

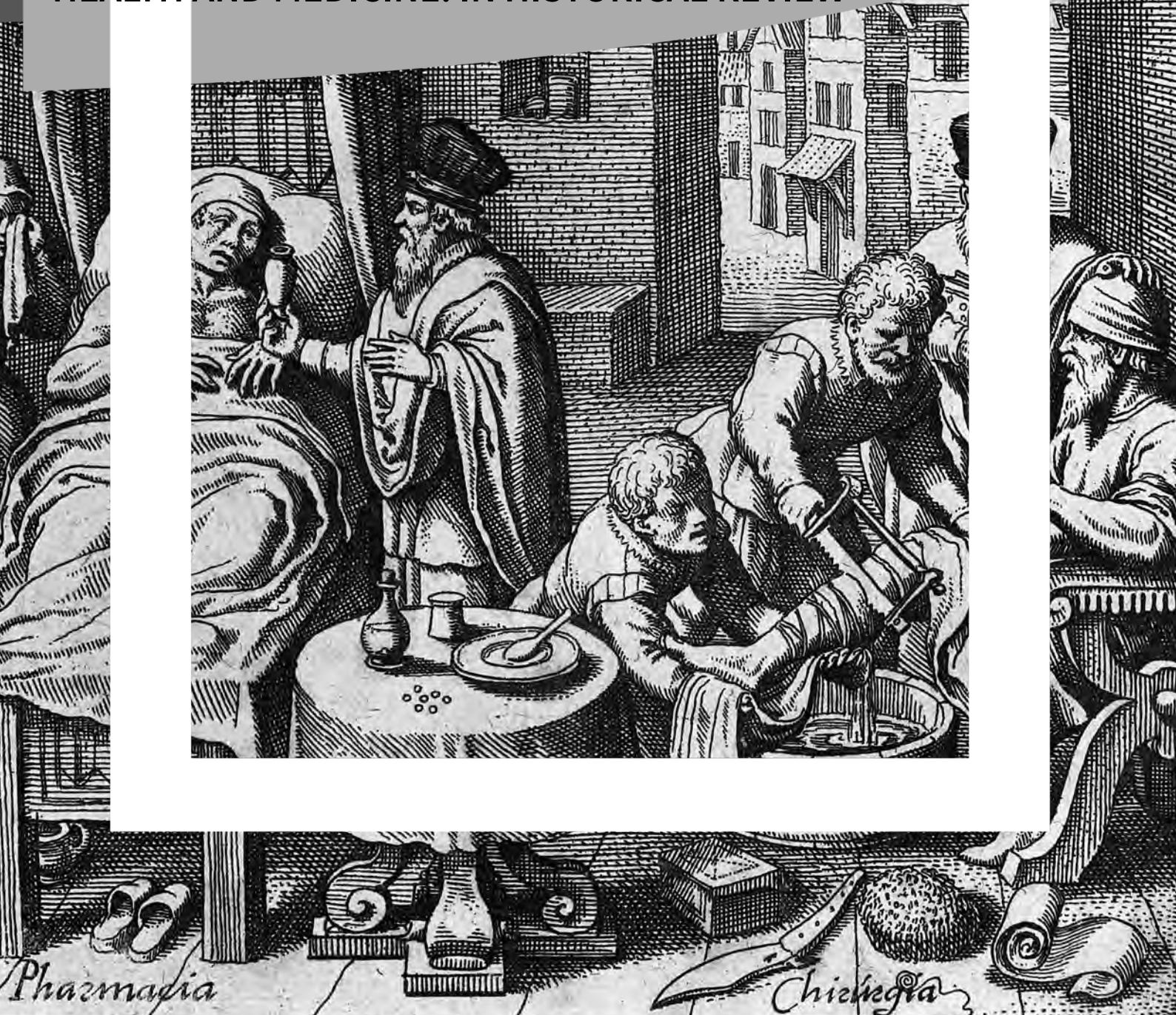
HST



UNIVERSITY OF LEEDS

HISTORY STUDENT TIMES

HEALTH AND MEDICINE: IN HISTORICAL REVIEW



Pharmacia

Chirurgia

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**THANK YOU TO THE TEAM OF
ASSISTANT EDITORS FOR ISSUE 1
2020/21**



HEALTH AND MEDICINE IN HISTORICAL REVIEW



Letter from the Editor

2020 has been an especially trying year for everyone. This year we have faced a multitude of challenges; restrictions, separation, isolation and loss to name a few. But what this year has shown us is the power of human perseverance, determination and knowledge. Our healthcare system, in which we have all depended on at some point in our lives, has supported us through this difficult year in unimaginable ways and reminded us of how we can often take the availability of healthcare and medicine for granted.

This first issue of History Student Times 2020/21 will seek to explore the development of health and medicine throughout history and across the world.

Health and Medicine in Historical Review has been a fantastic issue to edit and truly showcases the incredible array of talent in the School of History. Thank you to both the writers and assistant editors and I hope you enjoy reading this issue over the holidays.

Jenny Speakman

NOTE: The content and discussion in this issue will necessarily engage with medical practices both old and new. Much of it will be emotionally and intellectually challenging to engage with. I have tried my best to flag especially graphic or intense content that might discuss elements of mental health, discrimination or violence that some readers may find triggering.

THE HISTORY OF PANDEMICS

CW: COVID-19

The current Covid-19 pandemic has caused historians to reflect on past pandemics and how we have adapted or continued the same trends.

A recent webinar on 'The History of Pandemic Responses' run by The Raphael Samuel History Centre sparked my interest in the parallels between the current pandemic and past equivalents. The historians speaking had various specialities, stretching across various points in history, all of them connected through this one title.

Matthew McCormack presented the power of the state as an important discussion point, questioning how far individuals are willing to go along with it, which we have seen particularly in the past year. Initially, there was a community spirit, this has not been seen as clearly in the most recent lockdown.

Rosa Salzberg specialises in the Early Modern Venice Plague. She argued that it was the strengths of a country or city that made it particularly vulnerable to the plague. Venice's excellent trade and commerce meant that it was much more vulnerable to have the plague enter Venice through these means.

The role of the state was once again explored by Matt Vester. He brought up the point that there was huge tension between public health and the economy, which is exactly what has happened in the current pandemic. With a huge split between countries that prioritised public health and countries that focused on putting the economy first. Vester's focus was on Valle d'Aosta in the 17th century where the response was driven from the bottom instead of top-down.

The final historian, Henry Irving, focused on World War Two and the 'Blitz spirit', like Matthew McCormack, explored the tensions between the state and wider society. Irving explored the strength of the community working together to protect each other, just as has been asked of us during lockdowns.

I found it strangely comforting to hear about past pandemics where they encountered similar issues that we see now. People breaking the equivalent of our lockdown rules in the early modern period partly reassured me, but it was also worrying to hear that there hasn't been much change in the reactions to pandemics and coping with them. It was not as comforting to hear from Salzberg that the response to the plague was a more permanent feature of society for centuries. Although the current restrictions won't be in place for centuries, the pandemic has made everyone make serious adjustments to the way they live, we will definitely remember 2020 for centuries to come.

In an article in *The Guardian*, entitled 'How humans have reacted to pandemics through history' various historic pandemics are explored. When exploring the mid-14th century Black Death, the spread of a virus across trade routes is noted, just as Salzberg mentioned regarding Venice.

When looking into how history is repeating itself in the last year the authors mention the 'scapegoating [of] outsiders', which is seen in Trump's blame on China calling it the 'Chinese virus'.

It is a common misconception that these medieval plagues and epidemics are outdated and cannot aid us in understanding the Covid-19 virus. However, that would be to misunderstand the process of history. Although, at the time they were less equipped to find a vaccine and suppress the spread of the virus, a lot of the mistakes which were made then can help us now. Moreover, the spread of these viruses indicate how they are transmitted.

Dr Caitjan Gainty ends *The Guardian* article with a study on more recent pandemics. She comments on the similarities between the public health response to the Spanish Flu and the public health response now.

The ongoing HIV/AIDS pandemic is also mentioned as an example of 'how political the designation of a pandemic can be'. HIV/AIDS took a long time to be acknowledged as a problem. Similarly, Covid-19 was passed off many times in the initial days by a few leaders as something we shouldn't worry about. It is clear from looking at previous pandemics, however, that although Covid-19 has been devastating, past pandemics have wiped out significantly higher numbers. A BBC article mentions the 6th Century Plague of Justinian killing half the global population and the 14th Century Black Death killing up to 200 million people. The writer, Bryan Walsh, believes that epidemics have been accepted as 'a terrible fact of life'.

Walsh also links to Vester's argument concerning the economy vs public health; suggesting that the 'interconnected global economy' has increased the spread of Covid-19. This has created a tough decision for governments to decide whether to save the economy or prioritise public health.

Clearly, pandemics will continue to emerge, so it is worth analysing past pandemics in order to build on what strategies were implemented. Once more, we are being asked to learn from history.

Ana Hill López-Menchero

MEDICINE THROUGH TIME – THE IMPORTANCE OF THE HISTORY OF MEDICINE IN EDUCATION.

For the past two years, I have worked as an online tutor alongside my studies, helping students with English and History A-Levels and GCSEs. In this time, many students approached me for help with the 'Medicine Through Time' history GCSE module, across different exam boards, including AQA, WJEC Eduqas and Edexcel. This very broad module, in which students often struggled with the volume of content, spans from as early as 500 to present day, covering major medicinal milestones from the long era of Galen and Hippocrates to the creation of the NHS. Teaching this complex module during a global pandemic has reminded me of the importance of such study and the impacts that learning this history could have on students.

According to the AQA Insight Report from the 2019 series of exams, from the three Thematic Studies modules at GCSE History, over 74.5% of students took the 'Health and the People' module (as opposed to 17.2% for 'Power and the People' and 8.3% for 'Migration, Empires and the People'). A popular choice, and one that AQA states will help students 'show an understanding of how factors worked together to bring about particular developments at a particular time, how they were related and their impact upon society'. Indeed, the module does cover many themes throughout time, such as the role of the church and the catalysts of war and conflict. Students are taught that the Church suppressed progression in the field of medicine until the Renaissance, and that war acts as an important melting pot in which improvisation and urgency can produce discoveries. Many examples are given; Edward Jenner who tested his smallpox vaccine in 1796, William Harvey's description of blood circulation in 1628, Andreas Vesalius' book on human anatomy in 1543. These examples celebrate experimentation, individual brilliance, and the development of education.

In other settings, the history of medicine and health factor into other studies. Individuals such as Florence Nightingale appear in Key Stage 1 studies. Looking at Ancient Greeks, Egyptians or the Stone Age at Key Stage 2 history often features a section on superstition and strange medicinal practices. Understanding of the Victorian age encompasses the suffering of the poor,

particularly of infant mortality and health conditions of chimney sweeps or factory workers. For the Tudors, teachers may discuss Elizabeth I's makeup made from lead that covered her smallpox scars. On placement in a primary school in Beeston, I noted that with younger children, engagement in history is essential and so those teaching may try and make the topics as interesting as possible, in which health can play a big part. I saw that the students were the most engaged in history when they could directly relate to it (such as when Year 1 looked at toys through time) or when it shocks and excites them. One needs only to watch a few episodes of 'Horrible Histories' to see that children engage well with gruesome and ugly history. Perhaps it is also comforting for them to perceive the differences in today's medicine and health practices.

The history of medicine in educational settings is vastly important. At younger ages, the grotesque nature of ancient medicine can engage more students and encourage a passion for history in later life. The content at GCSE level engages students in ideas about communications, gender, poverty and hierarchy, individuals, and ideas on the responsibility of the government in matters of public health. All of these factors are increasingly relevant in the discourse on medicine and public health that surrounds us in the COVID-19 era. It is natural for us to want to look back on historical examples to guide us forward, and the history of medicine can absolutely do that. Widespread teaching of the subject can help young minds develop understanding as to how we reached the present and allow them to join ongoing conversations.

Esmee Fitton

MERCURY FOR YOUR STD AND COCAINE FOR YOUR TOOTHACHE: HARMFUL MEDICINE THROUGHOUT HISTORY

CW: MEDICALLY GRAPHIC

Nowadays we rarely distrust the treatments that are prescribed to us by our doctors, knowing that the extensive scientific trials have rendered them safe for human consumption. However, if you were born into a different era, you may have been prescribed a cocktail of toxic treatments with life-threatening side effects.

The Sixteenth Century: Lead and Mercury

The use of lead wasn't just a fad that came and went during the early modern period; it was used for around 2,000 years, beginning with lead-covered plasters prescribed by the Roman Emperor's personal physician in the first century AD. Centuries later, during the Renaissance period, and influenced by the alchemy of the Ancients, physicians began to recommend ingesting lead for the treatment of tuberculosis, asthma and other ailments.

Unaware of the dangerous effects of lead poisoning, such as seizures, hearing loss and even learning difficulties in children, lead continued to be advocated by physicians for centuries. At the beginning of the Industrial Revolution, in the mid-eighteenth century, an epidemic of metal intoxication allowed scientists and physicians to study the effects of ingesting lead and end its use as a medicinal ingredient.

Lead wasn't the only metal used for medicinal purposes. Mercury was used to treat the most critical medical problem of the sixteenth century: syphilis. Physicians sold 'blue pills' containing the toxic calomel (mercury chloride) to those infected with the disease. A typical dosage of these 'blue pills' - two or three a day - was more than one hundred times the daily limit set by the Environmental Protection Agency today. The dangerous side effects of mercury ingestion were blamed on the development of the initial disease until a study in 1861 by Adolf Kussmaul, a German physician, demonstrated that the symptoms of mercury poisoning were drastically different from those of syphilis.

Alicia Ward



The Eighteenth Century: Bloodletting

Considered one of medicine's oldest practices, bloodletting is the withdrawal of blood from a patient in an attempt to prevent or cure illness. The practice arose from the 'Theory of the Four Humours', proposed in the second century AD and revived during the Middle Ages and Renaissance period. The theory claimed that the body was made up of four 'humours': black bile, yellow bile, blood and phlegm, and that any illness is caused by an imbalance of these. For the overabundance of blood - believed to cause diseases like the plague, smallpox and epilepsy - bloodletting was a common treatment. The practice became so popular that its patients included George Washington, Marie Antoinette and Charles II!

Excessive bloodletting would result in a dangerous drop in blood pressure and even cardiac arrest. Surprisingly, the practice wasn't questioned until the 1800s when Benjamin Rush, an esteemed doctor, began draining 80% of his patients' blood during the 1793 yellow fever epidemic. His extreme treatment caused disputes between doctors for decades until the practice eventually died out.

The Nineteenth Century: Cocaine and Heroin

In a bid to find a fast-acting anaesthetic that was non-addictive, scientists in the mid-1880s isolated the active ingredients of the coca leaf and the opium poppy, creating cocaine and heroin. An Australian ophthalmologist discovered that a few drops of a cocaine solution caused a patient to be de-sensitised to pain, leading cocaine to be widely used in eye and sinus surgeries. It soon became marketed as a treatment for everything from toothache to depression, sold in many forms, from lozenges to cigarettes.

With cocaine serving multiple purposes and being available for a cheap price- Allen's Cocaine Tablets were sold for just 50 cents in the US- people rushed to buy it. Simultaneously, Bayer pharmaceutical company advertised heroin-laced aspirin to children to treat sore throats, coughs and colds. Some bottles even depicted children reaching for the medicine whilst their mothers handed it to them on a spoon.

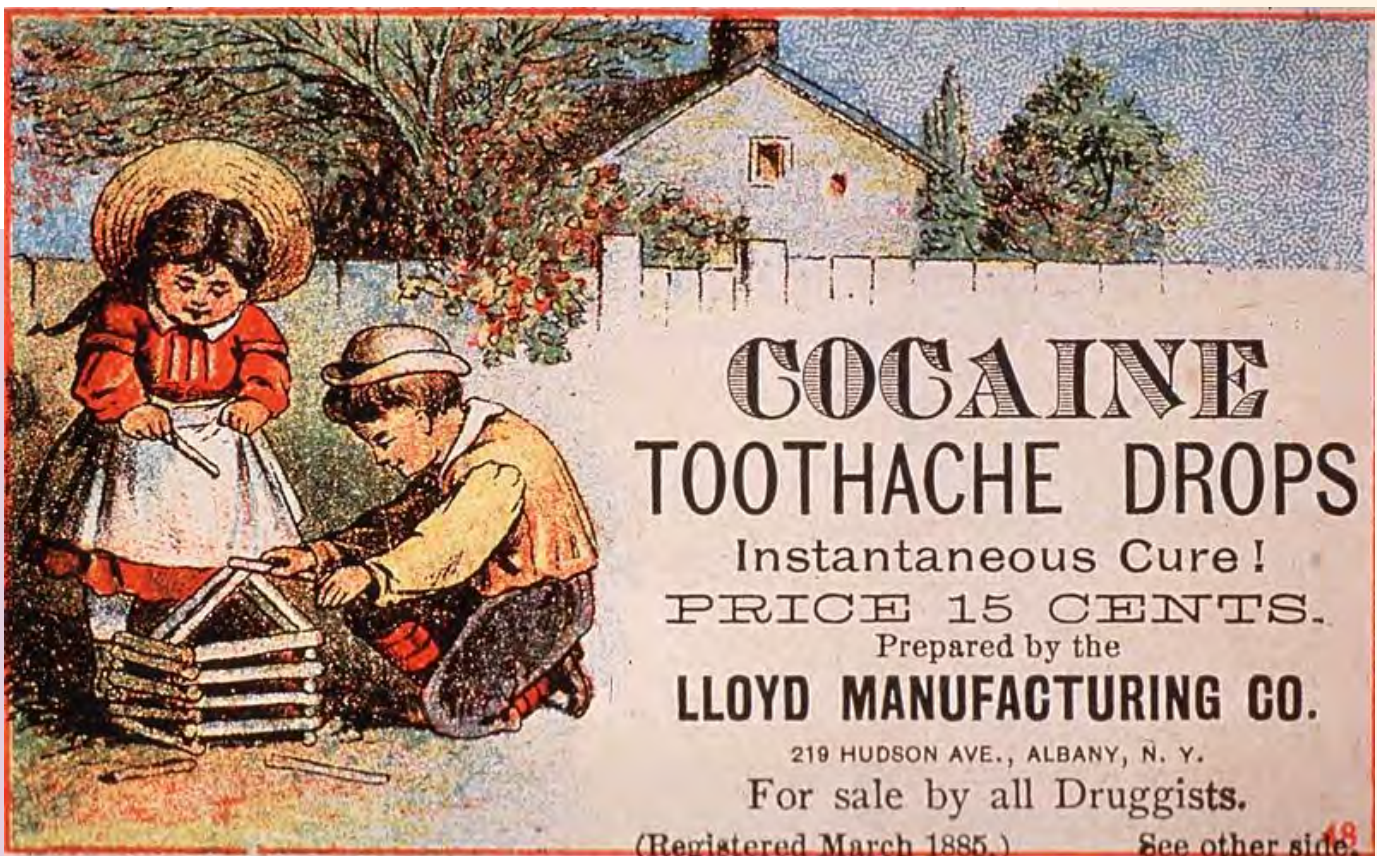
By the time the dangerous side effects of these drugs became apparent, it was too late. Heroin addiction reached a peak in 1895 and by 1902 there were an estimated 200,000 cocaine addicts in the US alone. The 1914 Harrison Narcotic Act outlawed the production, importation and distribution of cocaine. However, the sale of heroin wasn't banned until 1924.

The Twentieth Century: Thalidomide

Considered the worst medical disaster of the 20th century, the majority of people today have heard of Thalidomide and its effects. Marketed as an effective treatment for morning sickness to be used in the first trimester of pregnancy, Thalidomide was advertised as 'completely safe' for everyone, including mothers and babies.

By the early 1960s, sales of Thalidomide were almost as high as aspirin and more than 10,000 children worldwide were born with deformities caused by the drug. Thalidomide caused damage to the brain, eyes, ears, face, arms and legs. Almost as soon as the effects of Thalidomide on unborn babies became apparent, the sale of it to pregnant women was banned. However, the drug is still used today to treat those with Hansen's disease (leprosy) and myeloma (a type of blood cancer).

By analysing medical history, it becomes apparent how much the health sector has advanced. We take it for granted today that medical treatments are likely to relieve our ailments rather than add painful and damaging symptoms, of which patients of the past were all too familiar with.



**COCAINE
TOOTHACHE DROPS**
Instantaneous Cure!
PRICE 15 CENTS.
Prepared by the
LLOYD MANUFACTURING CO.
219 HUDSON AVE., ALBANY, N. Y.
For sale by all Druggists.
(Registered March 1885.) See other side.

ANCIENT GREEK MEDICINE AND THE FOUNDATIONS OF MODERN MEDICINE

Katie Winfield

Ancient Greek society is widely known to have created the foundations on which modern medicine is built. An impressive feat for a society which was formed around 700 BC. This article will explore the Greek beliefs and the impression which remains in modern medicine.

The beliefs of the Greeks surrounding health revolved around the balance of humours. The four humours included: black bile, yellow bile, phlegm and blood. This was inspired by the four natural elements: earth, water, air and fire. Illness was said to occur when too much or too little of one humour occurred in a person. This was a substantial belief as it remained in Western Europe until the 17th century, demonstrating the impact Greek medicine had on western society.

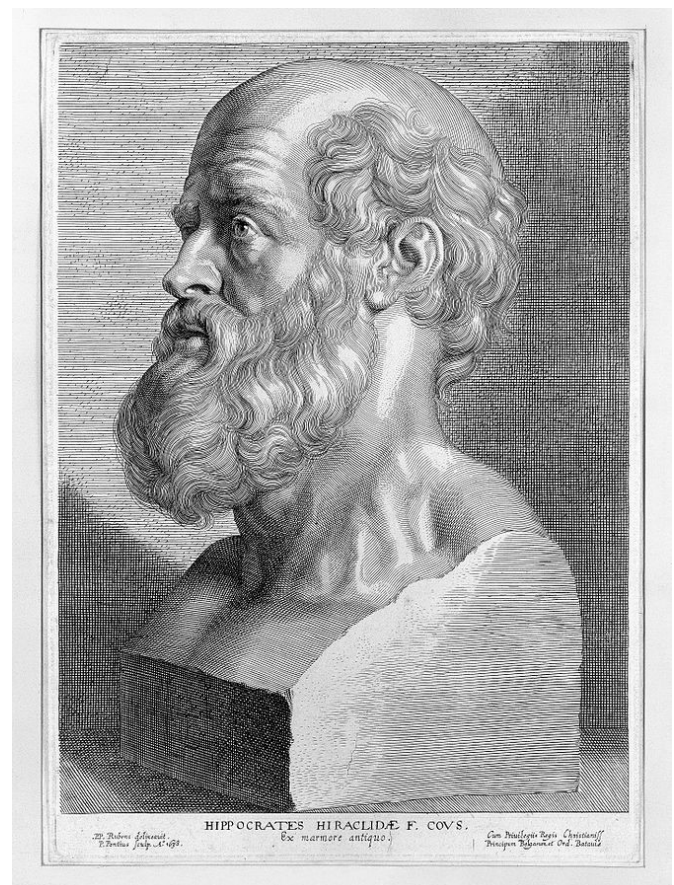
Math was an important tool used in medicine with great mathematicians such as Pythagoras being Ancient Greek, his theorem being widely used in maths today. However, their knowledge of maths and medicine was more abstract. They believe that four and seven had special meanings associated with health. For example, seven x eight equalled 28 days, the length of a moon cycle as well as a menstrual cycle. They also believed a baby prematurely born in the seventh month enjoyed better health than those full-term. Forty was also considered a sacred number. The quarantine period was Forty days for this precise reason rather than the scientific reasoning present in modern society.

The Greeks sustained the majority of their injuries through two activities: war and the Olympic games. War required doctors to heal wounds whereas the Olympic games involved inquiry into fitness and prevention of injury. This resulted in the practice of warming up before physical activity which is still in use today. They understood body temperature was important in a warm up and often used olive oil to raise it.

Moreover, there are numerous other contributions by the Greeks still prevalent in modern medicine. Hippocrates studied the body and teaching at his school revolutionised the practice of medicine establishing it as a discipline in its own right. He documented many diseases which are still diagnosed today including clubbed fingers; a sign of illnesses such as lung disease and heart disease. Furthermore, medical terminology

arose from Hippocrates and his school including words such as: relapse, chronic, epidemic, genes (meaning birth), gynec (meaning women) amongst many others. He was also responsible for coming up with observations and physical examinations to distinguish between potential illnesses and those to rule out. The Hippocratic oath is still taken to this day signalling the long effect Hippocrates had on the field of medicine.

Some theories that emerged from Hippocrates' school were from the process of dissecting and studying dead bodies. In certain morbid cases, criminals were cut open alive and studied. Later in Ancient Greece, they deduced that the brain, rather than heart, controlled the movement of the lungs, and that blood moved through the veins. They were unsure of where the veins were in the body, but these beliefs show the incredible knowledge they obtained as a civilisation existing thousands of years ago.



Although their beliefs were advanced, their treatments varied in success. Chest diseases involve treatment with barley soup and honey to bring up phlegm. With a similar goal, pneumonia was treated with a bath in which the patient was instructed to remain completely still. To normalise temperature, they understood that opposites were important; keeping a patient warm when they were too cold and vice versa. They often bled patients in an effort to restore balance as well as giving laxatives to induce sickness to recover the balance of bile. In more abstract treatments, music and theatre was a therapy-based treatment including flute and harp treatment and watching tragic plays. Other forms of treatment included appealing to the Gods if the treatment they used saw no results. These appeals would be to Asklepios, God of healing, who had many temples that doctors took their patients to.

Many doctors were adept in practical first aid due to the volume of wars, including skill in setting broken bones, fixing dislocated limbs and curling slipped disks. Military doctors were also tasked with removing arrowheads and other pieces of weaponry; to stop the spread of gangrene many amputations were also carried out. Closing a wound involved thread, much like stitches, but deeper surgery was not conducted due to the lack of anaesthetic medicine. Patients were encouraged to eat foods such as celery for anti-inflammatory properties. This suggests that their treatments were more limited than their knowledge of the body.

The steps the Ancient Greeks made in medicine were extraordinary for the resources of their period. Many of their theories are still in practice today showing the great reach Ancient Greek medicine had beyond its time.

MEDIEVAL MISCONCEPTIONS: HEALTH AND DISEASE IN THE CRUSADES

Jamie Ashton

In view of contemporary events surrounding medicine and health, it is interesting to consider these themes within the medieval context of the Crusades. The Crusades is a subject strewn with misconception, offering unique circumstances for both the spread of disease as well as its treatment. This article shall give a brief overview of these transformative events, considering disease and treatment within the Latin East.

The Crusades were a series of holy wars directed against Jerusalem and the Eastern Mediterranean. They were incited by Pope Urban II's speech at the Council of Clermont in 1095 and culminated with the First Crusade and the establishment of the Latin East, also known as the 'Crusader States,' lasting until the fall of Acre in 1291.

The Crusades brought a new aspect to medieval medicine and pose interesting context for the study of disease. We can separate disease into three categories: disease during the 'journey', disease and health during warfare, and disease in the Latin Eastern territory.

We must consider the connotations of mass migration in sequential waves of tens of thousands of people to the Latin East. The challenging journey overland and overseas posed a great many issues and the threat of malnutrition is well documented in the crusader chronicles. In addition, frostbite, drowning and scurvy were commonplace in these chronicles. Moreover, with unsuited immune systems to the Middle East, many succumbed to geographical ailments such as heat stroke or food poisoning. Similarly, encountering unfamiliar diseases such as the parasite *Dracunculiasis* would also pose a health issue with western medicine unaccustomed.

Health concerns from warfare were an obvious problem with many dying from wounds and injuries sustained in battle. The nature of medieval warfare and the siege connotes issues of sanitation; staying in one place for a considerable amount of time increased the likelihood of gastrointestinal diseases such as Dysentery from contaminated drinking water. These were especially problematic causing severe stomach cramps and diarrhoea

requiring hydration. These conditions also festered fevers as well as epidemics which are both mentioned by the Chronicler Joinville.

This environment was what Mitchel coined a 'collision of cultures' and had a profound impact on disease and also those aiming to treat it. The assumed notion that medical practitioners in the East were superior to their Frankish counterparts is largely unsubstantiated, with Mitchel arguing for little differentiation between treatment methods based on Hellenistic tradition and available medical knowledge. Examples of innovation and ingenuity can be seen in the Latin East and by crusade doctors, with evidence of autopsy as early as 1103 to greater understand treatment. Surgery can be separated between elective and that which is undertaken as emergency treatment for trauma.

In the medieval period, 'surgery' by the *Cyurgicus* covered all those diseases which may at some point require an operation thus explaining the variety of treatments covered in 12th-century medical texts. *Cyurgicus* were considered inferior to the University-educated *Physici* with surgery seen as a more manual trade and common in the Crusades. Barbers would often perform blood-letting and minor surgical procedures with the *Apothecarius* or *Herbolarius* able to prepare drugs.

Examples of these stratifications can be seen in infirmaries of the Knights Hospitaller also known as the Hospital of St John, set up in the Latin East and recognisable as hospitals. One must stress the varied nature of these institutions and of course the lack of standardisation. In addition, little is known about their practices - especially in the battlefield hospitals - yet these field hospitals were critical to the Crusades and an essential part of warfare since classical times.

One must be wary when studying medieval medicine for an inevitable contemporary bias and although little is known about exact practise, many textbooks survive relating to medievalist techniques. Arsdall has cautioned for this bias as an obstacle for studying medicine in the period, causing the dismissal of ingenuity with many textbooks simply copied for posterity and little evidence of use.

Although difficult to analyse fully, disease and treat-

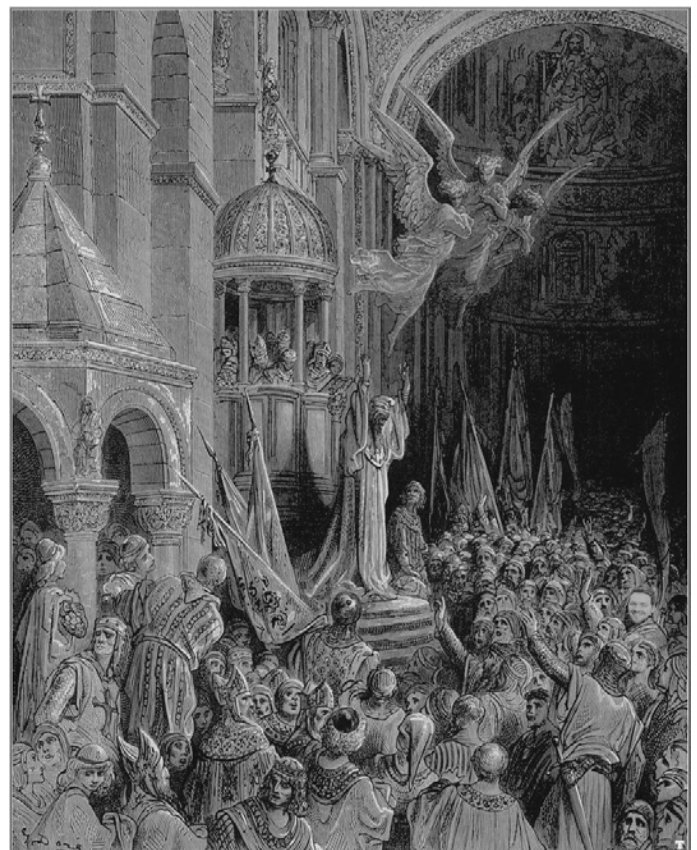
ment played an inevitable part in the Crusades with issues of health and disease a constant threat to the Latin East as such matters of the human condition still do to this day. It is important to recognise this very human characteristic on both sides and to see these events in all their horror.

Further Reading

Mitchel, Piers, *Medicine in the Crusades: Warfare Wounds and the Medieval Surgeon* (Cambridge: Cambridge University Press, 2004)

Arsdall, Anne, 'Rehabilitating Medieval Medicine' in *Misconceptions about the Middle Ages*, eds. by

Stephen Harris and Bryon Grigsby (Oxon: Routledge, 2008), pp. 142-150



THE DEVELOPMENT OF MEDIEVAL MEDICINE

Medieval Medicine was influenced by the works of Greek physicians, Galen and Hippocrates, and their ideas surrounding the human body. Hippocrates is considered the 'Father of Medicine' and created the theory that health was dependent upon the steady equilibrium of the four bodily humours- blood, phlegm, black bile and yellow bile. His rudimentary understanding developed the idea that an imbalance of these substances resulted in illness. This thinking contributed towards the development of treatments, as opposed to heavily praying to God for assistance that was used eagerly prior.

Furthermore, Galen was also a Greek physician whose ideas were prevalent towards shaping medicine within the Middle Ages. Galen used anatomy to provide descriptions of the body, including the fact that the arteries carry blood - a concept that remained unchallenged over centuries. Some of this thinking is still used today, such as the Hippocratic oath that doctors must ensure no harm is exerted upon their patients.

In the Middle Ages, the Church's philosophies impacted medical ideas, for example suggesting that sickness was a punishment for sin. Occult healing of prayers and religious rituals were still present and used to combat this. One of the main methods used to diagnose illness was examining stool, blood or urine. A common treatment of this period was bloodletting whereby a lancet was used to withdraw blood from the patient. This treatment was based upon the humoral system as it was thought that this would help balance the substances within the blood that would simultaneously maintain health - showing the continuation of Hippocrates' ideas. It was so common that barbers would even offer this treatment. Another more deeply invasive treatment used within this period was trepanning which involved drilling a hole into the human skull. This was mainly used to treat more severe illnesses such as epilepsy and migraines, but as one can imagine this often proved to be fatal for patients.

The Black Death was one of the deadliest pandemics which swept across Europe in the 1340s wiping out around 40% of Britain's population alone - this signifies that almost half of the population of England died in around 18 months. The enormity of this disease meant that there were not enough living people to bury the dead. Symptoms of the plague included swelling and

boils in areas such as the groin and armpits, spitting blood, fever. Death was expected within 3-5 days.

As a result, this pandemic resulted in a dramatic population and economic decline. The plague was seen as a direct punishment from God and so people increased their sufferings in order to gain God's mercy. However, scientists believed that the suffering was caused by miasma or corrupt air and so people of this period used distinct vapours, such as burning ornate spices, in order to penetrate the air.

Interestingly, similarities in Medieval societies low tech approaches to the pandemic are visible in our current circumstances. For example, quarantine and isolation methods developed in the 15th century to prevent the spread of the contagious disease.

Overall, this article highlights the importance of the contributions from Greek physicians for the development of medicine in the Middle Ages and the impact of one of the largest pandemics our history has witnessed.



Isabella Di Liberto

HENRY VIII'S PLAGUED REIGN

Many of you may remember the Tudors as one of your first encounters of studying history; at the forefront, the notorious executer of wives – Henry VIII. Perhaps you chanted ‘divorced, beheaded, died; divorced, beheaded, survived!’ around the playground – yet the notoriety of Henry VIII’s cruelty to women has been accepted as a memorable – perhaps even amusing – trait of his reign, rather than a detrimental cause of the Tudor line’s demise. His obsession with having a son drove Henry to insanity, and two of his unfortunate wives, Anne Boleyn and Katherine Howard, to the executioner’s block. Only in the last decade has scholarship considered that the common factor across the stillborn babies, the miscarried foetuses and the high child mortality among Henry’s offspring was the obvious; Henry himself. Arguably, women in Early Modern history, especially those like Henry’s wives who are simply accessories to their more famous male counterparts, are often seen as vessels for heirs. Henry’s wives were vessels for unhealthy children – of six wives who carried multiple children to varying terms, just two survived to adulthood.

As advanced by Whitley, a new theory poses that Henry VIII was Kell positive. When a Kell positive man impregnates a Kell negative woman (as Anne Boleyn and Katherine of Aragon almost certainly were, according to Whitley), the foetus is attacked by the woman’s immune system. So was Henry VIII’s Kell positivity and associated McLeod syndrome the cause of multiple miscarriages, stillbirths and unhealthy children who died within months? Or are Henry’s ‘symptoms’ simply circumstantial, made to fit by historians wanting to save the reputations of women seen as unfortunate Queens who could not bear healthy sons for a tyrant?

Whitley dismisses claims of myxoedema, Type II diabetes, and syphilis. Although Kell syndrome and McLeod do conveniently fit the pattern of Henry VIII’s misfortune – one healthy firstborn and subsequent miscarriages, stillborns and infertility – one wonders whether diagnosing monarchs like Henry with such illnesses perhaps excuses their behaviour. Whitley attempts to argue that Henry’s sudden turn upon Anne Boleyn was McLeod syndrome – but what if it was simply the mark of an overindulged, paranoid tyrant, as Starkey argues Henry had been as the spoilt child of Elizabeth of York?

Henry VIII’s possible Kell positivity absolves Henry’s wives of being viewed ‘as failures’ in a couple’s inability

to produce healthy children consistently. But is this wishful thinking? Can we diagnose historical figures posthumously with diseases discovered centuries later? Henry and others like him lived decadent, grossly unhealthy lifestyles and did not have adequate medical care to prevent miscarriages, to deliver children safely or to alleviate fertility issues. Even saving young children from early deaths was a challenge.

Perhaps Henry VIII was Kell positive, perhaps he was unlucky. Perhaps he suffered from McLeod syndrome or a severe bout of a spoilt child growing into exploiting a position of power to a tyrannical extent. One must only survey his treatment of Thomas More, Katherine of Aragon post-divorce, his two daughters prior to Jane Seymour’s intervention and Cardinal Wolsey to acquire a holistic view of his true nature, illness or not.

Further Reading:

Stride, P and K. Lopes Floro, ‘Henry VIII, McLeod Syndrome and Jacquetta’s Curse’, *The Journal of the Royal College of Physicians of Edinburgh*, 43.4 (2013), pp. 353-360

Whitley Banks, Catrina and Kyra Kramer, ‘A New Explanation for the Reproductive Woes and Midlife Decline of Henry VIII’, *The Historical Journal*, 53.4 (2010), pp. 827-848



Evie Hallitt

THE CODPIECE: A FASHION

NECESSITY OR A MEDICAL SOLUTION?

Renaissance fashion historians have argued that the codpiece was an important component of male dress in the construction of masculinity in the sixteenth-century. They highlight that men began to wear the codpiece as an accessory when they adopted the shorter doublet in place of longer, knee-length coats. The doublet left the genital area exposed and the codpiece was used as a cover. However, the extreme proportions of the codpiece in the 16th century, giving the allusion of a permanent erection, must be considered in ways other than just an outward image of male virility.

Portraiture of the period shows that the size of the codpiece grew as the century progressed, reaching a pinnacle in the 1540s and 50s, before steadily declining in fashion and use by the 1580s. This trend can be viewed as coinciding with the rise of syphilis, a new STI that began to spread rapidly across Europe around 1495. This was a result of the armies of Charles VIII invading Italy in 1494, which caused an outbreak that spread across Europe upon diseased soldiers returning to their homelands.

Syphilis became dubbed the *French pox* in England and Charles VIII himself contracted the disease. The sexual

pandemic reached Russia by 1499 and became a deadly killer throughout Renaissance Europe.

Con Scott Reed in the *Internal Medicine Journal* put forward the argument that 'the codpiece fashion developed because of necessity and not by whim.'

Reed looks at how the codpiece was used to disguise the disease, provide protective padding for swelling and to reinforce the application of a remedy.

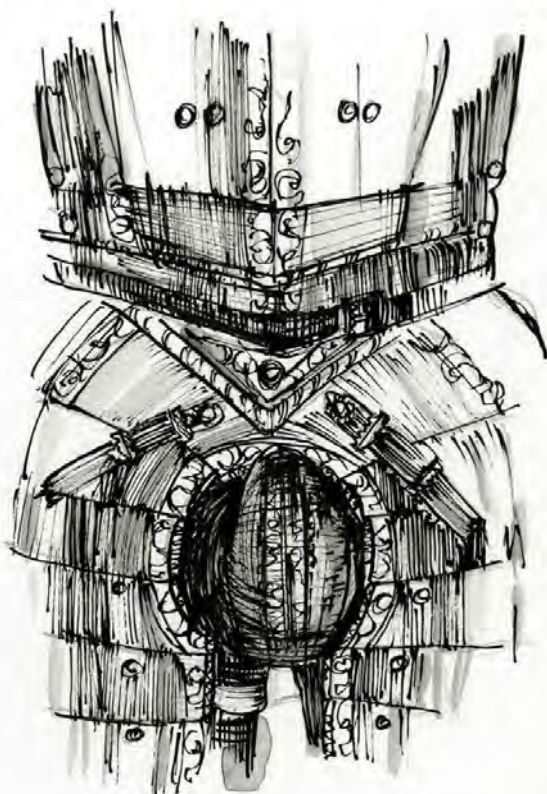
The disease would cause large amounts of pus and blood to be discharged from the genitals as well as swelling of the groin tissue. The discharge required bulky woollen pads to cover the genitals. The bulky dressings caused an issue in terms of fashion for shorter doublets; therefore, the emphasised codpiece allowed dressings to be disguised.

Doctors and physicians of the period subscribed to the treatment of mercury, applied locally, to reduce symptoms. However, the intense dosage and long-lasting toxicity could easily be described as a medical error that increased symptoms. The most commonly used ointment of mercuric oxide, sulphide and cinnabar created a scarlet colour that could stain easily. Therefore, codpieces were generally made from scarlet dyed material that protected costly velvet, brocade, and embroidered satin clothes.

As fears of catching syphilis increased we could view the codpiece either as a preventative to the disease or a male chastity device. Kings and their courts adopted the codpiece as a fashion statement which could have begun as a practical medical solution. However, it is virtually impossible for the historian to determine who had contracted syphilis or whether he was conforming to fashion norms that were expected of elite men. Portraiture of soldiers and nobles generally feature the codpiece, raising the question, to what extent were men in the sixteenth-century victims of fashion or disease?

Further Reading:

Reed, C. S., 'The Codpiece: social fashion or medical need?', *Internal Medicine Journal*, 34 (2004), 684-686



George Helliwell

THE BLACK DEATH: MEDIEVAL LONDON'S RESPONSE TO AN EPIDEMIC IN THE FOURTEENTH CENTURY



When the Plague first arrived in Europe in 1347, the continent faced an unfamiliar situation: an unknown pestilence, spreading swiftly across the lands. The wonder surrounding it caused people to speculate on the disease's cause. In 1348, the Faculty of Medicine at Paris proposed several possibilities: the configuration of the heavens, which poisoned the air; and corruption of the air by a mix of "evil" vapours, possibly caused by an earthquake. The surgeon Guy de Chauliac, who wrote nearly two decades later, indirectly agreed with Paris on the conjunction of the heavens, but he also claimed that some people believed Jews, the poor, or the nobles were to blame. Religious authorities, like the Archbishop of York in 1348, believed the plague to be a punishment from God.

Unclear about its cause (and what exactly the pestilence was), European authorities responded differently to the plague. Florence, for example, initially reviewed its sanitary regulations before the disease arrived in the city-state and re-informed its citizens of these regulations. England, on the other hand, did no such thing. Some historians, such as Robert Gottfried and Richard Britnell, have argued that England's lack of both an initial response and a centralised plague-prevention body proved that the country was "backwards" and behind other European places, but this does not appear to be true. While England, indeed, lacked an initial response and was not as centralised in their prevention of the plague as some Italian city-states, its local authorities

enforced measures to prevent the plague from spreading and infecting people. London is to be used as an example here.

London experienced five plague outbreaks in the fourteenth century (1348-9, 1361-62, 1368-9, 1379 and 1391). Despite knowing about its arrival in England, the city did not prepare for the plague's arrival. After it *had* arrived in late 1348, London's officials made no sustained attempt to announce new sanitary regulations; its pre-existing regulations had diminished around the time of the Black Death and were no longer enough. This is evident through the involvement of King Edward III in April 1349. He ordered the mayor and aldermen to clean the city of filth, so all would return to the same sanitary state as before, and to stop the filth from polluting the air.

The idea of filthy or bad vapours polluting the air came from different medical authorities. Two of these, who had an almost certain influence on London's interaction with the plague, were Avicenna and Bartholomaeus Anglicus. The former, in Book I of his *'Canon of Medicine'*, wrote a section on air and water, and its effects on the human body. Briefly summarised, if people breathed in polluted air or drank polluted water, the substance unbalanced their bodily fluids (the four humours) and thereby made them ill. Anglicus agrees with Avicenna on the subject of air, in Book Eleven, Thirteen, and Nineteen of his 13th-century book *'De proprietatibus rerum'*. However, he does not link water's dangerous properties to the human body and its health.

Both books were widespread in 14th-century England, with the 'Canon' also being a part of Cambridge's and Oxford's curricula.

London's authorities evidently used this medical knowledge in their plague regulations. After London's second outbreak, the mayor and aldermen passed ordinances against butchers who kept their rotten meat within the city, under punishment of being put in the stocks with their meat burning next to them. This punishment was not new, but this was the first time it was officiated. The reason for the punishment was the pollution animal remains were thought to bring with them. With the possibility of the pestilence polluting the air and general anxiety surrounding the plague, the authorities acted thusly. In 1391, they next forced butchers to slaughter animals outside the city.

Alongside rotten meat, London's authorities were anxious about the sanitation of the city's waterways. They understood the importance of clean water for street-cleaning and sanitation even before the plague. However, London's two water sources, the Thames and private wells were contaminated: the Thames was used as a sewage system by lavatories, which were built above the river, while the pollution of wells is seen through the cases of asphyxiation of well-cleaners.

Since people used this polluted water daily, London's authorities had to do something to preserve their citizens' health. Their first attempt in 1368 was to lease the water supply. The lessee had to pay the city ten marks annually for ten years and was responsible for the

above-ground pipes. The city, in return, claimed responsibility for the pipes' upkeep underground. Another attempt at sanitation was made in 1395, after a failed extension experiment in the 1370s, when the city built another water base in Cheapside.

Concluding, London's authorities experimented with pre-existing medical knowledge to try and stop the pestilence from spreading through the city. They reinforced older regulations on butchers to stop them from polluting the air. And they realised the importance of the availability of clean water, and hence first leased the water supply in the 1360s and thirty years later built another water base for London's residents.

Further Reading

Ciecieznski, N., 'The Stench of Disease. Public Health and the Environment in Late-Medieval English Towns and Cities', *Health, culture and society*, 4.1 (2013), 92-104

Rawcliffe, Carole, *Urban Bodies: Communal Health in Late Medieval English Towns and Cities* (Woodbridge: The Boydell Press, 2013)

Quinty Uitman



THE SEVENTEENTH CENTURY BUBONIC PLAGUE OUTBREAK IN LONDON

Victoria Beningfield

In 1664, the parish of St-Giles-in-the-Fields, just outside the London city walls, noted a small outbreak of the 'Black Death' among its population. By the following Spring, this had spread into the city itself with devastating effect; almost 20% of the population of London at the time was killed. Though certainly smaller than the 14th-century outbreak of the same disease, the epidemic posed a significant threat to the livelihood of the city until the winter months, when sharp frosts in November and December appear to have killed the majority of the fleas and rats which spread the disease, leaving the city largely free from plague once more.

It was noted at the time that there appeared to be two different strains of the plague; bubonic, which caused painful buboes and was spread by fleas on rats, and pneumonic, which was airborne and spread by sneezing. The pneumonic plague was the more deadly of the two, with those infected often dying within a day of becoming infected. With an estimated death toll of nearly 70,000, perhaps being as high as 100,000, the plague left London almost entirely incapacitated at its height, and though the impact on the wider countryside was more limited than in the 14th century, the rest of England was not left entirely unscathed. The village of Eyam, in Derbyshire first became exposed to the plague in 1665; the source is believed to have been a bale of cloth that had come from the capital which was infested with fleas. The village decided that they would quarantine themselves to prevent further spread of the disease, resulting in the deaths of around three-quarters of the inhabitants in about a year after they were first exposed.

The well-known diarist Samuel Pepys provides much of our understanding about the atmosphere in London during the outbreak, as he stayed in London for the duration of the epidemic bar one month at its height when he joined his wife in Woolwich. Pepys was quick to note the absence of many of his peers, writing in his diary in May 1665 that 'the quality are wont to leave town.' Pepys was not wrong in his admission that the wealthy left London, indeed all those who were able to do so did leave. King Charles II and his court left, as did much of the clergy and government. This meant that those who were unable to leave the city, i.e. the poor, were adversely affected by the plague. With many doctors also having left the city, even those who could have afforded medical care, ineffective though it may have been, were unable to receive it.

At the epidemic's peak in September 1665, 7,000 Londoners died in one week. Pepys wrote on the death toll that at the epidemic's height burials during the day were becoming necessary, as there was not enough time during the night to complete all the funerals required. The city was deemed by many to have been safe upon King Charles' return to the capital in February 1666, though this was not entirely the case. Though the worst of the epidemic was certainly over by spring 1666, plague victims were being recorded in the city until 1679.



THE BLACK DEATH VS. CORONAVIRUS: A COMPARATIVE STUDY OF HIGHER EDUCATION

CW: COVID-19

Kathryn Mee

It is fair to say that the country's current University students feel hard-done-by, with Coronavirus leaving us with an academic experience comprised of Blackboard Collaborate and Microsoft Teams. However, the admittedly smaller student population in the 14th century faced much worse problems than being put in a break-out room without having completed the seminar work. The Black Death peaked in Europe in the years 1347 to 1351 and was far more deadly than the Coronavirus pandemic we experience today, claiming the lives of 75-200 million people across the globe.

The huge number of lives claimed by the Black Death stands as the main point of contrast between the two pandemics. In the years 1348-9, 30-40% of the English population died from the plague, suggesting that university enrolment would have severely decreased. However, like today, those studying at university were young, typically ageing from fifteen to thirty-five, and so were more resistant to disease. This was also because they often came from wealthy families, thus had better living conditions compared to the bulk of society. University enrolment did temporarily dip because of the plague, but this was mostly because students quickly fled home. Interestingly, universities grew in the decades following the Black Death, suggesting its failure to cripple the European Educational Renaissance that was already underway. In particular, there was a 28% increase of students studying theology from 1350-60, probably because death rates among the parish clergy ran as high as 40% which left numerous vacancies within the church. Leading universities had to build additional colleges to accommodate this new influx of students, including New College in Oxford and Pembroke

and Gonville in Cambridge. This increase could have also been because many peasants left their manors in search of higher wages due to a decrease in property value, meaning they achieved the mobility and funding to attend university. Additionally, many people would have acquired this money from an unexpected inheritance.

Death rates were impactful on the quality of learning in these institutions because the older faculty had a smaller chance of survival. Also, incoming students were expected to have advanced knowledge of Latin, logic and maths, but many teachers and clergy died in towns and so students will have missed out on this essential preparatory education. While Coronavirus starved modern students of their opportunity to learn the last term, we have greater access to other sources of education through the internet to ensure we do not fall behind.

The plague also stimulated a change in the intellectual interests among medieval English scholars. Faced with the prospect of death, many became interested in humanistic ideas surrounding mortality. Patrick Egan argues that we should expect a similar contemporary spike in theological and spiritual interests and greater criticism of faith, however, this can be expected to be underwhelming considering today's largely secular society and the differing severity of the pandemics. There has been more research into vaccines and medicine, teaching methods and mental health to cope with the new strains that came with 2020. While these strains have made significant changes to our student experience, it does not compare to the social upheaval that was caused by the Black Death.



RUNAWAYS FLEEING FROM THE PLAGUE

BEAKS, BREAKDANCING & 'BLY MANOR': PLAGUE DOCTOR IMAGERY IN 2020

The shape of a plague doctor mask is bold and distinct. A long and pointed beak attached to a hood with murky eyepieces - it's common to feel slightly uneasy when looking at one. Historically, plague doctors appeared in seventeenth-century Europe, attempting to treat outbreaks of disease. Their beaked masks contained a mixture of herbs, intended to counter the illness that they believed spread because of miasma or 'bad air'. The image of the plague doctor is extremely recognisable even though many medieval and early modern practitioners never donned the mask, and there is no evidence that this outfit was used in England.

No matter the historical origins, the association of plague doctors with certain emotions began almost immediately. Paulus Fürst's 1656 engraving of such a physician used satire to accuse them of exploiting the dying for financial gain. Since then, the image of the plague doctor has walked the fine line between fear and comedy, being used both to portray past medical beliefs as outdated but also represent the fear of disease. This duality is more relevant than ever in 2020 and was perfectly captured in the public's response to a Norwich teenager walking around dressed as a plague doctor in May - some found it funny and some thought it terrifying.

Links between the infamous mask and fear are present in modern popular culture. The unsettlingly long mask is mostly associated with evil, an example coming from the world of pro-wrestling where Marty Scurll uses a steampunk version to embody his gimmick 'The Villain'. Similarly, the anime and manga 'My Hero Academia' contains an arc where the group of villains wear beaked masks. Alongside this association of plague doctors with moral corruption, the leader has an aversion to germs and their primary goal is the cleansing of a 'diseased' society.

A more recent depiction of the plague doctor came to our screens this October through Netflix's 'The Haunting of Bly Manor'. Lauded for its technique of hiding many ghosts in the background of shots but never directly addressing them, the show often uses the hidden silhouette of a plague-masked phantom to unsettle viewers. The ghost never actually does anything to hurt the characters, just provides a distinctive scare, a depiction that is slightly different from the usual villain archetype. In this instance the doctor is also a victim, misunderstood but still associated with death and fear, a good summation of the emotions surrounding plague doctors in horror generally.

With the fear aspect of plague doctor imagery covered, let's turn to the 2020 phenomenon of plague doctor TikTok. The app creates a tailored page of videos based on a personalised algorithm and has had a huge boost in

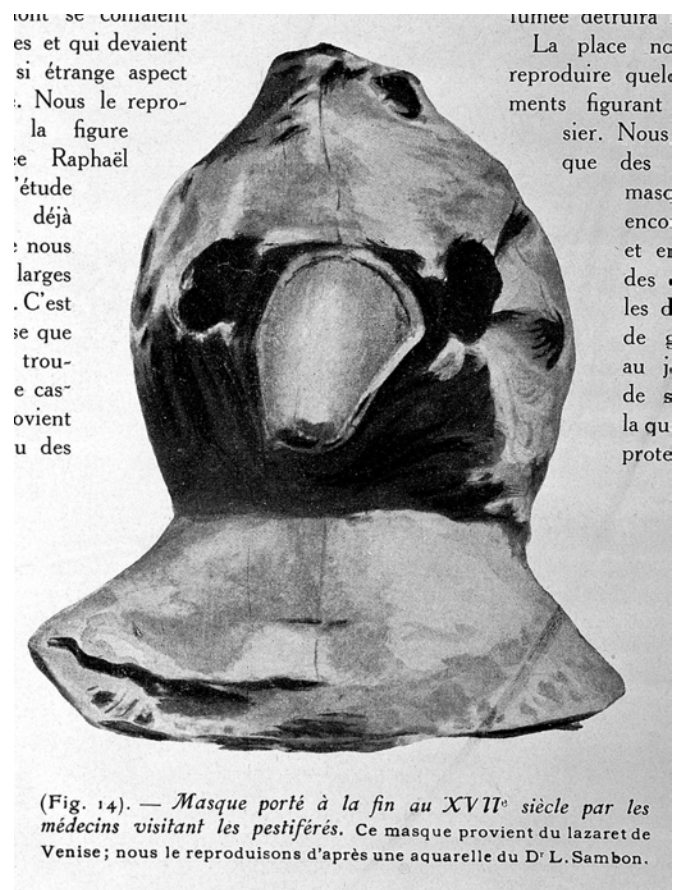


popularity this year as a source of entertainment and communication. Anyone who uses it will know about the different 'sides' of TikTok: collections of videos shown to you surrounding a common theme. One of these 'sides' happens to be plague doctor TikTok. If you make it here, you'll be bombarded with videos of people in stylised plague doctor outfits dancing, making historical memes, and even plague doctor thirst traps.

An explanation of this collective trend of dressing as plague doctors for viral content could come from a multitude of reasons. It could be read as a direct response to increased use of Personal Protective Equipment in everyday society, either mocking those who choose not to wear masks against medical advice or using comedy to normalise something that could be seen as frightening. Alternatively, it could be an attempt at gallows humour by associating the pandemic with the plague in a comedic way to deal with fear.

I spoke about these images to Claire Turner, a PhD student at the University of Leeds who specialises in sensory experiences of the plague in seventeenth-century England. She explained how people can use historical figures and ideas to navigate modern understandings of illness even if the representations are skewed. She spoke about TikTok dancing videos humanising the idea of the plague doctor and giving them a personality, creating an image of them as fluid beings instead of the static depictions they have in historical sources. From this, she suggested it was interesting to consider what characteristics of the plague doctor have been brought forward and what has been left behind. Modern depictions have the long beaks but often don't mention the presence of herbs, forgetting the concept of smell as a protective layer from disease, and instead focusing on the visual sense.

Claire's comment on plague doctors being used for meme material but other aspects of the plague being seized for academic arguments really struck me. As an image, the plague doctor is so alien to modern society that it has manifested in the two extremes of horror and comedy. With discussions of PPE so prevalent in today's news I believe these depictions will continue to increase as a manifestation of our emotions surrounding the pandemic. It will be interesting to see if images of modern doctors decked out in PPE will permeate popu-



lar culture in the same way, provoking similar visual and emotional associations in the future.

Further Reading

- doctor._direst. 2020. <https://www.tiktok.com/foryou?lang=en#/@doctor._direst/video/6848388326458756357>
- Turner, Claire. *Sensing the Past in the Present: Coronavirus and the Bubonic Plague* (2020) <https://www.historyworkshop.org.uk/sensing-the-past-in-the-present-coronavirus-and-the-bubonic-plague/>

Becca Iliffe

THE WITCH DOCTOR: HOW MEDIEVAL 'WITCHES' ARE RESPONSIBLE FOR MODERN MEDICINE.

Henna Ravjibhai

The atropine solution is still used as an antidote for nerve-gas poisoning.

Another poisonous plant which revolutionised modern drugs belonged to the foxglove species. Digitalis was said to be discovered by an English witch and the properties of the foxglove plants helped heart problems. The plant led to drugs such as Lanoxin to be produced which is still used in modern medicine. Although witches had been using this drug, the discovery is credited to William Withering in 1775, when he was struggling to cure a patient of heart disease. He sought advice from a local gypsy woman, who gave him these plants which helped cure his patient.

This example of male doctors and physicians being credited for certain discoveries that were used centuries earlier by persecuted 'witches' highlights women's invisibility within the history of medicine. Without these ingenious women, it might have taken longer to find the cures or possibly not at all. Women were not taken seriously and their ability to discover and create various cures to help their local people should be celebrated and acknowledged rather than hidden from history as a 'supernatural' existence.

Further Reading:

Ehrenreich, Barbara and Deirdre English, *Witches, Midwives, & Nurses (Second Edition): A History of Women Healers*, (New York: The Feminist Press at CUNY, 2010)

Thompson, Helen, 'How Witches' Brews Helped Bring Modern Drugs to Market,' *Smithsonian Magazine*, <<https://www.smithsonianmag.com/science-nature/how-witches-brews-helped-bring-modern-drugs-market-180953202/>>



Since the middle-ages, witches have been a supernatural force clouded in mystery, incantations, cauldrons and often depicted as a 'satanic' feminine threat to the civilised male. During the 15th and 16th centuries, mass 'witch trials' were held with hundreds of women executed or burned at the stake for their questionable practises. However, their practices in natural herbal remedies have shaped modern medicines and treatments such as aspirin, muscle relaxants and various drugs for heart failure including Lanoxin.

Firstly, witches were often believed to be pagan peasant wives who engaged in 'unnatural' practices which threatened the daily existence of the male elite. Male society blamed witches for religious heresy, political subversion and were believed to have magical qualities that could harm or heal another person. The church believed witches were serving the devil, that their sexuality and lust derived from Eve in the Garden of Eden. Thus, women were a threat to patriarchal society and should invariably be punished for their satanic practices.

It is important to acknowledge that many contemporary sources describing witches and witchcraft came from their male persecutors. It is believed that although over five hundred 'witches' were executed in England; thousands were persecuted throughout Europe. Many of these accused were probably innocent.

According to Ehrenreich, women Healers, although seen to be 'good witches', were equally prosecuted and their works were undermined by male doctors from the 14th century. These 'good witches' were generally the only local healers in a village where there were no doctors or hospitals. As people didn't believe that a woman could have the knowledge or gain proper medical education to cure a person of an ailment, they simply believed the witches were once again, performing magic.

Although some medieval folk cures may have been ineffective, some discoveries have since been used in modern medicines thanks to witches. The creation of aspirin, which is an anti-inflammatory and blood-thinning drug, was developed using willow bark. Willow bark contains salicin, a natural anti-inflammatory.

Plants which contained a toxin called tropane alkaloids such as deadly nightshade were helpful to relax the muscles before going into surgery. In the 19th century, scientists isolated the toxin to form atropine, which would help calm the patient before administering anaesthetic.



HEALING MASTERS: WOMEN, WITCHES AND HEALTHCARE IN EARLY MODERN EUROPE

Anna Cronin

In a sixteenth-century petition, a female healer named Katherina Plumanerin Carberinerin wrote to the city council of Munich, informing them of why she must be allowed to practice. She told them of how ‘if someone comes to me in an emergency and pleads with me, I cannot deny them my time or my troubles or the skill that God has given me out of friendship’.

Indeed, despite health care being perceived as a divine right by some women, it was a subject of controversy which resulted in the female healers of early modern Europe having to fight against the rigid patriarchal norms which aimed to restrict their practice. Women and witches who were involved in medicine were a cause for great anxiety not only in the male-dominated health sector but also for the Church, with the demonic possession of individuals often blamed as a result of their healing methods.

However, this didn’t deter these women from their practice. The tenacious female practitioners in this period turned to alternative and often unorthodox methods of medicine to help poorly neighbours in their local communities. Illnesses could be cured with traditional remedies and organic medicines that made use of herbs and ointments. Meanwhile, others performed tasks from blood-letting, bone-setting and diagnosis, to curing women with menstruation problems.

‘White witches’ combined these traditional healing methods with spiritual procedures of prayers and chants, even involving magnets to promote good health and wellbeing. They were considered to have a type of magic formula in the healing process that they used. This innovative version of health care led French historian Jules Michelet in the 19th century to call witches ‘women of superior knowledge’, truly acknowledging that women and witches in early modern Europe were health care professionals in their own way.

In this case, women and their vital role in medicine in the

early modern period is something that must be given more attention. In the 1970s, second-wave feminism in North America began to lead the way in starting this previously silent topic of conversation, initiating questions of why women’s participation in medicine had previously been ignored, when in fact, women and witches were healing masters.

In a truly masterful style, women came together in a communicative way to help and care for each other in early modern Europe. Within dense networks of women, individuals had a comprehensive medical knowledge which capacitated a complex understanding of the female body itself and female-specific issues of pregnancy, childbirth and childcare. For example, Anna Harding was a trusted healer by the women of Eichstätt, whose particular skill was to control menstruation in women. She could reduce its flow where it was too heavy or induce it where it failed to materialise and utilised herbal drinks as her method of cure.

The talent of women as healers in early modern Europe should therefore be celebrated. Not only did they subvert traditional patriarchal norms in the male-dominated medical arena, but also produced effective remedies which contributed to the wellness of their communities. The ingenuity possessed by these women may have not been recognised at the time, but can now be applauded in acknowledging them as medicinal experts.

Further Reading:

Durrant, Jonathan Bryan, *Witchcraft, gender and society in early modern Germany* (Leiden; Boston: Brill, 2007)

Whaley, Leigh Ann, *Women and the practice of medical care in Early Modern Europe, 1400-1800* (Basingstoke: Palgrave Macmillan, 2011)

WITCHCRAFT AND MEDICINE: MEDIEVAL WITCHCRAFT AND ITS ROLE IN THE PROGRESSION OF MEDICINE

Aisling Lantorp

The witch-hunting craze, lasting from the fourteenth to the seventeenth century, is characterised in popular memory by the dramatic trials of the accused women followed by the brutal means of punishment, such as drowning or burning alive. This attack was deemed an urgent necessity to protect God's holy order and the very souls of citizens that were at stake. Witches represented a religious, sexual and hierarchal threat to the state as reincarnations of the devil who were able to inflict damage on human and natural events. Accusations of sex crimes, murders and poisoning were prominent as were crimes of helping and healing, with female healers becoming targets for ruthless persecution by both civil and clerical authorities.

The ecclesiastical nature of society meant clerical control over hospitals and reliance on prayer as a significant form of remedy. Therapy focused on the soul over the body with pain attributed to the original sin of Adam and Eve. Patriarchal suppression of women confined their roles in the medical profession to that of herbalists and midwives. Women were barred entry into universities, with society favouring the progression of male physicians. Female healers took an empirical approach, learning their skills not through institutions, but by word of mouth and experience. The branding of women as witches instead of medical professionals relates to the lack of control the church felt they had over these women. Clerical society could control prayers but not charms or incarnations. Magic was an expression of rebellion against societies established gender and religious identities. Female healers' reliance on their senses and naturalist remedies, as opposed to faith or doctrine, led to their branding as dangerous.

The suppression of women in the medical profession is not only a gendered issue but one of class. Female healers were often the general medical practitioner for those in rural communities who couldn't access traditional male doctors and hospitals. Medicine was institutionalized towards the male upper class. Social issues of poverty remain ingrained in society with men, deemed professional with medical training, serving the ruling class - whereas women, deemed inferior, serving those poorer.

The pain of childbirth was considered a punishment from the 'Curse of Eve' and one which was a women's

duty to endure without alleviation from organic medicines. In taking advantage of natural remedies, women enduring the pain of labour were believed to transfer this pain to their husbands and denying their duty given by God. Midwives, refined to the domestic setting, could be blamed for stillborn births and malformed infants reflecting the rampant superstition and hearsay. Accusations of midwives obtaining infant bodies for pagan purposes were not uncommon. The lack of training available for midwives in rural European areas and the distressingly high mortality rate in medieval Europe meant, even if they weren't involved, midwives became targets for rumours of sorcery.



The herbal remedies developed by these 'witches' still hold a place in modern pharmacology. Ergot, a fungus grown on grass, used to calm the pain of labour in medieval times, is related to principal drugs similarly used today. Furthermore, Belladonna, a perennial herbaceous plant which was used to inhibit urine contractions that miscarriage threatened, is today uses as an antispasmodic.

Regardless of whether these women were in fact witches, female healers served to aid those less fortunate in society playing an essential role in rural communities. Patriarchal beliefs reigned prominent with the idea that women were able to obtain beneficial knowledge of naturalist remedies out of the realm of reason. It was ruled acceptable in the eyes of God for the upper class to be healed under the auspices of the Church, yet not for lower classes by women. Female healers' consciousness was considered a threat to the established norms inherent in an ecclesiastical and male-dominated society.

MEDICINE, MUSIC, MONEY: THE SOCIAL SIDE OF HEALTH IN THE OTTOMAN EMPIRE



Health and medicine are experiences inherently embedded within society. Their fundamental nature ensures that society never stops being interested in health and will never stop trying to improve it, but it is not often that modern medicine is informed by or considered to be part of social discourse.

Well-being in the eighteenth-century Ottoman Empire was a fully integrative social idea – the role of society and the environment in health was undeniable. Medicinal practices were preventative, aiming to treat underlying damaging elements in a patient's life, not their symptoms. This is in dire contrast to the curative and heroic nature that exists within current medicine. Miri Shefer-Mossensohn argues for the Ottoman view that emotional, spiritual, and physical elements of a person acted as one system and should thus be treated as such. It is as a result of this theory that Ottoman medicine utilised human senses to promote health through social surroundings. Food and nutrition were seen as both curative agents and as an insurance against illness. Oil, poppies, coffee, pistachios, and dates were all crucial forms of medicine, prescribed by hospitals, doctors, and family members. Interestingly, eighteenth-century Ottomans valued music and sound, believing it to rebalance the humours and forces within a person. Significant hospitals, such as Mehmet II and Bayezid II provide evidence of the invitations to artists to perform regularly, creating an image of musicians administering cures – a far cry from cold surgery rooms. Visual surroundings were elemental in promoting well-being and imperial hospitals were enveloped by sculptured gardens, believed to be calming.

This all paints a picturesque view of the Ottoman Em-

pire's understanding of health. But what happens when well-being is considered under the guise of social restrictions? Historian Andrew Robarts raises an interesting point in discussing well-being as a means of social control. The architectural grandeur of hospitals of Bursa, Edirne, and Istanbul reflected imperialist discourse; the methods of controlling plague and the creation of the provisional Quarantine Council in the 1830s acted as customs and surveillance posts for the empire; the idea of medical charity reigned supreme as a manner of improving the benevolent standing of the hospital's patron. Health was an imperial social tool. Main imperial cities also saw the social stratification of food. The lower strata, often servants, received food that satisfied their hunger but provided a much lower nutritional value; bread or milk. The rarity of music as a medical practice implies its significance only in high-status treatments and Turkish hospitals arguably worked outside of the balance of family, neighbourhoods, and community – it was the lack of a supporting structure that forced patients into these institutions. It is clear that imperial Ottoman medicine evaluated not only how to treat patients, but whether or not they were socially *worthy* of these treatments.

Ultimately, well-being was a notion that was inextricably socially informed – whether to the improvement or detriment of its implementation. Modern discussions of health should acknowledge the social role of medicine, its accessibility, and its uses, and perhaps utilise an Ottoman understanding of well-being to inform this.

Harriet Price

Elizabeth Blackwell: Education for All

Hannah Tottie

“She would have been spared her worst suffering if her physician had been a woman,” remarked Elizabeth Blackwell.

Watching her close friend suffer from a long illness until death took her, Blackwell felt that if she was treated with the gentle touch of a woman, her suffering would have been reduced. This sparked schoolteacher Elizabeth Blackwell to seek an education in medicine and would go on to become the first female to qualify as a doctor in the United States, as well as being the first female on the British Medical Register.

Early Life

Blackwell was born in Bristol, England, in 1821, one of eight siblings to Samuel and Hannah Blackwell. The family was liberal by nature and taught their children that anyone could achieve whatever they wanted, as long as they worked for it. Due to the circumstances at the time, which did not allow for females to be educated, Blackwell and her sisters were all educated at home by their parents. They grew up with their parents' compassion for others, belief in equality and basic human rights for everyone, which influenced later campaigns for the family including the abolishment of slavery, education for women and equality of rights between men and women. In 1832, the family moved overseas to New York due to Samuel Blackwell's unemployment, where Elizabeth Blackwell took upon the 'female job' as a schoolteacher to help with the family's financial crisis.

Fighting for her education

Following the death of her friend, Elizabeth needed to gain access to a qualification in Medicine. She believed that if more females were involved in higher levels of medicine patients would suffer less, due to their gentle and sensitive nature. Women could be nurses and midwives, however, there was no formal education available at the time. Therefore, gaining access to a medical school would be more of a challenge than Elizabeth would expect. She applied to schools all over America but faced rejection after rejection because of her gender. Elizabeth tried applying to smaller institutions in the hope that they would be more willing to give her a chance but was again faced with rejection. It was only when a professor in the New York Geneva Medical College, who believed it was a joke, took a vote with his students if they should let in Blackwell, that she was accepted.

However, this was only half of the battle, the prejudice against her gender was not going to stop just because she was accepted. Blackwell was forced to sit separately, refused entry into lab classes and made fun of by other students for not being 'the right kind of women'. Summer clinical experience was the same, with very few patients letting Blackwell examine them due to conceptions about women in medicine as being 'abortionists'. Feeling isolated, Blackwell stayed in her room most of the time and studied. In 1849, Blackwell

would become the first female to earn an M.D degree and graduate at the top of her class, despite her hardships. Regardless of her success, Blackwell would struggle to gain patients and respect from other colleges in her field due to her gender.

Education for all:

During one of her residencies in Europe, Blackwell contracted Purulent Ophthalmia from a young patient in a hospital in Paris. Blackwell slowly began to lose her sight in one eye and knew her dream of being a surgeon was over. She returned to New York in the early 1850s, with more motivation than ever to make sure that women were granted a Medical Education. In 1857, Blackwell with the help of her sister Emily, who by now had her medical degree, set up the New York Infirmary.

This was a place to educate women who had previously faced rejection from other medical institutions due to their gender. She published several books in the 1860s on the issues of women in medicine, including the lack of women in the profession and addressing how and why women should be granted an education. Blackwell also wrote many articles on the need for personal hygiene in the profession after watching male doctors spread on diseases by not washing their hands. At the same time in Europe, she was also degraded to an 'assistant' or a 'nurse', more suitable roles for women in medicine. During the Civil War, both Blackwell sisters used their institution in New York to train Union nurses, placing emphasis on maintaining hygiene, bedside care, basic medical training and compassion. Elizabeth Blackwell also spent time in London throughout this period, helping establish the London School of Medicine for Women, which was a specialised institution that educated women in all disciplines of medicine.

Overall, Blackwell was more than just the first female in the medical profession, it was in being an active reformer for equal rights for women and education where she gained even more success. She argued that women had a distinctive role to play in the profession due to their natural compassion and empathy for patients. Blackwell thought that women had the 'spiritual power of maternity' that pushed them to a greater de-

votion to caring for the sick than their male counterparts. Blackwell wasn't saying that men should abandon or reduce their role in medicine but that women had a role in the profession too. As well as the scientific basis of medicine, it also must have a moral one: a role to reduce the suffering and pain of patients.

Further Reading :

" Elizabeth Blackwell", *Changing the Face of Medicine* 2020 <https://cfmedicine.nlm.nih.gov/physicians/biography_35.html>

Harrison, Pat, "Elizabeth Blackwell's Struggle To Become A Doctor", *Radcliffe Institute For Advanced Study At Harvard University* <<https://www.radcliffe.harvard.edu/news/schlesinger-newsletter/elizabeth-blackwells-struggle-become-doctor>>



'The Deadly Stigma' - Postnatal Depression & Gender Roles in the Twentieth Century

CW: MENTAL ILLNESS

Rosie Harkin-Adams

The stigmatization of mental illness has been present in society for millennia and for some people already struggling to cope, dealing with prejudice can be overwhelming. Stigma is often informed by stereotypes, whether that stereotype is based on the disorder itself or other factors. One example of a stereotype that affects stigma is gender. A mental illness that imposes on established gender roles is often subject to an extra layer of 'shame', one that shuns the sufferer's inability to live up to a false ideal.

This article will explore how gender roles have affected the stigma surrounding mental health in recent history, focusing on the example of postnatal depression in women. It will also seek to answer the important question of how deadly stigma really can be.

The term postnatal depression (henceforth PND) presented itself in the mid to late twentieth century and currently affects one in ten new mothers. The first recorded reference to postnatal depression comes from Hippocrates in the fourth century B.C, who proposed that the condition was caused by suppressed lochial discharge (vaginal discharge that comes from the uterus after giving birth) that had travelled to the head and caused agitation.

While medical understanding of PND had advanced somewhat by the 20th century, there remained a clear stigma surrounding the women who suffered from it. Accounts from women with PND in the early twentieth century often shared a theme of deep shame and uncertainty, with terms such as 'weakness' and 'failure' repeatedly mentioned.

In 1911, one doctor stated that "[children] are as necessary to [a woman's] happiness as the food she eats and the air she breathes". In essence, society expected women to be wholly fulfilled by motherhood and when this expectation was not met, women were seen to have failed in their 'purpose'. With the standard set so high, it is easy to understand why women of the early twentieth

century were reluctant to share their struggles and often suffered in silence, making the stigmatization of the condition all the more deadly.

By the mid-twentieth century, the fight for women's rights had begun to take hold. Women's liberation shed new light on postnatal mental illness, creating a safe space where women could discuss their experiences without the threat of stigma. In the 1960s, Betty Friedan and Hannah Gavron both published books proposing that the idolized perception of motherhood established by a patriarchal society did not match up with the real and often harsh reality met by new mothers after the birth of their child. Furthermore, this idealized, outdated perception of motherhood caused crises among new mothers who could not live up to this impossible ideal and subsequently felt they had 'failed' in their role.

This narrative continued to evolve into the 1980s, with more women feeling able to share their own experiences of postnatal depression in national forums. While the theme of 'weakness' was still prominent in these women's accounts, there were real efforts made to highlight the negative impact of strict societal expectations, and to encourage other women to place the burden of fault on society rather than themselves.

Furthermore, throughout this period the term 'postnatal depression' and similar variants began to emerge through open discussion, providing women with the opportunity to consolidate and name their experiences like never before.

By the late twentieth century, the narrative surrounding PND had evolved greatly. While early accounts had been characterized by shame, women were now sharing their experiences openly through memoirs. However, despite these advances, the view of the medical community, who often labelled women's described experiences of PND as simply 'baby blues', preserved the stigma around the condition.

It wasn't until the end of the twentieth century when

the production of the first SSRI (Selective Serotonin Reuptake Inhibitor) antidepressant drug brought the 'chemical imbalance' model of depression – in that depression is caused by an imbalance of serotonin – to public attention that general attitudes towards postnatal depression witnessed a real change. The 'chemical imbalance' model gave PND a sense of legitimacy in the judgemental eyes of society.

While the stigma around PND persists today and will continue to do so while we still have engrained societal expectations of gender roles, the efforts of the Women's Liberation Movement alongside the brave women who chose to share their personal experiences and question

the established 'ideal' have created a more accepting society for the women of today.

However, that is not to say that stigma surrounding PND is not still deadly; even now suicide is the second leading cause of death in postpartum women. Furthermore, recent statistics indicate that almost nine out of ten people who suffer from mental illness say that stigma has had a negative effect on their lives. This indicates that the advancements of the twentieth century have only brought us so far in truly understanding mental illness and that as a result, stigma sadly continues to be deadly.

'Monstrous Births' in Early Modern Europe

CW: HISTORICAL ABLEISM

Miri Hodnett

The Early Modern period represented a departure from the religious fears of the Medieval era, with the slow development of scientific discourses. The sixteenth-century French surgeon Ambroise Paré wrote *On Monsters and Marvels* in an attempt to explain the causes of birth defects and congenital deformities, such as limb difference. During this period there was a strong preoccupation with this, children born with these were referred to as 'monsters', their births 'monstrous'. Paré argued that children born with birth defects were called monsters because they 'appear [ed] outside the course of Nature'. As God's creations were representations of His will, anything that seemed contrary to nature or the perfection created in his name was looked at with much interest.

Before discussing any bodily reasons for these 'monstrous' births, Paré focuses on both the glory and the wrath of God as possible reasons. The example he uses for the glory of God is from the Bible. A man is saved from his congenital blindness by God. He asks Jesus whether his blindness was a result of his or his parents' sin and is told that he was born blind so that he could experience the glory of God in being saved and by recovering. The examples he uses for the wrath of God are much more physically extreme than blindness, for example being born with 'talons'. In these cases of congenital deformity, the blame is placed on the sins of the parents, such as 'the disorder they make in copula-

tion'. The child is not born guilty of sin themselves but is simply a sign of sin.

Most of Paré's book, however, is preoccupied with bodily explanations for 'monstrous' births, such as the quantity of seed or the poor posture of the mother. These bodily reasons are signs in the earlier years of the period of a future focus on scientific, rather than religious, causes of birth defects. However, Paré emphasises that these children, whether born as a result of God's wrath or from bodily reasons, such as the quantity of seed, were 'usually signs of some forthcoming misfortune'. This means that the child, whether perceived to be born as a result of the sins or laxity of the parents rather than being guilty of sin themselves, are signs of sin, and so are unable to escape this stigma.

In the later part of the period during the eighteenth-century, there was an even further departure from God's wrath as the cause of birth defects to an almost lore or popular culture idea of the maternal imagination. This was the belief that a mother's thoughts and fears had an impact on their unborn child. Paré briefly touches on this but not to the extent of its importance later in the period. This emphasis on maternal imagination expresses the beginnings of the move which increased in the Victorian era, away from a religious fear of sin, and towards a more biological fear of moral corruption.

In the eighteenth-century, children with birth defects, still known as ‘monstrous’, were displayed in shows for entertainment. The fear that these children were warning signs did still exist by this period, for example, pregnant women who attended these shows feared that they would give birth to a ‘monstrous’ child as a result of their maternal imagination. There was, however, a departure from the fears of the earlier part of the period where there was more of a preoccupation with God’s role. In these later cases, mothers feared to give birth to ‘monstrous’ children after looking at one for too long, rather than the knowledge that they had committed a sin that would be punished by God.

In the Victorian era, this gap between God’s wrath and maternal imagination was bridged. The maternal imagination became linked to morality due to the new focus on physiognomy. This meant that children with congenital deformities were seen as morally corrupt due to their physical appearance, becoming known as ‘freaks’ rather than ‘monsters’.

Further Reading:

Paré, Ambroise, *On Monsters and Marvels* (London: University of Chicago Press, 1982)

Wilson, Philip, ‘Eighteenth- Century “Monsters” and Nineteenth-Century “Freaks”’: Reading the Maternally Marked Child’, *Literature and Medicine*, 21 (2002), 1-25



Famine: Predictable and Avoidable

Famines are often erroneously explained as a Malthusian event or because of ‘Food Availability Decline’ (FAD). The commonality between the Bengal famines of 1770 and 1943 support the growing discourse that famines are actually man-made. Understanding famine as a manifestation of administration policies and social structures helps us to dispel myths that they are inevitable and unpredictable.

Between assuming *Diwani* (the right to collect revenue) in 1765 and transferring power to the Crown in 1858, the British East India Company (EIC) caused twelve famines and four severe scarcities. Famine and scarcity are not interchangeable because famines contain factors besides food availability such as having little purchasing power.

By 1770, economic disruption and community dislocation had diminished traditional strategies to cope with scarcity in Bengal. Colonial modernisation and commercialisation forced India’s integration into the global economy, this shifted local economies from co-

Dorothy Harper

operation and exchange to a cash nexus. The EIC coerced cultivators to specialise in rice and exploited their capacity to create a grain surplus. As a result, Bengal was more dependent on agriculture and more vulnerable to economic crisis via crop failure. Colonial markets manifested famine and their administrative policies destroyed coping strategies.

EIC policy condemned Bengalis to famine by embargoing the movement of grain and collecting more revenue during the famine than the previous year. The relief was inadequate and ignorant to pleas of local officials to remit land tax. The EIC added 10 per cent land tax after the famine despite 50 per cent of cultivators perishing. Belligerent prioritisation of revenue manifested a preventable and predictable famine. Clearly, FAD and Malthusian explanations fall short when we consider the role of colonial economics and policy.

Revenue prioritisation continued under direct British

rule. In 1897 India suffered their 'most intense' famine with an official death toll of 4.5 million and unofficial estimates reaching 16 million. Dutt claims there was plenty of food in 1897 to avoid famine which suggests the issue was poverty and dislocation caused by colonial policy. Deforestation and high revenue extraction devastated Indian industry and resources. Predictably, the Viceroy maintained a FAD explanation, claiming no administration could anticipate nor prevent famine.

The British press held the colonial administration responsible and called for economic 'retrenchment' and greater Indian 'representation' in administration. Contemporary politician Dadabhai Naoroji blamed colonial policies for destroying Indian industries and increasing dependency on agriculture (India's economy was largely agricultural despite its agricultural productivity being amongst the lowest in the world). Reactions to this famine marked a shift towards seeing famines as man-made.

British administrators, namely Churchill, continued to use FAD explanations to disguise their failures. A cyclone causing localised crop failure in Bengal was a negligible cause of famine compared to colonial policies. Famine began in March 1943 but was not acknowledged by the British parliament until October. Bengal's food supply was greater in 1943 than the previous year and even boasted a record harvest in December. However, issues with distribution and epidemics meant the death rate was higher in 1944 despite scarcity subsiding. This debunks FAD explanations and exposes the government's responsibility in causing and exacerbating famine.

A modest estimate of 3 million people died. The death toll demographic indicates that landless agrarian workers suffered the most. This sector was still facing slow growth due to the depression of the 1930s. Colonial interference in credit and market exchange made India vulnerable to fluctuations in the global economy. Changing Indian economic structures to a colonial model of food markets allowed grain price rates to rise 69 per cent by September 1941. Significantly, the government's 1942 Foodstuffs Scheme subsidised rice prices for colonial employees and industrial workers in Calcutta. Prioritising employees and the military radically

transformed exchange entitlements and subsistence throughout Bengal.



The decline in Bengali workers' exchange entitlements worsened their already vulnerable reliance on food markets. The government's 'policy of denial' to the Japanese in 1942 also co-opted famine by creating widespread displacement and confiscating surpluses. The British took 45,000 boats which disrupted grain and labour movement in a fashion similar to the 1770 grain embargo. No compensation was offered for this massive disruption that ultimately condemned Bengalis to famine. The 'policy of denial' and Foodstuffs Scheme further eroded traditional coping strategies and respect for colonial authority.

Sen's 'direct entitlements' theory neatly posits that the amount of food owned by a family is more significant than a region's total output in causing famine. Colonial policies continually extracted revenues and supplies from families by weakening their exchange entitlements and creating community displacement. It is unsurprising that famine violence was directed upwards and contributed to the Quit India movement.

Experience of famine undermined colonial legitimacy in India. Educating ourselves on these famines helps us debunk FAD explanations that obscure how best to remedy famine. As Alex de Waal aptly stated: 'hunger crises are readily predicted and averted'.

What impact did WWI have on the Spanish Flu and how did Post-War societies manage the impact of both a global war and a pandemic?

Kerry Pearson

The year 2020 marks a century since the final severe outbreak of the Spanish Flu. Surfacing in 1918, the Spanish Flu was the third-deadliest pandemic in recent history: within just two years, five-hundred million people contracted the disease, and fifty-million perished, surpassing the number of First World War casualties which was a heinous seventeen million. The gravity of the pandemic, which overlapped with the Great War by nine months, was largely underestimated by contemporary media and is frequently unaccounted for in history books. Nations were forced to simultaneously deal with the catastrophic social, economic and political impacts of the war, alongside the lethal virus.

How did WWI conditions escalate the virus?

War tends to trigger social change and alter cultural norms, and the Great War is the paradigmatic example of this. It is arguably the single most important event in the history of globalisation as the war increased scope for travelling, with millions of soldiers moving between European countries. Although revolutionary, this mass movement led to a more virulent strain of influenza as soldiers returned home at the end of the war.

The facets of trench warfare, such as proximity living, constant damp, and contaminated uniforms, created ideal conditions for the virus to spread and mutate quickly. New research reveals that from 1914 to 1919 there was a period of unusually cold conditions and long episodes of torrential rain, which proliferated the number of cases of frostbite and pneumonia in soldiers. As the illness spread throughout trenches and ships, doctors labelled it nothing more than a 'three-day fever', signalling the widespread dismissal of the virus.

Wartime censorship in Europe and America also proved detrimental in intensifying the spread of the virus. The Defence of the Realm Act (DORA) was passed in Britain in August 1914 and allowed the government to exercise authoritarian social controls such as censorship. This enabled the suppression of news stories that were perceived as a threat to national morale, including the impact and severity of the uncon-

trollable disease. America implemented similar legislation in 1918 with the passing of the Sedition Act which criminalised publications that jeopardised the war effort. Consequently, the media underestimated and underreported the true scale of the virus, with *The Times* concluding that the illness was solely a result of the 'general weakness of war-weariness'. Sir Arthur Newsholme, chief medical officer of the British Local Government Board, called it 'unpatriotic' to be more concerned with the flu than the war, demonstrating one of the reasons that the government were delayed in constructing a national response to the virus until the war was over.

How did the Spanish Flu affect domestic life in war-time nations?

The British economy was in ruins after the war: industry was disrupted, public services had been damaged, and unemployment rose sharply to over ten per cent after the conflict. Unsurprisingly, the virus did nothing to improve the state of the economy. In July 1918, an article from *The Economist* commented on the dire economic consequences of the pandemic, writing that 'credit crunch had hit the money market' and that British banks struggled to gain access to 'really cheap money'.

The natural consequences of the war, malnourishment, overcrowding and poor hygiene, led to an overburdening of hospitals, where doctors had to deal with both war casualties and sufferers of influenza. Hospitals and healthcare systems were devastated: over fifty per cent of doctors were fighting on the



front line, and elderly doctors, whose research was often outdated, were run off their feet. One doctor from Nottingham reported that he was so busy with influenza patients he resorted to telling his patients to pass their prescription notes onto other sufferers.

Can the pandemic be attributed for any positive legacy?

Although devastating, the pandemic can be credited for revolutionising many aspects of society. Governments were put under pressure to increase social security systems, and throughout the 1920s, many governments embraced socialised medicine and healthcare for all: Russia was first to do so, followed by Western Europe. America continued to favour an employer-based insurance policy. The pandemic also kindled a coordinated international response to health crises with the found-

ing of the Health Organization of the League of Nations, which continues today as the World Health Organization.

The gravitas of the Spanish Flu was momentous and its interconnections with World War One must not be understated. At the hand of a shrinking world, troops were mobilised, uprooted from their homes, and connected in a way that society had never witnessed before. The pernicious influence of wartime censorship hindered a coordinated, multilateral response to the pandemic which ultimately cost the lives of millions of people. It was not until the armistice was signed in November 1918 that open discussion and coverage of influenza materialised, and countries could begin to recover from one of the deadliest wars and pandemics human nature had ever endured.

Hitler's Practitioners: Why were medical professionals willing to implement the will of the Nazis?

CW: VIOLENCE AND NAZISM

Thomas Poole

Over the past year, medical professionals have cemented their reputation as amongst society's most trustworthy individuals. Doctors and nurses are our angels and heroes. Today, we stand on our doorsteps and cheer them. What happens if they chose to violate our trust?

This inherent trust exacerbates our shock and horror when the fundamental tenets of medicine go wrong, and when the Hippocratic oath is violated. This applies most often to Josef Mengele, the Nazi doctor known for his horrendous human experiments implemented in Auschwitz. However, the participation of medical professionals in the Nazi regime went beyond this. One contemporary report estimated that 90 per cent of the medical top brass were involved in the deliberate harm of patients in some way or other. The Nazi policy of *Rassenhygiene* (racial hygiene) and their deep belief in eugenics is well known and fundamentally rooted in pseudo-'science' led by so-called medical professionals.

Notable amongst the practices of this was Aktion T-4: a programme of forced euthanasia initiated in 1939. It targeted a wide variety of individuals who were deemed 'undesirable' to Nazi society. Victims ranged from those considered to have hereditary diseases, such as epilepsy

or schizophrenia, to those hospitalised for mental health issues, including even dementia patients. The full extent of the programme is difficult to discern; in most instances, families of the victims would receive death certificates where 'natural causes' was given as the cause of death. Nazi ideology branded victims as *Lebensunwertes Leben* - 'Life unworthy of life'.

Finding staff to carry out Aktion T-4 was the easier than one might expect. Of all those asked to participate, only two doctors refused. It involved a significant number of staff, taking place across at least six different hospitals in Germany. Totalling between 80,000 and 300,000 victims, these sites earned their harrowingly paradoxical titles - as the 'killing hospitals' of the Third Reich.

How was it that medical professionals could be involved in such horrific acts? What made them participate?

The reasons for taking part were different for all. A high proportion of doctors were members of the Nazi Party, and so for those who supported the Nazi ideology of racial hierarchy and eugenics, they willingly carried out their tasks. However, this was considerably less the case for nurses. Others claimed that they had been coerced

by the state; they feared the same underlying threat that haunted everyone in Nazi Germany, that upon saying the wrong word or doing the wrong thing, one might be taken away and punished.

For others, it was a matter of duty because the state had deemed it permissible. We might think about Christopher Browning's now-famous thesis of 'Ordinary Men', where he considers that many of the worst atrocities were committed by otherwise normal people – mixed factors of indoctrination, peer pressure, circumstance, authority, and alcohol could make people do terrible things. People did not necessarily have to be born killers to commit mass atrocities; nor did they have to be diehard ideologues to implement the extreme racial theory. Can we really call those that applied Nazism to medicine simply 'ordinary' doctors and nurses?

When reading accounts from nurses involved, the professional attitude to their actions is haunting. One nurse, who had been associated with up to 150 deaths, said:

I didn't experience it one single time that a patient would take such a large quantity of dissolved medicine voluntarily. It's a fact of experience that medicine doesn't taste good, and people generally are not readily prepared to take medicine.

It was perceived by some as merely an unpleasant part of the job to kill people that the state had deemed to be racially inferior. Nurses told of how 'procedures' needed to be performed by two staff; if only one, they may have changed their mind, or been unable to bring themselves to do it. This momentary remorse is described as a 'weak moment' to be overcome.

Many staff were convinced that what they were doing was ultimately a positive thing. It was seen as helping the patient; many parents of young children or newborns were convinced to hand over their children in the same way. A nurse, accused of killing up to 210 patients, said of her acts:

I was aware of the fact that a person was killed, but I didn't see it as a murder, but as a release.

Perhaps, to coax a cautionary tale out of this would be to oversimplify a complex question. However, the ways in which Nazi practitioners were willing to violate their positions of trust in the name of pseudo-scientific ideology, remains disturbing and unsettling to this day.

Further Reading:

Susan Benedict and Jochen Kuhla, 'Nurses' Participation in the Euthanasia Programs of Nazi Germany', *Western Journal of Nursing Research*, 21.2 (1999), 246-263

The Spanish Flu and its Comparisons to Coronavirus – a case of Déjà vu?

Lottie Almey

CW: COVID-19

The Spanish Flu of 1918 has often been classed as a ‘forgotten’ aspect of history, that is, until the outbreak of Covid-19. Spanish Flu originated in Kansas, America, from a military base – not in Spain, as the name would imply – and spread through the globe as a result of mass mobilisation in the First World War. The Spanish flu came in three waves from March 1918 – February 1919, with the second wave being the deadliest, and there are many comparisons to our present situation in the second wave of the coronavirus pandemic.

Firstly, there are many differences that need to be considered. In 1918, the infrastructure and healthcare systems we have in place today did not exist. In fact, Spanish flu is attributed to the formation of the NHS in 1948. Antibiotics were not introduced until the 1930s, and doctors were unaware of such a thing as a virus. A major difference is that the world was at war with 52% of the medical profession in England being assigned to military service – leaving some areas with 1 doctor for every 5000 people! Hospitals were overcrowded, and there were no intensive care units. It is also worth remembering that the Spanish flu was far more deadly than Covid-19, killing 50 million people worldwide with a peak mortality age of 28 (due to the average age of troops), contrary to usual pandemic mortality ages of the elderly and people with pre-existing health conditions. Despite this, 98% of those infected recovered.

Today we are presented with a very different world view in a world of capitalism and globalisation. When Covid-19 arrived, it appeared to change our world in an instant. But this is not the first Coronavirus, with the SARS outbreak of 2002-2004 being another strain of Coronavirus. Despite this not being the ‘first rodeo’, the coronavirus response today was modelled on a response to an influenza pandemic by the British and US governments with 1918 being the worst-case scenario.

So, in 1918, what was done? This was the first example of ‘social distancing’ measures.

In places like Australia, travel bans were erected and there were strict port quarantines. New York staggered its opening hours of factories to eliminate rush hour and set up 150 emergency health centres. In Japan and the healthcare professions in England, the wearing of a gauze mask was recommended – with much debate over its effectiveness like today.

Newspapers played a key role in the distributing of in-

formation, educating and shaping compliance, as with social media and the news today, but governments were keen to keep the news to a minimum to stop inciting panic. For example, the *Corriere Della Sera* newspaper in Italy that published the daily death toll was banned by civil authorities as it was causing anxiety. Public information campaigns advised people to use handkerchiefs when they sneezed, to wash their hands regularly, to avoid crowds and keep windows open, and theatres and schools were closed. Resembling the response from our amazing front line workers today, 1918 was no different with health workers staying at work until they were no longer physically able to do so. A 2007 survey showed that the public health measures such as banning mass gatherings and imposing the wearing of masks in 1918 collectively cut the death toll in some American cities by 50%.

There is much more that could be said, but it is clear that the response to the Spanish Flu pandemic of 1918 influenced the response to Coronavirus today and with undoubtable success! Today, we are no longer at war, our scientific knowledge is far more advanced, and our healthcare systems have massively improved. These figures should create confidence that we are on the right track.

Further Reading:

Honigsbaum, Mark, *The Pandemic Century: A History of Global Contagion from the Spanish Flu to Covid-19* (London: W H Allen, 2020)

Spinney, Laura, *Pale Rider. The Spanish Flu of 1918 and how it changed the world*, (London: Vintage, 2017)





Hello Historians!

It's been a weird first semester for us all, but hopefully everyone's settled in well and is doing okay! Thank you to everyone who's come along to our socials so far this year, we're all having to adapt to everything being online but we're all really enjoying it and can't wait to host more events next semester!

This semester's events included a successful welcome drinks for all our lovely new freshers, a quiz and pumpkin carving for Halloween, as well as some more casual events such as a coffee and cake meeting and study along with us sessions. We've got lots more planned for you all, including collaborations with other societies and more fun events so stay tuned for those and remember to check out our Facebook group for more info.

Have a good day and don't be afraid to keep in touch!

Megan Glanville (Academic Sec)

Thankyou to the 2020/21 Issue 1 Assistant Editing Team!

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**HISTORY
STUDENT
TIMES**