and new weapons, was the main factor that affected medicine and particularly surgery – which, within the old system, was disdainfully called ‘manual medicine’ (teb-h-e ‘amali). In this respect, the role of the military in the development of modern medicine was even more important in Iran than in Europe.

In the second part of the 19th century, we find even among the learned traditional physicians an increasing emphasis on the importance of ‘manuel medicine’ or ‘practical medicine’ (teb-h-e ‘amali). Writing in 1877, the traditional court physician Mirzâ Mohammad Kârem Rashî – who accumulated the court titles of ‘prince of physicians’ (Malek al-‘âlâm) and ‘philosopher of the state’ (Filâf al-dawlah) – warned his colleagues that not all throat diseases could be cured by humoral treatment (sildâh-e ‘amali), in some cases these required surgical operations, which should not be ignored. The distinction between humoral medicine, based on theory, and ‘practical’ or ‘manual’ medicine persisted, but surgery and clinical medicine gained currency at the turn of the 20th century.

The influence of Western medicine was certainly crucial in medical modernisation. Dr Polak, the instructor of anatomy at the Dâr al-Fonun (polytechnic school), was during 1851–60 the first to teach anatomy and surgery at the school and the military hospital.

ELIZABETH SIEGEL WATKINS

Every woman who lives to a certain age reaches menopause. Decreased oestrogen production in the years during and after menopause has been blamed for causing everything from hot flushes to heart disease to diminished femininity. One possible remedy has been to replace that lost oestrogen with hormones from outside the body.

The scientific and commercial development of pharmaceutical oestrogen in the 1930s produced the hormone replacement therapy (HRT) that would become the most popular drug in America by the 1990s. Physicians prescribed HRT not only to relieve the temporary symptoms of menopause but also to forestall the diseases of ageing and to maintain youthfulness.

Opinions on the use of this drug have been sharply divided: it was hailed as “one of medicine’s most revolutionary breakthroughs” and condemned as “the greatest experiment ever performed on women”.

The story of oestrogen is woven from several strands: blind faith in the ability of science and technology to solve a broad range of health and social problems; social and cultural imaginings of ageing, shifting meanings and interpretations of femininity and female identity; and the pitfalls of medical hubris in the 20th century. Oestrogen became much more than a drug in the American pharmacopoeia, as media representations of its roles in both medicine and culture reflected the engagement of the expanding authority of medical science with transformations in perceptions of ageing women in society.

Simply put, too much was expected of oestrogen. Had it remained a short-term antidote for menopausal symptoms, it would have generated little controversy. Indeed, to this day, oestrogen remains the single most effective remedy for the hot flushes of menopause, and few critics dispute its value as a temporary treatment. But because it was promoted as a lifelong therapy, even as an elixir of life, with so many promised benefits, the stakes got higher, and when it failed to live up to the hype, disenchantment and incrimination ensued.

The chequered history of this controversial drug therapy is the subject of my forthcoming book, The Estrogen Elixir: A history of hormone replacement therapy in America.

By the late 19th century and first decades of the 20th century, other dispensaries and civil hospitals were established by foreign missionaries or physicians. Following the chequered victory of the Constitutional Revolution (1906–11), a parliamentary law compelled physicians to hold permission or diploma from confirmed medical authorities to practise.

Many practitioners who applied for such diplomas referred, in their application letters, to their periods of ‘practical’ training at a hospital or at the cabinet of famous physicians, including the Western physicians. In my work, I argue that it is misleading to view Western physicians as the sole cause or engine of the process of medical modernisation. Rather, it was the social and political context – in this case, military modernisation aimed at strengthening the central state – that necessitated the introduction of modern medicine in Iran, just as it caused local traditional medicine to evolve.

Dr Hormoz Ebrahimnejad is a Wellcome Trust Lecturer attached to the Department of History, University of Southampton.
product Prempro (a combination of oestrogen and progesterin) reported that Prempro increased the risk of heart attacks, stroke, blood clots and breast cancer. But the story of oestrogen neither begins in 1942 with FDA approval of Premarin nor ends with the findings of this study in 2002. It roots date back to the 19th century, and its life as a medical therapy continues today. The biography of HRT spans the ‘long’ 20th century, from its conception in the 1980s, through its infancy in the 1920s and 1930s and its midcentury adolescent growth spurt, to its maturity into one of the most prescribed drugs in America in the 1980s and 1990s - and, in the past few years, to hints of its senescence. As the times have changed, so too have the roles of science and medicine, the roles of men and women in society, and attitudes toward ageing - so too have the rationales for the prescription and use of hormone therapy.

This book tells the story of the rise and fall, and rise again and fall again, of oestrogen and its promise to stave off the effects of ageing. This was not a conspiracy of pharmaceutical manufacturers and physicians to dupe women, although drug makers aggressively promoted their products and many doctors believed in them. But its widespread use – by some 40 per cent of the postmenopausal population by the end of the 20th century – indicates the willingness of many Americans to put their trust in this drug product.

Three themes guide my explanation of the development, spread and shifting fortunes of HRT in America. The first concerns the authority of medical science in American life and explores how the relationship between science and society shaped the dissemination and reception of HRT. The second theme considers the significance of the medicalisation of menopause and ageing as oestrogen fell in and out of favour. I aim to develop a nuanced interpretation of the process of medicalisation, within the broader context of the dominance of health as a cultural preoccupation in recent American society and its implications for multiple approaches to and interpretations of menopause and ageing. The third theme deals with the varying meanings of and frameworks for ageing in America and locates HRT in the cultural context of changing expectations and roles for older women in American society. By using oestrogen as a lens through which to illuminate the complex and changing relationships between menopause and ageing, drugs and alternatives, doctors and patients, and providers and consumers of healthcare services, products and information, I hope to shed historical light on one of the most pressing debates in medicine today.

Elizabeth Siegel Watkins PhD is Associate Professor in the History of Health Sciences at the University of California, San Francisco. She is the author of On the Pill: A social history of oral contraception, forthcoming The Estrogen Elixir: A history of hormone replacement therapy in America. (E Watkins@dadsm.ucsf.edu).

The Second Roy Porter Memorial studenthip has been awarded to Erin Sullivan to support her PhD research into ‘Physicke for mind, body and soul: the diagnosis, treatment and experience of melancholy in early modern England’. Erin was selected as the most outstanding student from a very strong field of applicants; the selection committee was particularly pleased to be able to recommend a student whose work continued Roy’s own interests in issues about mental health.

Erin is enrolled at the Wellcome Trust Centre for the History of Medicine at UCL, where she will work under the supervision of Professor Hal Cook and Dr Andrew Watkins. Previously she studied at the Shakespeare Institute at the University of Birmingham, where she was awarded a Distinction in her MA, and at the University of North Carolina, where she graduated with highest honours in English and Italian.

The Centre wishes to record its thanks to the Wellcome Trust for its generosity in continuing to support the work of Roy Porter in this way.

By Professor Hal Cook, Director, Wellcome Trust Centre for the History of Medicine at UCL (E h.cook@ucl.ac.uk).

Our study pursues these themes through micro-histories that explore the emotional impact, processes of appropriation, and social and cultural contexts of poster use. Our first site is Munich at the turn of the 20th century – a place where we can link modern medicine to mass culture through the emergence there of both poster art as a self-consciously modernist form and new ways of representing the body based on popular celebrations of scientific medicine within a rapidly changing public healthcare system. While Munich refers to a moment when health-related posters were struggling to gain public purchase, our second site, the London Borough of Bermondsey in the interwar period, re-creates a time when posters were an accepted form in health education. Bermondsey’s socialist leaders firmly believed that modern medicine, especially in its preventative guise, was one of the primary means to improving the health and welfare of populations, and they were exceptional in the extent of their attachment to visual media of various types. Thus this site allows us to explore how political decisions were made around the use of different types of media for health education. That Bermondsey was exceptional in its use of visual health propaganda also allows us to ask questions about why the rest of Britain

Picturing the modern body: posters of health and hygiene in visual culture

ROGER COOTER AND CLAUDIA STEIN

One of the most striking features of contemporary culture is not just the dominance of the visual over the printed word, but the visualisation of things that are not in themselves visual. All kinds of data and experience now submit to this, perhaps nowhere more so than in medicine, where everything from fetal heartbeats to brain activity has been transformed into visual patterns. The incalculation of such visualisation is not confined to hospitals, doctors’ offices and TV documentaries, however. The encounter is far more pervasive; indeed, it is inseparable in our everyday lives through the relentless proliferation of body images in all forms of mass media.

Our study explores how the visual came to occupy such a powerful place in the production of meanings of our physical and mental selves. As such, it is less concerned with the formal and self-evident features of modern medicine than with study of visual culture itself – a field of research still very much in the making and without clear disciplinary boundaries. The risks and ambiguities involved in its pursuit are all the more felt if one wishes (as we do) to understand visual culture not simply as a site of the ‘history of images’, handled with a semiotic notion of representation, or sociologically, with images granted almost autonomous independent power in reality’s construction. Instead, in this study we approach visual culture in an interactive manner. Put simply, our interest is in how the visualisation of the human body shapes and is shaped by the wider culture in which it occurs.

Pictorial posters dealing with matters of health and hygiene, we submit, provide an ideal medium through which to study this interactive mediation. After all, these cheap, mass-produced and disposable material objects were never designed as unique pieces of art for art’s sake. They were (and are) intended to make an impact and then disappear (which partly accounts for their historical neglect). In itself, the very fact of their ephemeral nature, along with their pervasiveness and the informality of their setting, helps substantiate the quotidian nature, as opposed to the strictly medical context, of the visual cognisance of the human body.

As important, historically, is the fact that these now taken-for-granted objects were not always thus regarded, nor inevitably destined. Since their first appearance in the mid-19th century, posters in general (and those dealing with health and personal hygiene in particular) endured moments of intense struggle and contestation. Thus their history permits us to see how the visual has interacted with its surrounding social world, and to show how this relationship has changed at particular moments, as well as with time and place.

Further, with regard to other media such as film or the internet, we can see how, as one mode of representing reality loses ground, another can take its place without the other disappearing.
The history of childbirth education, 1930–80

Painless childbirth.

Our fourth and final site of interaction is the AIDS epidemic of the 1980s and 1990s. Working outwards from Toscani’s famous poster ad for the United Colors of Benetton, ‘Dying on Aids’ (1992), we explore the use of modern technologies to prepare women for childbirth and alleviate pain during delivery through education, and both physical and psychological training. The book begins with the Soviet drive in the 1930s and 1940s to develop a method of painless childbirth, chronicles the rise of PPM in the late 1940s, follows its transmission to France in the 1950s, and then its migration to and development in the USA during the 1960s and 1970s. While faith in the liberating power of science was powerful across developed countries, nowhere was it stronger than in the Soviet Union. Promising women freedom from the pain of childbirth as part of its widespread modernising mission, the Soviet state and Communist Party catalysed the PPM drive. In the West, by contrast, a handful of professional supporters initially spread the word, but as medical consumers women played an instrumental role in popularising the Lamaze method. Encouraging women to take control of their own bodies and health became a central concern for feminists in the 1970s, who saw the Lamaze method as a way to empower women in the delivery room. My study ends in 1980, when the so-called walking epidural, which allowed labouring women to be fully awake and able to participate without pain, became standard obstetric practice in both France and the USA. Back from the brink of fulfilling its revolutionary potential in the hands of feminists, Lamaze became mainstreamed into a conventional, medicalised model of childbirth and largely divorced from the efforts of those who advocated childbirth without the routine use of analgesics and anesthesia. Meanwhile, in the Soviet Union the method continued to be nominally taught and practised, but research on it ceased and the question of pain relief in childbirth was largely relegated to the back burner, seen as a low priority in an environment of scarce resources.

My study examines the transfer of PPM from one national setting to another and how those shifting sociopolitical conditions reshaped its application. Using medical journals and textbooks, the popular press, and a variety of archival records, I explore arguments within the medical communities over this childbirth preparation approach, its popular reception, negotiations about it between medical professionals and medical consumers, and the ways in which the discourse of PPM inscribed with new meanings of women’s civic duty, parenthood, childbirth, pain, and what constitutes ‘natural’ and ‘normal’ for women during labour and delivery. The transnational nature of this study provides an opportunity to look at these meanings in diverse culturally and historically specific settings.

Efforts to spare women the pain of childbirth cannot be divorced from the broader national and international political environments in which they emerged, and the history of PPM provides a way to trace developments in these broader political concerns. The development of a childbirth education method that promised pain relief without the use of risky anaesthesia or anaesthesia dovetailed well with state-sponsored pronatalism, especially in the West, where medical professionals denounced it on ideological rather than scientific grounds.

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On the trail of Dr Lamaze: a transnational history of childbirth education, 1930–80

PAULA A MICHAELS

At the 1950 International Congress of Gynaecology in Paris, Soviet Professor Anatoly Petrovich Nikolaev delivered his speech before a rapt, but largely sceptical crowd. He spoke of Pavlov’s theory of conditioned response and how its obstetric application had at last brought women the miracle of painless childbirth.

Known as psychoprophylaxis, or PPM (for ‘psychoprophylactic method’), this approach taught women to react to uterine contractions not as pain, but also how posters in this context helped serve the purposes of local knowledge and practices and global market strategies – fully justify historical attention. The extensive collections in the Wellcome Library, the National Library of Medicine and the Deutches Hygiene Museum need not serve only decorative ends.

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Leprosy and Empire: A medical and cultural history by Rod Edmond.

This is an innovative, interdisciplinary study of why leprosy was a disease with a very low level of infection, has repeatedly provoked revulsion and fear. Rod Edmond explores, in particular, how these reactions were refashioned in the modern colonial period. Beginning as a medical history, the book broadens into an examination of how Britain and its colonies responded to the believed spread of leprosy. Across the empire this involved isolating victims of the disease in ‘colonies’, often on offshore islands.

Discussion of the segregation of lepers is then extended to analogous examples of this practice, which, it is argued, has been an essential part of the repertoire of colonialism in the modern period. The book also traces the medical and fictionalised representation of leprosy in Romantic, Victorian and 20th-century writing, and concludes with a discussion of traveller-writers, such as R.L. Stevenson and Graham Greene, who described and fictionalised their experience of staying in a leper colony.

Cold War microbiology and the health of nations

JUSTIN SURAN

In their classic paper on “the substance inducing transformation of pneumococcal types”, Oswald Avery, Colin MacLeod and Maclyn McCarty singled out the nucleic acid DNA as the genetic material.

When their paper appeared in 1944, all three men were engaged in medical scientific projects of interest to the military. Avery had been appointed to the Army Epidemiological Board (AEB), whose members advised the Army Surgeon-General on the control of infectious diseases. McCarty had been assigned to the Naval Medical Research Unit at the Rockefeller Institute while on active duty in the Navy Medical Corps; and MacLeod was directing the AEB’s wartime commission on pneumonia. In fact, in 1944, MacLeod was supervising a clinical trial of a pneumococcal pneumonia vaccine at the Army Air Force technical school in Sioux Falls, South Dakota.

The wartime activities of this famous research team illustrate two interconnected themes at the heart of my work-in-progress: first, the significance of microbiology to the US military from the 1940s to the present; second, the influence of the military on the development of the health sciences and the emerging field of population health. I have identified seven individuals whose activities as scientists and institution-builders bring into focus the dynamic historical relationship between the US military establishment and the medical sciences. By tracking their involvement in military projects and following their movement in and out of military contexts, I plan to reconstruct an important chapter in the history of the life sciences and public health.

The individuals I’ve chosen to study are:

- Alfred Newton Richards, the pharmacologist who helped to make penicillin widely available as chairman of the wartime Committee on Medical Research;
- Harold C. Hodge, the Manhattan Project’s senior toxicologist and an ardent postwar proponent of water fluoridation;
- MacLeod, the above-named microbiologist whose career epitomised the emergence of molecular biology;
- Alexander D. Langmuir, chief epidemiologist at the Communicable Disease Center and architect of the Epidemic Intelligence Service;
- Richard E. Shope – Richard Shope’s son – whose service in the US Army Medical Corps launched a lifelong career in the study of arthropod-borne viruses and emerging infections
- The Surgeons-General of the Army, Navy, and Air Force have traditionally borne responsibility for the health of US service members. Since World War II, however, the military has become increasingly invested in the health of civilian populations, for example in defence against biological weapons. Over the last 60 years, the military has become one of the most powerful institutions in world history, as reflected in the size of the Pentagon’s budget, the sophistication of its weapons systems and the impact of its global interventions. True to its Cold War mission to fight “anywhere in the world at any time”, the military was increasingly preoccupied with tracking epidemics in other countries and studying diseases that occurred with greater frequency in other parts of the world.

Understanding the military’s historical role in the development of the health sciences is particularly important in the USA, where there has been relatively little consensus about the role of the state as a guarantor of collective wellbeing and where the voting public has frequently resisted the expansion of health-improving social programmes. Since the 1940s, national security concerns have sometimes justified a higher degree of health socialisation and coordination of public and private participants in targeted R&D programmes (as in the case of vaccine development).

The Cold War, embodied in the sprawling institutions of the national security state, at times produced the forms of social solidarity and public investment necessary to improve health within and even beyond the nation’s borders.

To recognise the military’s critical contributions to medical science and to the health of populations is not to advocate or endorse the militarisation of medicine and public health. It is to argue that the history of medicine and the life sciences ought to encompass the military and civilian uses, microbiology and medical science and to the health of populations is not necessary to improve health within and even beyond the nation’s borders.

Other historians of science have discussed the profound significance of nuclear physics and nuclear weapons to the history of the 20th century. Shadowing and at times intersecting the history of atomic bombs and thermnuclear devices is a less familiar history of antibiotics, vaccines and infectious agents. Richard Shope, one of the 1956 visitors to the USSR, was also the chair of a military scientific commission working to develop the US biological weapons programme. MacLeod was a member of Shope’s commission. By the mid-1950s, the USA and the Soviet Union had developed active, state-sponsored biological weapons programmes alongside their active, state-sponsored biomedical research programmes.

Just as nuclear science and technology had both military and civilian uses, microbiology and medical science were dual-use. Bringing epidemiologists, toxicologists and virologists into mainstream accounts of Cold War science – accounts now dominated by physicists, mathematicians and engineers – promises to deepen our understanding of the “military–industrial–academic complex.”

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Right: Colin MacLeod, one of the 1956 visitors to the USSR, was also the chair of a military scientific commission working to develop the US biological weapons programme. MacLeod was a member of Shope’s commission. By the mid-1950s, the USA and the Soviet Union had developed active, state-sponsored biological weapons programmes alongside their active, state-sponsored biomedical research programmes.
These studies have raised important questions that underpin the current debates about science and medicine in the post-colonial and post-Cold War world. Yet they are exclusively based on Western powers with non-European colonies and consequently fail to offer explanatory frameworks for the role of science and medicine in the expansion and maintenance of two geographically contiguous empires of Central and Eastern Europe: the Habsburg Empire and Russia. Little historical attention has been given to the ways in which the particular forms of governmentality, as well as the multiethnic and multicultural environments of these empires, shaped medical and scientific knowledge and practices.

It was precisely this historiographical blank space that historians have shown how Western powers employed science and medicine to reinforce their rule and propagate their culture in the countries they colonised. Research has highlighted how the colonial socio-economic organisation affected the health of populations and how, simultaneously, Western medicine itself was profoundly reshaped by encounters with new cultures, diseases and medical practices.
The National Committee on the T4 Nazi euthanasia campaign

Marion Hulverscheidt

In September 2006, an international colloquium on the T4 Nazi euthanasia campaign took place in Heidelberg, Germany. Ten sections that involved more than 40 contributions, a panel discussion and two evening lectures offered an opportunity to explore the historical conditions, the campaign itself, and its consequences for contemporary medicine and medical ethics.

The colloquium programme can be found at www.klinikum.uni-heidelberg.de/fileadmin/prosektete/ pdf/programm_14.pdf.

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The Nazi T4 euthanasia campaign

The colloquium took place in Heidelberg, Germany. Ten sections that involved more than 40 contributions, a panel discussion and two evening lectures offered an opportunity to explore the historical conditions, the campaign itself, and its consequences for contemporary medicine and medical ethics.

The codename T4, derived from the organisation’s central office in the Berlin Tiergartenstraße number 4, indicated the organised assassination of more than 200,000 mentally ill and emotionally disturbed citizens during World War II. In the relatively short time between September 1939 and August 1941, six ‘killing institutions’ and a perfunctorily organised administration murdered more than 70,000 ill and ‘unworthy-of-living’ people, and many others were murdered by collaborating institutions in the years that followed. Patient relatives received letters with falsified statements on reasons of death, place and date of death. The euthanasia campaign was intended as a trial run for the eventually million-fold murder of European Jews. Historical science classifies it as the implementation of the race hygiene policy of the National Socialists. In 1941, the very well-organised killing was stopped, but was succeeded by the so-called ‘wild euthanasia’, which mainly relied on starvation and overmedication with barbiturates in order to achieve its goals, to get rid of the human lives that were considered as burdensome to society.

International experts gathered in Heidelberg to share information on the T4 campaign and to evaluate the data collected. The organisers – Maik Rotzoll, Petra Fuchs and Gerrit Hoehndorf – were successful in drawing well-known representatives of international historical science, from memorial institutions, victims’ associations and other organisations. In recent years, they themselves had headed an extensive research project, funded by the DFG (German Research Foundation). This project aimed at a qualitative and quantitative evaluation of T4 patients’ files kept at the Federal Archive in Berlin. The colloquium’s objective was critical reflection on and evaluation of the research results achieved within this project.

The difficult question as to whether it is morally appropriate to subject the patient files of the victims of systematic murder to a quantitative analysis may clearly be answered affirmatively. The admissibility of 80 items into a database allows conclusions on the entire campaign and its organisation, conclusions that were previously drawn from the study of single cases. A comparison cohort of files on patients of mental clinics who were not included in the T4 euthanasia campaign allows further conclusions. The larger survey also makes it easier to place individual life histories into a context.

Within the T4 campaign, medical experts evaluated patients hospitalised in mental asylums and clinics, based on their files and special registration forms (Meldärkten). The evaluation criteria were oriented by so-called ‘hierarchy of handicaps’. This trend was, she recently, it had been assumed that the label ‘unfit to live’ was used to define citizens suffering from hereditary diseases, which supposedly posed a threat to the quality of the German Volks. This view is currently undergoing revision, as the selection criteria seem to have been subject to wide variations, depending on the area as well as the particular point in time. The capacity to work, and therefore the measurable exploitability of a patient, seems to have had greater influence on the expert evaluation than actual hereditary disease or other reasons related to racial hygiene.

This result is rather startling, particularly as the T4 experts were also involved in the anthropological investigation that intended to chart the entire German population. This programme was based on the work of the interdisciplinary ‘Science Speaks To Policy’ programme of the London School of Hygiene and Tropical Medicine history group, where all the authors collected in this volume have worked at some point in their careers. Each essay examines a particular aspect of network theory and its implications for the study of health policy in postwar Britain.

In the early 21st century it seems almost self-evident that health policy should, in Berridge’s words, “be based on the best available evidence, research or science”. But this is, as she shows in her introductory essay, an idea with a history, finding its roots in the changed relationship between medical research and government policy in the aftermath of World War II. She takes pains to point out that this is not a broad-brush history of ‘science’ or ‘societal science’ and its relationship to policy making, but very specifically the history of evidence and policy in health and medicine. Berridge also provides a short discussion of what exactly a research policy network might consist of, what it might look like and how it might behave, drawing on the substantial historiography of network theory for this purpose.

The body of the book is divided into three themed sections: ‘Making public health policy’, ‘Evidence and health services’ and ‘The media, science and policy’. The essays touch on many of the major themes in health policy since 1950: smoking; heart disease; alcoholism; drug abuse; the tension between cost-based and need-based provision of expensive treatments such as renal dialysis or intensive care; and the growing media presence of scientific and medical research. One obvious omission here is HIV/AIDS (though this is mentioned in passing by several authors), and a network-based analysis of medical and media constructions of the disease would have fitted well into the third section of the collection.

Following Berridge’s lead, each author sets out to historicise their case study in health policy. Luc Berlivet’s essay traces the transformation of epidemiology by Richard Doll and Bradford Hill’s work on the relationship of lung cancer and tobacco in the 1950s and its role in shaping new discourses of public health conceptualised in terms of ‘causation’ and statistically generated ‘risk factors’. Betsy Thom persuasively challenges the idea that governmental guidelines for alcohol intake have ever been based on clinically determined evidence. Sarah Mars shows that in the writing of the first official recommendations for the treatment of drug abusers in 1984, the personal experiences of an ‘expert’ panel with no supporting clinical evidence were deemed sufficient for determining good practice.

Perhaps the most compelling section is the third, written entirely by Kelly Loughlin. She argues that with the development of mass media from the 1940s and 1950s, public relations became a central part of scientific and medical research. This trend was, she claims, reflected in the ritualisation of media contact with governmental guidelines for alcohol intake.
The Catalogue of Jyotisa Manuscripts in the Wellcome Library

Rahul Peter Das, in his magnum opus, proceeds to tell us about the origin of the life of a human being in ancient Indian ayurvedic and Kama Sutra literature. Among the questions he asks at the outset is: ‘What happens in a woman’s body at the time of conception?’ Thus women are, empirically speaking, centre stage in this voluminous work, though the same cannot be said in an analytical sense.

Das’s foray into studying sexological literature stems from the fact that the focus of this work is the origin of life, to answer the question of how human beings come into existence, the physical fact of intercourse between the male and the female assumes utmost importance. Owing to this, even while eight chapters of this work deal with ayurvedic treatises such as the Charaka Samhita and Sushruta Samhita (plus commentaries by Cakrapani Dutta and Dalhana), Astangasamgraha of Mall and Madhavanandana, one chapter deals with orgasm and ejaculation as elaborated in the sexological literature (Kamashastra and Yasodhara’s commentary, Ratnavahaya, Nagarsuvavsa, Ratnavatnapalika, Ratisastra etc.).

Das states that his intention is to study how ancient Indians came to grips with the problem of the role of the female in conception. But his attempt at understanding this issue lacks critical insight. What he fails to appreciate is that the sources with which he is dealing are essentially gendered. Ayurvedic texts are always addressed to the bhisaja or to the buddhiman, pandita, or bidvan (the physician, wise or learned man and the scholar – all masculine categories). Therefore, the nature of their queries and the solutions that they advance are framed within a gendered context.

While describing the female who reaches orgasm prior to her male partner, Das is mystified as to why it should be treated in the ayurvedic texts as a disorder. The answer to this lies in the fact that for the ayurvedic writers such a woman was seen as not being attentive/receptive to a man’s semen due to her being lost in the ecstasy of sex. As such, her state was considered a disorder.

Das notes that for ayurvedic writers the procreative fluids of both the male and the female were considered important for conception. It follows that the organs of women too, must have been considered of paramount importance for begetting progeny. Das wonders how it is then that the subject of female orgasm is not discussed in greater detail in the medical texts – which, after all, contain detailed discussions on other matters relating to conception and embryology. He answers that the discussion on orgasm in ayurvedic texts was regarded as superfluous because it was to be found elsewhere. He then zeroes in upon the Kamashastra as the source of such a discussion.

What Das is unable to appreciate here is that if female orgasm was something to be discussed in the Kamashastra alone, the same logic is not applicable to male ejaculation, which should also have been discussed only in the sexological literature. But we see that ayurvedic writers do not apply the same standard to men and women. In the Astangasamgraha, one whole branch of medicine, vraschiksha, deals exclusively with semen and its treatment as well as the treatment of the penis (suya, mendra) that discharges it. While vajikarana or vihnlikarana for men is prominently discussed, a woman’s menopausal stage is completely ignored.

If ayurvedic texts prioritise male sex and treat female sex as a disorder, it is therefore of much consequence. Wherever female desire is asserted, it is marginalised (in the Kamashastra) or treated as a disorder (as in Ayurveda).

The main body of this book has been augmented with several supplements on special items of Indian medicine and sexology. Furthermore, at the end of the text there is a thorough appendix where select technical terms and medicines from ayurvedic texts are juxtaposed with those of the Greek and yunani traditions. This exhaustive and scholarly work will serve as a useful resource for research scholars for a long time to come.


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The Catalogue of Jyotisa Manuscripts in the Wellcome Library

Mall to “Kashmir, Bikaner, Jodhpur, Jaipur, Ajmer, Bharatpur, Gwalior, Badaun, Bahalpur, Haidarabad, Mysore, Tanjore [and] Travancore”.

In 1954, the famous Indian Sanskritist V Raghavan had looked at 3000 of these Sanskrit manuscripts in the Wellcome Library, which became very useful to Pingree when he set out to work on his catalogue in 1983. Pingree’s labour of two decades has resulted in this lovely and most valuable volume. Pingree also acknowledges here the important effort of Wujiastik, who organised the manuscript “in a rational way, assigning to each as it was ‘identified a shelf-mark’, and prepared ‘handlists of the texts in many of these manuscripts’. The documents recorded in this volume mostly belong to ancient Indian Jyotishastri (astronomy, mathematics and astrology).

Scholars working in this field will find this volume singularly valuable, for all the manuscripts within have been “catalogued and identified: a detailed introduction to the volume describes how this has been done. David Pingree has truly rendered a most significant service to indology in general and to manuscriptology in particular.

Reproductive Health in India/ Old Potions, New Bottles

KAI KHIUN LIEW

For better or worse, the story of colonial medicine has generally been the familiar imposition of ‘modern’ Western medical regimes on previously timeless non-Western traditions. In turn, the scholarly assessments of this legacy are usually benchmarked along the extent of influence and control of the colonial state, or its specific public health institutions. Despite the critical insights generated, the historiographical directions of colonial medicine are still largely dependent on the perspectives of medical and public health officials taken from official records. With the primacy given to the state, it becomes inevitable that the role of society becomes perceived as marginal in the grand tussle between tradition and modernity.

The various articles in Reproductive Health in India, edited by Sarah Hodges, and Kavita Sivaramakrishnan’s Old Potions, New Bottles, seek to refocus the lens on the negotiations of non-state subjects with Western medical discourses. Deviating from the mainstream theories of the hegemonic and patriarchal natures of the increasingly medicalised maternal health institutions, the authors in Reproductive Health in India portray significantly more active players shaping medical discourses according to relatively fluid notions of ideals of progress and civilisation. Collectively, these accounts present an extrapolated social interest towards reproductive and maternal health beyond the government hospitals and clinics were in their infancy, these guilds catered to the increasing demands of the medical market, evén to the extent of taking public health responsibilities in containing epidemic outbreaks. In the meantime, they sought to professionalise their practices through establishing officially sanctioned medical schools, setting up medical journals and advertising therapies in the vernacular press. In the process, Old Potions, New Bottles represents an important case study in revealing the growth of new traditions rather than the romanticised ‘resistance’ of apparently antiquarian crafts in the encounters with colonial medicine. Both books not only open up new potentials for archival research, but also further sensitise the understanding of the sociocultural dynamics of medical discourses and interactions: interactions that took place outside the realms of the state.


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Gandhi himself, the control of childbirth became increasingly linked with the fate of Indian civilization. While these groups were trying to incorporate ‘modern’ ideas, the medical guilds or vaids in colonial Punjab were in the process of ‘reinventing tradition’ in response to the competition from what they saw as Western medicine. The consolidation of British rule in the region might have corresponded with the gradual disenfranchisement of royal physicians in the Punjab courts. But the fortunes of these players were not representative of ‘traditional’ medicine in the territory. Instead, the rapid socioeconomic changes to the colony, particularly urbanisation and the spread of the printing press, empowered the status of the vaids. Where the government hospitals and clinics were in their infancy, these guilds catered to the increasing demands of the medical market, even to the extent of taking public health responsibilities in containing epidemic outbreaks. In the meantime, they sought to professionalise their practices through establishing officially sanctioned medical schools, setting up medical journals and advertising therapies in the vernacular press. In the process, Old Potions, New Bottles represents an important case study in revealing the growth of new traditions rather than the romanticised ‘resistance’ of apparently antiquarian crafts in the encounters with colonial medicine. Both books not only open up new potentials for archival research, but also further sensitise the understanding of the sociocultural dynamics of medical discourses and interactions: interactions that took place outside the realms of the state.

The Wellcome Library is returning to its historic home as part of Wellcome Collection on 16 April 2007. Popular author Sebastian Faulks will officially launch the new and vastly enhanced Library, which houses over 2.5 million items spanning 3000 years.

The refurbished Library accommodation will provide easy access to far more of its collections, an attractive and spacious Rare Materials Reading Room and Viewing Room, a state-of-the-art Conservation studio, and an E-Learning Room. The entire Library space of 23,000 square feet will be Wi-Fi-enabled and the Library will be open six days a week.

The return to Henry Wellcome’s intended location at 183 Euston Road comes at a significant time. The opening of Wellcome Collection will enable the Library’s collections to be seen by the public in new ways, and at the same time the Library is about to embark on a programme of digitisation of the collections, to enable researchers to access them from anywhere in the world.

Uncover – a virtual library – will be unveiled in June. Uncover will allow browsers to explore the Library virtually – to create their own ‘exhibition’, go on a ‘tour’ of the collections, view items in detail, hear Library staff describe the significance of items, and send images to others. The Wellcome Trust Medical Photographic Library will also re-launch as Wellcome Images. This is a digital image collection of about 200,000 images depicting medical and social history, as well as contemporary healthcare and biomedical science. Images will be available on demand in digital form, and where possible will be released under a Creative Commons licence for non-commercial use.

All lectures take place at Wellcome Collection, 183 Euston Road, London NW1 2BE. Registration is not required.

• Wednesday 25 April, 13.00–14.30
  A Miracle Happened There: The West and central African smallpox eradication programme and its impact
  Dr Joel G Breman (Senior Scientific Advisor, Fogarty International Center, National Institutes of Health, USA)

• Wednesday 2 May, 13.00–14.30
  The Last Challenge: The Horn of Africa
  Dr Ciro A de Quadros (President and CEO, and Director of International Programs, Albert B Sabin Vaccine Institute, Washington, DC, USA)

• Wednesday 30 May, 13.00–14.30
  The Global Eradication of Smallpox: Historical perspectives and future prospects
  Professor Donald A Henderson (Professor of Medicine and Public Health, University of Pittsburgh; and Resident Scholar, Center for Biosecurity, University of Pittsburgh Medical Center, USA)