Calendar of events

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

SEPTEMBER 2007

5–8 **22nd Congress of the British Society for the History of Medicine**
University of Dundee
Contact: David Wright (**E** dr.david.wright@virgin.net)
www.bshm.org.uk

12–15 **European Association for the History of Medicine and Health Conference**
Brunei Gallery, SOAS, London
Contact: Ingrid James (**E** ingrid.james@lshtm.ac.uk)
www.lshtm.ac.uk/history/EAHMH.html

13–15 **One Hundred Years of Tropical Medicine**
Conference celebrating the centenary of the Royal Society of Tropical Medicine and Hygiene, Queen Elizabeth II Conference Centre, London
Contact: Nina Woods (**E** n.woods@elsevier.com)
www.rstmh.elsevier.com

20–21 **Public Enemy No. 1: TB since 1800**
Conference, Centre for the Social History of Health and Healthcare, Glasgow Caledonian University
www.gcal.ac.uk/historyofhealth/

25 **Clinical Pharmacology in the UK *c.*1950–2000: Industrial and regulatory aspects**
Witness Seminar with Dr Jeff Aronson (University of Oxford), Wellcome Trust Centre for the History of Medicine at UCL
Contact: Wendy Kutner (**E** w.kutner@ucl.ac.uk)
www.ucl.ac.uk/histmed/events/

OCTOBER 2007

11–12 **Journeys into Madness: Representing mental illness in the arts and sciences, 1850–1930**
Conference, Wellcome Trust, London
Contact: Sabine Wieber (**E** sabine.wieber@plymouth.ac.uk)
www.plymouth.ac.uk/pages/view.asp?page=17933

24–25 **Children, Disability and Community Care from 1850 to the Present Day**
Conference, Swansea University
Contact: Pamela Dale (**E** pamela.l.dale@exeter.ac.uk)
www.centres.ex.ac.uk/medhist/conferences/children/

NOVEMBER 2007

22 **Back to the Monastery: Evolution in the design of hospitals for the mentally ill**
Talk by Professor RHS Mindham (University of Leeds), Thackray Museum, Leeds
Contact: John Turney (**E** john.turney@ntlworld.com)

29–30 **Medicine and Space: Bodies, buildings and other borders**
Anglo-Dutch Wellcome Symposium, Radboud University of Nijmegen, Netherlands
Contact: Patty Baker (**E** p.a.baker-3@kent.ac.uk)

JANUARY 2008

9–10 **Second International Conference in the History of Medicine in Southeast Asia: Treating diseases and epidemics in Southeast Asia over the centuries**
Universiti Sains Malaysia, Penang, Malaysia
Contact: shakila@usm.my

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The next issue of *Wellcome History* is due out in winter 2007.

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

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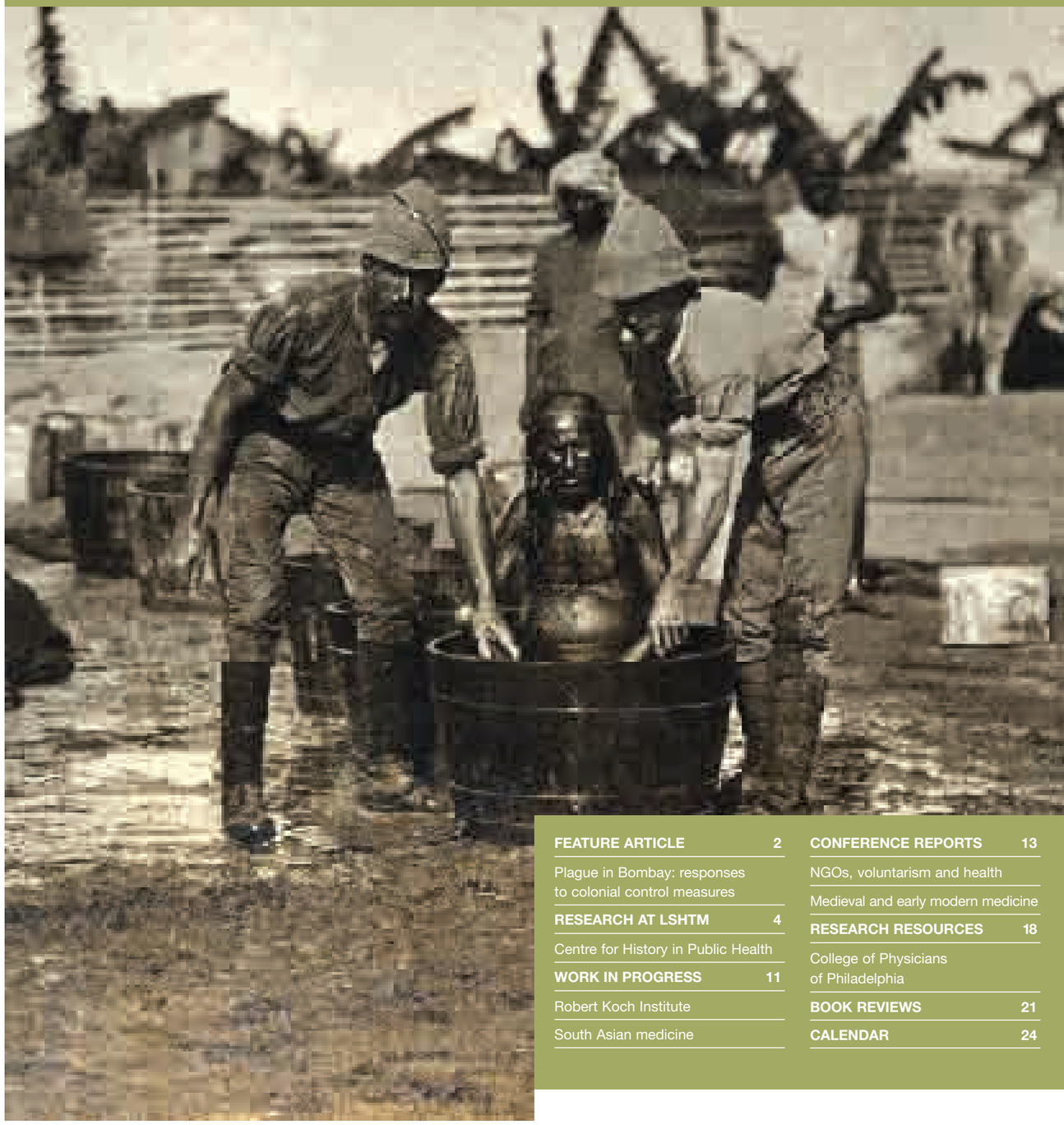


wellcome trust

Plague in Bombay

Responses to colonial authority control measures

MRIDULA RAMANNA

The 1896 plague outbreak in British India began in Bombay city. The authorities had no idea where the disease had come from, and their problems were compounded by the fact that no colonial official could confidently claim to have specialist knowledge about how to counter its spread.

The resultant panic in official circles caused the introduction of rigorous controls, in the form of mass disinfection, inspection of homes, segregation, isolation, hospitalisation and – in case of death – even corpse inspection. The measures were frequently culture- and gender-insensitive, invading homes and violating beliefs about ritual pollution.

Analysis of Indian reactions to this unprecedented state interventionism, based on extracts from contemporary newspapers and on reports from different parts of Bombay Presidency, shows that while directives may have been formulated centrally, the sensitivity of the officers on the spot determined responses. Local commentators would, thus, contrast F W Gatacre's handling of the situation in Bombay city to the abrasive manner of W C Rand, chairman of the Poona Plague Committee.

While Gatacre had relied on civilian help and volunteer committees, the latter had depended upon military aid. The intense hostility to the interventionist measures in Poona culminated in the assassination of Rand and Lt Ayerst (who was mistaken for another officer on plague duty) in June 1897. These events had a notable impact on the formulation and application of official policies. After the so-called Rand incident, rules were amended so that British soldiers would take no part in the search parties and would remain outside the premises; instead, Indian soldiers, accompanied by Indian volunteers, went in to look for possible plague cases, and women were examined by female doctors in their own homes.

What is noteworthy is that responses were not uniform among indigenous communities. Voices were raised in a public meeting against Badruddin Tyabji, by some of his fellow Muslims, for supporting Gatacre's campaign. While some resisted all controls, others accepted the need for such regulations, but objected to the mode of their enforcement. There were protests against male doctors inspecting women's armpits, against Brahmins and 'Chamars' being housed in the same segregation camps, or against Hindus and Muslims being subjected to disinfection with solution taken from the same cask. To elude the vigilance of plague officials, various ruses were adopted: hiding the sick under mattresses, keeping the sick and dead together behind locked doors and even tying up corpses and placing them in the sitting position near the cooking places, as if they were preparing meals. Many Indians attributed the plague to the carelessness of the health and engineering departments, the greed of landlords, the extreme 'irreligiousness' that had taken hold of Bombay city and the 'sins' of the rulers of the land; the health officials, on the other hand, blamed the 'habits' of their subjects.

Above: A temporary hospital for plague victims, *c.*1890s.

Right: A family made homeless by the plague outbreak, 1896/97.

Cover: Disinfecting patients during a plague outbreak in Karachi, 1897.

Rules were amended so that British soldiers would take no part in the search parties and would remain outside the premises.

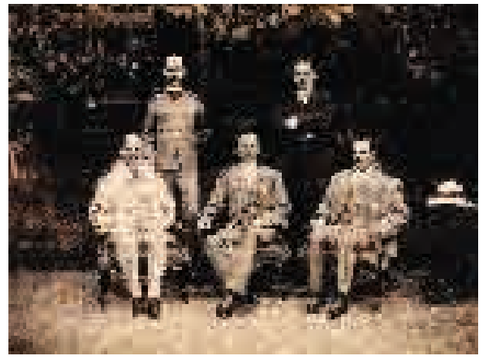
N H Choksy, who was in charge of Bombay's infectious diseases hospital, noted not only that he had to contend with the ignorance and prejudices of his patients, but also that they were beyond all help by the time they were brought in. Apprehensions that the authorities were taking people to isolation hospitals to kill them off – and widely held suspicions about the subcutaneous injections intended to fortify the strength of those suffering – resulted in the spread of a variety of rumours. It was claimed, for instance, that the patients were deliberately killed and their hearts were being sent to the Queen in England, to appease her wrath on account of the disfigurement of her statue.

Public hostility culminated in a raid on the hospital on 29 October 1896, when an estimated 800–1000 mill workers rushed in, broke open the gates and scaled the walls in order to avenge the alleged killing of patients. Some of them reached the wards, but no one was seriously hurt; they had to be dispersed by the police, who continued a vigil on the premises for some time. Choksy found that the clamour at the infectious disease hospital was not so much due to isolation *per se*, as to the compulsion in hospitalisation. Once again, dramatic events like this had an impact on official policy – separate isolation hospitals for different communities and castes were developed across the province, with 29 such institutions being started in Bombay city alone. These were financially supported by Indian philanthropists and were closed once the epidemic was considered to have abated.

From 1900, the colonial authorities abandoned medical interventionism. But plague continued to appear regularly and cause many deaths. This led to the formulation of the Government of India resolution of 1905, which sought the people's support in the fight against epidemics. Some elements of the local press hailed the policy for having the courage to admit the "futility of making war on such an enemy" without the cooperation of the people; others were less supportive. This is explained in part by the fact that the funding of the anti-plague campaign had also been a sore point from the outset of the announcement of the emergency. The cost of the anti-epidemic measures in Bombay Presidency in 1896 was 2.5 million rupees and there was annoyance that the Government of India had only paid for one-fifth of these expenses. Newspaper articles contrasted these investments in public health with the 250m rupees spent on the military campaigns on the Afghan frontier and the significant funds spent by officials every summer on the hill 'sojourns' in Mahabaleshwar and Simla.

Right: The Bombay Plague Committee, 1897.

That said, there can be little doubt that there were significant changes in practice in the early decades of the 20th century. Indeed, this period witnessed the active involvement of voluntary organisations, civic leaders and Indian doctors, who were now accepted by government agencies as important allies in the promotion of preventative medicine. Also, evacuation, a strategy that the people often adopted spontaneously, became the focus of official support; so did rat-killing (promoted with monetary inducements) and the inoculation of a prophylactic developed by Waldemar Mordecai Haffkine in Bombay city. In addition, greater efforts were made to promote higher levels of sanitary consciousness, and the setting up of the Bombay Sanitary Association (BSA) at the initiative of Choksy and J A Turner, health officer of Bombay, was an important component of these initiatives. The BSA sponsored public lectures titled 'Some common sense views on plague', as well as exhibitions and 'magic lantern' demonstrations in cities such as Karachi, Dharwar, Broach and Ahmedabad.



All these new official policies were, of course, not universally welcomed. There was, for instance, some resistance to Haffkine's prophylactic, which was partially overcome with the help of the support of Indian doctors, and local community and political leaders. A good example of this was endorsement given by the Aga Khan, which resulted in the Khoja communities in Bombay and Karachi getting themselves inoculated. Similarly, the intervention of Marishankar Govindji Shastri, an influential ayurvedic practitioner, appeared to reduce hostility to the plague vaccine. Shastri's initiatives were replicated by others.

B K Bhatavadekar, a respected doctor and civic leader, advertised the harmless nature of plague vaccination, a message that was also disseminated by the Bombay Medical Union in the early part of the 20th century. Strikingly, these efforts were also supported by nationalist leaders such as Bal Gangadhar Tilak and Gopal Krishna Gokhale: the latter organised a team of volunteers, led by Gopal Krishna Devadhar, who worked closely with the municipal agents charged with the task of propagating inoculation, rat destruction, evacuation and the orderly disposal of the dead.

It was claimed that patients were deliberately killed and their hearts were being sent to the Queen, to appease her wrath on account of the disfigurement of her statue.

All these trends point to the significance of studying regional specificities in relation to the control of epidemic outbreaks of diseases such as plague before efforts are made to develop overarching generalisations about British India as a whole. This regional review shows that colonial officials cannot all be tarred with the same brush of being uncaring. At the same time,

Indian responses were characterised by internal contradictions and variations, which are worthy of detailed assessment by historians of colonial medicine.

Dr Mridula Ramanna is a Reader attached to the History Department at SIES College, University of Mumbai, India (**E** mridularamanna@hotmail.com).

The Centre for History in Public Health at LSHTM

VIRGINIA BERRIDGE

The Centre for History in Public Health at the London School of Hygiene and Tropical Medicine (LSHTM) began as the AIDS Social History Programme in the summer of 1988, funded by the Nuffield Provincial Hospitals Trust. Sir Edgar Williams, the Chair of Trustees, was a historian and the Trust saw AIDS as "history in the making".

Despite generous funding, the early years of the programme were not easy. The grantholder, Professor Patrick Hamilton, died suddenly. The programme itself was relocated in different departments and units as the School underwent a period of necessary restructuring. My Co-Director, Phil Strong, died of a heart attack in 1995.

The historical work in the programme began to expand from 1990. Betsy Thom came to work on an alcohol policy project funded by the Economic and Social Research Council (ESRC). My first grant from the Wellcome Trust funded Jenny Stanton to look at hepatitis B as a 'precursor' of HIV.

My post was short-term and the negotiations to secure it were lengthy and complex. Dr David Allan of the Wellcome Trust was a great support. In 1996, when I was promoted to Reader, years of short-term contracts came to an end. From 1997, a Trust-funded programme, Science Speaks to Policy, drew on themes that had arisen in the AIDS work. The final 'book of the programme' has now been published, along with other outputs along the way.

Further developments have built a critical mass. Funding for an archivist was achieved after lengthy negotiation (the archive catalogue is now online at www.lshtm.ac.uk/archive). In 2002 the 'history group' was awarded School Centre status. The School supported a University Award at senior lecturer level, to which Martin Gorsky was appointed in 2003. He and I successfully applied for a Wellcome Trust five-year Enhancement Award, which began in 2004.

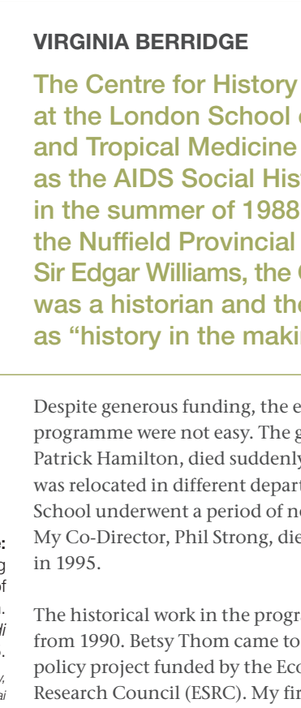
Currently the Centre consists of one professor, one senior lecturer, two part-time lecturers (Ornella Moscucci and Kelly Loughlin) and three research fellows (Susanne Taylor, Rachel Herring and Alex Mold), and includes attached staff (Ginnie Smith, Susanne Macgregor, Stuart Anderson and Ros Stanwell Smith, who runs our public health walks). Joanna Moncrieff is a clinician fellow, working on postwar mental health. We have a cross-School network of supporters and a management committee with School and outside membership. Funding, in addition to our core support from the Wellcome Trust, has come from the Joseph Rowntree Foundation, the ESRC, the Medical Research Council, the National Institute for Health and Clinical Excellence and others. All staff, with the exception of Martin Gorsky and myself, are soft funded.

Our focus is generally on public health from the mid to late 20th century and health services inter- and postwar, with an interest in cross-cutting issues such as science, evidence and policy; voluntarism and gender; and a subset of projects on substance use history. Particular projects currently include binge drinking, the medicalisation of cannabis, and health and social care intersections; some are surveyed in other articles in this issue. Our Enhancement Award has given us two PhD studentships and two MSc studentships this year. This year our seminar theme is international health; we recently held a workshop on health voluntarism. Overseas visitors add to the vitality. Linda Bryder, Signild Vallgarda and Dorothy Porter have been in the School in 2006, with Dorothy giving our annual public health lecture.

There are plans for the future that involve the consolidation of our interrogation of the nature of mid-to-late 20th-century public health. Being historians in a School of public health is not always an easy matter, as the history of the Centre itself makes clear. However, the location offers many opportunities. Two examples of interaction: an afternoon interview session with School visitor Dr Jeff Koplan, former Director of the US Centers for Disease Control and Prevention, saw colleagues question him about his career and some fascinating insights about relationships with the Bush Administration. I am interviewing School staff who have worked as health advisers in completing a study of the use made of history by policy makers. The location offers an exciting opportunity for historical development that support from the Trust and the School has made possible.

Professor Virginia Berridge is Head of the LSHTM Centre for History in Public Health.

Right: A malaria poster and an AIDS ribbon sign (*Sasha Andrews*). International health has been a recent seminar theme.



Above: Cartoon showing the failure of plague serum. From the *Hindi Punch*, 1905.

Fort Library, University of Mumbai

New publication

Medieval Islamic Medicine by Peter E Pormann and Emilie Savage-Smith.

This new analysis takes a fresh approach to the history of medical care in the lands of Islam during the medieval period (*c.*650–1500). Drawing on numerous sources, many previously unpublished, the authors explore the development of medicine across the social spectrum, comparing and contrasting medical theories and treatises with evidence of actual practices, as well as folkloric and magical medical traditions. It is the story of contact and cultural exchange across countries and creeds, affecting people from kings to the common crowd. In addition to being fascinating in its own right, medieval Islamic medicine formed the roots from which modern Western medicine arose. Contrary to the stereotypical picture, it was not simply a conduit for Greek ideas, but a venue for innovation and change.

Taking a thematic rather than a chronological approach, the book is organised around five topics: the emergence of medieval Islamic medicine and its intense cross-pollination with other cultures; the theoretical medical framework; the function of physicians with the larger society; medical care as seen through preserved case histories; and the role of magic and devout religious invocations in scholarly as well as everyday medicine. A concluding chapter on the 'afterlife' concerns the impact of this tradition on modern European medical practices and its continued practice today. The book includes 22 black-and-white illustrations, a map, an index of historical figures and their writings, a general index, a comprehensive bibliography, a timeline of developments in the 'East' and the 'West', and chapter-by-chapter annotated bibliographic essays.

Published in the UK by Edinburgh University Press – part of the New Edinburgh Islamic Surveys, series editor Carole Hillenbrand (ISBN 978-0-7486-2067-8 paperback; ISBN 978-0-7486-2066-1 hardbound). www.eup.ed.ac.uk

Published in North America by Georgetown University Press (ISBN 978-1-58901-161-8). **E** gupress@georgetown.edu. www.press.georgetown.edu

Published in the Middle East by The American University in Cairo Press (ISBN 978-977-416-070-7). **F** +202 794 1440. www.aucpress.com

The rise of the user?

ALEX MOLD

The illegal drug user currently appears to occupy a central position in British drug policy. Drug users are represented on both national and local bodies that manage and develop treatment and other services. At the same time, users have begun to form their own groups to agitate for improvements in treatment and also broader political objectives, such as reform of the drug laws.

Since July 2004, a research project entitled Drug User Patient Groups, 'User Groups' and Drug Policy, 1970s to the Present, funded by the Economic and Social Research Council and based at the Centre, has aimed to historicise this supposed 'rise' of the drug user. The project has looked at the position of the drug user in drug policy and practice, and at the wider role of voluntary organisations in this field, throughout the recent past.

We have identified four distinct phases in the 'rise' of the user. The first phase was before the NHS, when the number of illegal drug users was very small, and they were catered for in private and voluntary hospitals alongside alcoholics. Our second phase starts in the 1960s, when drug use started to increase. Drug users played a key role in the work of many new voluntary organisations founded in the 1960s and 1970s to deal with the medical, social, legal and political consequences of drug use. However, their work was largely hidden from public view. In the third period, during the 1980s, the user began to 'come out', becoming a much more visible figure within drug policy and practice. This was partly as a result of the impact of HIV/AIDS, but also of more general shifts around the notion of patients as consumers. Such a development was more fully realised in our fourth and final phase, from the 1990s onwards. This period has been characterised by a focus on the drug user as the key consumer of drug services, but also by increased activism on the part of users themselves.

The presence of the user across these four phases suggests that the drug user has not risen in a neat, linear way. Rather, the user, to some extent, has always been involved in drug policy and practice. Our findings also raise some implications for current policy. Users might be a much more visible presence, but a number of critics have pointed to limitations to user involvement. Some have argued that user involvement can sometimes be tokenistic, a box-ticking exercise for bureaucrats. Others have questioned how far user groups can be representative of the views of all users. By setting these issues in historical perspective, this project has demonstrated that such matters have deep roots, the uncovering of which could help to enhance future policy developments.

Alex Mold is a Research Fellow at the Centre for History in Public Health.

Chasing the archive: health education records on the move

KELLY LOUGHLIN

The grey literature holdings of the Health Education Council and its successor body, the Health Education Authority, have been inaccessible to historians and health researchers since 1999, when the Authority was transformed into the Health Development Agency (HDA).

Maintaining a publicly accessible library was beyond the remit of this new organisation, and the records were placed in off-site storage. The fate of this collection, much of which is unavailable elsewhere, has been regularly monitored by historians at the Centre. The possibility of 'doing something' with this collection was first explored in 1999, resurfaced in 2002 with the HDA, and has finally come together in 2006 through the involvement of the National Institute for Health and Clinical Excellence (NICE).

NICE took over the functions of the HDA in April 2005, and inherited the collection of grey literature, which was moved to another storage facility in east London. Following discussions with the Centre, NICE agreed to fund an initial mapping exercise to establish the scope and potential of this material as a public health resource. This is the first time the organisation has funded historians. The mapping exercise had three main objectives: to provide a sense of the collection as a whole; to locate the collection in relation to postwar changes in public health and health education; and to identify specific areas or themes suitable for further development as in-depth reports.

Work commenced in July 2006, although access to the paper records proved impossible due to a serious fire at the storage facility. The fire burned for three

days. Initial reports looked bad, with suggestions that all the material was lost. The mapping exercise continued, using a database of titles and a portion of the collection that had been copied onto CD-ROM. Mapping a collection that may or may not have survived a major fire was somewhat dispiriting.

Thankfully, some 40 boxes did survive and the project went ahead. NICE agreed to fund two reports based on the surviving material: one on smoking and health, and one on HIV/AIDS and sexual health.

The records represent a valuable source on the development of postwar public health, health education and health promotion. The long-term aim of the project is to establish the collection's value as a public health resource. Ultimately, the goal is resource enhancement, whereby the collection and reports produced during the project will be accessible online, with a full-text search facility, available on the NICE website.

Kelly Loughlin is a Lecturer at the Centre for History in Public Health.

Medicalising cannabis: science, medicine and policy

SUZANNE TAYLOR

Cannabis has been the subject of much policy and media attention in the last few years. The UK's recent downgrading of cannabis from a class B to a class C drug, under the Misuse of Drugs Act, has been widely, although incorrectly, presented as liberalisation or legalisation of the drug.

These contemporary debates over cannabis's value as a medicine and its danger as a narcotic reflect a long and often controversial history. Widely used in Ancient Greek and Asian medicine, cannabis as a therapeutic was introduced to the UK from India in the 19th century. It was initially hailed as a new wonder drug, but claims of a link to insanity, the lack of an isolated active principle, supply problems and competition from the more readily utilised opium, combined with prohibitive international legislation that developed from the 1920s onwards, meant that it fell into obscurity for much of the 20th century.

Interest in cannabis's medical properties re-emerged on the Continent in the 1950s, and in the UK with the work of those such as Sir William Paton in the 1960s. The 1980s onwards saw a snowballing of scientific interest: expert committees delved into the benefits and risks of therapeutic cannabis; people with diseases lacking effective treatments, such as AIDS and MS, pressured for access; and one pharmaceutical company began developing drugs derived from it. Conversely, debates intensified over the detrimental effects of cannabis, namely in relation to mental health, as well as the possible stimulation to additional recreational use. These fluctuating perceptions of cannabis as an illicit drug or as a potential licit medicine provide a useful insight into not only the 'boundary shifts' of cannabis but also the shifting dynamics between science, industry, the lay and professional spheres, and national and international policy over the last 50 years.

Specifically, the Centre's Medicalising Cannabis project involves an examination of the role of scientific research, and encompasses the importance of different professional communities including pharmacologists and sociologists; it considers the importance of the rise of disciplines such as psychopharmacology and phytopharmacy. The role of lay knowledge and user activism has been an important aspect of the re-medicalisation of cannabis, and this project focuses

Above:
Health records.
Justine Desmond

Right:
Cannabis leaf. Kirlian photograph.
N Seery

on the role of the MS community, which has played a crucial role in the UK. The impact of scientific and policy transfer via professional organisations and expert committees such as the House of Lords Science and Technology Committee in 1997 is an important dimension. Lastly, the influence of international agencies has been of increasing importance and the international science policy exchange is being examined, concentrating on the role of the World Health Organization and International Narcotics Control Board.

The project utilises a wide variety of written and unpublished sources including Paton's papers, held at the Wellcome Library, and the minutes of the Advisory Council on the Misuse of Drugs at the National Archives. Semi-structured oral history interviews are being carried out with key scientific, industry and policy participants.

Suzanne Taylor is a Research Fellow at the Centre for History in Public Health.

Binge drinking in the UK: contemporary and historical perspectives

RACHEL HERRING

Binge drinking is a matter of current social, media and political concern. The UK Alcohol Harm Reduction Strategy states that there are 5.9 million people in the country who are 'binge' drinkers.

Binge drinking is associated with an array of individual and social harms such as public disorder and injuries. The Centre is undertaking research funded by the Alcohol Educational Research Council examining the history of binge drinking, its definition and measurement, and its current prominence. The overall aim is to draw lessons for policy through the interaction of social science and historical perspectives. Two of the key emerging themes give a flavour of the research.

First, what is evident from this study is that although the term 'binge drinking' is ubiquitous in public and policy discussion, there is confusion about its meaning and import. Within the academic literature the term has come to describe two quite distinct phenomena. One usage describes a pattern of drinking that occurs over an extended period (usually several days) set aside for the sole purpose. This definition (accepted by the World Health Organization) is the historical one, linked to more clinical definitions of alcohol abuse or dependence, such E Morton Jellinek's 1960 classification of alcoholism. This is the type of binge drinking portrayed in the Charles R Jackson's 1944 classic *The Lost Weekend*. 'Binge drinking' has also come to be used to describe a single drinking session leading to intoxication, often measured as having consumed more than a given number of drinks on one occasion. It is this second meaning that has come to prominence in recent years and that informs current UK policy. However, within this general definition there is no consensus as to what level of intake constitutes binge drinking. The result is a vast array of perplexing statistics. Moreover, there is no consensus definition of binge drinking among key stakeholders (e.g. the Home Office and the Department of Culture Media and Sport), which hampers the development of responses to binge drinking.

Right: A Victorian gin shop. Coloured etching by G Cruikshank, 1848.

Secondly, by taking a historical perspective it is clear that the current governmental concern about the 'crisis' of binge drinking follows in the footsteps of earlier responses to alcohol matters. For governments alcohol is a periodic concern and at times alcohol has largely been ignored. These periods of heightened concern and activity (characterised by copious legislation) are usually the result of concerns about the socioeconomic impact of alcohol – generally drunkenness and especially public drunkenness. Notably, women's drinking is often singled out as a matter of particular concern. These 'ingredients' are all present in the current 'moral panic' surrounding binge drinking in contemporary Britain, with its particular focus on public drunkenness and women, and has led to comparisons with the 18th-century 'gin craze'. Peter Borsay argues: "The parallels…are uncanny: street violence, damage to public health, costs to the economy, the corruption of women, the reduction of the maternal instinct, and the threat to family life and English identity." Furthermore, he says that these similarities are reinforced by the urban location of the "problem" and the key role played by the media in shaping and driving the moral panic.

Periods of heightened activity (characterised by copious legislation) are usually the result of concerns about the socioeconomic impact of alcohol…women's drinking is often singled out as a matter of particular concern.

This study has highlighted that although binge drinking is often presented as a new phenomenon it has a history, and that the confusion surrounding the concept arises in part because there has been a shift in the meaning of the term – but what remains to be answered is quite 'how' and 'why' this change came about.

Rachel Herring is a Research Fellow at the Centre for History in Public Health.

The MRC childhood leukaemia trials

ORNELLA MOSCUCCI

Widely regarded as a medical and organisational success, the Medical Research Council's (MRC) childhood leukaemia trials are beginning to attract increasing historical attention.

This MRC-funded study focuses on the research methodologies and organisational structures that might account for the dramatic changes in both survival and recruitment rates seen over the past 50 years. When the trials began in the late 1950s, only a tiny proportion of children diagnosed with acute lymphoblastic leukaemia (ALL) survived for more than five years. By the mid-1990s the five-year survival rate had increased to 80 per cent in both sexes. Recruitment to the trials has also increased considerably over time. Only 40 children were enrolled in the first trial that started in 1959. By the early 1980s, this figure had risen to 1614 patients.

The MRC childhood leukaemia trials can be seen to represent the successful application of an organisational system widely advocated by clinical researchers since the 1930s: the cooperative approach. After the discovery of antileukaemic agents in the late 1940s and early 1950s, multicentre trials became central to the evaluation of chemotherapeutic regimes for childhood ALL – not because they were associated with better science, but because of their reputation for efficiency. As the compounds used for leukaemia possessed only marginal activity, single hospitals could rarely make enough observations to give adequate data in a reasonable amount of time. The advantage of the cooperative approach was that it enabled researchers to gather large numbers of patients in the shortest possible time.

Led by haematologists, the movement for clinical trials for leukaemia got off to an uncertain start in the late 1950s as clinicians proved unwilling to give up their autonomy and conform to a common plan of treatment. Many practitioners also resisted the idea of trials for childhood leukaemia on both ethical and practical

grounds. The momentum for trials nonetheless built up in the mid-1960s as news of American breakthroughs in the treatment of childhood leukaemia began to reach the UK. Although British haematologists were sceptical about such claims, parental and media pressure forced the profession to give more serious consideration to the work of the American cooperative groups.

The series of trials that started in the early 1970s aimed to replicate the US research, but the more modestly endowed NHS setting made direct copying of the Americans impossible until sufficient resources were put into the provision of adequate supportive treatment. The research to date has revealed important differences of opinion between clinicians and statisticians over methods and objectives, highlighting the growing influence of the statistician as the trials' 'policeman'. It has also shown the value of the trials structure to clinicians both as a source of advice and as a means of establishing a consensus around treatment regimens.

A report summarising the preliminary findings of the research has already been submitted to the MRC. Plans for further work are currently under discussion.

Ornella Moscucci is a Research Fellow at the Centre for History in Public Health.

NHS and service integration

MARTIN GORSKY

My research focus is the history of Britain's health services in the 20th century. I recently published (with John Mohan) a history of the hospital contributory schemes.

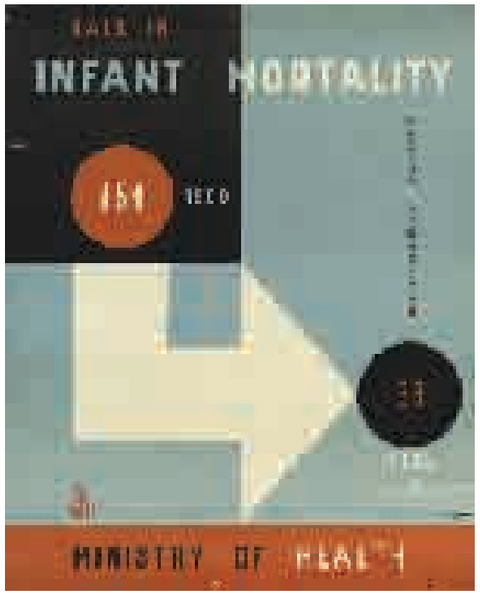
The book sheds new light on the pre-NHS funding and administration of hospitals and on the subsequent development of private medical insurance. It also raises questions about the extent of popular participation in hospital governance before 1948, an issue especially salient today in the debates about 'patient power'.

My principal research project is a regional study of the coming of the NHS, organised around the theme of service integration. A central motif in the policy debates that preceded Bevan's reform was the need for greater 'coordination' between the disparate providers of British healthcare: the voluntary hospitals and associations, the public health, public assistance and education arms of local government, national health insurance and private practice. Yet the tripartite system that emerged in 1948 did not solve this problem and fissures remained, for example between health and social care (soon manifested in the 'bed-blocking' controversies) and in the marginalisation of public health within local government.

The project explores these issues in the period between 1929, when the Local Government Act inaugurated a new phase of municipal health provision, and 1974, when the health service reorganisation sought to strengthen administrative coherence. The geographical focus is the area that under the NHS became the northern region of the South West Regional Hospital Board: Somerset, Gloucestershire, and the cities of Bath, Bristol and Gloucester. An early output discusses the widely cited Gloucestershire Extension of Medical Services Scheme (see *Medical History* 50, 2006), an interwar experiment in rural medical provision that unsuccessfully attempted to fuse private and public facilities.

The next publications will deal with the Poor Law institutions mutated in the postwar period into chronic care hospitals or residential homes; these explore the extent to which the public assistance legacy left mental health and long-term care isolated and financially disadvantaged in the early NHS. Indeed, a key theme will be the continuities over the period, notably the emergence in the 1930s of a regional planning elite of doctors, academics and industrialists who consolidated their role in the 1950s.

Martin Gorsky is Senior Lecturer at the Centre for History in Public Health.



Right: Ministry of Health poster proclaiming lower infant mortality, 1939.

The Robert Koch Institute for Infectious Diseases during National Socialism

MARION HULVERSCHEIDT

Since May 2006, an interdisciplinary research group has been investigating the role of the Robert Koch Institute for Infectious Diseases during the National Socialist era. Three researchers are accompanied by an advisory board made up of renowned historians of science, historians of medicine and contemporary historians.

Over a two-year period three research projects will investigate the material available, produce scientific articles and a monograph on the Institute, and organise a workshop and a congress on the subject. Much to do, but this seems like a good path for a new kind of institutional history intending to decisively influence the history of science.

The public health policy and the population policy during National Socialism are the subject of intensive historical research. While the Robert Koch Institute for Infectious Diseases (RKI) was not the focus of these recent research projects, it has always been part of the envisioned landscape, as it was an integral component of the state health administration. Some of the employees were involved in medical war crimes in concentration camps, such as for example Claus Schilling or Eugen Haagen. Schilling headed the department for tropical medicine at the RKI until 1936, when he retired from this position. In 1938 he went to Italy to work on his lifelong research quest for a malaria vaccine. He continued to work on this issue in the Dachau concentration camp near Munich between 1941 and 1944. During these trials more than 1200 unconsenting inmates were infected with malaria. Schilling was prosecuted and convicted in Dachau and hanged in 1946.

Eugen Haagen, one of the leading virologists in Germany in the 1930s, was involved in involuntary typhus fever trials and the use of humans in testing vaccines against the fever. Between 1936 and 1941 he worked at the RKI as head of the department for virology. Others held important positions in the polycratic science system of the Third Reich, such as Gerhard Rose, Schilling's successor in the position as head of tropical medicine. Rose also held the position of a physician-general (*Generalarzt*), and was the advisory expert for hygiene and tropical hygiene at the air force sanitary inspection. Furthermore he served as an adviser for healthcare in the forced resettlement in eastern Europe. The department of tropical medicine at the RKI is the subject of one of the projected detailed studies.

Largely civilian in nature, the work of the smallpox and rabies research department was for a long time characterised by a consistency of research objectives, research fields and staff. These '*long-durée*' departments seem to be prolific subjects in a field of international research and are the focus of another detailed study.

During these trials more than 1200 unconsenting inmates were infected with malaria. Schilling was prosecuted and convicted in Dachau and hanged in 1946.

Looking at the Institute, its departments, research members and research topics, the predominant impression is one of great heterogeneity, making it somewhat difficult to discern relevant issues and questions. This research group wants to focus on the range of research questions, asked at different times, by different persons, in different connections. This seems to be a promising approach for understanding the different influences within medical research and science. Taking this into account, it seems worthwhile to focus on the interconnections with, and the threats the Institute presented for, other persons, institutions and subjects.

My detailed study focuses on blood group serology, which was the topic of research of several RKI departments. In the beginning of the 1930s, this was still a relatively new and innovative field; legal implementation was only achieved in 1928.

Right: Claus Schilling, who experimented on Dachau inmates in search of a malaria vaccine.

It was therefore still under critical examination. Blood group serology was subject to strict quality control, which on the civilian sector was one of the tasks the Reich's health department (*Reichsgesundheitsamt*, RGA) and the RKI. Authority went back and forth between the RGA and the RKI, which may be interpreted as an indicator of persistent competition between these two Berlin institutions. Blood group serology at the RKI was mainly related to forensic questions: paternity tests and blood group determination in criminal cases, supplemented by race-serological blood tests from hunting and wildlife preservation, such as determining whether blood on a poacher's clothing came from boar, deer or rabbit. Blood group determination for blood transfusions was of minor importance only, at least as far as may be determined from the number of requests. Nevertheless, the RKI was given final control of the blood group determination for the civilian blood donor programme introduced in 1940.

An important question is which department within the RKI was actually responsible for blood group determination. Ostensibly, this seems to have been the department of serodiagnostics, lead by Werner Fischer. This department was founded in 1938 through a reorganisation of the entire Institute. But Günter Blaurock, an RKI staff member at the department for tropical medicine, who had previously been employed at the Cologne Institute for Hygiene, was also involved in the determination of blood cell characteristics. He continued to do so during his time at the RKI; his signature may be found under a letter to Adolf Würth, an assistant to the 'Gypsy' researcher Robert Ritter. The letter referred to the examination of 600 blood samples, which Ritter and his staff had taken from 'Gypsies'.

Peter Dahr had also worked at the Cologne Institute for Hygiene before coming to Berlin, as the head of the division for blood group research to the RGA. This is where he worked from 1942, creating 'in personam and institutionam' competition to Werner Fischer. Nevertheless, both parties were members of the German Association for Blood Group Research, a National Socialist, racist organisation that was subject to critical observation by foreign colleagues. This association aimed at creating an international inventory of blood groups, using the distribution of blood groups within individual populations as an indicator for racial and national difference.

What is remarkable is the fact that blood group serology, even though it was not classified as 'war-important', received such extensive attention at the RKI during the National Socialist period. This attention did not cease after the end of the war, which was only in part due to this sector's lucrativeness: the postulation of the rhesus factor and its clinical relevance within the scope of erythroblastosis turned it into a meritorious field of research. This development, too, is characterised by competition in and around the RKI, which shall be highlighted in this project.

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The social fabric of medicines in South Asia

LAURENT PORDIÉ

The recent reform of the French Institute of Pondicherry in India aimed to foster its role as a mediator – a platform where researchers from many disciplinary backgrounds and nationalities would base themselves to advance their work in the study of India and South Asia.

Such is the case for the international Societies and Medicines in South Asia programme. A network of over 40 researchers and PhD students, belonging to European, American and Asian (mostly Indian) universities and research institutions, has established itself as a regional research unit on the social production of South Asian medicine.

The programme intends to study the present state of healing systems and their historicity. The general objective is to understand how contemporary therapeutic spaces are constructed, identified and legitimated. To this end, research is conducted in social and medical anthropology, history, geography, political sciences and economics. While the various therapeutic practices of the region are the chosen port of entry, it is in fact entire sections of the concerned societies that are studied here. After all, medicines – and more generally the means of which people avail to prevent, relieve or heal suffering and disease – are formed, transformed and reformed in the field of health and beyond. The use of the 'medical' as a prism makes a thorough exploration of the social world possible, an exploration that becomes all the more relevant through the comparative approach offered by this programme.

The programme explores themes such as the networks of power surrounding health, therapeutic innovations, the transnationalisation of 'traditional' medicines, and the government politics pertaining to health and the body. These encompass a number of fundamental questions concerning the political dimensions of health and issues of medical and social identities, which constitute the very framework of the programme. Besides these themes that concern all projects, vertical axes of research are also retained. They pertain to the institutionalisation of therapeutic practices and the study of governance, the commoditisation of indigenous medicines, and their biomedicalisation, especially in the case of clinical trials and the quest for efficacy. Research is examining the social logics at play in the transformation of folk medicines and religious therapies, scholarly indigenous medicines, or homeopathy.

Empirical data and theoretical approaches are the object of group discussion; methods and approaches are shared and compared, with the aim of enhancing the heuristic dimension of each individual work. While there is certainly still a lot to undertake to improve the efficiency of the programme, Societies and Medicines in South Asia exemplifies the necessity for modern research to leave aside individual, isolated works, and to embrace collective and collaborative enterprises.

Details of activities (publications and thesis abstracts, individual research highlights, lectures, conferences, etc.) can be found at www.ifpindia.org/Societies-and-Medicines-in-South-Asia.html.

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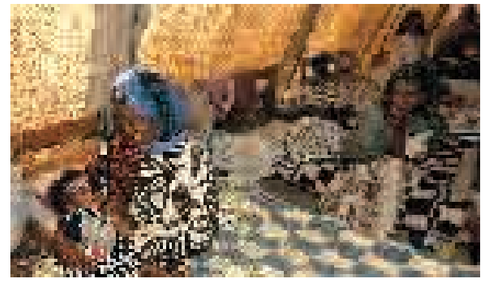
NGOs, voluntarism and health

ALEX MOLD

On Wednesday 22 November 2006, researchers from a range of institutions came together for an afternoon workshop on NGOs, voluntarism and health. This workshop, at the Centre for History in Public Health, London School of Hygiene and Tropical Medicine, was designed to provide historical and contemporary perspectives on the role of voluntary organisations in health and healthcare.



Right: French voluntary hospital in Eritrea. *N Durrell McKenna*

The workshop began with a presentation from the Centre's own Martin Gorsky, who spoke about community involvement in hospital governance before the NHS, looking specifically at the contributory schemes supporting the hospitals run by voluntary organisations. Particularly interesting were the connections he made between this work and the current attention being devoted to community involvement in foundation hospitals.

This contemporary focus was extended by Judith Allsop (University of Lincoln), who presented a summary of her collaborative project on health consumer groups, assessing their contribution to policy and practice and looking at the limits to this. She began by addressing some definitional problems, explaining why she had chosen to use the term 'consumer group' rather than patient or user group.

Issues of definition also cropped up in James McKay's (University of Birmingham) presentation on the Database of Archives of UK Non-Governmental Organisations (DANGO). He explained that the term NGO was used instead of voluntary organisation because the team felt this conveyed a sense of 'doing' – a sense that these organisations were (and are) sociopolitical actors.

After tea, Alex Mold (LSHTM) gave an overview of the project she and Virginia Berridge have been working on around illegal drug user groups and voluntary organisations. She questioned the extent to which there had been a 'rise of the user', pointing to user involvement in the past, and to tensions around the current position of the drug user in policy and practice.

The afternoon's final speaker was Jude Howell, Director of the Centre for Civil Society at the LSE. She outlined some key issues in the changing contours of donor–civil society relations. A central concern was an apparent backlash against the notion of civil society, and the dilemmas this raises for donor and receiver countries alike.

The workshop was concluded by Susanne MacGregor (LSHTM). In her closing remarks, she offered the view that the 'big idea' at work in all of these presentations was the rise and fall of the welfare state and the move to issue-based politics. This stimulated further discussion from speakers and audience alike, giving everyone more to think about for their own future research.

Dr Alex Mold is a Research Fellow at the London School of Hygiene and Tropical Medicine's Centre for History in Public Health.

Approaches to the history of medicine: discussing methodology

LISA GRANT AND KAT FOXHALL

Despite gales playing havoc with the transport network, 20 scholars made it to Warwick on 19 January 2007 for an informal workshop explore methodological approaches to the history of medicine.

The organisers had felt that there was a need for an event exploring new approaches to medical history as a discipline, rather than being constricted by a thematic agenda. In particular the day was aimed at academics in the early stages of their careers in order to provide a space to work through queries and explore a range of debates. Four invited speakers led the sessions.

The day was started by David Arnold, who has recently joined the University of Warwick from the School of Oriental and African Studies. He revisited his own major work *Colonizing the Body* and explored wider debates surrounding colonial bodies, medicine and control, as well as positioning his own current work within a wider emergent interest in the 'global'. Initial discussion questioned the claims to universality of 'Western' medicine, with Professor Arnold suggesting that these were implicit as early as the 17th century in the writings of travellers. It was asked whether former colonies were re-evaluating their own place within colonial medical systems, and whether colonies are insufficient areas of debate. Should we be considering shared regional experiences, for example, across South and East Asia? Among the themes that emerged clearly in this session was the centrality of conflict in the history of the colonised body, a theme that re-emerged throughout the day.

Right: Mummy of Ramses II. The diagnosis of tuberculosis has been challenged.

Claudia Stein's (Warwick) exploration of approaches to disease reflected her own diverse research interests, from the French pox to AIDS, and the varying ways in which diseases can be explored historically, from palaeopathology, through social construction and Bruno Latour's questioning of the diagnosis of tuberculosis in Ramses II, to Rosenberg's 'framing' and Sontag's 'illness as metaphor'. Stein's talk raised many important questions, including whether a current disease such as AIDS should be considered the same disease, or indeed treated in the same way, in South Africa or Britain. Further questions again raised the question of conflict, and whether resistance is inbuilt to any given episteme. Explicit in her discussion of approaches to disease was the need for historians to choose a concept or theory reflecting their own worldview.

Medical geography, argued the University of Birmingham's Jonathan Reinarz, is the key to transcending traditional thematic barriers within the discipline. Historians have generally regarded science and medicine as 'placeless'; however, it was concluded that medicine is most certainly dependent on the place in which it is conducted. Reinarz urged a return to local history and reviewed works by Cresswell, Livingstone, Naylor and Warner, who have used medical geography to demonstrate the interconnectivity of scientific and medical history. The session reviewed the Foucauldian concept of 'spatial nomadism', and opted in favour of Chris Philo's 'spatial precision' as a concept requiring more attention from scholars. Colonial medical historians have traditionally been conscious of place as a key factor in writing history, and the links between David Arnold's earlier presentation were capitalised and expanded upon. It was suggested that only through an increased awareness of medical geography can scholars in the discipline hope to 'synthesise the disparate micro-studies' that have been written and move forward with productive, comparative analysis of hospitals, cities, countries and regions.

The final session of the day was conducted by Flurin Condrau from the University of Manchester. Building on themes explored by the previous speakers, he examined the historiography of the 'view from below' and raised a heated debate on the feasibility and productivity of attempting this type of history. Where is the patient in medical history and did he/she even exist before bioscience invented the concept of the 'patient'? After examining cultural and social approaches to conducting history from below, Condrau suggested the importance, especially in late 19th- and early 20th-century medical history, of taking into account the politics of medicine. Patients and power relations in modern history are an important vehicle for understanding policy development and implementation. There is undeniably a problem of sources and bias in writing the history from below, but it was largely agreed that the benefits of such an approach far outweighed the drawbacks.

The level of debate and participation confirmed the need for conversation between widely divergent interests, all focused on the uniting principle of health, its importance in the past and its relevance around the world today.
The organisers would like to acknowledge the support of the Wellcome Trust in providing funding through the Warwick Centre for the History of Medicine Strategic Award, all the attendees, and in particular the speakers for providing four completely different, but equally impassioned and enthusiastic discussions about what constitutes, and is important in, the history of medicine.

Lisa Grant and Kat Foxhall are PhD students at the Centre for the History of Medicine, University of Warwick.

Medieval and early modern science and medicine

JENNIFER RAMPLING

On Friday 23 March 2007, 20 postgraduates attended a PhD workshop that focused on developing the research skills necessary to tackle pre-modern history of science and medicine.

The workshop resulted from an observation made by University College London's Anne Hardy during the Wellcome Trust doctoral training programme at UCL. It was a shame, she had remarked, that no dedicated doctoral training was available for historians of medicine working on the early modern period. As a lonely medievalist-cum-early modernist myself, I took her point. Students researching medieval and early modern science and medicine face particular challenges, often having to acquire or refine language and palaeography skills in parallel with the main thrust of their research, while using material that may be dispersed, fragile or incomplete.

Four months later, the PhD Workshop on Medieval and Early Modern Science and Medicine took place at the University of Cambridge, funded by the Wellcome Trust and Cambridge's Department of History and Philosophy of Science (the latter also providing the venue). Twenty current and prospective PhD students arrived from universities across the UK, and even as far afield as Vienna, to discuss their research, make new contacts and improve their skills. The aim of the workshop was to provide the most practical advice possible – how to frame appropriate questions from a range of material, how to read difficult texts, whom to ask when problems arose with any of the above, and other issues relating to the daily practice of research.

An overview of the historiographical issues facing early modernists was provided by Andrew Wear (Wellcome Trust Centre for the History of Medicine at UCL), who opened the workshop. His talk was followed by a panel session on framing research questions. Stephen Clucas (Birkbeck, University of London) spoke on approaches to textual sources, Sachiko Kusukawa (Trinity College, Cambridge) on images and Timothy McHugh (Oxford Brookes University) on using data, while Catherine Eagleton of the British Museum not only discussed objects but also produced a mysterious instrument borrowed from Cambridge's Whipple Museum. Following some hands-on examination and a ten-minute crash course in early modern instrument design, participants were able to comment on the function and provenance of the object – a 17th-century ship-shaped sundial.

Right: Caesarean section. From *Apocalypsis S Johannis cum glossis*, *c.*1420–30

After lunch, a second panel session discussed the practical skills necessary for research in the medieval and early modern periods. Peter Forshaw (Birkbeck) introduced the problems of translation and language acquisition, and Tessa Webber (Trinity) spoke on palaeography and working with manuscripts. John

Young, Transcription and Tagging Manager for the Newton Project, provided an online guide to electronic editions, and Alisha Rankin (Trinity) concluded the panel by discussing approaches to archival research.
The workshop closed with a Q&A session, after which speakers and students repaired *en masse* to the Eagle pub.

Throughout the day, a number of common themes emerged. One was the sense of isolation often experienced by researchers working on pre-modern history of medicine and science, and the corresponding delight generated by meeting several dozen like-minded addicts. The feedback exercise captured this enthusiasm. "Meeting other students" and "being inspired" were frequently cited as the most valuable overall results of the day. The need for planning and perseverance was also stressed, illustrated by terrifying moralia of researchers arriving at libraries to find missing or irrelevant archives, or battling with illegible script. A successful research trip, clearly, is as much a practical as an academic exercise. Happily, another clear theme was the availability of expert assistance for those in such dire straits, thanks to the generosity of palaeographers, linguists, archivists and curators in communicating their knowledge to junior scholars – an enthusiasm and generosity of spirit that was abundantly in evidence on the day.

Jennifer Rampling, who organised and chaired the workshop, is a doctoral student at the Department of History and Philosophy of Science, University of Cambridge.

Epidemics in South Asian history: a review of medical, political and social responses

ROHAN DEB ROY

This international conference was held within the campus of Burdwan University (West Bengal, India) on 7–9 November 2006. It was jointly organised by the Wellcome Trust Centre for the History of Medicine at UCL and Burdwan's Department of History, and was generously funded by the Wellcome Trust.

The spectre of epidemics has historically played on the imaginations and anxieties of a wide range of medical officials and civilian populations. Thirteen historians of medicine in South Asia, including globally acknowledged experts and a few graduate students, presented refreshing new analyses. Indeed, the presentations went beyond the conference goals. The papers did not confine themselves to merely detailing the implementation of public health policies – apart from assessing a variety of medical and civilian attitudes and the nature and impact of different diseases, the papers also dealt with shifting identities of various maladies described as epidemics, the relationship between dramatic outbreaks of disease and everyday practices, the responsibility of non-medical perceptions in shaping attitudes towards disease control, and, not least, attempts to problematise the use of the term 'epidemic' in 'scientific' and 'indigenous' medical theory.

The conference started with a keynote address delivered by Harold J Cook, Director of the Wellcome Trust Centre. His paper, 'Global History and Medical History: Opportunities and challenges' proposed a methodological shift involving the shedding of the insularities imposed by national boundaries; the paper did not undermine the relevance of the 'nation' as the geographical frame for medical history, but attempted, instead, to decentre it. Ideas about 'epidemics', he suggested, were objects of medical knowledge that traveled through routes of trade and empire.

Presentations by Mark Harrison and Sanjoy Bhattacharya followed. These continued to engage with methodological questions relevant to the writing of medical history in South Asia. Highlighting new possibilities in the history of diseases in colonial India, Professor Harrison spoke on the relationship between the emergence of medical stereotypes as well as the shaping of disease identities with the convergence of place names and names of maladies (for example, Burdwan fever). His paper hinted, also, at the connections between the emerging geographies of empire and the perceived geographies of disease incidence. Dr Bhattacharya dealt the need to return to historical archives, with their multifaceted collections; he also urged caution in relation to the development of overarching and simplistic generalisations that are frequently based on preconceived ideas and incredibly little systematic research. Using examples of his work on colonial Indian smallpox control policies, he argued that careful empirical work could be used to question several assumptions about the politics of healthcare in India that have been unquestioningly accepted and propagated by numerous historians.

The proceedings of the second day began with detailed addresses by two Wellcome Trust representatives – Clare Matterson, Director of Medicine, Society and History, and Tony Woods, Head of Medical Humanities.

Right:
A plague victim being lowered onto a cremation pyre, 1896/97.

Ms Matterson spoke on the history of the Trust, the vision as well as the implications of the legacy of Sir Henry Wellcome; her speech outlined the Trust's most important academic agendas and their relevance to South Asia. Dr Woods, in turn, focused on funding strategies for Asian scholars in relation to the history of medicine; he gave patient and informative answers to many queries from the floor.

The academic programme then continued. Achintya Kumar Dutta spoke on a subject he has been engaged with for quite some time: the history of Kala-azar in eastern India. He spoke on how perceptions of the disease were informed by the circulation of plantation labour from Bihar into Assam. Sujata Mukherjee's paper traced the manifold ways in which the discourse on malaria in colonial Bengal was shaped by the traffic of nascent environmental ideas in British India and the imperial metropole. Kavita Sivaramakrishnan's richly researched paper was an effective follow-up, and she showed how factional rivalries between the urban elite in Punjab shaped multiple responses towards colonial plague interventions. Kalinga Tudor Silva's paper, on the changing terms in which the identities of fevers were articulated through the course of the 19th century in British Ceylon, stoked further discussion and debate, about the formulation and deployment of the term 'epidemic disease'.

The next paper dealt with government measures in tackling plague epidemics in the Bombay Presidency between 1896 and 1920. Presented by Mridula Ramanna, this went beyond the tendency to refer to a rigid colonial reforming state, the unquestioning groups of native collaborators and, not least, the supposedly monolithic groups of resisting local nationalists. Referring to the figure of the Indian Western-educated doctor, she talked, convincingly, about the multilayered tensions in relation to colonial efforts at plague control. Manjari Kamat's paper, 'Epidemics and Working Class in Bombay', showed how moments of plague-induced panic in the early 20th century revealed the stereotypical and condescending ways in which the mill owners made sense of those they employed. She went on to describe how these notions, in turn, informed the shape of disease control efforts sponsored by them. Amna Khalid kept up the tempo with a wonderful presentation that effectively problematised the simplistic 'tool of empire' thesis by highlighting the 'fractured character' of the colonial medical administration – this accomplished paper dealt with the role of the non-medical, local, lower rank of police personnel, who were instrumental in shaping and implementing medical policies in pilgrimage sites in north India.

Papers by Arabinda Samanta and Rohan Deb Roy dealt with the relationship between epidemics and everyday practice. Dr Samanta described what it could have meant to suffer from tuberculosis in the 19th century, and highlighted the trauma of the individual patient in negotiating interactions with family, colleagues and the society at large. Mr Deb Roy's paper talked about the outbreak of 'Burdwan fever' in Bengal in the late 19th century and debated whether the term 'epidemic' could be used for this episode. Harish Naraindas's paper ended the conference: dealing with an 'indigenous theory of epidemics', he argued, on the basis of the detailed analysis of a few texts, that historians needed to be attentive to the distinctions between the 'esoteric' and the 'exoteric'.

The conference provided an occasion for different generations of academics to interact; it also allowed these scholars to share ideas with young under- and postgraduate students, which was widely appreciated within Burdwan University. A cultural programme organised by the cultural committee of the local university, to honour the conference delegates, was a highlight of the conference – needless to say, everyone who attended the meeting made it clear what a great privilege it was to visit Burdwan and its university.

Rohan Deb Roy is a doctoral candidate at the Wellcome Trust Centre for the History of Medicine at UCL.

Researching the history of obstetrics and gynaecology at the College of Physicians of Philadelphia

TANFER EMIN TUNC

In the last three decades, studies in the history and sociology of technology have taught us a great deal about the processes of invention, development and diffusion. However, very few of these studies bring the insights of the history of technology to bear on medical and reproductive technologies. For example, almost nothing is known, historically, about the science and technology of physician-induced abortions in the USA between the years 1850 and 1980. No scholar has ever thoroughly explored the changing technologies of abortion during this period of time when, even though the procedure was, for the most part, illegal, its technologies were in a constant state of flux. My work-in-progress, 'Technologies of Choice: A history of abortion techniques in the United States, 1850–1980', is an attempt at filling this historical vacuum.

The research I conducted at the College of Physicians of Philadelphia helped to elucidate that between 1850 and 1980, there were three major transition periods in American abortion technology. The first of these transitions occurred between 1850 and 1900, and involved a shift from female-dominated home abortions, using herbs, to male-dominated, professionally administered abortion care, using surgical instruments (dilation and curettage or 'D&C'). The second transition occurred in the 1950s and 1960s, and dealt with the shift from late surgical abortions (craniotomies and hysterotomies) to late chemical (saline/prostaglandin) abortions. The third transition occurred between the late 1960s and the late 1970s, and involved transition from the D&C to vacuum suction for first-trimester abortions, and from the chemical saline/prostaglandin techniques to the surgical procedure of dilation and extraction ('D&E') for second-trimester abortions.

My research at the College has played a crucial role in the development of the first chapter of my manuscript, which traces the rise of the surgical abortion, or more specifically, how D&C became the dominant technique for early abortions between 1850 and 1910. Rare sources housed at the College Library, which include John Burns's *Observations on Abortion* (1808) and Horatio Robinson Storer's *Why Not?: A book for every woman* (1867), have helped to confirm the hypothesis that the transition from herbal to surgical abortions came at a moment when allopathic medical practitioners were being challenged by lay healers. Moreover, the College's extensive collection of 19th-century medical journals has also allowed me to illustrate that the American Medical Association's successful campaign to criminalise abortion during the 1860s and 1870s was not simply based on physicians' moral objections to the procedure; rather, it was perhaps more a strategic manoeuvre by a professional organisation to distinguish itself by eliminating its competition (midwives and homeopaths). My research has uncovered that articles written by allopathic physicians disparaging the herbal techniques used by alternative healers effectively channeled abortion into the surgical and physician-controlled therapeutic realm, thus eliminating the possibility that any form of abortion technology would be used by, or developed by, anyone but themselves.

The introduction of surgical techniques into abortion practice during the late 19th century also reinforced the notion that medicine was no longer an art or a vocation, but rather a profession that required special skills and training, especially in antiseptic and aseptic theory. This special training included the study of the growing number of medical textbooks that dealt with the newly emerging speciality of obstetrics and gynaecology, as well as those that were written specifically about surgical abortion techniques. The College's collection of 19th-century medical textbooks facilitated my examination of the specific type of medical ideology that was espoused by these newly professionalised American physicians, while providing insight into abortion techniques, the manner in which abortion procedures were taught, and the burgeoning industry of commercially produced surgical abortion instruments that were being used by abortion-providing physicians. Two textbooks that I found particularly useful were Robert Reid Rentoul's *The Causes and Treatment of Abortion* (1889), and Theodore Gaillard Thomas's *Abortion and its Treatment: From the standpoint of practical experience* (1890). While both texts describe surgical abortion techniques in a language that was originally designed for the ears of medical students, 21st-century historians of medicine will find these works easily accessible and saturated with rare glimpses into the private worlds of turn-of-the-century abortion-providing physicians.

In addition to housing American obstetric/gynaecological texts, the College also has an extensive collection of 18th- and 19th-century European medical texts (written in French, English and German), as well as a number of rare early 20th-century works by both US and European authors. For scholars whose focus is on modern history, the College has complete runs of major medical journals, and archival materials on prominent American physicians, especially those from the Philadelphia area. Those conducting research on material culture will find the College's varied collection of antiquities (from skulls to fetal remains to centuries-old medical instruments), most of which is on display at the Mütter Museum, particularly useful.

The College offers numerous funding opportunities to scholars who are interested in using its resources (I personally benefited from the Francis C Wood Institute for the History of Medicine Resident Research Fellowship). Application materials, and a more complete list of the College of Physicians of Philadelphia's holdings, can be found on their website, www.collphyphil.org.

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Fifteen minutes of fame

ANDREW CUNNINGHAM

You may have heard one or more episodes of a series of 30 talks on the history of medicine that I have recently done with BBC Radio 4. This is the first time I've ever been involved in any public outreach project this large, and that's one reason I thought I'd share the experience with my fellow historians of medicine. I'll come to the other reason later.

I know it was tasteless, but it was also spontaneous that I said to the producer when he first contacted me by phone: "So Roy Porter really is dead?" It's a question worth asking, because he's still publishing books! I was very surprised to be approached to do this, not because I'm not qualified to do so (after all these years in the Wellcome family I actually am), but because media people work to very short deadlines, and when they have a project on hand they naturally turn to whomever they used last time. And, as we know, Roy was a great worker to deadlines, a great media personality, and he never said no. So he used to be the first person they turned to, and as he always said yes he became the public voice of the history of medicine (and many other topics) in Britain for over 20 years. And very well he did it too. It's just that the rest of us never thought our 15 minutes of fame would ever come. But for me they did: 15 minutes every weekday for six weeks!

Well, not really, because it turned out that the actors who were employed to read the historical quotations are much more famous than I'll ever be, and they got top billing!

The series was the idea of the man I now like to call 'my producer', Adrian Washbourne, who's a staff producer in the science section at the BBC. He got it approved in outline by his bosses, and then he needed someone to write and perhaps also present it. That's where I was invited in. But in the course of doing the series I was often struck by my good fortune here: if the idea had originally been mine, then I would have had to draw up a detailed schedule and probably write several specimen episodes, and then it would have had to go to committee after committee – as I'm a virtually unknown quantity at the BBC – and would probably have been unrecognisable as a proposal when it came back. And who knows whether they would have wanted it anyway? In addition, as you can imagine, it would have probably been reshaped to fit the Whiggish prejudices of non-historians. But as it was in fact the producer's idea, all he had to do was find someone to do it, and have him or her approved by the powers that be. The actual content, message, tone and format of the episodes was then just worked out between the two of us, in a very harmonious relationship.

The programmes were to fill a weekday afternoon slot that for months had a series on the history of Britain called *This Sceptr'd Isle*. So, naturally, I initially wanted to call my series *This Septic Isle*. But one of the mysterious 'commissioners' (at first I misheard and thought they were commissionaires) thought that wasn't quite serious enough.

Medical history is simply the most interesting subject in the world! It's a story of all of the best and much of the worst of human nature, and sometimes at the same moment.

Initially the format was open. Could I have discussions with fellow medical historians in the studio, could we fly off to historical sites to do our recordings, could we try bloodletting live in the studio? But it narrowed down to me writing and presenting, and modern actors reading the words of historical actors. Anyway, the bloodletting – I was prepared for it to be my own blood – was ruled out for 'health and safety' reasons, which is a bit ironic given its historic practice as a health measure. But it was quite strange doing the recordings. There was just my producer and me in the studio, with one technical person at the machines. All quiet and low-key. I never saw the actors, and their bits were all woven into my narrative at a later date by the producer. So, even though the chair I was sitting in had much more famous bottoms in it the rest of the week, there was no feeling of:

"Here's little me doing the big series, wouldn't my Mum be proud…" Just: "Could you try that once again, but with more energy and, er, better, this time?"

As far as the theme of the series was concerned, it had to meet a number of requirements – some stated, some tacitly understood. Each episode had to be complete in itself, but the series had to have a distinct theme. The level had to be the 'intelligent talk' typical of Radio 4. To avoid current controversy, the cut-off date was set for me at the 1950s. It seems that there's never been a large series on medical history on the radio, so this was quite an opportunity. So, rather than presenting successive but disconnected 'moments' in medical history, I wanted to tell a big story, which is now encapsulated in the title, *The Making of Modern Medicine*. And given where I think modern, scientific, medicine began, it meant that there'd be a lot more modern than ancient. So we had just ten episodes (two weeks) from Hippocrates to 1789, and 20 episodes from what I call the 'big bang' to the 1950s.

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As for the choice of topics, I had to keep in mind that this was not addressed to my fellow historians, so it couldn't be a polemic or boring, nor could it be a critique of modern medicine and its ills looked at via history. It had to be interesting at first, casual, and it had to have all the big names of medical history (though not necessarily given the hero treatment). Some of the episodes are the result of my having been 30 years in the business, others from three intensive days in the library. I wonder if the Radio 4 listener could tell which are which? What I was always trying to do was to promote the fascination of medical history, and get someone, somewhere, to say to somebody else, "Did you hear that programme on hospitals (or whatever) the other day, I had no idea they were originally Christian institutions (or whatever). Isn't that interesting?" It's the sort of thing my friends and I have been saying to each other for years about other Radio 4 programmes.

Doing the series helped me remember why I went into the subject in the first place: medical history is simply the most interesting subject in the world! It's a story of all of the best and much of the worst of human nature, and sometimes at the same moment, as in the controversy over child bed fever, or more recently the competitions between teams of transplant surgeons. It's overflowing with human passion and emotion, and it's also full of the making of cold facts. I don't think that in the event I said anything that you, my fellow medical historians, would disagree with (except of course those bits that came out of my own research, which no one seems to like for the first few years).

Apparently Radio 4 listeners, never shy to express their opinions, can't bear being talked down to by academics. So they really dislike the word 'thus'. I never realised how much I use it. And the current ruler of Radio 4 can't bear 'cannot' and the like, so I had to bloke it all up a bit, and my script ended up with more apostrophes than a greengrocer's stall. From my side as a historian, I didn't want talk of any 'fathers' of anything (except children, of course), nor the 'birth' of anything (again, except children). Only one of those has got past me so far – "the birth of antibiotic treatment" (whatever kind of image that conjures up, given that the first penicillin treatment was given to a dying man!); it appeared on a BBC website associated with the programme, but I didn't get to see that first. But that sort of historical talk is everywhere and hard to stamp out.

Obviously as an academic, you have to be quite hard-skinned about criticism. But usually academic critics of our work know something about the subject (even if they're still wrong). But newspaper critics, I now see, don't have to know anything or listen properly, as long as they can sound witty. They feign repugnance to blood and guts, and then complain when there isn't any!

This is getting a bit like what the actress said to the bishop: "But enough about me, how did you like my performance?" So, time to close, with the other reason I wanted to connect with my fellow medical historians. It's to say thank you. Because in a project like this there are no footnotes: credits and thanks can't be given as they usually are in the academic world. I am grateful to a whole host of you for information and guidance I derived from your works, and the Wellcome Library of course had all the otherwise unobtainable material I needed. My former colleagues Perry Williams and Harmke Kamminga were typically generous with their knowledge, as was Debbie Brunton at the Open University, which was linked into the project. In particular, of the fellow scholars I know personally, Jon Arrizabalaga, Codell Carter, Wai Chen, Jacalyn Duffin, Nicholas Fox, Gerry Geison, Roger King, Chris Lawrence, Charles Webster and Adrian Wilson (I hope I haven't forgotten anyone) may hear their ideas in my mouth, without acknowledgement. I hope they won't feel offended, but rather gratified to hear their ideas spread to Radio 4's millions of listeners.

Andrew Cunningham is a Senior Research Fellow in History of Medicine at the Department of the History and Philosophy of Science, University of Cambridge. His Radio 4 talks are available on CD from BBC Audiobooks.

Rockefeller Money, the Laboratory and Medicine in Edinburgh 1919–1930

CAROLE REEVES

The Rockefeller Foundation, established in 1913, launched a massive global scientific and medical makeover, which in developed countries involved the reform of medical education and the attempt to create university clinics dedicated to scientific investigation. In furthering its programme of human betterment by single-mindedly promoting "the American way of health", the Foundation frequently rode roughshod over local traditions and practices.

British medicine was criticised for its lack of specialisation, its focus on anatomy at the expense of physiology, and its general suspicion of laboratory methods. There were further controversies over part-time versus full-time chairs of medicine and surgery as advocated by Rockefeller, and in the British time-honoured practice of promotion through the ranks rather than appointment on merit.

Christopher Lawrence examines Rockefeller involvement in Edinburgh medicine during a 'crisis' decade of confrontation not only between cultures but also between champions of the new medical science and those steeped in an older tradition, who valued individualism and the art of clinical judgement. By the 1920s, however, familiar clinical disorders such as diabetes and thyroid dysfunction were being recast as 'metabolic diseases' and the laboratory test was raised to definitional status. Clinical biochemistry as an adjunct to patient care appeared in Britain chiefly during this decade. The Biochemical Laboratory at Edinburgh Royal Infirmary was created and directed by Jonathan Meakins, an energetic Canadian appointed first Christison Professor of Therapeutics (1919). Meakins soon attracted an international team of talented young scientists but maintained the delicate symbiosis of University and Infirmary by combining research with routine investigations.

Onto this stage stepped Richard Pearce, Director of the Rockefeller Foundation's Division of Medical Education, who believed that he could do "valuable missionary work" in Edinburgh that would benefit the whole of the British Empire. Using a well-honed strategy of enlisting inside help from a reform-minded individual and dangling a heavy purse before the Faculty, Pearce determined to overhaul Edinburgh medicine and its medical school around the thoroughly modern Meakins. His British adviser in this exercise was Walter Morley Fletcher, Secretary of the Medical Research Council, an institution sharing Rockefeller ideas about what constituted medical innovation. The story of politicking and manipulation that took place in an effort to release the Rockefeller purse strings while retaining inbred traditions older than the American colonies is told with a wry humour and Lawrence's intuitive understanding of Scottish cultural idiosyncrasies. Meakins, meanwhile, homesick and frustrated with his colleagues' "lack of cooperation and coordination", debunked to a new Rockefeller-funded university clinic at Montreal (1924), being replaced by the home-grown (and in Pearce's terminology, second-rate) David Murray Lyon.

The work of the Biochemical Laboratory under its two very different directors is the central theme of the book. Lawrence outlines the growth of routine testing and Meakins's attempts to import a new style of medical thinking into the Infirmary based on the investigation of physiological problems (especially of metabolism) in health and disease. Edinburgh's insulin trials, first reported in May 1923, embodied the ideal of academic medicine. Murray Lyon's programme was closer to the clinic than the lab and to pathological anatomy than to physiological chemistry. While a few clinicians used the lab as a stepping-stone to a scientific career, its history during the decade was far from being one of continual academic progress. The Infirmary, for example, "placed an absolute ban…on experimental animals". Analysing the case notes of Edwin Bramwell, Professor of Clinical Medicine and a rather traditional physician, Lawrence demonstrates the confusion and occasional blunderbuss approach of clinicians embracing the new diagnostics while endeavouring to preserve their bedside skills.

There are many levels to this rich reconstruction of an early 20th-century laboratory but no winners or losers. Modernisation on Rockefeller lines, even with Rockefeller money, was not inevitable when older cherished models of the social order were challenged. The distinctly Scottish as opposed to 'British' nuances are here superbly defined in the first study of Edinburgh's encounter with the new medicine.

Lawrence C. Rockefeller Money, the Laboratory and Medicine in Edinburgh 1919–1930: New science in an old country. Rochester, NY: University of Rochester Press; 2005.

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A Bibliography of Medical and Biomedical Biography

DIANA E MANUEL

This publication has a long and one might say distinguished lineage. It is the last of a trio of medical bibliographies published collaboratively since 1989 by two librarians, friends for 42 years, one of whom – Leslie Morton – died at age 96, following completion of the manuscript for this work but prior to its publication.

Both librarians had worked in a range of university and medical institutions. Morton had already, during World War II, been preparing a bibliography of significant texts in the history of medicine as an extension of the prewar checklist of Fielding Garrison. His own resulting publication *A Medical Bibliography* was published in 1943 and Garrison's name generously appears before his own; it became well known under the soubriquet 'Garrison–Morton'.

The authors/editors of the present publication had themselves in their first joint publication taken up the mantle of John Leonard Thornton, whose two editions of *A Select Bibliography* had appeared in 1961 and 1970. These works had been confined to books published in the English language during the 19th and 20th centuries. Significantly, in establishing his criteria for inclusion, Thornton had already acknowledged that biography was more than a mere list of dates and achievements, and he excluded such material as often hagiographical pieces (frequently written by medics). He could be said to have helped pave the way for reflecting in his works of reference the expansion during the second half of the 20th century the increasingly diverse range of scholars researching in the field of history of medicine and the rise in the intellectual standards of work produced. These scholars were and are in disciplines including philosophy, history, sociology, literature and art, as well as the wide range of sciences, technology and public health.

In their joint work, Morton and Robert Moore recognised the importance of including sources in periodical literature, in archival collections and in other European languages at least. Not surprisingly, their initial count of about 2000 entries soon extended to 3700. They also appreciated that an alphabetical index of the individuals whose biographies were being included, rather than of their biographers, was essential. Furthermore they have been imaginative enough to include a few 'truants from medicine', individuals who qualified as medics but who devoted their careers mainly to politics, the arts and other subjects. Thus Arthur Conan Doyle has continued to find a place in all three editions.

It is research in the sciences, technology and public health that has informed and driven forward the practice of clinical medicine and it is interesting that Professor Lord Robert Winston, whose initial education and training were in medicine, always describes himself as a scientist. There are others, including the really scientifically notable Colin Blakemore. Morton and Moore have shown pleasing awareness of this situation by trying to provide some reference material on topics such as named diseases and on themes such as physiology. Some of these categories have but a single entry.
It is not surprising that the authors seem to have been overwhelmed in their ambitious endeavour by the sheer amount of material they needed to handle, indicating the degree of specialisation within the sciences and their application to medicine, surgery and related areas, and which could have been included. Such inclusion would have greatly further expanded the work and involved even more time for its completion.

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While the internet will now probably be the first port of call for most researchers and others interested in history of medicine, this book still represents a repository of much valuable source material.
And who will act as these two librarians have sought to, as selective gatekeepers of the often ephemeral material online? In the introduction to their first joint work, they declared that the completion of any bibliography is a hazardous undertaking because of the risk of omissions and lack of balance. Hence one small quibble that underlines the scale of their task and the vanity of the present reviewer: why, having included the reviewer's 1980 Royal Society publication on Marshall Hall (1790–1857) did they not also include or replace it with the later book on Marshall Hall published in 1996?

Morton LT, Moore RJ. A Bibliography of Medical and Biomedical Biography, 3rd edn. Aldershot: Ashgate; 2005.

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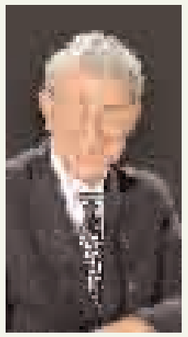
Obituary



Professor William Ian McDonald MB ChB PhD FMedSci FRCP FRACP FRCOphth (Hon) and Hon DSc; neurologist and medical historian; born Wellington 15 March 1933, died London 13 December 2006.

Over some 40 years Professor McDonald made a number of outstanding medical and scientific contributions to the understanding of multiple sclerosis. He was also widely respected as a medical historian and an Associate of the Wellcome Trust Centre for the History of Medicine at UCL since 2004.

I was very fortunate to have met Prof. McDonald, albeit recently: in trying to locate someone else at the Centre he happened to ask me for directions. Recognising his face, and knowing that so many historians and physicians had strongly advised I meet him, I dared to delay his search and introduce myself. His response was characteristic: his generous smile and genuine interest was immediately matched by a diary date for lunch.

Over lunch we discussed his native New Zealand and the practices and personalities of the neurologists who were his mentors. He brought them to life with a warm and at times wry humour. He studied medicine at Otago University and completed his PhD in 1962. The following year he moved to the National Hospital for Neurology and Neurosurgery, Queen Square, London, which became his professional home for the majority of his career. He began his experimental research on demyelination and remyelination at a time when it was unusual for neurologists to actively engage in laboratory research. In 1966 he demonstrated that demyelination resulted in slowing conduction in nerves. In the following decade he illustrated that delays in visual evoked responses provided invaluable information in optic neuritis. In the 1980s, Prof. McDonald understood that magnetic resonance imaging could demonstrate, non-invasively, the pathological changes in patients suspected of having MS. From 1984 to 1995, he developed and directed a research unit at Queen Square supported by the MS Society. He was on numerous editorial boards and a past president of the European Neurological Society and Association of British Neurologists. He received the Charcot Award in 1991 and the John Dystel Prize for MS Research in 1999. These are but a few of his many achievements; still he found time for his wider interests, one of which was the history of medicine.

He was Harveian Librarian at the Royal College of Physicians of London from 1997 to 2004, a role he greatly enjoyed and found intensely fulfilling. While there, he safeguarded for the Library the Wilton Psalter, an illuminated medieval manuscript written for use at Wilton Abbey.

Prof. McDonald had been a regular attendee at the seminar series run by the History of Twentieth Century Medicine Group, now part of the Wellcome Trust Centre. The Group was created to bring together historians, scientists, clinicians and others interested in the history of modern biomedicine. Tilli Tansey, the Convenor of the Group, says: "It was in 1991 that Ian first came to give a lecture on the history of MS at a symposium I organised on the history of neurosciences. We had known each other since I was an MS Society Research Fellow in the early 1980s. We shared an interest in medical history, and when I left the lab we kept in touch – usually through the Physiological Society or over lunch at the Garrick Club. In 2000 I asked him to join the Programme Committee of the Twentieth Century Group, and he remained a member until his death. He was always extraordinarily diligent in reading through all the proposals we receive for Witness Seminars, and commenting on each. I always appreciated his advice, and often his suggestions for wording a tactful 'rejection' of an unsuccessful proposal."

His particular historical studies were the history of the idea that the functions of the brain depend on electricity, Gordon Holmes, and the institutional history of Queen Square. His posthumously published article on Holmes outlines the significance of a 'neurological heritage' that Prof. McDonald held dear. Prof. McDonald was tremendously modest but he knew what he could achieve and help others to achieve. He was a really constructive mentor, an excellent lecturer, and he gave of his time and amusing conversation generously.

His personal and descriptive account, published in 2006, of a small stroke he suffered is testimony to his generosity of spirit and easy communicating style. The stroke affected his ability to read music and play the piano expressively. As a neurologist, musician, writer and recovering patient he had much to offer us.

During the service of thanksgiving, held on 24 April 2007, at the beautiful St Marylebone Parish Church, Professor Shirley Wray recalled the many happy dinners that she had shared with Ian and his partner, Stanley Hamilton. She noted that "he was an extraordinary man, with an extraordinary life" and whom she will miss tremendously. She is not alone.

My thanks to Tilli Tansey for her comments.

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