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Michael Skjelderup

Michael is a publication series named after professor *Michael Skjelderup* (1769-1852), one of the fathers of Norwegian medicine. He was born in Hof, Vestfold in Norway as the son of a priest, and was raised in the Norwegian countryside. Because of severe speech disturbances as a boy he did not get proper schooling, but was at last accepted as an apprentice in an apothecary's dispensary in the city of Fredrikstad at the age of 16. During his youth he tried through hard work and by means of an intensive self-discipline to overcome his handicap, and he really succeeded, except for in stressed situations.

Lacking a student examination, an academic training seemed out of question, in spite of his obvious bright mind. However, in 1789 he was admitted to the new Surgical Academy in Copenhagen, where academic qualifications were not required.

From now on, his career flourished. He passed the surgical examination with the highest grade in 1794, entered positions in Copenhagen hospitals and at the University, where he defended his doctoral thesis in 1803 and was appointed professor in 1805.

The first University in Norway was founded in Christiania (now: Oslo) in 1811. Medical teaching was supposed to commence from the very beginning, and from 1814 the new medical faculty could offer medical training. Michael Skjelderup was appointed its first professor 1813, and started his teaching, mainly in anatomy in the fall of 1814, after a dramatic war time sea voyage from Denmark across the waters of Skagerrak where hostile Swedes fired at his swift sailing vessel.

As a University pioneer, he became active in several medical fields. Among other achievements, he published an authoritative textbook in forensic medicine in 1838. When he resigned in 1849, eighty years old, he had seen all Norwegian trained medical doctors in his lecture room.

Skjelderup was instrumental in building a scientific medical community in Christiania. Together with his University colleague Frederik Holst (1791-1871) he founded the first Norwegian medical journal *Eyr*, named after a norse medical goddess, in 1826. A reading club of physicians established in 1826 was formalized into an association in 1833, the still existing Det norske medicinske Selskab (The Norwegian Medical Society), which over the decades to come played an important role in the development of the health services and of a national medicine.

Michael is devoted to the memory of the man who first realized the importance of a regular, national medical publication activity in Norway and implemented his ideas in 1826. *Michael* is published by the same association as was founded by Michael Skjelderup and his colleagues – Det norske medicinske Selskab.

The editors

Øivind Larsen

Interdisciplinarity

Michael 2006;3:53–4.

This issue of *Michael* draws attention to a problem which in no way is new to any scholar: Interdisciplinarity.

The problem comes to sight in different disguises. One of them deals with the objects for study, e.g. in the social sciences, where a process might be so complicated and context-linked that reviews seen from different professional angles will result in quite different perceptions of the reality. An example: In this issue of *Michael* Stewart presents a complicated and multifaceted topic where the history could be written from many points of standing, successfully synthesizing the aspects into a balanced overview (1).

Another problem of interdisciplinarity lies within the professions and scientific communities themselves. Scientific reductionism may easily be accompanied by a certain scientific arrogance towards others who address the same objects from other points of origin.

As a rule, cooperation and combined efforts will yield more results than the sum of the single contributions would have done. Most people who have been engaged in successful interdisciplinary work will probably agree on that.

Interdisciplinarity is difficult. But why?

Admittedly, there may be psychological explanations, also sometimes with good reason, to why many researchers defend their field eagerly and look with scepticism on intruders. However, more interesting are the obstacles which may be sought in the organisation of research in the academic world. Scientific topics are often linked to special institutes or working groups which then on the one hand takes responsibility for the crucial work of developing methods and setting standards, but which on the other hand because of this specialisation are weakened in their ability to put their achievements into a proper context; that is to discuss implications with the same scientific depth as they cover their discipline.

Even if it may be felt as a violence against the academic freedom, some organisational changes seem both possible and desirable in order to get around this interdisciplinary problem. University departments and research institutes could to a larger extent set up their activities according to a matrix model leaning on a dual division into a set of scientific groups and project groups: The work in scientific projects could be arranged in a way where scholars with different scientific background simply are forced to work together in project groups with the same, defined objectives. Then the interdisciplinary element becomes an undisputable part of the way of working, at the same time as the scientific standards of the different fields are held.

However, when people are reluctant to interdisciplinary work and cooperation across conventional borders, there also may be reasons for that. In the paper by Gradmann presented in this issue (2), the discipline of medical history in Germany is an example of the dangers of being consumed, if the cooperation and integration is not properly steered through scientific arguments.

Obstacles to interdisciplinarity and cooperation sometimes also have to do with language and culture. Although such barriers should have diminishing importance these days, they still exist. Even if a large amount of ongoing research is published in English, work of general interest also for good reasons is published in other languages, addressing readerships and scientific communities which nevertheless should attract interest. In this issue of *Michael* we therefore bring some book reviews in English on non-English works which we think deserve attention. Of course an English review brings the reader no language proficiency in the language of the author of the book, but if interested, you could then take direct personal contact with the author.

Interdisciplinarity remains as a problem, but this fact should not be a hindrance to try to do something to it.

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**Aleck Ostry, Tara Shannon,
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The origins of Canada's first national dietary standard

Michael 2006;3:55–68.

Introduction

Dietary standards were, at least until the late 1940s, developed by governments in response to food shortages because of war, agricultural failures, or distribution problems arising from economic and political crises (1). In 1862, the British government, in response to an agricultural crisis and related civil unrest, developed the world's first dietary standard (2). A second dietary standard was developed towards the end of World War One, by the British government in response to the potential for wartime food shortages (3).

The economic depression of the 1930s spurred the next round of dietary standard setting. In 1993, a committee of the British Medical Association established a dietary standard designed to maintain the working capacity of the population and, in the same year an American researcher, Hazel Stiebeling, established a standard to maintain optimal health (4, 5). And, in 1935, the League of Nations developed an international dietary standard to both improve national diets and to re-stimulate agricultural production and international trade (6).

In Canada, in 1933, two years prior to publication of the League's standard, the Ontario Medical Association (OMA) established a dietary standard for families receiving social assistance which was used by some municipal and provincial welfare administrations to determine social assistance rates in the mid-1930s (7). In 1936 the Canadian federal government endorsed the OMA relief standard and, within two years, established both a national nutrition policy making organization, the Canadian Council on Nutrition (CCN) and, a Canadian national dietary standard (8).

Widely publicized vitamin discoveries, new metabolic studies, and dietary survey methods had, during the inter-war years, increased the effectiveness and status of nutrition science in both lay and scientific circles. The 1933 Stiebeling standard established requirements for a number of miner-

als and vitamins, representing a major scientific improvement in dietary standards since the first British standard in 1862.

While the new science of nutrition gave governments a rational tool for planning diets for large populations, it was the persistently high levels of unemployment relief payments in Canada during the 1930s, within the context of growing provincial and municipal governments' inability to finance these that shaped the timing and the content of the 1938 national dietary standard. The Canadian standard was also highly influenced by the League of Nations which, throughout the 1930s, took leadership in promoting nutrition research by encouraging members to form national nutrition policy-making institutions and to develop dietary standards.

The purpose of this paper is to describe the political, social, and scientific origin of Canada's first national dietary standard promulgated in 1938. This is an historical case study framed within an ecological model of policy making in which a specific policy issue, in this case the development of a national dietary standard during the decade of the 1930s, attracts the attention of groups within and outside government who view a policy change as important within a social climate that either enables or restricts policy adoption and forward momentum (9). The three pillars in this ecological model are first, the identification and characterization of the main elements in the social environment shaping policy, second, the identification and characterization of the main stakeholder organizations guiding and shaping policy, both domestically and internationally, and finally, a determination of the way in which science was used in the policy process (9).

The official adoption of national dietary standards by governments was an early example of the conscious use of a newly emerging health science by policy makers and serves as an interesting historical example both of the ways in which scientific uncertainties were negotiated within the field of nutrition science as well as the ways in which the new science was utilized by policy makers. As Smith has noted, in discussing the evolution of food policy in the 1930s in Britain, "the links between science and food policy can rarely be straightforward. Policy making and implementation involve processes of negotiation between, among others, scientists, administrators, politicians, and industrial interests" (10).

This paper is divided into four sections. In the first section, the problem of unemployment in the 1930s in Canada is introduced as this was the single most important political influence on dietary standard setting. Second, domestic and international policy developments in relation to unemployment and dietary standards are outlined and main stakeholders identified. Third, policy developments leading to the formation of the Canadian

Council on Nutrition and the first dietary standard in Canada are outlined. In the final section, the way in which Canadian nutrition scientists negotiated with peers and policy makers to develop Canada's first dietary standard is described.

Unemployment and dietary standards

The Wall Street crash in October 1929 triggered an international economic depression that, in Canada, reached its nadir in 1933 and lasted until 1939. The impact of the Depression was disproportionately borne by the agricultural sector. Between 1929 and 1933 agriculture's share of national income fell from 23 to 12 percent while the proportions earned from the manufacturing and service sectors, remained stable (11).

The crisis in agriculture was felt throughout the world as tariff walls were erected and trade ground to a halt. The common problem faced by almost all nations in the early 1930s, with the collapse in international trade was, on the one hand, unemployment, low incomes and the specter of nutritional insufficiency or malnutrition, and, on the other hand, "often massive food surpluses as crops and foodstuffs were being deliberately destroyed in a bid to stabilize prices" (12).

In Canada, in response to these difficult conditions, increasing social unrest, and the growth of left-wing opposition parties, private charities and municipal and provincial governments, initiated at patchwork of largely uncoordinated and inadequate relief efforts consisting of a combination of direct distribution of food and financial assistance. By 1933 the mushrooming cost of relief payments left many municipalities and provincial governments near bankruptcy forcing a reluctant federal government to provide grants and loans to deal with growing insolvency among these lower levels of government (14, 15). This situation became increasingly untenable because the federal government had no constitutional authority over the administration of unemployment relief programs and therefore no control over costs but, by the mid-1930s, it was footing most of the national unemployment relief bill.

In an attempt to rationalize the patchwork relief system across Canada, the federal government imposed standards for relief administration as a condition for cash grants and loans to the provinces (14). As the unemployment crisis deepened in 1937, the National Employment Commission advised the federal government that in order to improve national labour mobility and productivity as well as the efficiency of relief spending, it should develop a nationally integrated system of employment training, placement, and unemployment insurance (16).

Federal policy discussions of the issue focused on labour and fiscal efficiency although there was limited recognition that the impact of long term unemployment, through sustained insufficient food intakes, could compromise health as well as labour productivity. For example, according a 1938 Royal Commission on Federal-Provincial relations, "the deficiency of relief food allowances in body building proteins and protective foods is bound to have bad effects on families who must live on them for long periods of time. Undermining of physique and destruction of morale are then inevitable. The state must later pay the permanent costs of unemployability, illness, crime, and immorality. The lack of standards in relief administration has injured the taxpayer and continues to do so" (17).

As the depression deepened pressure from left-wing political groups and organizations of unemployed workers grew for expanded and more generous relief programs from municipal and provincial governments. Because of the high proportion of relief incomes spent on food, debates about the adequacy of relief rates centered increasingly on the quality and quantity of food required to sustain the health of families receiving cash assistance [1]. At the same time, on the international stage, the League of Nations was making the "business case" to its member nations, for similarly making nutrition and health in general, and dietary standards in particular, central to any international solution to the crisis of unemployment. It is to a description of these growing domestic and international pressures and emerging stakeholders that we turn in the next section.

Domestic and international stakeholders

Domestic stakeholders and Canadian nutrition science

Pressure to establish a nutrition policy making capability at the Canadian federal level and a dietary standard came from both domestic and international sources. The Canadian and Ontario Medical Associations and various women's and children's organizations formed nutrition committees that worked closely with community groups concerned with the health status of the unemployed (19).

In Ontario, early in the Depression, when under the pressure of growing unemployment relief payments, the provincial government moved to standardize the administration of relief, debate centered on the proportion of the relief allowance to be spent on food (20). These were debates about

[1] In September 1936 the proportion of relief allowances spent for food ranged from a low of 44% in Hull Quebec to a high of 77% in Victoria, British Columbia (18)

money, which focused on arguments about government's ability to pay, as there was little scientific information available on the quality or quantity of food required to maintain health, particularly among low income and unemployed families.

This changed in 1933 when the Ontario Medical Association (OMA) published its dietary standard largely based on Stiebeling's American standard (21). The OMA applied their dietary standard to typical Toronto family diets and then costed these demonstrating that the cost of feeding a family of five was approximately 30 percent higher than the relief food allowance established by the Ontario and various municipal welfare administrations (22). This information was used by public health and welfare officials, community groups, trade unions, and groups of unemployed workers to pressure government to increase social assistance rates (23).

At this time, in Canada, unlike in the United States and Britain, very few dietary surveys had been conducted so that scientific information about diet and health, particularly in low income and unemployed populations was limited. The earliest dietary surveys in Canada, undertaken in 1931 and 1935, were marketing investigations conducted by the Department of Agriculture on the relationship between family income and milk and meat purchases (24, 25). While these surveys demonstrated that families with higher income purchased more of the "protective" foods, (i.e. higher quantities of vitamin-rich dairy products and meat) they said little about the nutritional status of low income families included in the surveys.

The first comprehensive dietary surveys in Canada undertaken with a specific health focus, among low income populations were conducted in Edmonton, (27), Halifax (28), Quebec City, and Toronto (29, 30,31) and published between 1934 and 1941, that is about the same time or after the promulgation of the Canadian national dietary standard in June 1938. Thus, other than the dietary standard created by the OMA and a few economically motivated dietary surveys conducted by the Canadian Department of Agriculture, scientific information on the dietary and health status of the Canadian population was limited and not widely available to community and other opposition groups agitating locally (i.e., at the municipal and provincial levels) for increases in assistance rates.

However, several nutrition scientists were engaged in the late 1930s conducting dietary surveys, mainly among low income urban populations. Most of these studies compared dietary intakes in these families with the Canadian dietary standard and found that intakes were largely inadequate, for energy as well as for many minerals and vitamins, compared to the standard. And, in the conclusions to most of this research, it was usually noted that a combina-

tion of poverty and lack of proper nutritional knowledge contributed to inadequacy of diet among these low income populations (27, 32).

In one of these earliest dietary surveys, E.W. McHenry demonstrated that among 100 Toronto low income families protein, calcium, and iron consumption was less than in middle income Toronto families (31). In discussing the results of this survey, McHenry stated that "we are forced to the conclusion that an appreciable number of our urban people are not properly fed. So far, data regarding rural conditions have not been secured. With regard to urban diets we can make a prediction with some certainty: that the average picture among those families with the lowest incomes is one of under-nutrition" (31).

McHenry, in discussing these and other results from dietary surveys emerging at this time suggested that "these results also point to the need for educational work giving information about nutritive values in relation to food cost. Especially great is this need among families with low purchasing power. An increasing amount of evidence shows clearly that many families are spending sufficient money to secure an adequate diet but are failing to do so because of a lack of knowledge regarding economical purchasing" (32 p.258). Other leading nutrition researchers at the time also shared the view that the problem was not so much lack of money for food but more, a lack of education, among the poor, on how to efficiently buy the best diets with the income they had (27). These attitudes were also common among American nutritionists at the time (33).

When McHenry's and other dietary surveys became available to the public after 1939 they were seized upon by Toronto area activists to pressure the Ontario government for increased relief rates. However, as war began in 1939 relief rolls across Canada dropped dramatically so that the cost to governments of increasing relief rates was drastically reduced. For example, between 1939 and 1941 the proportion of Ontario's population receiving social assistance decreased from 9.8 to 1.9 percent of the population (22). Ironically it was only towards the end of the war, in 1944, with increasing wartime prosperity when relief rolls had virtually been eliminated in a full-employment economy that the Ontario government accepted the use of the new Canadian national dietary standard in establishing food allowance relief payments for those on assistance (22).

Although dietary standards established by the OMA were available in Canada as early as 1933 and although these were used by opposition groups to agitate for increases in relief rates this process was largely unsuccessful prior to the war, at the municipal and provincial level as governments held the line on increased relief spending. While these domestic pressures to in-

corporate scientific dietary standards into municipal and provincial relief administration largely failed to produce results in Canada, international efforts to further scientific nutrition policy making found an increasingly receptive federal government as it began, after 1937, to develop a national program of unemployment insurance.

International stakeholders

Efforts spearheaded by the League of Nations, and based largely on research conducted by John Boyd Orr in the early 1930s in Britain, were brought to bear on many national governments by the mid-1930s. Using Stiebeling's dietary standard, Body Orr demonstrated widespread deficiencies in the British national diet that increased with decreasing income. Because his research demonstrated severe nutritional inadequacies, among the poor, it was used, by trade unions, and unemployed and anti-poverty organizations to pressure the government to increase relief rates (34).

At a time of mass unemployment, plummeting wages, and fiscal retrenchment, British government ministers "were desperately concerned to disprove links between malnutrition, ill-health and low income" and the Ministry of Health moved quickly to block publication of his research (35). In spite of Ministry efforts, the report was published and widely read by the lay public and in medical and nutrition circles internationally and in Canada.

His work was championed by the Mixed Committee of the League of Nations which reported in 1936 "there are good reasons for believing that the trend of dietary habits, particularly in countries with a Western civilization, towards a larger consumption of protective foods would coincide with a parallel evolution of agricultural production, which would in all probability benefit the rural populations of the various countries, and might also greatly contribute to a resumption of normal economic relations between the nations" (36).

This vision rested on the implicit assumption that governments would increase relief payments putting cash in the hands of the needy to provide the economic stimulus. This Keynsian idea of using scientifically determined dietary standards to forge a "marriage between nutrition and agriculture" would never be entirely embraced, at least in the late 1930s, by a Canadian federal government which was determined to hold the line on relief spending rather than increase it as the League was urging (17).

The Mixed Committee's also urged national governments to form national nutrition councils by collecting "the opinions of technical experts concerned with the various aspects of nutrition" specifically to develop national dietary standards (37).

The Canadian government was receptive to establishing a dietary standard as part of its program to rationalize a new labour strategy linked with an unemployment program but was not interested in the standard being used as the League had intended. The Canadian government desired to take control of the patchwork relief system to rationalize and constrict existing levels of expenditure not expand them (38).

As early as 1933, on the urging of the League of Nations, Canada had established a high level committee (with the unwieldy name of the Canadian Preparatory Committee of the British Commonwealth Scientific Conference) which included the Deputy Ministers of Agriculture and Pensions and National Health, the Director of the National Research Council and representatives from the Dominion Bureau of Statistics, and External Affairs. They established a nutrition sub-committee charged with the task of developing a national nutrition council and a dietary standard (39).

The Canadian Preparatory Committee's Sub-Committee on Nutrition was the key federal stakeholder responsible for introducing the new international nutrition thinking and research into Canada and its high profile membership and mentorship by the League gave it prominence and credibility. It is to the work of this committee that we turn as it shaped nascent federal nutrition policy from 1935 until the formation of the CCN in 1938.

The origins of the Canadian Council on Nutrition (CCN)

The Canadian Preparatory Sub-Committee on Nutrition report was tabled in the summer of 1936. In the report, Dr. F. Tisdall, chairman of the OMA Sub-committee on Nutrition and lead author of the OMA dietary standard, justified the OMA dietary standard in the context of both John Boyd Orr's research in Britain and the League of Nations, recently published dietary standard.

While dismissing the applicability of Boyd-Orr's research to the Canadian situation, Tisdall, stated that Boyd Orr's work "is from such a different angle than the material presented in our OMA report so that very little comparison can be made" (40). He went on to outline the scientific basis of the OMA standard stating that it "is essentially the same as Stiebeling's standard, however, being lower than usual, due to the fact that this is a relief standard where the head of the family is not working" (41). Further Tisdall said that "a study of our standard from the economic standpoint shows that it is less than the recent standard issued by the League of Nations".

Having positioned his standard in this way, Tisdall noted that if Canada used the OMA relief standard as the basis for calculating unem-

ployment relief rates rather than the League's standard cost savings would result (42). The report showed detailed calculations that with the OMA standard, food allowance costs in Toronto would be 28 percent higher than the then current food allowance in the city but that use of the League's standard would increase these costs a further 30 percent indicating that adoption of the League's standard would raise Toronto's current food allowance by 58 percent.

The adoption of the OMA standard did not apply as much upward pressure on relief rates as would have adoption of the League of Nations standard. This was essentially a compromise in which a lower Canadian standard was adopted because it met the criteria of scientific acceptability by the scientific and political establishment and, very importantly, it minimized the impact of relief rates. While adoption of this standard by an inter-disciplinary multi-ministerial committee was an important first step, the authority of such a committee was limited both within the federal government, and in relation to its ability to influence relief administrations given the peculiar constitutional situation in Canada at the time which gave the federal government no authority in social assistance policy and therefore, in this context nutrition policy. Therefore, on February 19th 1938, at a special meeting chaired by the Deputy Minister of Pensions and National Health, the Canadian Council on Nutrition was formed and the decision made that Canada should establish its own national dietary standard. In the next section we will turn to the scientific negotiations underway during this18 month period which finally led to the Canadian dietary standard.

The 1938 Canadian Dietary Standard

Because dietary survey data were almost entirely lacking in Canada, in 1938 Hazel Stiebeling, who as the world's pre-eminent expert in this area was in contact with the Canadian government, advised the Canadian Preparatory Committee to wait until they had more scientific data before setting a national standard (43) The committee ignored Stiebeling's advice and instead decided to proceed. This was likely because of the unique Canadian situation in which the federal government was moving quickly to develop a national employment program which needed a dietary standard (43).

The key figure in drafting the new Canadian standard was Dr. E. W. McHenry, who was appointed as a CCN scientist in February, 1938. CCN meeting minutes indicate that he drafted the standards and coordinated subsequent negotiations with peers and policy makers over its final content and form throughout the year 1938 (44). The bulk of this correspondence

is with the leading nutrition scientists in Canada as well as more limited direct correspondence with Hazel Stiebeling in the United States.

In an early draft of the Canadian standard McHenry states that, "in relief work the lack of a suitable standard has caused a great deal of controversy. Whether a diet is considered adequate or not depends on the standard of comparison. The statement has been frequently made that a family cannot be considered properly fed unless a diet equal to the League standard is provided. Such a diet for a family of five in Toronto would cost approximately twelve dollars a week, an amount greatly in excess of that provided by relief authorities. Obviously it is of importance to determine whether this standard should be followed or whether alterations in accord with Canadian customs should be made." (45)

McHenry offers the following rationale to use in altering the League's standard "in accord with Canadian customs". "Measurements of food consumption of healthy persons of sedentary occupations in Toronto have shown that men actually consume about 2,500 calories per day and women about 2,000. The Leagues allowances for men agree very well with these actual records of consumption and with averages of physiological measurements of energy requirements. The discrepancy in the case of women is obvious and is explicable in several ways. Many European women must work, of necessity, in the fields and must spend as much energy as men. This is not the case in British or American communities. Hence, in men-value scales customarily employed in Great Britain, the caloric allowances for a woman is generally given (as in the Cathcart scale) as 83% of the value for a man, since the basal metabolism and body-area of women is lower than those of men. If we accept the basal standard for a man as 2,400 Calories and employ the Cathcart coefficient, the standard for women should be approximately 2,000 Calories. This agrees with the consumption figures quoted above and may be regarded as a modification in the League standard suitable for Canadian conditions". (46)

In his draft, McHenry goes on to explain that using the League's standard a married couple on relief in Toronto would require 5,400 Calories versus the proposed Canadian standard in which the couple would require 4,800 calories per day. He also noted that the 1935 League standard, like the 1933 OMA standard, did not have separate consumption figures for boys and girls. But, because American data showed that girls ate less than boys and because in Britain, women's consumption was reduced in relation to men this provided scientific justification for altering the League's standard according to "Canadian customs".

The use of this rationalization is ironic as McHenry, in commenting on his own dietary survey results in Toronto, observed at this time that women

in low income households tended, in the face of food shortages, to stint on their own consumption to ensure that their husbands and children received adequate nutrition (22). The CCN's method of adapting the League's standard, using a British rationalization and American data on children's nutrition, to reduce women's requirements is difficult to understand given the limited, but fairly compelling, Canadian evidence derived from a scientifically designed dietary survey that poor women's low caloric intakes might reflect personal sacrifice in the face of scarcity rather than "real" caloric consumption.

As well, the final Canadian national dietary standard agreed upon in June 1938 was likely even lower than the OMA standard due to the reduced standard for women and the separation of requirements for boys and girls and reduction in these for girls in the national standard. [2] Although CCN correspondence between McHenry and a number of nutrition scientists in Canada in early 1938 indicates that many disagreed with his rationale for downgrading the standard for women, this standard was finally adopted in the spring of 1938.

Conclusion

This historical case study demonstrates that while an international body did initiate new institutional developments and stimulate new nutrition research in Canada the federal government used this external stimuli to manage its own domestic policy agenda, particularly in relation to the national unemployment program.

As well, the study shows how lack of basic information on nutrition and health hampered public and local community groups in their efforts to influence the content and shape of the national dietary survey. In the five years leading up to promulgation of the standard, information on nutrition standards among the poor was available in some academic journals but, other than the OMA's standard and related background information, the community had very little information with which to mobilize public opinion. And, the scientific establishment, while in possession of fairly strong evidence that the poor were not well fed, posited that this was due in some measure to their lack of education rather than their lack of income providing policy makers with some comfort that the leading nutrition sci-

[2] It is difficult to directly compare the OMA and the national standard because the OMA standard did not separate requirements for boys and girls and because the age ranges used in the OMA standard for children were different than those used in the national standard.

entists of the day were not likely to use the emerging data from dietary surveys to pressure for increased relief rates.

In the period leading up to establishment of the Canadian dietary standard, while the moral and scientific pressure and prestige of the League's standard was ever present, the lack of national dietary survey information and the consequent lack of information to mobilize the public, left its final negotiation and formulation entirely up to a scientific elite with a firm eye and strong understanding of the need to reduce the League's standard in order to satisfy the federal government's need to keep relief rates low.

The lack of information not only reduced public involvement but it also increased the level of scientific uncertainty which accorded a larger role for scientists as adjudicators in this situation. The final stage in the development of the standard, largely overseen by E. W McHenry, indicates it was weakly rationalized using current social prejudice rather than science, and, in fact at odds with McHenry's own results indicating that poor women's caloric intake as measured in dietary surveys would be low because many were restricting intake in order to better feed their families. These judgments resulted in a much lower standard than advocated by the League and somewhat lower than the OMA standard, but one that was in accord with the domestic policy agenda insofar as related to the new national unemployment plan.

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KEY WORDS: Dietary standard, Nutrition policy, Unemployment, History, Canada.

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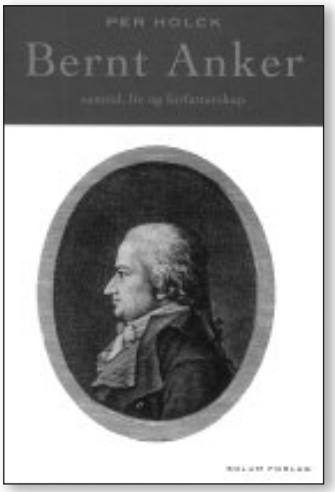
Book review:

Wealth and values – On the life and fate of Bernt Anker (1746-1805)

Michael 2006;3:69–72.

Holck P. Bernt Anker – samtid, liv og forfatterskap. Oslo: Solum, 2005. 183 pp. ISBN 82-560-1505-5. Price: NOK 289,00.



Studies of topics from the last decades of the 18th century Nordic countries are often puzzling. Like in greater parts of Europe at the time, major changes took place in politics and culture. However, here in the Northern region the processes often became even more visible because of local circumstances. The case of Norway was quite special: Political decisions by the government in Copenhagen had led Denmark, then including Norway, into an unfortunate war with Sweden and Britain. The communications between Denmark and Norway were severely hampered. This isolation of Norway, lasting for years, became serious for the population. Foreign trade dried up, and when peace was restored, economic crises got a severe impact on daily life. Norway also faced major political changes, as the country loosened its ties to Denmark after the years of war, got its relative independence in 1814 and became part of a union with Sweden. The 19th century brought something quite new in nearly all fields, so new that many old structures simply fell apart. Norway shifted away from a traditional life where changes had been few and slow for a long time.

This book, written by professor of anatomy and physical anthropology Per Holck at the University of Oslo, deals with a quite peculiar person in

the Norwegian capital of Christiania, the merchant, ship-owner and industrialist Bernt Anker (1746-1805). Anker was in the last decades of the 18th century the richest man of the city, his wealth exceeding almost everything thinkable at the time. His many sawmills, his forests, his estates and his ships employed thousands. Personally, he led a luxurious life in Christiania. At this time, the city faced the sea towards the Bjørvika bay in the east. Here, Bernt Anker was living in a palace at the seaside, built by his father Christian Anker (1711-1765) in 1744-1755 on the top of old storage vaults, and with a nice garden stretching out to the water.

As a businessman, his successes have to be seen in their context: Norway had no efficient banking system at the time, and much of his fortune was locked up in real estate. Swift and favourable trading and transactions added to his wealth. But often this type of making business required cash money, instantly available. Therefore he had to rely on a complicated system of credits given by business partners and other members of the local elite, which in turn earned money for their favours through interests and mutual services. An utmost attention was necessary all the time, in order to keep up with what was going on. In spite of his solid position, Bernt Anker had to be alert all his life to prevent bankruptcy, at the same time as maintaining the family façade by means of a life in luxury was both a social necessity and a requirement for enjoying the trust and credit he needed to promote his business. Scandals staining the family had to be avoided for any price, even if the cover-up could be extremely painful, as when he chose to pay the debts of his unfortunate brother Jess Anker (1753-1798).

Holck describes the life and achievements of Bernt Anker in a well written text. The reader learns about the background and is introduced to the small group of key families and persons who in fact constituted the informal leadership in Norway at the time. The rich young boy Bernt Anker had already at the age of 14 been to England to learn the language, and 1764-1768 he was travelling Europe on a "grand tour", leaving him with an intention to become a diplomat. However, his wealthy father died in 1765, and Bernt Anker had to return to Norway and take over the family company, which he for the first 16 years ran together with his mother.

Anker had also studied at the University in Copenhagen, and he had wide cultural interests, accompanied with a liking for the decadent upper class life he had experienced abroad. Christmas parties of ten days' duration are only one example of his posh life-style, another the dinner given at his wife's birthday on 28. May 1793, where the friend, business-partner and distant relative John Collett (1758-1810) under his napkin at the table

found an extraordinary gift: the signed transaction document for the large estate Ullevål outside the capital.

A biography on Bernt Anker may emphasise different traits of his work and personality, e.g. his efforts to introduce a national banking system in Norway. Holck, however, has highlighted the cultural sides of his life. Bernt Anker promoted the establishment of a national university; in his palace were given lectures on scientific topics, he was instrumental in the establishing of a theatre in the city, he was writing plays for the stage and even took over parts as an actor himself. Bernt Anker eagerly pursued also other values of life than wealth.

Bernt Anker had ambitions as an author, as a man of letters. He left behind many manuscripts, meant to be published after his death. He appears to the modern reader as a sort of renaissance person, yet closely linked to a society of the *ancien régime*.

Perhaps Bernt Anker's ties to his time were part of the explanation for what happened later, when society had changed. Prior to his death at the age of 59 in 1805, his health was failing, As a widower from 1801 he felt lonely. Attempts to find a second wife were unsuccessful, despite his wealth and position. He did not fit into society anymore as good as he did before. Perhaps he also experienced some mental problems. However, he had written a detailed will where one of the main points was that his company should be kept running in his own spirit also in the future.

But times and people changed. The general economic turmoil in society hurt the business severely. The international market for the main export product, logs, lumber, boards and planks of high quality, failed. Combined with the effects of the weak leadership exerted by his successors, an incident put a full stop for the once so flourishing business empire: the great fire of 4. May 1819. The flames devastated all the lumber products which were piled up and were ready for exportation. And there was no insurance.

The people who had taken on to publish his writings did not follow the instructions in the will. It might be that the manuscripts did not keep up with the highest literary standards, but they might have shed more light on an interesting person and the social circles he belonged to. It is still not too late to make what still has been preserved in the archives, available to readers interested in this particular historical period by publishing his texts.

The palace, "Paleét" near the place where the main railway station later was built, was, according to the will, donated to public use. But soon the building went into decay, was used for different purposes and finally burnt down in 1942, allegedly put to fire by some bureaucrats who wanted to hide traces of economic irregularities when documents stored there were destroyed.

Bent Anker's beautiful garden, bequeathed to the Cathedral School, soon became a wilderness.

Apart from the name of a street in what now is a more humble part of the city of Oslo, there are only few reminiscences back commemorating one of the really influential persons in the Norwegian society at the end of the 18th century. In many ways, memories of Bernt Anker have been lost.

Per Holcks discussion of this phenomenon is interesting reading, and has bearings beyond being only a biography of Bernt Anker.

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Book review:

Jens Rathke – a scientific traveller

Michael 2006;3:73–5.

Jarnæs J (ed.) Jens Rathkes beretning fra oppholdet på Madeira og i Portugal i 1798-1799. Oslo: Solum, 2005. 293 pp.
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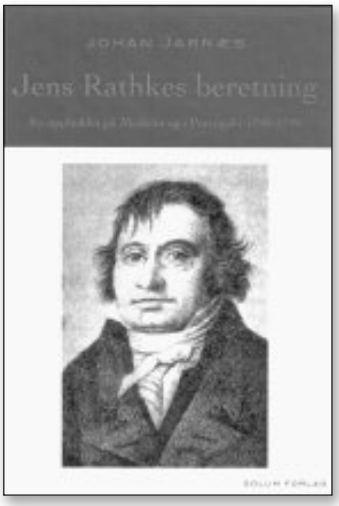

Sometimes, travel diaries may survive for centuries and their contents even gain in interest as time goes by. Here is an example:

The scientist Jens Rathke (1769-1855) was one of the most remarkable personalities in the period when a national academic world should be built up in Norway, following the establishing of a national University in the capital of Christiania in 1811 and the independence from Denmark in 1814.

Rathke was attending the Cathedral School in Christiania until 1787, then moved to Copenhagen, became a student and received his degree in theology from the University of Copenhagen in 1792.

However, in Copenhagen there was a flourishing environment for studies in natural sciences, even if these disciplines were not represented at the University. There was a private society for natural history, where famous scientists, such as the botanist Martin Vahl (1749-1804) and the zoologist Peter Christian Abildgaard (1740-1801) were giving lessons to interested students. Examinations were also arranged. Jens Rathke had been fascinated by natural science, started research on his own, and could already

1794 present an important work on the anatomy of a fresh water mussel *(Anodonta anatina)*. His achievements in natural history made him an obvious choice when the conditions for the fisheries along the Norwegian coast should be studied, and ha was sent out by the government on extensive travels, resulting in reports with lasting value for the development of the Danish-Norwegian, later Norwegian fishing industry.

Rathke was appointed as a teacher in natural history at the Cathedral School in Christiania 1899, a position he never took over because of commitments as a scientific traveller in Norway and Russia, leaving him with a lot of publication work in Copenhagen. In 1810 he was appointed professor at the University of Copenhagen. In 1813 he became professor of zoology in Christiania, one of the very first professors at the new Norwegian University. Here, he also took over teaching obligations in botany and mineralogy and was curator for the new botanical garden, besides pursuing interests in fisheries and in social conditions for the population living in the regions he visited. On of the reasons for his commitments in botany, was that the first professor in Norway in this discipline Christen Smith (1785-1816), another scientific traveller, suddenly died during an expedition to Congo.

After settling in Christiania Rathke obviously became so occupied with practical work that the flamboyant enthusiasm of his youth faded and his publication activities decreased, although he kept on teaching until the age of 75. It might also be that the natural sciences in general developed so rapidly at this time that he felt himself more and more outside the new trends.

However, this book covers a period when his scientific spirits were at their strongest. In the years 1798-1799 he set off for Madeira and mainland Portugal. In these parts of the world, it was generally perceived, there was still a lot of secrets of nature to discover. Perhaps studies of geology even could reveal something about the mechanisms behind earthquakes?

Rathke had been sent out by the society for natural history in Copenhagen, and a lot of preparatory work had been undertaken. Both the society in Copenhagen and their representative Jens Rathke were working in the tradition of Carl von Linné (1707-1778), where the mapping of nature and its constituents, putting the different elements making up our world into a comprehensive system, was a core issue in research and the establishing of new knowledge.

To make a voyage to Madeira in the 1790'ies was no easy task. Rathke at last got the opportunity to travel on board a naval ship, the frigate "Freya" which called at Funchal on its way to the Danish West Indies. During the trip, during the stay in Madeira and during his later stay in conti-

nental Portugal, Rathke made meticulous notes. These notes have now been transcribed, carefully edited and published in this book.

What makes the book particularly interesting, are its detailed descriptions of natural objects, people and landscape in the Linnean spirit. Anyone with a command of a Nordic language, planning a trip to Madeira or to Portugal, should supplement the reading of "Let's go", "Lonely Planet" and other travel literature with this diary by Rathke, written more than two hundred years ago. It is definitely rewarding.

Professor John Peter Collett from the University History Forum in Oslo has written a good introduction which puts the text into context.

To a reader with interests in science history, the book adds to the knowledge about shifting paradigms. Probably, Jens Rathke was one of the last ones of the enthusiastic researchers from the colourful enlightenment period which disappeared together with the 18th century.

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Book review:

Politics of prevention, health propaganda, and the organisation of hospitals 1800–2000.

Michael 2006;3:76–7.

Andresen, Astri, Elvbakken, Kari Tove and Grønlie, Tore (eds): Politics of Prevention, Health Propaganda, and the Organisation of Hospitals 1800-2000. Conference Proceedings. RAPPORT 10-2005, Rokkansenteret, Stein Rokkan Centre for Social Studies, Bergen. 175 pp.

The Stein Rokkan Centre for Social Studies and the Department of History, University of Bergen, have hosted four Nordic-British workshops on the history of health and medicine, the most recent of these in February 2006. This book is a presentation of the proceedings of the third workshop, in March 2005. The articles are presented in three main sections according to the themes given in the title of the book and the workshop.

Proceedings from a conference or workshop will often be interesting to the reader, but these proceedings make me as a reader also wish I had been present on the occasion of the presentations! Although the three main themes seem to have been chosen more from availability than from logic, several of the articles are interesting descriptions and reflections on past events which, at least some of them, have not been well known to everyone interested in the history of health and medicine.

Anne Hardy's article on food and hygiene in Britain 1945-2000 describes the rising number of food poisoning incidents in England and

Wales, leading as recently as in 2000 to a symposium on hand hygiene, in order to focus attention on individual personal habits.

Jo Robertson tells the story of Culion, a small island in the Philippines that in 1904 was set up as a reservation to isolate people with leprosy in the Philippines. The initiative came from the American Army, due to concerns that American soldiers might otherwise contract leprosy. Legislation was adopted and a society constructed that in 1910 consisted of about 5000 inhabitants. The story of attempts to segregate young men and women and to remove newborn or young children from their parents is moving, as is reading about the author's meetings with persons born on the island while it was still a colony for people with leprosy.

Elisabeth Hurren's article on trafficking of bodies of the poor for medical research in England also gives food for thought. The Anatomy Act of 1832 and the New Poor Law of 1834 both further impoverished the poor and laid the foundation for this business of anatomy, that flourished from 1873 when an anti-welfare experiment ("the crusade") was underway, and continued until 1914. We can read about anatomists at Cambridge University going on body-finding drives around the country, and about Oxford anatomists negotiating supply-deals with poor law guardians to outbid Cambridge in the purchasing of bodies of the poor. Hurren discusses these activities as a background to present-day debates in a biotechnical age.

Four articles focus on structure and organization of hospitals from historians' viewpoint. We get to know part of the background of the creation of the National Health Service (NHS), even with a traditionally weak Ministry of Health. We read about the strong traditions of voluntary hospitals and charitable funding in England before the NHS. We share reflections on the attempts from the present-day Labour government to reconstruct the NHS as a regulated market, and proposals that in a worst-case scenario could open up for a creeping privatization of the service.

This book has points of interest both to historians, people in health administration and in the health services, and to those generally interested in present-day biotechnical debates as well.

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John Stewart

Psychiatric social work in inter-war Britain: Child guidance, American ideas, American philanthropy.

Michael 2006;3:78–91.

Summary

Concerns about children's mental health led reformers in inter-war Britain to press for the establishment of a child guidance movement similar to that of the USA. This duly happened, not least because of the funding received from the American philanthropic body, the Commonwealth Fund. American influence was, however, concerned with ideas as well as finance. The profession of psychiatric social worker took off in Britain as a result of British social workers travelling to the US and receiving training in that country's schools of social work and child guidance clinics. Furthermore, these psychiatric social workers in turn brought back to Great Britain ideas based on American psychiatry and social work practice, and thus a highly medicalised version of social work. This article examines these influences and interactions.

Introduction

Much of the original research for this paper, part of a larger research project on child guidance and psychiatric social work in Great Britain and in particular in Scotland[i], was done in the archives of the American philanthropic body the Commonwealth Fund, which are held in New York; and of the London School of Economics, held in the British Library of Political and Economic Science – the significance of both of these will, hopefully, be clear by the end of the paper. But I have also drawn on the work of, in particular, American historians of ideas and of philanthropy, and we start by saying something very briefly about the ideas I have taken from their work. First, we should note what Daniel Rodgers calls the movement of 'politics and ideas throughout the North Atlantic' in what he terms the sphere of 'social politics' – that is, social welfare and social policy.[ii] While some work on the development of British social welfare acknowledges such ideas, it is nonetheless not commonplace in the historiography. Second, while a num-

ber of American scholars have examined the dynamics of the relationship between philanthropy and public policy formation this, once again, has been largely neglected in British historical writing on the development of social welfare. Third, recent historians of American philanthropy have pointed out some of the tensions inherent in the act of funding abroad wherein the donors might both accentuate the difference between themselves and their recipients – a difference underpinned by a form of American superiority and exceptionalism – while also emphasising the universality of human experience alongside the need to recognise cultural difference. This idea may be less applicable in non-Western European contexts, but it also goes some way to explaining the rigidity of the visits organised for trainee British psychiatric social workers to the United States, dealt with further below. Less problematically, perhaps, these scholars also point out that the original religious impetus behind much American philanthropic activity overseas had, by the period with which we are presently concerned, given way to a 'secularized emphasis on uplift through science and technology'; or, as another scholar has put it, to place 'the health-care, education, and social-service professions on a scientific, non-sectarian basis'.[iii]

To the insights of these American scholars we should add the observation made by the British historian of childhood, Harry Hendrick, that what is seen in the period from around the First World War is an emphasis, in child health, on minds as well as bodies.[iv] The significance of these analyses for this paper are that I argue that psychiatric social work in interwar Britain did indeed owe a large part of its existence to American funding and influence; that this was, however, a complex relationship, particularly in the realm of ideas; but that, nonetheless, there was a significant step in the direction of professionalizing British social work and that this in turn contributed to the development of British social welfare; and that this is institutional evidence which further backs up Hendrick's argument about minds and bodies with the former now being seen as at least as important as the latter.

Child guidance and its psychiatric orientation

It is now well known that the Commonwealth Fund, one of the leading and influential American charitable foundations in the early part of the twentieth century, was crucial in developing child guidance in both the United States and indeed in Great Britain, although having said that it is also the case that relatively little is as yet known about the dynamics of this relationship.[v] Of course it would be wrong to ignore the indigenous roots of British child guidance, most obviously through the Child Study tradi-

tion with its emphasis on the scientific investigation of child psychology.[vi] Nonetheless, it was to be the Commonwealth Fund which had the financial weight to actually implement what came to be recognised in Britain as child guidance, and indeed in England, although not in Scotland, psychology was to be largely displaced, after an inter-professional struggle, by psychiatry. In this context we might thus note that rather less commented on, not least because of the relative dearth of literature on the subject, is that at least as far as Britain was concerned the movement towards child guidance resulted in the creation of a professional course aimed at training psychiatric social workers.[vii] An important step in this process was the setting up, in 1929, of the Diploma in Mental Health course at the London School of Economics (LSE) which was financially underwritten, throughout the inter-war period, by the Commonwealth Fund. The course was, until the 1940s when psychiatric social work truly 'took off', the only one of its kind in Britain and on it students were exposed to both practical and more academic work. The former was gained through placements at, for example, the London Child Guidance Clinic, also supported financially by the Commonwealth Fund. At the LSE itself students took a broad range of courses, including psychiatry, mental deficiency, physiology, psychology (including the psychology of adolescence and childhood), and public administration and social casework.[viii]

Although both the practical and the academic content of the course were frequently adjusted and refined, not least as we shall see through American pressure, we can get some sense of its actual psychiatric content from a memorandum submitted to the LSE by the Child Guidance Council in the late 1920s. This suggested that the psychiatric strand include the work of Freud, Jung and Adler; psychiatry and 'its bearing on Family and Social Relations'; and symptoms of disorder specific to children, including thumb-sucking, nail-biting, lying, bed-wetting, temper tantrums and extreme anti-social behaviour.[ix] This list highlights two particular points: first, that there was created what Nikolaus Rose has famously described as a 'specific repertoire of disorders' of childhood. And, second, that in creating a professional group – psychiatric social workers – with at least some expertise in such areas the numbers of those involved in monitoring and evaluating children, for analysts such as Rose and David Armstrong a characteristic of the first half of the twentieth century, were significantly increased.[x]

The setting up of the LSE course also had wider repercussions. As Noel Timms, an early historian of psychiatric social work as well as a member of that profession put it, the location of the course in a university social sci-

ence department 'had a considerable effect on the status and the development of training for psychiatric social work' not least since it was 'the first course within a British University which had the acknowledged aim of giving professional training in social work' – an acknowledged instance, therefore, of our earlier point about professionalization.[xi] An analysis of graduates of the course in the late 1930s found that in the first ten years of its life some 179 individuals had successfully gained the Diploma. All of these had Social Science Certificates, generally from the University of London and in a third of cases from the LSE itself: they had already been exposed, in other words, to contemporary thinking in the social sciences. Around 40% also had undergraduate degrees. The course was, of course, predominantly taken by British nationals but it was also the case that individuals from the Netherlands, Sweden, Norway, Canada and Australia had participated successfully. Indeed the Commonwealth Fund was, albeit reluctantly, to allow students from the British Empire to apply for its scholarships. The largest single destination for course graduates was child guidance.[xii] That child guidance and professional psychiatric social work were linked was explicitly acknowledged by the Commonwealth Fund's Director, Barry Smith, when he wrote to the London Child Guidance Council in 1928 that 'the training of psychiatric social workers is an essential and fundamental part of (Britain's) child guidance program'.[xiii] Timms, in his early history of psychiatric social work, picked up this and, perhaps unwittingly, other themes already noted when he remarked that in 'the treatment of the maladjusted child psychiatric social workers have played an essential part in the establishment and development of the child guidance movement'; and that child guidance itself had 'influenced both its direct clientele and in profound, if untraced, ways the manner of child rearing in our society'.[xiv]

The nature of the Anglo-American relationship: The politics of finance

Clearly, then, psychiatric social work and child guidance were intimately linked in the British context (as they had been and were in the United States); and were supported, financially and as part of its broader programme, by the Commonwealth Fund. In terms of training, this was most obviously so by way of the London School of Economics course. We still need, however, to examine more closely the actual nature of the relationship between the Fund and the LSE. At this stage of my research, two are of particular significance for this essay. First, the Commonwealth Fund on occasions found the financing and control of its British operations in these fields – in the first instance the London-based Child Guidance Council and

Child Guidance Clinic and the LSE course in Mental Health – immensely frustrating. On the Fund side the key players were Smith and his assistant Mildred Scoville. Significantly, both were trained social workers and had strong views about the organisation, content and personnel of their British programme, views which they sought at various points to impose. So, for example, Smith wrote to the Child Guidance Council in 1930 arguing that the LSE course should seek recognition from the Royal Medical Psychological Society and that should this not be forthcoming then the Fund would have to seriously consider whether to continue its financial support. In the same year Smith emphasised that he did not seek to dictate but, nonetheless, that he wanted his voice heard: as he put it, perhaps rather disingenuously, in another letter to the Child Guidance Council: 'You know, I feel certain, the interest Miss Scoville and I take in the English mental hygiene work and that the suggestions which we make are only made in the interests of its success'.[xv] It is notable here that Smith was prepared to use the threat of a withdrawal of funding, a tactic he was often to employ throughout the 1920s and 1930s without actually, at any point, putting it into force. More positively, Smith wrote to the School in the spring of 1932 that Scoville had enjoyed a worthwhile trip to London and that in her opinion the 'course has definitely improved'. Scoville, and on occasions Smith himself, made numerous trips to England and it is difficult not to see these, along with the regular reports the LSE was required to submit, as an exercise in control and monitoring beyond the simply financial. Smith himself offered direct advice on aspects of the course suggesting, for example, that students should have previous experience of social work this being 'of value not only in itself but in enabling students themselves to judge of their adaptability for work in the mental field…'.[xvi]

If Smith, Scoville and the Commonwealth Fund were concerned about the content of what they were supporting financially, they were also aware that the British recipients were frequently engaged in a complex game whereby they sought to extract as much as possible from American philanthropy while remaining non-committal about their own input. This was most obviously so in the case of the London School of Economics and in particular its Director, William Beveridge, soon to be famous for his wartime Report. Beveridge was quick to see the opportunities afforded by US foundations such as the Commonwealth Fund.[xvii] As he himself put it, as the LSE grew in size and reputation 'people with ideas came to look on it as good ground in which to plant their ideas and to water the ideas with money. Thus, in the session 1928-29, a body known as the Commonwealth Fund gave to the School £400 a year to establish a course for welfare

work with backward children…'.[xviii] Leaving aside the inaccuracy of the phrase 'backward children', this is teasingly ambiguous about the relationship between the School and the Fund. In any event, judging by the material in the Fund and LSE records, Beveridge was, in fact, a skilful, possibly devious, negotiator over the financing and control of the Mental Health course. As one official of the Child Guidance Clinic wrote to Mildred Scoville in 1931: 'The School of Economics course is a worry. Beveridge is out to get full control'.[xix] The immediate response from the Fund was that Smith was travelling to England to sort things out and had written to Beveridge that 'unless things straighten out satisfactorily' the Mental Health Course, along with the Child Guidance Council, would no longer be funded.[xx]

Despite an ongoing strained relationship, as we have already noted this threat, and that to move the course to another college of the University of London, was never actually carried out although various tense exchanges continued right up until the outbreak of World War Two. Given its commitment to what it described as 'mental hygiene work in England' and the LSE's premier role in the training of social workers, the Fund had, to some extent, painted itself into a corner. On more than one occasion Smith and Scoville went so far as to question the LSE's honesty in its dealings about the Mental Health course – Scoville told Smith in 1931 that she had no doubt that the School had 'deliberately "wangled" the budget for their own purposes'[xxi] – and it would seem that overall Beveridge and the LSE came out winners in financial matters, at least in the first instance. Despite the Fund's clearly signalled intention by the late 1930s to eventually withdraw support from the Mental Health course – it should here be noted that it did not fund *any* projects on a permanent basis – we still find Beveridge's successor, the social scientist Alexander Carr-Saunders, seeking a further extension of financial support for the course in late 1938/early 1939 and on a reduced scale funding persisted into the wartime era.[xxii]

Nonetheless, if the School was in a strong position, the Fund too was not unwilling to exert force where it could. On the issue of even relatively junior appointments to the LSE course team, for example, it was made clear that Smith and Scoville had to approve. The significance of this approach was most evident in a case which did not involve the LSE directly, although the individual concerned did give classes on its Mental Health course, but had wider implications for both child guidance and psychiatric social work. This was in the appointment of Dr D.R. MacCalman as General Secretary of the Child Guidance Council. MacCalman had been trained in medicine at the University of Glasgow but had also travelled to

the United States – possibly on a scholarship from another powerful American philanthropic body, the Rockefeller Foundation - to work under, as part of his psychiatric training, Adolf Meyer in Baltimore and Charles McFie Campbell in Boston. Meyer was a profound influence on British psychiatry at this period and had a particular interest in child welfare and the use of support staff such as psychiatric social workers. MacCalman clearly drew from this and became one of the foremost exponents of psychiatric social work in Britain. Throughout the appointment process Smith made his support for MacCalman clear and it was his approval which was key to the latter's appointment. [xxiii] The particular case of MacCalman also attests to the significance of transatlantic influences. Overall, therefore, the relationship between the Commonwealth Fund and those it was supporting in Great Britain was complex and negotiated, in the realms of both ideas and material resources.

The nature of the Anglo-American relationship: Experiencing American psychiatric social work

The second broad point which emerges from this preliminary analysis of Commonwealth Fund and LSE material concerns the way in which British social workers chosen to specialise in psychiatric social work were deliberately exposed to American ideas and practices. Candidates, already with some social work experience and for the most part women (social work then, as now, was a highly gendered occupation) were carefully selected and then, with Commonwealth Fund approval and financial support, taken to the United States. Here an intensive and extensive programme was followed. To take but one example, in 1928 year Miss Olive Crosse was put forward by the Charity Organisation Society (COS) as its top candidate for a year's training in psychiatric social work. Miss Crosse had already studied at the LSE and Bedford College, London, had been trained by the COS as a social worker, and was District Secretary of its St. Pancras, London, branch. She was duly awarded a one year scholarship to study, in the first instance, at the New York School of Social Work. Her time in the US was not, moreover, spent solely in New York. From May 1929, as part of her programme, she travelled extensively, visiting cities such as Boston, Cleveland, Chicago, Philadelphia, and Detroit. Among the more than twenty clinics, hospitals and other institutions she observed in action were the Boston Psychopathic Hospital and the Institute for Juvenile Research in Chicago. Such schedules, it is worth noting, were set up and monitored by the Commonwealth Fund, which clearly wanted a strong measure of control over these young women experienced.[xxiv] A sense of what such visits in-

volved can be gained from a letter from the Director of the Cleveland Child Guidance Clinic to Barry Smith: 'We shall not only try to give them (ie. Miss Crosse and an English colleague) an opportunity to get an idea of what we are trying to do in Cleveland in child guidance clinic work', he wrote, 'but will be only too glad to make any and all appointments for them to get a good grasp of what the social situation in Cleveland is'.[xxv] Because of the training received by Olive Crosse and those like her, the first cohort of truly professional psychiatric social workers in Britain were, as Mildred Scoville observed shortly afterwards, trained in the United States.[xxvi]

And such trips were not just confined to those at the beginning of their careers in social work or psychiatric social work. In 1928, that is before the setting up of the LSE course, Edith Eckhard, Tutor in the School's Social Sciences Department, paid an observational visit to the USA at the invitation of the Commonwealth Fund. Like all such visitors she had a heavy schedule, visiting, *inter alia*, the Boston Psychopathic Hospital, the Philadelphia Child Guidance Clinic, the Simmons School of Social Work and Harvard Law School. On her return she wrote to Scoville that she had been very impressed by the extent and thoroughness of the social work she had observed,

not only psychiatric social work but also family welfare and child placement…I hope very much that I shall be able to improve the family case work experience which we give our students in London, to bring it into line with what is being done in the States.[xxvii]

William Beveridge also wrote to the Commonwealth Fund on the subject of Ms Eckhard's trip, remarking that she had urged upon him the setting up some 'experimental courses on Mental Hygiene' in anticipation of the creation of a Child Guidance Clinic. Beveridge stressed how impressed Eckhard had been 'by much…of the teaching of social psychiatry in the United States' although this has to be put in the context of his (successful) request for Commonwealth funding to pay for specialist staff.[xxviii] Shortly afterwards Mildred Scoville wrote to Ms Eckhard claiming that she had learned that the latter had 'formulated definite and valuable ideas for introducing training in psychiatric social work into the curriculum of the London School of Economics'. 'I am so glad', Scoville continued, 'that you feel this to be an important development and that you were able to obtain helpful ideas here'.[xxix]

Sibyl Clement Brown, Tutor for the LSE Mental Health Course, too paid a CF funded observational visit to the US, this time in 1935. She, like Crosse and Eckhard, visited a number of cities and institutions with the aim, as Scoville put it to her in a letter immediately prior to her trip, of see-

ing at first hand 'the schools of social work providing psychiatric social work training…the field work centers being used for such training, and…social work developments in the mental hospital field'.[xxx] On her return to London Brown produced an interesting memorandum on her trip which noted, *inter alia*, that despite certain problems psychiatric social work and child guidance had now a firm foundation in US social welfare provision, comments which she was careful to put in the broader context of President Roosevelt's 'New Deal'.[xxxi] At an organisational level, close links developed between British psychiatric social workers and their counterpart's professional body in the United States. Doris Robinson, Chair of the Association of Psychiatric Social Workers, and Noel Hunnybun, another prominent worker in the field, became 'senior members' of the American Association of Psychiatric Social Workers in 1934.[xxxii] Kathleen Butler, Chief Social Worker at the London Child Guidance Clinic, told Scoville that reading the newsletter of the American Association had given her 'a very keen sense of the unity existing between all the psychiatric social workers in England and America'.[xxxiii]

Conclusion

What are we to make of all this? In this brief essay it has only been possible to touch the surface of major and complex issues, but for present purposes the following points can be made. First, it is clear that there was an organic relationship between the development of child guidance and the development of psychiatric social work in Great Britain and that this was part of a conscious plan on the part of the Commonwealth Fund. Although there was clearly an element of instrumentality involved given the opportunities presented by US philanthropic monies, nonetheless leading figures at the LSE and in the child guidance movement generally were more than happy to go along with this. Second, this process contributed to the professionalisation of social work in Great Britain, with psychiatric social work acting as a sort vanguard for the profession as a whole. This can also be related to a point we made at the beginning about the 'scientific' ends to which American philanthropic bodies were by this point committed. While, as noted above, psychiatric social work expanded rapidly in the era of the post-war 'welfare state', it is also clear that the foundations were laid in the inter-war period.[xxxiv] For these two reasons alone, we can identify a profound American influence on British development.

Third, there is, however, the much more problematic issue of the influence of ideas. We have already noted the trip made by LSE staff member Sybil Clement Brown to the US. Interestingly and significantly, she was

later to deny any wholesale adoption of American practices and techniques.[xxxv] We have also noted that child guidance in Britain had its own, indigenous roots. The psychologist Gertrude Kerr, in an article outlining the history of child guidance, was at pains to emphasise the part played by British psychology and was critical of 'medical writers' on the subject – for example D.R. MacCalman – who emphasised the role of American psychiatry.[xxxvi] Nonetheless the question is surely more complex than a simple rejection of American ideas. As we have seen, Mildred Scoville at the Commonwealth Fund explicitly noted that the first generation of British psychiatric social workers had been trained in the United States and this of itself must have had some impact on both ways of thinking and of practice. We have also seen that Ms Eckhard, already an experienced tutor by the time of her American visit, had nonetheless committed herself to injecting American ideas into the fledgling Mental Health course. Agreed, she might just have been telling Mildred Scoville what the latter wanted to hear, but superficially at least we have in this case a fairly specific influence of 'Atlantic Crossings', both literally and figuratively.

We can also find evidence of the significance of American influences from other sources. A work on child guidance written jointly by a psychiatrist, an educational psychologist and a psychiatric social worker – their teamwork in authorship significantly mirroring the teamwork of the clinic - and published in 1945 noted that the first medical Director of the London Child Guidance Clinic, Dr William Moodie, had studied the field in the US. Perhaps more importantly, this book also acknowledged the influence of American authors in providing an underlying philosophy for child guidance practice, a philosophy which informed the British authors' approach throughout the rest of their book. There is a chapter specifically on the training of psychiatric social workers in this text which would repay comparative analysis with similar American works.[xxxvii] Timms is also revealing about the complexity of influence in his early work on the history of psychiatric social work. He notes variations on American practice and how the tutors, themselves just back from the US, struggled to adapt their teachings to a British context. He also notes, however, the impact of American study on its British subjects and, specifically, how in the development of a new specialism in social work, psychiatric social work, 'it was necessary to learn from American experience'.[xxxviii] This insight can be extended, in the case of an influential player such as MacCalman, from the content of training for the profession to the very need for such a profession itself. Again suggesting both influence and adaptation, a contemporary piece on the Notre Dame Child Guidance Clinic in Glasgow noted the emergence

of a 'powerful Child Guidance Movement in America' and, consequently, 'with help from America the first steps in Britain, with modification of the American technique to suit our own country'.[xxxix]

It will be evident from the above that much work remains to be done on the issue of, in particular, the transatlantic transmission of ideas on the theory and practice of psychiatric social work and the practice with which it was, at least in the first instance, intimately bound up, namely child guidance. Nonetheless it already seems clear that American influence was not confined to simple matters of finance, not least because the Commonwealth Fund itself had its own agenda. The recipients too, however, seem to have absorbed American theory and practice, at least to some extent, and to have brought these back to Britain where not unnaturally adaptations were made and other influences brought to bear. The central point, though, is that Rodgers' 'Atlantic Crossings' seem to have been alive and well in the field of psychiatric social work and further investigation will, it is to be hoped, reveal how this operated in a more nuanced way than is currently possible. This in turn will contribute both to the currently weak British historiography on the personal social services and, more broadly, to how British social welfare was influenced and shaped by concerns, ideas, and practices from other countries.

Acknowledgements

A different version of this paper was given to the Stein Rokkan Centre, University of Bergen, in February 2003 and I am grateful for the useful comments it elicited. Discussions with colleagues in the Child Guidance/Child Psychiatry network set up by Asmund Arup Seip, which first met in Oslo in 2003, have proved extremely helpful in clarifying my ideas. I also wish to acknowledge grants received from the Rockefeller Archive Center, New York, enabling me to work on the Commonwealth Fund papers. The archives staff at the Center and at the British Library of Political and Economic Science have been extremely helpful in finding relevant and appropriate materials for me. Finally, I would like to thank the organisers of the EAHMH conference, held in Oslo in September 2003, for a further opportunity to discuss my research on child guidance; and the British Academy for providing financial support to travel to this conference.

Notes.

[i] An essay complementary to this piece, and employing some of the same evidence, will appear in a volume edited by A. Andresen and W. Hubbard to be published by the Stein Rokkan Centre, University of Bergen.

[ii] D. T. Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age*, (Cambridge, Mass., 1998), p.3. For an analysis of an area close to that currently under discussion see M. Thomson, 'Mental Hygiene as an International Movement', in P. Weindling (ed), *International Health Organisations and Movements, 1918-1939*, (Cambridge, 1995), 283-304.

[iii] E. S. Rosenberg, 'Missions to the World: Philanthropy Abroad', in L. J. Friedman and M. D. McGarvie (eds), *Charity, Philanthropy, and Civility in American History*, (Cambridge, 2003), 242, 256; and, in the same volume, D. C. Hammack, 'Failure and Resilience: Pushing the Limits in Depression and Wartime', 274.

[iv] H. Hendrick, *Child Welfare: Historical Dimensions, Contemporary Debate*, (Bristol, 2003), 1-7 and passim.

[v] The partial exception to this is D. Thom, 'Wishes, Anxieties, Play, and Gestures: Child Guidance in Inter-War England', in R. Cooter (ed), *In the Name of the Child*, (London, 1992), 200-19.

[vi] Hendrick, *Child Welfare*, 99-100.

[vii] On the Commonwealth Fund, see A. McG. Harvey and S. L. Abrams, *'For the Welfare of Mankind': The Commonwealth Fund and American Medicine*, (Baltimore, 1986); on the Fund's role in the development of American child guidance and psychiatric social work see M. Horn, *Before It's Too Late: The Child Guidance Movement in the United States, 1922-1945*, (Philadelphia, 1989), J. Sealander, *Private Wealth and Public Life: Foundation Philanthropy and the Reshaping of American Social Policy from the Progressive Era to the New Deal*, (Baltimore, 1997) and H. M. Prescott, *A Doctor of Their Own: The History of Adolescent Medicine*, (Cambridge, Mass., 1998); for developments in a closely-related field also funded by philanthropic body, see J. Grant, 'Constructing the Normal Child: The Rockefeller Philanthropies and the Science of Child Development, 1918-1940', in E. C. Lageman (ed), *Philanthropic Foundations: New Scholarship, New Possibilities*, (Bloomington, Indiana, 1999), 131-150..

[viii] See the list of examiners in British Library of Political and Economic Science, Archives of the London School of Economics and Political Science (hereafter LSE), Minutes of School Committees/16/5 – Mental Health Course Academic Sub-Committee, Minutes 15th March 1937.

[ix] LSE, Central Filing Registry/514/A, letter, 3rd June 1929, from the Child Guidance Council to the LSE.

[x] N. Rose, *The Psychological Complex: Psychology, Politics and Society in England, 1869-1939*, (London, 1985), cited in Hendrick, *Child Welfare*, 104; D. Armstrong, *The Political Anatomy of the Body*, (Cambridge, 1983).

[xi] N. Timms, *Psychiatric Social Work in Great Britain (1939-1962)*, (London, 1964), pp.17-18. On the London School of Economics and Political Science see R. Dahrendorf, *A History of the London School of Economics and Political Science, 1895-1995*, (Oxford, 1995), and J. Harris, *William Beveridge: A Biography*, (Oxford, rev.ed. 1997). For the setting up of the course see LSE, Central Filing Registry/514/1/A, letter, 31st January 1929, from Child Guidance Council to LSE Director, William Beveridge.

[xii] LSE, Central Filing Registry/514/2/C, Minutes of the Consultative Committee of the Mental Health Course, 1st December 1938; on the matter of funding Empire stu-

dents, see LSE, Central Filing Registry/514/2/C, letter, 6th December 1937, from CM Lloyd (LSE) to Barry Smith, and letter, 16th December 1937, from Barry Smith to Sibyl Clement Brown (LSE).

[xiii] Commonwealth Fund Archives, Rockefeller Archive Center, New York (hereafter CFA) Box 2, Folder 14, letter, 20th December 1928, Smith to London Child Guidance Council.

[xiv] Timms, *Psychiatric Social Work in Great Britain*, 6-7.

[xv] CFA, Box 2, Folder 19, letter, 13th October 1930, Smith to Child Guidance Council.

[xvi] LSE, Central Filing Registry/514/2/A, letter, 14th April 1932, Smith to C.M. Lloyd, Head of Social Science and Administration.

[xvii] On the similarly complex relationship between the LSE and the Rockefeller Foundation, a major funder of the School in the inter-war period, see the references in Dahrendorf, *A History of the London School of Economics*; and Harris, *William Beveridge*.

[xviii] W. Beveridge, *The London School of Economics and Its Problems*, (London, 1960), pp.85-6.

[xix] CFA, Box 2, Folder 20, letter, 11th March 1931, Dr Moodie, Medical Director London Child Guidance Clinic, to Scoville.

[xx] CFA, Box 2, Folder 21, letter, 1st April 1931, Smith to Moodie.

[xxi] CFA, Box 16, Folder 164, memorandum, 17th December 1931, Scoville to Smith.

[xxii] LSE, Central Filing Registry/514/2/C, Minutes of the Professorial Council, 16th November 1938; CFA, Box 16, Folder 167, memorandum, 20th February 1939, Smith to Scoville; see also Dahrendorf, *A History of the London School of Economics*, p.373.

[xxiii] On Meyer see M. Gelder, 'Adolf Meyer and His Influence on British Psychiatry' in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry*, (London, 1991); on MacCalman see J. Stewart, '"The Most Precious Asset of a Nation is Its Children": the Clyde Committee on Homeless Children in Scotland', *Scottish Economic and Social History*, 21, 1, (2001), and MacCalman's application for the post of General Secretary of the Child Guidance Council in CFA, Box 3, Folder 29; and on Smith and his support see CFA, Box 3, Folder 29, Correspondence May and June 1935.

[xxiv] I am grateful to Erik Ingebrigsten, Norwegian University of Science and Technology, for highlighting this point at the Oslo conference.

[xxv] CFA, Box 20, Folders 217, 227.

[xxvi] CFA, Box 18, Folder 187, memorandum, undated but probably late 1929/1930, by Scoville, 'Mental Hygiene and Child Guidance: England'. A sense of what the experience was like for the British visitors can be had from 'Far Away and Long Ago', *British Journal of Psychiatric Social Work*, 10, (1954), 9-11.

[xxvii] CFA, Box 23, Folder 259, letter, 6th March 1928, Eckhard to Scoville.

[xxviii] CFA, Box 2, Folder 17, letter, 9th May 1928, Beveridge to Smith.

[xxix] LSE, Central Filing Registry/514/4, letter, 1st June 1928, Scoville to Eckhard.

[xxx] CFA, Box 23, Folder 260, letter, 21st March 1935, Scoville to Brown.

[xxxi] CFA, Box 23, Folder 260, memorandum, September 1935, Sibyl Clement Brown, 'Some Impressions of Social Work in America, 1935'.

[xxxii] CFA, Box 3, Folder 28, letter, 19th June 1934, Robinson to Scoville.

[xxxiii] CFA, Box 11, Folder 112, letter, 26th April 1932, Butler to Scoville.

[xxxiv] I am grateful to John Welshman, Lancaster University, for raising this issue with me at the Oslo conference.

[xxxv] M. Ashdown and S. Clement Brown, *Social Science and Mental Health: An Essay on Psychiatric Social Workers*, (London, 1953), 17.

[xxxvi] G. Keir, 'Symposium on Psychologists and Psychiatrists in the Child Guidance Service. III – A History of Child Guidance', *British Journal of Educational Psychology*, XXII, 1 (1952).

[xxxvii] W.M. Burbury, E.M. Balint, and B.J. Yapp, *An Introduction to Child Guidance*, (London, 1945), 4-6, and Chapter 7.

[xxxviii] Timms, *Psychiatric Social Work in Great Britain*, 20-21.

[xxxix] M.D.L. Dickson, *Child Guidance*, (London, 1938), 15.

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Book review:

The introduction of child psychiatry in Norway – a witness report

Michael 2006;3:92–5.

Sommerschild H, Moe E. (eds.) ***Da barnepsykiatrien kom til Norge. Beretninger ved noen som var med.*** **Oslo: Universitetsforlaget, 2005. 379 pp. ISBN 82-15-00619-1.**

The build-up of child psychiatry as a clinical and academic discipline in Norway is mostly a post-World-War-II process, and in this book the story about it is told by two of the persons central in the development, the child psychiatrist Hilchen Sommerschild and the clinical psychologist Einar Moe. Both of these senior scholars played instrumental roles in the field during many years, and so the book has to be seen as a "witness report", fitting well into the emerging genre of historical literature which provides facts and information for later discussions, interpretations and surveys. The greater part of the book is written by the two editors, and the rest by collaborators and other colleagues.

Please allow this reviewer to clarify his special background for commenting on this book: In the interesting introductory part of the book, sketching the background for the development of child psychiatry in Norway, the authors among other things describe how intelligence tests, as part of the process, came into use in Norwegian schools, intended to be a tool for tailoring teaching and caring support for the individual pupils, however soon being turned into a sorting system for administrative purposes. In the

autumn of 1944, at the age of six, the author of these lines was subject to an intelligence test and was swiftly expelled from school because of few answers and a deviant behaviour. I still remember what happened: Half way in the test, consisting of filling in boxes and similar corny stuff, which I perceived as utterly stupid, I worded my opinions about the test and the people presenting it loudly and explicitly and ran away. That made it: Out! Although I quite soon was taken in again, my attitudes towards child psychologists, child psychiatrists, school teachers and the like are still influenced by this incident. However, when reading the book by Sommerschild and Moe, I maintain that this fact is no bias, but a reason for reading with special interest.

The first parts of the book take the reader back to the 18the century, when the new child raising principles presented by Johann Heinrich Pestalozzi (1746-1827) were launched. Institutions aimed at taking care of needy children in his spirit were gradually built up many places, also in Norway. It is refreshing to read that also the authors Sommerschild and Moe question the statement held by the influential French social historian Philippe Ariès (1914-1984) about the historically recent "discovery" of childhood. Parents and children have probably had feelings and worries, even if the historians did not believe in them, and such eternal concerns are what the new attitudes towards the child were about. However, some human institutions replacing family care and intended to give unfortunate children a home, easily could take on a sort of concentration camp hardship, depending on the local leaders, and so they also did.

The development of child psychiatry is closely related to the development of psychoanalysis and the theories on mental dependence of childhood experiences set up by Sigmund Freud (1856-1939). Psychoanalysis early manifested itself as a forceful tool to explore human mind and to treat mental disorders. To treat adult patients this way required medical training, whilst taking children under psychoanalytic cure was free and therefore also taken up by others. A dramatic event, showing for all the dangers of releasing subdued sentiments through psychoanalysis happened when the philosophically trained psychoanalyst Hermine Hug-Hellmuth (1871-1924) was killed by a then 18 year old long time patient.

The early international history was filled with conflicts between different "schools" in theory and practice. A special attention should be paid to the two different directions pursued by the followers of Anna Freud (1895-1982) and of Melanie Klein (1882-1960). Klein's interest was concentrated on the unconscious mental life of the child, while Freud highlighted motherhood and social life. Norwegian child psychiatry came to develop in

the Freudian tradition. A somewhat odd addition to that was the astonishing influence exerted by the eccentric Austrian analyst Wilhelm Reich (1897-1957) who in the years 1934-1939 settled in Norway.

Although built up on biographies of important persons, the general introductory chapters give a broad and interesting survey. The book also touches on clinical examination methods, e.g. is the chapter of the use of a sand box and the observation of children who plays in it, fascinating reading.

On the Norwegian stage local pioneers were active, and they are duly portrayed, such as Helga Eng (1875-1966) and Åse Gruda Skard (1905-1985). However, the really outstanding person for Norwegian child psychiatry was the physician Nic Waal (1905-1960), born Caroline Schweigaard Nicolaysen. Lengthy parts of the book deal with how Nic Waal dominated the further development, gathering people around her like in a royal court. She was obviously beloved and admired, almost like a religious leader; seemingly democratic, yet obviously increasingly authoritative, nevertheless humbly adored by pupils who already were or later became visible and influential members of the Norwegian medical establishment. Also after her sudden death development can be seen as her legacy. She was even honoured with a postage stamp in 2005.

In Norway, the foundation of child psychiatry was closely related to provoking left wing politics and elitist bourgeoisie radicalism, not least because of the orientation by the circles around Nic Waal. The deeply socialistic later General Director of Health in Norway 1938-1972, Karl Evang (1902-1981) was her student days' fiancée, and her later marriage to the avant-garde novelist Sigurd Hoel (1890-1960) put herself and her professional work on the cultural agenda. Besides that, some of the other people occupied with the new discipline and clinical field of child psychiatry also had personal interrelationships and an eccentric life-style which caught public attention. Private and professional life in the group was more mixed up than society was used to.

The description of the build-up of institutions for child psychiatry in Oslo and in other places in Norway is interesting, but perhaps of more appeal to the internal professional circles than are the general parts of the book, which address a broader readership.

The book tells the story as it was perceived by the actors themselves. In this way it has to be regarded as a "white paper", and it has its values, virtues and flaws as such. The adherence to the "white paper" category is underlined by the cover, which is white, yet astonishingly decorated by a photograph depicting small girls' feet, a somewhat misleading metaphor for the topic, as outraging boys often were the most visible group in child psychiatry.

As a "white paper", the book tells about something that has more resemblance to the ventures of a movement, to the achievements of missionaries, of enthusiasts who have defeated counterparts and obstacles for the sake of their cause: building up a discipline against odds and practicalities. A historian would then ask for the positions and arguments held by the other side, by the opponents, by those the enthusiasts had to convince. The shortages here are the weaker part of the book, but when it presents itself as a "white paper", the objection is not relevant. The rest of the story has to be written by someone else. This quest for context is especially important because the external reader might wonder: Why was a clinical field like child psychiatry so provoking in society, why not fields like hygiene or microbiology, where, despite that conflicts here e.g. already had been presented by Henrik Ibsen (1828-1906) in "An Enemy of the People" (1882), the evolving body of knowledge should imply even larger potentials for stirring up society. Therefore, this reader had liked to learn something more about the build-up of child psychiatry and its reception in other countries for comparison. However, the topic is these days covered by increasing interest in the field of public health history and has lately been on the programme on several conferences.

The parable referred to in the text, on how the old Greek goddess and daughter of Asklepios, Panakeia, gained in popularity because her treatment of the sick gave more immediate results than did the efforts by her sister Hygieia who worked long-sightedly with disease prevention, is relevant and appropriate in child psychiatry and could have been interpreted even broader and more deeply.

As a "white paper" from Norway the book has its definite place in the source literature. An index of persons had added to the accessibility of the contents, especially because the approach is biographic.

My conclusion: This is an important, well-written work of lasting value in Norwegian medical history. The book deserves to catch attention and should be read with interest also by those who were not expelled from school due to some arrogant child psychologists (who will never be forgotten by this reviewer) more than sixty years ago.

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Book review:

Health and social policies in Europe

Michael 2006;3:96–7.

Abreu L. (ed.) European Health and Social Welfare Policies. Brno: Mazaryk University/ Compostela Group of Universities, 2004. 533 pages. ISBN 84-607-3621-X.

This comprehensive volume is the fourth in the Compostela Group of Universities' series on European Issues. It is based on a selection of papers from a conference organised in 2002 in Évora, Portugal, organised by PhoenixTN, an Erasmus Thematic Network approved by the European Commission. The participants represented a wide variety of scientific backgrounds and the presentations covered a chronological range from the Middle Ages to the present.

The more than 500 pages long volume is divided in four sections, with an introduction by the editor, the Portuguese historian Laurinda Abreu, and an epilogue by Daniel M Fox, President of the Milbank Memorial Fund in New York, USA.

Health between self-help, informal and formal institutions is the title of the first section, which consists of six articles. With high relevance for the debate on hospital locations of today, it is interesting to note that the opening of a hospital in a Rhenish town in the Middle Age did more to upgrade the infrastructure of the town, than to help the sick!

The seven papers on *Social welfare policy and changes in the health of the population* deal with examples of socio-economic and political changes af-

fecting health. Quoting the Linköping-based historian Jan Sundin: "during the nineteenth century medical knowledge concerning the causes of infectious diseases and public health interventions, especially on the local level, was able to reduce infant and child mortality in Western Europe" (p. 134).

The third section is titled *Innovation in health policies and the institutional level*. It consists of eight papers, including Kari Tove Elvbakken's description of the history of public health and the state in Norway.

Choices of welfare policies and their consequences: local and regional environmental health effects, is the last section and include four articles. These articles address the impact of political decisions on the population's health and welfare. Examples from Hungary. UK, Norway (by Øivind Larsen) and Sweden are presented.

In his epilogue Daniel M Fox discusses "the politics of policymaking". "Policy for population health evolves constantly", Fox writes. "Those who are charged with making it and their staff calculate what the people to whom they are accountable want (in comparison with other wants). They also assess what the groups (including researchers) trying to persuade them that their interests are the same as those of the public want (and what they are willing to do to promote their interests). Policymakers also know that many, perhaps most, people are not eager to pay for what they say they want" (p. 532).

Comparative history is complex, and these 27 chapters provide a mosaic, making up a picture of the development of European health care and welfare over more than 700 years.

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Book review:
La dolce vita in 18th century Norway

Michael 2006;3:98–9.

Arnesen F. (ed.) Morten Leuch d.y.'s dagbog 1757-1762 – Da Bogstad var lystgård. Oslo: Bogstad Stiftelse, 2006. 132 pp. Ill.
ISBN: 82-9939939-9. Price: NOK 150,-.

Tourists in Oslo, interested in 18th century history, should include a visit to the Bogstad manor outside the city during their stay. Situated in a beautiful park on the slopes of a lake, surrounded by a peasant landscape with forests, fields and meadows with grazing livestock, the old buildings have been preserved and are today open to the public as a museum and cultural centre.

From 1757 until his death, the rich merchant Morten Leuch d.y. (the younger) (1732-1768) was the owner of Bogstad. He used the estate as a country residence, where he took his friends and business partners for dinners and parties. His widow Mathia Leuch, born Collett (1737-1801) remarried, and her second husband was the merchant Bernt Anker (1746-1805). In 1773 she sold Bogstad to his younger brother Peder Anker (1749-1824) – also a central person in Norway at the end of the 18th century, and in the beginning of the 19th, when he even served as a Norwegian prime minister in Stockholm.

However, it was in the years under Morten Leuch Bogstad most typically served as a resort. For the period 1757-1762 a diary exists, telling about the daily life on Bogstad. It has the form of a protocol, perhaps resembling what Norwegians often have till this day in their cabins or second

homes – a "hyttebok" ("log book for the hut"). The protocol has been transcribed from an earlier copy, and the editor has added useful notes, family charts and illustrations.

The reader finds a text which in a way is surprisingly monotonous; it tells about a seemingly endless series of dinners, parties and outings. Guests are coming and guests are leaving. Beautiful young ladies are courted by visiting gentlemen etc. etc. However, these stories call for an interest which goes beyond their contents: They tell about the handful of wealthy families which in fact ruled Norway of the time. And these families were intermingled with numerous ties, as marriage partners very often were found in the close circles. Many of these people led a private life obviously filled with so much leisure that the elite exerting the real power in society in fact was even less numerous than the number of families should indicate – mostly counting just the few persons like Morten Leuch, Peder Anker, Bernt Anker and others, those who combined the role of the hard and progressive businessman with that of the party lion.

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Book review:

Can market forces save the welfare state?

Michael 2006; 3: 100–2.

Berg O. Fra politikk til økonomikk. Den norske helsepolitikks utvikling det siste sekel. Oslo: Den norske lægeforening, 2006. 115 pp. NOK 150. ISBN: 978-82-8070-036-6.
[Berg O. From politics to economics. The development of Norwegian health politics during the last century. Oslo: The Norwegian Medical Association, 2006.]

"If we study the health politics in Norway very concrete, one can easily become overwhelmed and scared away from trying to find the longer lines. In this work these lines are the main objects for attention".

Such reads the blurb of this well designed, though not easily read book on the politics behind the health services in Norway during the 20th century.

Professor Ole Berg (b.1944), a political scientist, is a prominent person in Norwegian health care. For more than 20 years he has been professor of health administration at the University of Oslo. Berg was the founding father of a Master programme in health administration in Oslo and he has published several books and papers on health politics and medical sociology.

Hardly any part of the Norwegian society has changed so much during the 20th century as health care services. At the beginning of the century only 0.3% of a tiny gross national product (GNP) was spent on health services. 100 years later, a 10% share of a GNP that had increased 25 fold (and is among the highest in the world), is used for the same purpose!

Reflecting the developments of the last century, 30 text pages of the book cover the first 70 years, and 70 pages cover the last 30 years.

Establishing a national health service was an important part of the nation building project when the union with Sweden was dissolved in 1905. The first health insurance legislation was approved by the Norwegian Parliament (Stortinget) in 1909. Berg sees the comprehensive Act on social insurance of 1967 as the completion of the Norwegian welfare state. Until then, redistribution of resources was the main issue, as part of the left oriented planned economy mainly implemented by the Norwegian Labour Party (Arbeiderpartiet). The Act of hospitals of 1969 included a very expansive funding system for new hospitals and this combined with other increases in health care costs gave rise to serious concern. Warning bells were ringing, as Ole Berg words it. Greater effectiveness became an aim across political borders. Berg describes three phases in the process initiated to cope with the increasing costs.

The first phase started with the White Paper of 1974 "On hospital development etc in a regionalised health care system" (St. meld. nr. 9 (1974-75) Om sykehusutbygging m.v. i et regionalisert helsevesen), characterised by Berg as the most "thorough report on health politics after the Second World War". This White Paper introduced the principle of Lowest Effective Level of Care (in Norwegian abbreviated LEON). Planned economy was still the basis, and the reimbursement system for funding of hospital services was in 1980 changed to fixed budgets.

The second phase, in the 1980ies was, according to the general political trend of the time, based on more liberal political ideas and increasing use of market mechanisms. Freedom of choice for the consumer (read: patient) was a coming mantra. Politicising reforms should reduce the medical impact on the management of health institutions, but it was not easy for non-medical leaders to take charge. As a non-medical manager told Ole Berg in the 1980ies: "When I meet with my medical consultants, I have this feeling that they look down at me. And what is even worse, I realise that I, myself, look up to them."

In the third phase, from the mid-1990ies, the health care services became "depoliticised" and there was a real breakthrough for liberal ideas. Paradoxically, it was the Labour Party that implemented this system, which included achievement based funding and the so-called diagnosis related groups' system (DRG). The process culminated in 2002 when the responsibility for specialist health services was taken away from the 19 counties and given to five newly established Regional Health Enterprises (Regionale helseforetak, RHF). These enterprises have become extremely powerful in-

stitutions and their independence and lack of cooperation are among the greatest threats to a true national health policy in Norway at the beginning of the 21th century. The current centre/leftist government now in 2006 tries to regain some control of these billion-institutions by nominating politicians at their boards.

Ole Berg describes the industry-like models for running the health care system as "right wing politics". And he argues that such means have been introduced to protect the basic principles of justice and equality named by Berg as "left wing politics". The development within the health care sector over the last decades is closely related to the so-called "New Public Management", a kind of "private" way to run public institutions.

Ole Berg shares an enormous amount of figures and factual information with his readers. But he writes in a complicated style and many paragraphs must be read over again to catch his message. If sufficient time is spent on the book, there are interesting matters to learn.

There are, however, surprising weaknesses. Berg's division between political "right" and "left" seems like an oversimplification of Norwegian health politics, which until the end of the 20th century hardly had any clear and strong internal antagonisms. In a country famous for its primary care it is also strange that the analysis almost exclusively is oriented towards the specialist health services.

And most surprisingly is perhaps Berg's passive and defeatist approach to the current challenges in Norwegian health care. It would be tempting to ask him the one million dollar question: Will we ever again have a true national health service in Norway, and can political control over the publicly funded health care services ever be recaptured?

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Christoph Gradmann

German medical history since the 1960s: Challenges and perspectives[1]

Michael 2006;3:103–15.

Summary

Changes in the academic discipline of medical history in Germany since the 1960s were mainly driven by curricular reforms in medical education at large and by challenges from other disciplines, such as general history and medical ethics.

In the 1960s and the 1970s there was an expansion of the discipline of medical history in Germany and also a gradual opening of the field. Medical history had so far in many places been history written by physicians for a physicians' audience. Now the discipline intensified its contacts with general history, which in turn discovered a subject which seemed interesting and contained new and promising perspectives.

However, from the late 1980s onwards, supported by curricular reforms in the medical schools, and by the introduction of medical ethics, this trend was effectively reversed. The discipline of medical history often became institutionally combined with medical ethics and in many places lost its ground to the latter. Its academic profile became unclear and around the millennium medical history in Germany by and large seems to have retreated into the medical faculties again.

Introduction

Let me begin with an anecdote: A historian was once asked about when the writing of history really starts. His answer was 'That's when the last contemporary witness is dead'. Of course, he had no intention to revile the field of contemporary history as such. Rather this fellow historian wanted to point to the notorious unreliability and deceptiveness of witnesses' ac-

[1] Delivered as a lecture at the University of Oslo, Department of History, 28.4.2006. Slightly revised for publication. I wish to thank Volker Roelcke, Lutz Sauerteig and Carsten Timmermann for their critical comments.

counts who often tell autobiographies at the expense of larger histories. This anecdote should serve to warn you that the recent history of German medical history, which I will be talking about, is one I have been living in myself for almost 15 years. I will attempt to give you an overview over the path that the field took in Germany over the last 40 years, and along that way I will highlight some of the international context where that seems appropriate. My aim is neither to give a full picture nor a comprehensive bibliographic survey, but rather to sketch out what I see as the main developments in the last decades.[2]

The pre-history

Modern German medical history as an independent field got started around the year 1900 when scholars like Julius Pagel (1851-1912), Karl Sudhoff (1853-1938) and others created a corpus of knowledge that essentially consisted of biographical work and of editions of medical texts from antiquity and the middle ages.[3] The foundation of professional societies such as the „Deutsche Gesellschaft für Geschichte der Naturwissenschaft, Medizin und Technik" (1901) and of a journal that came to be known as *Sudhoff's Archiv* (1907) also took place in this period.

Intellectually, the field of medical history was heavily dependant on classical philology whose methods of editing old text was expanded into the medical tradition. And the outcome were e.g. editions of the Corpus Hippocraticum, of texts from Roman medicine and from German Paracelsian medicine. It is also from these days on, that new institutes for medical history which were founded in Germany, usually were placed in the medical faculties. For the decades to come, medical history therefore remained as a field which was physically and intellectually close to medicine.

The interwar years saw a gradual expansion of this still very small field consisting of no more than a handful of professionals.[4] Methodological innovations were under way with Henry Ernest Siegrist's (1891-1957) reception of cultural history and his later turn to sociology, Erwin H. Ackerknecht's (1906-1988) much more political approach to 19th century medicine and Paul Diepgen's (1878-1966) attempts to write a history of

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[2] Literature cited, places and names mentioned are only intended to illustrate my arguments. This text is not a bibliographic survey of the field. Such overviews can be found in Dinges 2004; Labisch 2002; Roelcke 1994.

[3] See the contributions in Frewer and Roelcke 2001. It is not that the field did not exist prior to that era, but it was around 1900 that it developed some features which remained dominant for decades to come.

[4] For overviews see Eulner 1970.

ideas of modern medicine. However, during the Nazi-era many of the proponents of such modern concepts of medical history had to emigrate. Consequently, the years 1933 to 1945 completed a process of self isolation in German medical history that can also be observed in some other fields and which had begun in 1914.

The year 1945 and the subsequent foundation of two German states changed the pre-existing situation only faintly.[5] In the German Federal Republic which is in my primary focus of interest, the curricular framework and the audience of medical students and physicians experienced few changes. Medical history remained to be seen as a humanistic complement to the professional self of doctors who in turn accepted the necessity for physicians to possess or at least pretend to have a classical background.[6]

A changing world: The 1960ies and 1970ies

A whole number of elements came into play from the mid 1960s on that resulted in a sweeping re-arrangement of the field in the subsequent years. In this period, the classical tradition gradually became less visible in medicine. Medical history which had essentially relied on a cultural comprehensiveness as a justification for its usefulness had to look for new audiences and new stories to tell. The subsequent changes can be summed up in four points:

1. There was a remarkable expansion of the German university system from the 1960ies onwards. With the fast growth of the numbers of medical students, medical history had to face a soaring number of students. Aided by a recommendation of a high-profile advisory council for science policy, the "Wissenschaftsrat", the result was the foundation or expansion of a number of institutes in the field.[7]

2. This general build-up of the university system was accompanied by a nation-wide curricular reform in medical education, an amendment to the so-called "Aprobationsordung für Ärzte" (AO) in 1970 that – among many other things, such as "multiple choice"-examinations - introduced compulsory training in medical Latin, "medizinische Terminologie" for med-

[5] For an overview: Roelcke 1994.

[6] See for example Artelt 1949 who offered an introduction which was closely related to German historiographic traditions as developed by Ludwig Dilthey and others around 1900.

[7] *Empfehlungen des Wissenschaftsrates zum Ausbau der wissenschaftlichen Hochschulen bis 1970* 1967.

ical students. Although medical Latin technically could have been taught by anyone with a proficiency in Latin, this language course usually came to rest in the hands of medical historians. This more than compensated for the otherwise dwindling interest for the field in medical faculties. It also seems to have initiated a process of making the field more heterogeneous in terms of qualifications. Academics whose principal training had been in humanities rather than in medicine began to enter the field in these years.[8]

3. At about the same time a younger generation of medical historians gradually opened medical history towards the wider public. Political discussions about the role of prominent protagonists in the Nazi-era and a perceived need to raise professional standards resulted in the foundation of a second professional society related to the field, the Gesellschaft für Wissenschaftsgeschichte, in 1965.[9] The following year saw the foundation of a second journal, the *Medizinhistorisches Journal*. Only a few years later popular writings such as Thomas McKeowns (1911-1988) "The Role of Medicine" (1976) or Ivan Illich's (1926-2002) "Medical Nemesis" (1975) and early discussions about the history of medicine in national socialism[10] gave impulses for the field so that it gradually expanded its focus and audience even more. A couple of years later, in 1978, a professional society, the "Fachverband Medizingeschichte", was founded to take care of the interests of the discipline in the medical world.[11]

4. From the 1970s on the discipline was gradually transformed from what had so far been largely a history *in* medicine into a history *of* medicine that positively responded to the methodological challenges posed by general

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8 For example: Werner Friedrich Kümmel (History, Ancient Greek, Musicology and Philosophy), Renate Wittern (Classical Philology and Ancient History), Ursula Weisser (Oriental and Indogerman Philology, Islamic Science and History of Natural Sciences), Klaus-Dietrich Fischer (Classical Philology and Anglistics).

9 Jobmann 1998.

10 A documentation of the Nuremberg trials on crimes committed by Nazi doctors by Alexander Mitscherlich and Fred Mielke (Mitscherlich and Mielke 1960) that first been published in 1949 had found only a small audience in those days, not least due to successful attempts by medical officials to actively hamper its circulation. Its re-edition in 1960 then became a standard sourcebook for the history of medicine in national socialism. Medical historians like Gerhard Baader, Fridolf Kudlien and others then opened the field for the discipline. The volume Baader and Schultz 1980, covering debates during a meeting of health professionals in 1980 (Gesundheitstag), gives a good impression of the growing concern for that history in the 1970ies.

11 See http://www.fachverband-medizingeschichte.de/ for details.

history and – remember we are in the 1970s – by sociology. Medical historians like Fritz Hartmann, Eduard Seidler and Gunter Mann wanted too put medical history into a larger context and a few years later Alfons Labisch claimed the status of the field as a social science.[12] It is also remarkable that it was in this period that a number of academics whose principal training had not been in medicine were able to pursue successful careers in medical history.[13] To be wearing a white doctor's coat while working as a medical historian slowly became unfashionable in these years.

The 1980s

At about the same time when medical history became a more open discipline, general historians began to discover this peculiar history as an important part of history at large. Mostly guided by sociological theories, historians like Ute Frevert, Gerd Göckenjahn or Claudia Huerkamp interpreted the history of medicine as one of the aspirations by the physicians to take control of the medical market from the late 18th century onwards.[14] The essential line in that process, according to the authors representing this direction, was the monopolising or at least control of the medical market which was taken over by academically trained physicians, including their pushing aside of competitors like midwives, artisan surgeons etc. What this resulted in was the medicalisation of health at large. So hygiene, which was a broad and heterogeneous movement in early 19th century, became more or less redefined around medical theories as medical bacteriology.[15]

Another trend in research that expanded the field of history of medicine was historical demography and social history. Here authors like Arthur Imhof, Øivind Larsen and Reinhard Spree and others did a lot to expand our knowledge about conditions for life and causes of death and disease in modernity.[16]

Even though the communication between medical and general historians from time to time included sharp undertones and sometimes even accusations of mutual incompetence[17], a general stimulus to medical history

[12] Labisch 1980.

[13] Such as e.g. Dietrich von Engelhardt, Werner Friedrich Kümmel, Ursula Weisser or Renate Wittern, who held or still hold chairs in Lübeck, Mainz, Hamburg, and Erlangen.

[14] Francisca Loetz' doctoral thesis (Loetz 1993) provides a comprehensive overview and discussion of such work.

[15] See e.g. Labisch 1992; Frey 1997; Hardy 2005.

[16] Imhof and Larsen 1976; Spree 1981.

[17] See the controversy between Ute Frevert and Gunter Mann in the *Frankfurter Allgemeine Zeitun*g in 1987, reviewed in Dinges 2004: 211/12.

as a discipline was a valuable outcome when seen in retrospect. Important works by medical historians such as Johanna Bleker, Wolfgang Eckart, Alfons Labisch, Heinz Peter Schmiedebach and many others were visibly and fruitfully inspired by the broader perspective which the 1980s offered to the field.[18] The distance between the fields of medical and general history seemed to diminish in these years and one could name a number of fine volumes that resulted from cross-disciplinary discussions.[19]

A second and rather different stimulus came from within the medical profession itself: In the 1980s the need to explore the history of medicine under National Socialism became more widely felt.[20] That peculiar history has remained in the focus of interest till today, and one could argue that the heuristic peculiarities it offers has been a continuous reminder to medical historians that a certain minimum of methodological standards have to be observed.[21]

Once triggered, the interest that general historians took in the history of medicine has remained constant. Up until today important work in the history of medicine is often written by colleagues in other historical disciplines.[22] In this context the role of the Robert Bosch Institute for the history of medicine in Stuttgart is of importance. In 1989, its yearbook was given a new title "Medizin, Geschichte und Gesellschaft" (MedGG) that reflects the atmosphere of these years. MedGG developed into a platform for the social and later the cultural history of medicine, which Robert Jütte, its current director launched in a programmatic paper in 1991.[23] In close connection with this institute important works by colleagues with both medical and historical backgrounds, such as Martin Dinges, Francisca Loetz, Sabine Sander, Thomas Schlich, Eberhard Wolf and others have been produced.

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[18] Bleker, et al. 1995; Eckart 1997; Labisch 1992; Schmiedebach 1995. A lot more titles could be named adding to these three which were on the author's reading list in these years.

[19] As examples from the author's reading: Mann and Winau 1977; Frei 1991.

[20] Bleker and Jachertz 1993 (1989) covering a much disputed series of articles in the widely read *Deutsches Ärzteblatt*, the weekly journal of the German chamber of physicians (Bundesärtzekammer).

[21] One reason for this could be that many colleagues from other countries and disciplines are present in this particular field of research.

[22] For an overview: Dinges 2004.

[23] Jütte 1990. The yearbook is older, but it was given the new and somewhat programmatic title in volume 8 1989. See also Robert Jütte's editorial to the first renamed volume.

Ethics and hot seats: New challenges

However, from the early 1990s onwards a new set of cognitive and institutional challenges made medical history move in different directions. Such challenges have in the past 15 years substantially changed the intellectual climate, institutional basis and professional composition of the field. It is, of course, the much disputed and worldwide rise of medical ethics that I am talking about here.

In Germany the upgrade of medical ethics resulted in a sweeping rearrangement of the field.[24] When in the late 1980ies the rising interest in medical ethics was felt, some of the rather prolific medical historians aimed at embracing rather than opposing the new field. At the same time medical ethics was quickly developing into a more professional form.[25] Medical faculties who ventured into building up capacities in that new speciality often did so at the expense of medical history. The visible result of this process can be summed up as a hyphenization of the field: Usually upon replacement of chair holders or directors, institutes names became lengthened into "Institute for Ethics, Theory and History of Medicine" or the like. A closer look at the profiles of such revamped places discloses a variety of intellectual goods on storage behind the new window dressings: While some colleagues tried to integrate the two fields and continued in historical research, others more decidedly shifted their focus in the direction of ethical research to which medical history would then be little more than a repository of useful stories. My personal interpretation is that this process – despite stimulating work by individual colleagues - gradually dwarfed and undermined the intellectual capacities of the field at large.

The transition that the field of medical history had to face in the mid 1990s was further accelerated by discussions about a nation-wide curricular reform of the medical education in these years. It showed that medical history as such was in the hands of those who where in command of the planning. Early versions of the new licensing regulations for physicians, the Approbationsordnung für Ärzte" (AoÄ), which essentially define the medical curriculum, became public in 1997. It turned out that medical history

[24] See Cooter 1995 for a polemical account from the earlier days. A collections of papers on the relatedness of the two fields can be found in Frewer and Neumann 2001.

[25] The „Akademie für Ethik in der Medizin", which also edits the Journal *Ethik in der Medizin*, was founded in 1986. Eduard Seidler; Richard Toellner and Ulrich Tröhler at that time institute directors in Freiburg, Münster and Göttingen, and influential colleagues where among the list of founding members. Personal notes by the society's manager Dieter Simon (Göttingen) obtained by the author through Klaus Gahl (Braunschweig).

had entirely vanished from the list of subjects to be taught. While the extinction of the field seemed a threatening prospect in these days[26] the final result in 2001, when the new regulations were launched, turned out to be somewhat less gloomy. It fact it did more to deepen the trends which had emerged in the previous years. While medical history finally lost its traditional, exclusive but small place in the curriculum, a new compulsory course branded "History, Theory and Ethics" was created, which all in all substantially expanded the curricular basis of the new hyphenated field of ethics and history of medicine.[27]

What's interesting is that while institutional and curricular reforms forcefully drew the field into the direction of incorporation with medical ethics, intellectual challenges in the 1990s offered formidable alternatives to more historically minded younger colleagues. It is not that the *history of science* was new in itself, but it was in these years that the intellectual stimulus it offered became widely felt in German medical history. Aided by international debates on how the history of medicine could profit from the neighbouring field[28] and guided by historical investigations of basic medical research such as physiology[29], the history of science offered alternatives to those who wanted to practice advanced forms of medical history. The foundation of a large research institute of the field in 1994, the Max-Planck-Institute for the History of Science in Berlin, in which at least one department is devoted to the study of the history of the biological sciences (but not medicine) offered a point of crystallisation that was made use of by some colleagues. An edited volume published in 1997 "Medizingeschichte: Aufgaben, Probleme, Perspectiven"[30] (Medical History. Tasks, Problems, Perspectives) illustrates the attractions that various methodologies from history of science seemed to offer to those who continued to see themselves

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[26] See Johanna Bleker's in these days widely recognised "Cry for help from German History of Medicine" published in the internet discussion list H-Sci-Med-Tech (http://www.h-net.org/~smt/) on 12.11.1997.

[27] The German title of the course is "Querschnittsbereich Geschichte, Theorie und Ethik der Medizin". A Group of authors from Hannover will shortly be publishing an overview on that course as taught by Institutes for history and ethics in Germany in *GMS Zeitschrift für Medizinische Ausbildung*. The paper is based on a survey which was performed through the *Fachverband Medizingeschichte* (Möller, et al. 2006).

[28] Warner 1995.

[29] See e.g. for the Germany the volumes Rheinberger and Hagner 1993; Hagner, et al. 1994. Internationally, Andrew Cunningham and Perry Williams' widely read volume on "The laboratory revolution in medicine" (Cunningham and Williams 1992) gives fine examples on transfer between history of science and medical history.

[30] Paul and Schlich 1998.

as medical historians. While the authors all agreed that German history of medicine needed vivid exchange with neighbouring fields most of them choose history of science or science studies for that purpose, while only a few resorted to new trends in general history such as cultural history. Although it makes little sense to see such alignments as being opposing in any sense, it seemed that by the mid 1990s history of science had gradually replaced general history as a leading discipline for German historians of medicine. There is a notable side-effect to this trend: German medical history had become more international towards the millennium.

The changes were to become even more relevant when in 2002 career patterns for younger scholars from any field changed dramatically in Germany. While German academics traditionally stayed on temporary positions for longer periods the federal government attempted to speed up careers by introducing a maximum employment period of twelve years on non tenured positions.[31] Since that period in fact was intended to cover the entire path from graduation to holding a chair it proved to be too short for many and created, as a newspaper put it, a generation of 'juniors on the hot seat' (Schleudersitz).[32] It effectively terminated numerous careers or made emigration to foreign countries seem as an attractive option.

The wave of emigration of relatively young, usually more historically minded scholars which the discipline of medical history experienced after 2000 was thus a variation of a global trend which rocked the German academia in these years. In the case of medical history most went to the land of milk and honey of that field, Great Britain,[33] but some left for the US, Canada and other places, thereby making good use of the internationalisation of the field that had occurred a few years earlier.

An outlook

Looking back at 30 years of medical history in Germany reveals that what remains these days is a changed field. Instead of a full grown conclusion I want to list what I see as the essential features of the state of the art today:

[31] Technically through an amendment to the federal law on universities the „Hochschulrahmengesetz".

[32] Best documentation of this is to be found in: historicum.net/aktuell/diskussion/hrg. The newspaper is *Süddeutsche Zeitung* where on 2.8.2004 Marion Schmidt wrote about "Junioren auf dem Schleudersitz".

[33] A few names of German colleagues who practice medical history in Great Britain these days: Flurin Condrau (Manchester), Andreas Holger Maehle (Durham), Thomas Rütten (Newcastle), Lutz Sauerteig (Durham), Claudia Stein (Warwick) , Carsten Timmermann (Manchester). Cf. Köhler and Dobrinkat 2006. On the same day the newspaper also covered short pieces on two such careers by Carsten Timmermann and Lutz Sauerteig.

The academic discipline of medical history is a lot smaller today than it was a generation ago: A place like Berlin that hosted no less than three permanent professorships in 1990 has just one non-tenured professorship left. Many other institutes have dwindled or ceased to exist. And in some places where medical history does still exist, it has lost the status of a faculty institute with a professorship and is simply present with a lower rank lecturer position such as in Marburg, Magdeburg, Rostock or Greifswald. Other institutes like in Bochum, Freiburg, Göttingen, Münster etc. are fairly stable in their staffing, but have developed into places where medical history is only one focus among others, notably medical ethics. However, in a few places like in Gießen or in Würzburg, upon replacements heads of departments where chosen who have a strong historical research profile.

Adding to this, I would like to draw attention to some interesting trends in the social history of the field. These become visible if we step back from all those debates about medical ethics, histories of sciences, federal laws on academics careers and the like:

In the first decades after World War II medical history in Germany was practiced by physicians wearing white coats and talking to a predominantly medical audience. The 1970s and 1980s changed the appearance and composition of the field. While white coats disappeared, non-medical scholars rose to professorships in considerable numbers. At the same time professional standards became more closely related to those of the social sciences, general history in particular. During the 1990s this trend was effectively reversed in some respects. It is not that the white coats returned, but during the last 10 years nobody has been made a professor in the field who did not have a doctor's licence. The need to teach a course that combines history, theory and ethics of medicine and which does exist nowhere outside of medical faculties has further accelerated the retreat of medical history into medical faculties. It needs to be clearly emphasised that this outlook and the associated career patterns are different from in other European countries, notably in Great Britain, where medical history hosts scholars with a diversity of professional backgrounds.

In a remarkable speech delivered in 2001[34], Alfons Labisch, head of the institute in Düsseldorf, has tried to intellectually come to terms with the ongoing changes which seem to enforce a new definition of medical humanities for him. Labisch's redefinition of the history of medicine as a

[34] Labisch 2002. Labisch's text grew out of a key-note lecture delivered to the Deutsche Gesellschaft für die Geschichte der Medizin, Naturwissenschaft und Technik in Hamburg, annual meeting, 1991.

medical humanity may be disputable, but it is certainly an attempt to develop a definition of medical history that reflects the changes in the past decades which I have discussed here. He clearly states that the traditional purpose of medical history, namely supplying a humanistic complement to the physicians self by teaching a canon of classical medical texts is no longer sought for by medical faculties. He also acknowledges that medical history has increasingly become a history of medicine in the past decades, which means a discipline that meets the methodological requirements of the social sciences and which does not necessarily address a medical audience. In what seems to be a certain revision of his own older positions he then forcefully argues that such studies need to be supplemented with a history *in* medicine that supplies answers to medical questions for a medical audience. This reformed discipline would then be intended to provide and reflect the anthropological basis of the various medical sciences. Medical history, which has seemed to lack a substantial legitimacy as a sub-discipline of medicine in the past decades, is envisioned by Labisch to be revitalised as a meta-discourse of medicine.

We do not have to discuss Labisch's position in detail to realise that it is well suited to supply an intellectual framework for this re-medicalisation of German medical history which I have described as an essential feature of the development of that field in the past 20 years.

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Book review:

Rural health – a difficult concept

Michael 2006;3:116–21.

Barona JL, Cherry S. (eds.) Health and medicine in rural Europe (1850–1945). València: Seminari d'estudis sobre la ciència, 2005. 372 pp. ISBN: 84-370-6334-5.

The dichotomy between rural and urban districts when it comes to health and medicine is met with considerable interest for the time being. Urban health has been a hot topic in medical and historical circles for long, and now conferences and publications on its rural counterpart are gaining in interest.

This book is an offspring from collaboration between the University of East Anglia, Norwich, UK, and the University of Valencia, Estudi General, Spain, later joined by historians from the Stein Rokkan Centre for Social Studies in Bergen, Norway.

The volume, published through the Spanish research project *Movimientos Sociales y Organismos Internacionales,* has a general, introductory part dealing with rural health and public policies. Here one of the editors, Steven Cherry, opens with a chapter on medicine and rural health care in 19th century Europe, followed by a paper where the other editor Josep L. Barona is first author of a review of the same topic for rural Spain 1854-1936. In a later chapter in this part of the book he also presents the European conference on rural health in Geneva 1931 and the relationship to the Spanish administration.

Francis King addresses rural health care in Russia 1864-1914. Astri Andresen from the Rokkan Centre in Bergen has written two of the papers of the introductory part; the first one together with Teemu Ryymin on rural health and health acts in Norway 1860-1912, which is the heyday period for establishing and consolidating of a public health service in rural Norway. Her second paper concludes the first part of the book, giving a thorough discussion of the interaction of medicine and rural cultures, based on the development in Spain, Norway, and European Russia from the 1860's and in the following fifty years.

The second half of the book presents point studies: Steven Cherry takes up the East Anglia region in England 1800-1948, Carmen Barona Vilar tells from rural Valencia, and so does also Maria-José Báguena Cervellera, who highlights the role of medical topographies in the study and combat of infectious diseases. The importance of the geographical approach is underlined in the next chapter, where Ian Farr draws attention to the medical, topographical reports from Bavaria in the 19th century.

Chapters 11 through 16 in the book deal with the disappearance of malaria from the East Anglia "fens", which are the low wetlands of the area (Tom Williamson), the story about the 20th century anti-malaria campaign in Alicante (Enrique Perdiguero-Gil), hygienic work in Catalonia in the early 20th century (Josep Bernabeu-Mestre), health care networks in rural Majorca (Isabel Moll), child care in an infirmary in Norwich 1854-1929 (Bruce Lindsay) and child care in rural and urban Alicante (Enrique Perdiguero and Josep Bernabeu).

There is a 12 page selected bibliography to the topics at the end of the book.

The general conclusion drawn by this reviewer after having read this book is very simple: I like it! Going into more detail: The two parts of it serve different purposes. The first part takes up the problem of studying health, medicine and health care in a rural setting, as opposed to the urban society. The examples given in the second part are interesting in themselves, but they will probably also serve as basic information for later surveys and analyses on a broader scale.

The emphasis which has been laid on medical topographies is important, as new quantifying methods make systematic historical studies of material of this type easier. Such sources are available for several countries.

However, if the book is to be used as an introduction to the field of urban/rural studies of health, there are some minor weaknesses. Studies of rural health imply a series of methodological problems. Some of them are duly dealt with in this book, especially in the chapters by Cherry and An-

dresen. Their papers should be read by everyone who takes up health issues in the urban/rural perspective. But there could have been even more discussions of methodology.

The theoretical considerations should start already with the concept of health, which is the point of origin for needs, setup and action-taking in health care. There exists a morbidity and mortality in every society, but the key to the contemporary and historical understanding of these parameters has often to be sought more in the local perceptions of the conditions and in the prevailing attitudes towards health, than in the situation itself, such as it comes to sight through figures and hard facts.

One also has to discuss the concept of "rural" even more deeply, as this links to the concept of "place" held by the geographers, where one of the main messages is that the definition and function of a "place" depends on what functions and impacts you look at, and to which context it belongs. What is "rural" in the health perspective? Is that different from "rural" as seen in a pure demographic sense? The topic is touched upon in the present book, but in studies of rural health it should as an example be more strongly stressed that "urban" health problems also may occur in "rural" areas. An appalling example is the heavy load of infectious diseases found in the fishing seasons in coastal Norway in the 18th century due to the work migration by fishermen, gathering in miserable fishing dwellings for short, but medically disastrous periods.

The importance of migration should also be underlined. In the period covered by the book, rural Europe was in no way a stable society. On the contrary, migration was substantial within the countries themselves, in addition to the emigration waves. The importance of commuting in districts close to cities should have been dealt with, and important issue for e.g. Norway, where the rapid urbanisation had a health impact on the rural societies situated close to the growing city.

The 19th century, and the first decades of the 20th century also were unstable because of the ravaging pandemics, from the cholera to the Spanish flu. Geographically, these diseases affected both the rural and the urban regions, but both the immediate and the long time effects of such diseases on society has to be studied on the local level.

The concept of "rural" also changes its contents during this time when the percentage of rural dwellers as compared to the number of inhabitants in the cities decrease substantially, at the same time as communications are becoming better and better. When almost all people lived in the countryside, the notion of urban health has less meaning as a special category or has at least quite another meaning as when large cities have de-

veloped, exposing greater number of inhabitants for the living conditions in a town.

In the migration perspective, together with people, not only diseases but also conditions for impairing and maintaining health were wandering, making even the most remote place a herd for spread of disease if luck was bad, or for prevention and cure if luck was good.

In the book rural North-West Russia is taken as one of the examples. It may be that this mainly forest-covered wilderness was a comparably stable region in the Russian society at the time. But if we look at the district covered by the chapter by King, and select one of its apparently most isolated places, the Kishi islands in Lake Onega, a closer acquaintance will make you doubtful: To reach the villages at Kishi today, you have to travel some 400 kilometres by train from St. Petersburg to the Karelian capital of Petrosavodsk, then change to a high speed hydrofoil vessel which in one hour and fifteen minutes cruises the open and windy lake before landing in the small settlement. Here is an interesting open-air historical museum which justifies the visit. One of the things the guide will point out to you is that this society in former times was not perceived as isolated at all, as traffic passed over the ice in winter and by boat in summer. And even more important for our topic: Men from the villages were regularly migrating to the distant metropolis of St. Petersburg for work in longer periods, then coming back for taking up farming on the fields in the summer season. In a perspective of medical topography, such tiny villages may be far more important for the function of the rural society and also for effects on rural health than their size and geographical position might indicate. In the book, Andresen gives an important discussion touching on these methodological problems.

The impact of rural health exerted by travel activities and migration has been beautifully shown on maps by the Giessen-, later Berlin-based Swiss historian and demographer Arthur E. Imhof; e.g. for the 18th century using demographic crises (years when mortality exceeds birth rates) as a crude indicator for failing health. An internet search will open up to an interesting literature in this field.

Quantitative studies performed by Imhof and his group even indicate class-related differences in health due to differences in demographic stability between the rural population layers. Possibly are differences found because the immunity towards infections could be higher among the survivors in high-mortality migrating groups, as compared to the more well-off but stable upper layers where less immunity made them more vulnerable when infections came back!

It was shown that quite typical patterns of countryside epidemiology followed the trade and the exchange of local products with imported necessities. However, most appalling were the effects seen in the wake of bad harvests or as a consequence of high grain prices. Wartime might inflict health even in districts only indirectly afflicted because men and horses had been taken away from farming work through mobilizing, and often even more seriously when soldiers returned and brought dangerous infections with them.

Admittedly, many of the early quantitative studies of rural health refer to a period which lies before the time covered by the book by Cherry and Barona. On the other hand, this research has revealed mechanisms which seem to be universal. Therefore, the reader of this book will miss a more explicit reference to the vivid interest for the historical dynamics of rural health which existed in the 1970's in Germany, and also in Sweden, where the access to digitalized rural data from *Tabellvärket* opened quite new perspectives for studying the geography of health over time, not at least because causes of death have been registered in the statistics.

Among the quantitative studies from the 19th century the studies of regional differences in infant mortality should be paid due attention when rural health is discussed. Here, the effects of medicine, medical skills and the health care for mother and child probably also comes statistically to sight, perhaps most clearly for those periods when mortality figures are more favourable in urbanized areas than in the countryside.

Medical reports submitted by local district physicians have been used for detailed quantitative studies of urban/rural differences, and also for studies of the function of health care, attitudes towards health and so forth. More references to newer works, e.g. from the Nordic countries could have been given.

Because the cultural impact of health is so important for the setup of health services and also for the considerations about prioritizing health when other values of life are at stake, there are clear links between the studies of rural/urban health and health care and the history of ideas and mentality. In other words: There is a relationship to the topics taken up by the *Annales*-school in France and the way of historical thinking which developed in this tradition in the 20th century. Some more attention to such issues had been an asset to the book.

The selected bibliography is comprehensive and useful. However, this reviewer looks in vain for some works which could have defended their inclusion, and feels that the list as a whole is a bit skewed towards writings in

English, so that some important studies in French and German are missing.

However, these comments should not throw shadow on the gratulations to the editors, and on the encouragement to the collaboration group behind this book, so that they continue their efforts to shed light on the history of rural health in Europe.

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Letter to the editor:

Academia and research in Boston – Excerpts of a student's perspective on an American academic institution and its approach to medical research

Michael 2006;3:122–26.

As a current student in a Norwegian medical school I feel that the influence of American medicine in our curriculum is substantial. History shows that the influence shifts. Before The Second World War Central Europe and Germany were the driving forces. These days we hear a lot about the strides made by our fellows Asians, indicating there might be an upcoming shift. I grew interested in trying to understand the American approach and the reasons behind the current American influence in medicine, and left The Norwegian University of Science and Technology (NTNU) and Trondheim in July 2005 to attend a one year Research Fellowship at Harvard Medical School and Children's Hospital Boston, in Boston, Massachusetts, U.S.A. My interest has always been pediatrics, and in particular the combination of surgery and pediatrics, so I headed for the Department of General Surgery.

The Longwood Medical Area

Children's Hospital Boston is located in Longwood Medical Area, Boston. Longwood is considered one of the largest medical areas in the world, with numerous renowned institutions. Children's has about 5000 employees, sizeable to be a pediatric institution, and 1.500 professionals are devoted purely to research. If you take into consideration the rest of the hospitals in the area, and add the pharmaceutical companies, the specialized research institutions and the medical schools around, a rough estimate gives us 60.000 people working specifically with healthcare within 2 square kilometers.

The rather congested area of hospitals and research institutions makes quite an impression, and a few notices should be made. Obviously there are a lot of synergies with this type of concentration; however there is another factor that has left a more interesting impression. In a privately run health

care system as the one you have in the America, even though everyone is the other ones' neighbour, the competition is apparent. One day you could be referring a patient to the neighbouring hospital, the next day you want your patient back. The collaboration and competition is fascinating. The competing environment in such a small area is in stark contrast to the system in Norway. In that sense, to be the only children's hospital around is a privilege.

Research cannot be generalized; the routines obviously differ greatly from department to department and from person to person, as it does in any part of the world. My focus has been on traumatized children, primarily with liver and spleen injuries and the incidence of complications after ruptures. Furthermore I have looked into alternative ways of grading liver injuries radiographically. I have also worked in basic science projects primarily investigating different medications for lowering blood pressure in hypertensive mice. In other words I have participated in a few different projects, which is a clear strategy at this institution.

The Fellowship program accepts about eight research fellows at any give time and all except me are physicians. A research fellowship lasts for a minimum of one year, usually two. It is a quite common program to attend for physicians who plan on a career in an academic institution. In order to get into certain specific residency programs, like pediatric surgery for instance, it is considered a necessity. I was set to work for Dr. David Mooney, who is Director of The Trauma Program at Children's, and a very skilled and supportive supervisor. Our group has meetings every Wednesday morning, presenting progress in our research and advising and criticizing each other's work. In the beginning the sessions took a lot of preparation, and the older wise men and women of the department often asked harsh questions. Eventually it has become a routine and a forum where a lot of obstacles are surpassed.

Publish, publish

One of the first, clear, and frank messages given in this forum was the importance of publishing. As a student and fresh researcher I appreciated the fact that considerations were taken to assure that all younger researchers were not working merely for the benefit of the institution, but also for him or herself. I found this candid attitude interesting; as it is something I have met wherever I have contributed with work this year. I have recognized the focus on "credit for your work" as something my American colleagues discuss openly and consider wisely before they engage in any projects. I am uncertain whether this focus is as outspoken back home.

In comparison to Norway I instantly felt a much stronger focus on securing reportable and valid results, and making sure you had projects to fall back on. Of course, every project conducted in Norway or in the US is focused on result. However, every project I have taken part in this year has led to a publication. This may not sound like a revelation to senior researchers, but as a student back home you often take part in projects or do a lot of work that more than often end up in the drawer. A lot of the projects I refer to that have been published here are comparable to work students do back home. The difference is the initial aim and the focus and help from supervisors. All work, no matter how big or small, is done with a publication as the ultimate goal.

Buzz word

For me research did not give a spark when I started studying. It seemed lonely and routine, and it often is. I have not missed out on the reality of research and for me it is the hypothesis and the results that motivate. However, somehow the word "research" has a very strong position over here, it's something you want or must do, depending on how you look at it. Most students I meet are involved in some sort of research and are groomed in that direction. Some might argue that this is a phenomenon of top institutions like Harvard, and they may well be right. However I find the comparison just as interesting then. Norway and Norwegian institutions are more comparable to New England and its many top institutions, than to America as a whole which is much more diverse than Norway is. We as Norwegians like to consider ourselves a people of quality in work, success in result and contributors in our world's progress. In short, we should embrace all that has to do with research. My reference is from a student's point of view, but I feel we lag behind in embracing the field. I hope to feel the buzz of "research" in the hallways of Norwegian universities in not too many years.

As a student I was concerned with the role I would get in a huge institution like Children's. Sooner than later, I recognized that I was privileged. Professors and physicians you read about in the literature are all respectful towards the young and I am deeply impressed by the patience and time put down on educating students. And eventually you are treated as any other as you get into your field of research. This is one of the most appreciating notes I have made till this day.

A normal day for me involves starting up in the lab around seven in the morning; the day is largely my own responsibility, though the hospital usually awakens around six so it is a good time to get started. In order to keep

The heart of Longwood Medical Area, the campus of Harvard Medical School. The building in the middle houses the administration of Harvard Medical School. To the left lies the Biotechnology and System Biology building, to the right are the educational premises. The size and architechture reflect the high ambitions. (Photo: K. Kristoffersen 2006)

up with what is going on I have to do something as obvious as to check email, I mention it because it has become a crucial part of my communication with colleagues, to a much greater extent than it has been for me back home. I ask myself whether this is good or bad. As I sit in my office listening to my supervisor's 67th email for the day ticking in; "pling!" I conclude that it's at least alarming. I usually start up my research work an hour later, and depending on whether I am in the lab working with animals or doing clinical work, I end the day somewhere between eight and nine in the evening. The culture is very much focused on work, and I have eventually got used to having my lunch in front of the computer. Most definitely something I find unfortunate.

An international community

Nevertheless, after one year as a Research Fellow at Children's Hospital Boston, what leaves the greatest impression is more of an interpersonal character. As we all know America attracts all sorts of people, and so does the research community. The most enjoyable days at work are the ones where you collaborate with colleagues from Russia, Ecuador, China and Sri Lanka, without giving the diversity a second thought. I find the mix fasci-

nating and very educational. This also goes for the medical school, which has a large group of international students. With so many different backgrounds and ways of approaching problems the chance of success is great, and it is undoubtedly a major contributing factor in the productivity and quality of research at this institution.

In that sense I believe a crucial step for creating institutions like the ones you have here in Boston, back home in Norway is to create a similar international template. By that I mean that Norwegian institutions should take active measures so that international scholars more easily can come and work. There are more than enough people who would like to contribute with their skills in a country like Norway, as their own country may not be able to offer the same opportunities. A lot of people would say that this is a long shot; however Europe is getting smaller and Norway either we like it or not will eventually become an integral part of Europe. An obvious factor that we should recognize is America's great advantage in its language, English, which is largely universal. In a continuously integrating Europe we will soon find ourselves in a situation where Norwegian (!) students and scholars are just as susceptible to work in Frankfurt or Aarhus as in Trondheim or Oslo. Assuming this theory is just, if Norwegian institutions want the same migration of scholars from abroad we have to make our institutions easier to adapt to. We see that institutions all over Europe are building programs in English. This is a feasible and concrete measure that I believe Norwegian institutions would benefit from. We have the quality and technology needed; however our language and geographical location is a challenge. It is our choice if we want to make an effort to minimize this challenge. For students and teachers it will be awkward to base everything on an English template the first ten years, but then it will become natural.

As education becomes an international trade, the Bologna Protocol that most European Universities are adapting to, is merely a beginning, and students and scholars from all over the world start moving around. I believe basing everything on an international template is a crucial move for building successful research institutions.

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Michael

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