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Preface

Sam Willner

We have the pleasure to welcome guest editor Professor Patrice Bourdelais from EHESS, Paris, to introduce this thematic issue of Hygiea Internationalis, mainly focusing on cultural aspects of public health history. The issue is based on selected articles presented at an international conference, Cultural History of Health and Beyond, held in Paris in September 2005. We would like to express our sincere thanks to Professor Bourdelais and all contributors to this interesting volume.

We will also invite our readers to submit articles dealing with the history of public health to coming issues of Hygiea Internationalis.

Introduction
Cultural history of medical regulations

Patrice Bourdelais

This issue is mainly focused on cultural and political changes in public health regulations since the end of the nineteenth century in several European countries. The most important task for historians, except of improving knowledge, is to analyse conditions in the past and to explain how and why they have changed, leading to the world we know today. One part consists of verifying the facts and events as precisely as possible. Another part is to analyse the situation and the factors responsible for evolution and changes. This is linked to general questions asked within social sciences, and to how historians use theoretical and methodological tools developed by other scientific disciplines. The set of articles presented here provide a wide range of examples of the historians' practices today and of the current state of research. As far as medical and public health history is concerned, the medical profession, the states, public institutions, and the population are traditionally seen as the main actors. But since the end of the nineteenth century, biochemical and pharmaceutical companies, media and international institutions have been more and more present.

Nevertheless, it would be naïve to think that, because of the numerous and extensive programmes implemented at that time, the importance of diet, environment, housing and behaviour as factors of personal and collective health was not acknowledged before the First World War, The Hippocratic tradition, rediscovered in Europe during the second half of the eighteenth century, emphasised the role of climate, local environment, diet and habits. The medical doctors paid attention to the public health during the nineteenth century. Hygienists tried to show the links between the mortality level and the gradient of wealth with Louis René Villermé as the foremost protagonist. At the end of that century, even after the discovery of the tuberculosis bacillus by Robert Koch, the representatives of the socialist movement argued that living conditions and the exhaustion of work were the most important factors for contagion, more than spitting and alcoholism, as claimed by the medical faculties.

The first dispensaries appeared at the end of the nineteenth century and just before the First World War. However, no coherent and broad programme to fight diseases and promote living conditions of the poor was implemented. The major reason for this lack of response is that the liberal ideology led governments to avoid public expenses. This reluctance explains why the role of philanthropy was so important.

The First World War changed the world of public health politics. The loss of millions of young men, the discovery of extended vulnerability to TB during the war, and the Communist revolution in Russia, led to a redefinition of priorities. The population had to be more efficiently protected against infectious diseases, leading to the implementation of extensive interventions to fight tuberculosis, venereal diseases and social health problems such as prostitution and alcoholism. It was argued that the poor population must be assisted with new lodging and housing programmes, making it less vulnerable to diseases and less susceptible to communist ideals. Hence, the political culture became more positive to public health regulations.

A first set of articles in this volume deals mainly with the ways in which medicine and public health has been more and more seen in the light of a social dimension. The example of projects lead by the new international institution, the League of Nations Health Organization (LNHO) during the interwar period are in line with ideas emerging during the nineteenth century even if, for instance, the role of nutrition had by then been further supported by science. The importance of the international institutions was to provide contacts and collaboration, especially during the period with huge political tensions between the states. What had not been possible to organize before the Great War was suddenly put on the agenda and implemented. Comparative surveys were organised by the LNHO from a social and contextualised approach as shown in Iris Borowy's article. To some extent this approach fitted well for authoritarian regimes, such as the Soviet Union Italy and Germany but some aspects were also appreciated by democratic states.

In each state the social dimension of public health policies was developed, theoretically and through the implementation of institutions or practices. Esteban Rodriguez Ocaña analyses the change from the use of biological terms to describe society to the introduction of social concepts within Spanish medicine, including the evolution of social medicine as a branch of public health. He describes how 'social diseases' were defined, showing that it "became an outstanding rhetorical device to attract public interest, and consequently money and jobs which produce new specialties through the timely health campaigns". The main priority areas for policy were infant mortality and tuberculosis, serving as models for other diseases. These campaigns also helped medical professionals to reinforce their monopoly, to strengthen the argu-

ments for political interventions by compensating for the bad conditions of work and life of the large majority of the population by massive programmes of prevention and care.

Another example from the inter-war period is the article about the First Czechoslovak Republic (1918–1938) by Hana Masova. The new political authorities tried to improve the situation after the disaster of the war by medical and social interventions and by creating new institutions in which preventive and curative measures could be complementary. Dispensaries were developed and the American Red Cross and Rockefeller Foundation brought money and organizational aid. The paper analyses how the district of Vršovice-Praha XIII used the newest available techniques in social hygiene and healthcare when coordinating social work and health service.

The circulation of knowledge on social hygiene and medicine was also found in the general media. Linked to the new public health institutions and to the new agenda more oriented to social factors, a large number of "educational" movies were produced in all European countries during the interwar period, Enrique Perdiguero, Rosa Ballester and Ramon Castejon present the case of Spain, especially focusing on two movies as examples of health campaigns directed against the high rates of infant mortality. They analyse the forms and the contents of the movies, which emphasize the role of medicine as a solution to the problems addressed, arguing for the importance of traditional values, including the special role of the woman in the family context. Some change in the latter respect is, however, observable during the Spanish political regime of 1928–1936 with less focus on "catholic" values and a less traditional image of the woman, for instance showing her when taking part in sports activities

A large number of this type of movies, devoted to traditional health campaigns, were produced in many European countries between the two World Wars, urging for more comparative research.

The second set of papers is more focused on different regulations in European societies regarding new medications, the fight against TB and venereal diseases, health insurance systems and the prevention against medical quacks and charlatans. Taking the case of the serum against diphtheria and its concomitant production in France and in Germany, Axel Huentelmann compares the ways in which the two states regulated the quality of the products. In Germany, several pharmaceutical companies produced the serum and the sale was controlled by the state, which delegated the oversight to different State institutions such as the Imperial Health Office and the Institute for Serological Research and Serological Survey. In France the story turns around the Pasteur Institute. There was no direct state control over serum production, and after the initial approval of the serum producers, the quality control of the

serum remained in the hands of the producers themselves. The analysis shows a complex reality with a lot of differences but also similarities between the cases.

It is difficult to speak about state activities in public health without considering the cases of tuberculosis and venereal diseases. Ida Blom compares the regulations of these two diseases in three Scandinavian countries: Norway, Denmark and Sweden. Differences appeared between the countries, in chronology and in the type of constraints imposed to ailing people. Due to different modes of contamination, venereal diseases were less of a threat for the whole society than tuberculosis but controls were obviously stricter for VD than for TB. Moreover, a gender dimension is evident. Women were seen as the main danger and hence the most controlled and prosecuted until recent years. Ida Blom also proposes explanations why the three neighbouring countries did not apply exactly the same policies due to their particular political, cultural and epidemiological histories.

During the interwar period, many European countries organized health insurance systems. Maria Isabel Porras presents results from a comparative study of the implementation of compulsory health insurance systems in France and Spain, two countries with different economic and social structures but very close in terms of medical issues. After the limits set by the policies of the nineteenth century mentioned above, the priority was to provide care for poor people at the turn of the next century, for instance represented by the French law on Free Medical Aid in 1892. But the trade unions of medical doctors were opposed to state intervention, fearing that it might reduce their free practice of medicine. This tension was present in France and in Spain until the Second World War, which delayed the introduction of new public medical insurance systems. Internal French debates were to some extent imported to Spain and adapted. There, the opposition against state involvement ceased after the Civil war by the arrival of the Franco's dictatorship. In France the same resistance was progressively weakened after the 1930 when "assurance social laws" were passed and after the Second Word War the entire system of Sécurité sociale was introduced. Finally the system included a compulsory health insurance which respected the principles of liberal medicine. Today we have learnt that social security systems, which gave access to care for the entire population, also proved to be been beneficent for the economic prosperity of the medical professions.

The complexity of regulations appears clearly in the case of the history of homeopathy in Sweden and the "Pill scandal" in the 1950's analysed by Motzi Eklöf. She shows how the history of homeopathy in Sweden passed through prosperous decades as well as periods of decline. A wide range of factors are listed as reasons for the decline, for instance the fear for all sort of sectarianism

after the Second World War the increased social legitimacy of the established medical science and the sensitivity of public opinion to "affairs and scandals". Finally, a trial against a homeopathy manufacture to produce just sugar pills, introduced a new strategy of charging lay healers with fraud instead of health quackery, which proved to be a successful weapon for the medical establishment. More generally, this episode addresses questions about the place of alternatives medicines in European societies.

The third set of papers is more oriented towards cultural issues. The links between enlightenment, science, medicine and religion are elaborated in the case of the Catholic Western Germany around 1800 by Walter Bruchhausen. He shows that they were more complex than usually thought. Many university professors in medicine were also be engaged in religion and it was not considered contradictory for them to be positively involved in the Enlightenment movement. For a previously rarely studied period, Sünje Prühlen gives her results from a work in progress regarding wet-nurses in European German speaking regions from the late Middle Ages to the Early Modern Period with examples of different Western European practices.

All the contributors to this volume demonstrate how - even if differences exist between countries – a common pattern was shared in Europe at the end of the nineteenth century and the beginning of the twentieth century, particularly regarding the acceptance of the necessity of the state's involvement in public health regulation. It became evident that, in order to make real and sustained progress, both medical knowledge and social reform had to be included in public health policies.

The last sentence of an important book by the Belgian doctor René Sand, one of the pioneers of social medicine, gives us a taste of the flavour of the global project: "By building a shelter, making clothes, kindling a fire, fashioning implements, or raising dams, primitive man claimed to be the master of his destiny. It behoves his descendants now to banish disease, poverty, ignorance and neglect. Sociological medicine is one of the instruments which will bring us nearer to this goal"[1].

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1 René Sand, Health and Human Progress. An essay on sociological medicine, London, Kegan Paul, Trench, Trubner and Co., 1935, p. 260.

International Social Medicine between the Wars
Positioning a Volatile Concept

Iris Borowy

The League of Nations Health Organisation (LNHO) was the first worldwide health organisation with a comprehensive mandate which enabled it to address a wide, almost unlimited, range of topics. This freedom of action proved a blessing as well as a curse. During the first decade of its existence the LNHO became involved in a large number of diverse problems without an overriding issue that would have lent direction and profile to their overall work. In the 1930s, it seemed to have found such an issue in social medicine.[1]

Social Medicine was an important topic in a number of countries in the early twentieth century. Though it had its origins in the nineteenth century, it reached its apex between 1930 and about 1948. It remained an elusive concept, which different people could interpret in different ways but as a central defining trait it had "at its core … a critical approach to health care that stressed the social determinants of disease."[2] This principle fairly described a number of large-scale studies organised within the LNHO, which came to overshadow all other areas of activities in their

1 See Iris Borowy, "Die Gesundheitsorganisation des Völkerbundes 1929–39", in Sylvain Schirmann, ed., *Organisations Internationales et Architectures Européennes 1929–1939*. Actes du colloque de Metz – Mai 2001, Publications du Centre de Recherche Histoire et Civilisation de l'Europe Occidentale de l'Université de Metz, no. 23, 2003, pp. 181–183; Marta A. Balinska, *Une Vie pour l'Humanitaire* (Paris, 1995), p. 121; Neville M. Goodman, *International Organizations and Their Work* (Edinburg & London, 1952; 2. revised edition 1971), p. 114.

2 About social medicine see Matthew R. Anderson, Lanny Smith, and Victor W. Sidel, "What is Social Medicine?", *Monthly Review*, 56 (2005) 8, 27–34; Edward T. Morman, "George Rosen, Public Health and History", biographical essay in George Rosen, *A History of Public Health* (Baltimore, 1993), p. xix; Gabriele Moser and Jochen Fleischhacker, "People's health and Nation's body. The modernisations of statistics, demography and social hygiene in the Weimar Republic"; and Lion Murard and Patrick Zylberman, "French social medicine on the international public health map in the 1930s," both in Esteban Rodríguez-Ocaña, ed., *The Politics of the Healthy Life, an International Perspective*, (Sheffield, 2002), pp. 151–179 and pp. 197–218; Dorothy and Roy Porter, "What was Social Medicine? An Historiographical Essay," *Journal of Historical Sociology,* 1(1989), 90–106.

second decade. However, there was not one coherent super-program but what may at first sight appear like a somewhat odd assortment of separate fields of work. The largest studies focussed on rural hygiene, on health during an economic depression, nutrition and housing. Further schemes were planned or begun on physical fitness and clothing but never fully implemented because the outbreak of the Second World War put an end to such ambitious plans and, in fact, to most LNHO activities.[3]

Why were these topics chosen? Where did they come from and how did they fit into the scenery of international health work? And what, in retrospect, is their historical significance? None of them was imposed by some superior body. Invariably, they originated from proposals by governments, and work on them was conducted with and through experts from many countries, who took part in international meetings, wrote reports and conducted studies in their countries, often with public funding, always with governmental approval. Clearly, the large-scale international program on social medicine of the LNHO satisfied some need felt in many capitals. However, in the process, the studies tended to gain a life of their own, and the LNHO corporate identity certainly influenced how the issues were approached, what questions were asked and, by extension, what findings resulted. In the end, the outcome was more than merely the sum of collected national efforts and not necessarily what most governments may have hoped to gain.

Yet, as mentioned, the studies did not develop in isolation. They formed an integral part of international – mostly European – medical discourse, and they grew organically from scientific and political developments of the time. Significantly, social medicine could gain ground because bacteriology was losing its dominant grip over the scientific scene. By 1917, the pathogens of all major infectious diseases, except influenza, had been discovered, and lacking further causative agents that could be identified, research into disease etiology had to expand.[4] While bacteriology developed on into the study of sera and, eventually, antibiotics, scientific interest was also receptive for new areas with a promise of discoveries and spectacular findings. One such area was nutrition. While the topic had already attracted some research interest in the nineteenth century, the period around the First World War was a time of major breakthroughs. In 1912, Polish-born biochemist Casimir Funk presented his theory of four nutritional diseases (beriberi, pellagra, rickets and scurvy). By then, studies into those parts of food necessary in

3 In addition, there were other topics with a social medical angle, like studies on infant welfare, social insurance etc., which, however, never achieved the status of major programs and did not form part of the main agenda of the 1930s.

4 Andrew Cliff, Peter Haggett and Matthew Smallman-Raynor: *Deciphering global epidemics. Analytical approaches to the disease records of world cities, 1888–1912*, (Cambridge, 1998), pp. 22–23.

minute quantities to ensure health was well underway, and most vitamins were identified in the 1920s and 1930s.[5]

At the same time, the Epidemiologic Transition in Europe directed attention away from infectious to chronic diseases. There is still no consensus on the precise reasons for the transition, and it did not happen simultaneously in all parts of Europe, let alone the rest of the world.[6] Yet it is safe to say that by the interwar years most European countries had experienced or were experiencing a marked decline of the mortality rate and a resulting increase in life expectancy. This development was paralleled by a transition of the disease spectrum, in which infectious diseases were replaced by chronic diseases as the prime cause of death.[7] These changes influenced not only the spectrum of prevalent diseases but also the geographical distribution of morbidity and mortality. As infectious diseases came increasingly under control and medical care was beginning to be truly effective, living in a city with high population density and medical institutions became relatively less of a health hazard than an asset. Probably for the first time in human history urban mortality began to equal rural mortality. In fact, in 1931 it was found that crude rural mortality rates were higher than urban rates in Germany, Switzerland, the Netherlands, Sweden, Bulgaria, Belgium and Italy.[8] Between the two world wars, increasing urbanisation was being felt in Europe, but most countries

5 Kenneth Carpenter, "History of Nutrition – A Short History of Nutritional Science," Part two, *The Journal of Nutrition*, 133(2003), 4, 975–984, and Part 3, *The Journal of Nutrition,* 133(2003), 10, 3023–3032; Kenneth J. Carpenter: *Protein and Energy. A Study of Changing Ideas in Nutrition*, (Cambridge, 1994); Harmke Kamminga and Andrew Cunningham, eds., *The Science and Culture of Nutrition, 1840–1940* (Amsterdam, 1995); Stephen V. Beck, "Scurvy: Citrus and Sailors", "Pellagra: the disease of Three Ds", "Beriberi: A Plague of Rice, and Rickets: Where the Sun doesn't Shine", all in Kenneth F. Kiple, ed., *Plague, Pox & Pestilence* (London, 1999), pp. 68–73 and pp. 118–135.

6 Improved nutrition, sanitary reform, the isolation of infected in hospitals or poor people's homes, an improved economic status of workers, a reduction in crisis, epidemic years, increasing benefits of urbanization, climatic influences and, after all, medical advances, have all been suggested as reasons. Most probably, it was a mixture of several causes which provoked these changes. For systematic surveys see Sylvia Hähner-Rombach, *Sozialgeschichte der Tuberkulose* (Stuttgart, 2000), pp. 74–83; Cliff / Haggett / Smallman-Raynor, Deciphering global epidemics., pp. 134–8; Roger Schofield and David Reher, "Introduction", in Roger Schofield and David Reher, eds., *The Decline of Mortality in Europe* (Oxford, 1991), pp. 1–17. See also contributions in their edited volume on various causes of mortality decline.

For the concept of the Epidemiologic Transition, see Abdel R. Omran, "The Epidemiologic Transition. A theory of the Epidemiology of Population change", *Milbank Memorial Fund Quarterly*, 49 (1971), 1, 1–42.

7 Paul Weindling, "From infectious to chronic diseases: changing patterns of sickness in the nineteenth and twentieth centuries", in Andrew Wear, ed., *Medicine in Society* (Cambridge, 1992, reprinted 1994), pp. 303–316; Alex Mercer, *Disease, Mortality and Population in Transition* (Leister, 1990).

8 Knud Stouman, *Mortality Conditions in Rural Europe*, C.H. 1052, reprinted from the Monthly Epidemiological Reports May and June 1931, Geneva.

were still dominantly rural.[9] Given the combination of these factors, research interests would naturally veer towards the conditions of long-term health status (as opposed to acute infections), nutrition and increasingly towards rural areas.

Political and economic events added their respective imprints. The Economic Crash of 1929 and the ensuing Depression forced public attention on mass unemployment, poverty and misery. Pauperisation was widespread, not only in the cities but also in the countryside, as prices for agricultural products fell to a fraction of pre-war levels.[10] The depression exacerbated social conditions which had already given cause for concern before. Nutrition had seemed far from perfect, and disastrous overcrowding in several countries gave rise to governmental public construction programs, which conditioned governments to see value in discussions of these issues.[11]

Meanwhile, democracies, which had been the most widespread form of government in Europe after the First World War, gradually gave way to a growing list of dictatorships which tended to decrease the concern of those governments for individual well-being but to increase their interest in collective health and prowess. In addition, this interest fed on the general climate of the time: the intense nationalism and the tangible competition between the ideologies that came to determine political life in Europe: democracy, communism and fascism. Even before the outbreak of open warfare there was a sense of a violent Darwinian assessment, of determining which nation and which world-view was the strongest, the most viable, the best. Public health was important, both as a measurement of relative success, and as a potential resource for actual warfare.[12] This situation was fertile ground for governmental concern about public health in general, and specific ideologies added their specific angles. Thus, the quasi mythological idealisation of earth and peasantry, prevalent in fascism, doubtlessly added to a concern about rural hygiene.[13]Taken together, these factors go far to explain the choice of specific topics of social medicine within the LNHO: rural hygiene, health during an economic depression, nutrition and housing.[14]

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9 Gerold Ambrosius and William H. Hubbard, *Sozial- und Wirtschaftsgeschichte Europas im 20. Jahrhundert* (Munich, 1986) pp. 41–46.

10 Charles P. Kindleberger, *Die Weltwirtschaftskrise*. Geschichte der Weltwirtschaft im 20.Jahrhundert, Vol. 4, (München, 1973, 3rd edition 1983), p. 87.

11 Iris Borowy, "World Health in a Book", in Iris Borowy and Wolf D. Gruner, eds., *Facing Illness in Troubled Times* (Berlin, 2005), p. 118; Colin G. Pooley, ed., Housing Strategies in Europe, 1880–1930, Leicester 1992.

12 Mark Mazower, *Der dunkle Kontinent* (Frankfurt a. M., 2002), pp. 117–156, [Engl. original: *Dark Continent. Europe's Twentieth Century* (London, 1998)].

13 Andrew Heywood, *Political Ideologies* (2nd ed., New York, 1998), 233–234; Joachim Radkau, *Natur und Macht. Eine Weltgeschichte der Umwelt* (Munich, 2000), pp. 294–296

14 Physical Fitness and Clothing had been planned as additional topics but work on them never got past initial preparations before the outbreak of World War II. Other topics that could

Rural Hygiene

The topic of rural hygiene was introduced into the LNHO agenda simultaneously by the Governments of India, Poland and Spain in 1928. Work began the usual collection of data and national position papers and through several international study tours.[15] It received a substantial boost with a Spanish proposal to organise a European conference on health in rural areas in the summer of 1930.[16] A few weeks later, a conference on Rural Health Centres took place under LNHO auspices in Budapest.[17] The concept of "health centres" was of recent origin and had initially described centres for specific tasks, like childcare or anti-tuberculosis work, mostly in large cities in England and the USA. After the First World War, however, an impressive number of such institutions developed in many countries, particularly the dominantly rural heirs of the Habsburg Empire, Austria, Yugoslavia, Czechoslovakia and Hungary, but also Poland and others, and their characters varied according to local circumstances and needs. The discussions in Budapest about their various forms and functions soon expanded into deliberations on rural healthcare in general. Though views differed on details, the talks gradually identified two major tasks for an improvement of rural healthcare:

1. getting healthcare services to rural people, and
2. getting rural people to healthcare services.

Neither was easy. The first task was complicated by several factors, at the most basic level, that of transport. Since by definition rural people lived spread out, visits by doctors or nurses entailed travel, often over bad or non-existent roads which prevented the effective use of cars and bicycles even when exceptionally doctors or nurses had access to them. Improving these conditions required money, lots of it, and during the early 1930s the necessary sums simply were not available. This scar-

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be termed part of social medicine, such as infant welfare or social insurance, had already received some attention during the 1920s, but work on them was scant and patchy, and they never developed into coherent programs. Therefore, this paper will focus on the four themes named above.

15 Annual Report of the Health Organisation for 1928, A.8.1929.III (C.H. 788), 18 April 1929, pp.5 and 50; Annual Report of the Health Organisation for 1929, A.9.1930.III (C.H.863), July 1930, pp.44–45.

16 Convocation of a European Conference on Rural Hygiene: Proposal of the Spanish Government, C.555.1930.III, *Official Journal*, November 1930, p.1515; cf. Minutes of the Health Committee, 29 Sept to 7 Oct 1930, C.627.M.248, pp. 26–28.

17 For the entire discussion on healthcare centres, see: Note on Health Centres, C.H./934(1), 23 Oct 1930; M. Stellar, *Public Health Nursing Service of a Health Centre*, C.H. 940, 23 Oct 1930; W. Chodzko, *Le Centre Rural d'Hygiène et d'Assistance Sociales et l'Assainissement Effectif de la Campagne*, C.H. 925, 2 Oct 1920; Schedule on Rural Health Centres, 9 Oct 1930, C.H. 933, all for: Conference on Rural Health Centres, Budapest, October 27th – 30th, 1930; Memo for the Second Session of the Preparatory Committee, C.H. 948, 29 Nov 1930.

city of financial resources not only made it difficult to get doctors to their patients once they were in the area but to get doctors into rural regions in the first place. Being a country doctor usually meant working longer hours under more difficult circumstances for less pay and prestige than colleagues in urban areas, and with little chance of career advancement. Many university trained doctors were understandably hesitant to choose this professional path. Obviously there were several possibilities of how to entice doctors into rural areas but each involved more far-reaching decisions about the general concepts of public health systems: if doctors were to get more money, where should it come from? (From central administrations? From the regional government? From private patients or, since it was unrealistic to expect peasants to pay high fees, from private health insurances?) If doctors were to be coerced into working in rural areas for all or part of their working lives, who should be responsible for organising what type of program? Should doctors be generally allocated their place of work, or should spending a certain period merely be part of their instruction or career? These questions had serious repercussions since they potentially entailed regulating academic training or bringing a liberal career under state planning and control.

Thus, inevitably, these decisions implied choices about not only patterns of rural administration but of the economic and political systems of the state at large. Besides, solving these problems was only half of the task, since having healthcare services in a rural area did not mean that people would use them. In fact, LNHO studies showed that in most countries, rural populations tended to regard visits to doctors as rare emergency events, occasioned only in extraordinary moments when all traditional remedies had failed. Obviously, this attitude ran counter to all efforts to establish a modern healthcare system with early diagnosis and preventive services. Once more, one central problem was financial. Most rural people were poor, particularly during depression times, and only a small minority of rural labourers was insured. Another part of the problem was psychological. Regular visits to doctors simply were not part of traditional ways of rural life and contradicted people's instincts. Thus, education of "ignorant country folks" was found an urgent necessity. Yet, it was not only farmers' minds that needed changing. Often, university-trained urban doctors and farmers with little or no formal education, came from such different worlds, speaking different dialects and sociolects, that relationships of mutual trust or even effective communication were difficult. Therefore, it was essential to involve other people in healthcare particularly nurses and midwives, who tended to come from the same areas and social groups as their patients.

Generally speaking, participants felt that "the rural health centre as defined by the conference was considered to be the best method of organising the health ser-

vices in rural districts."[18] In order to be effective, however, it was important that these centres should not merely focus on health in a narrow sense but as a place of reference and counselling for a number of health-related concerns, particularly maternal and infant welfare. Beyond that, it was desirable to find ways of social contextualisation so that health centres should serve various social functions within communities as well as health in a narrow sense. Such multifunctionalism was not only to increase the acceptance of the centre in its community but to also reflect a holistic understanding of health which could not be separated from other spheres of everyday life. Thus, health education was at the same time part of education about nutrition, home economics, hygiene, childcare, education and a large number of topics that would help manage a healthy life, including even basic skills as literacy.[19]

These findings were adopted as part of a long list of recommendations, which a committee of international experts prepared in May 1931 for discussions at the European Conference on Rural Hygiene in July.[20] Representatives of twenty-five European States took part as well as observers from eight extra-European countries. For its time, it was impressively large. It demonstrated both the vivid interest in and the intimidating breadth of the issue.

After ten plenary and many committee meetings, the participants endorsed almost verbatim the recommendations drafted by the preparatory committee in May:

- In the smallest rural settlement, people were to have access to first aid and a doctor's services.
- Effective medical assistance in rural districts demanded the collaboration of public authorities, the medical profession, health insurance institutions, mutual benefit associations, private agencies etc. Careful planning and co-ordination was necessary to avoid duplication of work.
- Public authorities were to ensure that the entire population benefited from effective medical assistance.
- Health insurance was helpful, and where it had not yet been established rationally organised free medical assistance might intervene.

18 Memo for the Second Session of the Preparatory Committee, C.H. 948, 29 Nov 1930, p. 3.

19 See footnote 17.

20 Technical Recommendations by the Preparatory Committee." Extracts from the Report of the Preparatory Committee, Document C.H. 1045, in *European Conference on Rural Hygiene*, Vol. II, Minutes, C.473.M.202.1931.III., pp. 142–161.

- The State was to either administer or supervise a rural health system. Both could give good results, and the form best suited depended on the general administration of the country.
- Rural health systems were to include programs on infectious disease control, campaigns against social diseases, maternal and infant welfare, sanitation, hygiene of milk and foods, education in hygiene, and sanitary supervision of medical institutions.
- Effective work needed accurate statistic on medical, social and economic conditions.
- An intelligent system of primary and secondary health centres was recommended highly.
- There was an urgent need for effective sanitation, especially as regards sewage, manure and garbage.
- The quality of water supplies depended on the protection of the source, inspection and supervision and – where necessary – purification.
- There was an urgent need for all aspects of rural housing.
- Further studies were recommended under LNHO auspices for a number of topics, including, public health nursing schools, the cost of rural health and medical services, treatment of garbage and manure to prevent fly-breeding, water analysis methods, the hygiene of milk and typhoid infections.[21]

Not all of the topics were actually adopted for detailed studies, but a surprising number were, and several of them developed into formidable programs in their own right.

Typhoid fever was a case in point. Surveys and studies of several schools of hygiene found that the disease was more widespread than expected and, indeed, a serious health problem. While the epidemiology of typhoid fever was as yet unclear, attention turned to flies whose alternate visits to manure heaps and kitchens made them a likely culprit and, in any case, a health threat.[22] Thus, the search for ways to keep flies from houses and manure attracted considerable attention. A number of LNHO reports documented experimentation on various forms of enclosed manure

21 European Conference on Rural Hygiene, C.473.M.202.1931.III, in *Official Journal*, Sept 1931, pp.1885–1898.

22 *Typhoid Fever in Rural Areas. Results of the enquiries so far effected in pursuance of the recommendations of the European Conference on Rural Hygiene*, C.H. 1276, 25 Oct 1937; *Typhoid Fever in Rural Areas*, C.H. 1286, 2 Nov 1937; *Draft Report of the Sub-Committee on Rural Typhoid*, C.H./Hyg.rur/Typh./13, 26 Nov 1937.

heaps and fly-proof homes.[23] The latter topic tied into the already ongoing studies into the role of housing in malaria and efforts to keep houses free from mosquitoes.[24]

Inevitably, housing and sanitation developed into a strong focus. The LNHO distributed information from national studies including very practical recommendations on how to construct a farmhouse so that water used for washing would not mix with drinking water, and human and animal waste would be at a safe distance.[25] The topic continued to grow, and the LNHO used every opportunity to reach as wide an audience as possible. In mid 1937 the LNHO participated in the International Exhibition in Paris with an exposition on rural housing.[26] In December 1938 a Report on Rural Housing summarised findings.[27]

Housing

In fact, by that time the issue had already outgrown the limits of rural hygiene. The course of considerations had increasingly called into question why an issue of such obvious relevance to general health as housing should be limited to rural populations.

In addition, studies on the economic crisis during the fall of 1932 called attention to the extent to which housing conditions of unemployed had an impact on their health. During 1934, calls in the League Assembly for an adoption of the issue within the Health Organisation prompted first moves to collect material on housing conditions in various countries. The Health Section provided guidelines to aid national administrations conduct studies in their countries.[28] They also recommended establishing national housing committees both for conducting research and for subsequent consultation. This idea was readily accepted in several countries, so that, in fact, after a while, some governments considered turning them into perma-

23 Jacques Parisot and L. Fernier, "The Best Methods of treating Manure-Heaps to prevent the Hatching of Flies", *Quarterly Bulletin of the Health Organisation*, Vol. III (1934), 1–31; Edm. And Et. Sergent, "Fly-free Manure Heaps", ibid. 299–303; Mathias Thomsen, "Fly Control in Denmark", ibid., 304–324.

24 S. R. Christophers and A. Missiroli, Report on Housing and Malaria, *Quarterly Bulletin of the Health Organisation of the League of Nations*, Vol II, no. 3 (1933), 357–482.

25 H. A. Whittaker, Water Supply and Sewage Disposal for the Isolated Dwelling, C.H./Com.Hab./70, R 6128/8A/35690/20823.

26 *Exposition Européenne de l'Habitation Rurale*, Sous la signe de la Société des Nations à l'Exposition Internationale de Paris 1937, League of Nations Archive (LONA), R 6122/8A/22858/20823.

27 M Vignerot, "La maison et l'aménagement ruraux", *Quarterly Bulletin of the Health Organisation of the League of Nation,* Vol. VIII (1939), 92–151.

28 *Studies on Housing*, C.H. 1155 (revised), 6 June 1935.

nent bodies.[29] However, establishing the status quo was only the first step towards systematic studies aiming at defining physiological needs, and in October 1935, the LNHO Health Committee established a Housing Committee. Studying the topic, however, turned out particularly difficult. It was virtually impossible to identify objective measurements for healthy housing (as opposed to a subjective feeling of comfort), and all issues were interdisciplinary and intertwined in a messy way and had a tendency to broaden into the sphere of public policy. After intensive discussions, the Committee established a list of nine sub-topics. The first four focussed primarily on conditions within buildings:

a. environmental condition
b. noise
c. insulation
d. lighting

But results, published in two reports in 1937 and 1938, showed that the situation inside a building could not meaningfully be separated from that outside.[30] So it was only a matter of degree when further studies moved attention beyond the realms of the individual house to its environment:

e. space planning
f. air pollution
g. water, sewage, waste disposal

The Housing Committee prepared reports on these issues in the summer of 1939, a few weeks before the outbreak of World War II. A detailed schedule for further studies on

h. administrative and legislative aspects of the hygiene of housing
i. the definition of urban and rural housing, or healthy cities and countryside and on conditions in tropical areas became immaterial.[31]

The program never succeeded in producing minimal standards or final conclusions. But the series of reports did issue a fair number of recommendations which served a similar function in calling for – among others –

29 *Rapport de la commission de l'habitation au bureau du comite d'hygiene*, undated (ca. Jan 1936), LONA, R6122/8A/20823/20823.

30 "Rapport de la Commission de l'Habitation", in *Bulletin de l'Organisation d'Hygiène*, Vol. VI (1937), 543–592; "L'insolation de l'éclairage Naturel et Artificial des Points de Vue de l'Habitation et de l'Urbanisme", in *Bulletin de l'Organisation d'Hygiène*, Vol. VII (1938), 628–656.

31 "Rapport de la Commission de l'Hybitation sur les Rèunions tenues du 26 juin au 1er juillet 1939", in *Bulletin de l'Organisation d'Hygiène*, Vol. VIII (1939), 789–858.

- low-noise buildings (using suitable material and construction methods)
- legislation and regulatory measures reducing the noises of car traffic
- careful, intelligent public town planning, including
    - zoning (separate industrial and living quarters)
    - adequate places for recreational outside activities (parks, swimming-pools etc.)
    - limitations on population density in all areas in risk of overpopulation
    - regulations on the size of apartments, buildings and streets, and for industry (height of chimneys, length of smoke release, smoke control)
- national plans regarding the availability and usage of water
- strict separation of drinking water reservoirs and sewage and the purification of all contaminated water
- use of light coal, oil, gas or electricity for – central – heating
- regular removal of normal waste in metal containers; final discharge according to local conditions and type of waste and after careful analysis.

The program was not universally welcomed. The British Minister of Health believed that "no useful purpose would be served by attempts to formulate an international standard on housing."[32] And the emphasis on central planning may have raised some eyebrows but it was relatively acceptable in the climate of the Depression era, which both justified and demanded large-scale governmental involvement in social issues.

Health during the Economic Depression

The Depression which followed the crash of 1929 presented public health experts with a perplexing problem: to identify the health effects of mass unemployment and misery. As a first report on "the economic depression and public health" made clear in 1932, this task was far from easy. The enormous scope of the crisis was beyond doubt: counting unemployed and their dependents, the report estimated that 50–60 million people were affected worldwide by unemployment. However, available mortality and morbidity data did not, so far, reveal any tangible effect on public health.[33] Discussions in the Health Committee confirmed the general bewilderment: "From every country comes the same story – official statistics reveal a

32 Internal memo of the British Ministry of Health, untitled, signed E.H.Y., 9 Jan 1935, Public Record Office, FO 371/19650.

33 "The Economic Depression and Public Health", Memorandum prepared by the Health Section, *Bulletin of the Health Organisation*, Vol. I (1932), 425–476.

healthier state than ever. And yet the feeling that the crisis must have deleterious effects on health is general..."[34] Thus, the two obvious tasks were 1. to identify the problem – if there was one – and 2. to consider appropriate actions.

In October 1932, the LNHO Committee agreed on six topics for immediate cooperative exploration, which reflected the desire to gain an understanding of the situation and to contribute to practical aid:

1. Methods of Statistical Study to Elucidate the Effects of the Economic Crisis on Public Health
2. Ways to Study Individual Nutrition
3. Ways to Safeguard Healthy Nutrition on a Reduced Income
4. Suitable Methods to Safeguard Public Health, in a Period of Economic Crisis, by the Co-ordination of all Public Health Work
5. Public Health Effects of the Exodus of Unemployed from the Towns to Suburban Agglomeration ("Colonisation")
6. Effects of the Economic Crisis on Mental Hygiene [35]

The study groups formed for each issue worked with different degrees of zeal and success. There were hardly any results for mental hygiene, or psychological health. Given the more pressing practical effects on healthcare and nutrition, there seemed less of a perceived urgent need. An initial report did little more than name possible effects (increase of free time, loss of work discipline and possibly a rise in crime) and express a hope to find information in unpublished material by company inspectors or the like.[36] Work appears not to have progressed any further.

Studies on the wild or planned colonisation of unemployed in housing with small gardens along the fringes of urban areas, were largely limited to gathering experiences from Germany, Scandinavia and, to a lesser extent, from the United States. Findings revealed that the families concerned tended indeed to be better fed than those without these resources. However, disadvantages also became apparent: often there was insufficient sanitary provision, especially, of course, in wild, unorganised settlements. The minimal financial input required from unemployed recipients in order to prevent a character of charity and also to, indeed, help finance schemes, proved unaffordable to the neediest, so that the schemes tended to exclude

34 Boudreau to Strode (RF), 21 Oct 1932, LONA R 5936/8A/39676/39674.

35 See C.725.M.344.1932; compare: Boudreau to Strode, 21 Oct 1932, LONA, R 5936/8A/39676/39674. and Olsen to Tandler, 20 Dec 1932, LONA, R 5936/8A/39809/39676.

36 *Influence of the Economic Crisis on Mental Health*, C.H. 1112, 1 Nov 1932, LONA, R 5936/8A/39785/39785.

the group it would have helped most. Besides, industrial workers did not readily adapt themselves to a life of part-time farmers.[37]

Similarly, studies about statistical methods to gain an understanding of the health effects of the depression showed difficulties as much as insights. Theoretical considerations decreed that the effects of unemployment were bound to be indirect and of a long-term character. Therefore, a scientifically sound method would be to study consistent groups of people before, during and after a period of prolonged unemployment.[38] In practice, such a statistically impeccable method proved near-impossible to implement. Rather than forming two clearly distinct groups of employed and unemployed, in real life people tended to move in and out groups, as the depression created a market with many in-between shades of partial, temporary and underpaid employment. Nevertheless, in 1933 researchers in Vienna found measurable effects of unemployment, such as stunted growth and reduced weight.[39] Even more disconcerting, a US study indicated that people who had suffered a drastic loss in economic status, experienced a marked increase in illness.[40]

The issue of the coordination of public health work at a time of economic crisis was more productive. After a period of collecting material and their vivid discussion, the expert group produced a report in late 1933. This report presented an impressive list of potentially money-saving devices, ranging from the standardisation of equipment to leaner hospital management. Above all, it emphasised the value of prevention and warned of the danger of ruthless, short-sighted budget cuts, which would only result in extra costs in the future. Instead, there was a need for intelligent cuts and/or restructuring measures. Such intelligent cuts pre-supposed a definition of priorities, either on specific population groups like children, or on specific programs. In other words, what was needed was a coherent concept of a health system. The report did not prescribe any particular health system relying on either public or private services, though it did recommend a co-ordination of both, as well as compulsory sickness insurance.[41] As usual, this report was communicated to member governments and also published so that it was theoretically freely available to anyone who was interested. However, in a highly unusual step, this time the Health Section went further and issued a public appeal, not to health administra-

37 *Settlements on the Outskirts of Cities: their Relation to the Public Health,* C.H./C.E./5, 10 Nov 1932; Report Stadtbauamt Frankfurt, Abteilung Gartenwesen, 10 Dec 1932, LONA, R 5936/8A/39677/39677.

38 Emil E. Roesle, *Health Statistics of the Unemployed*, C.H./C.E./20, 15 Feb 1933.

39 A. Götzi, W. Kornfeld and E. Nobel, "The Effects of the Economic Depression on the Population of Vienna", *The Quarterly Bulletin of the Health Organisation*, Vol. III (1934), 461–522.

40 Edgar Sydenstricker et al.: Health and the Depression, reprint from the *Quarterly Bulletin of the Milbank Memorial Fund*, XI (Oct 1933) Nr. 4.

41 "Report on the Best Methods of Safeguarding the Public Health During the Depression", *Quarterly Bulletin of the Health Organisation*, Vol. II (1933), 286–332.

tions but directly to "public opinion." Mirroring the findings and sharpening them in the process, the appeal called for the following:

- Cuts only after consideration as part of a comprehensive program
- Recommended: compulsory sickness insurance
- One centralised health organisation rather than a variety of different services
- Rational planning and management of health institutions
- Experience won during depression used for establishing general principles of efficient public health system.[42]

While there are indications that the process of producing both the report and the appeal had been marked by substantial – supposedly political – "obstacles," the direct response was relatively subdued. The British representative in the Health Committee, conservative George Buchanan, vehemently opposed both the report and the appeal and protested against "making the economic crisis a pretext for international action for the rationalisation of all public services." However, he remained isolated while the Committee as a whole voiced agreement.[43] Indeed, there was one enthusiastic reaction from the health inspector of Algeria, Lasnet, who considered this issue of particular importance for non-European countries.[44] Preparations to establish national committees for an overview of the entire health system began in Spain, Denmark and England[45] but there is little indication, that either the report or the appeal provoked extensive reorganisations of health systems. Its significance is therefore difficult to assess. It may have subtly strengthened the position of those people within administrations who aimed at a strong and efficient health policy.

Nutrition

Meanwhile, the bulk of the studies on health effects of the economic crisis increasingly focused on nutrition and thereby merged with the other ongoing nutrition related studies. The topic had already attracted some, though unsystematic, atten-

42 *Appeal to Public Opinion and General Recommendations of the Conference*, C.H.1130, Dec 1933.

43 *Report to the Council on the Work of the Twentieth Session of the Health Committee*, C. 652.M.312.1933.III, pp. 9–10.

44 Lasnet to Olsen, 28 April 1934, LONA, R 6058 / 8A / 9180 / 938.

45 The exact nature of these "obstacles" remains unclear. Boudreau to Cahen Salvador, 14 February 1934, LONA, R 6058/8A/9180/938.

tion in Geneva since 1925.[46] Rural hygiene had added another angle.[47] Concern about the health effects of the economic crisis added a third approach. That nutrition constituted a major problem was perceived as self-evident. Press reports singled out inadequate nutrition as supposedly the most immediate consequence of the depression.[48] In how far this was true was, once more, a question of intuition rather than firm knowledge. The first task, therefore, was to identify ways to gain more robust information on the nutrition status of different populations.

A conference was called and took place in Berlin in December 1932 and began with some general considerations on the factors to be taken into account in any investigation of health effects of the depression such as its intensity and duration, working conditions, cost of living and general health level. In order to gain more meaningful insight into the existing reality of (mal-)nutrition the conference called for further studies and issued guidelines. Thus, both medical and social studies were recommended, covering a sufficient number of people (at least 1,000 families or 10% of the population affected by the depression). As a general rule, large-scale investigations would necessitate simple and swiftly applied methods, while smaller medical studies could add clinical criteria. No uniform method was prescribed, it being understood that there was no one exact method, but several approaches were endorsed and publicised. These used combinations of indicators like weight, height, blood content of the skin, amount of subcutaneous fat, water content, muscular development, and, for clinical examinations, nitrogen content of the urine, protein content of serum, pulse after different activities etc.[49] This appeal was remarkably successful. Within a year research programs were drawn up and put into practice in Austria, Belgium, Germany, Hungary, the Netherlands, Poland, Yugoslavia and, with some changes, in the United States.[50]

Parallel to these schemes, Wallace Aykroyd, member of the Health Section, worked on guidelines regarding a healthy diet on a very restricted budget. This was not an easy task as it necessarily presupposed a number of definitions. What constituted a healthy diet for whom? What were the requirements of male and female adults and children, engaged in various types of work or unemployed, in calories, protein, fat, carbohydrates, vitamins and minerals? What percentage of income

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46 See Paul Weindling, "The Role of International Organizations in Setting Nutritional Standards in the 1920s and 1930s", in: Harmke Kamminga and Andrew Cunningham, eds., *The Science and Culture of Nutrition, 1840–1940* (Amsterdam, 1995) p. 323.

47 *The Problem of Nutrition with Special Reference to Rural Districts*, C.H./Hyg.Rur./E.H. 3, 2 April 1935.

48 See *The Economic Depression and Public Health*, C.H./C.E.1, 8 Nov 1932

49 "The Most Suitable Methods of detecting Malnutrition due to the Economic Depression", (Conference held at Berlin from December 5th to 7th, 1932), *Quarterly Bulletin of the Health Organisation*, Vol. II (1933), 116–129.

50 "Report of the Health Organisation, Economic Depression and Public Health", in *Quarterly Bulletin of the Health Organisation*, Vol II (1933), 532.

could a family spend on food so that it was considered "affordable"? What are the actual prices paid for food in contrast to official prices according to statistical indices? To what extent could needs be temporarily curtailed and for how long to justify the recommendation of an "emergency diet"? To what extent did eating habits and traditions have to be taken into account and to what extent could or should they be changed by health propaganda? These were scientific as well as political questions that could lead directly into an ideological minefield of who was responsible for the well-being of the nations. Its sensitivity was obvious from studies such as one by Paton and Findlay, quoted in Aykroyd´s report on "maternal efficiency," which indicated that "the relation of the height and weight of children to the average depended less on income available than on the character of the housewife."[51] Inevitably, working on this subject was a balancing act, naming scientific findings and plausibilities without pretending certainty where there was none but also avoiding polemics without shying away from controversial questions and conclusions. In a report that was published in 1933, Aykroyd made a brief presentation on the contemporary understanding on nutritional needs and compared average and recommended diets for people living on a low income from different countries.[52] Comparisons between the cost of an assumed adequate diet and unemployment benefits revealed that in England, a family of parents with three children had to spend 63% of their unemployment allowance on food, and in Germany, a family consisting of a man, his wife and a child of ten year of age had to spend no less than 83% on food.[53] Implicitly, these numbers confirmed earlier assumption that parts of the population were bound to be malnourished because they did not have the money to be anything else. Aykroyd tried hard to retain an even-handed approach. He honoured the concept of "maternal efficiency" pointing out that "even where comparatively low income levels are concerned education of mothers is theoretically capable of bringing about dietary amelioration." But his critical stance is clear from his comments on the significance of education during the ongoing crisis:

> Tact and skill are obviously needed in preparing propaganda with the object of improving the diet of the necessitous. Such propaganda may easily become insulting if it is directed at a population struggling to feed itself on a totally inadequate wage or allowance. Further, there is implied irony in urging the use of frugal if well-balanced diets in a world suffering from over-production of food-stuffs.[54]

51 W.R. Aykroyd, "Diet in relation to Small Incomes", *Quarterly Bulletin of the Health Organisation*, Vol. II (1933), 149. The study quoted was „Poverty, Nutrition, and Growth", Med. Res. Counc., Spec. Rep. Ser., No. 101, 1926.

52 W. R. Aykroyd, "Diet in relation to Small Incomes", *Quarterly Bulletin of the Health Organisation*, Vol. II (1933), 130–153.

53 Ibid., p. 148 and 143 respectively.

54 Ibid., p. 150.

For those so predisposed, the nutrition reports of the Health Organisation could be read as general critiques of existing socio-economic conditions. This tendency continued in a follow-up report which defined nutritional standards, demanding higher minima than prevalent national standards.[55] After 1935 the program on nutrition divided. The Health Organisation formed a "Technical Commission" that cooperated with various scientific research institutions and focussed on scientific goals like the quantification of nutritional requirements of different age groups and on specific foods, particularly milk.[56] A more comprehensive and political approach was taken by a mixed commission, consisting of members of the LNHO, ILO, the International Agrarian Institute in Rome and the Financial and Economic Section of the League Secretariat. Their report, published and widely distributed in 1937, discussed ways to ensure healthy public nutrition. Echoing Aykroyd´s report of 1933, it stated that the quality of nutrition could be improved by improving knowledge and/or income. Though difficult, improving knowledge was relatively the simpler task. All it needed was more research and an improved communication of the research findings through public education. Income was politically more sensitive. It could be achieved either through economic growth or, if that was not possible (as it supposedly was not during a time of a worldwide economic crisis), it necessitated a redistribution of wealth. The radicalism of this demand was slightly obscured but not really mitigated by a long list of other very practical suggestions to improve the economic side of nutrition: adequate minimal wages; social regulations; school meals for needy or all children; a suitable trade policy which aimed at a maximisation of affordable food rather than national self-sufficiency (a clear snub of Nazi Germany), or agricultural credits which allowed small farmers to invest.[57]

Conclusions

All of these programs were put to an abrupt halt when war broke out in 1939. Six years later, the basic questions remained, but the LNHO no longer existed and the new institutions, the cold war climate and the discovery of new technologically promising drugs and chemicals like antibiotics and DDT ensured different

55 Et. Burnet, W.R. Aykroyd, "Nutrition and Public Health", *Quarterly Bulletin of the Health Organisation*, Vol.IV (1935), 232–474; Paul Weindling, Nutritional Standards, pp. 325 and 327.

56 See "Report on the Physiological Basis of Nutrition drawn up by the Technical Commission of the Health Committee", *Quarterly Bulletin of the Health Organisation*, Vol.V (1936), 391–416.

57 *The Relation of Nutrition to Health, Agriculture and Economic Policy*, Final Report of the Mixed Committee of the League of Nations, A.13.1937.II.A. Geneva 1937.

approaches. For many years, the radicalism which questioned the basics of national and international systems was no longer thinkable.

So what was their significance? What did those programs have in common? What did they aim at, and what is their legacy?

At the simplest level, all programs asked what social conditions must exist for people to live a healthy life. Their point of reference was not so much the individual body – though in the last instance all health concerns individual bodies – but the circumstances in which groups lived, which did or did not allow individuals to make certain choices. As such, they demonstrated a holistic understanding of health as an integral component of a complex interactive web of factors which constituted people's lives. In the process, the significance of health was substantially elevated. Since almost everything somehow influenced health and health was somehow part of almost everything else, health became much less clearly defined. It defused into other spheres of life until it became practically synonymous with life itself. This effect was most pronounced with rural hygiene, which was, indeed, found to be so deeply and justifiably ingrained in everyday rural life, that logically the abortive sequence of the European Conference on Rural Hygiene was to concern itself explicitly with "Rural Life". Not all programs went that far but at the very least, all programs integrated considerations of substantial non-health factors, in a narrow sense, particularly economic and social needs as well as political circumstances.

Secondly, all topics touched on questions of social justice and accountability. How much food did a person need? How much room did he deserve? Who was responsible for his fresh air to breathe and for his clean water to drink? Who should pay for infant healthcare? Governments? Economic players? Housewives? Insurances? Voluntary institutions? Very quickly, all studies arrived at issues which questioned the basics of societal structures. The studies drew attention to public health requirements which were frequently not satisfied, and by defining them as needs rather than as personal duties they emphasised what authorities owed to people rather than what populations owed to authorities. Health was a tangible paradigm which made visible the social glue that tied individuals and society together. Inevitably, a critical assessments of the state of that relation entailed re-thinking what combination of rights and duties did, could or should define society.

The judgments implicitly or explicitly passed in the studies and reports aimed at fairness, but they could not be even-handed. All topics involved elements or personal responsibility, but invariably their focus was on social conditions clearly beyond the control of the individual. In listing conditions which every person needed but could not individually ensure, the LNHO program on social medicine formulated an impressive list of goods and services, for which national populations depended on their governments. It was only a small step to arrive at the conclusion that they were entitled to demand them:

- Minimal Standards for bare necessities (nutrition and housing);
- Towns that were planned to supply air, space and opportunity for recreation for their inhabitants;
- Minimal Wages which were high enough to allow the purchase of healthy food;
- Clean Water;
- Waste Removal Services;
- General Health Insurance;
- Acces to International Food Markets;
- Access to perinatal care;
- Various Policy Tools which would compensate for differences in food-related purchase powers (credits, school meals, soup kitchens...);
- Health education;
- ... and others.

Together these demands constituted a formidable load on any society of that time but underlying they entailed even more than a collection of tangible goods and services, which sufficient money and competence would supply. In a wider sense, the tangible demands were about the principle of entitlement. The central point was that all these needs were shared by all people, and that, if people were similarly entitled to health, by implication, they must be similarly entitled to food, recreational space and healthcare. This assumption had sensitive implications. Collectively, the studies contained far-reaching immaterial demands:

- a commitment of governments to take responsibility for public welfare;
- accountability of their governments to their people, entailed in making public a wide range of vital statistics;
- equal rights of all members of society to a – relatively high – minimal standards of health read life; and thus, by implication,
- an egalitarian society.

As mentioned, all programs originated from and depended on continual input from national governments. All countries had a lively interest in the topics discussed, as their consistent – though sometimes muted – support of the work demonstrates.[58]

58 There was no official cooperation on the part of those countries that had left the League of Nations, like Germany and Japan. But there are indications that German authorities continued to follow LNHO activities. Iris Borowy, „Freundschaft, Feindschaft, Neutralität? Die

But presumably, the unexpected width of the studies and the resulting political repercussions made for somewhat ambivalent reactions on the part of European governments of all ideological shades. All could find something to relate to. The expectation that governments take active responsibility for public health did not pose much of a problem for authoritarian systems, such as those in Germany, Russia and Italy, where governmental involvement in public health was considered one of a number of investments in national strength and was therefore accepted as a given. By contrast, the demand would be less acceptable in countries like Great Britain, whose tradition in hands-off liberalism spurred a view in which health was much more of a private affair. Yet, this same tradition eased the understanding of simultaneous demands for free trade, plainly at odds with ambitions towards autarky in the aforementioned countries. The focus on rural hygiene and vital statistics was compatible with the fascist obsession with national earth and peasant mythology.[59] The emphasis on prevention similarly agreed with totalitarian focus on collective health. Individual rights, including that to make choices tied into democratic values of individualism and freedom. Egalitarianism was reflected in communist theory, though not in Stalinist reality, and it coincided with democratic idealism, but not with the reality of surviving democracies of the time.

In the mixture of different, sometimes radical, often contradictory world-views of the 1930s, the program easily fit in to some extent in all of them in various forms and niches, but did not fit in totally anywhere. It was both attractive and disconcerting. Above all, the studies made it clear that effective public health came with a price. Implementing the practical recommendations was impossible without adopting some of the underlying belief system. Improving public health meant questioning basic assumptions of existing countries and societies. It meant changing in potentially threatening ways.

The far-reaching character of the underlying demands was not openly discussed. In fact, it may sometimes have been overlooked, because it was not necessarily easy to detect on the basis of individual studies or documents. The masses of paperwork that were produced, and the amount of work spent on minute details, easily obscured that collectively the program expressed fundamental principles. Given more years, the separate projects might have become woven into a coherent unified program on the "social determinants of health." As it was, this process had to wait more than another half century[60] but even as a sum of isolated projects, the studies contained demands of compelling timelessness. Egalitarianism, particularly, this most difficult demand of all and an old dream of humanity, must have been the

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LNHO des Völkerbundes und das Deutsche Reich während des Zweiten Weltkrieges", in Wolfgang Eckart and Alexander Neumann, eds., *Medizin in Deutschland während des Zweiten Weltkrieges*, forthcoming.

59 Andrew Heywood, *Political Ideologies* (Basingstoke, 2nd ed. 1998), pp. 232–233.

60 See below.

most serious challenge to authorities, then as now. Yet, with the benefit of scores of additional data, recent studies appear to confirm that social equality may, in fact, be the one key factor which determines public health as a whole, particularly but not only that at the lower end of the social strata.[61]

Towards the end of the 1930s, the tangible approach and then the outbreak of World War II considerably reduced interest in interwar social issues in many places.[62] Nutrition obviously continued to command substantial attention, and LNHO staff contributed their nutrition expertise to allied institutions, though not necessarily as originally intended.[63] "[B]y painful irony, the scientific standards of diet drawn up by the League were used first by Germany, then by other governments, as a basis for their rationing systems in time of war."[64] In the long run, League nutrition work fed into the ever-growing stream of nutrition research, both national and international, which is continuing today. Rural Health and Housing, however, were no issues until after the war, and it is difficult to detect a direct influence of LNHO activities in the fragmented post-war policies, though it is plausible that there was some, as health and planning officers in various countries would be influenced by theses introduced in the public discourse by LNHO publications.

For the most part, the exact effects of interwar activities on social medicine are difficult to define and even more difficult to measure. In the most general terms it can be speculated that they spurred discussions within individual states which, in various forms, eventually contributed to the rise of the welfare state. In some cases, the transmission of ideas can be observed more closely. The British representative at the Geneva discussions on the rational coordination of healthcare systems, Wilson Jameson, went on to have an important role in defining public health. After several more years as Dean of the London School of Hygiene and Tropical Medicine he initiated the so-called "Gasbag Committee" in 1939, a Saturday morning group of prestigious doctors and health experts that discussed issues of public health. Later, he took an active part in the selection and work of several expert committees that surveyed existing hospitals and made suggestions for a restructured hospital system which would integrate traditional voluntary hospitals and elements of further coordination. As chief medical officer in the Ministry of Health during World War II, he was instrumental in organising a national nutrition policy, for which he made

61 Richard G. Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier* (Oxford, 2005); Lawrence A. Jacobs and James A. Morone, *Healthy, Wealthy and Fair: Healthcare and the Good Society* (Oxford, 2005).

62 Nancy Krieger / Elizabeth Fee, "Measuring Social Inequalities in Health in the Uniter States: A Historical Review, 1900–1950, *International Journal of Health Services*, 26 (1996), 3, 409.

63 Iris Borowy, "Manoeuvering for Space. International Health Work of the League of Nations during the Second World War", in Susan Gross Solomon, Patrick Zylberman and Lion Murard, eds., *"On Shifting Ground:" Health and Space in the Twentieth Century*, forthcoming.

64 Frank P. Walters, *A History of the League of Nations* (Oxford 1952, reprinted 1969), p. 755.

use, among others, of LNHO interwar studies on nutrition, and he played an important part in the formation of the National Health Service.[65] Principles of LNHO papers can also be found in the Beveridge Report of 1942. Its medical part was heavily influenced by the Interim Report of the British Medical Association Planning Commission, whose call for better co-ordination of preventive and curative service, for health centres and extended insurance reads like a repetition of LNHO recommendations. though the direct path of influence is difficult to establish.[66] A re-appraisal of the Beveridge Plan in 1994 makes no mention of international sources whatsoever.[67] A paper by André Shepherd includes the ILO input, which may have served as transmission vehicle of ideas.[68] As José Harris points out, the Beveridge Report contained little original thought but largely built on widely held views.[69] It is conceivable, that by that time, principles stated in LNHO commissions had triggered into the general discourse, and were no longer attributed to the LNHO, a discredited institution in England in the 1940s.

What is even more surprising is the degree to which the social medical program in international health policies in the 1930s seems to have been forgotten by today's heirs. A brief historical overview of the developments towards present-day WHO schemes on the social determinants of health mentions Virchow but overlooks the LNHO activities.[70] However, this does not mean that they have had no legacy. The definition of health in the WHO constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," and other social medical elements derived directly from war-time drafts by LNHO employees.[71] These traits were eclipsed as politically inopportune during the early Cold War but made a strong, albeit temporary, comeback at the 1978 WHO conference in Alma-Ata with the presentation of the "Health for All" concept. Though the ideas were soon once again sidelined by an upsurge in neo-liberal thinking, they have recently re-emerged. The establishment of a Commission on the Social Determinants of Health in March 2005 testifies to the increased recognition of the

65 Neville M. Goodman, Wilson Jameson. Architect of National Health (London, 1970), 91–94, 111–124; http://www.nhshistory.net/ems_1939–1945.htm, accessed 28 March 2006.

66 Goodman, Wilson Jameson, p. 113–114.

67 W. John Morgen (ed.): *The Beveridge Plan 1942–1992. Fifty Years On*, Institute of Modern Cultural Studies, (University of Nottingham, 1994).

68 Andrée Shepherd, "Le rapport Beveridge de 1942: Social Insurance and Allied Services," in J. Carré and J.-P. Révauger, ed., *Ècrire la Pauvreté* (Paris, 1995), 274.

69 José Harris, "Social planning in war-time: some aspects of the Beveridge Report," in Jay M. Winter, ed., *War and economic development: essays in memory of David Joslin* (Cambridge, 1975), 239–256.

70 *Action on the Social Determinants of Health: Learning from Previous Experiences*. Background Paper Prepared for the Commission on Social Determinants of Health, March 2005, WHO, http://www.who.int/social_determinants/about/en/.

71 Borowy, Manoeuvering for space.

social dimension of health. The Commission leaves not doubt about the gravity of the issue concerned: "Evidence shows that most of the global burden of disease and the bulk of health inequalities are caused by social determinants."[72]

Supposedly, as the problem of sub-standard health due to poverty, inequality and social injustice remains, so will attempts to address it. Inevitably, the fundamental requirement of reasonably equitable societies will remain the unchanged, as will the tangible requirements of health, access to sufficient healthy food, clean water, housing, health-care and basic security.

At both the most banal and most moving level, the 1930s programs of the LNHO in the field of social medicine have been one step in the long struggle of humanity for a better world.

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72 *Action on the Social Determinants of Health: Learning from Previous Experiences*. Background Paper Prepared for the Commission on Social Determinants of Health, March 2005, WHO, http://www.who.int/social_determinants/about/en/, p. 7.

Medicine as a Social Political Science
The Case of Spain c. 1920*

Esteban Rodríguez-Ocaña

Introduction

"Social Medicine" was a complex and evolving set of principles that produced a particular understanding of the aims of public health and medicine that highlighted the need to protect the great masses of population. It endowed doctors with a mission and made them authoritative agents of the salvation of nations, for the sake of science – a weak protection from racial and political prejudices. The label lacked a constant or universal meaning, depending on national and chronological contexts; consistently though, it dealt with some form of methodological relationship between social sciences and medical sciences. Great differences are found between developments in Germany and Central Europe regarding Great Britain, for instance, in the first half of the twentieth century, and similarly between Latin and North America in more recent times.[1] In many places in Europe and Latin America, as in Spain, in the early 1950s it became the official name of a more or less thoroughly redefined academic discipline of Public

* A preliminary version of this paper was presented at the EAHMH-SSHM Paris Conference, September 2005.

1 George Rosen, "What is Social Medicine? A Genetic Analysis of the Concept", *Bull. Hist. Med.*, 21(1947), 674–733; Rudolf Thissen, *Die Entwicklung der Terminologie auf dem Gebiet der Sozialhygiene und Sozialmezidin im deustchen Sprachgebiet bis etwa zunm Jahre 1930*, (Düsseldorf, 1968); Erna Lesky, ed., *Sozialmedizin, Entwicklung und Selbstverständnis* (Darmstadt, 1977); Dorothy Watkins, "What was Social Medicine? A Historiography of the Concept (or, George Rosen Revisited)", *Bull. Soc. Hist. Med.*, no. 38 (1986), 47–51; Esteban Rodríguez-Ocaña, ed., "Introducción", in *La constitución de la Medicina Social como disciplina en España, 1884–1923* (Madrid, 1987), pp. 9–51; Dorothy and Roy Porter, "What was Social Medicine?" *J. Hist. Sociol.* 1(1989), 90–106; Dorothy Porter, "Introduction", in *Social medicine and medical sociology in the twentieth century* (Amsterdam, 1997); Howard Waitzkin, Celia Iriart, Alfredo Estrada and Silvia Lamadrid, "Social medicine then and now: Lessons from Latin America. *Amer J Pub Health*, 91(2001), 1592–1601; Esteban Rodríguez-Ocaña, "La medicina como instrumento social", *Trabajo Social y Salud*, no. 43 (2002), 19–36.

Health/Preventive Medicine. Playing names is an old tradition within public health, deeply rooted in its disciplinary structure such as has been critically depicted.[2]

Present scholarship assumes that the gestation of social medicine started at the epoch of Enlightment and crystallised during the industrialization process, particularly around "the revolutions of 1848", as a new understanding of the human environment under the conditions of industrial life. Its basis stood on the growing strength of social sciences to describe and explain collective phenomena, particularly thanks to quantitative methods, as well as on the transformations of the complex health/disease/care linked to the development of laboratory sciences and the health transition. In the mid-nineteenth century, the term *Hygiène sociale / soziale Hygiene* was used to underscore the risks derived from urban living. At the beginnings of the twentieth century, as social insurances appeared and a number of mostly philanthropic interventions, known as health campaigns, developed, a series of teaching positions appeared, either for social medicine or for social hygiene, in Vienna (Ludwig Teleky, 1907), Düsseldorf (Schrakamp, 1909), Munich (Ignaz Kaup, 1912), or Berlin (Alfred Grotjahn, 1912 – who was later promoted to *Ordinarius* in 1921, the author of a paradigmatic lecture on *Was ist und wozu treiben wir Soziale Hygiene?* published in 1904).[3] In countries such as Belgium or Italy medical associations of the same quality (1913, 1917) appeared also following the trail

2 Didier Fassin, "Comment faire de la santé publique avec des mots. Une rhétorique à l'œuvre", *Ruptures, revue transdiciplinaire en santé*, 7 (2000), 58–78.

3 There is a long German tradition on the study of this topic; see, among others: Dietrich Tutzke, *Alfred Grotjahn* (Leipzig, 1979); Esteban Rodríguez-Ocaña, "Aproximación al concepto y práctica de la Medicina Social en Ludwig Teleky (1872–1957)", *Dynamis*, 2 (1982), 299–323, and "La Academia de Higiene Social de Düsseldorf y el proceso de constitución de la Medicina Social como especialidad en Alemania", *Dynamis*, 3 (1983), 231–264; Daniel Nadav, *Julius Moses und die Politik der Sozialhygiene in Deutschland* (Gerlingen, 1985); Ulrich Koppitz and Alfons Labisch, eds., Adolf Gottstein. *Erlebnisse und Erkenntnisse. Autobiographische und biographische Materialien* (Berlin, 1999); Dietrich Milles and Norbert Schmacke, eds., *Ludwig Teleky und die Westdeustche Sozialhygienische Akademie. Arbeiten für eine soziale Medizin* (1903–1939) (Düsseldorf, 1999); Heinrich Weder, *Sozialhygiene und pragmatische Gesundheitspolitik in der Weimarer Republik am Beispiel des Sozial- und Gewerbehygienikers Benno Chajes* (1880–1938)(Husum, 2000); Gabrielle Moser, *Sozialhygiene und öffentliches Gesundheitswesen in der Weimarer Republik und der frühen SBZ/DDR* (Frankfurt a. M., 2002). Interest has now spread to broader circles, as with Dorothy Porter, ed., *Social medicine and medical sociology in the twentieth century*, (Amsterdam [Clio Med. 43], 1997); contributions by Paul Weindling, Gabriele Moser and Jochen Fleischhacker, Marcos Cueto, Lion Murard and Patrick Zylberman, and James A. Gillespie in Rodríguez-Ocaña, E., ed., *The Politics of the Healthy Life, an International Perspective*, (Sheffield, 2002); Patrick Zylberman, "Fewer Parallels than Antitheses: René Sand and Andrija Stampar on Social Medicine, 1919–1955", *Soc. Hist. Med*. 17 (2004), 77–92; Paul Weindling, "From Germ Theory to Social Medicine. Public Health 1880–1930", in: Deborah Brunton (ed), *Medicine Transformed. Health, Disease and Society in Europe, 1800–1930*, (Manchester, 2004), pp. 257–283.

opened by the German *Gesellschaft für soziale Medizin, Hygiene und Medizinalstatistik* (1905). The European distinction between a 'social medicine' and a 'social hygiene' in the first decades of the twentieth century was mainly derived from the birth of a new field of medical practice related to social insurances, designed as "social medicine", while hygiene was used to denote the preventive domain. But the flourishing health campaigns drove care and prevention to merge, so that by the 1930s a broad consensus on the single title of social medicine was reached. The campaigns, directed towards great masses of population supposedly at risk for some condition among the so called "social diseases" (like VD, tuberculosis, infant or child mortality), blurred the distinction between health and illness, as they moved around the existence of environmental conditions that created danger for all people involved. At the same time, the new dispensaries or health centers did not wait for patients to come in, they went to search them instead, by direct inspection of homes, schools and the like.[4]

In this paper I analyse the Spanish contribution to this European trend. I particularly focus on the inter-professional groups that championed the banner of social medicine in Spain, as a rhetorical and social and political banner. But a thorough explanation requires a certain acquaintance with the Spanish medical literary tradition on the links between social sciences and medicine which I try to provide in the first place, looking at the forming of the key concept of social disease.

The Place of the "Social" in the Medical World: The Making of Social Diseases

From the extensive and systematic reading of Spanish texts produced in the first twenty years of last century, five notions can be singularized as the bricks of the social-medical discourse: i.e. the quantification of demographic phenomena, the economic value of health, the social etiology of disease, the danger of race degeneration and the reformist will. All of them are carried forward from the last half of the nineteenth century, the novelty being their addition in articulated forms, where most of them are present, during the first third of the twentieth century, therefore revealing the maturity of the discourse.[5] All these concepts are connected by the

4 Esteban Rodríguez-Ocaña and Jorge Molero, "La cruzada por la salud. Las campañas sanitarias del primer tercio del siglo veinte en la construcción de la cultura de la salud", in L. Montiel, coord., *La Salud en el Estado de Bienestar. Análisis histórico* (Madrid, 1993), pp. 133–148. Jorge Molero and Francisco Martínez, "Las campañas sanitarias como paradigma de la acción social de la medicina", *Trabajo Social y Salud*, no. 43 (2002), 119–148.

5 Rodríguez-Ocaña (1987), "Introduction", see note 1.

notion of quantity, which set itself as one of the central intellectual tenets of social life in the industrial world.[6]

The analogy between the human body and the social body is known since the time of ancient Greek thinkers, like Aristotle, and was a working metaphor during the second half of the nineteenth century due to the influence of Herbert Spencer's doctrine. The combined ideas of evolutionism, originally Lamarckian, and scientific positivism, affected by a Darwinian bias as we get closer to the end of the century, were crucial for the forming of Sociology. As it has recently been shown for the case of France, by the last two decades of the nineteenth century practically all social discourse employed a biological or medical rhetoric, which in itself became a metanarrative.[7] Medicine, on its side, grew in scientific consistency thanks to development of basic biological sciences, such as physiology, microbiology and others, while the broadening of healthcare facilities produced a decently bourgeois way of living for generations of practitioners. In fact, it boasted of being one of the paradigmatic professions of the industrial, liberal society. This notwithstanding, socially eminent practitioners sought also to produce a stronger link with the dominant elite, which they achieved by sharing the same rhetorical facilities. That is, during decades they applied the correspondence biology/society, to describe and to explain social processes in biological terms and from the beginnings of the twentieth century they applied social terms to explain medical matters.

The forming of the concept of social disease can help us to produce some examples.

The first condition so defined was pauperism, "a congenital social disease".[8] Indeed, mid nineteenth century authors looked at society through a medical gaze that defined "diseases" instead of social disorders. The author responsible for this quotation, Pedro F. Monlau (1808–1871), a reputed hygienist, became a fellow of the Academy of Moral and Political Sciences in 1870, where he read a paper on *Social Pathology. A brief study on crime*.[9] Again, the same metaphor: any challenging

6 Theodore M. Porter, *Trust in Numbers. The pursuit of objectivity in science and public life* (Princeton, 1995); Iris Borowy, "Counting death and disease: classification of death and disease in the interwar years, 1919–1939", *Continuity and Change*, 18 (2003), 457–481.

7 Snait Gissis, "Late Nineteenth Century Lamarckism and French Sociology", *Perspectives on Science*, 10 (2002), 69–122.

8 Pedro Felipe Monlau, "Remedios del pauperismo", *El Amigo del País* (Madrid), 1846, pp. 213–215 [reprinted in *Estudios de Historia Social*, no. 10–11 (1979), pp. 374–385].

9 Mercedes Granjel, *Pedro Felipe Monlau y la Higiene española del siglo XIX* (Salamanca, 1983); Rafael Alcaide González, "La introducción y el desarrollo del higienismo en España durante el siglo XIX. Precursores, continuadores y marco legal de un proyecto científico y social", *Scripta Nova. Revista Electrónica de Geografía y Ciencias Sociales*, no. 50 (1999), [http://www.ub.es/ geocrit/sn.50-htm]. Ricardo Campos, *Monlau, Rubio, Giné. Curar y gobernar. Medicina y liberalismo en la España del siglo XIX*, (Tres Cantos, Madrid, 2003). Esteban Rodríguez-Ocaña, "Confort, ornementation, hygiène. Modernisation urbaine et hygiénisme dans

of the order of society (as decided by the ruling class) should be depicted as a disease. In this paper, an argument is made in favour of the death penalty as the elective treatment in case of riots or rebellions. Those were the days of the short lived First Spanish Republic (1870–1872).

Later, in a context of political stability, another Hygiene professor of Madrid University sustained that social diseases were "those that are able to influence the physical and moral sides of individuals as well as to distort the social organism"; he then listed prostitution, alcoholism, vagrancy and beggary, gambling, murdering and suicide.[10] Accordingly, the prominent surgeon Federico Rubio (1827–1902) included under the same proposition all "public disasters" by any cause —ranking from telluric to zymotic to distortion of social classes—, the "individual vices" (such as alcoholism, nicotism, prostitution and the like) for they impinged upon families and communities, and the "collective vices", which included non-democratic political organisation, ignorance, pauperism and functional disorders as strikes or riots.[11]

Both Angel Larra (1858–1910, a high Navy medical officer) in Madrid, in 1902, and Ignaci Valentí Vivó (1841–1924, Professor of Forensic Medicine), in Barcelona, in 1905, stuck to the opinion that explained social pathology as a parallel phenomenon to medical pathology; but where Larra considered the sociological trail as a guide to the study of medicine, particularly hygiene, Valentí highlighted the influence of medical rationale on the forming of sociological concepts in the realm of Economics.[12] Significantly in both cases they referred to Paul (Pavel) Lilienfeld as source of authority, a partner of René Worms at the International Institute of Sociology, a well known fellow of the social-organismic tendency of *fin-de-siècle* sociology.[13]

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l'Espagne du XIXe siècle", in Patrice Bourdelais, dir., *Les Hygiénistes: enjeux, modèles et pratiques* (Paris, 2001), pp. 297–318.

10 Francisco Javier Santero, *Elementos de Higiene Privada y Pública* (Madrid, 1885), II, p. 487.

11 Federico Rubio, "(La Socio-Patología.) Discursos leídos en la solemne sesión inaugural del año 1890 de la Real Academia de Medicina", *Memorias de la Real Academia de Medicina de Madrid* 10, no. 5 (1890), 25–49. See Campos, Monlau, (2003) note 8 and Juan L. Carrillo Martos, ed., *Medicina y sociedad en la España de la segunda mitad del siglo XIX: una aproximación a la obra de Federico Rubio y Galí* (1827–1902) (El Puerto de Santa María, 2003).

12 Ángel de Larra y Cerezo, "Los grandes problemas higiénicos y sociales en relación con las instituciones armadas", *Discursos leídos en la Real Academia de Medicina... el día 9 de noviembre de 1902* (Madrid, 1902), p. 35; Ignacio Valentí Vivó, *La sanidad social y los obreros. Ensayo antropológico* (Barcelona, 1905), II, p. 112.

13 Paul Lilienfeld, *La Pathologie sociale* (Paris, 1896). See Gissis (2002), note 6, and Ulrike Schuerkens, "Les Congrès de l'Institut International de Sociologie de 1894 à 1930 et l'internationalisation de la sociologie", *International Review of Sociology*, 6(1996), 7–24, also at http://www.tau.ac.il/~iisoc/history.html.

No doubt, in the words of prominent professors and most respected citizens, "among all traditional professions, Medicine is the genuinely biological and social", and particularly as Public Health, "is intended to solve the most difficult problems of life in great groups".[14]

Through this display of selected quotations, I have tried to show the factual coexistence of both fields of experience, from the natural and from the social sciences of their time, in the minds and voices of medical writers by the end of the nineteenth century, who seemed happy to explain the social world through medical patterns. But as far as the medical gaze focused on human groupings – which, simultaneously, meant a concern over the problems of governance – the social sciences gained in utility to the medical world.

Let's look to the definition employed by Philip Hauser (1832–1925) – a Jewish physician migrated to Spain from the AustroHungarian Empire, and prolific writer.[15] In a fine monograph of 1884, Hauser analysed its time "from a social medical point of view", showing the increase of nervous disorders and mental diseases, alcoholism, tobaccoism, syphilis, nutritional dystrophy, pulmonary consumption, abdominal typhus and diphtheria. These should be all considered as social diseases, for, first, they sprang "inherent to the vicious organization of society".[16] Secondly, they had to be considered social diseases because of their "ubiquity", i.e. their huge number of victims and last but not least, their consequences on race as "weakening agents" should also be considered. The two last conditions were intimately close to the economic reasoning that summarizes deaths and illnesses in monetary terms and that Chadwick, Pettenkofer or Rochard had turned into fashionable accounting.

Therefore, the "social" condition impinged over the cause, the number of affected and the collective consequences of any given disease. Positivistic minds favoured taking the road of quantification, which in Spain was facilitated by the opening of the National Civil Register in 1871 (although the publication of the series on the Annual Movement of Population started only in 1902).[17] As Barcelona province and municipality were the leading administrations in implementing such demographic tools, quantitative studies on health became a regular feature of the

14 Ignacio Valentí, *Discursos leídos en la Academia de Higiene de Cataluña* (Barcelona, 1892), p. 54; Francisco Laborde y Winthuyssen, *Lecciones de Higiene Privada y Pública* (Sevilla, 1894), II, p. 8.

15 Juan Luis Carrillo, ed., *Entre Sevilla y Madrid. Estudios sobre Hauser y su entorno* (Sevilla, 1996) and *Entre Sevilla y Madrid. Nuevos estudios sobre Hauser y su obra* (Sevilla, 1999).

16 P. Hauser, "El siglo XIX considerado bajo el punto de vista médico-social", *Revista de España,* 101(1884), 202–224; 333–358 (p. 219).

17 E. Rodríguez-Ocaña and Josep Bernabeu-Mestre, "Physicians and statisticians. Two ways of creating the Health Statistics in Spain", *Continuity and Change*, 12(1997), 247–264.

Urban Hygiene Institute of the city of Barcelona from the 1870s on.[18] Luis Comenge (1854–1916), at the time director of the Institute, plot demographic against other economic and social data in 1899 looking for a fuller description of the urban mortality figures up to 13 years of age. A classification was drawn taking into account income levels, cost of renting, type of funeral and place of death, which resulted in a three-layered picture of Barcelonian society, composed by *poor*, *moderate* and *rich* families. Using the death rates found among the rich as a level of comparison, Comenge described an increasing proportion of young deaths as the families departed from that level.[19]

Thus, the pursuit of quantitative studies on population became the way of election to the display of diseases and its harmful consequences as social objects, therefore contributing to the establishment of the idea of a social etiology. Social diseases so constructed in turn acted as irritant spines on the consciousness of *intelligentsia* and pushed it to act. In the liberal world, private philanthropy played a decisive role on the launching of public interventions that were called health campaigns.

Thus, at least since the 1860s there existed a wide acceptance of the idea of the paramount importance of poor housing and nutrition, as well as moral corruption, on the causation of tuberculosis. Although such opinion was mainly based on the professional experience of doctors, quantitative studies started to be led from 1895 on, linking specific deaths with social conditions, as in Madrid and Barcelona. This quantitative evidence fuelled the organisation of several initiatives from the civil society intended to curb this evil, from 1899 to 1907, that evolved into a single national organisation in 1924. Urban dispensaries and mountain sanatoria were the places of the fight against tuberculosis, health education its principal weapon. Statistical accounts of the task of dispensaries, started in 1912, brought new evidence on inequalities.[20]

Another important trend of local demographic studies was centered on infant and child mortality.[21] At first, the numerical evidence served to produce grief and sorrow, a picture of a national catastrophe, and to point out strong social inequalities, but by

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18 E. Rodríguez-Ocaña, "La labor estadística de Luis Comenge (1854–1916) en el Instituto de Higiene Urbana de Barcelona", *Dynamis* 5–6 (1986), 279–306.

19 There were 34,33 rich people dead among every 100 of its class, and the number increased to 38,94 among the moderate class and to 44,49 among the poor class.

20 Jorge Molero, "Tuberculosis como enfermedad social en España", in: J. Molero, ed., *Estudios médicosociales sobre la tuberculosis en la España de la Restauración* (Madrid, 1987), pp.14–21; and "La tuberculosis como enfermedad social en los estudios epidemiológicos españoles anterior a la guerra civil", *Dynamis*, 9 (1989), pp. 185–223.

21 For further precisions on this subject, see Aron Cohen, "La infancia entre la vida y la muerte: la mortalidad de los niños", in J.M. Borrás Llop, dir., *Historia de la infancia en la España contemporánea, 1834–1936* (Madrid, 1996), pp. 109–148; 185–188; E. Rodríguez-Ocaña, "La construcción de la salud infantil. Ciencia, medicina y educación en la transición sanitaria en España", *Historia contemporánea*, no. 18 (1999), 19–52.

1900 it turned into an argument to foster health interventions that led to the developing of a new field of medical practice, under the mid-nineteenth century French name of *Puericultura* (Puériculture). It was defined as "the medical and social activity needed to protect natality, to curb mortality and therefore aimed to sustaining the rise of the population".[22] It had to do with the technical guidance of child rearing and leaned over the shoulders of women, either mothers or mothers-to be. Physicians, then, saw themselves as a kind of preceptors, who sought to free women from the bonds of superstition and traditional habits and to educate then in the new scientific culture ("scientific motherhood" as Apple put it).[23]

The weight of social considerations made that, in such process, individual rights became subordinated to higher strategic purposes, meaning that forceful measures could be applied in order to modify risky behaviour as long as it carried any danger to the public health. A Nation's body stood over infants' bodies, who "although they are linked by blood to their families, they belong to the Fatherland".[24] Such was the spirit of the legislation passed for the protection of infancy and childhood in 1904 as well as the sustaining argument in the development of private and municipal caring centers such as Milk Stations and Well-babies' clinics, that spread over cities.

The definition of an ailment as a "social disease" became an outstanding rhetorical device to attract public interest, and consequently money and jobs which produce new specialties through the timely health campaigns. That which was happening around infant mortality or tuberculosis, served as a model for what was sought concerning other conditions. The main contribution to the knowledge of a new public health problem – first observed at the end of the previous century – was significantly titled *Ankylostomiasis or miners' anaemia as a social disease* (1912). It emphasized its danger as a disaster to industry and a catastrophe to some territories, even though its epidemiological basis was weak, just composed of the working and clinical records of some sixty miners and of an enquiry among some mine doctors. Not surprisingly, its effects were compared to those of tuberculosis.[25]

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22 Jesús Sarabia y Pardo, *Discurso leido en la sesión inaugural del año académico de 1913 en la Sociedad Ginecológica Española por el presidente de la misma* (Madrid, 1913), p. 6.

23 Rima Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries", *Soc. Hist. Med.*, 8 (1995), 161–178.

24 Juan Aguirre y Barrio, *Mortalidad en la primera infancia, sus causas y medios de atenuarlas* (Madrid, 1885), p. 250.

25 José Codina Castellví, *La anquilostomiasis ó anemia de los mineros como enfermedad social, especialmente en España*, (Madrid, 1912), p. 25. On this subject, see E. Rodríguez-Ocaña and Alfredo Menéndez, "Higiene contra la anemia de los minerso. La lucha contra la anquilostomiasis en España (1897–1936)", *Asclepio*, 58/1 (2006), 219–248. On the relationship of health campaigns and the forging of new specialties, Rosa M. Medina and E. Rodríguez-Ocaña, "Profesionalización médica y campañas sanitarias en la España del siglo XX", *Dynamis*, 14 (1994), 77–94.

These studies on local data matched a long standing strand of international literature, producing the corollary that disease and poverty, poverty and disease, joined in a chain that held the greater part of society in a subordinate position. This particular metaphor of a vicious circle chaining workers to poverty was employed by Francisco Murillo (1865–1944) – a member of the National Institute of Hygiene who was later to become head of the General Directorate for Public Health – as one of his main arguments in favour of the implementing of social insurances in 1918.[26] The same metaphor can be also found in the arguments employed by René Sand (1877–1953) as he turned "from a sociological biology to a social epidemiology" in the early 1930s.[27]

However, the development of microbiology posited new explanations that challenged at first the older social paradigm. Hauser (1902) recognized this challenge and drew a distinction between infectious and "true" social diseases (comprising alcoholism, syphilis and consumption) (at that moment, Hauser was 70 years old).[28] He thus primed the global degenerative effects of diseases as the core tenet for its social definition but, in general, the question was solved thanks to the numerical method, and the social label was applied to all disorders (including transmissible diseases) that affected the populations at a great scale, in account of their economic and racial outcomes and consequences on the strength of the nation. An extensively distributed handbook *circa* 1910 by Alfredo Opisso (1847–1924) – a very prolific medical translator and publicist, who contributed heavily to some successful paperback series (*Manuales Soler*, and *Manuales Gallart*) intended to the dissemination of knowledge – included a section on "social diseases", listing anaemia, slow starvation, tuberculosis, alcoholism, venereal disease, madness, neurasthenia, heart diseases, arteriosclerosis and brain stroke, several epidemic and endemic diseases, cancer, unhealthy industrial shops, women's work, diseases at school, animal diseases transmissible to human beings, infant mortality, depopulation and crime. As we may see, the list is not made upon a single axis, and together with purely anatomical and pathophysiological disorders there can be found conditions linked to modern patterns of life as well as conditions that are read as diseases of the political body, such as the last two.[29]

Remainders of the old view of social pathology, corresponding to a medical reading of the evils of society, some physicians defended a direct modelling of the

26 Francisco Murillo Palacios, "La defensa social de la salud pública», *Discursos leídos en la Real Academia de Medicina... el día 14 de julio de 1918* (Madrid, 1918), pp. 11–60.

27 Patrick Zylberman, "Hereditary disease and environmental factors in the 'mixed economy' of public health. René Sand and French social medicine (1920–1934)", in J. P. Gaudillière and I. Löwy, eds., *Heredity and infection. The history of disease transmission* (London, 2001), p. 267.

28 Ph. Hauser, *Madrid bajo el punto de vista médico social* (Madrid, 1902), I, pp. 49–50.

29 Alfredo Opisso Viñas, *Medicina social. Estudio de las enfermedades colectivas, sus causas, profilaxis y remedios*, Manuales Soler, no. 78 (Barcelona, c. 1910).

human society on biological organisms and discussed "the wrong functioning of cells that form the Nation"[30] by "applying the laws of medical pathology".[31]

Manuel López Comas, Provincial Officer of Health of the Balearic Islands, in 1907 defended the change of name of the former Public Hygiene into a new Social Hygiene, that comprised both a theoretical part, based on sociology, and an applied part (*Sanidad*), which resulted in the application of those theoretical principles to the guidance of people (in the sense of governance). López Comas also pointed out that public health as thus defined should keep "an indissoluble partnership" with the public charities organisation (*Beneficencia pública*).[32]

The link between social hygiene and the public schemes of healthcare, that is between the description of population effects of widely suffered diseases, the study of their causes, the invention of means of protection against them and the provision of actual care for those in need, gave way to the label of social medicine being applied to this special set of medical theory and practice, which eventually won over the former. Early evidence can be found in Opisso's work (*c.* 1910) already quoted, where the definition of social medicine joined aspects of pathology, hygiene, sociology and political economy – albeit recognising that as a discipline it stood still "on an embryonic state". This view stressed the value of applying knowledge, through some "hygienic institutions", as the sole way to fight collective diseases; therefore, the character of this medicine departed from that of clinical medicine, centered on the individual.

A Political Character for Social Medicine

The politics of formally democratic Spanish Monarchy, since its Restoration in 1875, were based on a broad agreement between two parties, Conservative and Liberal, of a marked oligarchic character, which substituted each other as the government at the Monarch's will. In this context, general elections played a subsidiary role, being the expression of the change in the central offices. The system cracked after the 1898 war, stagnated between 1909 (riots of the so called Tragic Week) and 1913 (murder of the Liberal Prime Minister José Canalejas) due to the fragmentation of the parties, and finally collapsed, as it was unable to integrate the emerging new actors in the social scene, such as Labour representatives, Regionalists and Republicans. From 1917 on, the political situation deteriorated rapidly due to growing social unrest, with an unparalleled number and duration of strikes, as

30 Saturnino García Hurtado, *Ensayo de Patología Social* (Madrid, 1909), p. 12.

31 Pedro Martínez Baselga, *Las penas del hombre: Patologia social española* (Zaragoza, 1903), p. 4.

32 Manuel López Comas, "Sentido sociológico de la sanidad pública", *Rev. balear de ciencias médicas*, 29 (1907), 141–153; 161–173.

much in industrial as in rural areas, spreading enormous fear among the well-off classes.[33]

Anyhow, a deep change in the moods of government came after 1898; *laissez faire* politics and forceful repression transformed into an interventionist stance on social relationships. Accordingly, a flood of medical (or health-seeking) projects, proposed by physicians but formally open to diverse contributors, spurred – including attempts to modernise the health administration. We can observe the lead of Catalonian initiatives over centralist ones at Madrid, a common feature of this time in the modern history of Spain, and that practically all were couched within the social medicine stance. Now I propose to follow the most significant of them.

The Catalonian Academy of Hygiene (CAH), gathered practically all Catalonian doctors who cared about large-scale implementation of modern hygiene. It was born in 1887, as a by-product of the process of generation of a Spanish Society for Hygiene, first launched in Barcelona around the publishers and contributors to the medical journal named *Gaceta médica catalana* but finally achieved in Madrid (1883) by the medical group around *El Siglo Médico*, the established leader of Spanish medical journalism.[34] Consequently, CAH became instrumental in the coming to being of the *Patronato de Cataluña para la lucha antituberculosa* (1903), a Board to fund and manage the first Dispensaries against tuberculosis, that after 1909 were merged with the general Spanish organisation.

In 1906, the CAH organised a first open conference, one of its three sections being dedicated to social hygiene. The contents of this session included three invited papers that dealt with core problems of industrial life (housing for workers, dust producing industrial processes and work accidents), and six registered papers, three on infant and child hygiene and two on venereal diseases. As wrote one of the most enthusiastic among its members, Jaume Queraltó i Ros (1868–1932), "hygiene, at the summit of its development, becomes the social science par excellence".[35]

Conducted by the same Queraltó, between April 1911 and November 1912 a Catalonian Institute for Social Medicine, *Institut Médic-Social de Catalunya*, organised several public series of lectures, up to some seventy, at the *Ateneo* of Barcelona, a private cultural circle of the Regionalist intelligentisa, and at the *Ateneo obrero* , a similar institution created by workers, to publicize "the betterment of medicine and social relations". His main character, Queraltó, was at the time the personal physician of Anselmo Lorenzo, one of the great names of Anarchist unionism. Among

33 F. del Rey Reguillo, "El empresario, el sindicalista y el miedo" in: R. Cruz and M. Pérez Ledesma, eds., *Cultura y movilización en la España contemporánea* (Madrid, 1997), pp. 235–272.

34 Rodríguez Ocaña (2001), "Confort,…", note 9.

35 Queraltó, *La tasca social de I'Higiene* (Barcelona, 1907), p. 15.

the forty lecturers one finds university professors, well-known physicians and lawyers, even the chief prosecutor of the province of Barcelona, together with a couple of known Anarchists and several Republican doctors. Nevertheless, the Institute enjoyed some official funding from the highest civil and military authorities until the forced exile of his mentor to Madrid, where he lived until 1917, put an end to these endeavours.

Another official of the CAH, its President in 1909 and President of the Tuberculosis Board in 1911, Enric O. Raduá i Oriol, a municipal medical officer since 1896, contributed with the funding of a journal, *Medicina Social*, that lasted between 1911 and 1919. Its clear subtitle read: *Monthly review of hygiene, demography, social medicine, pedagogy and sociology*. It followed a short lived adventure, the *Revista Demográfica y Social* (social and demographic journal) of 1908. The editorial board included more than a dozen physicians, mostly extracted from the circles of medical Catalanism, as well as one engineer, one architect and one lawyer. At the head of the 65 contributors, the chief editor produced a rough 25% of all articles. The key questions were mortality statistics – for years, Raduá held a position in the municipal office for health statistics – and the fight against tuberculosis.

These Catalonian initiatives found a tardy echo in the capital of the Kingdom, where also a journal and an institute devoted to social medicine were created during the critical conjuncture of 1917–1920.

As stated before, the political system was totally upset by 1917. Internal reasons add to external sources of concern, as were the colonial war in Northern Morocco, derived from an agreement with France and England of 1912, and none the less, the Great European War. Spain kept neutral, although Conservative leaders and most of the high command of the Army, including King Alphonse were in favour of Central Empires – which in turn helped the Allied cause to grow close to Republicanism and the Left. Not surprisingly, the opposing aims by Western and Central powers concerning Spain ended up favouring both the same outcome, a severe social and economic instability.[36] The flu epidemics of 1918–1919 increased drama with the deep disruption of social life it brought about, not less than by the dismal feelings of impotence associated and by its heavy toll of victims.[37]

In front of such crises, professional groups, a part of the growing urban bourgeosie, developed an original answer of their own mainly composed by proposals on

36 Carlos Seco Serrano. *Alfonso XIII y la crisis de la Restauración* (3rd. ed., Madrid, 1992); Francisco J. Romero Salvadó, *España 1914–1918. Entre la guerra y la revolución* (Barcelona, 1999).

37 E. Rodríguez-Ocaña, "La Grip a Barcelona. Un greu problema esporàdic de salut pública. Epidèmies de 1889–1890 i 1918–1919», in: *Cent anys de Salut Pública a Barcelona* (Barcelona, 1991), pp. 131–156; Isabel Porras Gallo, *Un reto para la sociedad madrileña: la epidemia de gripe de 1918–1919* (Madrid, 1997); Beatriz Echeverri, *La gripe española. La pandemia de 1918–1919 en España* (Madrid, 1993).

the health domain.[38] In 1917 and 1918, the first official discussion on national health insurances was led. Ideas were drawn on "nationalization of medicine", that crawled into painstaking and unsuccessful parliamentary negotiations over a new Health Law to substitute the obsolete version of 1855. Medical journals launched a campaign asking for an independent Health Ministry, which they all described as an independent technical institution, conducted by a prestigious medical doctor and protected against the frequent changes in office that were the norm for the government in those days. Following the ravages of the flu epidemic, words were heard in favor of *una dictadura sanitaria* (a public health dictatorship).

The professional mind favoured an understanding of political crisis in terms of technical inefficiency. This tendency supported the opinion, then expressed by younger intellectuals as José Ortega y Gasset (1883–1955), about the legitimacy of professional elites to conduct the masses of the people, due to their knowledge and expertise.[39] This political direction included a strong commitment with education, and one of the public enterprises of this period led by philosopher Ortega was the foundation of a League for Political Education (1913).

Such was the moment of the greatest visibility for social medical discourse, aimed to curb social conflicts and to produce a peaceful relation among classes. As previously said, a journal (*La Medicina Social Española,* 1917–1920) and an Institute of Social Medicine (1919–1923) were created in Madrid, but encompassing the whole nation. The journal and the Institute seemingly addressed different circles; while the former mobilized the newly formed corps of health officers, and kept links with the Conservative fraction led by Juan de la Cierva Peñafiel (1862–1938) an epitome of law and order, the later recruited members among the professional elite and had an array of political sensibilities represented, including some prominent Conservative lawyer and social scientist Manuel Burgos Mazo (1862–1946), Republican and philo-Anarchist publicists as Odón de Buen (1863–1945) or José García Viñas (1838–1931).

The editor in chief of the journal was the general secretary of the official Commission against tuberculosis, Bernabé Malo de Poveda (1844–1926) – who later counted as correspondent among the members of the Institute. Its first issue dressed a roll of 132 contributors, 45 among them were provincial health officers (practi-

38 Hedwig Herold-Schmidt, *Gesundheit und Parlamentarismus in Spanien. Die Politik der Cortes und die öffentliche Gesundheitsfürsorge in der Restaurationszeit (1876–1923)* (Husum, 1999); Rafael Huertas, "Fuerzas sociales y desarrollo de la Salud Pública en España, 1917–1923", *Rev. San. Hig. Pub.*, 68 (monograph issue II Encuentro Marcelino Pascua) (1994), 45–55; Rafael Huertas, "Medicina y política en la crisis final de la Restauración. La propuesta de un Ministerio de Sanidad", in M. Nash and R. Ballester, eds., *Mulheres, trabalho e reproduçao. Attitudes sociais e politicas de protecçao à vida* (Porto, 1996), pp. 285–299; M. Isabel Porras Gallo, "La lucha contra las enfermedades evitables en España y la pandemia de gripe", *Dynamis* 14 (1994), 159–183.

39 Francisco Villacorta, *Burguesía y cultura: Los intelectuales españoles y la sociedad liberal, 1808–1931* (Madrid, 1980).

cally, all there existed at that time), 21 were university professors and a great deal of the rest, physicians employed by the administration. In 1920, the list was reduced to 47 contributors. The founding of the journal responded to "social needs scarcely met", which had given rise to a "clear, well defined movement" (*Med. Soc. Esp.* 1916; 1*:* 7–8), that sought to promote a Spanish Company of Social Medical Institutions, which never went true due to the failure of the journal (*Med. Soc. Esp.* 1920; 5*:* 1–3). It was written that the operation was known and approved by de la Cierva and the King. Its content was fairly exhaustive; the greatest number of papers appeared under the general heading of Hygiene and public health (28%), followed by those on Tuberculosis (18%), Infectious diseases (17%) and Infant and child diseases (9%). A section of Feminist Notes (12%) displayed for the first time in a systematic way comments and analysis on matters related to women and health, most of the papers written by medical women or by women teachers. Of the nine authors that contributed with more than the half of all published papers, three were also women: Concepción Aleixandre (one of the first women to win a medical license, in 1886) and the teachers Concepción Saiz de Otero and María Carbonell.

The Institute for Social Medicine, which has become a token to research on the introduction of Eugenics in Spain, aimed to renew or "regenerate" the health situation of the state, through the education of population and the guidance of authorities, as the only means to put an end to social conflict.[40] Therefore, their membership was open to other than physicians, and lawyers, educators and military personnel joined it, in numbers that doubled, in less than one year, the initial list of 270 members. For instance, more than a dozen high Navy officers, including the chief of the health services, fourteen provincial health officers, three professors of forensic medicine and two of hygiene were included. The call to form the Institute was expounded in the last weeks of 1918 through an exchange of public letters between two physicians, a military one expert in psychiatry, César Juarros (1879–1942), and Antonio Aguado – related to Antonio Piga, professor of Forensic medicine at the University of Madrid, who was also among the earliest members.[41] The 1st January 1919, a founding board of twenty fellows, fifteen physicians, two lawyers, one Navy officer, one veterinary surgeon and one educator settled its consti-

40 Raquel Álvarez Peláez, "El Instituto de Medicina Social: primeros intentos de institucionalizar la eugenesia (en España)", *Asclepio*, 40 (1988), 343–358; "Introducción al estudio de la Eugenesia española (1900–1936)", *Quipu* 2 (1985), 95–122; and, "El pensamiento evolucionista y su influencia en las ideas medico-sociales durante el primer tercio del siglo XX", in Miguel Angel Puig-Samper, R. Ruiz and Andrés Galera, eds., *Evolucionismo y cultura. Darwinismo en Europa e Iberoamérica* (Madrid, 2002).

41 Pedro Samblás, "El Dr. César Juarros y la Escuela Central de Anormales", in José Martínez-Pérez et al., eds., *La Medicina ante el nuevo milenio: una perspectiva histórica* (Cuenca, 2004), pp. 539–550 ; and "César Juarros y el Tratamiento de la morfinomanía: ¿cura u ortopedia? ", *Frenia*, 2 (2002), 123–137. Antonio Piga, A. Aguado Marinoni, *Las bebidas alcohólicas. El alcoholismo*, Manuales Soler, #52 (Barcelona, c. 1910).

tution. The Institute divided into four sections, respectively aimed to 1. "the study of Spain as a social body", 2. teaching, 3. publicity and 4. political action. In practice, its activity was reduced to lectures and pamphlets, such as *A popular primer on social medicine*[42] but it associated with others (the Red Cross, the Madrid provincial Medical Association and the Spanish section of the International Group Pro Humanité, unregistered in any known previous study) to build of a Spanish League for Social Medicine (1920–1923) that searched to conduct government decisions with "biological sense".

Some relevant members of the Institute took part in a Social Medical Week, held in honour of the Royal Family at their vacation resort in Santander, in August 1920.[43] Alphonse XIII, at the inauguration of the lectures, described two paramount health problems, tuberculosis and malaria, as the axes around which health policies should developed. Subsequently, the Chief Health Officer, Manuel Martin Salazar (1854–1937),[44] boasted that thanks to His Majesty's words, the government had given him a supplementary budget worth half a million pesetas to public health purposes. This was the formal excuse to the beginning of the organised fight against malaria, under the direction of Gustavo Pittaluga (1876–1956),[45] although the budget was rejected by Parliament and the money was never made available. Pittaluga coined a definition of Spain's main health problem as the need to implement interventionist policies – sustained by the science of hygiene, the technical devices of public health and the will to act through social medicine.[46] Malaria was an extensive, century-old handicapping condition for extensive rural regions in Spain that became a "social disease" once peasants grew to political subjects.

To conclude and summarize: the analogy biology/society cherished by first wave sociologists in the nineteenth century was sustained and used by Spanish medical writers. If during many years, this use could be considered mainly a pure figure of speech, a rhetorical style shared with other layers of the professional elites to discuss about contemporary problems of social life and politics, there was a moment –

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42 A. Aguado Marinoni and Luis Huerta, *Cartilla popular de Medicina Social* (Madrid, 1919).

43 Manuel Martín Salazar, "La Semana Médico-social de Santander", *Med. Soc. Esp*. 5(1920), 385–392.

44 Francisco Salas Fernández, *Manuel Martín Salazar. Apuntes biográficos* (Sevilla, 1998), also available at http://fcosalas.eresmas.com/frames.html.

45 Esteban Rodríguez-Ocaña, "International Health Goals and Social Reform: The Fight against Malaria in Interwar Spain", in I. Borowy and W. D. Gruner, eds., *Facing Illness in Troubled Times. Health in Europe in the Interwar Years, 1918–1939* (Frankfurt A.M., 2005), pp. 247–276. E. Rodríguez Ocaña, Rosa Ballester, Enrique Perdiguero, Rosa M. Medina and Jorge Molero, *La acción médico-social contra el paludismo en la España metropolitana y colonial del siglo XX* (Madrid, 2003).

46 Gustavo Pittaluga, *El problema político de la sanidad pública*, (Madrid, 1921).

around the new century – when social methods (quantitative) and social worries served as a way of constructing a medical thought. Doctors started to explain medical matters in social terms, as they strove in search of massive programmes of prevention and care. Political crisis and growing professional ideology, though, helped to instil a new life to the old analogy and physicians – not only public health people – sought to serve their country providing a (social) biological guidance to governments and a (social) biological education to the people. Social medicine in Spain, from the 1920s to the 1960s produced a deep influence on the shaping of public health policies, no matter the political regime.

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Social Hygiene and Social Medicine in Interwar Czechoslovakia with the 13th District of the City of Prague as Its Laboratory

Hana Mášová

In the First Czechoslovak Republic (1918–1938) the main focal points for social access to medicine were the external activities of medical and social workers, operating outside the framework of the traditional curative institutions. It was hoped that the interconnection between curative and preventative medical care consequent on the creation of such institutions would ensure unity, and enable society to cope efficiently with the demographic disaster caused by the First World War and later exacerbated by the economic depression in the 1920s/1930s. In the modern era – at the time of democratisation and collectivisation of the productive and social life – neither the conventional work of family doctors nor the activities of traditional hospitals could cope adequately with social illnesses. They could not keep up to date with discoveries of science and make efficient use of them.

Modern concepts of public health in Middle Europe have their roots in the eighteenth century, in the work of J. P. Frank (System einer vollständigen medizinischen Polizay, 1779–1817) especially. Though it developed in our historical lands, during the first decades of the twentieth century Czechoslovak hygienists and health officials began to question how it was possible that the development of public health in our country had been by-passed by various systems of health care abroad, especially in Anglo-Saxon countries, and if it was possible to seek inspiration there, and to apply their methods towards the modernisation of the Czechoslovak health and social services. The Imperial Health Act of 1870 (and provincial Acts as well, that were subsumed into the republic's laws in 1918) was in reality an act organizing health services only, and it was obsolete, and bureaucratic. Health Service referred more to health administration, health insurance was without medical supervision, and not controlled by physicians. Preventative medicine lacked status. Curative medicine was specialised and the poor had uneven access to specialists, although therapeutic care in public hospitals was available also to the

poor, as the fees, for those unable afford treatment themselves, were paid out of public funds.[1]

The main tasks the newborn Czechoslovak Republic in this area were: post-war reconstruction and consolidation; rescue of finances; reforming bureaucratic administration; handling the housing shortage; addressing the "national suicide" rates, e. g. by reducing morbidity and mortality rates; and to further positive population dynamics by effective means, increasing the natural increment of the population which had been dropping steadily; acknowledgement of the progress of medicine (preventative as well as curative) and the new social circumstances while responding to them by the reorganisation of health service ("Health for all!"); definition and application of social hygiene, social medicine – a huge evolutionary field of scientific and practical work; as well as enhancing the role of the City of Prague as a national capital.

In Czechoslovakia positive factors manifested themselves in a large extension of health and social insurance,[2] and a relatively dense network of public hospitals (especially in Bohemia and Moravia), as well as increasing numbers of municipal, district and provincial physicians. What was crucial indeed was the attitude of the state administration – opportunities for reforming Public Health were affected by the ideas and theories of those at the government, who currently supported the trend of a change. In the early 1920s there were attempts at radical novelties in the organization of public health, some of them strongly advocated by the Ministry of Health and Physical Training constituted on the 2nd November 1918.[3] Not all of the attempts at the reform of the public health services were successful, some plans had been radical but the results were often modest. That they were not realised was due in the main to the financial causes, the weak Ministry of Health was chronically short of money.[4] Also important were reluctant attitudes of professional medical organisations and the outflow of the revolution wave in the early 1920s.

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1 According to the right of domicile since the 2nd half of the nineteenth century (and Poor Law 1862) the commune was responsible for the care of its poor and powerless members.

2 The insurance system constituted in 1888 was being improved and in the mid-1930s 7 million people (over half the population of the Republic) belonged to the Health insurance associations (membership of insurance associations was compulsory for all workers, servants or apprentices and their families).

3 E.g. in the concept of reorganization and nationalisation of hospitals and of community doctors: by the Law on the Nationalisation of the Health Administration (April 15th, 1920) all health services (sanitary police measures) were brought directly under State control and community doctors became state servants. By the Law of April 9th, 1920 on the Provisional Arrangement of the Legal Status of Hospitals and Charitable Institutions all the public institutions and the private ones, possessing the status of public hospitals (with the rights and obligations of a public institution), came under control of the State, some of them being nationalised.

4 The Health insurance associations were the remit of the Ministry of Welfare, which therefore become fairly moneyed.

Generally speaking, health conditions after the four-year war and conseqent destruction quickly returned to their pre-war level in the so-called historical lands, e.g. Bohemia and Moravia-Silesia, to the status quo with its natural tendency of steadfast though slow progress.[5] In Bohemia and Moravia there existed a long tradition of a relatively good health care, clinical disciplines at a high level; and preventive efforts penetrating into medical care, though Austrian health services were based on a police, i.e. repressive, principle. Duties delegated by the state health administration to the local authorities in the nineteenth century contributed to establishment of system containing elements of local autonomy and civic responsibility for health questions. Due to the relative efficiency of the old system, which was even strengthened in the new state by innovations introduced in the course of years, it was not easy to push a brand new radical arrangement. This can be seen, for instance, in the discord between practitioners and insurance institutions and their mutual difficulty getting used to one another, and later on, in the widening gap between prevention and treatment, and a painful way to the abolishment of the contradictions between them.

Traditions of social hygiene (Gustav Kabrhel and Friedrich Breinl) and social medicine (František Procházka) were set at both (Czech and German) medical faculties at the Prague university as long ago as the era of the Habsburg monarchy, but now they had to respond to a new wave of social medicine as taught at the new universities in Brno – Moravia (František Hamza) and in Bratislava – Slovakia (Stanislav Růžička), and to the ambitious experimental and educational plans of the State Health Institute (the scientific body of the Ministry of Health and Physical Training).[6] Social approaches emerged in the preparation of new legislation including a basic Health Act.

There were more initiatives attempting to transfer the old system of police health organisation to the modern social public health ethos. At the same time voluntary welfare organisations, spreading in the country after the revolution 1918 in great number, based on private endeavours and private material support, as well as social and health centres dispersed and economically weak and limited to purely preventive measures, had to face tasks beyond their ability. Many consulting rooms developed, and later some of them were combined in so-called "Health and Social Care

5 The application of the health care model existing in Bohemia and Moravia to the eastern acquisitions – Slovakia and Subcarpathian Ruthenia – lands of a different levels in many regards, and the protection of the country from diseases spreading from neighbouring countries were considered the most important tasks of the new Ministry.

6 Časopis pro zdravotnictvo. Orgán sdružení profesorů hygieny universit Čsl. republiky a Čsl. eubiotické společnosti zdravotnické. Bratislava 1909– (Časopis pro veřejné zdravotnictví, vyd. Hygienický ústav, Praha 1/1899–), ed. G.Kabrhel and S. Růžička; Kabrhel, G.: Po 50 letech. Praha 1933; Procházka, F.: Sociální lékařství. Praha 1925; Hamza, F.: Sociální lékař. Praha 1923, and: Úvahy o sociální práci zdravotní. Praha 1921; Pelc, Hynek: Sociální lékařství. Praha 1937; etc.

Houses" or "National Health Institutions". Their organization and scope for employment, and their relation with institutional "closed" (residential) care, emerged from domestic roots at the beginning of the 20th century, but after the First World War not only did their number rise considerably (over 1000 baby-and-mother clinics, nearly 200 dispensaries for TB, and about 30 for sexually transmitted diseases, among others) but they responded also to the new trends coming in from abroad.

Principles of Public Health, as understood in Germany, France and Britain, were fairly well-known in our lands in the 1910s–1920s. Closer contacts between Czechoslovakia and the U.S.A. were novel after the War.[7] Importantly, it was stressed, Americans brought help, money and guidance when it was so urgently needed in the post-war period. It is nearly impossible to overestimate the assistance of the American Red Cross, YMCA, YWCA and other American organizations in the post-war destitution. Their advice in organising social work was eagerly requested, also. Consultancy as introduced by the American Red Cross (registers of children up to 10 years, family visitation, health registers) was to be involved in work of the local dispensaries for TB, venereal diseases and in other health-care institutions. Experience of the work of American social nurses was to enrich Czechoslovak ideas of modern socio-medical nursing. A lot of work was achieved with their help in Prague itself. American post-war relief, charitable missions, and especially the Rockefeller Foundation, not only facilitated the construction of the State Health Institute (opened with their aid in Prague as early as in 1925), but also influenced dozens of the Czech hygienists – the Rockefeller Foundation grantees studying in the USA the work of American health centres. This American experience led to great emphasis on research, focussed on statistics and synthesized methods of the biological and social sciences; but at the same time they advocated the "pure" preventative aim of consulting rooms. This approach was also conveyed to some protagonists of the professional medical organizations who were more oriented towards private practice and were afraid of competition with the non-profit policlinics and consulting rooms.

The attempt to amalgamate the scattered specialized consultancies which had existed up to then, and to organize them on a comprehensive basis into Health Centres, started as early as the end of the First World War and the period immedi-

7 The daughter of the Czechoslovak president T. G. Masaryk, dr. Alice Masarykova, invited representatives of the Rockefeller Foundation to the Czechoslovak Republic as counsellors to the Ministry of Health in 1919. On its activities see: Niklíček, L.: Založení Státního zdravotního ústavu republiky Československé a spory o koncepci jeho práce; in: Československé zdravotnictví 25/3 (1977), 97–108; Page, B.: Imprese: Rockefellerova nadace a rané Československo. Počátky; in: Dějiny věd a techniky 35/3–4 (2002), 151–176; Page, B.:. Imprese: Rockefellerova nadace a rané Československo. Práce… a kritika; in: Dějiny věd a techniky 36/2 (2003), 89–119; etc.

ately after it (Vyškov, Hradec Králové, Moravská Ostrava, Pardubice, Plzeň)[8]. District socio-healthcare institutions (Health and Social Care Houses or National Health Institutions) arose, at the end of the war and soon after, as a result of the initiatives of volunteers, such as the executive bodies of the American and Czechoslovak Red Cross, the Masaryk League against Tuberculosis, Care for Youth, Protection of Mothers and Children, Our Children consultancies, and others. They were administered by boards of trustees composed of state representatives, healthcare bodies and representatives of the afore-mentioned associations, whose operations were subsidized with the support of those associations.

The dichotomy between of outpatient (extramural) service in hospitals on the one hand and private consulting rooms of practitioners on the other, and the tasks of health centres run either by voluntary bodies or by the state/regional authorities seems to have been the crucial issue to be dealt with. There existed some scarce cases of medical institutions associated with consulting rooms in one building, or of physicians who worked at the same time as in-patient doctors and as chiefs of some voluntary consulting rooms out of their institute. But the ambitious goal was to find out new and more effective ways of the cooperation among the various subjects of health assistance, consultancy, and – eventually – social aid. As an example of such an institution providing both the curative and preventive/consultant service can serve one founded in one of the most rapidly developing part of the city of Prague – the new Czechoslovak capital. The "model district" in Prague XIII should have become the place utilizing the latest methods of social hygiene and healthcare organization, an enterprise of coordinated social work and health service, supervised by the State Health Institute.

Greater Prague

When the Czechoslovak Republic was constituted in 1918, Prague, which under the Habsburg rule had been reduced to the status of a provincial city, was transformed from a city of minor importance into the capital of an independent state. The law decreeing the formation of Greater Prague in 1920 (Law No.114 from the 6th February 1920, implemented on the 1st January 1922) joined to Prague (with some 200,000 inhabitants) 38 neighbouring independent communes, and united all these districts (with 750,000 inhabitants and continuous immigration influx) into one city having a single economic and cultural administration. Construction was undertaken on a grand scale and in short time placed the city among the biggest and most advanced in Europe. In particular in dealing with the social and humani-

8 In 1937 such socio-health institutions could be found in 15 towns.

tarian problems, as well as in hygiene and the organization of the city, remarkable advances were made.

Prague was described as a city of very good health conditions, with an excellent supply of good water – though the drainage system of 1897 had not been completed; beautiful position, with many public gardens, a healthy climate, children´s infectious diseases under control (through the school inspections initiated in 1904), and excellent hospitals and sanatoria, the ministry of health; and an intelligent man of broad knowledge in charge of the office of the City Physician (i. e. Ladislav Prokop Procházka). On the other hand commentators pointed to aftermath of the war, relics of imperial bureaucracy, the fact that the discipline which existed under the Austrian rule was not replaced by a new one, genuine lack of money, high TB mortality rates (356 per 100,000 inhabitants) and the infant mortality rate (143 per 1,000 childbirths); venereal diseases not being appropriately treated because of consideration of confidentiality; and the low social status of nurses had part.[9]

According to the Chief Physician Procházka himself the position of Greater Prague was not as good as described by Platt: it had bad ventilation, only 1/3 of the town had adequate drainage (9/10 of the adjoined districts had none and wells were of varying quality). The housing shortage had been worsened by war and immigration. School hygiene, based on German methods, needed to be complemented by physical training, and disinfection would have to be applied more pragmatically. It was not possible to repeat the style of slum clearance done in the case of Josefov (formerly a Jewish ghetto) at the turn of the nineteenth/twentieth centuries – it was not possible any more to move poor people out and to build showplaces for the rich in their place. A regulatory plan was of the essence.[10] Procházka believed that the many of the problems of organised social and health care could be alleviated by upbringing.[11] In his concept the only adequate therapy for social pathology was the elimination of its causes. This was not the business of doctors; their job was to remove symptoms; the impacts of the social conditions on health. Social legislation established an eight-hour working day, protection of pregnant women, aid in motherhood, reducing levels of child labour, health insurance etc. Health policy on the other hand was more heavy-footed. It was necessary to prepare doctors for change. They were accustomed to curing individuals seeking their aid; and now they had to learn how to seek out the diseased themselves. It was not enough to stay

9 By P. S. Platt, lieutenant of the American Relief Association; see Platt, P. S.: Přehled veřejného zdravotnictví Velké Prahy. II. Praha 1920. There were 36 hospitals (11 general, 13 military, 4 religious and 8 private) with 15,621 beds, but only 1,483 nurses in Prague that time.

10 Procházka, L. P.: Zdravotnictví Velké Prahy. Popis, úkoly a návrh organisace, Praha 1922.

11 Prague with its 0.64 % illiteracy rate over than 7 years of age was in the 1st position of literacy among big European towns of that time and in a good position therefore to benefit from education and training. Procházka, L. P., op. cit.

in and wait for patients to attend in private practices any more. And this change had to be coordinated by the health authorities. Not only Procházka was of this opinion. The extending role of doctors in the health care was an important issue of theoretical debates, a goal of endeavours throughout the country, as will be mentioned later.[12]

Prague was a statutory city, administrated by municipal authorities. The Health Department of the City Council[13] with rights to initiate and executive authority was a domain of jurists, and focussed on control – dispensing licences, pursuit of trespassers, charge of health-insurance, requisitioning reimbursements for hospital treatment of poor patients from domiciles, etc. The Office of Chief Physician was an advisory one and was without executive power. Nineteen town-district doctors and district physicians had to cure paupers, exercise the inspection and supervision of hygienic activities, but they were answerable to the Health Office. Fourteen school-doctors and three dentists cared for the children under the municipal structure. The Chief Physician Ladislav Prokop Procházka (the chief health officer of Prague in the years 1910–1935; minister of health in 1920–1921) produced a brief for the re-organisation of the health service in the early 1920s. He proposed the creation of a Health Office for the City of Prague with executive rights and with a chief physician at its head. The existing Health Department of the City Council would be transformed into one of Health Office sections and the existing Office of the Chief Physician with equal rights would be another, next to statistics, chemical, bacteriological, demographic, veterinary and market sections. The Health Commission would act as an appeal board and contact body for the central city authorities. His aim was to reduce the bumbledom of health administration controlled by jurists; but also to create a model for the state-run Public Health administration in country districts. Overall control of the health offices would be the remit of the Ministry of Health and Physical Training (founded in 1918) and not the political administration (municipal and district authorities) that were subordinated to the Ministry of Internal Affairs. Social hygiene would obtain proper authority this way, it was hoped. The Health Office of the City of Prague would manage five town district offices and the sixth one would be the health district Prague XIII controlled directly by the Chief Physician.

Another of Procházka´s proposals was to build up a Central Board of Consulting Rooms (post-natal clinics, baby and children´s clinics, vocational guidance etc.) whose constituents would be the municipality, the Central Social Office, the Chief Physician´s Office, Red Cross, League against Tuberculosis, Care for Youth and others. This cooperation with the voluntary organisations, hitherto existing on an

12 Procházka, L. P., op. cit.; Pelc, H.: Poradenství v rámci sociální politiky. Praha 1934; et al. See also the related literature at the end of this article.

13 60 health districts – each district had approximately 15,000 inhabitants.

ad hoc basis, unequal, without control, without accord, with uneven subsidies, would be proved in the model 13th district of Prague.

The 13th District of Prague – Praha Vršovice

The "model district Vršovice – Praha XIII" was one of the enterprises using the newest techniques in social hygiene and health-care, an enterprise of coordinated social work and health service.

At the national 1st Congress of Health and Social Work, on 28 April 1928, the plans for the next ten years were elaborated. These aimed at effective division of labour. Methods of social and healthcare work were to be examined in several exemplar districts distributed round the state in rural as well as urban areas (e. g. Kvasice, Unhošť-Kladno, Turčianský Sv. Martin). Some of them had been already operating for couple of years. It was challenging to experiment and to demonstrate the results of social hygiene.

Procházka was the initiator of a "model district in Prague XIII". For him social-health consulting rooms would be national institutions maintained in action by the co-operation of state administration (for management, maintenance, and supervision) and citizens, who would take part in the administration of organised voluntary charitable care. Their activities would be advisory and analytic. Next to doctor-specialist cooperation, similar was envisaged from lawyers, chemists, vets, statisticians, clerks, disinfectors, nurses and midwives. Procházka was aware of the fact that Prague could not come up to the health levels of Zurich or Stuttgart (with similar terrain conditions) by further slum clearances – something that could last for centuries and cost milliards. But if detailed registers of mortality and morbidity rates of the particular communes is elaborated and used in the selection of areas for sanitation, then "reasonably and virtually performed socio-health care will help us to save work from one half, and can supply a thorough urban renewal for tenths of money".[14]

The reasons why the 13th district of Prague (Vršovice, Hostivař, Strašnice, Záběhlice, a part of Spořilov), one of the biggest districts of Greater Prague with over 80.000 inhabitants, was chosen to serve as a demonstration area for "model work" were: 1) Suitable location; 2) Good tradition of voluntary activities and willingness to take part in the experiment (maybe even in the hope of obtaining an adequate water supply quickly); 3) The district was one of the overcrowded ones, and had expansive population growth (workers and clerks, and partly also farmers) – it combined the problems of a big town with rural, especially hygienic, problems (the most urgent perceived practical tasks of the district were the protection of

14 Procházka, L. P., op. cit.

nursery age children, combating TB, and the abatement of abdominal typhus in rural Hostivař and Záběhlice); 4) According to the plans of the State Regulation Committee it should be rebuilt as a modern district; 5) The local branch of the Czechoslovak Red Cross (formated in 1920) had successfully and constructively built up a network of consultation rooms, First Aid, health resorts for children, dentist's clinic, and distribution services for the provision of food to the needy, etc. here.

Cooperation with the State Health Institute was substantial. The 13th district was its close neighbour and could serve as its "laboratory", a tutorial workplace for its department of social hygiene (which had been scheduled as one of the five basic departments of the State Health Institute). The up-to-date methods of practical hygiene could be tested here as well as schemes for the best organisation of health service. Hynek Pelc, a senior lecturer of social hygiene at the Charles University, one of the Rockefeller Foundation grantees and a significant personality at the Institute, was a wholehearted supporter of Procházka´s project.

The scheme was supported by the Ministry of Health and Physical Training, and the Rockefeller Foundation promised financial support for the first five years. The Centre of Social and Health Associations of the 13th district founded in November 1927 represented the citizenry. The Centre associated all local socio-health organisations (Our Children consultancies,[15] Care for Youth, the Masaryk League against Tuberculosis,[16] Czechoslovak Red Cross, Protection of Mothers and Children,[17] Association against Venereal Diseases,[18] and Fire-brigade with its Samaritans) were members of the Centre. In terms of the "model district" the first Czechoslovak addicts´(alcoholism) rehabilitation centre was established here as a consulting room for mental hygiene in 1928, and was conducted by a psychiatrist. In the board of the Centre there were the social committee, the committee of local district and consultancy doctors, the District Health-Insurance Company and the Physician's Office of Prague alongside the local council. Procházka retained the right of supervising. Hynek Pelc, representative of the State Health Institute, and since 1938 its director, prepared an analysis of the demographic and health situations and the needs of the district in advance. He was entrusted with the technical provision of the enterprise.

Procházka wanted to confirm his idea that the district physicians could become responsible in allotted sectors of Prague, if they could have available the district doctors – vocational hygienists – and to show that it was possible and necessary to

15 Founded by the American Red Cross after the War and taken over by the Ministry of Health.

16 Since 1924 in Vršovice, funded by its headquarters and by municipality of Prague.

17 Founded in 1916 in Vršovice as a consulting room for nursing mothers and their children, and administratively linked with the Our Children organisation.

18 Since 1927.

coordinate social and health work. He proposed that all authority would be in the hands of the leading doctor/district physician, who would be in contact with the local health administration as well as with the external actors, and who would supervise the health work in the area. He would have control over the office, district doctors and all staff of consultancy rooms. The local Centre of Social and Health Associations of the district would be responsible for the economical use of the funds of all the institutions (which for the most part came from municipal and state subsidies).

From the beginning H. Pelc emphasised the scheme of educating health service personnel of all ranks in the programmes of the educational activity of the State Health Institute – the necessary training field for the future candidates of Public Health administration.

The president of the Czechoslovak Republic, T. G. Masaryk, appreciated the experiment and took part in the ceremony of laying the foundation stone of the Social and Health Care House to be built in the 13th district. The House was never erected, neither was the Hygienic School at the State Health Institute. Their fate foreshadowed the destiny of the whole project.

Outcome

The 13th district of Prague should have become the "social laboratory" for the State Health Institute, and a tool for the re-organisation and decentralisation of the health service for the Chief Physician Office of the City of Prague. Several years later Procházka commented on that period in the words: "The time was favourable for grand projects, but antipathetic as regard achievements".[19] Pelc also had to admit, in 1937, that the educational activity of the State Health Institute had not developed even then, as had been originally scheduled. And worse times were ahead.

Nevertheless, the first years of the "model district" were successful. In 1927 there was a working unit composed of the staff of Public Health and voluntary organizations; the service of nurses was re-organised on a regional basis; the educational campaign as to the goals of the action and of Public Health generally had begun; ambitious projects to build up a stable House for all organisations of the Public Health service in the district were initiated. In 1928 the programme for the school service was launched and equipment obtained; consulting rooms for children and day nurseries were opened in Strašnice and Hostivař; the service of district nurses was intensified; child welfare administration was unified; the alcoholics´ rehabilitation centre and antenatal consultancy service were established; the campaign against

19 Osobní pozůstalost [Memories] L. P. Procházky.

infectious diseases (especially diphtheria) was modernised particularly by large scale immunisation; the educational campaign against TB and a competition for the healthiest child as part of it were set up.[20] One of the most important novelties was the new role of the so-called social-health nursing sister, henceforth working on regional, not on branch (specialization) basis.

However, although the plans were proposed for a period of at least the following five years, from the early 1930s all the detailed reports about achievements of the "model district" faded away. Naturally, these were the years of the Depression at the turn of 1930s, and were soon followed by the increasing menace of war. Nevertheless it is questionable if these are the sole reasons for the silence, for the lack of information about the subsequent circumstances of the project.

The fate of the local Centre of Social and Health Associations of the 13th district of Prague and of the planned Social and Health Care House (the House of Enlightenment and People's Health) is recorded in the archive data: from the enthusiastic beginnings, across several notices providing evidence of Nazi interference in the 1940s,[21] until the formal ending of the Association in the early 1950s, as a result of its non-activity (which had actually obtained for many years).[22]

Medical journals had comments on the project quite frequently until the early 1930s; later only the address of the "model work" figures in the phone directories.

Failure?

The sanitary police (medical police) established in the eighteenth century in our lands fell behind in its work in the twentieth century. Its achievements as well as its setbacks were due to centralisation; and the result, according to Pelc, was the dearth of well-educated hygienists. However, medical education carried out at the State Health Institute, which he had advocated, had its opponents, too. Some representatives of medical faculties considered the endeavours of the State Health Institute supported by the Rockefeller Foundation as an idle competition dividing

20 Vzorná práce zdravotní v XIII. okrese Velké Prahy; in: Péče o mládež. Měsíčník pro veřejnou i soukromou sociální péči o mládež VI (1927), 284–285; Pelc, H.: O vzorové práci zdravotní a sociální v XIII. okrese Velké Prahy; in: Časopis lékařů českých LXVIII/11 (1929), 368–372; Pelc, H.: Zdravotní a sociální přehled XIII. okresu Velké Prahy, Praha 1927; Prošek, V.: Soutěž zdraví; in: Praktický lékař IX (1929), 20.

21 E.g. occupational authorities ordered the renaming of all institutions, which had words such as Czechoslovak, Masaryk etc. in their titles. Hynek Pelc was executed by the Nazi authorities in 1942.

22 Also the Czechoslovak Society for Research and Social-Health Work was abolished in the same time because of inactivity since 1937.

or weakening efforts in the field of Public Hygiene.[23] They saw the weak point of the Institute in the excessive details overloading its work while, they alleged, it paid little regard to the main matter of concern – the attitudes of the people concerning their own health.

Dissimilarity of American and Slavonic mentalities was from time to time an issue commented on by the both sides[24] and it seems that the Rockefeller Foundation may have gradually lost patience with the Czech mentality. The State Health Institute did not developed entirely as Pelc had intended. It had not become the centre of postgraduate education of hygienists, but many modern methods of hygiene practice did take root there but the existence of the experiment they were involved in was not totally forgotten. The principle was kept in mind by the post-war health care reformers, as well as the established network of social and health care institutions in Prague, which had survived. The system of the district allotment of social-health nurses/sisters instead of division according to medical specialisation as it was established, or at least proved, in the 13th district, was an important advance and one that was incorporated in all consequent Health Care reforms in Czechoslovakia.

The aspiration of the State Health Institute to become an educational counterpart of medical faculties in the field of social hygiene was not successful but meanwhile such an informal academy was spontaneously being built up elsewhere. Friendly meetings at conferences on preventive medicine, held annually (with a wartime break) from 1931 to 1946 in various parts of the Czechoslovak Republic, were acting as free tribunals of a kind, a so to speak free parliament of practitioners and experts of all branches connected with Public Health. Discourse was aimed at the basic problems of public health and medicine and social approach was dominant. The integrative principle of the debates became prevention as an integral part of medicine. The conclusions of these 13 conferences in the form of resolutions and proposals were active constituents in the preparation of the new Public Health Act, the first step of which was the draft legislation regularizing in-patient compartments for social, preventative and after-care at public hospitals and other medical institutions (hospital social service, and the so called "necessary care" provided by all these institutions). This outcome resulted from a consensus of doctors at conferences on preventative medicine, which began to act as a counterpart to the somewhat clumsy university and state administration decision-making procedures. Among the organ-

23 Some hygienists objected to the ceding of the work of the Public Health from the Medical Faculties and its delegation to the State Health Institute. "American dollars dictate the scientific development of hygiene, whoever pays the bills, also decides what is to be done in his institutions; and the scientific branch is being divorced from the basis of national culture, from the academic freedom," protested professor of hygiene, Stanislav Růžička, in: Časopis pro zdravotnictvo XVI/8 (1925), 143–145.

24 Page, B.: Imprese; op. cit; Platt, P.S, op. cit; Růžička, S., see note 23.

izers of those conferences were the leading representatives of the various modern trends of the reform movement in Czechoslovak medicine, specialists in particular areas, as well as delegates from the Ministry of Public Health and Physical Training. One of the first items discussed at the conferences from the very beginning was the question of Health Centres.

Health Centres, as defined by the European Conference on Rural Hygiene in Geneva in 1931, were close to the concept of the Czechoslovak "National Health Institutions". In the Czechoslovak Republic, however the concept of medical centres as a structural component part of the public health service gradually evolved, as against a provisional arrangement in certain locations without a sufficiency of GPs. The propagator of the systematic expansion of socio-healthcare services, together with the director of the State Health Institute in Prague, Bohumil Vacek, was Josef Vanický, a general medical practitioner from east-bohemian town Hradec Králové. The so-called Vacek / Vanický Proposal for the organization of all consultancy care in Czechoslovakia sought to expand and make public all such care, incorporating it into public administration with the cooperation of voluntary healthcare organizations and charities. Their idea of preventative medicine stemmed from the organization of healthcare in consultancy. The aim was to develop a network of socio-healthcare institutions in all districts. The benefits of socio-healthcare institutions as compared to specialized consultancies would be the screening of all social diseases threatening a family at once (since the family environment is an essential support in the battle against social disease), and the district doctor – educated also as a social hygienist – would acquire healthcare assistants, including doctors, who would be distributed equally over the entire region. The idea was incorporated by other theorists into the new hospital concept, which is known under the name of the Albert / Trapl Plan.[25] In its spirit a draft of the Act on Legal Relations of Therapeutic Institutions and Institutions for Socio-Healthcare (the so-called Hospital Act) was prepared by the Ministry of Public Health in 1937, but it was never enacted. After postponement and provision for re-arrangement, the long although thoroughly drawn up law was presented to Parliament but too late. This was the period leading up to the Second World War, and as a result it was never voted on. Some of its principles were later applied to the system of unified healthcare in the 1950–1960s.

25 Albert, B.: Reforma nemocnice se zřením na preventivní a sociální medicinu, Československá nemocnice 3/1933, s. 27–32.

Conclusion

The exemplary 13th district was to have realised the methods of social hygiene presented by the State Health Institute, but the aspirations of the State Health Institute (Hygienic School) were not realized in the end. The project had as a goal to co-ordinate voluntary and official social-health work; to modernize and to debureaucratise the work of health authorities; to gain experience; and then, to organize health and social care on a regional principle in other districts and eventually throughout the state.

Only in the first years of its existence did it work in accordance with its purposes; especially as a teaching arrangement – a tutorial service of the State Health Institute for the education of medical personnel – health and social nursing sisters, and as a source of statistical research. The work of the voluntary organizations and health officers was successfully coordinated. But ambitious plans to reorganise the Health Office of the City of Prague, and to extend the system to other districts, faltered and eventually failed.

It is difficult to assert what played the decisive role in the failure of the project in the long run: whether it was the retirement of its author Procházka in 1935; the ebbing of interest on the part of the Rockefeller Foundation, the changing orientation of the State Health Institute; shortage of finance, lack of time, the Great Depression and the impact of the neighbouring fascist regimes; those and/or the unreality/naivety of expectations that voluntary activity could overcome obstacles caused by social and political circumstances.[26] However, the efforts of thousands of volunteers in action, like that in the 13th district, not only saved or gave a helping hand to the thousands of sick and jeopardized families and individuals, but helped to introduce new methods of social hygiene and medicine.

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26 Consultancies were nationalized after the Second World War by the Law No. 49 of 1947.

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Films in Spanish Health Education: The Case of Child Health (1928–1936)

Enrique Perdiguero, Rosa Ballester and Ramón Castejón

Introduction

From the end of the nineteenth century and the beginning of the twentieth century the fledgling Spanish public health services[1] were keen to cope with collective health issues by means of educating the general public. Therefore, in addition to the more traditional methods such as conferences and educational talks, the services also began to use the mass media. The earliest medium was the poster[2] and then in the 1920s, the decade which produced the consolidation of public health services[3], there also arose the possibility of using new media such as the radio and the cinema, which were considered as powerful tools for the

1 On the development of the Spanish Public Health Services see: Esteban Rodríguez-Ocaña, "The Making of the Spanish Public health administration during the first third of the Twentieth Century", *Quaderni Internazionale di Storia della Medicina e la Sanità*, 3 (1994), 49–65 and Esteban Rodríguez-Ocaña, "Los servicios de salud pública en la España contemporánea", *Trabajo Social y Salud*, 42 (2002), 91–116.

2 On the uses of poster by the Spanish Public Health Services we have presented several contributions in recent years: Enrique Perdiguero, Rosa Ballester and Ramón Castejón, "Health and the general public. Child health information campaigns in Spain (1920–1950)", in *Health between the private and the public –shifting approaches. An international conference*, Oslo, Norway, 3–7 September 2003. Enrique Perdiguero, Rosa Ballester and Ramón Castejón, "Mass-media and health informations campaigns in Spain (1920-1936)", in ITEMS Network, *Medicine, health and society in Europe: trends and prospects: contributions to the Symposium*. (Coimbra, 2005), pp. 216-220.

3 Enrique Perdiguero, "Hacia una organización sanitaria periférica: Brigadas Sanitarias e Institutos Provinciales de Higiene", in J. Atenza and J. Martínez-Pérez, eds., *El Centro secundario de Higiene rural de Talavera de la Reina y la sanidad española de su tiempo* (Toledo, 2001), pp. 43–73.

spreading of educational messages to wide sectors of the population. In this sense Spain followed a path common to other countries.[4]

In this article we analyse two films on child protection. 'Valencia, Protectora de la Infancia' [Valencia, Protector of Children], an almost hour-long, silent film produced in 1928, and the twenty-minute long "Vidas Nuevas' [New Lives], produced in 1936. Together with 'La Terrible Lección' [The Terrible Lesson],[5] also produced in 1928, and dedicated to the fight against venereal disease, these films were among the earliest examples of this type of health education medium that we have managed to retrieve in Spain. Other films on malaria[6] and tuberculosis[7], which were produced at an earlier date, have not, as yet, been recovered. The film 'Malaria' (1925) was used in the Spanish Malaria campaign[8] but, as is widely known, this film was produced by the Rockefeller Foundation.[9] We have recovered another film produced by the Catalan government in 1935 to raise funds for the construction of child-care institutions,[10] but it is not analysed in this contribution. Although recorded production of public health films in Spain is well below the level of other countries[11], we need to bear in mind that the Spanish film industry showed signs of

4 For a general account on the uses of media in health education see Susan E. Lederer and Naomi Rogers, "Media", in R. Cooter and J. Pickstone, eds., *Companion to Medicine in the Twentieth Century* (London and New York, 2003), pp. 487–502.

5 On 'The Terrible Lesson' see: Joan M. Minguet, "La terrible lección", in J. Pérez Perucha, ed., *Antología crítica del cine español, 1906–1995* (Madrid, 1997), pp. 68–70; Ramón Castejón-Bolea, *Moral sexual y enfermedad: la medicina española frente al peligro venéreo (1868–1936).* (Granada. Alicante, 2001), pp. 188–192 and Alberto Elena, *Ciencia, cine e historia. De Méliês a 2001* (Madrid, 2002), pp. 65–69.

6 The film was made by the pupils of the Health National School before of 1927: Esteban Rodriguez Ocaña, Enrique Perdiguero and Rosa Ballester Añón, "La labor dispensarial: observatorios contra el paludismo", in Esteban Rodríguez Ocaña et al., *La acción medico-social contra el paludismo en la España metropolitana y colonial del siglo XX* (Madrid, 2003), p. 196.

7 We have news about two films on tuberculosis, one of them produced in 1916, 'El milagro de las flores' [The miracle of the flowers] and the other produced in 1926, 'Corazón de reina' [The Heart of the Queen]: Nacho Lahoz and Antonio Laguna, 'Maximiliano Thous", in *Historia del cine valenciano* (Valencia, 1991), p. 83; Elena (2002), p. 65; Minguet (1997), p. 70.

8 Rodríguez-Ocaña et al. (2003). p. 196.

9 Marianne Fedunkiw, "Malaria Films: Motion Pictures as a Public Health Tool", *American Journal of Public Health* 93 (2003), 1046–1054.

10 Enrique Perdiguero and Ramón Castejón, "El Seguell Pro Infância i la propaganda sanitària", in *Actes de la VIII Trobada d'Història de la Ciència i de la Tècnica*, (Mallorca, 2006), pp. 229-236.

11 We must remember that both in the United Kingdom and in France, dozens of films were made in this same period: Timothy M. Boon, *Films and the contestation of public health in interwar Britain*, unpublished PhD. Dissertation (London, 1999). Elizabeth Lebas, "'When Every Street Became a Cinema'. The Film Work of Bemondsey Borough Council's Public Health Department, 1923–1953", *History Workshop Journal* 39 (1995), 42–66. Elizabeth Lebas, "Sadness and Gladeness: The Films of Glasgow Corporation, 1922–1938", *Film Studies* 6 (2005), 27–45. Christel Tallibert, "Jean Benoit-Lévy", in F.Albera and J.A. Gili, eds., *Dictionnaire du cinéma*

relative weakness and that only 10% of total production is believed to have been saved.[12]

In recent times, it has become apparent that relatively little attention[13] has been paid so far to public health films in the context of medical history. Not only because the medium has existed for little over one century, and is therefore new in comparison with other more common subjects in historical works, but also because there are various difficulties involved in their analysis. The works of Timothy M. Boon[14], and in particular his doctoral thesis,[15] consider in great depth the difficulties which arise when analysing public health films and insist on the need to pay special attention not only to the form and final content but also to the context in which the film was produced in order to understand the reasons for choosing it as a suitable vehicle of health education. Ludmilla Jordanova had already made a

français des années vingt, *1895. Revue d'histoire du cinéma* 33 (2001), 51–53. Christel Tallibert, "Cinema d'education", in Françoise Albera and Jean A. Gili, eds., *Dictionnaire du cinéma français des annes vingt*, *1895. Revue d'histoire du cinéma* 33 (2001), 108–111. Christophe Gauthier, "1927, Year One of the French Film Heritage", *Film History* 17 (2005), p. 293. Valérie Vignaux, "Jean Benoit-Lévy, réalisateur prolifique er méconnu de documentaries didactiques dans l'entre-deux-guerres", in *Colloue International "La fiction éclatée: petits et grands écrans francais et francophones"*, 6–7 July 2004, p. 62.

12 Roman Gubern, "Precariedad y originalidad del modelo cinematográfico español", in R. Gubern et al., *Historia del cine español* (Madrid, 2005), pp. 9–17.

13 Films dealing with venereal disease have so far attracted most attention, in the case of both educational and features. See, as examples, Annette Kuhn, "A moral subject: The VD propaganda feature", in *The Power of the Image. Essays on Representation and Sexuality* (London and New York, 1985), pp. 96–132. Suzanne White, "'Mom and Dad' (1944): Veneral Disease "Exploitation"", *Bulletin of the History of Medicine* 62 (1988), 252–270. John Parascandola, "VD at the Movies: PHS Films of the 1930s and 1940s", *Public Health Reports* 3 (1996), 173–175. Susan E. Lederer and John Parascandola, "Screening Syphilis: 'Dr. Ehrlich's Magic Bullet Meets the Public Health Service", *Journal of the History of Medicine* 53 (1998), 345–370. Thierry Lefebvre, "Représentations cinématographiques de la Syphilis entre les deux guerres: séropositivité, traitement et charlatanisme", *Revue d'histoire de la pharmacie* XLII (1995), 267–278. Thierry Lefebvre, "Le cinéma contre la syphilis. Des débuts prometteurs", *La Revue du practicien* 54 (2004), 459–462. Moreover there were many feature films dealing with alcoholism, tuberculosis (Elena, 2002), p. 66–67, and eugenics: Martin S. Pernick, *TheBlack Stork: Eugenics and the Death of "Defective" Babies in American Medicine and Motion Pictures since 1915* (New York, 1996).

14 Timothy Boon, ""Lighting the understanding and kindling the heart?"; social hygiene and propaganda film in the 1930s'", *Social History of Medicine* 3 (1990), 140–141. Timothy Boon, "'The smoke menace': Cinema, sponsorship and the social relations of science in 1937", in M. Shortland, ed., *Science and Nature. Essays in the History of Environmental Sciences* (Oxford, 1993), pp. 60–61. For the importance of the context of production see also: Timothy Boon, "'The shell of a prosperous age': History, Landscape and the Modern in Paul Rotha's 'The Face of Britain' (1935)", *Clio Medica* 60 (2000), 107–148.

15 Boon (1999), pp. 7–51.

call for the need to consider the construction process of the images.[16] Marianne Fedunkiw,[17] who has made a detailed study of Rockefeller Foundation's film 'Malaria', also insists on the same point, as well as on the difficulties which often arise in analysing the production process of the films, and other aspects of their use as an educational medium. Often documents are missing which would help to answer questions such as: who produced the script and who filmed it? What filmic language was chosen and to what end? How much did it cost to produce and distribute? Where was the film shown? How many people saw it? Was the film accompanied by a conference or educational talk? Was the film effective from a public health point of view? When and why did the authorities stop using the film? Boon is more sceptical on the questions dealing with audiences and believes that, in general, it is very difficult to obtain enough information which would enable us to assess the impact of the films on the public.[18] He has only very scarce information about audiences of public health films in the case of Britain, and prefers to consider the problem analysing the 'modes of address' of the films, as we have considered. Obviously, another difficulty arises from the fact that, with the passing of time, only some of those films that were made and used as health intervention technology have survived.

The films that we have chosen only allow us to give partial answers to some of the questions related to the production context. As so often happens, there are few documents, or at least we have been unable to uncover many documents, which would have enabled us to understand better the contexts in which the production of the films we have studied took place. As Boon proposes[19], we have had to resort, above all in the case of 'New Lives', to deduce from the film itself the reasons for its production and content. However we believe the two films under consideration, not yet studied from the point of view of the history of public health,[20] are of historical interest and enable us to study not only the workings of a specific health campaign carried out in Spain within the framework of social medicine, but also,

16 Ludmilla Jordanova, "Medicine and Visual Culture", *Social History of Medicine*, 3 (1990), p. 96.

17 Fedunkiw (2003), p. 1046.

18 Boon (1999), pp. 13–20. Timothy M. Boon, "Health education films in Britain, 1919–39", in G. Harper and A. Moor, eds. *Signs of Life. Medicine & Cinema* (London and New York, 2005), pp. 52–54.

19 The films used different modes of address to their viewers, and from this we can deduce the relationship established between producers and audiences, and the kind of authority they wished to exert or maintain: Boon (1993), p. 61. Boon (2005), pp. 54–55.

20 'Valencia, Protector of Children' has received attention recently after its restauration by the 'Institut Valencia de Cinematografía': Nacho Lahoz, *Valencia, Protectora de la Infancia* (Valencia, 2002). 'New Lives' is cited in the biographical accounts of its director (see below), and in the *Catálogo de documentales cinematográficos producidos o adquiridos por organismos oficiales del Estado Español [Catalogue of cinematographic documentaries produced or acquired by official bodies of the Spanish State]* (Madrid, 1964), card 46, wrongly dated in 1940.

once again, the close relationship between this campaign and certain moral values which are presented as part of the health message which the campaign seeks to transmit. The consideration of childhood as a vulnerable age appears clearly in both films in images which allow us a close-up of the means of the visual representation of infancy. There are also images of women, who obviously are responsible for childcare. The two films were produced within a short time of each other, but under very different political circumstances. 'Valencia, Protector of Children' was filmed towards the end of General Primo de Rivera's dictatorship, set up with the consent of the Monarchy. 'New Lives', filmed just before the outbreak of the Civil War, although sponsored by a pharmaceutical company, can be seen as part of the impetus which the authorities of the II Republic sought to give the public health services, and in particular to infant hygiene. This allows us to consider the discussion about the 'mode of address' which Boon[21] included in his work, as we are faced with two different policies concerning the positions to be taken on the problems of childhood.

Valencia, Protector of Children

This film was commissioned by the Protection of Childhood Board of Valencia, set up, like all such provincial organisations, as a result of the child protection legislation passed at the beginning of the twentieth century in Spain.[22] It was recently retrieved (2002) by the Valencian Film Archives.[23]

A production team (P.A.C.E.),[24] set up in 1924 to produce feature films and documentaries by the man who was also the director of the film, Maximiliano Thous, was commissioned to make the film. Thous was a unique figure: a journalist, politician, who in his youth belonged to the Liberal Party and then later in life joined the conservative nationalist movement, author of the words of the Valencian regional anthem and, chronologically speaking, one of the first Spanish film direc-

21 Boon (1999), pp. 20–25. Boon takes the concept from Bill Nichols, "Documentary, Theory and Practice", *Screen* 17 (1976/7), 34–48. We have used the Spanish translation of a later work: Bill Nichols, *La representación de la realidad. Cuestiones y conceptos sobre el documental*, (Barcelona, 1997).

22 Cándido Ruiz-Rodrigo, *Protección a la infancia en España*. *Reforma Social y Educación* (Valencia, 2004), pp. 49–60. Josep Lluis Barona, "El Consejo Superior de Protección a la Infancia y Represión de la Mendicidad. Su ideología social y sanitaria", in Enrique Perdiguero-Gil, ed., *Salvad al niño. Estudios* sobre la protección a la infancia en la Europa mediterránea a comienzos del siglo XX (Valencia, 2004), pp. 121–153.

23 Lahoz (2002), pp. 3–8. We follow the description give by this author related to the preparation of the film.

24 P.A.C.E.: Producciones Artísticas Cinematográficas Españolas (Spanish artistic cinematographic productions).

tors.[25] His team, after the failure to premiere his last feature film, 'Moros y Cristianos' [Moors and Christians] (1926) produced several documentaries highlighting institutional activities and the beauties of the Region of Valencia in order to present them in the international exhibitions of Seville and Barcelona in 1929.[26] The scriptwriter was Alejandro García-Brustenga, an active Valencian paediatrician, secretary of the Valencia Childcare School of Valencia and author of several articles related on childcare institutions.[27]

The aim of the film was not educational, although as we will see, it was also used to this end. The intention was to showcase the work done in Valencia in relation to childcare at the International Fortnight of Child Protection and Social Action in Paris in July 1928.[28] In the project report, the argument was put forward that the film should be made in order to show the achievements of Valencia in this field and, incidentally, in order not to be overshadowed by the other Spanish cities present at the event, Madrid and Barcelona.

The idea came from García-Brustenga who proposed to the Protection of Childhood Board of Valencia the making of a film that gave an "honourable view of Valencian charity and science". The Board requested and obtained the financial backing of the Provincial Council and the City Council of Valencia, as their measures in relation to childcare would take up a large part of the film. Thus Valencia subscribed to a policy which, encouraged by the imminent staging of the exhibitions of Seville and Barcelona, as well as other international events at the end of the 1920s, led some Spanish public administrations to fund the production of cinema documentaries. The aim was to highlight their work governing cities, provinces or institutions, and praise their urban or artistic values and thereby to improve the poor image of the dictatorship both in Spain and abroad. This proliferation of films sought to use the enormous potential of the cinema as an instrument of political and ideological propaganda – as illustrated by such titles as 'The resurgence of Spain', also made in 1928[29] – at a time when the Primo de Rivera's regime was

25 Lahoz and Laguna, (1991), pp. 81–93.

26 Francisco Narbona, "La Exposición Iberoamericana de Sevilla", *Historia 16*, 10 (1985), 50–56. María Rosa Cal-Martínez, "El mundo de las exposiciones (III): del IV Centenario a Sevilla-Barcelona (1929), *Historia 16*, 17 (1992), 86–93.

27 Carmen Barona-Vilar, *Las políticas de la salud. La sanidad valenciana entre 1855 y 1936*. (Valencia, 2002), pp. 178–180, 260–261.

28 On international events related to child protection held in the first third of the XXth Century see Catherine Rollet, "La santé et la protection de l'enfant vues a travers les congrès internationaux (1880–1920)", *Annales de démographie historique* (2001–1), 97–116.

29 This film had nothing to do with international exhibitions. It was sponsored by the party of the dictator, the 'Unión Patriótica', and sought to show the achievements of the government.

already in decline.[30] This was even more notable in the case of 'Valencia, Protector of children', which when shown abroad projected to the World an image of modernity and social advance in the Spain of this period. Indeed the dictatorship provided indirect funding for the propaganda in an attempt to spread the values it defended via the local authorities.

The starting point was the script by García-Brustenga based on the ´Notes on a Pro-Childhood National Exhibition Project´[31], which he himself presented in the City Council of Valencia on 4 April 1924[32] and which he had intended to hold, precisely, between May and October 1928. Some of the subjects of the pavilions of the exhibition served as a source for the various scenarios of the film: the child at birth, feeding the child, the sick child, the institutionalised child, the abandoned child, the child at school, the abnormal child, the child in the park.[33] In order to illustrate each of these realities, the images take us through over twenty different institutions: clinics, the milk depot, hospitals, homes, charitable institutions, children's camps, reformatories and schools. The institutions which appear in the film included both municipal and provincial public services and charitable institutions. Thus the film reflected the way in which childcare and the struggle against infant mortality were organised in Spain, with a mixture of public and private resources and a low-level implication of the central power, in spite of the laws governing infant protection then in force.[34] In any case, and as set out in the project for the exhibition, the film sought to highlight the institutional activities and successes of the public authorities. The film, a propaganda documentary, did not require the active involvement of the audience. All that was required was passive viewing of images which illustrated the achievements of institutional activities and private charity in child protection. Although not a work of fiction, we can include it within the vision of the more conservative and paternalistic wing of health education,[35] a feature of the other films produced during the Primo de

30 Luis Fernández-Colorado, "Visiones imperiales: documental y propaganda en el cine español (1927–1930)", in *Actas del VI Congreso de la A.E.H.C.* (Madrid, 1998), pp. 97–110.

31 This work received a mention in the annual contest held by the High Council of the Protection of Children in 1922. The subject for this year was the struggle against infant mortality.

32 Alejandro García-Brustenga, *Notas para un Proyecto de Exposición Nacional Pro-Infancia como medio de disminuir la mortalidad infantil en España* (Valencia, 1924).

33 Excluded from the film were: the child and clothing, the child and furniture, children and music, recreation, theatre and children, the child and toys and children's sports.

34 Esteban Rodríguez-Ocaña, "La construcción de la salud infantil. Ciencia, medicina y educación en la transición sanitaria en España", *Historia Contemporánea*, 18 (1999), pp. 19–52.

35 Boon (1999), p. 133–175 considers those health education films produced by voluntary associations which adopt the fictional mode, and which seek the identification of the audience with the fictional characters, who represent a more conservative and hierarchical vision of society. This is certainly the case of "The Terrible Lesson" (1928), a curious fictional documentary, with a conservative vision of the family and family life, while defending the contribution of medicine in

Rivera dictatorship and which dealt, as we mentioned above, with the questions of venereal diseases and tuberculosis.

'Valencia, Protector of Children' has some similarities with one of the films studied by Lebas in the context of the task developed by the Public Health Department of the Bermondsey Borough Council:[36] a newsreel-style film made from a compilation of previously made footage to summarize the Council's various services and activities. Both of them sought to illustrate the achievements of the authorities showing for this purpose the main spaces, clinics, institutions and campaigns that had been set up. Both films have children and their health as one of the main goals of the activities of the authorities. However as Lebas reminds us in the last paragraph of her article,[37] films are means to different conquests. The political environments of Valencia Council and Bermondsey Borough Council were very different. Valencia, as all the cities in Spain, was under the dictatorship of Primo the Rivera, without political freedom. The film, as we have mentioned, was one of the political propaganda products of the regime. On the contrary the London Metropolitan Borough of Bermondsey had been governed democratically by the Independent Labour Party since 1922 and by the late 1920's had highly comprehensive and unique social welfare. Probably the two films are rather similar in conception, style and content, in the sense they intend to show the role of the authorities in social welfare, but they serve very different political agendas and pursue very disparate ways to the achievement of the welfare of the population.

The production of 'Valencia, Protector of Children' was simply brilliant. The director balanced the requirements of the script and the propaganda assignment with careful stage managing and photography which were extremely rare even in the feature films of the time. From the first sequence, picture postcard scenes of the most famous sights of Valencia, the port and the fruit-growing areas, the film seeks to highlight the privileged nature of the area in which the scenes unfold: hospitals next to the sea, the beauty and functional practicality of the buildings where they are accommodated, the wide open spaces for the enjoyment of many different activities in the Mediterranean sun and light. With the collaboration of the already veteran cameraman, Juan Andreu,[38] not only did he transform these places into model institutions, but he also managed to catch the moving authenticity of desti-

coping with venereal disease. Although a documentary "Valencia, Protector of Children" does not show any connection with the British documentary movement: Boon (1999), pp. 205–253.

36 Lebas (1995), pp. 61–62. Se also the webpage http://www.planum.net/archive/main/m-mov-bermondsey.htm. The title of the film was 'Some Activities of Bermondsey Borough Council' (1931).

37 Lebas (1995), p. 62.

38 José Ginés, "Tras la huella de Andreu y el prestigio de Thous", in *Historia del cine valenciano* (Valencia, 1991), pp. 62–73.

tute children. In these scenes he is able to create a remarkable dramatic effect enwrapped in an idyllic atmosphere of gentle and efficient care.[39]

The aim of the film, pursued faithfully by Thous, means that unlike 'New Lives' there are no explicit educational messages. Nonetheless the film transmits the idea that successful childcare requires medical and technical supervision. The illustrations of lessons about bathing, clothing, sterilised bottles, health professionals supervising child growth, of laboratories, of cleanliness in the institutions, and psychiatric care are important elements of the discourse of the film. However, there are no explicit messages blaming parents for failing to bring up their children properly. The film did not seek to involve the audience directly. Its objective was different; to show the vigorous work of the institutions and charities, and to serve as a propaganda medium of the Primo the Rivera regime. Local and provincial institutions, the financial backers of the film, sought to legitimise their activities and provide a glowing report of their successes to the international arena.

Together with the medical discourse, the importance of the Catholic Church is another essential element of the film. The overwhelming presence of religious orders within the institutions, in health care, the upbringing of children and care for the handicapped, represents an assumption of the dominant moral code, that of the Catholic Church. This, in turn, is a feature of the work of García-Brustenga, and the Spain of this period,[40] and underlines once more the conservative character of the film.

Gender-defined roles are also obvious in some charitable institutions. This illustrates how children were raised to be men or women, with a clear division of roles. Washing, ironing and sewing are activities which often appear when the film turns to the training offered to young girls. Boys were trained in other skills such as shoe repairs or tool-making.

Also noteworthy and demonstrating the political context, in which the film unfolds, is the amount of time given to the physical exercise of the boys and girls in the different institutions. The Primo de Rivera dictatorship defended a nationalist and patriotic idea of Spain which led it to set up a series of institutions to promote physical education among the general public.[41] The number of scenes showing keep-fit exercises and military style training in 'Valencia, Protector of children' can be interpreted as support for this ideology, although physical education in Spain, in

39 Lahoz (2002), p. 5.

40 Vicente Faubell, "Educación y órdenes y congregaciones religiosas en la España del siglo XX", *Revista de Educación*, nº extra (2000), 137–200.

41 Alejandro Quiroga-Fernández de Soto, "«Los apóstoles de la patria». El ejército como instrumento de nacionalización de masas durante la Dictadura de Primo de Rivera", *Melangés de la Casa Velázquez*, 34 (2004), 243–272.

spite of organisational weakness, was used for party political ends by groups across the whole political spectrum.[42]

The film was well received in its Paris adventure and instead of the three days scheduled originally, the film was shown throughout the fortnight. Indeed the press in Valencia went so far as to claim the film had won the film competition, although the 1928 report of the Valencian Provincial Council makes no reference to this. In spite of this success, in Valencia the film came up against the usual difficulty confronting Spanish films of the time of gaining access to screens. Its premiere in Valencia was delayed until May 1929, though it was used again at the exhibitions of Barcelona and Seville.[43]

The film was also used in health education campaigns. Of the child hygiene educational campaigns carried out by the Childcare School of Valencia, set up in 1927, one of the most original was the creation of a 'Roving Department of Childcare' which started work at the end of 1929. This involved public events held in theatres, cinemas or large commercial premises for audiences, essentially, of mothers and mothers-to-be. The act had two parts. In the first session doctors and teachers gave talks about the raising and education of children. In the second, the audience was shown Valencia, Protector of Children. During the break the 'Childhood Hygiene Booklet' and other leaflets were handed out. The occasion was also used to vaccinate children of between one and three against diphtheria. Between the end of 1929 and the beginning of 1934 a total of 35 events were held in over thirty towns, usually in cinemas and theatres, which suggest that the film reached a wide audience, at least in the province of Valencia.[44]

New Lives

As is well known, it was in the early part of the 1930s, when Spain underwent the change from monarchy to republic that the reinforcement of the public health services[45] really led to an increase in health propaganda campaigns.

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42 Lucio Martínez-Álvarez, "A vueltas con la historia: una mirada a la educación física escolar del siglo XX", *Revista de Educación*, nº extra (2000), 83–112.

43 Lahoz (2002), p. 8.

44 Carmen Barona-Vilar and Manuel Martínez-Pons, "La lotta contra la mortalità infantile nella provincia di Valencia nel quadro della Seconda Republica (1931–1936)", in L. Pozzi and E. Tognotti, *Salute e Malattia Fra'800 e '900 in Sardegna e nei paesa dell'Europa Mediterranea*, (Sassari, 2000), pp. 293–307. Barona (2006), pp. 182–187.

45 There is abundant bibliography on public health in the Spanish Second Republic. See as examples: Josep Bernabeu-Mestre, "La utopía reformadora de la Segunda República: la labor de Marcelino Pascua al frente de la Dirección General de Sanidad, 1931–1933', *Revista Española de Salud Pública*, 74 (2000), 1–13 and Juan Atenza and José Martínez-Pérez, eds., *El Centro*

Figure 1. Poster published by the General Health Board during the Spanish Second Republic, probably in 1932–1933. Unknown author.

One of the priorities for the General Health Department of the Republic was child health. Just as the previous film showed, in the case of Valencia, the fight against childhood mortality, through the education of mothers and the monitoring of young babies, was an urban issue, carried out by local authorities and charitable associations. The founding in October 1931 of the Child Hygiene Service was intended to carry the struggle against infant mortality to the rural areas, through state health services.[46] The Provincial Hygiene Institutes were gradually staffed with personnel who specialised in childcare and the next step involved recruiting similarly specialised staff for the Secondary Centres of Rural Hygiene. By the time the civil war broke out, a total of 46 had already been opened. As shown by the poster (Figure 1), published within the framework of this new service, the aim of the Child Hygiene Service was to ensure that the infant population had access to preventive services in order to reduce infant mortality. Collaboration by the public, in this case the mothers, was a fundamental element in this and in each of the health education campaigns.

secundario de Higiene rural de Talavera de la Reina y la sanidad española de su tiempo (Toledo, 2001).

46 Rodríguez-Ocaña (1999), p. 30.

Therefore, the Social Hygiene and Propaganda Department[47] was set up –also in October 1931– to bring together the propaganda of different health campaigns. The decree which established the Department stated the need for "[…] an appropriate consultative and executive organisation for questions affecting both public health (such as those covered by so-called social hygiene: alcoholism, venereal disease, cancer etc) and the scientific and administrative advantages of making the Department responsible for personal and public hygiene propaganda, a neglected, almost non-existent element of utmost importance today in the development of a technical-medical programme […]". Julio Bravo-Sanfeliu, who had already performed an important role in health propaganda within the framework of the anti-venereal disease campaign[48], was awarded the post of Chief Medical Officer of the service.[49] He had written a passionate article in 1932 in praise of the cinema[50] as a means of official health propaganda,[51] and became a key figure in health education through posters and film. In his opinion the cinema offered the advantage of wide public support and also meant that mobile units could deliver health propaganda to any village. He made calls therefore for the production of sound films for health education both before and after the Civil War and maintained his involvement after the Nationalist victory[52].

Indeed the figure of Julio Bravo[53] stands out in the Spanish context given the dearth of health education materials.[54] Having studied medicine in Zaragoza, where

47 *Gaceta de Madrid,* 14 October 1931.

48 Castejón-Bolea (2001), pp. 176–188. Julio Bravo, "Algunas consideraciones sobre propaganda sanitaria", *Ecos Españoles de Dermatología y Sifilografía* 7 (1928), 487–496.

49 Order, 27 April 1933 (*Gaceta de Madrid*, 2 May 1933).

50 On documentary in Spain during the Second Republic see Roman Gubern, "El cortometraje republicano", in P. Medina, L.M. González and J. Martín-Velázquez, eds., *Historia del cortometraje español*, (Alcalá de Henares, 1996), pp. 35–55. "Tierra sin pan" [Land without bread] (1932) of Luis Buñuel is considered the starting point. For the use of cinema with pedagogic aims during this period see Gonzalo Sáenz-de-Buruaga, *Val de Omar y las Misiones Pedagógicas* (Murcia, 2003). For other outstanding documentary-makers of the period see Miguel Anxo Fernández, *Carlos Velo mestre do documental* (A Coruña, 2001).

51 Julio Bravo, "Algunas consideración acerca del porvenir del 'cine' sonoro en propaganda sanitaria", *Revista de Sanidad e Higiene Pública* 7 (1932), 475–478.

52 His publications on health education after the Civil War were: Julio Bravo, *Algunas consideraciones sobre propaganda en general y propaganda sanitaria en particular* (Madrid, 1951). Julio Bravo-Sanfeliu, *La técnica moderna en la didáctica y la difusión de los progresos médicos* (Zaragoza, 1953).

53 On Julio Bravo see Juan Domínguez-Lasierra, "Acerca de la vida y obra de Julio Bravo Sanfeliu", in Julio Bravo, *El contemplanubes y otros filósofos menores* (Zaragoza, 1999), pp. 9–34. Juan Domínguez-Lasierra, "María de Montblanc', in Julio Bravo, *María Bellesguard* (Zaragoza, 2002), pp. 9–31.

54 We only have some local examples as the production of the Provincial School of Childcare of Gijón. Carmen Chamizo, *La Gota de Leche y la Escuela de Enfermeras. Instituto de Puericultura de Gijón* (Gijón, 1999).

he was born in 1894, and in Madrid, he began his career in dermatology. He trained in several European capitals and on his return to Spain dedicated his work to the struggle against venereal diseases. In order to learn more about how the struggle was organised abroad, he travelled to Belgium and England in 1924 and to the U.S.A and Canada in 1926. He had a special interest in literature and wrote prose, drama and poetry and won critical acclaim for some of his novels. His passion for the cinema first took shape in 'Todos a una' [All for One] (1932) a publicity film on the lottery of the Ciudad Universitaria de Madrid. In addition to 'New Lives' he made an 18-minute educational documentary 'La tuberculosis pulmonar' [Tuberculosis] (1941) and another 14-minute documentary, 'El Tren' [The Train], on rail transport in Spain. He continued his work as dermatologist and health educationalist until his retirement. He died in 1987.

The importance given to propaganda, even before the republican triumph, can be seen in the work of the National Health School[55], reopened in 1930, for the training of Medical Officers. One of the compulsory subjects for students had the highly expressive title of: 'Museum, iconography, propaganda and extension of the health culture'.[56] The task of connecting with the population at large and transmitting appropriate health messages was considered part to the work of public health officers.

In the following years, leading up to the outbreak of Civil War, the Social Hygiene and Propaganda Department promoted poster competitions and the compulsory showing of health propaganda films in cinemas, as established in rules published over the period.[57] Naturally, special attention was given to the struggle against infant mortality. A whole series of materials on the subject was produced and distributed (stamps, post cards, posters, pamphlets, instruction sheets) aimed at encouraging mother-child health.

The health propaganda initiated by this state service was well received by the medical press,[58] which judged as positive the effect produced on the population of the capital. Nevertheless, according to the data we have available so far, there is no indication whether the activity increased in the following years or whether, as a result of the political pendulum, it was indeed reduced. The same observer, who warmly welcomed the appearance in the streets of Madrid of the posters against infant mortality, also complained of the shortage of health propaganda films. Only

55 Josep Bernabeu-Mestre, "El papel de la Escuela Nacional de Sanidad en el desarrollo de la Salud Pública en España", *Revista de Sanidad e Higiene Pública*, 68 (1994), 65–89.

56 Julio Bravo himself taught this subject: Domínguez-Lasierra (1999), p. 12.

57 Order 4 April 1933 (*Gaceta de Madrid,* 7 April 1933). Order, 3 October 1933 (*Gaceta de Madrid,* 8 October 1933).

58 J. Morales-Díaz, "Propaganda sanitaria", *La Medicina Íbera*, 26–1(1932), cxvii-cxix. J. L. Pando-Baura, "Educación sanitaria", *La Medicina Íbera*, 26–1 (1932), clxxxiii.

two were available and as a result of over-exposure people no longer paid them any attention.[59]

Partly within this framework, another film devoted to childcare[60] was produced by the Bayer Laboratory[61] in 1936, in this case, with sound. 'New Lives' was an instructional film[62] with an explicit educational aim. The script was written by Julio Bravo himself, with the support of the paediatrician Miguel Echegaray, who worked at the Childcare School of Barcelona. The sound track included some original music and some adaptations of popular children's songs. Photography was by Andrés Pérez and Arturo Porchet, a Swiss film-maker who spent several years in Spain before the Civil War, and whose sons were closely linked to the anarchist movement.[63]

The film is in three parts; an introduction, a section on pregnancy and then the final and longest part concerning the care of the newly-born, breast-feeding and the weaning period. 'New Lives' was conceived as a documentary designed to involve the audience actively in the content. Although we know little of the context of its production, and although at the end of the Civil War the man behind the film, Julio Bravo, was on the side of the victors, the film was made in a more progressive context than that offered by the dictatorship of Primo de Rivera. The narrator reels off the messages using an impersonal third person and in a tone designed to be neutral, with relatively few concessions to sentimentality and, above all in the second and third parts, an attempt to secure a certain level of rationality. The cinematic techniques used are designed to achieve the pedagogic aim. The camera is static, using frontal angles. In the same vein the interior backgrounds are very plain.

The thread of the film begins with the scene of a peasant worker sowing seeds, a metaphor illustrating the conditions necessary for the birth of a healthy child: good seed and good soil, in other words healthy parents. It is as well an easy metaphor for the public to understand: in the Spain of the thirties almost 85% of families were working class or peasant. Health is seen as the engine of happiness and welfare: "the

59 J. L. Pando-Baura, 'Pro-Sanidad', *La Medicina Íbera*, 28 (1934), xxix-xxxi. We have no information about the two films cited in this article.

60 Gubern in his study of short movies during the Spanish Second Republic includes this film in the category of 'social and political documentaries': Gubern (1996), p. 41

61 We have as yet been unable to recover information which would enable us to understand better the management process of the production of the film and the sponsorship of the Bayer Company. Among the credits at the beginning of the film, the sponsors stated the following aim: "The Bayer Company, in the interest of public health, has made this film and has the honour of dedicating it to Spanish mothers. If the film contributes to a decline in infant mortality, the Bayer Company will have accomplished its goal. We hope that "New Lives" helps to save as many lives as possible."

62 On instructional films see Boon (1999), pp. 176–204.

63 Ramón Sala-Noguer, *El cine en la España republicana durante la Guerra Civil* (Bilbao, 1993), p. 26.

best gift, the best investment, the best legacy that parents can offer their children". There is a note of optimism, with scenes of a new stronger generation, of young men and women enjoying outdoor activities. In short, a vision based on eugenics, omnipresent, as is well known, in the thirties, but in this case from a perspective which might be considered 'progressive'.[64]

There are four central elements in the cinematic analysis of 'New Lives' which we will summarise as: the ideological component, the perspective of gender, the perspective of social class and the appearance in the film of medical technologies.

Our interest was focussed on how the film contextualised the problem of infancy socially. Of course, the images are not a reflection of the problem, they are instead a construction of the problem. Social reality is shown as a scenario which does not create the problems and the film is based on trust in the possibility of changing the behaviour of the individual. Julio Bravo seeks to deal with infant mortality from an essentially medical perspective, just as he had stated was necessary in the case of venereal disease[65], ignoring other circumstances. In spite of his post in the republican health service, the film was produced privately and did not have an explicit 'republican' ideological expression. Nor is there any reference to religion which is so much a part of 'Valencia Protector of Children'. Since the end of the nineteenth century, the field of education and social work in the protection of childhood had been one of the central issues in the controversy between clericals and anticlericals which Republican Spain was unable to resolve and which, as we all know, ended in violence.[66] 'New Lives' is set within the apparently neutral context, in which only the aseptic rationality introduced by medical science, appears to be the guide.

How are women portrayed? It is important to underline this aspect because the II Republic, at least on paper, improved the situation of women with the proclamation of their right to vote, the law of civil marriage and divorce and the abolition of laws regulating prostitution. Nonetheless, life was hard: the illiteracy rate was over 50%, and salaries were, of course, below those of men, even in the same jobs.[67]

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64 On eugenics in Spain see the works of Raquel Álvarez-Peláez: "Origen y desarrollo de la eugenesia en España", in J.M. Sánchez Ron, ed., *Ciencia y Sociedad en España: De la Ilustración a la Guerra Civil* (Madrid, 1988), pp. 178–205; "Eugenesia y fascismo en la España de los años treinta", in R. Huertas and C. Ortiz, eds., *Ciencia y fascismo*. (Aranjuez, 1998), pp. 76–95; and "Características y desarrollo de la eugenesia española", in T. F. Glick, R. Ruiz and M.A. Puig-Samper, eds., *El darwinismo en España e Iberoamérica*. (Madrid, 1999), pp. 215–229.

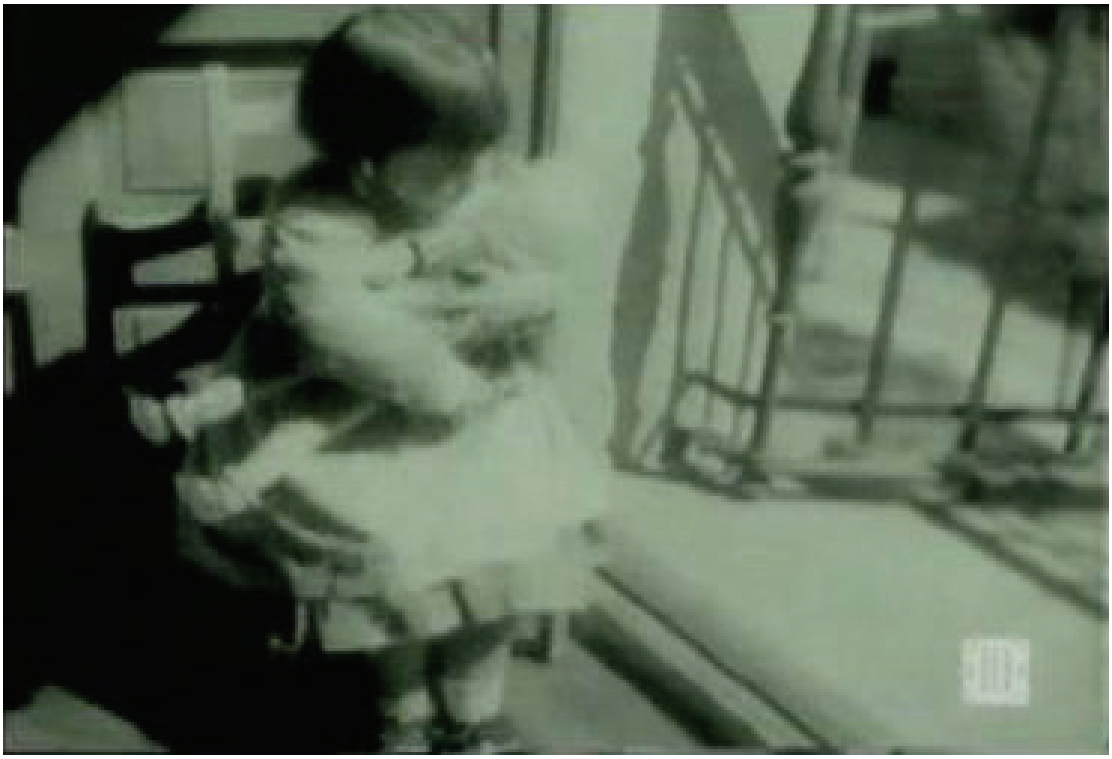
65 José Fernández-de-la-Portilla and Julio Bravo-Sanfeliu, *Cómo debe organizarse en España la lucha antivenérea* (Madrid, 1925).

66 Ana Aguado, "El proyecto cultural de la II República. La búsqueda de una sociedad laica", in A. Aguado and Mª D. Ramos, *La modernización de España (1917–1939)* (Madrid, 2002), pp. 153–162.

67 Mary Nash, "Les dones i la Segona República: la igualtat de drets i la desigualtat de fet", *Perspectiva Social* 26 (1988), 75–83. Mary Nash, *Rojas. Las mujeres republicanas en la Guerra Civil* (Madrid, 1999), pp. 35–83. María del Rosario Ruiz-Franco, "Transformaciones, pervivencias y estados de opinión en la situación jurídica y social de las mujeres en España",

Figure 2. Still from "New Lives" (1936): a bride in her tulle veil superimposed on the image of a cot covered with the same veil.

Figure 3. Still from "New Lives" (1936): a young girl rocking her doll.



Historia y Comunicación Social 5 (2000), 229–254. Ana Aguado, "Relaciones de género en el contexto republicano", in A. Aguado and Mª D. Ramos, *La modernización de España (1917–1939)* (Madrid, 2002), pp. 203–221.

Figure 4. Poster published by the Ministry of Education and Health during the Civil War showing a woman throwing a javeline. The author was a woman, Juana Francisco.

Three types of women are portrayed in the film. The first is the mother or mother-to-be with traditional features highlighting the importance of the 'natural' maternal instinct, and devoted towards the future child. The film uses two very powerful images: the first, almost ghostly, of a bride in her tulle veil superimposed on the image of a cot covered with the same veil (Figure 2), showing that the purpose of women is maternity. The second, a young girl rocking her doll (Figure 3). As a counter-balance, but still compatible with the first, the modern woman, very typical of the inter-war period, seen here enjoying sports, with an athletic figure, frequently seen in posters of the period (Figure 4). Finally, we see the professional woman, as a qualified nurse, one of the few job opportunities of this kind for women in the

Spain of this period. There is no time for affection in these images; the nurse is at work with the child.

The principles behind the socio-political programme of the republican government sought to eliminate the profound historical social inequalities in Spain. As such they had substantial support among the popular classes and the intellectual minorities. However, the creative capacity in discourse and image of the middle classes remained much more powerful. In the film that we are analysing, it is interesting that the educational discourse is not aimed at the poorer mothers, undoubtedly those who needed it the most, but rather at the middle and upper-middle classes. From his own social origins and upbringing Julio Bravo constructed an audience not of the working mother, but rather of the woman devoted to her home and family care, the most visible among social representations of women at the time. In the second and third parts of the film, where we see practical advice for pregnant women and mothers during breast-feeding, the scenes take place in middle-class surroundings: the pregnant woman who dreams of her future child lives in a house where the details, the lamp, the type of cot, her clothes, suggest a middle-class background. On the other hand, we assume that these are the only women who could look after themselves and visit the doctor, as in the case of working-class women, missing a day's work meant losing a day's wage[68]. In the childcare scenes, this idea is reinforced: not all families could afford baby clothes, suitable for the new-born child, or a push-chair (in one scene, the narrator optimistically claims "there is a wide price range") or even to feed the child properly. Women appear in the film in their most traditional version, a generic reality in republican Spain, even when at war and in spite of the iconic rhetoric of the 'miliciana'.[69] The reality of working women, of working outside the home, of the difficulties that this caused in motherhood and child-feeding were ignored in 'New Lives'. The emphasis was placed not on social problems which might lead to infant mortality, but, as so often, on the necessity of indoctrinating women in their responsibility of maternal duties under the supervision of medical science.

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68 Although the implementation by the Republic of the Maternity Insurance did relieve the situation. See Esteban Rodríguez-Ocaña, "Medicina y acción social en la España del primer tercio del siglo XX", in *De la beneficencia al bienestar social. Cuatro siglos de acción social* (Madrid, 1985), pp. 257–262, and Esteban Rodríguez-Ocaña, "La asistencia médica colectiva en España hasta 1936", in *Historia de la acción social pública en España. Beneficencia y previsión* (Madrid, 1990), pp. 336–346.

69. Mary Nash, "Women in War: 'Milicianas' and Armed Combat in Revolutionary Spain, 1936–1939", *The International History Review* XV (1993), 269–282. Nash, (1999), pp. 85–108. See also our contribution Enrique Perdiguero, Rosa Ballester and Ramón Castejón, "Health Propaganda and Motherhood in the II Spanish Republic (1931–1936)", in *Meeting PhoenixTN "The creation of the public health systems and the answers of social agents: the Church, the public administration impulse and the family behaviour"*, Palma de Mallorca, 6–8 October 2005.

A fundamental element in the film is the specific weight given to the use of medical technology. Indeed the central theme of 'New Lives' is health education through means implemented by medical science for the healthcare of children and mothers-to-be. The message is transmitted through a series of icons. In the scenes showing prenatal care, considerable footage is dedicated to the presentation of obstetric instruments, medical records, and laboratory and blood pressure tests. In the case of those scenes related to the care of the very young, the technology is not seen only from the angle of physical and chemical artefacts (use of silver nitrate to prevent the ophthalmia of the new-born child, the use of natural vitamins, vaccination against tuberculosis, smallpox or diphtheria), but also, and above all, of procedures. The film shows a complete protocol perfectly organised in basic steps for the care of the new-born baby and the very young child: not a single detail escapes the careful watching eye of the expert doctor and the nurse who is carrying out the procedure (feeding, clothing, and monitoring of growth through anthropometric measures).

Infancy:[70] Images of Vulnerability

Some years ago, E. Seidler[71] concerned himself with a historical analysis of the essential weakness of infancy, a cliché of significance both polyvalent and omnipresent in the political, social and medical discourse of the first half of the twentieth century. Frailty, lack of energy, lack of vigour, weakness, impotence, all indicated differentiated aspects of the same reality. Infancy is the age of dangers. The novelty of the twentieth century consisted mainly of overcoming the traditional fatalism when faced with this situation of biological inferiority, which conditioned social vulnerability, and of using the weapons of science to cope with the challenge.

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70 There is an extensive bibliography on the history of infant health in contemporary times, featuring the ever more marked integration of plural perspectives (anthropological, sociological, demographical, pedagogical, and from the history of science). The link with the history of public health has raised great interest and in this context we should include such event as the 'V Conference of the European Association for the History of Medicine and Health' held in Geneva in 2001 ("Health and the Child: Care and Culture in History"). Esteban Rodríguez-Ocaña has provided a recent analysis of how historiography has dealt with the issue of infant health and illnesses: "La salud infantil, asunto ejemplar en la historiografía contemporánea", *Dynamis* 23 (2003), 27–36 offers a select and updated bibliography. In Spain, where the films under consideration were produced, the most recent monographic work on the subject is by Enrique Perdiguero, ed., *Salvad al niño. Estudios sobre protección a la infancia en la Europa Mediterránea a comienzos del siglo XX* (Valencia, 2004). See the "Introducción" of this volume (pp. 15–25) for more bibliography on the history of child health, especially, pp. 15–17.

71 Edward Seidler, "Uber die Lebensschwäche", *Episteme,* 1 (1967), 45–60.

The 'figurations' of the child's body- a term used by C. Castañeda[72] as a tool for describing the child's appearances in discourses as well as across them include both material and symbolic elements of this state of fragility.

In the case of the two films that we analysed, there are several types of material elements. First, we see the protagonists, the 'actual children', the focus of attention of the institutions in those situations where their lives are at risk, in other words in almost all situations. Then, the other main actors: the 'doctors', social agents who, armed with science and technology, present themselves as figures able to transform weakness into strength. The 'nurses' play a secondary but nonetheless important role in giving form, through the routine work of care and prevention (vaccinations, weighing and measuring, general care of the baby), to the new paediatric theories which are able to save the child. The 'mothers' are the final link in the chain and ensure that the culture of the active struggle against biological weakness is carried into each home in defence of each child. Finally we have the protective 'spaces', the institutions, with an architecture, facilities and regulations to consolidate the manifesto statements of doctors and politicians. These spaces will provide complete, considered, systematic and carefully planned protection and supervision.

The camera accurately captures the fragility of the child protagonists. In the case of "New Lives", there are two powerful images: firstly, in comparison with other animal species (the birds or lambs which appear at the beginning of the third part) we are made aware of how long it takes human beings before they are able to fend for themselves and, in the second place, we see a still with ghost-like silhouettes of deceased children designed to show the advantages of maternal breast-feeding.

Medical science comes to the assistance of children, banishing popular beliefs (a baby's head should not be covered all day, the dummy is unadvisable, babies should not wear tight dressings) and regulates each and every one of the aspects of their life. In very clear terms the child is shown as an object of knowledge and scientific practices. The scenes showing the childcare measures carried out by the nurse, do not in truth look like rooms in normal homes, but instead the conditions appear aseptic, cold, and almost hospital-like. The rules of hygiene which the mother must follow in the preparation of bottles are similar "to those of the surgeon in the operating theatre", says the narrator. This is a means of persuasion which puts women on a par with surgeons, if they are capable of emulating them in their own small family and domestic environment.

The biological weakness is also illustrated in the film by Thous, but by showing us different institutions much more attention is focussed on the various social problems. In this case the camera searches out that infancy in which the biological weakness is exacerbated by social hardship. The children who appear in 'Valencia, Protector of Children' come from the disadvantaged social classes. Abandoned chil-

72 Claudia Castañeda, *Figurations. Child, Bodies, Worlds* (Durham and London, 2002).

dren, accommodated in homes like the 'House of Mercy', are the most obvious expression, but in addition there are those who attend the Milk Depot or the Breast-feeding Home. They are poor children, humbly dressed, their hair badly cut and on occasions with signs of malnutrition. They are the children of poor mothers, with espadrilles and aprons, untidy hair and no jewellery. In this case they do appear more like the working woman that we see in 'New Lives'. There is an exception, the scenes within the premises of the Provincial Childcare School, we see some women who are well dressed, with lace collars and fashionable hair styles. These are the women who devote their time to the home and family and are able to fulfil their duties under the guidance of medical science.

The stills in the film by Thous show the changes which take place in closed institutions. The abandoned boy or girl, dirty and untidy, is transformed into another child, clean, tidy and dressed in the uniform of the home, which identifies all the children as guests of the institution. These are the typical 'before' and 'after' pictures which have been described by other authors.[73] The children housed in reformatories, dangerous children but still children in danger, have an added feature: their hair is cropped short, an unmistakeable sign of their status as inmate.

The weakest children are exposed to a thousand dangers. Illness and death are real possibilities. The propaganda message of the Valencian film is achieved by means of panoramic views of the health institutions, and above all, by the appearance of sick children in the Maritime Hospital or the Tuberculosis Clinic. The film seeks to avoid any drama. In the stills, everything appears to be under control: perfect rows of beds with clean linen, children undergoing tests and receiving heliotherapy. The pictures are aseptic and removed from the immediate life of these deprived children. No concessions are made, no appeals designed to arouse feelings of compassion. There are very few close-ups of children's faces and yet the pictures are tremendously dramatic.

From the symbolic point of view, in both films the institutions seek to demonstrate their protective actions as a sign of civilisation, in a new humanitarian culture, the legacy of the Enlightenment. Science is the highest rung in this civilised state and uses all the means at its disposal; from the controlled natural elements, sun and climate, to the most sophisticated technical resources, both in closed institutions and with out-patients.

73 Janet Golden, "The Iconography of Child Public Health: Between Medicine and Reform", *Caduceus* 12: 3 (1996), 55–72.

Conclusion

The use of cinema in the 1920s and 1930s in Spain as an instrument of health propaganda was restricted to rather isolated, sporadic ad hoc projects, and was always at the mercy of changing political circumstances – both frequent and dramatic in those times. However these isolated productions have a special cinematic and documentary interest.

The two films considered here, produced in very different political contexts, have different aims and characteristics. 'Valencia, Protector of Children', is a political propaganda film designed to show foreign audiences what could be achieved with the resources allocated to childcare. There is no educational message, though it was used in the Valencian rural context to raise awareness of proper childcare. On the other hand, 'New Lives' had a clearly educational message aimed at women.

In order to achieve their purposes, the two films chose different approaches. Unlike the documentary 'Valencia, Protector of Children', with its series of picture postcard scenes, 'New Lives' has a narrative and didactic component which seeks to involve the audience.

However, as we have pointed out, prominent in both cases is the role given to medical technology as a powerful instrument able to solve health problems. Medical science takes on a fundamental role in seeking changes in the behaviour of the general public. The different images associated with childcare and children's health problems have a very clear message in both films: the way to solve them is an upbringing based on the criteria of medical science which teaches how to wash, dress and feed the child.

Both films also emphasise specific moral values which are linked to health, but while in the first film these are supported by the moral discourse of the Catholic Church and its huge role in childcare, the second illustrates a code of civic and secular values without any explicit reference to religious ones. Although the two films show a particular view of the woman in which she is assigned roles related always to the home and the care of their children, there are nuances. In the 1936 film, we see the image of women playing sports, either alone, or with men, and a more professional image of nurses. This reflects the changes sought in the Spain of that time.

Did the films achieve the ends we have considered? There is probably no answer to this question which does not simply lead us into the realms of speculation. The event in Paris, for which the Valencian documentary was designed, received it warmly, and later it was shown at other exhibitions and was probably seen by thousands of Valencian mothers or mothers-to-be. We have no information about the projection figures of the second film made during the republic, though the fact that the year of production coincided with the outbreak of the Civil War, suggests that

in spite of the good reviews it received at its first showing[74], it probably had little or no impact, at least before the conflict.

But regardless of the audience figures of both films: did they bring about the desired changes in behaviour? There is no way of knowing. During the Civil War and under the Francoist regime, health experts retained their faith in health education, especially through cinema. For instance, Julio Bravo, who continued to be involved in health propaganda, produced a film on tuberculosis,[75] which as yet we have been unable to retrieve. Therefore those in charge of health education continued to trust in this medium as a way to transmit specific messages to the general public, although in a radically changed context.[76] Public health retained more or less the same organisational format[77] after the end of the Civil War, until the setting-up in 1942 of the Compulsory Health Insurance and the greater emphasis on health-care relegated it in the medium term to a secondary role.

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74 Domínguez-Lasierra (1999), p. 13–14.

75 Domínguez-Lasierra (1999), p. 14. Domínguez-Lasierra (2002), p. 17.

76 On the health education projects of the Francoist regime concerning mother and child see Enrique de Yturriaga, "Plan de propaganda sanitaria maternal e infantil", in *Estudios oficiales de la Primera reunión anual de Médicos Puericultores del Estado*, (Madrid, 1943), pp. 83–98.

77 Esteban Rodriguez-Ocaña, "The Politics of Public health in the State-Managed Scheme of Healthcare in Spain", in I. Löwy and J. Krige, eds., *The images of Disease. Science, Public Policy and Health in Post-war Europe* (Luxembourg, 2001), pp. 187–210.

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Two Cultures of Regulation?
The Production and State Control of Diphtheria Serum at the End of the Nineteenth Century in France and Germany

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At the end of the nineteenth century, diphtheria was one of the principal causes of mortality in children. The search for a remedy for the disease represented an important challenge for bacteriologists and microbiologists, and was perceived as an urgent social task. In the late 1880s two groups of scientists simultaneously started searching for a cure for diphtheria: Émile Roux (1853–1933) at the newly founded Pasteur Institute in Paris, and Emil Behring (1854–1917) in Berlin. Following Behring's successful animal experiments initiated in 1890, a serum against diphtheria was available in pharmacies starting in August 1894. Indeed, diphtheria serum represented a major therapeutic innovation in modern medicine, offering an effective curative approach first against diphtheria and subsequently against other diseases. A medicine of biological origin, the new serum therapy also attracted intense state attention in the hope of minimizing any associated public health risks.

In this article, I compare the two cultures of regulation of serum production and distribution in France and Germany at the end of the nineteenth century. In Germany, several pharmaceutical companies produced the serum and its sale was regulated by the state, which delegated the oversight of this industry to different institutions: the Imperial Health Office and the Institute for Serological Research and Serological Survey (hereafter – the Serological Institute). The collaboration and connections between the state-run institutes and the private chemical-pharmaceutical industry was particularly important, while for France the story turns around the Pasteur Institute. In France, there was no direct state control over serum production. After an initial approval of the serum producers, the quality control of the serum remained in the hands of the producers themselves. Based on an examination of the differences and similarities of

serum production and regulation in the two neighbouring countries, this article aims to characterize the different cultures of control and the different forms of governmental oversight. In this context, culture refers, on the one hand, to everyday (laboratory) life, the culture of production, the procedures and the specific ways of behaving in each case. On the other hand, culture is not understood as something natural but rather is taken to be socially constructed. Regulation includes all kinds of legislation, (state) control, instructions, adjustments, governance, and also the influence of the state and the state-run or semi-public institutions. Regulation also refers to price regulation or the regulation of industrial processes in terms of state intervention. The state itself is not viewed as a monolithic institution: the term state is used to refer to a set of actors including politicians, government, governmental institutions or semi-public organisations acting in the public sphere or simply the associated bureaucracy. The article asks about how these different actors cooperated in the two national cultures to regulate serum production, because diphtheria serum offered on the one hand the possibility of enhancing public health but on the other hand, as an unknown biological drug, the serum also represented a public health risk that had to be dealt with and minimized. In both cases we need to illuminate the nature of the collaboration between politicians, science and industry and we have to locate the different actors in the triangle "state – science – industry". Furthermore, the article will treat the effect of these different styles of governmental influence on matters concerning public health.

I will, therefore, give a short overview of the process of serum production, which was more or less similar in the two countries. Then, I will present the regulation of the serum therapy in the two countries in two different sections. Afterwards, as a detailed case study, I will examine the financial aspects of serum production and scrutinize the interactions between the different actors. Finally, I will summarise and conclude the results of this analysis and show the differences in administering and regulating serum production and the different cultures of governmentality.

Sources

In order to talk about two cultures of organisation and regulation, we first have to consider two different cultures of archiving. With respect to this issue, the two cultures are difficult to compare. In Germany we have a large quantity of continuous sources that provide a wide range of information. In the archives of the pharmaceutical companies, there are calculations and information about serum production and regulation. Moreover, in the Prussian Archive, the Archive of the Paul Ehrlich Institute and in the Federal Archive we find several

folders on diphtheria serum concerning the related state-run institutes, their budgets and personnel.[1] In France, apart from some regional archives with scattered information there is the Archive of the Pasteur Institute.[2] In practical terms this means that, for example, we have several folders containing files on the budget of the Serological Institute. The sources available in Germany include information about the planned budgets with annual plans, folders for the accounting office and the income and expenses of the institute.[3] At the Pasteur Institute we have a few sheets of notes, with rough calculations of the receipts and the expenses for this period.[4] Thus, when comparing the financial aspects of serum production we have a detailed record available for Germany, documented in numerous sources while for France we have approximate information based on sporadic sources.

The differences we have just noted concerning the sources available reflect an important difference in the structure of serum production in France and Germany. All the participants in Germany were answerable to some higher institution: the state institutions were answerable to the ministry, while some of the commercial companies were answerable as a stock corporation or directly to the shareholders, to whom they had to give reports. In France, it is not clear if the Pasteur Institute was answerable to any higher institution. The only institution to which they may have reported was the supervisory board of the institute, but apparently not with any detailed reports.[5] Moreover, the lack of sources reflects the central position of the Pasteur Institute in the process of serum production and regulation. While in Germany several actors had to

1 Regarding the research into and the state control of diphtheria serum for example: in the Federal Archive (Bundesarchiv, Berlin – hereafter BA Berlin) the collection of the Imperial Health Office R 86, folder 1179–1184, 1646, 2710–2712, 2886; in the Prussian Archive (Geheimes Staatsarchiv – Preussischer Kulturbesitz, Berlin – hereafter GStA PK) the collection of the Prussian Ministry for Cultural Affairs the folders HA 1, Rep. 76 VIII B, No. 3747–3755; in the archive of the Paul Ehrlich Institute (Paul-Ehrlich-Institut, Langen – hereafter APEI) the folder of the department V.

2 In the archive of the Pasteur Institute, Paris (hereafter AIP), there are for example the assets of the Head Office (DR-COR, DR-DOS) and the collection of Émile Roux.

3 Cf. GStA PK, HA 1, Rep. 76 Vc, Sekt. 1, Tit. XI, part II, No. 19; GStA PK, HA 1, Rep. 76 Vc, Sekt. 1, Tit. XI, part II, No. 21, vol. 1 and 2; APEI, Boxes reg. staff, administration, budget, accountancy – each box with several files.

4 For example concerning the calculation of the "service de la séro-thèrapie" AIP, DR-DOS 2, fol. 9265, 9268–9279, 9285, 9288, 9296, 9371, 9376; concerning the calculation of staff AIP, DR-DOS 1, fol. 18474, 18476–18477, 18479, 18482; see also the Séances du Conseil d'Administration de l'Institut Pastuer, AIP.

5 It was only after the financial crises of the institute in the 1930s that some detailed information about the annual budget started to become available, cf. the correspondence in AIP, DR-COR4.

communicate over long distances and between different hierarchies; in France all the relevant actors were gathered together at the Pasteur Institute.

Production and Distribution of Diphtheria Serum in France and Germany

If we compare the different cultures of regulation of serum production in France and Germany, we can see in detail several differences but overall they present many similarities.[6] A first similarity is that the relevant research took place in non-university research institutions – the Prussian Institute for Infectious Diseases in Berlin and the Pasteur Institute in Paris. The development of the diphtheria serum took place in a public context within the scientific community. The research results were published in France, for example, in the *Annales de l'Institut Pasteur* and in Germany in the *Deutsche Medizinische Wochenschrift* or in the *Zeitschrift für Hygiene*. Summaries of research results were published very rapidly in weekly journals with detailed accounts following later in widely read medical journal. This policy of prompt publication was used to establish priority for the relevant scientific innovations with the side effect that everybody could, in principle, reconstruct the published experiments. This immediate publication also enabled a constant exchange of information about current research. This indirect exchange of knowledge was probably one of the reasons that the process of serum production showed many similarities in both countries. In Germany as well as in France there were several actors producing serum. While in Germany there were several competing pharmaceutical companies, in France the Pasteur Institute was the main actor, and the only one producing the serum "industrially". "Industrially", here, means the production of large quantities of serum – thousands of litres – for national or international supply, even though the stables for the horses and the associated laboratories looked more like a farm than a factory (see fig. 1). In France, besides the Pasteur Institute there were some regional institutes in cities like Bordeaux, Montpellier,

6 For the problems, difficulties and opportunities presented by historical comparison see Hartmut Kaelble, *Der historische Vergleich. Eine Einführung zum 19. und 20. Jahrhundert* (Frankfurt, 1999); and Christian Bonah, *Instruire, Guérir, Servir. Formation et Pratique Médicales en France et en Allemagne pendant la deuxième moitié du XIXe siècle* (Strasbourg, 2000), pp. 5–7, 27–69. For a direct comparison between the Prussian Institute for Infectious Diseases and the Pasteur Institute see Paul J. Weindling, "Scientific Elites and Laboratory Organisation in fin de siècle Paris and Berlin. The Pasteur Institute and Robert Koch's Institute for Infectious Diseases compared", in Andrew Cunningham and Perry Williams, eds., *The Laboratory Revolution in Medicine* (Cambridge, 1992), pp. 170–188; and J. Andrew Mendelsohn, *Cultures of Bacteriology. Formation and Transformation of a Science in France and Germany, 1870–1914*, Phil. Diss. (Princeton, 1996).

Figure 1. Serum Production at Merck around 1909, Darmstadt

Source: Merck Archive (Y 1/00280), Darmstadt.

Lyon, Nancy, Grenoble and elsewhere that produced serum only in small quantities for their local region and were generally attached to the Faculty of Medicine, the local municipality or both.

The process of serum production starts with the fabrication of the diphtheria toxin. The toxin is extracted from pure bacteria cultures sown on an appropriate culture medium, and killed after a few days of breeding, using a disinfectant. This was not a simple process, with the amount of toxin produced depending on the strain of bacteria used and the handling of the culture medium, among other factors, and the details of toxin production differed from company to company. Increasing doses of the toxin were then inoculated into horses over the course of several evenly spaced injections (see fig. 2). Test-bleedings indicated when the antitoxin content of the serum was at its maximum level, at which time the horse could be bled regularly. After bleeding, the blood was left to stand so that the serum separated out. Again the different companies had different techniques involving filtration and centrifugation to ensure the purity of the serum. After the serum's quality and effectiveness had been checked,[7] it was poured into a phial at an appropriate dose (5 or 10 millilitres), labelled with the immunisation power and date of preparation, packed and was then ready for distribution.[8]

7 The process of evaluation is too complicated to explain here, for the German procedure see Axel C. Huentelmann, "Evaluation and standardisation as a practical technique of administration. The example diptheria-serum", in Christoph Gradmann, ed., *Evaluations. Standardising Pharmaceutical Agents 1890–196*0 (in Print, app. 2008).

8 For a detailed description, see the outline for the founding of a state-run control station in the archive of the Paul Ehrlich Institute in Langen (hereafter APEI), Dept. Va, No. 1, Vol. 1. A general account is given in Carola Throm, *Das Diphtherieserum. Ein neues Therapieprinzip, seine Entwicklung und Markteinführung* (Stuttgart, 1995); see also Arnold Eiermann, "Die Einrichtung zur Darstellung des Diphtherie-Heilserums in den Höchster Farbwerken", *Münchener Medicinische Wochenschrift*, 41 (1894), pp. 1038–1040.

Figure 2. Production of diphtheria serum at the Behring-Werke around 1906 On the left, the inoculation of the toxin, and on the right, the bleeding of an immunized horse.

Source: Behring Archive, Marburg.

The first phials of diphtheria serum produced by the Farbwerke Hoechst were on sale in German pharmacies in August 1894. One month later, at the Eighth International Congress of Hygiene in Budapest, the scientific world was introduced to the new therapy against diphtheria and the serum was greeted as a great breakthrough in the treatment of a terrible disease.[9] In Germany, the Farbwerke Hoechst had a leading position on the national serum market, providing nearly three quarters of the diphtheria serum, while in France the Pasteur Institute dominated the national market. Apart from the Pasteur Institute

9 For example: Émile Roux to Émile Duclaux, Head of the Pasteur Institute, 15.9.1894, Museum of the Pasteur Institute, fol. 11504. A report about the congress in *La semaine médicale*, 14 (Issue 51, 8.9.1894); Le Bulletin Médical (1894), pp. 827–829, 844–845, the paper of Roux given on the Congress on pp. 1165–1168. For Germany see several articles of German newspapers in BA Berlin, R 86/1182; a report in the *Deutsche Medizinische Wochenschrift*, 20 (Issue 35–37, 1894), pp. 700–703, 715, 729–731; detailed and with a print of several talks given in Budapest in *Centralblatt für Bakteriologie und Parasitenkunde*, 16 (1894), pp. 737–742, 778–784, 822–826, 881–896, 908–914, 955–959, 960–965, 1013–1018, 1054–1058; and in the *Deutsche Vierteljahrsschrift für öffentliche Gesundheitspflege*, 27 (1895), pp. 209–276, 401–464.

some regional institutes produced serum to provide serum in their districts because the Pasteur Institute was incapable of delivering the requested quantities of serum in the last months of 1894. The serum phials were distributed via pharmacies, hospitals, public health and welfare institutions especially of the municipalities or the districts. Economically, the new serum represented a major market. Thus, for example, in the first year of production, Farbwerke Hoechst made around 707,000 Marks of profit on the serum.[10] The large quantities of serum on the market made the question of regulating its sale particularly urgent. Despite the similarities in the production process, the regulation of the serum production was different in the two countries – configurations that depended on the national cultures and traditions.

State Regulation of Serum Production in Germany

As mentioned above, the research results about the new serum therapy were published in several medical periodicals. The articles were freely available and so in August 1894 it was in principle possible for a well-informed microbiologist to reconstruct the production process and to produce the serum. Moreover, there was no patent covering the production and use of serum therapy and there was no protection of any particular trademark. In general, in Germany the patent legislation that applied to chemicals was transferred in 1891 onto pharmaceuticals, meaning that only processes and not products could be protected.[11] Thus anybody could copy the serum (as a product), and would just need to vary the production procedure to be sure to avoid encountering legal problems. Only a few years earlier tuberculin, the unsuccessful treatment for tuberculosis launched by Koch in Berlin in 1890, had triggered a public health scandal that continued to echo around the public health administration. In the tuberculin case, an initial optimistic mood had quickly turned to one of deception, while the administration watched ineffectively from the sidelines not knowing how or whether to intervene.[12] The novelty of serum therapy and a lack of information concerning its long-term effects, as well as the prospect of high

10 Cf. Throm, *Diphtherieserum*, pp. 54–55 and Tab. IV.

11 Cf. Wolfgang Wimmer, *"Wir haben fast immer war Neues". Gesundheitswesen und Innovation der Pharma-Industrie in Deutschland, 1880–1935* (Berlin, 1994), pp. 85–101; Erika Hickel, *Arzneimittel-Standardisierung im 19. Jahrhundert in den Pharmakopöen Deutschlands, Frankreichs, Großbritanniens und der Vereinigten Staaten von Amerika* (Darmstadt, 1973).

12 Christoph Gradmann, "Ein Fehlschlag und seine Folgen. Robert Kochs Tuberkulin und die Gründung des Instituts für Infektionskrankheiten in Berlin 1891", in idem and Thomas Schlich, eds., *Strategien der Kausalität. Konzepte der Krankheitsverursachung im 19. und 20. Jahrhundert* (Pfaffenweiler, 1999), pp. 29–52, in particular pp. 36–38.

profits in the serum industry pushed high-ranking government officials down the road of legislation. Nevertheless, the principle aim was probably to avoid any scandal concerning ineffective or impure serum sold by unscrupulous firms.

A conference was organized in early November 1894 by the Imperial Health Office – the highest medical authority in the German Empire – bringing together medical officials from the Prussian Ministry for Cultural Affairs, representatives of the Federal states, the Imperial Health Office and scientists from the Prussian Institute for Infectious Diseases, like Paul Ehrlich (1854–1915), Robert Koch (1843–1910) and Emil Behring. Later on, representatives of the pharmaceutical industry were also included in the discussion.[13] The participants at this conference discussed the regulation of the new serum therapy and the need to protect the public against impure or ineffective serum.[14]

Interestingly, the initial German proposals for state regulation took the Pasteur Institute as their model, proposing an Imperial institute to produce and distribute the serum.[15] Later on, however, this idea of a state-run institute was only raised by government medical officials as a threat to the serum producers.[16] Furthermore, there was also a call for donations in the name of the Empress to found such a state-run institute for serum production,[17] along with several other appeals, especially in the early months, for funds to pay for free serum for the poor.[18]

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13 The minutes of the meeting from 3rd and 5th of November 1894 in BA Berlin, R 86/1646. Furthermore background information regarding the importance of the conference in Heinz Zeiss and Richard Bieling, *Emil von Behring. Gestalt und Werk* (Berlin, 1941), pp. 153–157; Axel C. Huentelmann, *Gesundheitspolitik im Kaiserreich und in der Weimarer Republik. Das Reichsgesundheitsamt von 1876–1933*, Diss. Phil. (University of Bremen, 2006).

14 Cf. the minutes of the meeting from 3rd and 5th of November 1894 in BA Berlin, R 86/1646.

15 Cf. the discussions on a meeting on October 19th 1894 in the Imperial Health Office, BA Berlin, R 86/1646; and the minutes of a meeting at the Prussian Ministry for Cultural Affairs on October 24th 1894, GStA PK, HA 1, Rep. 76 VIII B, No. 3747; furthermore an undated report from B. Fraenkel about the distribution of diphtheria serum in France, ibid; see also Throm, *Diphtherieserum*, p. 71.

16 Cf. Althoff an Behring, 15.11.1894, Behring-Archiv Marburg, folder 8–01: Correspondence Althoff, Doc. 1; the head of the Imperial Health Office, Carl Koehler, about Althoff's idea in a letter to Josef von Kerschensteiner, extraordinary member of the Imperial Health Office and privy council in the Bavarian Ministry of the Interior, 27.11.1894, BA Berlin, R 86/1646; about the plans to found a state-run institute of serum production reports a newspaper article in the *Berliner Tageblatt*, 26.2.1908.

17 Cf. the appeal for funds in the name of the Empress for a German Institute for serum production, BA Berlin, R 86/1646.

18 The Kaiserin-Friedrich Hospital in Berlin received 30,000 Marks for this cause, and a call for donations from the *Lokal-Anzeiger* in Berlin also raised some money, cf. the donation of 30,000 Marks the letter of Rudolf Virchow to an unnamed privy council, 17.10.1894,

Between November 1894 and February 1895 a series of meetings gave rise to draft legislation covering serum production. In accordance with an imperial decree from January 1890 the diphtheria serum could only be sold in pharmacies, ensuring that the distribution of diphtheria serum was limited to medical specialists. Secondly, in accordance with a Federal resolution of July 1891, a prescription was required for the diphtheria serum and the serum was inscribed in the *Pharmacopoeia germanica* as *serum antidiphthericum*.[19] In the absence of empirical knowledge about the action of the serum it was decided to accompany its introduction onto the market by the compilation of medical statistics to prove the effectiveness of the new serum therapy.[20]

The most important point in the German scheme was the state control of the production and distribution of the serum. Until the 1880s, the quality control of the ingredients and the preparation of the pharmaceuticals were entirely in the hands of the pharmacists. With the rising pharmaceutical industry, it became difficult for the apothecary to analyse the ingredients, meaning that he could no longer guarantee the quality of the tablets or pills that he sold in his shop.[21] Indeed, only a trained expert could determine the potency of the serum, and the mass production of the serum only reinforced this state of affairs, with the industry increasingly becoming the site of both production and quality control instead of the pharmacies.[22]

The surveillance of serum production combined centralized and local elements involving not only the monitoring of the production process but also the use of a state institute for serum control. In every production plant the process was permanently monitored by a medical officer, paid by the producer but answerable to the state in the form of the Prussian Ministry for Cultural Affairs or the district president. In addition, the serum was tested for purity as well as being evaluated and certified centrally at the Serological Institute founded in February 1895. There were also strict regulations concerning the

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GStA PK, HA 1, Rep. 76 VIII B, No. 3747. The "Appeal to all philanthropists" for funds to buy serum for the poor by the newspaper owner August Scherl in October 1894, ibid.

19 Reichsgesetzblatt 1895, p. 1.

20 Cf. the minutes of the meeting from 3rd and 5th of November 1894 in BA Berlin, R 86/1646. The results of the statistics had been published as "Ergebnisse der Sammelforschung über das Diphtherieheilserum für die Zeit vom April 1895 bis März 1896" and send to every library in the German Empire and to several institutions, cf. BA Berlin, R 86/1646; and a summary had been published in *Arbeiten aus dem Kaiserlichen Gesundheitsamt*, 13 (1897), pp. 254–292.

21 The aim of the control was the reduction of sources of error. With the industrialisation process it was easier to control a few producer than to control thousands of pharmacies.

22 Cf. Jürgen Holsten, *Das Kaiserliche Gesundheitsamt und die Pharmazie. Dargestellt an der Entstehung des Deutschen Arzneibuches, fünfte Ausgabe*, Diss. med. Free University (Berlin, 1977); Hickel, *Arzneimittel-Standardisierung*; Wimmer, *Gesundheitswesen*.

handling and packaging of the prior to distribution, and the sale price was regulated, with special tariffs for social security insurance, welfare institutions and hospitals. Finally, the producers guaranteed the withdrawal of phials from pharmacies after two years or in the case of ineffective or impure serum. The legislation was implemented within a few months, and the state institute for serum control set up.[23] Thus, after April 1st 1895, only state-certified serum could be sold in Germany.

Regulation and Serum Production in France

In France, the Pasteur Institute produced, distributed and monitored the quality of the vast majority of diphtheria serum.[24] There was enormous public enthusiasm for the new serum therapy. In September 1894, *Le Figaro* launched a public subscription, which raised over one million Francs in a few months.[25] Just as in Germany, there was discussion in France about regulating the preparation, distribution and sale of diphtheria serum to protect the public against impure, harmful or ineffective serum. As with the German legislation, the French pharmacists traditionally bore the responsibility for the purity and quality of the ingredients and their prescribable combinations as defined by the official pharmacopoeia. Thus, the French pharmacist was accountable for anything that he sold, whether he had prepared it in his pharmacy or not.[26] After the development of the diphtheria serum in 1894, a bill was introduced in March 1895 and debated in the *Chambre des Députés* and the *Sénat* before finally being proclaimed law by the French President on the 25th of April 1895.[27] The law cov-

23 See the minutes of the meeting from the 17.12.1894, 17.1.1895 and 1.2.1895 and the correspondence between the participants of the meetings in BA Berlin, R 86/1646; GStA PK, HA 1, Rep. 76 VIII B, No. 3747; about the foundation of the Serological Institute see GStA PK, HA 1, Rep. 76 Vc, Sekt. 1, Tit. XI, part II, No. 18, vol. 1.

24 For detailed information about the Pasteur Institute see *L'Institut Pasteur et ses Annexes. Organisation et Fonctionnement et ses divers Services* (Paris, undated – after 1900); Albert Delaunay, *L'Institut Pasteur. Des Origins a Aujourd'hui* (Paris, 1962); Michel Morange, ed., *L'Institut Pasteur. Contributions à son histoire* (Paris, 1991); and Ilana Löwy, "On Hybridizations, Networks and New Disciplines The Pasteur Institute and the Development of Microbiology in France", *Studies in History and Philosophy of Science*, 25 (1994), pp. 655–688; Anne Marie Moulin, "The Pasteur Institute's International Network: Scientific Innovations and French Tropisms", in: Christophe Charle et al., eds., *Transnational Intellectual Networks. Forms of Academic Knowledge and the Search for Cultural Identities* (Frankfurt, 2004), pp. 135–164.

25 Cf. the subscriptions the press clipping in the AIP, DR-DOS2.

26 Hickel, *Arzneimittelstandardisierung*.

27 LOI relative à la preparation, à la vente et à la distribution des sérums therapeutiques et autre produits analogue, cf. Ministère de l'Interiéur, *Sérums Thérapeutiques et*

ered more than just "therapeutic serums", including "attenuated viruses," "modified toxins" and other similar products including the whole range of "injectable substances of organic origin not chemically defined".[28] Concerning serum, the law was similar to the German legislation on several points, such as stating that the diphtheria serum could only be distributed through pharmacies and required a prescription.[29] As the distributor of the diphtheria serum, however, the pharmacist was now exonerated from his official responsibility with respect to any approved serum, with responsibility for quality control transferred from the site of distribution to that of production. Anyone who wanted to be a producer first had to prove that he had the ability to prepare effective and sterile diphtheria serum, and only authorized institutions would be allowed to produce and distribute the serum. The audits and authorization were overseen by a committee that was set up under the auspices of the Academy of Medicine and answerable to Ministry of Interior.[30] This committee, the serum commission, was constituted in May 1895 and consisted of 16 members: civil servants from the Ministry of Interior, members of the Academy of Medicine and of the Consultative Committee for Public Health in France. Some of them were also members of or related to the Pasteur Institute, such as Édmond Nocard (1850–1903), Professor at the veterinary school in Alfort and associated member of the Pasteur Institute, or Émile Duclaux (1840–1904), Pasteur's successor as the Director of the Pasteur Institute.[31] Thus, the serum commission was dominated by members of the Pasteur Institute. Indeed, in the state's delegation of authority to the Serum commission of the Academy for Medicine, they were relying heavily on members of the Pasteur Institute, who, within the academy, were the only once to have the technical competence to audit potential serum producers. Furthermore, most of the French microbiologists were educated at the Pasteur Institute or had attended the "Grand cours", a course in bacteriology taught by Émile Roux. Indeed, anyone who wanted to produce the serum had to learn or had already learnt the technique of serum production at the Pasteur Institute.

Thus, we have seen that in Germany as in France, a number of different actors were involved in the process of serum production and regulation. The following section consists of a financial analysis of serum production in the two countries,

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autres Produits Analogues. Législation et Réglementation 1895 (Extract from Recueil des Traveau du Comité Consultatif d'Hygiéne Publique de France et des Actes Officiels de l'Administration Sanitaire, vol. 25), Paris 1896.

28 Ibid., art. 1.

29 Ibid., art. 2.

30 Ibid., art. 1–2.

31 See the Décret du 15 mai 1895, in: Ministère de l'Interiéur, Sérums Thérapeutiques; see also *L'Institut Pasteur et ses Annexes*, p. 26–31.

with the aim of illuminating the interaction between the different actors and the impact of the state regulation.

Financial Aspects of Serum Production and Regulation – a Comparative Case Study

Financing is one of the key elements of production, with investors generally expecting a return on their investment. Nevertheless, profit does not have to be interpreted in financial terms, but can be realised in prestige, power or other expected advantages. Thus, an analysis of the financial aspects of serum production illuminates the direct and indirect connections between the different actors in the spheres of science, state and industry. Due to the separation of the functions of production and regulation of the serum in Germany we have to consider the financial aspects from both a local and a national perspective. Overall, we can suppose that the costs of production in France and Germany were comparable, although due to unequal sources, no detailed comparison is possible.

Initial Costs and Investments

Even prior to production in Germany, the Farbwerke Hoechst had invested in Behring's research and Schering in Hans Aronson's (1865–1919).[32] After the experimental phase turned into an industrial one, and large-scale production started, the German companies involved invested in horses to try and maximize their profit, as well as introducing their own bacteriological departments,[33] often

32 In 1892 the Farbwerke Hoechst signed a contract with Emil Behring concerning the sponsorship of Behring's experiments, cf. August Laubenheimer, *Zur Geschichte der Serumdarstellung in den Farbwerken* (The History of the Serum Therapy at the Farbwerke Hoechst), June 1904, Behring Archive, University of Marburg, 8–01, Correspondence with the Farbwerke Hoechst, doc. 678 (hereafter Laubenheimer, *Geschichte*), p. 10. August Laubenheimer was a member of the supervisory board at the Farbwerke Hoechst. The details of Schering's payments to Hans Aronson are not known, but they were probably less than Behring had received, cf. also Throm, *Diphtherieserum*, pp. 48-49.

33 The Farbwerke Hoechst installed an own laboratory at the same time they supported Behring. After it became apparent, that the experiments of Behring would be successful and also cure human, the Farbwerke Hoechst decided to enlarge the bacteriological laboratory to an own bacteriological department, see Laubenheimer, *Geschichte*. As the head of the bacteriological laboratory Arnold Libbertz was recruited, a friend of Robert Koch, cf. Throm, Diphtherieserum, pp. 48–49. Between 1892 and 1894 also Schering had built up an own laboratory. Merck started to build up an own bacteriological department in 1894/1895.

building new stables and laboratories.[34] In France, the research on the serum was funded by the Pasteur Institute, and after September 1894 they started to produce the serum in Garches, a suburb of Paris. For this, they used a large former military stable that had been made available to Louis Pasteur for his rabies research. Part of the money from the *Le Figaro* subscription was invested in new stables and other building work at Garches,[35] as well as paying for the horses to produce the serum. Between autumn 1894 and the end of 1895 the Pasteur Institute bought between 79 and one hundred horses for around 26,000 Francs.[36] Thus, this public subscription provided the start-up financing necessary for large-scale production in France, and also provided the Pasteur Institute with long-term income through the interest on investments. In Germany, the competing companies were exposed to a significant financial risk, having to invest their own money based on prospective sales of the serum, while in France, following the unexpected success of the public subscription campaign, the Pasteur Institute had made money on the venture even before production had started. Nevertheless, the risks taken by the German investors paid off, because they were able to deliver serum far earlier than the French.

Running Costs

The running costs for the production process included the cost of feeding the horses and test-animals (mice and guinea pigs), as well as the test procedures and the maintenance of the buildings and laboratories. In addition to the material costs there were personnel costs: stable boys, laboratory assistants, the scientists and laboratory director.[37] While, detailed running costs no doubt differed

34 The price for one horse was 300 Marks for each in Germany, price out of the calculation from Schering, cited after Throm, *Diphtherieserum*, p. 83.

35 The construction of the new laboratories cost 180,000 Francs, cf. the draft for a report of the "Service gratuits" to competent minister, see AIP, DR-DOS2, doc. 9286.

36 Based on an article in Le Figaro of January 1st 1895. Jonathan Simon differentiated the quoted sum of 136 horses: 79 horses in Garches, 42 in the stables of Grenelles and 15 in Alfort, see Jonathan Simon, Jonathan Simon "Monitoring the Stable at the Pasteur Institute", *Science in Context*, 2008 (forthcoming). We can hypothesis that the 79 horses were bought from the donated money, because there were no more capacities on the terrain of the Pasteur Institute. But it is likely that much more from the 136 horses were bought after October 1894 and taken shelter in Grenelle. In a German newspaper article that based on a statement of the Pasteur Institute a figure of 100 horses is cited, cf. *Neue Preußische Zeitung* No. 76, 14.2.1895. – The amount of 26,011.10 Francs is cited in a draft for a report of the "Service gratuits" to the competent minister, see AIP, DR-DOS2, doc. 9286.

37 Some members of the Pasteur Institute received additional income from the Ministre de l'Instruction publique, but otherwise the cost for personnel were similar, cf. for France the lists in AIP, DR-DOS1; for Germany the file with documents concerning accountancy of the Serological Institute GStA PK, HA 1, Rep. 76 Vc, Sekt 1, Tit. XI, part II, No. 21, vol. 1–3.

between France and Germany (the Pasteur Institute, for example, bought unfit military horses, and Farbwerke Hoechst bought them on the regular market), overall the cost for serum production was roughly comparable.[38]

Expenses Due to State Regulation

Under German regulations, the serum producers nevertheless bore extra expenses, having to pay the salary of the on-site government inspector.[39] Furthermore, every producer who wanted to sell serum had to pay a fixed "entrance" fee of 1,000 Marks to the state institute. In addition, after the first of April 1895 every producer had to pay fees to the Serological Institute, which charged a minimum of about fifty Marks for any amount up to five litres of serum plus ten Marks for every subsequent litre.[40] The test fees were a constant topic for debate in Germany, with the industry arguing that they hindered German competitiveness, and, as a consequence, the fees were waived for any serum sold abroad. In France, the serum producer did not have to pay any fees to any outside agent, as they were themselves responsible for quality control. On the other hand, the Pasteur Institute did have to deliver serum to the "assistance publique" in and around the city of Paris for free. Between October 1894 and February 1895 the Pasteur Institute distributed 50,000 doses free of charge.[41] While in France, the Pasteur Institute had a quasi monopoly over serum production, the German market was limited to the companies who could afford the 'entrance fee' associated with testing, making it difficult for newcomers to enter the market.

38 For subsistence (food, rent for the stable, staff) of the horses the Pasteur Institute calculated 1,000 Francs per year for every horse, cf. *Neue Preußische Zeitung* No. 76, 14.2.1895. For Germany Throm, *Diphtherieserum*, pp. 83–91, 105–110, is quoting an amount of 600 Marks for subsistence and 600 Mark for the test procedure.

39 For detailed information see Throm, *Diphtherieserum*, pp. 83–91, 105–110. The Farbwerke Hoechst for example paid 2,000 Mark each year for the medical official.

40 In short Throm, *Diphtherieserum*, pp. 148–151. See also the again and again blazing discussion about the fees in BA Berlin, R 86/1182, R 86/1646, R86/2711; GStA PK, HA 1, Rep. 76 VIII B, No. 3747–3753; and the box about fees in the APEI.

41 Cf. the report "Service gratuits – Année 1894" in the Museum of the Pasteur Institute, doc. 9269. The money for the provision of the "Service gratuit" amounting to 55,000 Francs. Cf. the draft for a report of the "Service gratuits" to competent minister, see AIP, DR-DOS2, doc. 9286.

Income Situation

In Germany the phials of diphtheria serum were sold in pharmacies. In 1894 a five centilitre, 500 Immunisation Unit phial cost five Marks, although later the price was reduced. Furthermore, the price was halved for health insurance funds, poor relief and municipal institutions as well as hospitals. Government intervention was another subject of disagreement between the serum producers and the state.[42] Nevertheless, despite price regulation the production of serum at the Farbwerke Hoechst, Schering and other companies was highly profitable. Indeed Hoechst paid off the cost of their new production plant in a matter of months and, as mentioned above, had made a profit of 707,000 Marks before the end of 1895.[43]

The Serological Institute also profited from the commercial success of serum, as it was principally financed by the fees for its tests. Thus, it only took the institute a few months to reimburse an initial equipment loan from the Prussian state.[44] In addition, the municipality of Frankfurt funded new buildings and paid 10,000 Marks per year to cover the running costs when the institute moved to the city in the autumn of 1899. In return, the state-run institute had to give bacteriological courses to Frankfurt physicians, as well as giving lectures on bacteriology and serology at the *Senckenbergianum* and conducting bacteriological tests for Frankfurt's public hospitals.[45] After the turn of the century, a donation was given to the institute to pay for serological and biochemical research.[46]

At the Pasteur Institute the main source of income in the first year of serum production was money raised by the public subscriptions organized by *Le Figaro* that was supposed to pay for a "service gratuit". Thus, the Pasteur Institute supplied hospitals and dispensaries in and around Paris (as well as the

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42 The price for the diphtheria serum was later on permanently reduced by an official decree, the price regulation in BA Berlin, R 86/1646 and R 86/1182.

43 Laubenheimer pointed out that the production plant with the amount of 444,000 Marks was written down with the profit of the first year, cf. Laubenheimer, *Geschichte*, p. 10.

44 Robert Koch to the Prussian Ministry for Cultural Affairs, 4.7.1895, GStA PK, HA 1, Rep. 76 Vc, Sekt. 1, Tit. XI, part II, No. 21, vol. 1, fol. 12.

45 The files concerning the transfer of the institute from Berlin to Frankfurt in GStA PK, HA 1, Rep. 76 Vc, Sekt 1, Tit. XI, part II, No. 19.

46 In Frankfurt the banker Georg Speyer and later his widow gave money to scientific and municipal welfare institutions, see Althoff an Ehrlich, 12.1.1901, Rockefeller Archive Center, Paul Ehrlich Collection, 650 Eh 89, box 1, folder 46; Ehrlich an Althoff, 19.1.1901, ibid. Later on, Paul Ehrlich spent the money he gained from Salversan. Before the First World War the Foundation of the "Georg-Speyer-Haus" had added up to more than four Million Marks, see the Correspondence with Ludwig Darmstädter in the Rockefeller Archive Center, Paul Ehrlich Collection, 650 Eh 89, box 1, folder 8.

military) with free serum.[47] Furthermore, they received a one-off subsidy of 100,000 Francs from the state.[48] The significant excess income was invested in bonds to assure a regular income.

To cover the running costs and the "Service gratuit", the Pasteur Institute also got a supplementary annual subsidy of about 80,000 Francs from the state, as well as an annual subsidy of 15,000 Francs from the city of Paris, and 5,000 Francs from the *Département de la Seine* to assure the delivery of serum to the community.[49] Besides the "Service gratuit", however, there was also a "Service payant" because patients who could afford it were expected to pay for the serum. In February 1895, a German newspaper reported several complaints in Paris from people who had given donations to the Pasteur Institute assuming that they would benefit from the free "Service gratuit," but later had to pay for the serum in the pharmacy.[50] The regular income from the sale of the serum, especially from exports, added up to an estimated total income of more than 420,000 Francs in 1895.[51] In sum, it could be said that the considerable investments represented by the new buildings and horses were met by subscriptions and donations, which comprised the largest part of the income in the years around 1895. The interest from the invested donations together with different subsidies from the state, departments and the city of Paris, as well as the commercial sale of the serum (which was nearly one third of the total income) covered the running costs. This mixed income structure for serum production reflects the general income structure for the institute.[52]

Financial Aspects and the Different Administrative Actors

At first sight, the financial aspects of serum production look quite different in France and Germany, as does the regulation. In France we see private or semi-private 'charitable' institutions, with the Pasteur Institute occupying a central position, and complemented by some regional serum producers. In Germany we have several competing for-profit companies operating in different federal states

47 See the draft of a report of the "Service gratuits" to competent minister, see AIP, DR-DOS2, doc. 9286.

48 See the notes in AIP, DR-DOS 2.

49 See the draft of a report of the "Service gratuits" to competent minister, see AIP, DR-DOS2, doc. 9286; and the annual report of 1895 in the museum of the Pasteur Institute, doc. 9274; see also the report about the congress in Budapest in the *Revue d'Hygiene*, 16 (1894), p. 1018; and *L'Institut Pasteur et ses Annexes*, p. 26.

50 Cf. *Neue Preußische Zeitung* No. 76, 14.2.1895.

51 See the annual report of 1895 in the museum of the Pasteur Institute, doc. 9274.

52 As an example compare the balance for 1890 in GStA PK, HA 1, Rep. 76 VIII B, No. 3592; see also Sandra Legout, *La Famille Pasteurienne. Le Personnel Scientifique Permanent de l'Institut Pasteur de Paris entre 1889–1914*, Diss. phil, Paris 1999, p. 8.

with a central state-run institute that acts on behalf of the state by policing the serum. On a more abstract level, in terms of the process of serum production, the financial situation looks much more similar. In both countries the serum producers had a similar structure of expenses: salaries for the personnel, the running costs for the horses, investments in new stables and laboratories, the cost of maintenance, feeding and performing the test procedures.

The income situation was likewise not as different as it is often suggested. The Pasteur Institute's subscription was used for one-off investments such as building a production plant in Garches and the rest was invested in bonds. The regular income of the Pasteur Institute was composed of interest, state and local subsidies, and receipts from the sale of the serum. In Germany, while companies made a profit out of the commercial sale of serum, the overall financing of serum was also mixed. The state-run institute was, after all, financed by the fees paid by the producers, which also received municipal subsidies and private donations. Another parallel can be seen in the cooperation of producers with public welfare institutions, in France, the "assistance publique" and in Germany health insurance and various charitable organisations. While in France the diphtheria serum was free of charge for the poor, in Germany, the cost for employees was largely borne by health insurance (which did not exist in France).

The mixture of numerous sources of income in both countries raises the question of the intentions of the investors and other actors. For the scientists, immediate publication of innovative research was a question of prestige and would evidently help in any priority disputes. The aim of the commercial companies was essentially to maximize profit. The Pasteur Institute as a scientific institution and as a large-scale producer of serum competing on the international market had an interest in making a profit as well, in order to finance future research. In both countries, the municipalities were involved in serum production and regulation: they took the opportunity to become more independent from the central power in the capital. Thus, while the city of Frankfurt provided the buildings of the Serological Institute for reasons of prestige, they also expected a direct payoff: members of the institute had to give bacteriological courses and lectures as well as conduct bacteriological tests and, finally following the installation of a scientific institution in the city, Frankfurt could more easily pursue its plan to build up its own university.

Despite certain similarities, however, we have to point out the significant elements that differentiated serum production and regulation in the two neighbouring countries. Thus, industry played a major role in Germany, while it was absent from the French picture. Also, the German state was much more present subsequent to legislation, with the government directing, ruling and supervising the whole process of production, although not directly paying for it.

In France, the Pasteur Institute assumed this role, although it was largely financed by charitable donations, and only secondarily by state and local government.

Two Cultures of Regulation?

Serum production and regulation in France and Germany display many similarities on different levels. In the triangle formed by state, industry, and science, the conformation of serum production and regulation in the two countries does not really represent two different or antagonistic types, as is often argued. As far as the intentions of the state are concerned, we can conclude that both states desired the provision of pure and effective diphtheria serum in the required quantities. The provision of the people with diphtheria serum was a major public health issue and the state had not only to ensure the supply of diphtheria serum but also to minimize public health risks, avoiding any repetition of the tuberculine affair of 1890 in Germany. Furthermore, neither France nor Germany had significant experience with medicines of biological origin.

In Germany, industry entered the scene and invested financially shortly after Behring presented his research results in the medical periodicals. Nevertheless, soon after the diphtheria serum came onto the market, the state took over direct control. The German Empire was a federal state and the serum producers were spread throughout the whole Empire. Although the Empire was responsible for the overall legislation, it nevertheless depended on the collaboration with the federal states, especially Prussia, for its application. Finally, the state (Empire and federal states) had to cooperate with the industry to guarantee the success of the control measures and it was certainly in the interest of the companies to cooperate with the state. Thus, we can say that the central control operated by the Serological Institute was necessary to supervise the serum throughout the empire. Nevertheless, there was also a medical official in each production plant representing another control mechanism at the federal level. The implementation of a state-run institute for quality control could also be seen as a technology of trust.[53] For the companies, the "state approved" stamp also had an effect on marketing, guaranteeing a high quality product, in this respect functioning like a trademark.

In France there was – apart from some small regional producers – one main centralized actor in Paris, the Pasteur Institute that produced the serum on an

53 Cf. Theodore Porter, *Trust in Numbers. The Pursuit of Objectivity in Science and Public Life* (Princeton, 1995).

industrial scale. The state was satisfied with implementing a law that covered not only sera, but "injectable substances of organic origin" more generally. A serum commission carried out an initial audit of the regional manufacturers before they were allowed to produce the serum. Most of the members of the serum commission were also members of the Academy of Medicine, and most of these were connected to the Pasteur Institute. The certification of the serum producers by members of the academic community also corresponds with the picture of a dominant medical elite in nineteenth century France,[54] and is also consistent with the culture of self-regulation and self-control in the medical industry. The absence of a central institution for quality control on the model of the Serological Institute did not mean, however, that there was no state regulation in France. Regulation in France was indirect, manifesting in a less concrete legislation that left the actors more freedom. The Ministry of Interior was at least involved and integrated into the self-regulation via the ministry officials who were also part of the serum commission.

On the level of representations of serum production, there is a significant difference between the two countries. While the state-run institutes in the German Empire were confined to the background, the Pasteur Institute was much more prominent in the public sphere. In order to assure the success of any future public subscriptions, the Pasteur Institute had to build up a solid reputation based on its public relations. Thus, there was an indirect form of public control in France, with publicity keeping a spotlight on the activities of the Pasteur Institute and the fate of the donated money. The serum producers and especially the Pasteur Institute had an essential interest in producing a high quality serum otherwise they would run the risk of their resources running dry.

Comparing the different cultures of regulation in the two neighbouring countries there was an indirect type of governance. In the German Empire the serum was produced by private pharmaceutical companies, but the state regulated the price and exercised control over the production process to ensure a pure and effective serum. Nevertheless, the system of quality control was not imposed by the state: it was worked out in cooperation with the scientists involved, state-run institutes, the federal states and the pharmaceutical industry. In France a process of self-regulation was implemented, leaving the different actors a free hand. This liberal type of governance was nevertheless a type of regulation and a way of regulating. As a more complete financial analysis reveals, the state was also involved in the process of serum production and as an investor via its subsidies, paying to supply the public, and more particularly the

54 Cf. Georg Weisz, *The Medical Mandarins. The French Academy of Medicine in the Nineteenth and early Twentieth Century* (New York, 1995).

military, with serum. Moreover, several members of the Pasteur Institute were members of different state advisory boards.[55]

Finally, the image of the Pasteur Institute as a state-free, purely scientific institution supported by donations that provided the public with serum free of charge is a self-constructed myth. A state-free zone was an illusion, especially when one takes into account that the state is more than just the sum of its institutions, regions or departments but also a virtual/fictional feeling of nationality.[56] The main donations in France were made by the country's elite to assure the political system, as was the case in Germany as well. The difference, however, was the elite; while in France there was a liberal elite, in Germany the elite believed in a strong and authoritarian state. What we have to take into account is that the construction of two different national cultures also involved the construction of the elites of two rival countries at the end of the nineteenth century.

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55 For example Émile Roux was also president of the "Commission supérieure consultative d'hygiène et d'Epidémiologie militaire", see a letter from Roux to the War Ministry, 31.1.1908, AIP, DR-DOS 3.

56 See for example Bruno Latour, *The Pasteurization of France* (Cambridge, 1988).

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Contagion and Cultural Perceptions of Accepted Behaviour

Tuberculosis and Venereal Diseases in Scandinavia c.1900–c.1950

Ida Blom

During the nineteenth and early twentieth centuries, industrialisation and urbanisation created densely populated areas, surroundings that facilitated the spread of contagious diseases. Simultaneously the growth of democracy paved the way for legislation to assist the needy without hurting their dignity. As social hierarchies weakened, so did the use of demeaning poor law institutions. Demand for social and political equality resulted in a growing system of social legislation that later developed into the modern welfare state. All this heightened respect for the individual citizen.

From the middle of the nineteenth century, public initiatives such as constructing sewage systems and assuring a supply of clean water aimed at safeguarding the population against disease. The advent of bacteriology during the final decades of the nineteenth century opened new ways of minimising contagion. Individual citizens were admonished to comply with certain rules of behaviour and political authorities were faced with the question of how far they should be allowed to intervene in private lives in order to protect society against contagion. To what extent should an individual be able to freely decide how to tackle contagious diseases such as tuberculosis or syphilis? What could and should be done to protect society against people who suffered from these diseases?

This paper investigates how cultural perceptions of accepted behaviour influenced preventive strategies in the fights against tuberculosis (TB) and venereal diseases (VD). I attempt to compare legislation adopted by Scandinavian parliaments between the end of the nineteenth century and until the middle of the twentieth century. The question to be considered is whether members of parliaments blamed certain behaviours for bringing disease and how the acceptability of such behaviours influenced measures to prevent contagion. I shall not discuss how the general public reacted to the laws or how the laws were practised.

Given the very similar social and political systems of the three Scandinavian countries it should not come as a surprise that they by and large solved the problem in rather similar ways.[1] But as this paper shows, some differences may be observed and I shall offer possible explanations for these differences.

Scandinavian Legislation against Tuberculosis

As the first of the Scandinavian countries, Norway, in 1900, passed a law to promote the fight against TB. The Danish parliament in 1897 included TB in the existing law on contagious diseases and in 1905 passed two laws particularly concerning TB. Small revisions in 1912 did not change the main characteristics of the Danish laws. Sweden legislated on TB in 1914 with important revisions in 1939. Like in many other parts of the world, also in Scandinavia bacteriology strengthened the perception that certain behaviours heightened the chances of infection: squalid living conditions, poor standards of nourishment, spitting, lack of fresh air. The image of the tubercular shifted from the pale genius of former times to the urban poor. The fact that TB was conspicuously more frequent with poor families confirmed such understandings and coloured legislation to combat the disease.[2]

The Norwegian law of 1900 was understood as '… a law for the healthy, … to protect as many as possible of the individuals in society against contagion.' [3] Legislation aimed to control the spread of disease from the infected to the rest of

1 Gösta.Esping-Anderson, *The Three Worlds of Welfare Capitalism* (Cambridge, 1990). Peter Baldwin, *The politics of social solidarity: class bases of the European welfare state 1875–1975* (Cambridge, 1990). Niels Finn Christiansen and Klaus Petersen, "Norden som folkehjem", in Edgeir Benum et al., eds. *Den mangfoldige velferden. Festskrift til Anne-Lise Seip* (Oslo, 2003), pp.13–25. Niels Finn Christiansen, Niels Edling and Klaus Petersen, eds., *The Nordic Welfare State – a Historical Re-appraisal*. (Copenhagen 2006).

2 Katherine Ott, *Fevered Lives. Tuberculosis in American Culture since 1870* (Cambridge Massachusetts, 1996). Linda Bryder, *Below the Magic Mountain. A Social History of Tuberculosis in Twentieth-Century Britain* (Oxford, 1988). Barbara Bates, *Bargaining for Life. A Social History of Tuberculosis, 1876–1938* (Philadelphia, 1992). Mark Harrison, *Disease and the Modern World 1500 to the Present Day*. (Cambridge, 2004), pp. 124–128. Ida Blom, "Bilder og budskap – tæring og tuberkulose" in Kari Tove Elvbakken and Per Solvang, eds., *Helsebilder. Sunnhet og sykdom i kulturelt perspektiv* (Bergen, 2002), pp. 19–40. Ida Blom, "'Don't spit on the floor'. Changing a social norm in early twentieth-century Norway", in Hilde Sandvik, Kari Telste and Gunnar Thorvaldsen, eds., *Pathways of the Past. Essays in Honour of Sølvi Sogner*, (Oslo, 2002), pp. 231–242. Ida Blom "'et Stykke ejendommeligt københavnsk Folkeliv?" Opplysningsstrategier i den danske kampen mot spyttevaner, c. 1900–1920", *Tradisjon*, 31:2 (2001), pp. 85–92. Ida Blom, "Voluntary Organisations fighting Tuberculosis c. 1900–c. 1940: A Norwegian-Danish Comparison" in Flurin Condreau and Michael Worboys, eds., *Tuberculosis in National Context*. (forthcoming Routledge).

3 Quoted from Anne-Lise Seip, *Sosialhjelpstaten blir til. Norsk sosialpolitikk 1740–1920* (Oslo, 1984), p. 237–238.

the population. Registration of cases as well as of deaths from TB was made mandatory. Medical treatment also became mandatory and occupations that involved producing or selling victuals or working as nannies or wet-nurses, were prohibited for the tubercular. Municipal authorities were authorised to inspect and disinfect, not only public premises but also private homes. For the better off this did not pose a big problem. In roomy homes with plenty of servants it was possible to take the precautions needed to limit contagion. This could be difficult for poor families. If contagion could not otherwise be avoided, patients might be compelled to move to a hospital or a home for tubercular. But married couples could not be separated and in order to further soften coercion state and municipality would pay for the treatment. Accepting such public assistance would not be seen as poor relief. The poor would therefore avoid the stigma and loss of civil rights that otherwise accompanied poor relief.[4]

The journal of the Danish Medical Association kept Danish physicians informed on Norwegian discussions on a law against TB and the laws enacted in Denmark in 1905 were very similar to the Norwegian law of 1900. But in some respects the Danish laws were less restrictive.[5] Coercive hospitalisation was not possible if this meant forcing a person to give up his or her occupation. It was feared that too strong prohibitions would weaken people's will to provide for themselves. But teachers and clerical persons who would be in contact with many people would loose their job if they caught tuberculosis. They would, however, be offered a small state pension. Also different from the Norwegian law, public economic support was offered to needy families of TB patients. As Signild Vallgårda has observed Danish TB legislation was coercive, but offered public assistance to the needy. [6]

There were even fewer restrictions in Swedish TB legislation.[7] The Swedish law of 1914 instructed physicians to report all deaths from TB, but contrary to in Norway and Denmark not all cases of the disease. Only patients who might represent an obvious danger of contagion should be reported. Registering the diseased was seen as stigmatising the patient and it was feared that ailing people might therefore

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4 Terje Andreassen, *Legene og tuberkulosen. Faser og forutsetnnger for tuberkuloseloven av 1900*. Unprinted master thesis (Bergen, 1997), pp. 14–15. Ida Blom, *Feberens ville rose. Tre omsorgssystemer i tuberkulosearbeidet 1900–1940* (Bergen, 1998), pp.14 –15. Ida Blom, "Frivillige organisasjoner i kamp mot tuberkulose 1900–1940. En dansk-norsk sammenlikning" in Monika Jarnfelt ed., *Den privat-offentliga gränsen. Det sociale arbetets strategier och aktörer i Norden 1860–1940*. (Copenhagen, 1999), pp. 219–221. Aina Schiøtz, *Folkets helse – landets styrke. 1850–2003. Det offentlig helsevesen i Norge 1603–2003*, vol. 2. (Oslo, 2003), pp. 64–71.

5 Blom 1999, pp. 220–221. Christine Ebbesen, *Tuberkulosebekæmpelse i Danmark 1875–1914*. Unprinted master theses (Copenhagen, 1995), pp. 52–73. Signild Vallgårda, *Folkesundhed som politikk. Danmark og Sverige fra 1930 til i dag* (Aarhus, 2003), pp. 100–102.

6 Vallgårda 2003, p. 111

7. Jenny Björkman, *Vård för samhällets bästa. Debatten om tvångsvård i svensk lagstiftning 1850–1970* (Stockholm, 2001), pp. 140–144 Vallgårda 2003, pp. 102–110.

avoid seeing a physician. Public inspection of private homes was never accepted. Treatment was not made mandatory, but publicly funded treatment was offered without the stigma of poor relief. Like in the other Scandinavian countries, tubercular persons were prohibited from working with milk and as wet-nurses.While the Danish law opened for state support to run TB institutions, the Swedish 1914 law offered public support only for dispensaries that should spread information and support the sick.[8]

A new law replaced the 1914 law in 1939. After long discussions, Swedish legislators now accepted that all cases of TB had to be reported and mandatory examination was made possible even by police assistance but treatment remained voluntary and consequently mandatory hospitalisation was never accepted. This was considered an unacceptable infringement on civil liberties. Swedish politicians argued that since tuberculosis was a long-lasting disease, coercion would have more serious consequences with TB patients than with people suffering from other contagious diseases. However, following the law on child care (barnavårdslagen), children could be forcibly removed from a tubercular home. Such precautions were not understood as coercion, but as protection of the weak. The main course of action in Sweden was information and preventive measures.

On the other hand, little economic assistance was offered to tubercular patients. Economic considerations were at work when decisions were made on compulsory measures. Mandatory treatment would necessitate construction of a great number of sanatoria, and public support for the families of patients who were hospitalised against their will would be a heavy burden for public finances. So would compensation to people who would be forbidden to work in certain trades because they suffered from TB.[9]

In all three Scandinavian countries the course of action legislated to protect the healthy against TB also contained some assistance to cure the sick. Most discussed was public financing of mandatory treatment and in Denmark economic assistance to the family of the diseased. Another approach simultaneously seeking to change unwanted behaviour and to assist the sick did not surface in legislation. Still, it should shortly be mentioned as a reminder of the complicated picture of anti-tuberculosis efforts.

Information Campaigns

Extensive information campaigns were organized not least by voluntary organisations such as the National Anti-Tuberculosis Organisations. Informing people of

8. Bjørkman 2001, pp. 145–154. Vallgårda 2003, p. 102.
9 Bjørkman 2001, pp. 152–154. Vallgårda 2003, pp.102–107.

how the disease spread and of what to do to minimise the danger of transmission meant appealing to the responsible and persuading or frightening the irresponsible to act according to certain rules. Information aimed to change unacceptable behaviour and mobilise individual responsibility in the fight against disease.[10] In this respect Swedish authorities made a monumental effort through the activities of hundreds of dispensaries. In Norway and Denmark intensive lecturing campaigns and distribution of leaflets with advice against TB were part of this activity and nurses visited tubercular homes to inform and assist people in fighting the disease. In all three countries sanatoria were not only seen as treatment institutions, but also as offering the opportunity of educating the sick and hopefully have them spread knowledge of how to combat TB when they returned to their homes.

Both in information campaigns and in legislation, the poor and irresponsible were the main target groups. They were understood as the most important carriers and in need of information and education. People living in roomy and prosperous homes would not be submitted to the coercion applied to the poor. They were supposed to understand how to behave and be able to adopt the needed precautions without interference from public authorities.

National Differences

As we have seen there were some differences in the overall similar pattern in Scandinavian TB legislation. Why was this so? Extensive comparative studies would be needed to indicate safe answers to this question, but some explanations may be suggested.

The Norwegian law was the most coercive, Denmark followed with a little less coercion while Sweden legislated even fewer mandatory measures. Could the threat from TB be perceived as more serious in one country than in another? Literature treating discussions in the Scandinavian parliaments gives no indication that legislators evaluated the dangers of TB differently in the three countries. Still, a glance at national mortality rates from TB may suggest a difference. Around 1900 deaths from TB reached a climax in Norway with 299 deaths from tuberculosis of the lungs per 100.000 inhabitants for men, 319 for women.[11] Something drastic seemed to be required to stop the disease and the Norwegian law was the most restrictive. Death rates from TB declined from 1900, but remained higher in Norway than in

10 Blom 2001. Blom 2002. Björkman 2001, pp. 149. Vallgårda 2003, pp. 107–110. Teemu Sakari Ryymin, 'Formaningens former i et flerspråklig område. Propaganda i anti-tuberkulosearbeidet i Finnmark.' in Kirsti Malterud og Kari Tove Elvbakken, *Rapport fra seminaret Sunnhet og sykdom i kulturelt perspektiv*, pp. 2005, 63–72. In print.

11 Mortality from tuberculosis 1896–1965. *Historical Statistics 1968*, Central Bureau of Statistics, (Oslo, 1968) Table 43, p. 64.

the other Scandinavian countries all through the period. Although statistics for Denmark are uncertain, there are indications that a reduction had already started in the major cities during the 1880s. A reduction in deaths from TB had also taken place in Sweden in 1914.[12] Where TB took fewer lives, less coercion might be seen as sufficient. Between 1900 and 1940 death from TB was seriously reduced, but rates remained higher in Sweden than in Denmark. The slightly more restrictive measures introduced in Sweden in 1939 may in part be explained as a consequence of this situation, but an absence of legislation in other countries with high death rates from TB shows that there is not necessarily a direct link between death rates and legislation.[13]

It seems that the political situation may also help understand the difference between Sweden on the one hand, Denmark and Norway on the other. Norwegian and Danish Social Democrats argued that it was not irresponsibility, but low wages and poor living conditions that made the working class the worst carriers of TB, but around 1900 when the Norwegian and Danish laws were enacted, Social Democrats were still a minority in the two parliaments. In 1914 when the Swedish law was accepted the newly adopted general suffrage for men, a quickly growing Social Democratic party and the recent adoption of parliamentarism may have made it less acceptable to submit the poor population to special constraints.[14]

Further, medical perceptions of the infectious character of TB may have had some impact. The discovery of the tuberculosis bacillus did not immediately convince physicians of the contagious character of the disease, but around 1900 there was agreement that the living conditions of the poor eased transmission of the disease.[15] Still, throughout the first decades of the twentieth century, Swedish physicians disagreed on the contagiousness of TB.[16] Some maintained that the most important provision would be to be careful when coughing and that mandatory treatment was to overdo precautions. Without denying social differences in trans-

12 Blom 1999, p. 211. Vallgårda 2003, p. 101.

13 Broadening comparison to include Finland – impossible in this paper-would probably be helpful for a discussion of how to explain different approaches. In Finland discussions around 1900 did not result in a law on TB despite the fact that TB was the most important single cause of death. It was not until 1927 that a law resembling the Norwegian law was enacted. I am grateful to Teemu Sakari Ryymin for this information, which is build on Maria Lähteenmäki, "En sjukdomsdrabbad familj i nord", *Historisk Tidskrift för Finland*, vol 89, 3 (2004), pp.193–209. Hanna Kuusi, "Tuberkuloosin torjunta ja moderni kansalainen" in Helen Ilpo and Hauho Mikko eds., *Kansalaisuus ja kansanlerveys* (Helsinki, 2003), pp. 33–57. "Om tuberkulosearbeidet i Finland", *Meddelelser fra Den norske nationalforening mot tuberkulosen*, 1928, vol. 18, nr. 87 (1928), pp. 45–48.

14 Political circumstances may have been important also for Finland. The difficult relations to Russia until 1917 and the civil war after independence may explain why TB legislation may have had to wait.

15 Ebbesen 1995, pp. 44–48. Andreassen 1997, pp. 102–103.

16 Bjørkman 2001, pp. 141–144

mission, in 1931 Sweden's main physician for TB advanced yet another explanation for the spread of the disease, the theory of natural biological immunisation of the population. It was observed that death rates from TB fell earlier in the southern part of Sweden while it was still rising in the northern districts. The explanation forwarded was that when TB had raged for some time in a given population, people developed a growing power of resistance to infection and the disease subsided.[17] In this light, costly public policies to combat the disease were less important. TB would extinct itself through biological changes in the human body. This argument was not found in the Norwegian and Danish discussions, although the same pattern could be observed in the spread of TB in Norway as in Sweden.[18] Divergent opinions on how TB was spread may be one more reason why Sweden followed a somewhat different path from the other two Scandinavian countries, when legislating on this disease.

Since TB was far more life threatening and widespread than VD, it might be expected that behaviour seen as causing TB was met with stricter provisions and more coercion than those adopted to fight VD. But this was not the case. On the contrary, fighting venereal diseases opened for much more coercion.

Legislating on Venereal Diseases

While in the case of TB coercive measures were directed at a broad group of individuals, where VD was concerned the target group was narrow. The danger of contagion was seen as almost entirely coming from the prostitutes. Perceptions of acceptable sexual behaviour strongly condemned prostitution. It was thought that for both men and women, sexual intercourse ought to be strictly limited to married life, but there was a widespread belief that men's sexual urges were so strong that it was very difficult for men to limit themselves to marital sex. Consequently, prostitution was seen as a necessary evil and throughout the nineteenth century, police

17 Dr. Ostenfeld, Dr. Heitmann and Dr. Neander, *Tuberculosis in Denmark, Norway and Sweden*, League of Nations Health Organisation. (Geneva, 1931), p. 115. See for a similar pattern in Europe Greta Jones, *'Captain of all these men of death'. The History of Tuberculosis in Nineteenth and Twentieth Century Ireland,* (Amsterdam/New York, 2001), pp. 1–2. The pattern of the spread of TB in Europe may seem to confirm this theory. Death rates from TB declined in England and Wales around 1870, in France and Germany towards the end of the nineteenth century, while it was still rising in Ireland and Norway. In these countries the reduction did not start until after 1900. Harrison 2004, p. 128.

18 Per Arne Hestetun, *Velferdsekspansjon og organisassjonsendring. Ei analyse av frivillige organisasjonar si rolle i arbeidet mot tuberkulosen*. Unprinted master theses, (Bergen 1985), p. 54. Blom 1998, pp.10, 12.

control with prostitutes was the main provision against the spread of these diseases.[19]

This policy was changed during the late nineteenth and early twentieth century. The Danish parliament in 1874, 1895, 1901 and especially in 1906 and 1947 legislated on the problem of VD. The Swedish Lex Veneris of 1918 introduced procedures very similar to those legislated in Denmark, while it was not until 1947 that a national Norwegian law regulated the fight against VD. Until then, municipal by-laws regulated approaches to VD.

Danish and Swedish Legislation 1874 to 1947

Danish legislation already in 1874 introduced provisions that would later characterize Scandinavian VD legislation, i.e. mandatory and free treatment of all infected citizens.[20] The condition was that they consulted a public physician. In 1895 the demand that prostitutes should live in a brothel was abolished and in 1901 brothels were prohibited. This change in attitudes to control of prostitutes were seen as the result of the efforts of the Association against the Statutory Protection of Immorality, founded in 1879 as a Danish branch of 'La Federation britanique, continentale et generale pour l'abolition de la prostution legale', and with a considerable number of women in influencial positions.[21]

In 1906 the Danish parliament enacted a law that widened provisions so far mainly applied to prostitutes to include the whole population. Medical control, at

19 For Norway, Aina Schiøtz, "Prostitusjon og prostituerte i 1880-åras Kristiania" and Kari Melbye, "Prostitusjon og kontroll" in Anne-Marit Gotaas, Brita Gulli, Kari Melby and Aina Schiøtz, *Det kriminelle kjønn* (Oslo, 1988), pp. 35–39 and pp.83-85. For Denmark, Karin Lützen, *Byen tæmmes : kærnefamilie, sociale reformer og velgørenhed i 1800-tallets København* (Copenhagen, 1998), pp.219-285. For Sweden, Yvonne Svanström, *Policing Public Women. The Regulation of Prostitution in Stockholm 1812–1880* (Stockholm, 2000), pp. 82-86. An early analysis of this discussion in Scandinavia is Elias Bredsdorff, *Den store nordiske krig om seksualmoralen*. (Copenhagen, 1973). For similar attitudes outside Scandinavia, see Judith Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge, 1980). Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth-Century Medical Discourse* (Basingstoke, 1997). Lutz Sauerteig, *Krankheit, Sexualität, Gesellschaft. Geschlechtskrankheiten und Gesundheitspolitik in Deutschland im 19. und frühen 20. Jahrhundert* (Stuttgart, 1999), pp. 57–62 and 89-125.

20 The Danish government already in 1790 issued a decree allowing free treatment of VD for 'the common people'. See Ida Blom, "From Regulationism to the Scandinavian Sonderweg – legislating to prevent venereal diseases in Denmark during long the 19th century", *Continuity and Change*, 20/2 (2005), pp. 265–286.

21 For more information on Danish legislation before 1906, see Lützen 1998, pp. 219–246, Merete Bøge Pedersen, *Den reglementerede prostitution i København 1874–1906*, (Copenhagen, 2000) and Merete Bøge Pedersen, *Prostitutionen og Grundloven*. Unprinted ph.d.thesis (Copenhagen, 2003). See also Blom 2005.

times assisted by the police, was accepted for any person who could not prove that he or she earned their living in a lawful manner. Resistance might result in prison or forced labour. This paragraph referred to the law on vagrancy and MPs openly admitted that despite gender neutral formulations the paragraph targeted prostitutes. The small group of Labour MPs and a few Radical Liberals strongly objected to such a course of action, characterising it as a class law with a gender bias. They argued that '…the Woman does not seem to be more culpable than the Man who buys her body.'[22] Consequently, the male customer should also be punished. But the supporters of the law argued that it was not fornication as such that was condemned. But 'when this becomes public, when this reveals itself in a way liable to harm the public, society has both a right and a duty to defend itself."[23] The opposition was defeated, the paragraph was accepted and no special provisions were made for customers of prostitutes.

Thus, coercion targeting a morally deviant group of women continued to be an important means to attempt to limit VD. Different from where TB was concerned, poverty alone did not suffice to stigmatise the diseased. Despite the fact that both men and women broke the code of sexual morality and that many more men than women suffered from VD, prostitutes continued to be seen as the main carriers.

Also for other citizens, VD was considered a stigmatising disease. If a VD patient did not follow medical instructions, the physician was to report the patient to the police and he or she would be brought in for medical examination and treatment. A minority of Danish MPs criticised such coercion. It would continue to make VD a shameful disease, and might tempt patients to keep their disease a secret as long as possible. Consequently, free and easy access to medical assistance would be a much better way of combating VD.[24]

Also in this case, the minority lost its cause. Suffering from VD was seen as a sign of indecent behaviour. Coercion of all recalcitrant patients was needed to fight these diseases, but prostitutes were singled out for special control.

A very similar law was enacted in Sweden in 1918. The Lex Veneris, as the law was called, also broadened coercion to include all citizens. Police control with prostitutes continued, like in Denmark now legitimised through the law on vagrancy. The main difference between the Swedish and the Danish law was that the Swedish law made it mandatory for physicians to trace sources of infection.[25]

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22 Holger Rørdam, MP for the Liberal Reform Party. Blom 2005, p. 275.

23 Kristian Bjerre, MP from the Agrarian Party. Blom 2005, p. 275.

24 This course of action was accepted in Britain. France and Italy continued to use the control of prostitutes as the main means in the fight against VD, while Germany from 1927 followed a policy similar to that of the Scandinavian countries. See Roger Davidson and Leslie Hall eds., *Sex, Sin and Suffering. Venereal disease and European Society since 1870*, (London and New York, 2001) for a broad presentation of VD policies in Europe.

25 Anna Lundberg," 'Passing the 'Black Judgment': Swedish social policy on venereal disease in the early twentieth century" in Davidson and Hall 2001, pp. 29–43. Ida Blom,

This expedient was not integrated in the Danish law until 1947, when a new law replaced the 1906 law. The titles of the two Danish laws indicate a change in the approach to VD. While the 1906 law had been called a "Law to Prevent Public Impropriety and Venereal Disease", the law enacted in 1947 was called "Law on Prevention of Venereal Disease" and it was expressly stated that the 1947 law was a law on epidemics.[26] A number of legislative changes during the 1930s had made a new law necessary. Among other things, all paragraphs targeting prostitutes had been removed and placed in the penal code. Consequently, the 1947 law was more consistently phrased in gender neutral language.

An important reason for the new law was the recent observation that contrary to what had usually been the case, during the war period VD had become almost as frequent with women as with men. This was seen as presenting a serious threat, and now not only prostitutes, but also young women frequenting dance halls were seen as carriers of infection.[27] When the parliamentary discussion touched on innocent victims, such as married women who contracted the disease from frivolous husbands, it became clear that husbands were protected. The penal code made it an offence, liable to imprisonment, to consciously infect someone else. When this happened within a family setting prosecution was only possible if the victim reported the case. Almost no wives who had contracted VD from their husbands would do so. The Danish Women's Society (Dansk Kvindesamfund) in vain attempted to make it possible to prosecute husbands also in cases where wives did not demand prosecution. Protecting marriage seemed more important than targeting a male carrier.[28]

An important new clause tightened coercion. Contact tracing now became mandatory and police assistance could be called in to make the search efficient. In most respects, then, by 1947 legislation on VD in Denmark and Sweden followed the same course of action.

"Fighting Venereal Diseases: Scandinavian Legislation c. 1800–c. 1950". *Journal of Medical History*, Spring 2006b, pp.209–234.

26 Blom 2006b.

27 Ida Blom, "From Cocercive Policies to Voluntary Initiatives. Legislating to Prevent Venereal Diseases in Denmark during the 20th Century." *The Scandinavian Journal of History*. Forthcoming 2008.

28 Danish women had won national suffrage in 1915, but women MPs were in 1947 still a very small minority. They tried to bring problems of special importance to women into the parliamentary debates but they had no impact on the final results. Blom 2006b.

Norway – A Slow Learner?

The Norwegian parliament did not legislate on VD until 1947. When this finally happened, it adopted the same principles as those presented in Danish and Swedish legislation.

This did not mean that VD was a neglected disease in Norway. Until 1947 municipal by-laws took care of provisions against VD. In Kristiania, the Norwegian capital, brothels were closed in 1887 and from 1888 provisions were introduced that were very similar to those legislated later in Denmark and Sweden: mandatory treatment of all VD patients, at times assured through police assistance.[29] But municipal by-laws varied from one municipality to another.[30] In some municipalities contagious VD patients were offered free treatment, elsewhere everybody had to pay. Free treatment of all VD patients was not the rule until a national law on VD was enacted in 1947. Like in the two other Scandinavian countries, prostitutes continued to be seen as the main target. Where the law on VD did not suffice, other legislation, the penal code and the law on vagrancy, made prostitution in public areas a criminal offence.[31]

Why did Norway legislate so much later on VD than Denmark and Sweden? Late industrialisation and less urbanisation may have made the problem less pressing in Norway than in the other two Scandinavian countries. However, the main explanation seems to be economic problems. A number of attempts at legislating for the whole country were made already during the 1890s. A bill very similar to the Swedish law of 1918 was suggested in 1923, but withdrawn for economic reasons.[32] At that time also provisions to combat TB were sometimes curtailed in order to not burden public finances.[33] Finally, opinions on how to combat VD still in 1947 varied greatly from one region of the country to another. This may have been a reason for leaving provisions to be adopted by local municipal by-laws instead of fighting for a national law where compromises might be difficult to obtain.[34]

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29 The name of the Norwegian capital was changed to Oslo in 1925.

30 Studies of municipal arrangements have only been made for Oslo and Bergen. For Oslo see Schiøtz 1988 and Ida Blom, "Fra tvang til frivillighet? – Forebygging av veneriske sykdommer i Kristiania, 1888–1910" in Benum et al., eds., 2003, pp.125-140. For Bergen see E. Koren, *"En Trusel for selve Samfundene." Venerisk sykdom: tiltak, medisinsk forståelse og moraldebatt i Norge 1880-1927*. Unpublished master's thesis. (Bergen 2003), 68–71, and Christopher John Harris, "Kontroll av prostituerte i Bergen" in Kari Tove Elvbakken and Grete Riise eds., *Byen og helsearbeidet* (Bergen, 2003), pp. 157–174.

31 Melbye 1988, pp. 112–116.

32 Koren 2003, pp. 50–55.

33 Anne-Lise Seip, *Veiene til velferdsstaten. Norsk sosialpolitikk 1920–1975*. (Oslo, 1994), pp. 101–102.

34 Koren 2003, pp. 57–58. Blom 2006b.

What finally sparked off a national law on VD in 1947 was the rise of reported cases during the Second World War. During and right after the German occupation special attention was paid to tracing women who suffered from VD. A provisional edict in 1945 allowed arresting women and placing them in camps on the suspicion that they might suffer from VD and consequently might spread the diseases. Consequently, reported cases of VD for the first and only time were much higher for women than for men. This raised fear that 'all these women' would spread VD among the male population.[35] A national law was meant to avoid this danger.

In all three Scandinavian countries all citizens were subjected to strict public control in order to limit contagion with VD. To suffer from VD continued to be seen as a sign of unacceptable sexual behaviour. But prostitutes, and during the interwar and postwar years a broader section of young women, were seen as the main sources of infection and special provisions were applied to control them.

Summing up

During the first half of the twentieth century, Scandinavian legislation to combat TB and VD bore the imprint of the coming welfare states. According to the letter of the laws all citizens were to be treated in the same way and submitted to the same kind of coercion, but a closer look reveals that certain groups were seen as more prone to spread disease than others, and consequently submitted to stricter control. This was met with broad acceptance. Few disputed the idea that the state had a responsibility to protect society against carriers of disease. There were few objections to policies that made it unavoidable to infringe on the civil liberties of diseased persons who could not – or would not – on their own take care not to spread the disease.

Concerning the timing of the laws, slightly different political circumstances as well as varying understandings of how the diseases were spread probably may help explain nuances in Scandinavian TB-legislation, while economic differences, variations in urbanisation and industrialisation as well as regional varieties could be seen as a reason for a later national legislation on VD in Norway than in Denmark and Sweden. No doubt, however, further comparative research is needed to fully understand the differences among the Scandinavian countries.

Cultural perceptions of accepted behaviour influenced the definition of who belonged to the groups of individuals that would have to be controlled as well as the kind of coercion applied to control them. There was no disagreement among

35 Ida Blom, "Krig og kjønnssykdom–Norge 1945–1953" in Göran Fredriksson m.fl. (red.), *Könsmaktens förvandlingar. En vänbok till Anita Göransson*. Skrifter från Institutionen för Arbetsvetenskap, (Göteborg, 2003), pp. 13–31.

Scandinavian lawmakers as to whom these groups were. In the case of TB class differences between lawmakers and carriers of infection were often pronounced. Where VD was concerned gender came in as a further marker of differences and opened for even stricter provisions.

TB legislation expressed the understanding that lack of cleanliness, the habit of spitting and irresponsibility was seen as unacceptable behaviour, prevalent with poor people. Such behaviour led to coercive measures. Sexual immorality was seen causing VD and much harder condemned, despite the fact that VD was much less dangerous and occurred much less often than TB. Consequently, cultural understandings of gender and sexuality made VD an even more stigmatising disease than TB. Gender neutral formulations of VD legislation did not conceal that VD policies continued to target women, especially prostitutes and young women, and coercion was stronger towards those who suffered from VD than towards TB patients.

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Between the German Model and Liberal Medicine

The Negotiating Process of the State Health Care System in France and Spain (1919–1944)

María-Isabel Porras-Gallo

Introduction

It is a well known fact that the collectivisation of medical aid began in Germany with the creation by Chancellor Bismarck of the so-called *Krankenkassen* system in 1883. This model was to be adopted by several European countries in the late nineteenth and early twentieth centuries, with the setting-up of social security and collectivised medical assistance receiving a considerable boost in the inter-war period and at the end of the Second World War[1]. However, each of the industrialized nations, confronted by similar problems, adopted remarkably different solutions[2]. In each case a solution was sought to suit the existing institutions, administrative traditions, popular customs or financial situation of the country[3].

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1 Among the many works devoted to this question, let us mention that a summary of information on the process of implementation of collective health systems in different countries is to be found in the now classic works of José Mª López Piñero, "La colectivización de la asistencia médica: una introducción histórica", in J. M. De Miguel, comp., *Planificación y reforma sanitaria*, (Madrid, 1978), pp. 21–47, and José Luis Peset, "Capitalismo y medicina: ensayo sobre el nacimiento de la seguridad social", *Estudios de Historia Social*, 7 (1978), pp. 185–216, as well as in Abram de Swaan, *In Care of the State. Health Care, Education and Welfare in Europe and the USA in the Modern Era*, (Cambridge, 1988), pp. 187–217; Dorothy Porter, *Health, Civilization and the State. A History of Public Health from Ancient to Modern Times*, (London & New York, 1999), pp. 196–230.

2 An idea of the different solutions adopted can be gained by consulting the abundant bibliography relative to the emergence and structure of the different policies of social protection and of the so-called Welfare States. In this sense, an interesting study of this subject, relating to Great Britain and France, and, to a lesser extent, to Germany, Sweden and the United States, is given in: Douglas E. Ashford, *The emergence of the Welfare States*, (Oxford, 1986). A comparative analysis of the social protection policies of the industrialized countries may be found in Abram de

Hence the importance of studying, from a comparative viewpoint hitherto largely unexplored, the negotiating process which took place in France[4] and in Spain[5] in the inter-war period, leading to the first establishment of compulsory health insurance in both countries[6]. In particular I propose to highlight the differences and similarities between the two negotiating processes, and to point out the main characteristics of the French and Spanish systems, as well as to show the positions and reactions of the doctors of both countries to compulsory health insurance. I shall also analyse the role played in this process by the political, social, and economic factors that existed in both countries. My intention, through this historical study and the preliminary results presented herein on the cases of France and Spain,

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Swaan, *In Care of the State. Health Care, Education and Welfare in Europe and the USA in the Modern Era*, (Cambridge, 1988); P. Kohler & H. Zacher (eds), *A Century of Social Security, 1881–1981: The Evolution in Germany, France, Great Britain, Austria and Switzerland*, (Munich, 1982); Margaret S. Gordon, *Social Security Policies in Industrial Countries: A Comparative Analyses*, (Cambridge, 1988); Dorothy Porter, *Health, Civilization and the State. A History of Public Health from Ancient to Modern Times*, (London & New York, 1999), pp. 196–277. The latter author includes a bibliography on pp. 349–356, which is helpful for a deeper knowledge of this subject.

3 At an early stage attention was drawn to this situation by Édouard Fuster, "L'évolution de l'assurance ouvrière en Europe et le Congrès de Düsseldorf", *Le Musée social: Annales*, 1902, 387–409, p. 388.

4 For the process of development and implementation of social security in France, as well as the illustrative and by now classic work of Henri Hatzfeld, *Du paupérisme à la Sécurité* Sociale, (Paris, 1971) [this was republished in 1989, quotes from this edition], it is interesting to consult Pierre Leclerc, *La Sécurité Sociale. Son histoire à travers les textes. Tome II – 1870–1945*, (Paris, 1996), the Minutes of the annual Symposiums held by the "Association pour l'Étude de l'Histoire de la Sécurité Sociale" between 1978 and 1992, as well as François Ewald, *Histoire de l'État Providence* (Paris, 1986) [I shall quote from the 1996 edition], a study centred on research into the Welfare State in France from a legal viewpoint.

5 An idea of the process of the development and implementation of social security in Spain may be obtained by consulting: Feliciano Montero García, *Orígenes y antecedentes de la previsión social*, (Madrid, 1988); Josefina Cuesta Bustillo, *Hacia los seguros sociales obligatorios. La crisis de la Restauración* (Madrid, 1988); Mercedes Samaniego Boneu, *La unificación de los seguros sociales a debate. La Segunda República*, (Madrid, 1988). Dealing more specifically with compulsory health insurance are the works of José Danón Bretos, "Sobre los inicios de la Seguridad Social en España" and Esteban Rodríguez Ocaña & Teresa Ortiz Gómez, "Los médicos españoles y la idea del seguro obligatorio de enfermedad durante el primer tercio del siglo XX", both published in M. Valera; Mª Egea & M. D. Blázquez (eds), *Libro de Actas. VIII Congreso Nacional de Historia de la Medicina. Murcia-Cartagena, 18–21 Diciembre 1986*, (Murcia, 1988), vol. I, pp. 482–487 y 488–501, as well as that of María Isabel Porras Gallo, "El camino hacia la instauración del Seguro obligatorio de enfermedad", *El Médico*, 679 (1998a), 70–77.

6 There is still no complete research of this type. Until now there have only been a few contributions which look specifically at this issue in France and Spain from a comparative perspective, such as the work of Josefina Cuesta Bustillo & Evelyne López Campillo, "L'Espagne devant le modèle français d'assurances sociales", in *Colloque sur l'histoire de la Sécurité sociale, Paris, 1989*, (Paris, 1990), pp. 73–91 or that of María Isabel Porras Gallo, "Un foro de debate sobre el Seguro de enfermedad: las conferencias del Ateneo de Madrid de 1934", *Asclepio*, 51 (1), 159–183.

is to help to offer a better perspective on the process of development and implementation of the different public health protection systems. I also hope to contribute to the debate provoked on this subject during the last quarter of the twentieth century, following on from the successive neoliberal reforms carried out as a result of the economic crisis of 1973, and the beginning of the questioning of the socio-political model known as the Welfare State[7], which still goes on at the present moment[8].

To make this paper clearer, I will start with a brief description of the situation in both countries concerning compulsory health insurance and social security prior to the First World War. Next, I shall look at the negotiating process in France, and then I shall deal with what happened in Spain. I shall conclude by showing the major differences and similarities between the two processes, the types of compulsory health insurance established and the role played by doctors in each case.

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7 This debate, present almost daily in the social mass media of the countries of the Western World, has found many other forums of expression. In fact, the principal specialist reviews of the different areas involved in the subject (history, sociology, medicine, history of medicine...) have published special issues on the question (such as the February 1997 edition of *Esprit*:"La santé, à quel prix?", or number 93, January-February 1998, of the magazine *M*: "La santé dans tous ses états: assistance, assurance ou droit universel") and a considerable number of monographs have been published from those same disciplines. Among this abundant bibliography, without claiming to be exhaustive, we may mention: Santiago Muñoz Machado, *La formación y la crisis de los servicios sanitarios públicos* (Madrid, 1995); Rafael Muñoz Bustillo (comp.), *Crisis y futuro del Estado de Bienestar* (Madrid, 1989, 1993, 1995); Pierre Rosanvallon, *La crise de l'État-providence*, (Paris, 1981, 1984, 1992); Pierre Rosanvallon, *La nouvelle question sociale: Repenser l'État providence*, (Paris, 1995); Rafael Huertas & Angeles Maestro (coords.), *La ofensiva neoliberal y la Sanidad pública*, (Madrid, 1991); Jean-Pierre Dumont, *Les systèmes de protection sociale en Europe*, (Paris, 1993); Robert Castel, *Les métamorphoses de la question sociale. Une chronique du salariat*, (Paris, 1995) ; Andrée Mizrahi & Arié, *La protection sociale*, (Paris, 1996) ; Martin A. Powell, *Evaluating the National Health Service*, (Buckingham-Bristol, 1997); Theda Skocpol, Boomerang: Health Care Reform and the Turn against Government, (Morton, 1997).

8 With the beginning of the new millennium, and the background of accumulated experience throughout the 25 years of successive neoliberal reforms of Europe's main collective health systems, works are now appearing which point out that the cost-reductions of these reforms have had little or no effect; and the increasing tendency towards privatisation of health systems and its negative effect of an increase of social inequalities in health and sickness. Of all of these I should like to mention that of Allyson M. Pollock, Professor of the Health Services and Health Policy Research Unit at University College London, on the British NHS. Allyson M. Pollock, *NHS plc. The Privatisation of Our Health Care*, (London-New York, 2004). This author hopes that her book will be an expression of hope for the future, and will contribute to the creation of "a new generation to work towards reclaiming the rights and entitlements that the NHS once conferred, and a new vision of health care for all" (p. x). A similar approach, but referring to the case of Spain, is found in the works of Rafael Huertas, *Neoliberalismo y políticas de salud*, (Mataró, 1999) and of Jaime Baquero, *Privatización y negocio sanitario: La salud del Capital*, (Ciempozuelos, Madrid, 2004).

France and Spain's Attitude to Compulsory Health Insurance Prior to the First World War

At the end of the nineteenth century and the beginning of the twentieth the Third French Republic, against a general liberal economic background, had to deal with a situation of growing social tension, in which socialism and revolutionary syndicalism exerted an increasing attraction over the workers. This situation was further aggravated by France's backwardness in social policies compared to its European neighbours, Germany, Britain, Belgium, and Italy. The Third Republic therefore tried to combat this by seeking a viable formula for national social security which would answer the needs of the workers, but which would be financially sustainable and compatible with the liberal principles of the Republic. Initially, the role of the State was limited to promoting laws of assistance (such as the A.M.G law of 1892) and encouraging the development of the mutualist movement (Charte de la Mutualité, 1898)[9], as a possible vernacular way to overcome France's backwardness in the matter of social protection[10]. Little by little the reluctance to accept state intervention and compulsory insurance was overcome: at the turn of the century, and with the debate surrounding the 1898 law of accidents in the workplace and the law of 1910 great progress was made in this area[11]. However, neither the expansion of the mutualist movement nor the increasing prestige of state interventionism and compulsory social insurance met with the approval of the doctors[12]. The latter, organized into unions deriving from the law of 1884, felt that it would reduce the practice of liberal medicine, especially in view of what had happened with the law of Free Medical Aid (1892) and that of Accidents at Work (1898), and what might be entailed by the application of the law of working-class and peasant retirement

9 On the part played by the French State in the development of the Mutualité, see: Pierre Leclerc, *La Sécurité Sociale. Son histoire à travers les textes. Tome II – 1870–1945*, (Paris, 1996), pp. 40–61. As this author himself points out on p. 225, the employers did not want the development of state intervention, and the Confédération Générale du Travail was guarded in its response to the State's role in the management of social protection.

10 Above all after the merger of the Mutual Aid Societies into the FNMF in 1902. For more on this subject, consult: Janet Horne, *Le Musée Social aux origines de l'État Providence*, (Paris, 2004), pp. 223–256.

11 Although it failed in the cases of 1898 and 1910, according to François Ewald the law of 1898 led to an atmosphere more favourable to insurance. From that moment on it was easy to accept illness, death, old age, unemployment, etc as another set of general risks to be recognised by legislators and dealt with by means of insurance. Further information on this question is to be found in François Ewald, *Histoire de l'État Providence*, (Paris, 1996), pp. 278–286 and seq., as well as in Henri Hatzfeld, *Du paupérisme à la Sécurité* Sociale, (Nancy, 1989), pp. 33–101.

12 Pierre Guillaume, *Le rôle social du médecin depuis deux siècles (1800–1945)*, (Paris, 1996), p. 123. On the difficult relations between the Mutualité and the doctors between 1880 and 1914, see Pierre Guillaume, *Mutualistes et médecins. Conflits et convergences (XIXe-XXe siècles)*, (Paris, 2000), pp. 79–122.

(1910)[13]. Small wonder, then, that the proposed laws on social insurance put before the French Parliament between 1880 and 1914 were not passed[14]. Although these initiatives failed, they allowed the creation of a state of opinion favourable to the need to find a way to overcome France's backwardness in social legislation.

As far as Spain was concerned, it is interesting to note that the years between 1875 and the end of the First World War were marked by the Restoration of the Monarchy, which found itself facing a difficult economic, political and social situation, under the influence of *regenerationism* and the desire to solve some of the serious problems then existing and the backwardness in social policies (even worse than that of France) by means of the modernization of the country, particularly in the health and social fields[15]. In order, then, to make up for lost time and to deal with the so-called "social question", institutions such as the Social Reforms Commission (Comisión de Reformas Sociales) (1883) or the Social Reforms Institute (Instituto de Reformas Sociales) (1903) were set up[16]. These bodies promoted legislative reforms in the area of social protection, embodied in the law on work accidents of 1900, and in the creation of a climate of public opinion in favour of state intervention and the establishment of compulsory insurance[17]. However, Spain was further behind in this field than France. Indeed, the idea behind the founding of the Instituto Nacional de Previsión (INP- National Insurance Institute) in 1908 was to set up a system of independent subsidised insurances[18]. It would be the economic,

13 To appreciate the positions held by French doctors and the syndicalist strategies they employed, it is worth consulting Pierre Guillaume, *Le rôle social du médecin depuis deux siècles (1800–1945)*, (Paris, 1996), pp. 117–142.

14 Pierre Leclerc, *La Sécurité Sociale. Son histoire à travers les textes. Tome II – 1870–1945*, (Paris, 1996), p. 225.

15 Information on this question may be found in Manuel Martín Salazar's illustrative *La Sanidad en España*, (Madrid, 1913) and in certain recent works, such as those of Esteban Rodríguez Ocaña, "Medicina y acción social en la España del primer tercio del siglo XX" in *De la Beneficencia al bienestar social*, (Madrid, 1985) or that of Delfín García Guerra & Víctor Álvarez Antuña, "Regeneracionismo y Salud Pública. El bienio de Ángel Pulido al frente de la Dirección General de Sanidad (1901–1902)", *Dynamis*, 14, (1994), 23–41. It is also useful to consult Rafael Huertas García-Alejo, *Organización sanitaria y crisis social en España*, (Madrid, 1995).

16 To gain some idea of the importance of, and the role played by, the CRS and the IRS, see: José Álvarez Junco. *La Comuna en España*, (Madrid, 1971); José Álvarez Junco. "La Comisión de Reformas Sociales: intentos y realizaciones" in *Cuatro siglos de acción social. De la beneficencia al bienestar social*, (Madrid, 1988), pp. 147–153; María Dolores de la Calle Velasco, *La Comisión de Reformas Sociales, 1883–1903. Política social y conflicto de intereses en la España de la Restauración*, (Madrid, 1989); Juan Ignacio Palacio Morena, *La institucionalización de la reforma social en España (1883–1924). La Comisión y el Instituto de Reformas Sociales*, (Madrid, 1988).

17 On this subject, consult Feliciano Montero García, *Orígenes y antecedentes de la previsión social*, (Madrid, 1988), pp. 9–208.

18 Along the lines of the initial Belgian and Italian system. For information about the conception of the INP and its characteristics, see: Feliciano Montero García, *Orígenes y antecedentes de la previsión social*, (Madrid, 1988), pp. 209–257, and María Esther Martínez Quinteiro,

political and social crisis of 1917, the inadequate development and implementation of this insurance among the working class, and the great importance acquired by social insurance, which would lead to the Institute's change of attitude in 1917[19], when it began to defend the compulsory nature of the insurance[20]. This was in line with the ideas of Spanish medical hygienists, who considered compulsory health insurance and social security as important weapons in the struggle against tuberculosis (Congresses of 1908, 1910 and 1912)[21] and for "hygienic redemption"[22]. As we shall see later, health insurance and social security were to come into greater prominence between 1919 and 1922.

From the Bismarckian Model of Social Security to Liberal Medicine

First Attempts to Set Up Social Security and Health Insurance after the Return of Alsace and Lorraine (1920-1924)

With the end of the Great War social security took on a new importance in France. This was due, on the one hand, to the poor results achieved by the law of 1910 on worker and peasant retirement and, on the other, to France's backwardness in social legislation. This latter became more apparent with the return of Alsace and Lorraine, which had a generalized compulsory social security system. This, together with the importance attached to social security at an international level, led to the

"La fundación del INP. Las primeras experiencias de Previsión Social" in F. Montero García, *Orígenes y antecedentes de la previsión social*, (Madrid, 1988), pp. 259–330.

19 Very strongly influenced, also, by the opinion of the Second National Economic Congress in Madrid (May 1917).

20 The first insurance of this type to be established was that of workers' retirement in 1919. For more about the importance acquired by social security in Spain from 1917 onwards, see the works of María Esther Martínez Quinteiro, "La fundación del INP. Las primeras experiencias de Previsión Social" in F. Montero García, *Orígenes y antecedentes de la previsión social*, (Madrid, 1988), 259–330, pp. 326–330; María Esther Martínez Quinteiro, "El nacimiento de los seguros sociales, 1900–1918" in *Historia de la acción social en España. Beneficencia y Previsión*, (Madrid, 1990), pp. 241–286, and María Isabel Porras Gallo, "Un foro de debate sobre el Seguro de enfermedad: las conferencias del Ateneo de Madrid de 1934", *Asclepio*, 51 (1), 159–183, p. 163.

21 Jorge Molero Mesa & Esteban Rodríguez Ocaña, "Tuberculosis y previsión. Influencia de la enfermedad social en el desarrollo de las ideas médicas españolas sobre el seguro de enfermedad" in M. Valera; Mª Egea & M. D. Blázquez (eds), *Libro de Actas. VIII Congreso Nacional de Historia de la Medicina. Murcia-Cartagena, 18–21 Diciembre 1986*, (Murcia, 1988), vol. I, pp. 503–505.

22 This was the opinion of Manuel Martín Salazar, *La Sanidad en España*, (Madrid, 1913), pp. 49–51.

start of a process of negotiation whose purpose was to set up a system for the whole of France similar to that in Alsace and Lorraine, including compulsory health insurance[23]. To this end, on 22nd March 1921 an extraparliamentary Commission, headed by Cahen-Salvador, Relator (*Maître des requêtes*) of the Council of State drew up and presented a bill before Parliament[24]. This proposed the Alsace-Bismarck model[25] (excluding unemployment), in which Departmental and Regional Funds played a key role, and the management of the insurance was the responsibility of the State. For doctors this model implied restrictions on liberal practice, such as payment *au forfait* (by flat fee) by the Funds; in other words, the *tiers payant* (third-party payment) system, which would provoke the rejection of the majority of the medical community[26], with the exceptions of the doctors of Alsace and Lorraine[27]. It would also be contested by a large sector of French society[28] (farmers, employers' organisations, the far right, or the Mutualité, who wanted to play a larger part[29]). It was supported only by Catholics [30] and Socialists[31], with the Commu-

23 Information on the new French context within which this negotiating process on social security began may be found in: Henri Hatzfeld, *Du paupérisme à la Sécurité Sociale 1850–1940*, (Nancy, 1989), pp. 142–144.

24 Pierre Leclerc, *La Sécurité Sociale. Son histoire à travers les textes. Tome II – 1870–1945*, (Paris, 1996), pp. 227–228.

25 On the rejection of this model by some sectors in France, and Grinda's way of counter-attacking, by appealing to the influence of the Alsace systems in the development of the German model of compulsory health insurance of 1883 and old age of 1889, see: Pierre Leclerc, *La Sécurité Sociale. Son histoire à travers les textes. Tome II – 1870–1945*, (Paris, 1996), pp. 225–226.

26 As will be shown throughout this text, this rejection would continue to increase all through the debate on the social security Law in France, giving rise to an abundant bibliography which appeared in the main medical periodicals of the time, and to an important number of monographs such as that of Fr. Guermonprez, *Assurances sociales. Études médicales autour de la loi 5 Avril 1928*, (Paris, 1928) or that of Paul Guérin, *L'État contre le Médecin. Vers une renaissance corporative*, (Paris, 1929).

27 An example of the position of these doctors is the text of Docteur Kopp, *Lettres du Docteur Kopp sur les assurances sociales*, (Paris, 1924).

28 A comprehensive view of the reactions of the different sectors of French society to social security can be found in: Henri Hatzfeld, *Du paupérisme à la Sécurité Sociale 1850–1940*, (Nancy, 1989), pp. 142–321.

29 In fact, the Mutualité soon demanded that, for the organization of the future Law of health insurance, it should have the exclusive right to be involved. Paul Boudin, "L'assurance-maladie. L'assurance-maladie obligatoire au XIIe Congrès Nationale de la Mutualité", *La Presse Médicale*, 12, (9–2–1921), 198–200, p. 199.

30 Although the Catholics (especially the socio-Catholics) were in favour of the social security Law, it was considered unacceptable by those who were Catholic doctors. A very informative article on this subject is by Docteur Jean Batailh, "Les Assurances sociales sont-elles un bien?", *Bulletin de la Société médicale de Saint Luc, Saint Côme, Saint Damien*, 3 (mars 1929), 84–93.

31 The wholehearted support of the Socialists was maintained throughout the debate on the social security Law, continuing even after the start of the application of the Law of 1930. An

nists defending a system similar to that of communist Russia[32]. However, the opposition of the medical community and the Mutualité was concerned mainly with the type of health insurance proposed in Cahen-Salvador's bill. Indeed, in 1920, each of these groups presented bills for the establishment of compulsory health insurance: one with the additional aim of reorganising the hospitals[33], and the other inclining towards the generalization of the Mutualité and the exclusion of any state-related organisation from the application of the law[34].

The enquiry into Cahen-Salvador's bill by the Commission of Hygiene, Insurance and Social security of the Assemblée Nationale[35], headed by the doctor and mutualist Grinda, changed the conditions of application of the law concerning the free choice of doctor (limited, from a set list), the collective contract (very different depending on region and means) and payment, introducing the *ticket modérateur* (partial payment by the patient) and keeping the *forfait*, or flat fee. In addition, the departmental and regional Funds lost importance, with the insurance being managed by those involved, without State intervention as one great mutual benefit society[36]. With these modifications Parliament passed the bill on 8th April 1924, sending it to the Senate where it was scrutinised by the Senate Hygiene Commission under Dr Chauveau, another mutualist but, as Guillaume has pointed out, more sensitive than Grinda to the opinions of the medical community[37].

The Loucheur Law (5-4-1928) on Social Security, the Reunification of the Medical Union Movement and the Triumph of Liberal Medicine

After considerable discussion in the Senate Commission, a new text was prepared which the Senate approved on 7th July 1927, and which became the Law of 5th

expression of this support can be found in: Georges Buisson, *Pour connaître les Assurances Sociales. Entretiens sur la Loi du 5 Avril 1928, modifiée par les Lois du 5 Août 1929 et 30 Avril 1930*, (Paris, s.d); Georges Buisson, *Les Assurances Sociales en danger*, (Paris, 1932).

32 An example of this is: Georges Levy, "Les Assurances Sociales. Les dangers du Projet Grinda », *L'Humanité*, (8-11-1923) ; R. Jacquet, « Les travailleurs contre la loi d'escroquerie. Le projet de la C.G.T.U. », *L'Humanité*, (3-7-1930); Racamond, "Les Assurances sociales dans l'U.R.S.S. », *L'Humanité*, (6-7-1930).

33 This proposal was reproduced in: "L'Assurance-Maladie. Proposition de loi ayant pour objet la réorganisation des hôpitaux et l'établissement de l'assurance-maladie et invalidité prématurée", *La Presse Médicale*, 69, (27-8-1921), 1249–1252.

34 Pierre Leclerc, *La Sécurité Sociale. Son histoire à travers les textes. Tome II – 1870–1945*, (Paris, 1996), pp. 227–228.

35 Presented 31 January 1923.

36 Further information on the Commission's report in: Chambre des Députés, *Journal Officiel*, documents annexes, nº 5505, session du 31 janvier 1923.

37 Pierre Guillaume, *Le rôle social du médecin depuis deux siècles (1800–1945),* (Paris, 1996), p. 187.

April 1928, or the Loucheur Law[38]. The practically unanimous vote of the House has been explained as proof of the boredom of the Assemblée and of the need to finish with such a long debate at the end of the mandate. In fact, medical demands for total freedom of choice of doctor and direct payment by the insured were still on the table. Although the new text re-established free choice of doctor (since the list of practitioners was drawn up by agreement between the Funds and the professional unions), the *forfait* was eliminated and a "fee-for-service" or mixed system was accepted[39]. On the other hand, the Mutualité did not get the monopoly it wanted, since the insured could sign up for health insurance in a wide variety of funds. All of this caused the hostility of the Mutualité and the medical community to become even greater, not only in the closing months of 1927 but also after the passage of the law of 1928. Thus in 1929, as Pierre Guillaume has pointed out, Raoul Peret declared that "social security will be done by the Mutualité or not at all", and in January 1930 the Mutualité sought to reform the law by turning the *Conseil Supérieur de la Mutualité* into the *Conseil Supérieur de la Mutualité et des Assurances sociales*, eliminating the national and departmental funds[40]. Although this proposal was unsuccessful, it provoked the wrath of the medical unions, who could sense their old enemy raising its head again[41].

For their part, the medical unions, divided since the crisis of 1926[42], now reunited (with the creation in 1927 of the Confédération des Syndicats Médicaux de France) and gained the commitment of all doctors to the principles of the *Charte de la Médecine Libérale* [43] to present a united position against health insurance[44].

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38 In order to gain a comprehensive view of all the texts, reports and steps taken from the first tabling of the social security Bill to the French Parliament until the passing of the so-called Loucher Law, consult Henri Hatzfeld, *Du paupérisme à la Sécurité Sociale 1850–1940*, (Nancy, 1989), pp. 144–154.

39 A text which is useful to appreciate the Law of 5 April 1928 is that of Étienne Antonelli, *Guide pratique des Assurances sociales. Commentaire et texte complet de la loi 5 avril 1928*, (Paris, 1928).

40 Pierre Guillaume, *Le rôle social du médecin depuis deux siècles (1800–1945)*, (Paris, 1996), p. 195.

41 To learn the positions of the Mutualité and the French medical union movement on social security, and the relations between them, see: Pierre Guillaume, *Mutualistes et médecins. Conflits et convergences (XIXe-XXe siècles)*, (Paris, 2000), pp. 122–160. For the position of the Mutualité, see also: Bernard Gibaud, *De la Mutualité à la Sécurité Sociale. Conflits et convergences*, (Paris, 1986).

42 Comprehensive and informative details about the disparity of opinions of medical syndicalism concerning the proposed bill on social security prepared by the Senate Commission, and the split of 1926 may be found in F. Jayle, "L'Assurance-maladie et la scission à l'Union", *La Presse Médicale*, 60, (28-7-1926), 955–956.

43 On the significance for French medical syndicalism of the seven principles laid out in this document, see: Pierre Guillaume, *Le rôle social du médecin depuis deux siècles (1800–1945)*, (Paris, 1996), pp. 195–197.

These principles were to respect the absolute freedom of the patient to choose his doctor; professional secrecy; the right to fees for any patient attended either in hospital or at home; direct payment of the doctor by the patient; complete freedom of treatment and prescription; and the control of doctors by themselves (their unions) [45]. The final medical offensive against the 1928 Law was based on absolute respect for these principles, until they achieved the passage of the new Law on Social Security of 30th April 1930, in which the *tiers payant* was eliminated and the demands of the medical unions were fully satisfied, giving practitioners total freedom (including in the matter of fees)[46]. In this way it was possible to establish a compulsory system of social protection in France, although for the insured it was a law of subprotection as far as health insurance was concerned[47]: it was necessary to introduce improvements in the years that followed, particularly with the decree of 28th October 1935. In spite of this it was only with the inauguration of the Social Security in 1945[48] that patients achieved the benefits provided for in the government plan of 1921[49].

Compulsory Health Insurance in Spain in the Inter-War Period

First Attempts to Design and Apply a Compulsory Health Insurance

As I mentioned earlier, although the boom in social insurance took place in 1917, it was to become more prominent between 1919 and 1922, under the influence of the serious effects of the flu epidemic of 1918-19 and the First World War, and indeed

44 An exponent of this is F. Jayle's article, "Vers l'accord entre l'Union et la Fédération sur l'Assurance-maladie", *La Presse Médicale,* 37, (7-5-1927).

45 "Le Congrès des Syndicats médicaux de France", *La Presse Médicale*, 97, (3-12-1927), 1488.

46 F. Jayle, "La loi des Assurances sociales du 5 Avril 1928 complétée par la loi du 30 Avril 1930", *La Presse Médicale*, 57, (16-7-1930), 969–971; F. Jayle, "Les Conventions-types pour l'Assurance-Maladie", *La Presse Médicale*, 70, (30-8-1930), 1181–1183.

47 Pierre Guillaume, *Le rôle social du médecin depuis deux siècles (1800–1945)*, (Paris, 1996), p. 213.

48 On this subject, consult Bruno Valat, *Histoire de la Sécurité Sociale (1945–1967). L'État, l'institution et la santé*, (Paris, 2001) and the bibliography included.

49 In fact, according to Hatzfeld, it would not be until 1960 that the majority of those covered by the social security would receive refunds of their medical expenses, in accordance with the wishes of the legislators of the nineteen-twenties. Henri Hatzfeld, *Du paupérisme à la Sécurité Sociale 1850–1940*, (Nancy, 1989), p. 289. On relations between French doctors and the Social Security, see: Henri Hatzfeld, *Le Grand tournant de la médecine liberale*, (Paris, 1963).

was even put forward as an element suitable for the public prevention of infectious diseases[50]. No wonder, then, that the French law on Social Security, the reactions it provoked in French society (most particularly among doctors) and the long-drawn-out negotiations which took place aroused the curiosity of the Spanish and influenced some of the actions taken in Spain in the 20's of the last century[51]. Indeed, the presentation to the French Parliament in 1921 of the social security bill gave rise to the drafting in Spain of a bill- inspired by the German model, and very similar to the French[52], on health, maternity and invalidity insurance, which would be presented at the National Insurance Conference in Barcelona in 1922[53]. However in Spain, as in France, some major difficulties arose which prevented its early acceptance and implementation. Indeed, at the 1922 Barcelona Conference an important section of doctors and (private) medical companies voiced their disagreement with the project, particularly concerning compulsory health insurance. Only the hygienists, the socialist doctors, and the doctors belonging to the INP (National Insurance Institute) defended the immediate implementation of the model of health insurance put forward in Barcelona. On the other hand, the majority of the doctors, formed into different professional associations, opposed it and demanded other different models. Thus, while rural practitioners asked for the nationalisation of medical care, the professional colleges and medical unions of Catalonia defended a system in line with the principles of liberal medicine. Like their French colleagues, they demanded freedom to choose a doctor, direct payment by the patient for each medical service, and their own intervention in the control of health care in exchange for their support for compulsory health insurance[54]. This discovery of the strength of the organised medical profession led the Spanish government to estab-

50 I dealt with this subject in: María Isabel Porras Gallo, "La profilaxis de las enfermedades infecciosas tras la pandemia gripal de 1918–19: los seguros sociales", *Dynamis*, 13 (1993), 279–293 and María Isabel Porras Gallo, "La lucha contra las enfermedades 'evitables' en España y la pandemia de gripe de 1918–19", *Dynamis*, 14 (1994), 159–183.

51 The reactions of Spanish society to the French social security law, from the presentation of the first proposal to Parliament until its application, and the influence which it had in Spain have been studied by Josefina Cuesta Bustillo & Evelyne López Campillo, "L'Espagne devant le modèle français d'assurances sociales", in *Colloque sur l'histoire de la Sécurité sociale, Paris, 1989*, (Paris, 1990), pp. 73–91.

52 On the similarities and differences between the French proposal of 1921 and that prepared in Spain by the INP to be presented to the Barcelona Conference, see: Josefina Cuesta Bustillo & Evelyne López Campillo, "L'Espagne devant le modèle français d'assurances sociales", in *Colloque sur l'histoire de la Sécurité sociale, Paris, 1989*, (Paris, 1990), pp. 77–82.

53 More detailed information on the characteristics of this first Spanish social security proposal, and on the Conference, are to be found in: INP, *Conferencia Nacional de Seguros de Enfermedad, Invalidez y Maternidad. Barcelona, noviembre de 1922. I. Ponencias, actas y conclusiones. II. Documentos de información*, (Madrid, 1925), 2 vols.

54 For further details on the different medical attitudes held, see: INP, *Conferencia Nacional de Seguros de Enfermedad, Invalidez y Maternidad. Barcelona, noviembre de 1922. II. Documentos de información*, (Madrid, 1925), t. II, pp. 251–294.

lish compulsory maternity insurance in 1929 and to set aside the implementation of health insurance until the arrival of the Second Republic[55].

Compulsory Health Insurance during the Second Republic

It was at this time that social insurance once again became an issue[56]. On one hand, the new Republican Constitution (in Article 46) recognised work as a beneficiary of the laws of social protection, among others that of health insurance[57]. On the other, in 1932 the Republican government ratified the agreements of the International Labour Conference of 1927 on the implementation of compulsory health insurance for wage earners in industry, commerce, agriculture, and domestic service. With this in mind, by a decree dated 10 May 1932, the Minister of Labour and Social Security, Francisco Largo Caballero, commissioned the National Insurance Institute (INP) to prepare and implement a complete and unified system of social security[58]. The Institute proposed a model similar to the German type, and whose introduction as we have seen was tried in France; but managed by the National Insur-

55 However, the matter was not totally forgotten. Indeed, the text of the 1928 French social security Law was published almost immediately in the *Boletín analítico de la Secretaría de la Cámara de Diputados*, [4 (1928), 9–35 y 5 (1928), 230–248].

56 The actions of the Second Republic in matters of Social Medicine have been dealt with by: Esteban Rodríguez Ocaña & Alfredo Menéndez Navarro, "Objetivos y estructura de la Medicina Social en la II República. El primer Congreso Nacional de Sanidad", in M. Valera; Mª Egea & M. D. Blázquez (eds), *Libro de Actas. VIII Congreso Nacional de Historia de la Medicina. Murcia-Cartagena, 18–21 Diciembre 1986*, (Murcia, 1988), vol. I, pp. 514–523; Isabel Jiménez Lucena, *Cambio político y alternativas sanitarias: el debate sanitario en la II República*, (Málaga, 1995), unpublished doctoral thesis: Isabel Jiménez Lucena, "El Estado como aliado. Los médicos y el proceso de estatalización de los servicios sanitarios en la Segunda República española", *Asclepio*, 49 (1) (1997), 193–216; Isabel Jiménez Lucena, "De intereses y derechos. Elementos del debate en torno a la asistencia médico-sanitaria durante la Segunda República", *Trabajo Social y Salud,* 43 (2002), 67–90.

57 Recent works dealing with compulsory health insurance during the Second Republic have been: Isabel Jiménez Lucena, *Cambio político y alternativas sanitarias: el debate sanitario en la II República*, (Málaga, 1995), unpublished doctoral thesis, pp. 158–181, 219–224, 246–257 y 298–324; María Isabel Porras Gallo, "Los médicos y la prensa frente al seguro de enfermedad en la primavera de 1934: una respuesta a la creación del Ministerio de Trabajo, Sanidad y Previsión", in J. Castellanos; I. Jiménez Lucena, Mª J. Ruiz Somavilla & P. Gardeta, *La Medicina en el siglo XX. Estudios históricos sobre Medicina, Sociedad y Estado*, (Málaga, 1998b), pp. 183–192; María Isabel Porras Gallo, "El Seguro de Enfermedad en la II República española: del decreto del 25 de diciembre de 1933 al I Congreso Nacional de Sanidad", in S. Castellano & J. Mª Ortiz de Ortuño (coords.), *Estado, protesta y movimientos sociales*, (Bilbao, 1998c), pp. 171–176.

58 Information on this subject and a summary of events concerning health insurance from the 1922 Barcelona Conference until the establishment of the Second Republic can be found in: INP, *Unificación de los Seguros Sociales. Antecedentes de los Seguros de Enfermedad y de Invalidez y Muerte*, (Madrid, 1932).

ance Institute (INP) and including preventive medicine. Although this model had enjoyed the support of the republican Government during the two-year rule of Azaña's Socialists, as well as that of most of the conservative sector[59], it was again disputed by a large part of the medical fraternity. True, the socialist doctors defended it, but the anarcho-syndicalists thought it was insufficient and the Communists, like their French colleagues, remained faithful to the USSR model. The rest, the majority of doctors (organised and grouped into professional associations, colleges and unions), criticised the lack of "freedom of choice" of practitioner and demanded a type of health insurance similar to that established in France in 1930. That is, closer to liberal medicine, but run entirely by the doctors with two different types of system for the payment of fees: in towns, it would be via a medical cooperative and in the country areas through the "iguala" (flat fee) system controlled by the Medical Colleges[60].

Negotiations which took place during the Second Republic to try to overcome the doctors' resistance and to gain their support only allowed the drafting of a new bill by the INP to unify social security, very similar to the German model, including health insurance[61]. The outbreak of the Civil War was to prevent its implementation.

Compulsory Health Insurance: A Necessity for the New Franco Regime

Under the new circumstances existing in Spain at the end of the Civil War compulsory health insurance again came to prominence. On one hand, on the international level, the majority of European countries had already set up a system of compulsory health insurance. On the other, Spain's internal situation, characterised by the poor social, economic and sanitary conditions of the post-war period, and the new regime's need to establish its legality, made it advisable to set up a social security system and, more specifically, compulsory health insurance. So although (as on

59 However, as was made clear by the extraordinary Congress of the Socialist trades union Unión General de Trabajadores (UGT) in 1932, there was no unanimity within the socialist ranks about the kind of public health service to be put in place: "XVII Congreso de la Unión General de Trabajadores", *El Socialista*, 17 October 1932. "XVII Congreso de la Unión General de Trabajadores", *Anales del INP*, 24 (99), (1932), 697–700.

60 A more detailed account of the type of compulsory health insurance wished for by the majority of the organized Spanish medical fraternity is to be found in: Ateneo de Madrid, *El Seguro de Enfermedad y los Médicos Españoles. Ciclo de conferencias organizado por la Sección de Ciencias Médicas*, (Madrid, 1934). In an earlier work I have analysed the contents of these lectures: María Isabel Porras Gallo, "Un foro de debate sobre el Seguro de enfermedad: las conferencias del Ateneo de Madrid de 1934", *Asclepio*, 51 (1) (1999), 159–183.

61 On the characteristics of the health insurance included in this Bill, see: INP, *El Seguro de Enfermedad en el Proyecto de unificación de Seguros Sociales*, (Madrid, 1936).

other occasions) there were protests from the doctors [62] and other sectors of Spanish society, compulsory health insurance was established by the Law of 14th December 1942[63], although it was not put into effect until 1st May 1944. A few days before this date, in true demagogic style, the health insurance was presented as "the Great Undertaking of the National Movement" (the National-syndicalist Falange) which was possible because Spain was at peace, unlike its neighbours who were at war. The insurance was presented as an element of unity between all the classes, and it was emphasised that its aim was to put the health and hygiene of all Spaniards at the highest technical level, and to prevent disease entering the homes of the workers and leading them away to misery and death[64].

The way in which the spheres of power were distributed among the different groups that made up the rebel side at the end of the Spanish Civil War meant that the National Health was tied to military and Catholic interests, and fell outside the scope of power of the Falange. On the other hand, with the appointment of the Falangist Girón de Velasco as Secretary of Labour, this Ministry and, therefore, the National Insurance Institute would remain under the control of the Falange. Hence the important role of the Falangists in the preparation and implementation of the law on compulsory health insurance, which would ultimately determine that the model finally adopted would be more like that of Germany than of Italy, although it included some of the modifications made by Mussolini. The National Insurance Institute would be in sole charge of the management of the insurance. The distribution of powers mentioned above also meant that the network of health insurance would be totally separated from that of the National Health System[65], and that the participation of the Medical Colleges would be completely dispensed with[66].

The implementation of this first compulsory health insurance was gradual. It was extended and introduced changes with which it sought (without any clear criteria) to adapt itself to the political ups and downs and the process of industrialization

62 An idea of the distrust shown by doctors, and of some of the strategies adopted to try to combat it, may be gained from: Sebastián Criado del Rey, *Problemas sanitarios del Seguro de enfermedad*, (Madrid, 1947).

63 On the characteristics of this first compulsory health insurance, see: INP, *Seguro de Enfermedad. Reglamento. Decreto de 11 de noviembre de 1943*, (Madrid, 1943).

64 On this matter, consult: INP, *Ante una ofensiva nacional. El Seguro de Enfermedad visto por quienes lo crean y organizan*, (Madrid, 1944).

65 As Molero has indicated, this distribution of power and the protagonism of the Falange in the elaboration and application of compulsory health insurance frustrated the creation of an insurance directed exclusively against tuberculosis. Jorge Molero Mesa, "Enfermedad y previsión social en España durante el primer franquismo (1936–1951). El frustrado seguro obligatorio contra la tuberculosis", *Dynamis*, 14 (1994), 199–225.

66 This attitude against the Medical Colleges, according to the Falangist Doctor Alfonso de la Fuente Chaos, was justified because they had not blocked the access of the enemies of the new regime to the National Health Service, nor had they shown any remorse: Alfonso de la Fuente Chaos, *Política sanitaria*, (Madrid, 1943), p. 161.

and modernization of Spanish society. After numerous reorganizations, the Bill of 1963 led to the transition towards a Social Security System which would imply, among other things, an increase in coverage (54% of the population in 1968). The passage towards a British-style National Health System would be made with the General Health Law of 1986, in a different political context.

Epilogue

The foregoing account has allowed us to see how, at the end of the nineteenth and beginning of the twentieth centuries, there was a shift towards positions progressively more favourable to state intervention, and the establishment of compulsory health insurance and social security in France and Spain. These factors would become more important at the end of the First World War, given the internal and external circumstances of the time, and the backwardness of both countries (even greater in Spain) in social legislation. Hence the start in both cases of a process of negotiation designed to set up a social security system, which would include compulsory health insurance. However in Spain, as we have shown, the doctors' opposition to health insurance prevented it from being realised for more than twenty years, until the socio-economic situation and political circumstances at the end of the Civil War acted as the driving force for the establishment of this insurance and the choice of a specific model (similar to the German system). On the other hand, in France political and socio-economic factors influenced the decision to install social security, but the sustained offensive of medical syndicalism (which got progressively stronger) against health insurance finally achieved the establishment of a model of compulsory health insurance which respected the principles of liberal medicine. This was the model which would be adopted, in spite of the fact that, just as in Spain, the point of departure had been the German system, and that the system finally set up was a model of underprotection for the patients.

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Outdated Fraudulent Healing? Homeopathy on Trial

The Homeopathic "Pill Scandal" in the 1950s and Modernisation of Health Care in Sweden

Motzi Eklöf

Introduction

In July 1951, news spread that certain manufacturers of homeopathic remedies in the Stockholm area had skipped part of the potentization process and had sold pure sugar pills under the false claim that they were homeopathic medicines. After extraordinarily time- and money-consuming investigations and legal proceedings, directors and others from Pharma-Drog AB and Drogon AB who were responsible for producing and selling the pills were charged with, convicted of and sentenced for fraud and tax evasion.

In court, the prosecutor maintained that homeopathy as such was a big fraud, since even correctly potentiated homeopathic remedies above D5 could not possibly have any therapeutic effect beyond that of suggestion.[1] This was a position also held by the Swedish Royal Medical Board, although homeopathic remedies above D6

1 According to the founder of homeopathy, Samuel Hahnemann (1755–1843), medicines should be prescribed in minimum doses in order to enhance a positive therapeutic effect and minimise negative side-effects. The potentization principle for drug preparation with serial trituration and agitated dilution was standardised in 1816. For example, the potency of D1 (D = decimal) is diluted 1:10 ("1" being the original ingredient, e.g. belladonna, arnica or lachesis, etc., and "10" being e.g. lactose, saccarose, water). D2 is diluted another 1:10 from the preparation that was already diluted once, and so forth. After D6, none of the original substance can be found in the remedy by means of ordinary chemical analysis. Dilutions beyond D6 (often D12, D30, D60, D200, CM) are called high dilutions. Some homeopaths prefer low dilutions, other use high dilutions, sometimes also called infinitesimal doses. For theory and clinical studies of homeopathy in a historical perspective, see Michael Emmans Dean, *The Trials of Homeopathy: Origins, Structure and Development*, Essen 2004.

were sold at pharmacies.[2] Accordingly, manufacturing and marketing of homeopathic remedies was to be considered fraudulent.

Perhaps somewhat surprisingly, most of the accused individuals joined in this stance. As part of their defence in court, they claimed that it could not be considered criminal to sell pills already commonly known to be of no benefit. On the contrary, they contended, it had been their praiseworthy intention to disclose the humbug of homeopathy by this large-scale experiment with unpotentiated pills, used by homeopaths and patients for years without any noteworthy complaints of absent therapeutic effects. The accused manufacturers referred to rumours that conventional pharmacies also cheated in the production of homeopathic remedies, and that medical authorities were aware of this and in any case, potentization above D6 was unnecessary, as the contents above this potency could not be checked out chemically.[3]

The one person taking a different position was the most prominent representative of lay homeopathy at the time. To the very last, he denied accusations of complicity in fraud and claimed that he still believed in homeopathy, although he was sceptical toward high dilutions. In the homeopathic journal he edited, he published a declaration swearing to God and all people that he had not known of the fraudulent activities.[4]

The courts chose not to take a stance on homeopathy as therapy. Instead they confined themselves to declaring that it was fraudulent to sell packages the contents of which did not correspond to the labelling. People would not have paid the prices they had paid if they had known the packages contained only pure sugar.[5] The lay homeopath who claimed that he was innocent of the charges never had to serve his sentence – it was suspended in April 1954 by the Minister of Justice, a decision commented on acidly in the press.[6] In early May of the same year, a huge bonfire in

2 "[…] A direct therapeutic effect of essentially all homeopathic remedies with a potency of D5 or above that are taken in reasonable doses can be precluded. The Swedish Medical Board does not rule out the effect of suggestion, which in certain contexts any remedy can have." Report from the Swedish Royal Medical Board to the Office of the Public Prosecutor, Stockholm, 22 September (1951), pp. 1351–1366, in the preliminary investigation, F1:14 in Verdicts of Criminal Cases no. 115/1952, Stockholm City Court, Division 24. Stockholm City Archives.

3 See, for example, case no. B 295/1951, pp. 393, 405–413, 563, and appendix 161 in Documents from Criminal Cases, 1951, F1:149, Stockholm City Archives.

4 Herbert Kant in *Tidskrift för homeopati* (Journal of Homeopathy) 1 (1953), p. 1.

5 Verdict from Stockholm City Court, Division 8, verdict no. 6, B 295/1951, regarding DW, among others. Verdict from Stockholm City Court, Division 24, 25 July 1952, Verdict no. 115/1952, regarding LG, among others. Verdict from the Svea Court of Appeal, 8 December 1952, B 715 a-c 1952, regarding LG, among others. All documents Stockholm City Archives.

6 See, for example, *Sundsvallsposten* 6 April (1954); *Arbetet* 2 April (1954); *Dagens Nyheter* 25 April (1954); *Stockholms-Tidningen* 3 April (1954); *Skånska Dagbladet* 7 April (1954).

Figure 1. "Miracle Pills". In May 1954 a bonfire containing confiscated homeopathic pills and handbooks represented the end of years of legal action against fraudulent manufacturing of homeopathic remedies. Photo from Bernhardsson, *Brottets krönika I* (1954), p 380.

a dump outside of Stockholm comprising tons of confiscated pills and homeopathic handbooks represented the spectacular end of years of legal proceedings.[7]

A Matter of Great Societal Importance

This so-called homeopathic "pill scandal" raises many questions on a number of different levels. The first – and for homeopathy as such the most precarious – being how it was possible for manufacturers of homeopathic remedies to sell pure sugar pills for years without, so it seemed, homeopaths and their patients noticing. Not all the pills that were sold were unpotentiated – it turned out that the number was

7 "Pillerskojarnas lager brännes på soptippen", *Svenska Dagbladet* 26 April (1954); "Pillerskojarnas lager blev jättebrasa", *Aftonbladet* 5 May (1954).

definitely smaller than initially claimed by the prosecutor – but there were enough to have made a difference (and in fact, some homeopaths had complained about not getting the expected therapeutic effect from some remedies).

According to medical authorities, homeopathy had finally unmasked itself and had been revealed as the self-evident quackery they had always declared it to be. Medical doctors regarded homeopathy as pharmacologically useless – the "pill scandal" being a gigantic disclosure experiment with blinded tablets – and hopelessly outdated. Any therapeutic effects were to be regarded as the result of self-healing or suggestion, functioning especially well in "the often somewhat childish and immature types of persons who, with their disposition for blind faith, miracles and mysticism, constitute the quack's most rewarding clientele and best propagandists".[8]

However, all of that had been said many times before. What was new in the early 1950s was that the trials of fraudulent manufacturers of homeopathic remedies were not solely considered embarrassing for homeopathy as such. Additionally, the "pill scandal" was turned into a matter of great societal importance and received a great deal of attention in the media. Politicians of different persuasions, the prosecutor, medical and pharmaceutical authorities, the media, as well as some of the prosecuted swindlers collaborated in the greater task of slandering and – hopefully – wiping out homeopathy from the Swedish medical marketplace. What will be discussed here are issues regarding why the homeopathic "pill scandal" got to be such a public affair, why it was considered so important to use this convenient opportunity to try to wipe out the most commonly used alternative therapy of the time, and how that was to be achieved. Homeopathic practice was not eradicated after the pill trials, but homeopathy was no longer to be discussed as a therapeutic alternative, and the topic vanished from the discursive level.

In this article, some general developments in society will be presented that I propose both directly and indirectly changed the prerequisites for homeopathic practice in Sweden. Discussions in the Swedish media – daily newspapers, journals, radio – concerning homeopathy in the middle of the twentieth century display some recurring themes that need to be discussed and analysed. Factors of importance include the processes of secularisation and modernisation, in parallel with an increased confidence in science. Growing State responsibility for the health of Swedish citizens, rapid expansion of hospital-based health care, and efforts to achieve political consensus for development of the welfare state were also significant factors. In addition, campaigns against sectarianism and fraudulent behaviour, especially economic fraud, in all areas of society played a central role regarding the

8 Gustaf Myhrman, "Om homeopatien", *Svenska Dagbladet* 2 August 1951. See also Carl-Gustaf Thomasson, "Kvacksalveriet i Sverige: Några synpunkter och data", reprint from *Social-medicinsk tidskrift* 3-5(1952), especially pp. 13–14.

fate of homeopathy in Sweden. With growing focus on consumers' rights, good value was demanded for the money spent on health care.

But this article does not deal only with the history of homeopathy in Sweden; the story can be told from another viewpoint. The history of alternative medicine is also closely linked to the history of conventional health care in Sweden. Homeopathy has played a central role for political decisions on legislation concerning health care and pharmaceutical products. Ninety years ago it contributed to the abolishment of the medical profession's monopoly on the practice of medicine, and has instead paved the way for the permission of lay healing that is still in force as a complement to state-supported health care. In the public debate, homeopathy incarnated the concept of "quackery", thereby meaning unauthorised practice of medicine. Homeopathy has thus played an important role in the efforts of conventional medicine and the state to define what separates modern scientific medicine from popular healing.

Homeopathy as an International Phenomenon

The principles of homeopathic practice were first presented by Samuel Hahnemann (1755–1843) in 1796 in Christoph Wilhelm Hufeland's *Journal of Practical Medicine*. In 1810 Hahnemann published his principles in the major work *Organon der Rationellen Heilkunde*. Homeopathy soon spread all around the world, in some countries to a greater degree than elsewhere, by means of German immigrants, journals, books, domestic self-help kits, patient networks, homeopathic colleges and hospitals and medical doctors trained in homeopathy.[9] During the second half of the nineteenth century homeopathy flourished in many countries, only to decline after 1900 and then increase in strength again in the 1970s and onwards.[10] Well-described factors influencing the position of homeopathy include support from patients from higher levels of society and/or with political influence, patient networks, support within the medical profession, institutionalisation with respect to hospitals and higher education, and the way in which the manufacture of homeopathic remedies has been pursued.[11]

9 M. Dinges 1996.

10 Martin Dinges, ed., *Weltgeschichte der Homöopathie. Länder – Schulen – Heilkundige* (München 1996); M. Dinges, "The Contribution of the Comparative Approach to the History of Homeopathy", in R. Jütte, M. Clark Nelson & M. Eklöf, eds, *Historical Aspects of Unconventional Medicine. Approaches, Concepts, Case studies.* (Sheffield 2001),pp. 51–72.

11 Martin Dinges, „Von den persöhnlichen Netzwerken der Gründergeneration zum weltweiten Boom einer Therapie in der Postmoderne", in M. Dinges, ed., *Weltgeschichte der Homöopathie* (München 199), pp. 382–419.

However, there are national differences in how homeopathy has developed. In Sweden, Hahnemann's theories of *similia similibus curantur*, like cures like, were briefly mentioned as early as 1797 in a Swedish scientific journal.[12] Homeopathy was introduced in academic teaching in 1826, but gained only weak support within academic medicine. In the mid nineteenth century, prominent representatives of Swedish medical science officially disassociated academic medicine from homeopathic theory and practice. It was deemed incompatible with the development of scientific medicine and was not to be used by the medical profession. In spite of this, some physicians, as well as laymen without academic medical education, continued to practice homeopathy.[13] This healing method entered a broader public domain in Sweden during the early decades of the twentieth century, started to lose ground in the 1930s, was scandalized in the 1950s, and today holds a more discrete position in contemporary alternative and complementary medicine.[14] As in the United States and several other countries, the period between 1930 and 1970 can be described as especially "dark years" for homeopathy[15], a time period coinciding with "optimum growth" of the welfare state.[16] Before dealing with events that occurred in the middle of this period, some mention will be made of processes that prepared the way for them.

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12 Sven Hedin in *Vetenskaps-Handlingar för Läkare och Fältskärer* nr 2 1797, p 51.

13 Anders Burius, "Homeopatien i Sverige: 150 års kamp för erkännande", *Sydsvenska medicinhistoriska sällskapets årsskrift* (1979), pp. 16–53; Jonny Strandberg, "Läkarkåren och homeopatien – En yrkeskårs bemötande av en alternativ lära genom dess tidskrifter under 1800-talet". C-Student paper in history (Uppsala 2004); Sofia Ling, *Kärringmedicin och vetenskap: Läkare och kvacksalverianklagade i Sverige omkring 1770–1870 (*Uppsala 2004).

14 According to a Gallup Poll in 1942, 18% of the Swedish population had visited a homeopath, traditional healer or a naturopath, and one out of 7 believed in homeopathy. ("Var 7:de svensk tror på homeopati", *Arbetet* 12/3 1942.) When a Parliamentary Commission on Quackery investigated those practicing what was considered quackery in the 1950s, homeopaths constituted by far the most common category: 305 of the 497 who were counted. (SOU 1956:29 *Lag om rätt att utöva läkarkonsten: Förslag avgivet av kvacksalveriutredningen* (Stockholm 1956). In the mid 1980s, it was found that 22% of the population had visited some kind of practitioner of alternative medicine: 13% had undergone some kind of chiropractic treatment, and 4% had undergone homeopathic treatment. *(Fakta och röster om alternativ medicin: En delrapport från alternativmedicinkommittén*. Stockholm 1987.) In the County of Stockholm in 2000, 7% had experienced homeopathy in a lifetime perspective, but only slightly more than 1% had used it in the last year. (*Stockholmare och den komplementära medicinen. Befolkningsstudie angående inställning till och användning av komplementär medicin genomförd under år 2000 i Stockholms läns landsting*. M. Eklöf and G. Tegern. Stockholm 2001.)

15 Anne Taylor Kirschmann, "Making Friends for 'pure' homeopathy: Hahnemannians and the Twentieth-Century Preservation and Transformation of Homeopathy", in R. D. Johnston, ed., *The Politics of Healing. Histories of Alternative Medicine in Twentieth-Century North America* (New York and London 2004), pp. 29–42.

16 Charles Webster, "Medicine and the Welfare State 1930–1970", in R. Cooter and J. Pickstone, eds. *Medicine in the 20th Century* (Amsterdam 200), pp. 125–140.

Early Homeopathy in Sweden

According to Swedish medical regulations (*Medicinalordningar*) from 1688, physicians had a monopoly on internal medicine, and practice in this field of medicine by other occupational groups or by laymen was prohibited. Homeopathy practised by anyone other than medical doctors was thus considered criminal, although fines for violating this regulation were low. In the period around 1900, the medical profession organised itself and demanded more effective laws against quackery. However, in 1915 the Swedish Parliament (*Riksdag*) instead chose to pass the Authorisation to Practice the Art of Doctoring Act, which allowed lay people to treat sick persons with only a few restrictions. Several reasons were given for this decision. There was still a shortage of physicians, especially in rural areas, and in the absence of conventional medicine, traditional folk healers were considered able to do some good. Certain Members of Parliament argued that people should have freedom of choice concerning whom to go to regarding matters of health, and that the only possible scientific stance was one that also permitted freedom of thought in medical science. Last but not least, some MPs had also had positive personal experience with homeopathic treatment where conventional doctors had failed, and they were not prepared to make the practice of lay homeopathy illegal. The principle of allowing lay healing instead of giving the medical profession a monopoly is still in force in Sweden, although laws and regulations have changed.[17]

During the first three decades of the twentieth century, homeopathy became the most widespread and widely discussed alternative to conventional medicine. The latter had problems in proving its superiority in practice over traditional folk medicine (still widely used in the countryside), natural healing and homeopathy. Patients, practitioners and a handful of homeopathic physicians – Swedish doctors and homeopaths with degrees from homeopathic medical schools in North America – joined together in study groups and organisations, started newspapers, and tried to get homeopathy tested by conventional medicine and more widely used in the population. Homeopathic remedies were either produced privately or imported from German manufacturers. According to regulations in effect in 1913, homeopathic remedies were classified as pharmaceutical preparations (*apoteksvara*) and could be produced and were to be sold in pharmacies.

In the 1930s times got harder for homeopathy in Sweden, as a result of various factors.

In the ongoing project of building up a welfare state, public health became a matter of great importance.[18] Education campaigns aimed at getting the public to

17 Motzi Eklöf, *Läkarens ethos: Studier i den svenska läkarkårens identiteter, intressen och ideal, 1890-1960* (Linköping 2000).

18 Karin Johannisson, ”Politisk anatomi”, in K. Johannisson, *Kroppens tunna skal: Sex essäer om kropp, historia och kultur* (Stockholm 1997), pp. 219–257; Jan Sundin, Christer

turn to medical doctors instead of "quacks", meaning unauthorised practitioners in the field of medicine. The provincial doctor was described as probably the most prominent reformer and revolutionary in the country, whereas it was thought that the priest was delaying progress.[19] The new director general of the Swedish Royal Medical Board as of 1935, Social Democrat Axel Höjer (1890–1974), declared that he would launch an attack on homeopathy. There were several attempts by the Medical Board to deter the use of homeopathic remedies, including requiring a doctor's prescription in order to obtain them, and prohibiting the import of these remedies, but these attempts did not receive sufficient political support.[20]

One case after another concerning alleged violations against the Authorisation Act were tried in court, with mixed results.[21] The press took the initiative in not publishing advertisements for homeopaths and other lay healers, and the medical profession even tried to prevent announcements of meetings of homeopathic associations.[22] The Association for Swedish Homeopathic Physicians (*Svenska homeopatiska läkareföreningen*), founded in 1912, slowly died out when it did not succeed in getting conventional medicine to take an interest in homeopathy.

In addition, the course of events in other countries also raised concerns. Political developments in Germany in the 1930s, including Nazi interest in natural healing and homeopathy, were discussed in the Swedish press. Some vociferous medical doctors considered measures that were taken based on race biology to be quite adequate, but were definitely hesitant to support homeopathy.[23]

After World War II, there were almost no physicians left in Sweden to defend homeopathy, and there was only one known homeopath with a proper education from a homeopathic medical school in the U.S. There were no private homeopathic schools in Sweden, no support from academic medicine, no homeopathic hospital, and no results from clinical trials to present. The private market was left to laymen; some of them had a full-time practice in the city, others travelled around and saw clients in hotels and restaurants in the countryside, a few hours here and a few

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Hogstedt, Jakob Lindberg and Henrik Moberg, eds, *Svenska folkets hälsa i historiskt perspektiv* (Stockholm 2005).

19 Ludvig Nordström, *Lort-Sverige* (Stockholm 1938), for example p. 23.

20 *Specialitetskungörelsen och de homeopatiska läkemedlen jämte Homeopatiens ställning i Storbritannien och Tyskland*, Svenska föreningen för vetenskaplig homeopati & Svenska homeopaternas riksförbund (1954).

21 Motzi Eklöf, „Doctor or Quack: Legal and Lexical Definitions in Twentieth-Century Sweden", in R. Jütte, M. Eklöf and M. C. Nelson, eds, *Historical Aspects of Unconventional Medicine: Approaches, Concepts, Case studies* (Sheffield 2001), pp. 103–117.

22 See, for example Homeopatiskt möte blev bojkottat. Biljettförsäljning och reklam stoppades. Polismästaren censurerade sandwichplakat", *Homeopatiska Husläkaren* 6 (1937), pp. 144–146.

23 For this debate, see Motzi Eklöf, "'…ein staubiges Spinnennetz am frischen Baum der medizinischen Wissenschaft': Homöopathie in Schweden", *Medizin, Gesellschaft und Geschichte* 22 (2003), pp. 201–232. The Swedish Institute for Race Biology was founded in 1921.

hours there.[24] The more serious homeopaths were concerned about the low standard of practice of some of these "homeopaths".

In spite of efforts to obstruct homeopathic practice and the non-existent academic support for homeopathy – or maybe partly because of this – public support for lay healing was still strong. According to a Gallup Poll in 1949, 18 percent of the population believed that "quacks" – meaning non-authorised practitioners like homeopaths, chiropractors and folk healers – were better at curing than medical doctors; another 6 percent were unsure.[25] Homeopaths received the most confidence: 16 percent believed them to be better than academically trained doctors, at least for some diseases. Confidence in quackery was reported to be slightly stronger amongst middle and working class people as compared to the upper classes, whereas it was considered noteworthy that people in rural areas believed in homeopathy to a somewhat lesser degree than the urban population.

When German manufacturers of homeopathic remedies had to start anew after the war, more Swedish firms began to produce and sell pills and tablets for the national market.[26] As early as the 1940s, rumours spread that some of the firms were cheating in producing the remedies. These rumours were mainly thought of as an element of rivalry between competing firms in order to gain market shares. In any case, the one homeopath who had been educated in North America raised serious concerns about the future of homeopathy in Sweden if the manufacturers did not act responsibly.[27] By about 1950, Drogon AB had managed to take over 50 percent of the market share for homeopathic remedies.[28] In 1951, the rumours of fraudulent activities were declared true, and the debate on the therapeutic basis for homeopathic practice was revitalised.

Religious and Medical Sectarianism

After 1945, the cultural debate in Sweden moved in new directions. The so-called "ideas of 1945" encompassed campaigns against fascism, communism, the monarchy, religion, the church, the clergy and systems of order. Sectarianism became a more general theme in the cultural debate. Fear of sectarianism, as well as the project of shaping a welfare state through consensus, played a central role in Sweden at

24 SOU 1956:29.

25 "En på fem tror mera på kvackare än läkare", *Sydsvenska Dagbladet* 6 April (1949).

26 Motzi Eklöf, „Läkekonst i motvind: Reklam för homeopati under svenskt 1900-tal", in R. Qvarsell and U. Torell, eds., *Reklam och hälsa: Levnadsideal, skönhet och hälsa i den svenska reklamens historia* (Stockholm 2005), pp. 74–101.

27 Hjalmar Helleday, "Ny redaktör för Homeopatiens Seger", *Homeopatiska Husläkaren* 6–7 (1947), pp. 103–105.

28 Interview with Bo Ramme, Göteborg, 6 September 2002.

this time: in politics (with the hunting down of communists during the Cold War), in religion (turning against the State church, but also against Free Churches, particularly with respect to faith healing), concerning sexuality (with male homosexual networks and conspiracies depicted as a great threat to society)[29], and medicine (medical cults, represented here by homeopathy). In the case of homeopathy in Sweden, some of these areas coalesced in one way or another. Sectarianism in this respect related not only to alternative theories or ideologies, but also to private and – as feared – subversive practices that lay outside societal control.

One of the most prominent exponents of the "ideas of 1945" was Ingemar Hedenius (1908–1982), professor of philosophy at Uppsala University from 1947 to 1973.[30] In the spring of 1949 Hedenius published his book *Tro och vetande*, (Belief and Science),[31] thereby initiating one of the most intensive cultural debates that has ever taken place in Sweden, and exerting great influence on the general intellectual climate in the country.

In his memoirs, Hedenius later wrote that he had always wanted to disclose humbug and that he intended to prove Christianity to be false and incompatible with the modern ideal of education and Bildung. "Only science is worthy of being wholeheartedly believed in second-hand".[32] The current standpoint of science could be accepted in good faith, while one had to prove everything else. Real Bildung meant being rational and adhering to science. A person in good mental health safeguarded his freedom of thought, and religious fanatics could not be considered healthy.[33] It was thought that holistic world and life views did not hold up to scientific scrutiny. Supporters of these holistic views were described as "victims of pathetic belief", willing to believe in the incredible, having a belief based on feelings, associated with passions, although not necessarily religious faith.[34]

Both then as well as today, the book is considered the starting point of real secularisation in the country.[35] Hedenius' views were in accord with the generally asserted "death of ideologies", later a postmodern critique of the "master narratives". They fit in well in the cultural climate of the time, dominated by strong

29 Göran Söderström, ed., *Sympatiens hemlighetsfulla makt: Stockholms homosexuella 1860–1960* (Stockholm 1999). See in particular articles by Söderström in this volume.

30 Svante Nordin, *Ingemar Hedenius – en filosof och hans tid* (Stockholm 2004), pp. 136ff.

31 The Swedish word "tro" is used as both belief and religious faith, a fact which in this context gives the double meaning a third associative importance.

32 Ingemar Hedenius, *Tro och vetande* (Stockholm 1949), p. 29.

33 Nordin, *Ingemar Hedenius* (2004), p. 175.

34 Hedenius, *Tro och vetande* (1949), pp. 44ff.

35 Ingemar Hedenius was actively supported by the publisher Herbert Tingsten, chief editor of the liberal and culturally radical daily newspaper *Dagens Nyheter*, considered the most important forum for cultural debate in Sweden. See Nordin (2004), pp. 178ff.

support for science and progressive development, whereas Christianity and the church represented something antiquated.[36]

State religion was in the process of losing its cultural influence, as were the Free Churches, which were considered to be sectarian.[37] It became difficult for the State to require all citizens to adhere to the Christian faith and to be members of the State Church. In 1951, the Freedom of Religion Act was passed by Parliament. Thereafter, people were allowed to leave the State Church without joining another church, as was previously required.

The medical community considered homeopathy to be based on belief, if not on faith, and any therapeutic gains were considered to be the results of suggestion.[38] In the 1934 trial of a female faith healer, the Supreme Court stated that her method could be used to induce a hypnotic state in the patient, which was an offence against the Authorisation Act. According to this redefinition, her activities could be considered criminal, and the woman was fined.[39]

In early 1950, the American faith healer William Freeman was invited to Stockholm by the Pentecostal Movement, and his public activities raised concerns about religious quackery. In February 1950, representatives of this movement and of homeopathy were invited by Swedish radio to discuss faith healing together.[40] In the same year, there were radio broadcasts of lectures on "Quackery and faith healing", where medical doctors talked about "quackery under the cloak of religion".[41]

Not only was homeopathy described in religious terms as a kind of faith healing; the Pentecostal Movement was in turn described using medical terminology as a "spiritual contagion".[42] Quacks were often identified as being former nonconformist preachers, when they were not portrayed as real criminals trying out new ways of making a living.[43] In fact, more than a few lay homeopaths in Sweden were mem-

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36 Johan Lundborg, *När ateismen erövrade Sverige: Ingemar Hedenius och debatten kring tro och vetande* (Nora 2002), especially p. 301.

37 See, for example, Carl-Gustaf Thomasson, " Kvacksalveriet i Sverige: Några synpunkter och data", *Social-Medicinsk Tidskrift* 3–5 (1952).

38 Thomasson 1952 deals here with religious sectarian healers, with homeopaths constituting one group.

39 Eklöf, "Doctor or Quack" (2001), pp. 103–118.

40 *Radiodebatten om helbrägdagörelse och homeopati. Det homeopatiska inslaget och pressens referat* (Stockholm 1950). Homeopathy had been debated on the radio as early as in 1943, but then only with representatives from homeopathy and the medical profession; this event was optimistically called "a milestone" in the history of Swedish homeopathy: "Homeopatien i radion. En milstolpe i den svenska homeopatiens historia", *Homeopatisk Journal* 3 (1943) 10, pp. 43ff.

41 Svenska läkartidningen/Swedish Medical Journal (1950) 47, pp. 569–575.

42 "Pam" (pen name) "Pethri fiskafänge", *OBS!* 8 (1951), pp. 45–48.

43 Arvid Wachtmeister, "Kvacksalveriet och rättvisan", *Svenska läkartidningen/Swedish Medical Journal* (1951), 48, pp. 354–367. On 20 February 1950, the newspaper *Expressen* reported that a minister of a Free Church, also a faith healer and homeopath, was being tried in court for

bers of a Free Church. They found support for their homeopathic practice in the Bible, and felt it was their duty to treat sick fellow human beings when they had found the means to do so. Further, the non-invasive character of this healing method suited their notion of the body as a temple of God that had to be handled with care. A prosecuted staff member of one of the homeopathic firms was a well-known member of the Pentecostal Movement. This led the press to declare that the connection between the homeopathic humbug and its "religious counterpart" in the circles around the leading figure Lewi Pethrus (1884–1974) had now become clear.[44]

The conventional medical profession's longstanding use of the terms "sects" and "sectarianism" in connection with alternative healing systems, as opposed to scientific medicine, has been well described by medical historians.[45] In the United States, a shift in vocabulary occurred in the 1920s and 1930s.[46] Those falling "outside" organised medicine were now designated as "cultists" rather than as "sectarians". This new terminology suggested that these groups sought not only to convert patients to a belief in an alternative medical view, but also to dangerously and deliberately brainwash the public. The term "cult" linked different kinds of healers together such as practitioners of Christian Science, naturopaths and homeopaths. In Sweden, this notion of "medical cults" could also be associated with more serious criminal acts like murder, as in the case of the so-called "Sala-liga" in the 1930s.[47]

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violations against the "quackery" law; he was later freed. Another example: "Metodistpastor var kvackare, tbc-sjuka ordinerades massage", *AT* 28 February (1951), he was also a homeopath.

44 Ed., "Pillertrillarna", *OBS!* 16 (1951), pp. 3–5.

45 See e. g. John Harley Warner, "The 1880s Rebellion against the AMA Code of Ethics: 'Scientific Democracy and the Dissolution of Orthodoxy", in R. B. Baker, A. L. Caplan, L. E. Emanuel and S. R. Latham, eds, *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society (*Baltimore and London 1999), pp. 52–69; Paul Root Wolpe, "Alternative Medicine and the AMA", in R. B. Baker et al, eds (1999), pp. 218–239; several articles in R. Jütte, G. B. Risse and J. Woodward, eds, *Culture, Knowledge and Healing: Historical Perspectives of Homeopathic Medicine in Europe and North America* (Sheffield 1998); Naomi Rogers, *An Alternative Path: The Making and Remaking of Hahnemann Medical College and Hospital of Philadelphia* (New Jersey 1998).

46 Rogers 1998, pp. 105–6; Rennie B. Schoepflin, *Christian Science on Trial: Religious Healing in America* (Baltimore & London 2003). In the *Swedish Medical Journal*, the term "therapeutic cults" was introduced as late as 1973 as an index term, following MeSH, Medical Subject Headings. For example, articles on naprapathy are commonly indexed under "therapeutic cults", when not referred to "quackery" as was done in 1988. See Motzi Eklöf, "Kvacksalveriet – hett debattämne under hela seklet", *Läkartidningen* 1–2 (2004), pp. 115–122.

47 The leading figure in the "Sala-liga", Thurneman, started off as a hypnotist, practising yoga and organising a Magic Circle comprised of his accomplices. They were later sentenced to lifetime imprisonment for several brutal murders. Thurneman was considered mentally disturbed and was committed to a mental hospital. C-O Bernhardsson, "'Professor' Thurneman", in *Brottets krönika. II. Märkliga kriminalfall under 100 år/Annals of Crime* (Stockholm 1955), pp. 586–599.

In the 1950s, the question of homeopathy and sectarianism was not only discussed within the medical profession; now it had become a more general theme, engaging broader spheres of society. Sympathy for lay healing was said to be especially strong among Free Churches and other sectarians.[48] At this time, the connections made between homeopathy and faith healing definitely failed to give homeopathy more credibility and legitimacy. The debate on belief as opposed to science made support for homeopathy even more impossible on a discursive level.

Media and the Pharmaceutical Industry

In parallel with discussions concerning religion and the superiority of science, representatives of medical research and the pharmaceutical industry made efforts to gain stronger societal and financial support for their endeavours and more than once, the press made common cause with representatives of the pharmaceutical industry and medical authorities in this regard.

For example, in 1942, *Vi*, the weekly paper of the consumers' co-operation, published a special issue on "The researcher, the physician, the people", pleading for free medical research as a prerequisite for progress, arguing against quackery, and urging people to go to a (real) doctor in time.[49] Greedy homeopaths, earning millions from useless remedies, were the focus of a 1947 article in the journal *Folket i Bild*. According to an interview with the director-general of the Medical Board, more medical doctors and the prohibition of lay healing were needed in order to fight the problem.[50] In late 1949, two well-informed articles on homeopathy and the manufacture of homeopathic remedies in Sweden were published by a right-wing, bi-monthly journal called *OBS!*.[51] The author, using the pseudonym "Montanus", was Matts Bergmark (1912–1980), a graduate engineer working in the pharmaceutical industry. In the following decades, under his real name, he became one of the most productive and well known writers of popular medical history in

48 Thomasson 1952, pp. 6, 8.

49 "Forskaren, läkaren, folket", *Vi* 14 February, 7 (1942). Some of the authors in *Vi* were later active in the debate concerning homeopathy in the 1950s, like Georg Kahlson och Gustaf Myhrman from the medical profession, Håkan Rydin, head of the State Pharmaceutical Laboratory and Arne Tallberg, journalist.

50 Jens Capare, "Homeopaterna tjänar 7,5 milj. per år", *Folket i Bild* 5 (1947), pp. 8–9, 46.

51 According to one of the accused manufacturers, DW, the articles were based on previous published articles in the journals *Socialdemokraten* and *Folket i Bild*, written by a C. J., a friend of the company director of the other fraudulent firm (see note 50). Pretrial investigation protocol Wednesday, 5 December 1951, registration no. 115/1952, B no. 119/1952. Stockholm City Court, Division 24, Judgements in Criminal Cases, 1952, A1:2, pp. 1694–1695.

Figure 2. Cartoonist Poul Strøyer illustrated an article entitled "160 (Swedish) crowns for one kilo of sugar – 60,000 crowns for a headache pill: Homeopaths and the Swedish people" in the journal *OBS!* (1949), p. 10.

Sweden.[52] The main argument in the articles in *OBS!* was that homeopathic remedies were sugar pills that were cheap to produce and that were earning a fortune for their producers, but that were totally worthless from a medical point of view. "Montanus" contended that the treatment of ill health always included irrational elements, but this did not legitimise the production and selling of useless homeopathic remedies.

The articles in *OBS!* were praised by a Social Democratic MP, Rickard Lindström (1894–1950).[53] Some weeks later he submitted a bill to the Swedish Parliament for a total prohibition of lay practice. The proposal became the focus of intense discussion, but was finally rejected in both chambers.[54] In 1950, Lindström

52 Montanus (pseudonym for Matts Bergmark), "160 kronor för ett kilo socker – 60.000 kronor för en huvudvärkstablett: Homeopaterna och svenska folket" *OBS!* 23 (1949), pp. 6–11; Montanus, "Frigjord atomenergi à 2:- per glas!", *OBS!* 24/25 (1949), pp. 73–78. Bergmark later wrote articles in *OBS!* under his real name. He also criticised Social Democrats for almost abolishing compulsory vaccination some years earlier and for supporting the idea of a chiropractic school. In 1976 he became an honorary doctor in medicine.

53 Letter from Rickard Lindström to the journal OBS! *OBS!* 24/25 (1949), p. 79.

54 Also cited in the medical press: "Motion i första kammaren angående behörighet att utöva läkekonsten", *Svenska läkartidningen* (1950), pp. 264–272.

also attacked the faith healing movement in Parliament.[55] Political support for the total prohibition of lay healing was lacking, but a committee – "*Kvacksalveri-utredningen*" – was set up to investigate other possibilities.[56]

In 1950, a reporter for the daily newspaper *Expressen* wrote a lengthy article on homeopathy together with Håkan Rydin, professor at the State Pharmaceutical Laboratory (Statens farmaceutiska laboratorium).[57] When the fraudulent manufacturing of homeopathic remedies had become a case for the court, the editors of the journal *OBS*! wrote to the State Pharmaceutical Laboratory and demanded that proper measures be taken against homeopathy.[58] A recurrent argument was that people were cheated out of their money when buying homeopathic remedies.

Medical and Economic Fraud

In the absence of political success regarding demands for restricted lay healing and homeopathic practice, legal proceedings against lay healers created new pathways. New legal tactics and new arguments in court focusing on the economic aspects of "quackery" resulted in convictions for violating the law.

In early 1951, the so-called Sulphur Doctor (Svavel-doktorn), as he was called in the press, was charged with – amongst other things – having prescribed and sold remedies consisting of washed flowers of sulphur. The preparations, which also contained other chemicals, were prescribed to hundreds of people for a variety of different ailments. Testimony by an expert from the Department of Pharmaceuticals at the Medical Board made it clear that a therapeutic effect from the oral intake of sulphur could not be expected. Although the products were considered useless (and unhealthy) from a chemical and medical point of view, quite a number of patients reported having experienced positive effects from the sulphur remedy.[59]

Previously, lay healers had usually been charged with violations against the Authorisation Act, termed quackery that is dangerous to health (hälsofarligt kvack-

55 "Kvacksalveri är en trossak", *Göteborgs-Tidningen* 28 April 1950.

56 SOU 1956:29.

57 Bernt Bernholm and Håkan Rydin, "Svenskarna kastar bort miljoner per år på overksamma läkemedel", *Expressen* 27 March 1950. See also note 45.

58 Ed., *OBS!* 1951.

59 Documents from criminal cases no. 390, 1951. F1:122 a and b. Verdict on 17 May 1952. Svea Court of Appeal, Division III: B 60. Svea Court of Appeal Court Archives. National Archives, Arninge (Stockholm). See, for example, pretrial investigation protocol, 19 June 1951, or p. 4397 in a letter from PJ to cabinet minister Gustaf Möller. In the latter it is reported that the police had confiscated J.'s patient register comprising 592 names. The police wrote to all of them to ask if the remedy had made them worse. 341 persons responded, 70% of whom reported that they had felt good, better or were recovered.

salveri). What was new in this trial was that this paragraph was not applied. Instead, the Sulphur Doctor was accused of fraud (bedrägeri). According to the law, the crime was considered to be especially heinous if the prosecuted person had misused public confidence.[60] The municipal court sentenced the Sulphur Doctor to three years' imprisonment with hard labour for having committed serious fraud, on the grounds that he had falsely claimed that his remedies were effective, thus getting people to pay for his preparations.[61]

The verdict in this case was considered a test case with respect to upcoming trials; for the first time a quack was convicted and sentenced for fraud, for knowingly having misled customers. The new strategy of charging lay healers with fraud instead of health quackery was successful, and was later identified as the winning concept in the coming homeopathic pill trials.[62] The shift in focus from the practitioners, and alleged assaults against the Authorisation Act, to the remedies per se, and from what was considered medical fraud to economic fraud, met with success.[63] An ambitious prosecutor played a central role in this process.

The Prosecutor and the Scandals

In the 1950s, attention was drawn to several so-called "affairs" and "scandals" in which prominent representatives of the state bureaucracy, monarchy, church and legal sphere were accused of, and sometimes convicted for, having committed

60 Chapter 21, §1 in the criminal code at the time on "bedrägeri och dylik oredlighet": "The person who uses deception to induce someone to commit acts or omissions that involve gain for the offender and injury to the person who is deceived or someone in that person's place, is to be convicted of fraud and sentenced to penal servitude for a maximum of two years or to prison." §3: "As stated previously in this chapter, if the crime is considered serious in view of the circumstances concerning the crime the person shall be convicted of serious fraud and sentenced to penal servitude for a maximum of six years. In judging whether the crime is serious, what should particularly be taken into account is if the offender misuses public confidence or makes use of false documents or deceptive bookkeeping, or if the crime is otherwise of an especially dangerous type, is of significant value, or involves extremely serious injury."

61 Verdict announced on 7 May 1951 against PJ. Case no. B 309/1950. Stockholm City Court, Division 8. Verdicts in civil criminal cases in 1951, A1:8 DB no. 195. Stockholm City Archives. After a psychiatric examination the sentence was transformed into "imprisonment in a maximum security facility".

62 "Mirakelpiller", in C-O Bernhardsson, *Brottets krönika. I. Ur kriminalpolisens annaler* (Stockholm 1954), pp. 380–388.

63 Other criminal connections were also disclosed at the time of the trial against the Sulphur Doctor. The press wrote about a "huge homosexual tangle", in which a homeopath and speech therapist was sentenced to one year's imprisonment for criminal homosexuality with underage boys. "Homosexuell jättehärva, nära 500 barn inblandade", *Sydsvenska Dagbladet* 10 April (1951); "Homeopat fick ett år för h-sex", *Arbetaren* 11 June (1951).

Figure 3. "I don´t like people paying big money for sweets, prosecuter Lennart Eliasson declared, and tasted some of the confiscated sugar pills". Photo from Bernhardsson, *Brottets krönika I* (1954), p 385. Eliasson was a member of the editorial board for this volume.

offences not only against the law but also against societal decency in general.[64] In the cultural debate, calls were made for a general "housecleaning" in the higher spheres of society – not the least because these "scandals" were considered to influence those at lower levels of society to behave in deviant, disloyal and anti-social ways.[65]

At this time, prosecutor Lennart Eliasson became a well-known symbol of strong action against fraudulent and scandalous behaviour. His career began with the trial of the Sulphur Doctor, and continued with the homeopathic pill trials. All these trials were turned into mammoth events; one of the two pill trials was already being described as "one of the greatest criminal cases the Swedish justice system has ever

64 Names like Kejne, Haijby, Enbom, Unman, Selling, Helander and Lundquist all became associated with the concept of "affair".

65 See, for example, Marie Cronqvist, "Fula fisken och stenansiktet: Spiontypologi och kallakrigsberättelse i 1950-talets folkhemsgemenskap", in K. Salomon, L. Larsson and H. Arvidsson, eds., *Hotad idyll: Berättelser om svenskt folkhem och kallt krig* (Lund 2004), pp. 57–80, and in the same volume also Sara Kärrholm, "Pusseldeckaren och folkhemmets bortträngda mörker", pp. 81–109.

had".[66] Eliasson was also a committed man outside the courtroom. In March 1952, on the very same day the municipal court in Stockholm announced its verdict in one of the two homeopathic trials, he wrote to the Swedish Medical Board and proposed measures to be taken against homeopathy.[67] After these trials, he proceeded with a case against a prominent representative of the Swedish justice system who was accused of having cheated people of their money. Several years afterwards, it became clear that Eliasson had lost 20 out of 25 charges in this case in the Supreme Court, but this was long after his morals, energy and skill had been paid homage to in the media.[68]

Lennart Eliasson collaborated with police reporters and consciously made use of the media in order to spread his views of the events in question. Journalists paid tribute to the press as the institution that had made the greatest effort to enlighten people about matters concerning quackery.[69] In 1955, readers of the newspaper *Aftonbladet* elected Eliasson "Swede of the Year", beating UN Secretary General Dag Hammarskjöld by 10,000 votes.[70] The following year he was elected to Parliament as a member of the Liberal Party. Throughout the 1970s and 1980s he continued to be portrayed as the "Standard Bearer of Justice" ("Rättvisans Ryttare").[71] His ambitions were well in tune with the Zeitgeist of the 1950s.

Public Health and Modernisation of Health Care

In the early 1950s, lay homeopaths comprised three out of five "quacks" in Sweden.[72] The so-called homeopathic "pill scandal" and the mass media attention surrounding it, can be seen as an important symbolic turning point in the carefully prepared process of transformation of health care that had started in the mid 1930s and continued until the 1970s. This was a publicly declared break with an older medical marketplace that was characterised by a relative shortage of physicians, therapeutic uncertainty, and an enforced and reluctant acceptance of rural folk medicine and lay healing. The time was now ripe for a rapidly expanding, modernised hospital-based health care system founded on solid scientific grounds under strong societal influence. In Sweden, medical expenditures nearly doubled in the

66 "Mirakelpiller", in Bernhardsson 1954, p. 385.

67 Eliasson to the Swedish Medical Board 15 March 1952.

68 Sven Standar, "Lundquistaffären", *Morgonbladet* 11 July (1957).

69 "Vi diskuterar: Bot mot kvackare", *Expressen* 23 April (1951).

70 Börje Heed, "Årets svensk en 'rättvis karl': Hela svenska folket tackar Lennart Eliasson", *Aftonbladet* 19 January (1955).

71 Claes Sturm, "Lennart Eliasson, rättvisans ryttare", *Dagens Nyheter* 22 August (1971); Bo Engzell, "Rättvisans ryttare stiger ur sadeln", *Dagens Nyheter* 24 August 1980.

72 SOU 1956:29, p. 86.

ten-year period between 1950 and 1960.[73] Disclosure of the fraudulent nature not only of a few manufacturers of homeopathic pills and tablets, but also of homeopathy as such, was meant to get the deceived, yet now hopefully and finally enlightened people to support the authorities in the development of modern health care.

It had long been the case that labels of "sectarianism" applied to different types of alternative medicine by conventional medicine in Sweden had been considered mainly as a rhetorical expression of an intra-medical rivalry, and of little interest to practical health care. At the beginning of the twentieth century, politicians could justify allowing lay healing based on the principle of freedom of choice in matters of both therapy and scientific theories. Several decades later this was no longer possible. Medical science had advanced, new drugs had radically changed medical practice, and consensus was required regarding the project of economic growth and modern health care. Following World War II, medical science gained broader societal legitimacy, both in science and in therapeutic practice, for its claims of superiority – although not based only on its own efforts but also in conjunction with other processes in society. Medicine was supposed to leave behind the notion of a "healing art" in favour of "medical science". Politicians were still not inclined to prohibit lay healing, but it was medical science that was to receive full support.

But societal support for science was and is not the same thing as the medical profession gaining legitimacy for its professional efforts. The Social Democratic director-general of the Swedish Medical Board, Axel Höjer, proposed reforms of Swedish health care that the Swedish Medical Association considered threatening to the autonomy and economy of the medical profession. The Association had much less success in negotiating with the State than was the case for the medical faculties.[74] In 1951 the Association finally adopted a written code of ethics in order to demonstrate the high moral standing of the profession – particularly in comparison with that of other healers – and its ability to make decisions concerning issues of its own, as an answer to threats to the profession emanating from both within and outside of the profession.[75] However, in the immediate post-war years the time was not yet ripe for all the radical reforms that were proposed, and which were leading to "socialised health care" according to the Medical Association, Nevertheless, this was not due solely to the resistance of the Association. It took some years, even decades, before the reforms were implemented, one after the other. In this process of

73 Webster, "Medicine and the Welfare State" (2000), p. 127.

74 Bo Bjurulf and Urban Swahn, „Health Policy Proposals and What Happened to Them: Sampling the twentieth-century record", in: A. J. Heidenheimer and Nils Elvander, eds, *The Shaping of the Swedish Health System* (London 1980).

75 Eklöf, *Läkarens ethos* (2000); Motzi Eklöf, "Kollektiva etiska regler inget för svenska doktorer: Först 1951 antog den svenska läkarkåren motvilligt en codex ethicus", *Läkartidningen* 37 (2001), pp. 3930–3932.

reforming Swedish health care, support from the medical profession was needed. The measures taken against lay healers and homeopathic remedies in the years that followed can be seen as part of this policy.

In 1956, general sickness insurance made it necessary for patients to turn to conventional physicians in order to get reimbursement. The Authorisation Act from 1916 was divided into two sections in 1960: one concerning authorised practice by physicians, and the other concerning non-authorised activities with the addition of more extensive restrictions regarding lay healing.[76] Homeopathic remedies were excluded from Swedish pharmaceutical legislation in 1964, and were definitely no longer to be sold in the pharmacies that were nationalised ten years later.[77] With the new laws in the 1960s, the health care arena was split into two more well-defined sectors with separate regulations: not only authorised contra non-authorised practitioners, but also real "pharmaceuticals" contra homeopathic remedies, which were now "free trade goods" – in accordance with the view that they were pure sugar candies. The last of the reforms proposed earlier was implemented in 1970, when the so-called Seven Crown Reform radically lowered and equalised the costs for visits to conventional health care. Lower fees and a shortage of physicians were no longer to be reasons to turn to popular healers. The difference between what was considered "proper" medicine and not medicine at all was made clear through different legislative measures – the former getting societal support, the latter being tolerated but excluded from the health care system.[78]

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76 Some restrictions were desired by the homeopathic organisations, e.g. prohibition of itinerant practice and practice by foreigners. These paragraphs have in later years been deleted from the law.

77 This was a political strategy to "save" homeopathic practice in Sweden, also desired by the homeopathic organisations as the next-best solution, with status quo as the best alternative. The Medical Board still wanted homeopathic remedies to be included in the regulations for pharmaceutical specialties and to be judged by the same standards as for other pharmaceutical products. This would in reality have resulted in the homeopathic remedies being prohibited – which the Medical Board admitted was the whole point. Homeopaths regarded the new law as "a victory". See S. H. Ramme, *Kommer de homeopatiska läkemedlen att förbjudas? Om läkemedelsutredningens framlagda förslag lagfästes kommer det att till sina konsekvenser medföra förbud för alla homeopatiska mediciner. Till Eder information överlämnas härmed en del uppgifter i detta viktiga ärende* (Göteborg 1961); "Yttrande i anledning av 1946 års läkemedelsutrednings betänkande", *Tidskrift för homeopati* 3 (1961), pp. 49–66; "Läkemedelspropositionen inför riksdagens avgörande", *Tidskrift för homeopati* 4 (1962), pp. 73–79; "Ny homeopatisk lagstiftning. De homeopatiska organisationernas insatser", *Tidskrift för homeopati* 1 (1963), pp. 1–3.

78 In 1993 a new law regarding pharmaceuticals stated that homeopathic "products" should be registered by the Medical Products Agency in order to be permitted to be sold on the Swedish market. No indication for use was to be allowed, nor was any judgement regarding efficiency.

Homeopathy and the 1950s – Some Concluding Remarks

Homeopathy, as practised both within and outside conventional medicine, had been under attack from the organised medical profession and the Medical Board since the nineteenth century. The relatively new and evolving scientific arguments and changing legal tactics in the 1950s were effective. Increasing societal support for medical science and reformed health care, in combination with a desire to get rid of reminders of old times were important factors regarding the almost complete extinction of homeopathy from the discursive level. In the rapid process of modernisation of Swedish society, official support for "old" medicine could not be retained.

The social and cultural associations connected to homeopathy at this time – not only belief and religious faith, but also deviant, fraudulent and criminal activities – facilitated the pronouncement of the end of this kind of healing. Homeopathy was designated an outdated dogmatic healing system based on belief and suggestion. It was considered unnecessary in modern society, where the whole population had sufficient access to rational medicine that was based on the results of scientific research. Claiming a "belief" in homeopathy in order to prove one's innocence in the pill trials – as was done by a prominent lay homeopath – was an argument with absolutely no persuasive power at a time when scientific proof in terms of chemical analysis or clinical trials had become all that mattered.

In Sweden, there were no homeopathic physicians left to discuss homeopathy on an academic level, and no prerequisites for homeopathic practice to adhere to some extent to scientific standards, as was the case in other countries such as the US.[79] Nor was conventional medicine open to the assimilation or integration of any part of homeopathy into mainstream medicine. Articles critical of homeopathy were given much space in the press, whereas voices favourable to this healing system were published – if at all – only as short letters to the editor. For decades after the homeopathic trials, the *Swedish Medical Journal* did not even mention homeopathy.[80] The "pill scandal" was a symbolic event with great impact on the public debate. Homeopathy was eradicated from the discursive level in society.

Nevertheless, despite the fact that homeopathy was heavily discredited in public arena, it did not vanish from the scene. People relied on their own experiences of homeopathic treatment. The press reported on persons bursting into tears in pharmacies when they realised they could no longer get the remedies from the fraudu-

79 John S. Haller, *The History of American Homeopathy: The academic years, 1820–1935* (New York 2005); Naomi Rogers, "Ärzte, Patienten und Homöopathie in den USA", in: Dinges, *Weltgsechichte der Homöopathie*, ed. (1996); Rogers, *An Alternative Path* (1998). In the US, criticism of the low standards at medical schools, both conventional and nonconventional, contributed as early as around 1900 to the closing of many schools – thus before the Flexner report in 1910 with its massive criticism – while with time, many homeopathic schools relinguished their homeopathic identity and were converted into conventional medical schools.

80 Eklöf, "Kvacksalveriet" 2004.

lent firms.[81] In the northern region of Jämtland, pharmacies reported no decrease in the sales of homeopathic products.[82] Sales figures for these remedies decreased only marginally for a year or so; the best economic results were attained in the 1980s.[83] As in many other Western countries at that later time, "alternative medicine" had become an issue in the public debate. Homeopathy has continued to exist, but in Sweden it has not recovered the more widespread and publicly defended position it held during the initial decades of the twentieth century. The number of medical doctors daring to articulate a positive interest in homeopathy can easily be counted. The Swedish Medical Board has not changed its judgement of homeopathy as being of no therapeutic use beyond a placebo effect.[84] As a consequence of political efforts to achieve a harmonisation of laws and regulations within the European Union, starting in May 2006 homeopathic products are – once again – to be classified as pharmaceutical products (although they are not to be sold at pharmacies). Continental medicine, with physicians openly practising homeopathy, has been criticised as being more "esoteric" as compared to supposedly more scientific Swedish medicine.[85] That homeopathy is more widely used by physicians within conventional health care in many other countries has never been an impressive argument in the Swedish debate.

The "pill scandal" of the 1950s is unknown to contemporary international manufacturers of homeopathic remedies, who are also represented in Sweden. Connecting the concepts of "fraud" or "quackery" with homeopathy is an unthinkable association for them.[86] The fraudulent activities of the 1950s may be forgotten, unknown or hushed up by homeopaths in Sweden today, but the effects of those associations with homeopathy at the time – with or without factual basis – remain. This emphasises the need for further studies in a wider socio-cultural context in

81 "Kvinna brast i gråt då hon nekades Drogon", *Aftenposten* 5 January 1952.

82 "Pillerförsäljningen oförändrad i Jämtland", *Dagens Nyheter* 5 January 1952. In the 1980s Jämtland was still the stronghold for homeopathy in Sweden. See *Fakta och röster om alternativ medicin* 1987, p. 47

83 This according to Bo Ramme, the son of the manager of another manufacturer of homeopathic remedies at the time, Drogcentralen in Göteborg, interviewed in Göteborg on 6 September 2002.

84 The National Swedish Board of Health and Welfare delivered an opinion to Uppsala University on 16 October 1986 regarding the Zetterling donation from 1874, intended for academic lectures on homeopathy. "Homeopathic remedies are nowadays not thought to be part of the therapeutic arsenal since they are no longer considered to meet requirements for active medical treatment." The National Swedish Board of Health and Welfare found that a parallel to placebo treatment was of relevance. Regarding the Zetterling donation, see Motzi Eklöf, "Om vetenskapens gränser och kolliderande kunskapsintressen: Exemplet homeopati", in I. Nordin, ed. *Rapporter från hälsans provinser. En jubileumsantologi* (Linköping 2004), pp. 221–235.

85 Bo Lennholm, "Intrikat fråga i dagsdebatten: Hur kan homeopatika ge effekt i kliniska studier?" Interview with Bertil Fredholm, *Läkartidningen* (1997), pp. 156–157.

86 Eklöf, "Läkekonst i motvind" (2005).

order to enhance our understanding of what factors facilitate or counteract the existence or relative non-existence of alternative medical cultures in different countries.

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Health Care between Medicine and Religion
The Case of Catholic Western Germany around 1800

Walter Bruchhausen

The relationship between medicine and religion belongs to the classical topics of medical history, in the studies of the so called early civilizations, mainly Egypt and Babylonia, of Greek and Roman antiquity, of the occidental and oriental Middle Ages and of the European early modern period. Yet about a century ago, preformed by enlightenment ideas on linear progress of humankind and often explicitly following Auguste Comte's cultural evolution theory of human development from magic via religion to science, many historians and sociologists dismissed any important role of religion in and for modern society. This was especially true for the view of health, illness and healing and has influenced the writing of medical history until today. Hence the period since the eighteenth century has been almost exclusively treated as an era with obvious characteristics: by that time science seemed to have excluded religion from medicine.

In Western societies during the last decades we should notice a phenomenon contrary to this alleged universal progress from religion to science. It was predicted early by the sociologist Peter L. Berger[1], recently also taken up by the leading social philosopher Jürgen Habermas[2], and received titles such as "the return of religion" and "desecularization" (Berger)[3], the "re-enchantment of the world" (a reversal of Max Weber's observations) and "postsecular world" (Habermas). The mere fact of this revival, which – not only in the forms of New Age esotericism, but also in more charismatic and spiritual movements within the Christian churches – concerns also healing centrally, already by itself justifies a new look at the historical relationship

1 Peter L. Berger, *A rumour of angels. Modern society and the rediscovery of the supernatural* (London, 1970).

2 Jürgen Habermas, *Glauben und Wissen. Friedenspreis des Deutschen Buchhandels 2001* (Frankfurt/M., 2001).

3 Peter L. Berger, ed., *The desecularization of the world. Resurgent religion and world politics* (Washington D.C., 1999).

between medicine and religion, that is less influenced by the nineteenth century's premises of medical historiography. Other circumstances, such as some regions, e.g. in the most Western part of Germany, where the vast majority of hospitals are run by the churches, or the influence of the churches worldwide in the bioethical discourse, add further motivations to focus on the role of religion and especially Christianity in modern health care. A return, however, to the classical studies of medical historians on church and medicine would certainly not be in line with the more recent ways of writing history. For the earlier authors, including prominent scholars like Paul Diepgen[4] and Paul Delaunay[5], took the existence of two distinct entities – of medicine, represented by the medical profession, on the one side and religion as embodied by the church on the other side – for granted. Their question was how the two supposed realms were intertwined, with regard to ideology, institutions and persons.

Since meanwhile in contrast to this rather static view, more anthropological, functionalist and social constructivist approaches have influenced our view of historical development the borders between medicine and religion are no longer given by nature or as an obvious distinction, but are the result of social processes. One type of such processes is the increasing functional differentiation. Following this idea of functional systems in society concentrating more and more on a central binary code, such as "diseased – not diseased" in medicine – an idea prepared by Talcott Parsons in the Anglophone world and influential mainly in German-speaking countries by the systems theory of Niklas Luhmann[6] – not only relations between medicine and religion, but primarily their continuing separation by functional differentiation should become a major subject of historians. On the other, the anthropological side which considers more the individual than social systems, concepts of cultural identity or mentality might explain why despite biomedicine's pledge of scientific objectivity and proof other ways of healing and looking on health and diseases have not disappeared completely.

Due to this double interest in social systems and mentalities the establishment of a social history of medicine should and indeed does increase an interest in the dialectic processes of secularisation in medicine. Secularisation has the double meaning of the more political and economic separation of state and church including expropriation of ecclesiastic institutions on the one side and of the more social and cultural loss of influence of the church on society and its functional systems on the

4 Paul Diepgen, *Über den Einfluß der autoritativen Theologie auf die Medizin des Mittelalters*. Abhandlungen der Geistes- und Sozialwissenschaftlichen Klasse der Akademie der Wissenschaften und der Literatur 1958, Nr. 1 (Wiesbaden, 1958).

5 Paul Delaunay, *La Medecine et L'Eglise* (Paris, 1948).

6 For medicine and religion cf. Niklas Luhmann, "Der medizinische Code", in N. Luhmann, *Soziologische Aufklärung*, vol 5 (Opladen 1990), pp. 183–195; *Funktion der Religion* (Frankfurt/M., 1982).

other side. Both developments have their noticeable impact on health care. For their study the period around 1800 during which the term "secularization" originates offers vast materials and examples.

Following Luhmann's example, the sketch given here will not focus on the general population, but on professional groups, as the relevant processes are often more obvious in those who devote their whole lives to the functional systems. Therefore this study will analyse the three groups of doctors with their academic medicine, priests in their medical tasks and nuns working as nursing sisters in hospitals. Of course, such a framework drawn from the existing more general studies on medical and religious institutions invites further micro- and comparative studies.[7]

This analysis is done on the particular situation in the German West during the time immediately before and after the French revolution and during the following restoration period. It focuses on the professional academic and health care institutions in the Catholic West of Germany, mainly the territories of the three politically most important archbishoprics of Cologne, Trier and Mainz, located along the middle and lower river Rhine. Their Prince Archbishops were at the beginning of the era under investigation simultaneously three of the originally seven Electors of the German emperor, and also rulers of other territories, among which is most notable Cologne's suffragan diocese Münster. After the Napoleonic wars most of these territories became provinces of Protestant Prussia.

Physicians: Academic Medicine and Church Authorities

During the second half of the eighteenth century, Catholic ecclesiastical institutions in Germany were divided concerning their attitudes towards recent changes in academic doctrines and the teaching of medicine, although generally a strong tendency for enlightenment ideas became dominant. At the universities of Catholic territories the philosophical and theological faculties were run by the Jesuits until the dissolution of their order by Pope Clemens XIV in 1773, whereas the faculties of law and medicine tended to be dominated by lay-persons who were generally more in favour of the enlightenment. However, in several of these universities, especially at the three old archiepiscopal seats in Cologne, Trier and Mainz, the medical faculties were in a state deplored by many contemporaries.[8] They lacked books, funds,

7 The study was part of the preparation of a larger interdisciplinary research project on the nineteenth century ideological and institutional roots of German Catholicism's engagement in health care and bioethics, enabled by a grant from the Deutsche Forschungsgemeinschaft.

8 Hannemarie Wolff, *Die Medizinische Fakultät der Kurfürstlichen Akademie und Universität zu Bonn (1777–1798). Ein Beitrag zur Geschichte des Medizinalwesens im Erzstift Köln* (Ph. D. thesis Bonn, 1940), pp. 10–13.

dedicated professors and therefore keen students who preferred Protestant universities in North-eastern Germany or Catholic universities in Vienna and France.

This situation of West German universities – not only in Catholic regions, for the Protestant university of Duisburg was in a similar state – given, several princes of larger territories opened academies for the education of their subjects, that were meant to be more in line with the interests of enlightened absolutism[9] than the existing universities with their often medieval or scholastic traditions. In those territories, where the enlightened prince was a member of the Catholic clergy, this meant a certain tension within religious control of medicine. E.g. in the territories of the Archbishops of Cologne, i.e. the archdiocese of Cologne and the diocese of Münster, there was a coexistence of the medieval university in Cologne dominated by the Catholic clergy and the new "Prince Electoral" ("Kurfürstliche") Academy or University of Cologne's Catholic Archbishop in Bonn and Münster.[10] This opposition was intended by the founders and clearly seen by contemporaries. The curator of the new university in Bonn praised its recent foundation by the Archbishop of Cologne as "the greatest damage to the clergy in Cologne, but the greatest advantage to his territory".[11]

Whereas the traditional university was rather meant to educate future representatives of scholarship and the professions, the princes' – secular as well as ecclesiastic princes' – new academies and universities were designed to train servants of the state or its sovereign. Therefore the latter showed far more interest in "medicinische Policey", medical police or policy, the precursor of public health. More than in the older universities, the new medical faculties were at the same time the medical colleges and the medical councils regulating professional affairs for all health practitioners as well as public health. Professors were regularly detached to commissions enquiring in outbreaks of epidemics.

At the medical faculty of Bonn, all the professors could be counted among those members of the medical profession openly propagating enlightenment ideas. The first professor Kauhlen who after giving up his education for the Catholic priesthood and a degree in law at the University of Cologne had pursued his medical studies at the Calvinistic university of Duisburg and the Lutheran university of Strasbourg was already a locally established medical doctor at the time of the faculty's foundation, joined under the name "Tassilo" the free-mason order of the

9 On the relationship between enlightenment and medical reform cf. Wolfram Kaiser and Arina Völker, "Aufklärung und Philanthropismus", *Medizinhistorisches Journal*, 26 (1991), 283–299.

10 During the rule of the Prince Elector Archbishop of Cologne Max Friedrich (1708–1784) the Academy in Bonn was founded in 1777 and the Vice-University in Münster in 1780, under his successor Prince Elector Archbishop Max Franz (1784–1794) the Academy in Bonn was elevated to University in 1786.

11 Franz Wilhelm von Spiegel, quoted in D. Höroldt, ed., *Geschichte der Stadt Bonn*, vol 3 (Bonn, 1989), p. 316.

Illuminati and published as an open opponent of church influence on science.[12] The other three Bonn professors of medicine were appointed rather as intellectuals, i.e. theoretically minded researchers, from outside the archbishop's territory: de Gynetti[13], Rougement[14] and Wurzer[15]. They adhered to versions of vitalism, combining the moderate iatromechanism of Hermann Boerhave, the animism of Georg Ernst Stahl and the theories of Albrecht von Haller on irritability and sensibility. These modern doctrines were regarded as results of the enlightenment and met opposition from conservative Christian circles as "materialism", although, of course, much of these doctrines came from a Pietistic background. These newly appointed medical professors saw themselves as opponents against old-fashioned traditions in medicine that according to their opinion were often related to religion. Thus in a public speech while still being the professor Primarius of the old medical faculty in Cologne, de Gynetti, like Kauhlen once destined for the priesthood and already recipient of the lower church orders, mocked Cologne's previous despise of scientific discoveries such as Harvey's on the circulatory system and advocated the dissection of corpses for scientific purposes against common prejudice.[16] As his obituary notice of 1804 mentions "duty of religion" before "beneficence and morality" in characterising him, he has, however, certainly not been an outspoken freethinker.

The medical faculty at Münster[17], advised by the Protestant physician Christoph Ludwig Hoffmann[18], took a rather pragmatic and experience-oriented approach and preferred to choose its professors from the Münsteranian territory (Lüders[19],

12 Franz Wilhelm Kauhlen (1750–1793), cf. Braubach, *Hochschule*, pp. 168–171; Richard van Dülmen, *Der Geheimbund der Illuminaten. Darstellung, Analyse, Dokumentation* (Stuttgart, 1975), pp. 439–453.

13 Peter Wilhelm Joseph de Gynetti (1735–1804), cf. Braubach, *Hochschule*, pp. 171–172; Everhard Hendrichs, "Peter Wilhelm Joseph de Gynetti", *Nachrichtenblatt des Vereins Alter Münstereifeler*, 54 (1979), 3–7; Hannemarie Wolff, *Die Medizinische Fakultät der Kurfürstlichen Akademie und Universität zu Bonn (1777–1798). Ein Beitrag zur Geschichte des Medizinalwesens im Erzstift Köln* (Ph. D. thesis Bonn, 1940), pp. 52–53.

14 Joseph Claudius Rougemont (1756–1818), cf. Wolff, *Fakultät*, p. 60.

15 Ferdinand Wurzer (1765–1844), cf. Wolff, *Fakultät*, p. 85.

16 Peter Wilhelm de Gynetti, *Programma anatomicum* (Köln, ca. 1775); cf. Friedrich Moritz, *Aus der medizinischen Fakultät der alten Universität*, in H. Graven, ed., *Festschrift zur Erinnerung an die Gründung der alten Universität Köln im Jahre 1388* (Köln, 1938) pp. 237–287, here pp. 276–277.

17 Cf. Gisela Böger, *Zur Geschichte der ersten Medizinischen Fakultät (1773–1818) und der Chirurgenschule (1821–1849) in Münster* (M.D. thesis Münster, 1956).

18 Cf. Maria Weidekamp, *Der Kurfürstliche Leibarzt Christoph Ludwig Hoffmann. Sein Leben und sein Wirken im Hochstift Münster von 1764–1785* (M.D. thesis Münster, 1936/Berlin, 1937); Broman, *Transformation*, pp. 55–57.

19 Bernhard Lüders (+1807), cf. Richard Toellner, "Medizin in Münster", in H. Dollinger, ed., *Die Universität Münster* (Münster, 1980), p. 288.

Druffel[20], Bodde[21], Roling, Wernekinck[22]), three of them without a doctorate. Thus both the new institutions founded under the rule of the Archbishop Prince Electors of Cologne, in Bonn and in Münster, can be classified as theoretical or practical centres of the Enlightenment. When Hoffmann was also called by the Archbishop and Prince Elector of Mainz to introduce medical reform in this principality he failed, obviously because of the resistance from the old medical faculty there.[23]

The new academic foundations together with the old institutions were dissolved during the French occupation of the Rhineland beginning in 1792, the following political secularization and the Prussian reforms. When also thereby all the bishops had lost their secular power, a remarkable change could be observed in their medical policy, too. As princes they favoured public health and therefore even fought some religious traditions regarded as detrimental for health such as baptism of the newborns in cold churches or various forms of religious healing. As mere pastoral bishops their responsibility and interest was different. Caused by their negative experiences with the revolution which was regarded as a result of the enlightenment most representatives of the church turned away from many modernised institutions and sought to revive church traditions. Thus pilgrimage and the interest in miracles of healing as well as other physical phenomena increased. There are obvious personal and intellectual connections between ecclesiastical restoration, Schelling's natural philosophy so influential on medicine, the medical discussions on Mesmerism or animal magnetism and the increasing number of devoted women demonstrating religious ecstasy, bleeding stigmata and fasting, especially in Catholic Bavaria.[24]

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20 Franz Ferdinand (von) Druffel (1763–1857), cf. Klaus Böger, *Aus dem Leben und Wirken des Medizinalrates und Professors der ersten Medizinischen Fakultät zu Münster Franz Ferdinand von Druffel* (M.D. thesis Münster, 1961); Helga Jagemann, *Franz Ferdinand von Druffels (1763–1857) "Pathologische Therapeutische Vorlesungen"* (M.D. thesis Münster, 1964).

21 Johann Bernhard Bodde, famous for his „enlightened" writings on the case of the stigmatised nun Anna Katharina Emmerick (s. below): Johann Bernhard Bodde, *Bericht über die Erscheinungen bey der A. K. Emmerich, Chorschwester des aufgehobenen Klosters Agnetenberg in Dülmen von dem Herrn Medizinal Rath Bodde mit Entgegnungen von B. A. B. Rensing Dech. in Dülmen* (Dorsten, 1818); *Sendschreiben an den Herrn Rensing, Dechant und Pfarrer zu Dülmen, worin derselbe einer Theilnahme an der Erkünstelung der Wundmaale der Jungfer Emmerich nicht beschuldigt, das Wundersame der Wundmaale aber standhaft verneint wird* (Hamm, 1819).

22 Franz Wernekinck (1764–1839), cf. Hans Kaja, *Franz Wernekinck, Arzt und Botaniker (1764–1839) und seine Pflanzenbilder aus dem Münsterland* (Münster, 1995).

23 Cf. Broman, *Transformation*, pp. 57–59.

24 Cf. Bernhard Gissibl, "Zeichen der Zeit? Wunderheilungen, Visionen und ekstatische Frömmigkeit im bayerischen Vormärz", in N. Freytag and D. Sawicki, eds., *Wunderwelten. Religiöse Ekstase und Magie in der Moderne* (München, 2006), 83–114.

In the West of Germany an early and well known case[25] that was also quite influential for the development of health care and characteristic for the internal conflicts of physicians being torn between enlightenment medicine and religion is the stigmatised "Nun of Dülmen" in the dioceses of Münster, Anna Katharina Emmerick. When she got the bleeding wounds in hand and feet, she was allegedly living without eating after her monastery had been dissolved as a consequence of the secularisation. Her literary memorial was written by the famous romantic poet Clemens Brentano. More than 30 physicians visited her in order to check the truth of the reports. The medical world was divided on this topic.

The immediate consequences in the field of health care that her miraculous suffering had for some of her visitors and friends were remarkable. At least two young physicians changed their life after their visits to Anna Katharina. The medical doctor Franz Wesener turned from the enlightened world view to traditional Catholic positions, recorded the nun's sufferings meticulously and thereby encountered strong resistance and open mockery from the medical establishment.[26] Clemens Brentano's brother Christian, also a physician, changed his interest to theology and became a writer.[27]

Several Protestant visitors and friends converted to Catholicism. They and other impressed visitors began activities for the sick. The most prominent among them was Friedrich Leopold Graf zu Stolberg who donated the means for the work of the Sisters of St. Clement, mainly engaged in nursing, who were founded by the Vicar General Clemens August von Droste zu Vischering at that time.[28] The daughter of a Protestant pastor Luise Hensel devoted her life to the poor and became a pioneer in female education.[29] Among her pupils were two later beatified founders of religious congregations also devoted to nursing, Franziska Schervier and Pauline

25 For her biography, visitors and influence cf. Clemens Engling, *Unbequem und ungewöhnlich: Anna Katharina Emmerick – historisch und theologisch neu entdeckt* (Würzburg, 2005); August Hölscher, *Emmerich oder Emmerick? Gutachten d. Historikers August Hölscher, bearb. im Auftr. d. Heimat- u. Verkehrsvereins Dülmen* (Dülmen, 1931); Peter Groth, *Die stigmatisierte Nonne Anna Katharina Emmerick 1774–1824. Eine Krankengeschichte im Zeitalter der Romantik – zwischen preußischer Staatsraison und 'katholischer Erneuerung'* (unpublished dissertation, 1994).

26 Cf. Wilhelm Hümpfner, ed., *Tagebuch des Dr med. Franz Wilhelm Wesener über die Augustinerin Anna Katharina Emmerick* (Würzburg, 1926).

27 Cf. Alexander Loichinger, "Sailer, Diepenbrock, Christian und Clemens Brentano", *Münchener Theologische Zeitschrift*, 52 (2001), 304–322.

28 Manfred Weitlauff, "Die Konversion des Grafen Friedrich Leopold zu Stolberg zur katholischen Kirche (1800) und seine 'Geschichte der Religion Jesu Christi' (1806–1818)", in M. Weitlauff, ed., *Für euch Bischof, mit euch Christ. Festschrift Friedrich Kardinal Wetter* (St. Ottilien, 1998), pp. 271–321.

29 1798–1876, cf. Barbara Stambolis, *Luise Hensel (1798–1876). Frauenleben in historischen Umbruchszeiten* (Köln, 1999).

von Mallinckrodt.[30] Apollonia Diepenbrock, also a friend of Hensel, left her homeland in order to serve the sick and poor in Koblenz and Regensburg.[31] Her brother Melchior (von) Diepenbrock, a junior military officer dissatisfied with his service, became a priest and finally prince bishop of Breslau where he was active in founding hospitals, too.[32]

This revival of nursing congregations and Christian hospitals will be treated separately later, but the romantic regret of what had been lost in comparison to earlier times reached also academic medicine, mainly in the highly diverse variations of natural philosophy. The textbooks of medical history tend to describe "romantic medicine" as characterised by "a special attitude of reverence for God, nature and man."[33] As has been demonstrated by medical historians extensively, romantic medicine was by no means a monolithic and mainly backwards oriented endeavour.[34] Many approaches of its representatives have been crucial for the

30 Cf. Relinde Meiwes, "Weibliche Lebenswege im 19. Jahrhundert. Das Beispiel der Kongregationsgründerinnen Franziska Schervier und Pauline von Mallinckrodt", in B. Hermans, ed., *Lebensläufe im Sozialkatholizismus des Ruhrgebiets. Historische Fachtagungen* (Essen, 2003), pp. 75–85.

31 1799–1880, cf. Ursula Finken, "Apollonia Diepenbrock (1799–1880). Ein Leben für die Armen", in W. Becker, ed., *Staat, Kultur, Politik. Beiträge zur Geschichte Bayerns und des Katholizismus. Festschrift Dieter Albrecht* (Kallmünz, 1992), pp. 237–247; Ulrike Philipp, "'Unseren lieben Heiland in seinen Kranken zu pflegen.' Die sozialfürsorgerischen Tätigkeiten Apolonia Diepenbrocks in Regensburg (1834–1880)", *Beiträge zur Geschichte des Bistums Regensburg*, 37 (2003), 197–291.

32 1798–1853, cf. Alexander Loichinger, *Melchior Diepenbrock. Seine Jugend und sein Wirken im Bistum Regensburg (1798–1845)* (Regensburg, 1988).

33 Karl E. Rothschuh, *Konzepte der Medizin in Vergangenheit und Gegenwart* (Stuttgart, 1978) p. 387.

34 Cf. Karl Eduard Rothschuh, "Deutsche Medizin im Zeitalter der Romantik", in L. Hasler , ed., *Schelling. Seine Bedeutung für eine Philosophie der Natur und Geschichte* (Stuttgart, 1981), pp. 145–152. For previous research on romantic medicine in general cf. Dietrich von Engelhardt, "Bibliographie der Sekundärliteratur zur romantischen Naturforschung und Medizin 1950–1975", in R. Brinkmann, ed., *Romantik in Deutschland* (Stuttgart, 1978), pp. 307–330. After medical historians around 1900 had described romantic medicine and natural philosophy as a cul-de-sac of medical progress, a view still influential in some textbooks, the higher esteem of Schelling's philosophy and more intense study of the sources demonstrated their importance for the following natural sciences in medicine. This emphatic judgement beginns with such early remarks as Karl Schmiz, *Die medizinische Fakultät der Universität Bonn 1818–1918. Ein Beitrag zur Geschichte der Medizin* (Bonn, 1920), pp. 3, and is still dominant in the resolutely secularizing interpretations after the 1960s such as Nelly Tsouyopoulos, *Andreas Röschlaub und die romantische Medizin* (Stuttgart, 1982). For more recent studies cf. Hans-Uwe Lammel, *Nosologische und therapeutische Konzeptionen in der romantischen Medizin* (Husum, 1990); Urban Wiesing, *Kunst oder Wissenschaft? Konzeptionen der Medizin in der deutschen Romantik* (Stuttgart-Bad Cannstatt, 1995); for a rather limited description cf. Werner E. Gerabek, *Friedrich Wilhelm Joseph Schelling und die Medizin der Romantik* (Frankfurt/M., 1995).

development of medical research, especially in physiology and psychotherapy.[35] These approaches, however, shared the conviction that several medical ideas of the preceding decades were fundamentally flawed by a too narrow, analytical focus, especially when compared to the synthetic approach in the alleged Golden age of ancient or Hippocratic medicine.[36] This turn made medicine again also open to religious, predominantly mystical speculation.[37] Recent historiographic studies, however, in reaction to the earlier medical historians' characterisation of this period as reactionary and confused,[38] rarely describe the obvious affection of romantic medicine to religion. One reason for this might be that the Christian churches indeed had their own problems with Schelling's natural philosophy and with the natural philosophical, e.g. Mesmerist explanation of miracles. Nevertheless, it remains remarkable that after 1800 several prominent medical academics showed similar tendencies of moving from medical practice to philosophy, from enlightenment to Romanticism, and some of them proceeded to open religion. A role model was the famous writer Joseph Görres,[39] coming from the Rhineland, but moving to Munich later, who had among other interests studied, taught and occasionally practised medicine, and turned from an adherent of the French revolution and a natural philosophical version of medical materialism[40] to a Catholic mystic.[41] A similar biography for the territories considered here is Karl

35 Cf. Nelly Tsouyopoulos, "Schellings Naturphilosophie: Sünde oder Inspiration für den Reformer der Physiologie Johannes Müller?", in M. Hagner, ed., *Johannes Müller und die Philosophie* (Berlin, 1992), pp. 65–83; Brigitte Lohff, *Die Suche nach der Wissenschaftlichkeit der Physiologie in der Zeit der Romantik. Ein Beitrag zur Erkenntnisphilosophie der Medizin* (Stuttgart, 1990), and "Johannes Müller und die Geschichte der Physiologie", in H. Schott, ed., *Medizin, Romantik und Naturforschung. Bonn im Spiegel des 19. Jahrhunderts* (Bonn, 1993), pp. 37–58; Henry F. Ellenberger, *Die Entdeckung des Unbewussten* (Bern, 1973), pp. 281–304.

36 Thomas H. Broman, *The transformation of German academic medicine, 1750–1820* (Cambridge, 1996) p. 141, especially footnote 33.

37 For the "turn of scientific activity to the religious" cf. Brigitte Lohff, *Die Suche nach der Wissenschaftlichkeit der Physiologie in der Zeit der Romantik. Ein Beitrag zur Erkenntnisphilosophie der Medizin* (Stuttgart, 1990) p. 32, especially footnote 14; for relations between Romantic medicine and religious ideas cf. Volker Roelcke, "Kabbala und Medizin der Romantik", in E. Goodman-Thau, G. Mattenklott and C. Schulte, eds., *Kabbala und Romantik* (Tübingen 1994), pp. 119–142, especially pp. 128–129.

38 Cf. Wiesing, *Kunst*, pp. 28–43, especially p. 31.

39 1776–1848, cf. Jon Vanden Heuvel, *A German life in the age of revolution. Joseph Görres, 1776–1848* (Washington, D.C., 2001); for his medical or natural philosophical views cf. Broman, *Transformation*, pp. 95–96.

40 Cf. Joseph Görres, *Aphorismen über die Organomie* (Koblenz, 1803), e.g. the explanation of brain and psyche/soul pp. 286–313.

41 Cf. Joseph Görres, *Christliche Mystik*, 4 vols (1836–1842).

Joseph Hieronymus Windischmann.[42] He had been earlier the author of an attempt to explain man and medicine in a highly materialistic approach, aiming at a "mechanics of nature"[43] and even admitted to Reil's "Archiv für die Physiologie" in 1800[44] which still built a stronghold against natural philosophy at that time.[45] Then he was the court physician of the enlightened Archbishop of Mainz, Karl Theodor von Dalberg and professor of history and philosophy at Dalberg's first place of exile in Aschaffenburg. After becoming a professor in the philosophical and the medical faculty at the new Bonn University he wrote in 1823 "About something which is necessary for medicine. An attempt to unify this art with Christian philosophy".[46] As the title indicates, the articles, a year later published as a book, propose a mystical approach to medicine where diseases are the consequences of general disorder, i.e. sin, and the task of medical research is conceived very encompassing: "The more a science refers to the human being and his inner nature and hidden ailments, the less it can be treated without religion"[47]. Windischmann explicitly expressed his dissatisfaction with a medicine confined to the "mechanics of nature" and the "jail of materialism".[48] He now saw natural remedies as part of a harmonious creation integrated at the bottom of a hierarchy for means to ensure human salvation ("Heil") – and ecclesiastical rites such as prayer and blessed water, the sacraments and exorcism forming the top.

Quoting Windischmann means returning to the history of universities, for he was not isolated by such ideas in the medical faculty. In that region of Western Germany that before the French occupation had got the mentioned six medical faculties of universities (Bonn, Cologne, Trier, Mainz, Münster and the Prussian, thus Protestant University of Duisburg[49]) there was now only the one in Bonn,

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42 1775–1839, cf. Adolf Dyroff, *Carl. Jos. Windischmann (1775–1839) und sein Kreis.* Görres-Gesellschaft zur Pflege der Wissenschaft im katholischen Deutschland. Vereinsschrift 1916/1 (Köln, 1916); Gerabek, *Schelling*, pp. 256–262.

43 *Versuch ueber die Medizin. Nebst einer Abhandlung über die sogenannte Heilkraft der Natur* (Ulm, 1797), pp. 14 and 39.

44 "Über den einzig möglichen und einzig richtigen Gesichtspunkt aller Naturforschung. Nebst der Ankündigung einer Schrift über die Mechanik der Natur", *Archiv für die Physiologie, 4* (1800), 290–305.

45 Reinhard Mocek, *Johann Christian Reil (1759–1813). Das Problem des Übergangs von der Spätaufklärung zur Romantik in Biologie und Medizin in Deutschland* (Frankfurt, 1995), p. 137.

46 "Ueber etwas, das der Heilkunst Noth thut. Ein Versuch zur Vereinigung dieser Kunst mit der christlichen Philosophie", *Nasse's Zeitschrift für Anthropologie*, III and IV (1823).

47 Karl Joseph Hieronymus Windischmann, *Ueber etwas, das der Heilkunst Noth thut. Ein Versuch zur Vereinigung dieser Kunst mit der christlichen Philosophie* (Leipzig, 1824), p. 150.

48 Ibid., pp. 68 and 70.

49 Gernot Born and Frank Kopatschek, *Die alte Universität Duisburg 1655–1818* (Duisburg, 1992); Günter von Roden, *Die Universität Duisburg.* Duisburger Forschungen, 12 (Duisburg, 1968); Walter Ring, *Die Geschichte der Universität Duisburg* (Duisburg, 1920); Hans-Ulrich

being part of the in 1818 newly founded Prussian university.[50] The professors of this new faculty[51], half of them Protestant, were influenced by the general development during this era and therefore at least initially largely inclined to natural philosophy and Mesmerism.[52] Against the assumption that the Prussian Chancellor Hardenberg's physician Koreff, a professed Mesmerist, had decisively influenced this composition of the Bonn medical faculty it has been demonstrated that Koreff mostly failed in his proposals for adherents of Schelling or Mesmer as candidates for chairs in Bonn.[53] Nevertheless, the only obvious exception from the general tendency towards natural philosophy was the staunch opponent of Mesmerism, the professor of Anatomy August Franz Josef Karl Mayer,[54] who had studied at the Lutheran University of Tübingen and had formerly taught in Calvinistic Bern. Among the other professors who beside their special interests also studied Mesmerism and natural philosophy were three very famous names: the clinician Christian Friedrich Nasse[55], the surgeon and ophthalmologist Philipp Franz von Walther[56] and the botanist Christian Gottfried Daniel Nees von Esenbeck.[57] Nasse and von Walther, however freed themselves from animal magnetism and natural philosophy later in their lives.[58] Among the less well known Bonn professors were some remaining loyal to natural philosophy like the new university's first medical professor Johann

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Müller, *Die medizinischen Promotionen an der Universität Duisburg 1655–1817*. Medizin im Museum, Beiheft 2 (Essen, 2004).

50 As the time gap between the actual end of the medieval and princely universities and the official foundation of new medical teaching institutions by the Prussian state was mostly at least more than twenty years (and some like in Mainz or Cologne were only re-founded in the twentieth century) there was hardly any continuity in personnel. The remarkable exception was the new school of surgeons in Münster which was founded in 1821 three years after the dissolution of the old university: Apart from Druffel all the previous professors (Bodde, Roling and Wernekinck) as well as Drs. Busch and Haindorf remained lecturers, according to Richard Toellner, "Medizin", p. 292.

51 Christian Renger, *Die Gründung und Einrichtung der Universität Bonn und die Berufungspolitik des Kultusministers Altenstein* (Bonn, 1982).

52 Schmiz, *Fakultät*, pp. 1–7.

53 Cf. Renger, *Gründung*, pp. 162–184.

54 1787–1865, cf. Johannes Dietrich Meyer, *August Franz Josef Carl Maye*r. Leben und Werk (Diss. Bonn, 1966); cf. Renger, *Gründung*, pp. 166–167.

55 Cf. Heinrich Schipperges, "Christian Friedrich Nasse 1778–1851", in *Bonner Gelehrte. Beiträge zur Geschichte der Wissenschaften in Bonn. Medizin* (Bonn, 1992), pp. 23–35.

56 Cf. Erich Freiherr von Redwitz, "Philipp Franz von Walther. 1782–1849", in *Gelehrte*, pp. 36–40. For his interest in natural philosophy cf. Wiesing, *Kunst*, pp. 244–255; Lohff, *Suche*, p. 122.

57 1776–1858, cf. Dietrich von Engelhardt, ed., *Christian Gottfried Nees von Esenbeck. Politik und Naturwissenschaften in der ersten Hälfte des 19. Jahrhunderts* (Stuttgart, 2004).

58 Cf. Redwitz, "Walther", p. 38; Renger, Gründung, p. 181; Nasse gave up his function as co-editor of the Archiv für thierischen Magnetismus in 1822.

Christian Friedrich Harless,[59] the pharmacologist Ernst Bischoff[60] and the ardent proponent of Mesmerism Joseph Ennemoser.[61] After becoming full professor at Bonn University in 1827, Ennemoser made his research programme explicit the next year:

> If man in general is the object of medical studies, then everything of man belongs to their area; and whoever reflects on the essence (Wesen) of the human being seriously cannot evade the religious perspective, yes, he even will have to deal with it primarily.[62]

Accordingly, like Görres in the influential work of the years in his famous circle in Munich, he discussed later in his life such religious and physical phenomena as the above-mentioned Anna Katharina Emmerick extensively.[63]

Thus the seemingly paradoxical situation resulted that the dominating teaching at the former archbishop's university had been openly connected to ideas of enlightenment and sometimes even materialism whereas the new university founded by the secular and Protestant Prussian king was a refuge for adherents of romantic natural philosophy with its links to Christian and especially Catholic mysticism.

Priests and Health Care: The Development of Pastoral Medicine

The common view as canonised in classical textbooks of medical and ecclesiastical history used to be that medical practice by priests ceased with the prohibitions by popes, synods and councils in the twelfth and beginning thirteenth century. Several medical historians, however, pointed out well-known priests as court physicians of popes and bishops in later times and the continuing medical practice of the lower clergy, often in direct extension of their spiritual power. It has been demonstrated for Dutch and English territories how extensively in the Early modern period

59 Cf. Charlotte Triebel-Schubert, "Johann Christian Friedrich Harless 1773–1853", in: Gelehrte, pp. 13–22.

60 Cf. Gernoth Rath, "Christian Heinrich Ernst Bischoff. 1781–1861", in Gelehrte, pp. 41–43.

61 Cf. Jakob Bremm, *Der Tiroler Joseph Ennemoser, 1787–1854, ein Lehrer des tierischen Magnetismus und vergessener Vorkämpfer des entwicklungsgeschichtlichen Denkens in der Medizin, Professor der Medizin in Bonn a. Rh. Ein Beitrag zur Kenntnis des sog. tierischen Magnetismus, zur Geschichte der Freiheitskriege und der Medizinischen Fakultät in Bonn* (Jena, 1930).

62 Josef Ennemoser, *Ueber die Aufgabe der anthropologischen Forschung und das Wesen des menschlichen Geistes* (Bonn, 1828) p. V.

63 Josef Ennemoser, *Der Magnetismus im Verhältnisse zur Natur und Religion* (Stuttgart, 1842) p. 154–157.

especially Catholic priests applied rituals for the healing of physical ailments whereas Protestants theology more successfully forced the clergy to refrain from such a magical blurring of borders.[64] As the peasants did not so much distinguish between natural and supernatural means they demanded both from their priests as the only educated men in their communities. Thus medical activities by priests, like the famous exorcist Father Joseph Gassner in Bavaria, were still common when the enlightenment produced the idea of popularising medicine, including actively spreading the achievements of medicine to people who could not afford or reach an academic physician. This idea started with medical books addressed to those non-doctors who could read, i.e. the gentry, the teachers and especially the clergy whose professional obligation to charity and knowledge of the people made them especially suitable for rendering services in health care. The famous examples of these books are written by Philibert Guibert in the seventeenth century and – the probably best-known of all times – Samuel Auguste Tissot in the eighteenth century.[65]

Based on these examples how educated people without medical training could help the sick the idea of employing priests for matters of health was often taken up in the decades around 1800.[66] Famous doctors such as Christoph Wilhelm Hufeland[67] and Johann Peter Frank[68] became involved in this enterprise.[69] As the

64 Hans de Waadt, "Chasing demons and curing mortals: the medical practice of clerics in the Netherlands", in H. Marland and M. Pelling, eds., *The task of healing. Medicine, religion and gender in England and the Netherlands* (Rotterdam, 1996), pp. 171–203; David Harley, "James Hart of Northampton and the Calvinist Critique of Priest-Physicians: An unpublished Polemic of the early 1620s", *Medical History*, 42 (1998), 362–386.

65 Philibert Guibert, *Le médicin charitable* (1624), in 1632 supplemented by *L'apoticaire charitable*, resulting in the combined volume *Oevres charitables*; Samuel Auguste Tissot, *Avis au peuple sur sa santé*, vol 1 (Paris, ²1763), pp. xliii-xliv.

66 Cf. Broman, *Transformation*, pp. 107–108.

67 1762–1836, Christoph Wilhelm Hufeland, "Medizinische Praxis der Landgeistlichen", *Journal der practischen Heilkunde*, 29/5 (1809), 1–10.

68 1745–1821, Johann Peter Frank, *Academische Rede über Priester-Aerzte* (1803); System einer vollständigen medicinischen Polizey, VI (1817).

69 Cf. Claudia Huerkamp, *Der Aufstieg der Ärzte im 19. Jahrhundert. Vom gelehrten Stand zum professionellen Experten. Das Beispiel Preußens* (Göttingen, 1985), p. 43; as examples for the passionate debate cf. Christian Gottfried Gruner, "Laßt die Aerzte absterben, und die Pfarrer an die Stelle treten", *Almanach für Aerzte und Nichtaerzte auf das Jahr 1787* (Jena, 1787), 188–194 [an attack on Bahrdt's proposal, Tissot's book and medical education for theologians]; Paulus Usteri, *Grundlage medicinisch-anthropologischer Vorlesungen für Nichtärzte* (Zürich, 1791); J. Krause, *Der medicinische Landpfarrer, oder kurzgefaßte medicinische Abhandlung und Heilart derjenigen Krankheiten, welche am meisten auf dem Lande vorkommen. Allen Herren Seelsorgern und Wundärzten in den Orten, in welchen keine Aerzte wohnen, zu ihrem Gebrauche und Wiedergenesung der Kranken redlichst gewidmet von J. Krause, der W. und A. D., Oberamtsarzt zu Neustadt an der Hardt* (Schweinfurth, 1794), reviewed *Medicinisch-chirurgische Zeitschrift*, Nr. 35 of 1 May (1794), 157–160.

absolutist state was more interested in health than in medical care, priests were expected to assist in public health, too. Medical historians have collected examples that priests should persuade their parishioners to have their children vaccinated, and in the territory of Hessen-Darmstadt a thorough knowledge of Tissot's book was even precondition for gaining a living as pastor.[70] Priests were also asked to discourage magical or unhealthy practices and to recommend, even assist an academic doctor.

One result of this participation of the clergy in medical tasks was a new genre of books which especially addressed priests. Titled "pastoral medicine", these publications were written by physicians in collaboration with priests and meant to provide the medical knowledge necessary for pastoral work. What was regarded as a pastor's job, however, was subjected to characteristic changes that have been analysed by pastoral theologians[71] and are shown for the medical side here. To reduce the development to the relevant traits it can be said that in the early writings the enlightenment idea of mobilizing more resources for increasing public utility was dominant. The question was how church and priest might assist in medicine and public health – and not so much the other way round. Priests were to be trained in knowing, preventing and treating the most common diseases. In accord with this humanitarian approach, there was hardly any denominational polemic in the early publications. They centred on medicine, not religion.

Of course, there are exceptions from the general focus on medicine, such as the probably best known and most thoroughly written book of pastoral medicine in that time, Franz Xaver Mezler's "Ueber den Einfluss der Heilkunst auf die praktische Theologie. Ein Beytrag zur Pastoralmedicin".[72] Although in the subtitle of its first volume it claims to treat the influence of "Heilkunst", medicine, on "Sittlichkeit", morality, which is perhaps best understood as social and individual conduct of life, it does much more. It provides medical knowledge in its broadest meaning, mainly anthropology including natural history of man and psychology, and deals only rarely with medical care. With this provision of anthropological, psychological and medical knowledge necessary or at least helpful for qualified pastoral care Mezler already aims at the core interest of the later established discipline of pastoral medicine. During the period of restoration, pastoral medicine does no longer want to train assistant physicians, but wants to make medicine an assistant to pastoral care.

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70 Robert Heller, "'Priest-Doctors' as a Rural Health Service in the Age of Enlightenment", *Medical History*, 20 (1976), 361–383; Robert Heller, "Johann Christian Reil's training scheme for medical auxiliaries", *Medical History*, 19 (1975), 321–332.

71 Cf. as the most comprehensive study Heinrich Pompey, *Die Bedeutung der Medizin für die kirchliche Seelsorge im Selbstverständnis der sogenannten Pastoralmedizin. Eine bibliographisch-historische Untersuchung bis zur Mitte des 19. Jahrhunderts* (Freiburg/Br., 1968).

72 In two volumes of 1794, second edition 1806 and third 1808.

Moving from literary discourse to social reality this change is also demonstrable in church discipline.[73] Whereas the priest in the immediate pre-revolutionary time was seldom punished by ecclesiastic authorities for medical practice this became more common when the bishops had to confine their power to spiritual tasks. Now priests were reprimanded and even suspended if medical practice on their part became known.[74]

Thus it can be argued that the separation of the church from the state, for Catholic territories with their former prince bishops more obvious than for Protestant ones, made an end to the toleration and even recruitment of rural priests as assistant physicians. One of the most convincing points for this argument is the opposite observation in countries where the administrative separation between church and state was far less advanced, namely Lutheran and Orthodox monarchies. Already at the beginning of the nineteenth century Johann Peter Frank mentioned for Russia plans, even an Ukase from the Emperor, to train candidates for the priesthood in rural areas also in medicine.[75] In Lutheran Sweden the parliament decided on funding a scheme for the medical training of theological students in 1810, and a medico-theological faculty was established at the University of Lund, formally existing until 1841.[76] So it was not so much the professionalisation of medicine or an increased availability of physicians in rural areas that decreased the medical activities of the clergy but the churches' withdrawal from duties in state and society in order to concentrate on their religious tasks. Thus political history seems to have perhaps more contributed to this development than the history of ideas or medicine itself. This might also explain why especially in areas with less social secularisation, that means with less separation between church and society such as Bavaria in Southern Germany, later in the century priests continued to be often consulted for health matters – despite and in the presence of medical doctors.[77]

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73 For the general turn from the enlightenment idea of "the priest as the people's teacher" to the new image of the "unworldly, sacred and spiritualised" clergy cf. Gissibl, "Zeichen der Zeit?", pp. 97–99.

74 Georg May, "Die Aufrechterhaltung der Disziplin im Klerus", in W. G. Rödel and R. E. Schwerdtfeger, eds., *Zerfall und Wiederbeginn. Vom Bistum Mainz zum Erzbistum Mainz (1792/97–1830). Ein Vergleich.* Festschrift Friedhelm Jürgensmeier. Beiträge zur Mainzer Kirchengeschichte, 7 (Würzburg, 2002), pp. 293–318.

75 Frank, *System*, VI, pp. 438–445.

76 Cf. Heinz Goerke, "Medizinische Ausbildung von theologischen Studenten an der Universität Lund von 1813 bis 1840", in H.-H. Euelner et al, eds., *Medizingeschichte in unserer Zeit. Festschrift Edith Heischkel-Artelt* (Stuttgart, 1971), pp. 352–358.

77 Cf. Michael Stolberg, "Alternative Medicine in Nineteenth-Century Bavaria", in R. Jütte, M. Eklöf and M. C. Nelson, eds., *Historical aspects of unconventional medicine: approaches, concepts, case studies* (Sheffield, 2001), pp. 147 and 153.

Nursing sisters: New Congregations and Hospitals

The Catholic contribution to the development of nursing as a profession in general is a well known chapter in the history of nursing and medicine.[78] Towards the end of the eighteenth century the new more clinically oriented, hospital-based type of academic medicine demanded qualified nursing which was widely missing at that time. Meeting this need, religious congregations followed the tradition of the well trained Sisters of Charity founded by Vincent de Paul in the seventeenth century. This tendency was supported by the policy of several enlightened catholic monarchs to dissolve monasteries without public utility, by which they understood activities in education or care for the poor and sick. Thus already before the French revolution Catholic religious congregations shifted towards more work in nursing.

After the dissolution of most monasteries by revolution, occupation and official secularization, that was equal to an existential crisis for many of the now former monks and nuns, the state's suppression of monastic life continued even after the end of the Napoleonic Wars and the Congress of Vienna. The only religious congregations that were allowed to have novices were again those devoted to health care and education, namely in Prussia the sisters of St. Ursula and St. Elisabeth and the Brethren of Charity.[79] Thus the again increasing number of those who felt inclined to a life as sister or brother in a religious order was forced to enter nursing or teaching. Promoted by leading romantic authors such as the already mentioned Joseph Görres and Clemens Brentano[80], the care for the sick was re-established as part of Catholic or – to be seen with the Protestant deaconesses of Theodor Fliedner – Christian identity.

The enormous increase of religious congregations living for and from nursing was made possible by the new hospitals founded in obviously all cities and towns. Members of religious orders also served in secular health care institutions, such as the new University hospitals, but their main interest was to work in Catholic hospitals and more and more even in their own hospitals. Catholic hospitals were certainly also a result of the attempt to strengthen Catholic identity in territories that were now ruled by Protestant monarchs and where therefore Catholic citizens tried to establish health care institutions independent from the state. An often imitated

78 Cf. Eduard Seidler and Karl-Heinz Leven, *Geschichte der Medizin und der Krankenpflege* (Stuttgart, [7]2003), pp. 166–167.

79 Erwin Gatz, *Kirche und Krankenpflege im 19. Jahrhundert. Katholische Bewegung und karitativer Aufbruch in den preußischen Provinzen Rheinland und Westfalen* (München, 1971), p. 37.

80 Cf. Clemens Brentano, *Die Barmherzigen Schwestern in Bezug auf Armen- und Krankenpflege* (Koblenz, 1831; Mainz, [2]1852, [3]1856); Brentano's most important contact in the care for the poor and the sick was the already mentioned Apolonia Diepenbrock.

model was the Johannes-Hospital in Bonn.[81] In 1842 citizens of all denominations, led by the town mayor, founded a society for a citizens' hospital. When, however, the Catholic majority in the committee of this society wanted to call Catholic sisters of charity as nurses, the Protestant and Jewish members left the society and founded institutions of their own. Bishops of Catholic territories in Prussia supported the foundation of new Catholic hospitals actively,[82] whereas in German territories with a Catholic monarch such as Bavaria the church's traditional influence on old and new hospitals did not make a similar wave of Catholic hospitals necessary.

Conclusion

The argument that there had been a certain move from the enlightenment idea of religion serving medicine (or to express it in analogy to the medieval relationship between theology and philosophy: "religio ancilla medicinae") to a romantic subordination of medicine under religion ("medicina ancilla religionis") in the majority Catholic regions of Western Germany was examined for three different groups of professionals. Although all of these groups, Catholic physicians, priests and nursing sisters in religious congregations, participated in the mental change from enthusiasm for public utility in the late enlightenment to the revival of devotion in the period of restoration, the practical consequences for each group were quite different. Whereas more women than ever before devoted their life to institutionalised nursing as members of religious congregations, priests had to refrain from medical activities, and the attempt by some medical doctors, Catholic as well as Protestant ones, to maintain or regain the academic connection between a

81 Cf. Ferdinand Doelle, *Das St. Johannis-Hospital in Bonn. Festschrift zu seinem 75jährigen Bestehen* (Bonn, 1924); Hugo Stursberg, *100 Jahre St. Johanneshospital in Bonn 1849 – 1949* (Bonn, 1949).

82 Leading figures were the Archbishops of Cologne and Breslau, Johannes von Geissel and Melchior von Diepenbrock, and the most famous proponent of Catholic social teaching, the bishop of Mainz, Wilhelm Emmanuel von Ketteler. For Geissel as adherent of the medieval hospital cf. Gatz, *Kirche*, p. 41; for Diepenbrock as supporter of religious congregations cf. Antoni Kiełbasa, "Die Restauration der Orden unter Bischof Melchior von Diepenbrock (1845–1853)", *Archiv für schlesische Kirchengeschichte*, 59 (2001), 247–270, for Ketteler's social work in general cf. Ludwig Lenhart, *Kettelers literarische, staats-, sozial- und kirchenpolitische Initiative in seiner und unserer Zeit. Eine literargeschichtliche Studie zu seinem Schrifttum. Bischof Ketteler: Staatspolitiker, Sozialpolitiker, Kirchenpolitiker,* vol 1 (Mainz, 1966), for his involvement with hospitals Wilhelm Emmanuel von Ketteler, *Sämtliche Werke und Briefe*, 11 vols (Mainz, 1977–2001), especially "Hülferuf zur Errichtung eines katholischen Krankenhauses in Berlin (1850)", vol I, 1, pp. 93–107; "Beleuchtung des Gemeinderäthlichen Commissionsberichtes über die Verhältnisse des Vincenz-Hospitals zu den Ortsfremden und den städtischen Hospizien (1864)", vol I, 5, pp. 591–603; many letters on hospitals in Beckum, Berlin and his own diocese Mainz, cf. index.

scientific and a philosophical or religious description of the world, finally failed, when natural philosophy was overcome by natural sciences in all the German faculties of medicine. It might be speculated that nursing was less affected by the natural sciences than medicine and therefore more easily offered this niche in modern society for devote women.

In a secularised way, the view that religion could profit from medicine, but not so much the other way round, remained dominant for more than a century – on both the medical as well as on the theological side. This tendency of making medicine serve the Christian religion concerns especially a more and more independent part of medicine, namely psychological knowledge, e.g. in counselling, and modern medicine by mission doctors and hospitals in overseas missions. Only the recent interest in spiritual aspects of health and healing, scientifically investigated in studies on placebo or psycho-neuro-immunology, has again changed the direction of the possible relationship between medicine and religion. Thus esoteric and charismatic movements repeat a central idea of the enlightenment era, although on a more psychological level: religion serving medicine and health.

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What was the Best for an Infant from the Middle Ages to Early Modern Times in Europe?
The Discussion Concerning Wet Nurses[1]

Sünje Prühlen

Who was the appropriate woman to care for a nursing infant: the wet nurse or the biological mother? This was a very important question for parents in the Middle Ages and the Early Modern Times. Parents found themselves amidst the conflict of theological and medical views and their own opinions concerning thoughtful baby care. These opinions might have been influenced by books about childcare especially addressed to parents in their language, marriage guides, or variously formulated statements in several other treatises. The following presents preliminary results of a larger research-project focussing wet nurses in the German-speaking Europe.

In the European medieval universities a discussion was carried on about women who breast-fed infants they had not born for remuneration. Many of these arguments were raised in Latin but were in large degree repetitions of those discussions originating in ancient times. This discussion was diverse and had been taken up by doctors, philosophers and theologians.[2] Of these sources only those which seem of greatest importance or which present special circumstances can be considered in the

1 Special thanks go to Helen Dwyer, New York, USA, who did the proof-reading.

2 E.g. Erasmus von Rotterdam, "Die glückliche Mutter", pp. 274–292, in H. Schiel (Transl.), *Erasmus von Rotterdam, Vertraute Gespräche (Colloquia familiaria)* (Stuttgart, 1985); "The New Mother Puerpera", pp. 590–618, in C. R. Thompson (Transl.), *Collected Works of Erasmus, Colloquies* (Toronto, 1997). Alberus Erasmus, *Das Ehbüchlein* (Frankfurt/Main, 1539), Chapter 4. Pages are not numbered. Marc Pinter (Ed.), *Die "Kinderzucht des Hieronymus Schenck von Siemau"* (1502) (Hamburg, 1996), pp. 36–39. Adolf Mauch (Transl.), Paolo Baggelardi, *Libellus de Aegrituditudinibus infantium, Padua 1472* (Bottrop, 1937), pp. 8–9. Monica H. Green (Transl.), *The Trotula. A Medieval Compendium of Women's Medicine* (Philadelphia, 2001), pp. 110–111. Erhart Kahle (Transl.), *Das Ammenregimen des Avicenna (Ibn Sina) in seinem Qanun* (Erlangen, 1980). Contain excerpt from his Liber canonis. Sabine Krüger (Ed.), *Konrad von Megenberg, Ökonomik. Book I* (Stuttgart, 1973), pp. 78–85.

following exposition. The inclusion of additional sources would go beyond the scope of this article.

Why were a relatively large number of intellectual involved in this debate starting always with the divinely ordained motherly love and the god-given ability of breastfeeding? Why did parents nevertheless choose the duty of a wet nurse? Why, on the other hand, did many academics point out the importance of making a careful choice? Is it possible to draw conclusions regarding a large number of wet nurses in society from the many treatises which still exist? Why was the topic so widely discussed? Caring for infants by wet nurses may have been prevalent, but up until the present there have been no opportunities at all for quantitative analysis concerning the period from the Middle Ages to the Early Modern Times. The pool for a comprehensive analysis is too small. In the following study another way of providing evidence of wet-nursing will be given, taking into account the period and the characteristics of the sources coming from the German-speaking parts of Europe. Because of the illiteracy of the wet nurses and thus their inability to author their own accounts, they have been the subject of sources written mostly by men. The prime instigator of the discussion in the Middle Ages was the men of learning. Wet nurses were mentioned in passing for example, in hagiographical sources[3], but there were very few references in testaments or letters. In the later Middle Ages wet nurses were then increasingly mentioned in autobiographical notes, especially in those of citizens or nobleman.

So far up to Middle Ages the discussion about wet nurses in the above mentioned German-speaking region was different from that carried on in other European countries. In the German-Speaking area the wet nurse was called 'Amme'[4] and worked under different conditions than her counterpart in other countries such as France, England or Italy. I would like to refer especially to the research results of Valerie Fildes, Sara Matthew Grieco and Dorothy McLaren.[5] These historians pub-

3 These kinds of sources are especially available in the early times of the Middle Ages, e.g. Hugeburc von Heidenheim, Vita Willibaldi episcopi Eichstetensis. See as well: Felix's Life of Saint Guthlac. Both cited in Klaus Arnold, *Kind und Gesellschaft in Mittelalter und Renaissance* (Paderborn, 1980), pp. 97–98.

4 The term 'Amme' or 'Säugamme' did not only mean the Latin word 'nutrix', it was also used for midwives (in German: *Hebamme* or shortened *Amme*). The word 'Amme' is verifiable in the Old and the Middle High German. Jacob Grimm, Wilhelm Grimm, *Deutsches Wörterbuch, 1* (Leipzig, 1854), col. 278. The German 'Amme' and the Iberian 'ama' has nearly the same meaning and should trace back to the Latin expression which little children babble. Cp. "Ama", *Dicionario crítico Etimológico Castellano e Hispánico, 1* (Madrid, 1980), 226–227, Carolina Michaelis de Vasconcellos, "Randglossen zum altportugiesischen Liederbuch", Zeitschrift für romanische Philologie, 20 (1896), 162–163.

5 Valerie Fildes, *Wet-Nursing. A history from antiquity to the present* (Oxford, 1988); Valerie Fildes, *Breasts, Bottles and Babies. A History of Infant Feeding* (Edinburgh, 1986); Sara F. Matthews Grieco, "Breastfeeding, Wet Nursing and Infant Mortality in Europe (1400–1800)", *Historical Perspectives on Breastfeeding* (Florence, 1991), 15–62; Dorothy McLaren, "Marital fertil-

lished their findings with other sources of greatest importance in the 1980s and 1990s. They have provided truly fundamental research in this area, especially for this era. There are no comparable German authors.[6] The findings of Fildes, Grieco and McLaren were based mostly on documents of the already mentioned countries. Beyond those findings of the mentioned European countries it is possible to find German sources documenting wet nurses as well as specific characteristics and circumstances which should receive attention. The author who perhaps had the most influence on parents, judging from the new edition of his books, is Bartholomäus Metlinger (c 1440–1492). He published the first paediatric book in German. It is one intention of this exposition between the demand for and the existence of wet nursing.

In contrast to England, for example, many wet nurses stayed in the houses of their German employees.[7] Wet nurses also took care of foundlings who were not usually sent to the countryside to stay with the wet nurses' families. These wet nurses were paid, controlled and supervised by city councils because such infants were foundlings or orphans. In the accounts of Zwickau, Saxony, a wet nurse who came from a respectable family had been listed since the year 1500. The town authorities not only paid the fee of the wet nurse but also paid for the baby's clothing, baptism and, if necessary, funeral.[8]

In this period foundling hospitals were not found everywhere in Germany. In northern German cities such as Hamburg a hospital was founded in 1595 solely for orphans of the city's inhabitants. In the southern part of Germany, for example in Munich, poor but married mothers had the possibility to deliver their babies in a special house. After their mothers died these abandoned child remained outside the city walls until they were weaned. Sometimes the families had to pay for the basic necessities of the infants. In the area of the Upper Rhine there were foundling hospitals in earlier periods. Some of the foundlings, for example in Strasbourg stayed in the country with their wet nurses as it was common in the proximate France.[9]

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ity and lactation 1570–1720", M. Prior (Ed.), *Women in English society 1500–1800* (London, 1985), 22–53.

6 Some authors only give a chapter in their treatises about wet nurses. E.g. Frank Meier, *Mit Kind und Kegel. Kindheit und Familie im Wandel der Geschichte* (Ostfildern, 2006), pp. 99–104.

7 Cp. Valerie Fildes, "The English Wet nurse and her role in infant care 1538–1800", *Medical History*, 21 (1988), 143–144. *Same, Breasts, Bottles and Babies* (Edinburgh, 1986), pp. 152–156.

8 Ute Rosenbaum, *Liebestätigkeit und Armenpflege in der Stadt Zwickau. Ein sozialhistorischer Abriss von Mittelalter und beginnender Neuzeit* (Hamburg, 1999), pp. 41–42. In Basel, Switzerland, the hospital put a foundling into a wet nurse's care. Michaela von Tscharner-Aue, *Die Wirtschaftsführung des Basler Spitals bis zum Jahre 1500* (Basel, 1983), p. 50.

9 E.g. the biography of the abbot saint Robert of Chaise-Dieu (†1065) written by Marbod of Rennes (c. 1035–1123). The saint Robert did not accept the wet nurse's milk, not because

Other foundlings were raised in orphanages. The city council also paid the allowance in the nearby monastery of Staßfeld. As well, the alderman of Frankfurt/Main placed their foundlings in Staßfeld, supervised the wet nurses until the children were weaned and could be returned to their towns of origin.[10] In contrast to the whole German-speaking Europe wet nurses who stayed in the country were the exceptions, for example in England. For foundlings a wet nurse was a necessity and increased the chance of survival.[11] These individual women might not have been the main interest in the discussion about wet nurses and the value of nursing-mothers. But with whom were the academics really concerned?

Wet Nurses and Wet-Nursing in German Sources

There is documentary evidence of only a small number of few wet nurses for this period; for many more there is none. More information about the circumstances of wet nurses can be found especially in autobiographical notes, as in the case of Hartmann Schedel (1440–1514), who acquired a Master of Arts and a Doctor of Medicine in adulthood.[12] Schedel's wet nurse is documented, because she stayed in the employer's house. She must have been seen almost as a family member and thus became a subject of the oral tradition, as evidenced by Schedel's having passed down facts related to her as an adult. Schedel mentioned his own wet nurse, Margareta, who came from Adorf – a town in Bohemia about 150 km away from her place of employment in Nuremberg. In addition Schedel put on record several wet nurses of his own children. In the Middle Ages and the beginning of the Renaissance wet nurses ranked higher in the social hierarchy than the maidservant or the

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of the smell but because of the wet nurse's sins. Cp. Klaus Arnold, *Kind und Gesellschaft in Mittelalter und Renaissance* (Paderborn, 1980), p. 103.

10 Ulrich Knefelkamp, *Das Gesundheits- und Fürsorgewesen der Stadt Freiburg im Breisgau im Mittelalter* (Freiburg, 1981), p. 149.

11 Gerry Hill has pointed out the importance of wet nurses and their influence on the survival rate of children. He omits in his essay the time of the Middle Ages. Idem., et al., "The Medical and Demographic Importance of Wet-Nursing", *Canadian Bulletin of Medical History*, 3 (1987), 183–193. John Knodel and Hallie Kintner analysed the modern times when the breast-feeding patterns changed. Idem, "The Impact of Breast feeding patterns on the Biometric Analysis of Infant mortality", *Demography*, 14 (1977), 391–491.

12 Hartmann Schedel, Hartmann'sche Familienbuch/Familienchronik. Staatsbibliothek Berlin, Cod. Germ. 2° 4472, fol. 16. Hartmann Schedel is author of the Chronicle of the world which was first published in Nuremberg 1493. His library holdings are known to have been considerable. Hartmann Schedel, *Weltchronik* (Nuremberg, 1493). Richard Stauber, *Die Schedelsche Bibliothek. Ein Beitrag zur Geschichte der Ausbreitung der italienischen Renaissance, des deutschen Humanismus und der medizinischen Literatur* (Freiburg, 1908, Reprint Nieuwkoop, 1969).

menial, but they were still part of the menial staff.[13] In some payment records only wet nurses were itemised. Apparently the merchant Michel Behaim (1459–1511) from Nuremberg only paid his wet nurse, Kunne.[14]

A wet nurse had less and lighter work to do than the other servants as it was recommended by the doctors. The academics dealing with the subject asked the employer to employ wet nurses during lactation. Parents were to be aware of the possible deleterious effect which hard labour on the part of the wet nurses could have upon the quality of milk. On the other hand laziness could be bad for the quality as well.

These are not the only examples from civic or noble families[15], but because of the low rank of the wet nurses, they have not often been listed. A future desideratum will be the precise interpretation of autobiographical notes to find reference to more wet nurses. In the upper classes the duties of wet nurses were more common, but it would be careless to assume that every baby would have been suckled by a wet nurse. While there is a great uncertainty, it is nevertheless possible to find in the sources more indications besides the wet nurses' names or the term Amme. Thus it may be possible that the academic and the public debates were closer to reality than it now seems. Why the topic has been discussed so widely in academic circles cannot be answered, but this might provide stimulus for looking into other lines of argument.

Many German writers of autobiographies of this period listed especially in registers the name and the date of birth of their own children.[16] The birth intervals in the example below are unusually short and do not correspond to the natural infertility of the biological mother in times of lying-in, lactation and normal pregnancy. Most of these children survived infancy. Therefore it can be assumed that they were born following a normal pregnancy. Stillbirths are noted in the sources and in some cases there are indications of premature births or birth defects. Some of these infants died, but especially in the case of premature births after seven months of

13 See the register of the professor's servants from the University of Helmstedt 1584. *Album Academiae Helmstadiensis*, ed. by Paul Zimmermann, 1, 1 (Leipzig, 1926, Reprint Nendeln, 1980), p. 53. Also Max Hermann (Ed.), *Albrecht von Eyb, Ehebüchlein* (Berlin, 1890), p. 19.

14 Q.v. J. Kamann, *Nürnberger Haushaltungs- und Rechnungsbücher aus dem 15. und 16. Jahrhundert* (Nürnberg, 1888), p. 17.

15 E.g., the memoirs of Helene Kottanerin are thought to be the earliest of a German woman. Karl Mollay (Ed.), *Die Denkwürdigkeiten der Helene Kottanerin (1439–1440)* (Wien, 1971). pp. 18–22.

16 E.g. Gudrun Litz (ed.), "Familienbüchlein Spengler", in Berndt Hamm, *Lazarus Spengler (1479–1534)* (Tübingen, 2004), pp. 361–402. Several datas from the sources are listed in Klaus Arnold, "Kindertotenbilder – Neue Zugänge zu Leben und Tod von Kindern im späten Mittelalter und in der frühen Neuzeit", K. W. Alt, A. Kemkes-Grottenthaler, eds., *Kinderwelten* (Köln, 2002), pp. 215–219. With this pool it might be possible to find out the infant mortality of these specific population groups.

pregnancy the authors noted this special circumstance and the will of the baby to live. These autobiographies may provide an under-utilised pool of information especially for the Middle Ages. After the Reformation Church records in the German-speaking Europe, as opposed to other regions, are another source of information which has become popular for such research.

The first postpartum menses is possible after two months and ovulation therefore occurs earlier. Exclusive breastfeeding prolongs this period although this is dependent upon the number of times a child is nursed in a day. Some physicians in the Middle Ages and the Renaissance advised a mother – or the wet nurses – to feed the child not more than three times a day; others never fixed a limit. This might point to an element of uncertainty. Breastfeeding exclusively during night and day provides a high probability of contraception for the first six months post partum.[17] In this specific point it may be possible to combine modern medical knowledge and historical data. The Brandis family from Hildesheim, lower Saxony, is a good example for this combination with a reverse. In their case the birthday of every child as well as some wet nurses are documented. The first seven of the 15 children (two pairs of twins) were born to one mother in intervals of 12 and half and 14 and half months, the others between 16 and 22 months. The children were born alive and survived infancy. In each circumstance the intervals of the births are unnaturally short, given that the biological mother breastfed every child.[18]

Another aspect to be considered is food. At this time the only way of nourishing babies to assure a high survival rate was breastfeeding. In the German archives – especially in the Early Modern period – recipes for formula for use at the time of weaning were found[19], but there was no reference to a formula using milk from ani-

17 The Lactational Amenorrhoea Method (LAM) is one method of contraception. The efficacy of the method for full breastfeeding women depends on the times of lactation. Alan S. McNeilly, "Lactational Endocrinology: The Biology of LAM", *Advances in experimental medicine and biology*, 503 (2002), 199–206. Intensive Breastfeeding of six and more times a day causes a Lactational Amenorrhoea up to 18 month postpartum. C. Keck, C. Kissel, "Regulation der Laktation", *Gynäkologische Endokrinologie*, 3 (2004), 130–131. Dorothy McLaren analysed others sources which are not available for a comparable time in German-speaking Europe. Idem, "Nature's contraceptive. Wet-Nursing and prolonged lactation: the case of Chesham, Buckinghamshire 1578–1601", *Medical History*, 23 (1979), 426–441.

18 Q.v. Sünje Prühlen, *"Alse sunst hir gebruchlich is"* (Bochum, 2005), pp. 73–75, Diagram p. 363.

19 There are a lot of prescriptions or recipes for weaning shortly after the accouchement. In the Heidelberg University Library there are many popular scientific treatises available which were passed over as paper manuscripts. Many recipes are written in German and copied several times. Most of these documents were undirected and anonymous. Some gynaecological prescriptions are titled "For women, who wean their child because the milk hurts, the child died or she doesn't want to breastfeed by herself" Cp. Heidelberg University Library, Cod. Pal. Germ. 236, fol. 122r, Cod. Pal. Germ 252, fol. 147r, Cod. Pal. Germ. 288, fol. 96r, 101r, Cod. Pal. Germ. 702, fol. 5v. There are also recipes to recover maternal ability of breastfeeding as well as to increase the lactation of the wet nurse. Cp. ibidem, Cod. Pal. Germ. 195, fol. 174r, Cod. Pal.

mals.[20] Thomas Platter (1499–1582), a Swiss author from the beginning of the sixteenth century, wrote in his autobiographical notes that he had been fed via a horn like those used for older children. His mother had not had the physical ability to suckle her little boy, so he received cow's milk from a cow horn. This method of nutrition had been essential for him. Normally this procedure resulted in the deaths of many infants because cow's milk was unsuitable because it could not be digested by a young child. Additionally, this animal milk was suspected of transferring the attributes of the host to the child.[21]

Feeding an infant from a horn or a suckle pot presented also a hygienic problem. Some mothers were afraid that their breasts became altered by feeding their own child directly from their nipples. So they decided to use a suckle pot or a horn for the breast-milk in order to preserve their physical beauty.[22] The employment of a wet nurse, therefore, did not seem to be a necessity but rather a luxury. Sometimes, however, the employment of a wet nurse has been a necessity if, for example, the biological mother died while giving birth or as a result of a caesarean section[23] or during the postnatal period. In these cases the chance of survival for the baby increased with the services of a wet nurse.

Apparently a greater number of wet nurses must have stayed in the employers' homes than was recorded in the autobiographical notes or in other registers. Wet-nursing was a more important factor in taking care of an infant than the focus of

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Germ 225, fol. 265r, 273v, Cod. Pal. Germ. 254, fol. 197v, 202v, 203r, Cod. Pal. Germ. 256, fol. 302r, Cod. Pal. Germ 270, fol. 68r–70r, Cod. Pal. Germ 288, fol. 7r, Cod. Pal. Germ 299, fol. 24r. A catalogue to some of these recipes can be found under the following address: http://archiv.ub.uni-heidelberg.de/volltextserver/portal/med-hs/ (12.06.2006)

20 Thomas Platter, *Hirtenknabe, Handwerker, Humanist. Die Selbstbiographie 1499 bis 1582*, Heinrich Boos, ed. (Nördlingen, 1989), p. 8.

21 Thus it might be possible that for this reason no experiment was conducted with animal milk at all. Konrad Bitschin (c 1400 – after 1464) gave an example of a wet nurse who fed the child entrusted to her care with pig-milk. In adulthood this child behaved like a pig. Richard Galle (Ed.), *Konrad Bitschins Pädagogik* (Gotha, 1905), pp. 17, 104.

22 Suckle pots and horns are known from the ancient times. Hans Schadewaldt, *Geschichtliche Übersicht über die zur Säuglingsernährung verwandten Geräte.* Wissenschaftliche Ausstellung, 54. Tagung der Deutschen Gesellschaft für Kinderheilkunde 1954. Hermann Brüning, *Geschichte der Methodik der künstlichen Säuglingsernährung, nach medizin-, kultur- und kunstgeschichtlichen Studien* (Stuttgart, 1908). See as well an English depiction of a woman who is feeding an older child from a horn. Bari Hooper, "A Medieval Depiction of Infant-feeding in Winchester Cathedral", *Medieval Archaeology*, 4 (1996), 230–233.

23 The first successful caesarean which mother and child survived in German-speaking regions is documented in 1610 in Wittenberg, Saxony. Gottfried Trautmann, *Der Kaiserschnitt des Jeremias Trautmann im Jahre 1610* (Wittenberg, 1978). There might have been more successful caesareans but they were subjects of oral tradition and not documented by eyewitnesses. E.g. Oswald Feis, "Bericht aus dem Jahre 1411 über eine Hebamme, die angeblich 7 Kaiserschnitte mit gutem Erfolg für Mutter und Kind ausgeführt hat", *Sudhoffs Archiv für Geschichte der Medizin*, 20 (1928, Reprint 1965), 340–343.

historical research up to now would indicate. It may be possible to approximate patterns of family life in this period by data analysis of the available sources.

It is not easy to provide evidence regarding the knowledge of the correlation of breastfeeding to fertility, conception, and minimising birth intervals in the sources of this period. The church could have disapproved of such knowledge because it might be misused. In his book of 1433 the German town clerk, Konrad Bitschin from Danzig (now Gdansk, Poland), found fault that an increasing number of women had their children fed by wet nurses because they did not want to stay sexually abstinent during lactation as the church recommended.[24] Medicine encouraged this point of view by asserting that sexual intercourse could affect the quality of the breast-milk and therefore the state of health of the child. This concerned the biological mother as well as the wet nurse. Against the background of Bitschin's observation it may also be possible that there was a common knowledge of a Jewish source of Regensburg from the fifteenth century.[25] Jewish families were advised to hire a wet nurse if there had not been enough children born to glorify God. This was a part of the oral tradition. This information could have been transferred by a dialogue between Jews and Christians.

This might be sufficient reason for parents to hire a wet nurse, but the theologians, philosophers and physicians had many arguments against wet-nursing. In addition to the above mentioned antique heritage of Hippocrates[26] and Galen[27] and the medieval Islamic influences of Rhazes, Avicenna, Constantinus of Africa and Averroes, it is possible to find special German contributions to the discourse about birth and childhood as well.[28]

The Academic Discussion on Breast Feeding

Following examples from antiquity many authors started their disquisition of breastfeeding with a description of the wonderful loving care that only the biologi-

24 Richard Galle (Ed.), *Konrad Bitschins Pädagogik* (Gotha, 1905), pp. 17, 104. Ole J. Benedictow explained the long term and wide spread discussion about breastfeeding women who should stay abstain from sexual intercourse. Cp. Ole J. Benedictow, "On the Origin and spread of the Notion that Breast-Feeding Women should abstain from sexual Intercourse", *Scandinavian Journal of History*, 17 (1992), 65–76.

25 Susanne Borchers, *Jüdisches Frauenleben im Mittelalter. Die Texte des Sefer Chasidim* (Diss., Köln 1998, Frankfurt, 1998), pp. 236–237.

26 Q.v. *Corpus Hippocraticum, De natura pueri.*

27 Q.v. Erich Beintker (Transl.), *Galenos Gesundheitslehre*, 1–3 (Stuttgart, 1939), pp. 34–35, 38–41.

28 Bartholomäus Metlinger mentioned these examples by name in his preface. Idem, *Ain vast nutzlich regiment der iungen kinder* (Augsburg, 1511). Pages are not numbered.

cal mother could bring the child through the process.[29] What could be more advantageous for an infant? The mother could pass on her love and also her character through the milk even as she had done via her blood in the womb. The blood was merely transformed into the milk. God created a woman with breasts and the possibility of lactating a newborn. So she could and should nourish her newborn baby until the child could tolerate solid food. This was always a sign and a symbol of motherly love, a wonderful devotion between mother and child. The theologian and musician, Heinrich von Laufenberg (c 1390–1460), added by way of explanation that the child should suck with "lust" at the breast of his mother[30] but this was never the only reason for nursing the biological infant. During gestation the character of a child was formed by the character of the mother.[31] Afterwards the nursling could come into contact with the character of a woman who was a stranger. In some cases this could be fatal – not in the sense, that the child really died – but that the entire life of the baby could be modified.[32]

So it was very important – if the real mother did not or could not suckle her own infant – to select a wet nurse very carefully. In the Middle Ages the doctor of medicine and sometimes other men of learning had the authority and the knowledge of childcare to enable them to instruct parents and midwives. In later times these men also placed wet nurses in the homes of the employers.

This task of the physicians changed when the German authors did not write in Latin anymore. Bartholomeus Metlinger is one of the most famous doctors of his times, as he describes himself in one of his later printings of his helpful regimen for young children.[33] Metlinger was the first paediatrician in Germany and worked in Noerdlingen (now in Swabia) and Augsburg (now in Bavaria) and published his advice in his 'Regiment der Kinder', reprinted several times since the original in 1473.[34]

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29 Albertus Magnus (c 1200–1280) summarized in his sermon that Mary had been a mother and wet nurse in one person. Under no circumstances she would have handed over Jesus to a real wet nurse. Albertus Magnus' Sermon about Luke 11,27 cited in Klaus Arnold, *Kind und Gesellschaft in Mittelalter und Renaissance* (Paderborn, 1980), p. 120.

30 Heinrich Laufenberg, *Versehung des leibs* (Augsburg, 1491), Chapter 6. The pages are not numbered.

31 This belief came out of the ancient world and has been codified in the middle ages. Ibidem.

32 Sabine Krüger (Ed.), *Konrad von Megenberg, Ökonomik*. Book I (Stuttgart, 1973), p. 78; Adolf Mauch (Transl.), *Paolo Baggelardi, Libellus de Aegrituditudinibus infantium, Padua 1472* (Bottrop, 1937), p. 9

33 Bartholomäus Metlinger, *Ain vast nutzlich regiment der iungen kinder* (Augsburg, 1511).

34 Bartholomäus Metlinger, *Ein regiment der jungen kinder*, Facsimile of the print from 1497 (Zürich, 1976); Ursula Gray, *Das Bild des Kindes im Spiegel der altdeutschen Dichtung und Literatur* (Frankfurt/Main, 1974). The pages of the Facsimile are not numbered. – As can be seen in the following compilation of theological and medical authors: Later Metlinger's treatise was

Metlinger's proposition never changed in any of the editions unlike the different German idioms. He gave advice for parental care until the child was seven years old. His audience was made up of parents – mostly out of the bourgeoisie as in a trading town like Augsburg. In the preface he addressed his book explicitly to mothers and fathers. Who actually read the book and followed the instructions is as yet unknown.

The 2nd chapter of his regimen was titled: "How you should nourish and feed a child". There he pointed out to the parents that a baby should not get the milk of the biological mother until the fourteenth day of the maternal childbed. In that period the quality of the milk would not be good for the infant. He proposed that young puppies should suck the milk out of the mother's breasts.[35] Authors of Antiquity recommended that another woman could suck this milk. Soranos, for example, advised waiting a period of about two or three days time after the birth.[36] This paradigm has been taken over in part as Metlinger wrote not to suckle the children for the first three days of their life. When a wet nurse was involved, this period could be extended.

Metlinger advised that if it was not possible for the mother to take a break in lactation, she should suckle the infant with a little bit of honey in his mouth. This would protect the baby against the bad quality of her milk. Who nursed the newborn in the time when the mother herself was not to nurse the infant at all? Nobody knows. These women – like those in Metlinger's case – were not called wet nurses in contrast to the practice of ancient authors like Soranos. They may have simply been women who remained in the puerperium longer than had the natural mother herself. So the term wet nurse was used for women who took care of little infants for a longer time.

Other authors as well as Metlinger tell us more about the proper choice of a wet nurse.[37] The selection criteria varied only a bit among authors. The age of wet

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also a part of the German pharmaceutical book for the matrimony (in German 'Ehestandsarzneibuch') together with the versions of Eucharius Rösslin's (c 1470–1526) textbook *Rosarium for Pregnant Woman and for Midwifes* ('Schwanger Frawen und Hebammen Rosengarten'). The *Rosarium* was the first really successful textbook for midwifery in German. This miscellany contains a woman's drug book – *Frawen Artzeney* – by Johannes de Cuba (1484–1503), a physician specialising in medicinal herbs, the Secrecies ('die Heimlichkeiten der Frauwen') by medically educated theologian, Albert the Great (1193–1280), and the Fortuities of Pregnant Women who causes concerns, ('Von sörglichen Zufällen der schwangeren Frauen') by the Italian obstetrician Ludovico Bonaccioli (–1540). Q.v. *Ehestandsartzneybuch* (Erfurt, 1542).

35 Ursula Gray, *Das Bild des Kindes im Spiegel der altdeutschen Dichtung und Literatur* (Frankfurt/Main, 1974), p. 220.

36 Owsei Temkin (Transl.), *Soranus' Gynecology* (Baltimore/London, 1991), p. 88.

37 E.g. Sabine Krüger (Ed.), *Konrad von Megenberg, Ökonomik*. Book I (Stuttgart, 1973) (Monumenta Germaniae Historica, Scriptores III, 5/1), p. 78.

nurses should have been between 20 and 35 years.[38] Metlinger defines the best age about 25.[39] The wet nurse's child – ideally a healthy boy – should be six to twelve weeks old so that the mother would be through the anastasis period. The wet nurse should be a good fit to the child's physical and mental abilities so that the parents using her services would not bring illness to the child. This maxim was derived from the Hippocratic idea of the humoral pathology.

A good wet nurse had an exemplary character, was not choleric, was moderate in all walks of life, especially in her eating and drinking habits. During the time of nursing a woman – whether biological mother or wet nurse – was not to have sexual contact at all.[40] This was thought to affect the quality of the milk as well as to promote illness and renewed pregnancy[41]. During the time of distress mothers – whether biological mother or wet nurse – aided one another. In 1541 the Swiss naturalist and physician, Conrad Gesner (1516–1565), noted in his brief book about milk and milk products, which also included human milk, that wealthy families should hire several wet nurses. If a wet nurse, for example, became ill, the problem thus could be solved more easily.[42] The question concerning what happened to the biological child of the wet nurse in this period cannot be answered because at this point of research there are no sources at all. Wet nurses may not all have been mothers who had given birth to a living child. Their babies may have died shortly after birth or have been stillborn during the latest stages of pregnancy. The nurslings of the wet nurses might have resided in the house of the employers where nobody talked about it.[43]

Metlinger advised that in the case that the wet nurse became pregnant the child should be weaned to avoid becoming ill. In this case the baby should be fed only

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38 Q.v. Erhart Kahle (Transl.), *Das Ammenregimen des Avicenna (Ibn Sina) in seinem Qanun* (Erlangen, 1980), pp. 6, 17; Adolf Mauch (Transl.), Paolo Baggelardi, *Libellus de Aegrituditudinibus infantium, Padua 1472* (Bottrop, 1937), p. 9.

39 Metlinger recommended a wet nurse being between 20 and 30 years of age, ideally 25 years old. Bartolomäus Metlinger, *Ain vast nutzlich regiment der iungen kinder* (Augsburg, 1511), Chapter 2.

40 Q.v. Richard Galle (Ed.), *Konrad Bitschins Pädagogik* (Gotha, 1905), pp. 17, 104.

41 See as well a German prescription in Heidelberg University Library about pregnancy being injurious to the child as well as a woman being unchaste during the nursing period. In this context Galen was mentioned by name. Cod. Pal. Germ. 292, fol 16r-16v. Q.v. gloss. No. 9.

42 Carl-Ludwig Riedel (Ed.), Conrad Gesner, *Büchlein von der Milch und den Milchprodukten. Libellus de lacte, et operibus lacteriis, philologus pariter ac medicus* (Mönchengladbach, 1996), p. 48. This seems to be only advice.

43 Only in later times can the circumstances of the infant and the family be focussed. Upon the eighteenth century wet nurses from the surrounding area of Hamburg left their children at home in their families with the father and stayed with the employers in the city. The wet nurse was so well paid that she could support the whole family. L.A.G. Schrader, "Beherzigungen über die moralischen und politischen Folgen des Ammendienstes in großen Städten auf die umherliegenden Distrikte", *Schleswig-Holsteinische Provinzialberichte*, 1 (1787), 457–461.

mush.[44] He went on recommending as well that the child should receive "more mush" if the parents or the wet nurse were confronted with a problem. He did not explain this further. Metlinger wrote that the infant should be fed a mixture of the wet nurse's milk and mush until the first baby teeth came in at the age of two. He never gave a fixed date for the beginning the regimen of milk and mush, but apparently this was to happen soon after birth, i.e., at a very young age for the suckling baby.

Metlinger was an author who gave good advice with regional distinctions. In the area around the cities of Augsburg and Noerdlingen it might have been normal to feed babies cereals at a very young age. For centuries the death rate in this area and as well in some regions of Wurttemberg was extremely high in comparison to other regions of Germany because children there were never fed with milk at all.[45] At the beginning of the nineteenth century physicians guessed an atrophy of the female breasts because they surmised that the mammary glands became mutated after a long period of disuse for generations. The doctors thought that women lost their ability to nurse their children.[46] When in history nutrition with grain began in these regions is unknown.[47] It may be possible to find indications by studying the mortality rate in parish registers and evidence in other documents. This is a desideratum for future research because the relation between Metlinger and his audience has never been focused upon. It is not clear whether Metlinger was acting on someone else's suggestion or if he himself initiated a development which resulted in the abandonment of breastfeeding across broad levels of the population.

Bartholomäus Scherrenmüller (c 1450 after 1493), medical professor at the University of Tübingen translated into German in 1493 on behalf of Earl Eberhard im Bart of Wurttemberg (1445–1492) the Latin version of the health regimen of William from Saliceto (c 1210 – c 1285).[48] William from Salicetos wrote the original De conservatione sanitatis a die conceptionis usque ad ultimum vite senij in the thirteenth century. Differing to Metlinger's broad target group, this German version has only been designed for court. Saliceto or Scherrenmüller advised that

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44 Ursula Gray, *Das Bild des Kindes im Spiegel der altdeutschen Dichtung und Literatur* (Frankfurt/Main, 1974), p. 221.

45 Georg Mayr, "Die Sterblichkeit der Kinder während der ersten Lebensjahre in Süddeutschland, insbesondere in Bayern", *Zeitschrift des königlich Bayerischen statistischen Bureau*, 2 (1870), 201–202.

46 Reinhold Altmann, *Über die Inactivitätsatrophie der weiblichen Brustdrüse* (Diss. Munich 1888, Berlin, 1888).

47 Hugo Bernheim remarks that there were reports in the year 1524 that in these regions the women did not nurse at all. Idem, "Schwankungen der Sterblichkeit in Bayern und Sachsen und deren Faktoren", *Zeitschrift für Hygiene*, 4, (1888), p. 575, note 1.

48 Wolfram Schmitt, *Bartholomäus Scherrenmüllers Gesundheitsregimen (1493) für Graf Eberhart im Bart*, (Diss. Heidelberg, 1970). It contains: Wilhelm von Saliceto, 'De conservatione sanitatis a die conceptionis usque ad ultimum vite senij' = 'Summa conservationis et curationis'.

the infant should only get breast milk until the child was between six and twelve months old.[49] Then the mother or the wet nurse could nourish the child additionally with rice pudding, dunking bread, and a little bit of tender, white meat. This seemed quite early because as Avicenna said – like Soranos as well[50]–, the child should be weaned by the age of two.[51] The theologian and natural scientist, Konrad von Megenberg (1309–1374), however noted in his house book ('Ökonomik') of 1352 that only poor parents were forced to nourish their babies for a period of one and half years or longer.[52] Children who suckled for a longer while would have stronger physiques. Heinrich Laufenberg recommended that the child should be fed with milk alone until a tooth appeared.[53] There is no documentary evidence as to how long children really were wet-nursed or breastfed by their biological mothers. Most of the wet nurses stayed for a longer period of time – two or three years – in the homes of the employers. As the child became older the wet nurse played with him/her and taught him/her to speak and to walk.[54] She took care of him/her, like she did before, for 24 hours a day. They slept in the same room and the wet nurse swaddled, bathed, cradled and calmed the infant.

The Selection and Supervision of a Wet Nurse

The biological parents supervised the wet nurse and the child. If something changed in the behaviour of the child, the employers had the duty to control the milk by taste, smell and appearance as at the onset of the employment. The Swiss naturalist and physician, Conrad Gesner, summarized all criteria from the ancient authors.[55] The milk of a good wet nurse had to be sweet at all times, white in colour and not too thick or thin. A colour of light green or yellow should be a warning to the parents. On a fingernail the milk should stay in a drop. If the breast milk would taste acrid or salty, this could be a sign for illness of the wet nurse. Parents were also to be attentive if the liquid was malodorous or foamy. In these cases the wet nurse

49 Ibid., pp. 58, 112.

50 Owsei Temkin (Transl.), *Soranus' Gynecology*, (Baltimore/London, 1991), pp. 117–118.

51 Erhart Kahle (Transl.), *Das Ammenregimen des Avicenna (Ibn Sina) in seinem Qanun* (Erlangen, 1980), p. 25.

52 Sabine Krüger (Ed.), *Konrad von Megenberg, Ökonomik*. Book I (Stuttgart, 1973), p. 83.

53 Heinrich Laufenberg, *Versehung des leibs* (Augsburg, 1491), Chapter 6.

54 Sabine Krüger (Ed.), *Konrad von Megenberg, Ökonomik*, Book I (Stuttgart, 1978), pp. 83–85. Wolfram Schmitt, *Bartholomäus Scherrenmüllers Gesundheitsregimen (1493) für Graf Eberhart im Bart*, (Diss. Heidelberg, 1970), p. 59.

55 Carl-Ludwig Riedel (Ed.), *Conrad Gesner, Büchlein von der Milch und den Milchprodukten. Libellus de lacte, et operibus lacteriis, philologus pariter ac medicus* (Mönchengladbach, 1996), pp. 48–49.

was to milk the liquid out of her breast. If the quality was still not satisfactory, the child was to receive other breast milk, or as Metlinger proposed, the infant should be weaned.

The wet nurse was to be in good physical condition. For the acceptance test Metlinger set even higher standards. The parents were to look very carefully at the physiognomy of the wet nurse. First of all the parents were to appraise the chest. The wet nurse should have a strong neck. If the wet nurse passed this test and was employed the parents were responsible for her health, the health of the child and the quality of the milk. Metlinger, therefore, offered much advice in this area. The wet nurse was to get good and healthy food with light white meet, grain, and fresh vegetables (except for onions and garlic). The meal was not to be hot and spicy. She should drink mild wine mixed with water and, and for the more northern German regions Metlinger recommended beer. He pointed out to the parents that beer could water down the breast milk. On the other hand beer could promote lactation.[56] If the wet nurse or the infant would have problems with their stomachs, their digestion or their appetite, the wet nurse should drink dill, fennel and caraway tea. If the child suffered from constipation the wet nurse should get an enema. The infant should be wet-nursed very carefully and properly so the baby grew, rested easily and would not cry for anybody. If the little one was not pleased with the situation, parents should first consider the child and then the wet nurse. If the employed woman showed signs of a bad character[57] or poor behaviour, the father was to educate the wet nurse. If the parents followed all instructions, the child would be sane, although not if the biological mother were taking care of him the entire time.

Thus the discussion about wet nurses left the medical faculties and the authority of men of learning. Perhaps the authority to place a wet nurse in the employers' homes changed at that point also. There had been a necessity to educate parents, and there had been a market for the wet nurses as well. This wet nurse market increased in German-speaking Europe in the late eighteenth and the beginning of the nineteenth centuries.[58] Then the whole system moved away from the employers' houses and the family relationship to foundling hospitals with permanent wet nurses. Wet nurses became more and more anonymous and left also the oral tradition of the family atmosphere. Physicians showed more interest in increasing the

56 Berthold Koletzko, Frauke Lehner, "Beer and Breastfeeding", in B. Koletzko, et al., eds., *Short and Long Term Effects of Breastfeeding an Child Health* (New York, 2000), pp. 23–28.

57 About the importance of character and the analogy between child and wet nurse see as well Sabine Krüger (Ed.), *Konrad von Megenberg, Ökonomik*. Book I (Stuttgart, 1973), p. 78.

58 The expanding discussion about wet-nursing in Germany has already been the subject of research. Johanna-Luise Brockmann, "Ammentätigkeit in Deutschland (1750–1925). Eine Problemskizze zu einem vernachlässigten Thema der Sozialgeschichte", *Zeitschrift für Pädagogik*, 28 (1982), pp. 695–714; see as well: Wolfram Malte Fues, "Amme oder Muttermilch? Der Disput um das Stillen in der frühen deutschen Aufklärung", *Aufklärung*, 5 (1990), pp. 79–126.

milk yield of the wet nurse[59] – an indicator of the depersonalization of the wet nurse.

Summary

The discussion concerning wet nurses in the Middle Ages and the Early Modern Times was widely diverse. Theologians, physicians and philosophers offered advice to the public. In earlier periods it was assumed that the literate public could read Latin. In German-speaking Europe the audience changed with the publication of the first paediatric book in German by Bartholomäus Metlinger in 1473. He gave advice about the selection of the right wet nurse and her supervision during her time of residence directly to parents in their own language. His advice about childcare did not agree with the opinions of other authors from the same period. It might be possible to conclude, however, that Metlinger's advice dramatically changed childcare in some regions because centuries later physicians still thought that the mothers could not nurse their own children anymore. In this society the women did not feed their children with mother milk. Was this the result of the debate about the divinely-ordained motherly love, the God-given ability of nursing and the right choice of childcare? This is a desideratum of the future research.

Authors like Metlinger, on the other hand, established criteria in this lively discussion as how to select a wet nurse. Autobiographical notes may provide references to a more realistic view on the phenomenon "wet nurse". Most of these women stayed in the employers' homes which complicated on the one hand, finding evidence of their existence, and on the other hand, complicated the circumstances of life of their biological child. The first complication maybe reduced by looking more at the facts which exists in combination to the biological ability of fertility. The question about the wet nurse herself and her child is at this point not answerable. These are subjects of future research. Questions concerning childcare, motherly love, infant mortality and improved survival rates are closely connected to the hiring of wet nurses. To consider the wide variety of sources of German-speaking Europe may answer many questions in this neglected area of research and will open up additional points of view.

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59 Chaja Brodsky, *Beobachtungen über die Lactation der Amme*, (Diss. Zürich, 1914, Stuttgart, 1915); Johannes Laurentius, *Zur Leistungsfähigkeit der Brustdrüse der Ammen* (Diss. Leipzig, 1911, ibid., 1912).

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