Citizens, Courtrooms, Crossings

Conference Proceedings

Astri Andresen
Tore Grønlie
William Hubbard
Teemu Ryymin
Svein Atle Skålevåg (eds)

Rokkansenteret
STEIN ROKKAN CENTRE FOR SOCIAL STUDIES

Report **10** 2008

Citizens, Courtrooms, Crossings

Conference Proceedings

Astri Andresen

Tore Grønlie

William Hubbard

Teemu Ryymin

Svein Atle Skålevåg (eds)

December 2008
STEIN ROKKAN CENTRE FOR SOCIAL STUDIES
UNIFOB AS

Design and production: Master Trykk og Kopi A/S

Layout: Rokkansenteret

ISBN 978-82-8095-062-8

ISSN 1503-4844

The Stein Rokkan Centre for Social Studies (the Rokkan Centre) runs a publication series consisting of two parts, Reports and Working Papers, in addition to a Reprint series. The Director of the Rokkan Centre together with the Research Directors form the editorial board of the publication series.

The editorial board is responsible for classification of publications as Reports or Working Papers.

The Report series includes scientific papers, such as final reports on research projects. Manuscripts are assessed by the editorial board or a senior researcher appointed by the board.

The Working Paper series includes working papers, lecture transcripts and seminar papers. The manuscripts published as Working Papers are approved by project managers.

The Reprint series includes papers that have previously appeared in academic journals or books.

Contents

Introduction

Citizens, Courtrooms, Crossings

Astri Andresen, Tore Grønlie, William Hubbard, Teemu Ryymin
and Svein Atle Skålevåg

In April 2008 scholars from Australia, New Zealand, United States, Spain, Great Britain, Sweden, Denmark and Norway gathered for the sixth Bergen workshop on the history of health and medicine. The workshop was made possible by funding from the Bergen Research Foundation, for which the organizers are very grateful. This volume contains a selection of the papers presented at the workshop; its publication was realised through the support of the Stein Rokkan Centre for Social Studies and the Faculty of Humanities, University of Bergen, and the editors wish to thank both institutions.

The themes discussed at the 2008 workshop – reflected in the volume's title *Citizens, Courtrooms, Crossings* – represent both change and continuity in relation to previous Bergen workshops. The first two themes are newcomers. *Health and Citizenship* focuses on the dynamic relationships between states and their citizens in a broad range of health concerns and health care policies, discussing to what extent and how extended rights as citizens have influenced health promotion, health services and citizens' rights, and how citizenship has regulated access to health and welfare services. Special attention was given to the role of ethnicity, race and gender; specifically, how have such variables influenced the relationship between the state and its citizens in health-related issues? *Medicine in Court* contains examples of the multifaceted relationship between medicine and the law. Throughout history courts of law have provided medical practitioners with an arena for obtaining professional recognition, a market place for services, and concrete medical problems to be solved. In turn, medicine has provided the law with scientific legitimacy, facilitating complex legal decision-making by anchoring it in the alleged, objective truthfulness of medical science. The issues of homosexuality and criminal responsibility, dealt with in three of the section's papers, constitute prime examples of how law and medicine have interacted in very complex ways to reach understandings that both professions and society could accept at least for a time. The third theme, *Travelling Knowledge and Science*, has appeared at several previous workshops, and in a different formulation it was the focus of the 2007 workshop. But it is by no means an exhausted subject. Public health policies and medical knowledge/science have crossed between countries in many ways, but the actual transfer processes, e.g. the agents and their circumstances, have often been paid relatively little attention. The papers included here, however, explicitly focus on the role of organisations, state representatives and individuals in transfer processes; furthermore, some investigate these processes in the conflictual contexts of colonialism and imperialism.

The section *Health and Citizenship* is introduced by Teemu Ryymin, who discusses ways of conceptualizing 'citizenship' and its relation to questions in the history of health and medicine. 'Citizenship' has two dimensions: (1) a formal juridical status that defines reciprocal rights and duties of citizens and states; and (2) an informal, substantive dimension related to membership in society or community, consisting of such notions as identity, belonging, participation and civic virtues. These different aspects of citizenship generate various questions: What has it meant to be a (healthy) citizen? Which ideals of citizenship have existed at different times and places, and who have defined them? How does one act as a citizen, in fact and ideally, and which circumstances hinder or promote such enactment of citizenship? How have rights and duties related to health been created; how has the balance of rights and duties evolved historically and geographically; how has regulation of access to health services changed; and how has the universalistic project inherent in the welfare state developed historically? All of the papers that followed took up some of these questions in specific historical circumstances.

In his contribution on medical relief in early 19th-century England, Steven King examines letters of female paupers to Poor Law officials to investigate the role of 'citizenship' in obtaining public welfare. He documents that in this case it was clearly the informal dimension of citizenship that was decisive. Supplicants and their advocates used the concept of 'belonging', which was projected as a de facto citizenship, as the basis for claims for medical relief from the local community. The specific rhetoric could vary from one example to the next, but the strategy was identical: to insist that the applicant belonged to the community in question and therefore deserved support. The argument that 'belonging' qualified the person for the benefits of contemporary health citizenship was gender-specific. It was found uniquely in the applications for parish support submitted by poor and sick women; furthermore it seems to have been widely accepted.

Ida Blom compares the development of legislation on sexually transmitted diseases in five European countries between the 1940s and the 1990s. The treatment of individuals infected by such diseases differs considerably depending on their citizenship, here understood as the formal juridical status of state citizenship and the associated physical residence. The fundamental distinction is the degree of coercion (or conversely, voluntarism) involved. In Britain throughout the 20th century infected individuals have been able to choose or refuse publicly financed treatment of their condition; in Norway and Sweden, by contrast, treatment has remained compulsory, although over time the penalties for non-compliance have been eliminated. Danish and West German legislation on sexually transmitted diseases adopted the principle of voluntarism in the 1980s. A key factor behind legislative change in all countries was the shift in focus from the traditional venereal diseases carried mainly by women (especially prostitutes) to AIDS, associated with homosexuals and intravenous drug users. Blom sees the relationship of these target groups to the changing acceptable norms of citizenship as a reason for differences in preventive health strategies and legislation. Prostitutes and intravenous drug users have always fallen outside the pale, whereas through anti-discrimination laws and the like homosexuals have gradually acquired social acceptability, albeit uneasy.

The next articles in this section consider how ethnicity and race have shaped the definition and practice of the health citizenship of indigenous populations in three countries: New Zealand, Austrialia and Norway. Linda Bryder discusses the historical development of efforts of health enhancement among the indigeous Maori in New Zealand, paying particular attention to how recognition of indigenous self-determination in the 1970s led to changes in health citizenship. Maori activists redefined the meaning of health citizenship, shifting from emphasis on equal access to health services to equality of health status. The change of focus required targeted health programmes rather than universalist welfare, which in turn provoked charges from both non-Maori and Maori that the new measures were discriminatory. Judith Raftery deals with Australian citizenship policies and the health of Australian Aboriginals. There are many similarities with developments in New Zealand, but also one fundamental difference: Australian governments and public have refused to concede the principle of indigenous self-determination or to accept the persistence of indigenous distinctiveness as a positive good in Australian society. Thus, Raftery argues, indigenous Australian citizens' health status has been and continues to be adversely affected by policies that insist on cultural assimilation as a de facto requirement of full citizenship. In the final article of this section, Astri Andresen shows that despite formal rights as citizens on par with others, the long-standing discriminatory practices hampered Sámi access to political, social and civil rights in Norwegian society. Since the 1980s, however, Sámi entitlement to the rights as citizens has made for reforms to counteract discrimination and the effects of former discrimination and particularly important regarding health and health care have been issues concerning language and culture. Andresen also problematises current ideals of health citizenship, showing how Sámi citizens of Norway are presented with different obligations in the field of health compared with other Norwegian citizens. She maintains that the Norwegian state's recognition of the Sámi as an indigenous population in the late 1980s led to particularistic policies in many fields, including public health. This particularisation has also affected ideals of healthy citizens: Whereas the ideal Norwegian citizen assumes individual responsibility for her/his health, the ideal Sámi citizen is supposed to maintain a traditional Sámi identity as a prerequisite to protect her/his health. All three articles demonstrate that the historical relationship between notions of citizenship, health and indigenous populations is highly dynamic: The development from the early 20th-century 'assimilatory' health citizenship to late 20th-century 'emancipatory', indigenous health citizenship would surely merit more comparative analyses.

The section *Medicine in Court* is opened by Anne Hardy's examination of how English courts dealt with the public health consequences of contaminated oysters in the early years of the 20th century. The British oyster industry burgeoned in the late 19th century, simultaneous with the increase of pollution from urban sewage. The result of the combination was shellfish that could infect consumers with typhoid fever. Medical inspectors called attention to the health risk, but attempts to control the problem were thwarted by the intractable issue of assigning responsibility for regulation and paying the costs: public local authorities or private oyster producers. The courts tended to interpret the problem from the perspective of private property rights and to assign the bill to the local authorities, whose sanitation policies lay behind the sewage disposal. In this example the medical profession was caught between contesting parties, supporting public sanitary works while calling attention to the danger of contagious organisms in the polluted oyster beds; it had no special competence with regard to the political-economic dimension. In the remaining papers of this session, however, which all deal with criminal law, medical knowledge and specialists were an integral part of the production and workings of the law itself.

It is widely acknowledged that forensic medicine has played an important role in the history of homosexuality. It is therefore appropriate that two of the papers in the section of medicine and law discuss the role of the medical discourse in the framing of same sex sexuality. Runar Jordåen discusses the different concepts of same sex sexuality that are found in Norwegian forensic psychiatric reports in the first half of the 20th century. In this material he identifies three distinct concepts of same sex sexuality: inborn homosexuality, acquired homosexuality and situational homosexuality. These preliminary findings suggest a more nuanced approach to homosexuality in history than the image of the sudden appearance of a “homosexual species” as a product of medico-legal discourse, which one can find in much of the historiography preoccupied with the transition from the sodomite to the homosexual. Àlvar Martínez Vidal and Antoni Adam Donat consider homosexuality and legal medicine in Spain in the second half of the 20th century in a quite different political context than Jordåen’s. They show that legal medicine played a crucial role in sanctioning a fundamentally *moralistic* concept of homosexuality, constructing same sex sexuality as an object that could be legitimately fought with a combination of judicial punishment and compulsory treatment. Hence, leading physicians pushed the Spanish legislation in a more restrictive direction at a time when other European countries were enacting a decriminalisation of same sex sexuality.

The two last contributions in this section discuss the rules on criminal responsibility in England and Norway respectively. Ivan Crozier examines the 1922 murder trial of Ronald True whose outcome generated a challenge to the M’Naghten rules that since 1843 had limited the role of forensic psychiatry in the determination of criminal responsibility in English courts. The trial rejuvenated the demand by England’s psychiatrists and their professional organizations that the long-standing rules be revised: a re-thinking of the scientific basis for criminal responsibility was required by changes in psychiatric knowledge, as cognitive criteria had increasingly come to be considered irrelevant for diagnosing a diseased mind. A similar move away from cognitive criteria in the rules for criminal responsibility is found in Norwegian criminal law. In his contribution Svein Atle Skålevåg discusses the law-making processes in Norway from the 1840s to the 1920s, focusing on the notion of criminal responsibility. The period witnessed the rise of medicine and psychiatry as a privileged legal expertise. The medical corps rallied around the notion of mental illness, which it succeeded in including in the country's new criminal code in 1929. Less conspicuous than this reform of the legal vocabulary, however, was another conceptual transformation paralleling the one that Crozier identifies in England: the elimination of cognitive criteria as the legally relevant concept of the mind. The most important advocate for this transformation, however, was not a psychiatrist, but a lawyer.

Ideas, knowledge and science cross borders and oceans in many ways. The section *Travelling Knowledge and Science* demonstrates how the travels of persons and the travels of ideas can accompany each other, how travels could be a prerequisite for establishing new knowledge, and, more fundamentally, how processes of learning across nations are an ingrained part of medical history.

Øivind Larsen and Arvid Heiberg explore the purpose and effects of the international travels of physicians in early 19th-century Europe through an account of two young Norwegian doctors on a "grand tour" in 1823–24. Drawing on Dean MacCannell's theory of "off-site" – and "on-site markers", they discuss whether "pleasure or professionalism" dominated on such tours. They conclude that travelling physicians overall had distinctive professional aims and purposes for visits and site inspections that went beyond accompanying social pleasures. Accordingly, they brought home important new knowledge, which was transferred into practice in due course, with important results both for their individual careers as well as for local or national health policies.

Niklas Thode Jensen queries the distinctiveness of colonial medicine in a case study of the Danish–Norwegian West Indies in the late 18th and early 19th centuries. The colonial authorities initially established a health system based on Danish organizational principles and the Danish doctors applied European medical knowledge to the treatment of diseases and health problems they found there. As Thode Jensen shows, however, this simple transfer of European practices to tropical Caribbean islands did not work. The resulting adaptation he calls "the creolization of medicine": an intermixing of culturally distinctive perceptions by which concepts and objects "are selected and given new meaning". Moreover, the creolization occurred bilaterally: both the non-European population – mostly enslaved labourers from Africa – and the Danish colonial authorities made compromises.

Mari Webel and Christoph Gradmann also deal with how European medicine responded to non-European conditions, in this case in east-central Africa. Webel examines British and German research on sleeping sickness in the Lake Victoria basin and stresses the importance of inter-colonial and inter-imperial communication – between British and German doctors in the field and respective colonial authorities both in Africa and Europe – in tropical medicine research. The mobility of the African peoples around Lake Tanganyika and Lake Victoria made sleeping sickness an inter-colonial and international problem; Webel insists that it is thus necessary to transcend colonial borders to understand African history of medicine. She also highlights the need of the European doctors to use local African medical auxiliaries to carry out their research and policies of disease prevention, although this accomodation never went as far as the creolization of medicine identified by Thode Jensen. Gradmann looks at the same area and period, concentrating on the activity of the famous German bacteriologist Robert Koch. Although Koch also conducted research on sleeping sickness, Gradmann focuses here on Koch's engagement in tropical veterinary medicine. This engagement took Koch on extensive travels in New Guinea and India as well as in Africa. Gradmann concedes that the scientific motivation behind the "colonial traveller" Koch was sometimes vague, but he documents firmly that Koch's long-standing interest in developing and applying epidemiological models benefitted from his studies of animal diseases in tropical areas.

John Stewart returns attention to Europe and discusses the common Western European experience of massive growth in health expenditure and the movement towards universal health services in the "golden age" of economic growth 1945–1973. Taking Gøsta Esping-Andersen's notion of welfare regimes as a point of departure, he argues a more important role for the state all over Europe "than an account of administrative arrangements might superficially suggest." Although Stewart does not look at specific agents of policy transfer, he suggests that the successive convergence of health systems throughout Europe implies a strong explanatory role for the idea of "policy learning", and points to the common OECD experience of comprehensive rational planning of the 1960s and early 70s as a potential point of departure for comparative research.

Health And Citizenship

'Health Citizenship' – a short introduction

Teemu Ryymin

From the 1990s, the concept of citizenship has been increasingly focused on both in Norwegian political science and, to a somewhat lesser extent, in historical research.[1] Today, issues of citizenship are clearly a hot research topic, as could be witnessed at the 2008 European Social Sciences History Conference in Lisbon where numerous papers dealing with this topic were presented. Within the history of health and medicine, a similar interest in citizenship is evident. This growing interest is probably connected to the fact that the relationship between states and their citizens is in many ways changing, and earlier notions of citizenship are increasingly coming under pressure. In the Nordic context, this interest has to do not least with the influence of market solutions and neo-liberal policies in many fields of society, with transnational migration and the growth of new social movements from 1960s, and probably a host of other things. In a situation in which neither the state nor the citizens are what they used to be, it is no surprise that the question of what their relationship has been like, and how it has developed, surfaces on many research agendas.

The concept of citizenship may be approached from many different angles. In these introductory remarks I would like to sketch some ways of discussing and criticizing the notion of citizenship, the relationship between citizenship and health, and why the notion of 'health citizenship' can generate new and fruitful insights in the history of public health.

A classic way of regarding citizenship is to consider it as juridical and/or political *status*, focusing on the rights and duties of states and their subjects. In 1950 the British sociologist T.H. Marshall made this dimension central to his definition of citizenship as "a status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties with which the status is endowed."[2] Even though it must not necessarily be so, the 'community' referred to here is often understood as a (national) state. Marshall's definition focuses on state membership and the connected rights and duties that each person acknowledged as a citizen is ascribed. The questions of interest for us are, naturally, who is included and excluded from the category of citizens, what are those rights and duties, and how do they evolve?

Marshall's outline of the historical development of citizenship and rights – from civil to political and finally to social rights – has been very influential: As the concept of citizen evolved, thus the rights and duties of citizens and states also changed. Prompted by the steady widening of the citizenry's demographic base due to extensions in suffrage, the concept of citizen has evolved from an early 19th-century legal category that referred to political membership in a state focused on basic civic rights to a much more encompassing category of political, economic and social rights as defined by the social and welfare state in the early and mid-20th century.[3] From a Nordic point of view, this trajectory is crude, but it does bring out central historical developments pertaining to the formation of the welfare states and citizenship.

Marshall's definition also highlights a very central aspect of citizenship, namely that of equality: All citizens are, at least in theory, equal before the state; it follows that the state has an ethical and legal obligation to treat all persons classified as citizens in the same way. In the development of the Norwegian welfare state, for example, how such equality was to be achieved and indeed whether the inherent equality has ever been realized have been theoretically and politically contested issues as well as central historical questions. Marshall's historical trajectory of rights pays heed to class differences, for the extension of rights from civil to political and finally social rights may be seen as a result of attempts to *equalize* class-based differences between citizens. But the aim of equalizing class differences between citizens has been criticized for neglecting other differences, most prominently gender. Thus, the universalistic pretentions of citizenship in the Nordic welfare states, for instance, have not been universal enough; indeed, a central political aim from the 1970s has been to *eradicate* gender-based difference among citizens.[4]

But what about other forms of difference, for instance those based on culture or ethnicity? In the last decades a debate about the need to particularize citizens' rights and the state's duties, first and foremost in culturally diverse societies, has emerged internationally. This debate on 'multicultural citizenship' raises important challenges to the universalism inherent in welfare states.[5] New ways of conceptualizing citizenship and criticizing the established notions are evolving, for example in the form of indigenous citizenship, which is advocated by a global movement of indigenous peoples.[6] But there is a fundamental difference between the class- and gender-based critiques of the universalistic pretentions of 'citizenship' and the critique from the standpoint of ethnicity. Instead of demanding better access to citizens' rights, that is, a more thorough universalism, this critique insists that the existing notions of citizenship have been too universal, too equalizing. Here, the point is not to *equalize* or *eradicate* difference, but to *enhance* it through a particularization of citizenship, or indeed, through acknowledgement that communities other than the nation-state can be a relevant basis of citizenship. The question arises: How does this challenge the previously existing notions of states' and citizens' rights and duties?

The questions of class, gender and ethnicity are also pertinent to this second way of perceiving citizenship. It differs from the formal–juridical aspects of citizenship status by including more informal aspects of community membership such as identity, belonging, participation and civic virtues in the definition of citizenship. According to this point of view, citizenship not only confers a formal legal status, it also has a *substantive* dimension.[7] From the angle of citizenship-as-substance, different historical questions emerge: What has it meant to be a citizen? Which ideals of citizenship have existed at different times and places, and who have defined them? How does one act as a citizen, in fact and ideally, and which circumstances hinder or promote such enactment of citizenship? In a historical perspective, one might suggest that a central goal of the modern democratic state has been to create citizens, that is, to transform its subjects into autonomous citizens capable of acting and exercising their positive rights and to implant in them through education an ethos of citizenship. Such civic education has been a main task of the public school system, but citizens have been created by other agents as well.[8] In the Nordic context, representatives of the *civic society*, female-dominated voluntary associations in particular, have had tremendous influence in the first decades of the 20th century in defining the substantial dimension of practical citizenship in many fields as well as having functioned as a training-field for citizens-to-be in the traditional legal sense. By taking into account the substantial dimension of citizenship as well as the rights and duties of citizens and states, an enlarged notion of citizenship encompasses not only the relationship between the state and its subjects, but also that of the state, the civic society, and the subjects, highlighting the agency of all three. So conceived, 'citizenship' is not a closed framework or a definitive answer, but an open, dynamic concept that allows analysis of historical and contextual change of what it means to be and act as a citizen.

What, then, about health and citizenship? How to study their relationship? Drawing together the status and substance of citizenship, it has often been noted that the historical development of citizenship has had important consequences on the field of health. After the French Revolution, an implicit requirement of membership in the polity was that citizens were to conduct themselves so as to remain healthy, while the state was to provide protection mainly from infectious disease. The formal responsibilities of the state increased during the 19th century, as the provision of health services to citizens was widened. The growth of welfare states from the early/mid 20th century has made the availability of universal, equal access to basic health services a fundamental right of citizenship, but it has also implied new modes of being a healthy citizen. In the late 20th century the social contract between the state and its citizens again changed emphasis: Although citizens as a whole acquired new rights in the field of health, the individual citizen was also increasingly made more responsible for her own health, at least as regards the ethos of health citizenship.[9] At the same time, the universalism of welfare services, including health services, has become increasingly problematic in many societies, for many different reasons.

Such a historical narrative raises many questions regarding the relationship between health and citizenship. From the perspective of status, we might wish to ask exactly how rights and duties related to health have been created, how the balance of rights and duties has evolved historically and geographically, how regulation of access to health services has changed, and how the universalistic project inherent in the welfare state has developed historically. In Norway, a specific Act regarding the rights of patients was passed in 1999. The purpose of the Act was to ensure universal access to health services by providing a legal basis for patients' claims. This individualizing approach is quite different from earlier attempts of providing universal health services, say, for instance, the state-directed institution building of the 1950s and 1960s that was controlled by medical experts.[10] How have patients become citizens with certain rights pertaining to the field of health? How has the domain of the state versus that of the citizens and the civic society developed with regards to health policy and health services?

From the point of view of citizenship-as-substance, the construction of healthy citizens looms large. As we all know, questions of hygiene and health played a key role in civic education in many places in Europe in the early 20th century. The phrase "Don't spit on the floor" catches some of the ethos inculcated in pupils, churchgoers, workers and so on: to be a healthy citizen was to *adhere to good advice*, so to speak. How has such health promotion developed in schools, through voluntary associations and such, seen not only as enlightenment and propaganda campaigns devoted to furthering certain ways of thinking and acting about health and disease, but also as the inculcation of civic duties? How have such duties changed – and how do they differ between countries and among different groups of citizens? Today, at least in Norway, a goal for a good and healthy citizen is to *make informed choices* regarding individual lifestyle, food and alcohol consumption, not to mention the use of tobacco; a healthy Sámi citizen has somewhat different ideals to live up to, as the paper by Astri Andresen in this volume emphasizes. Are we, then, facing a situation in which the ideals of citizenship are being fragmented or particularized? And how does this eventually affect the legitimacy of citizenship and universal welfare means?

Finally, what does the concept of health citizenship give us as historians – why should we spend time on it? A central aspect of citizenship is how citizens are constructed and how they participate in their own making. The study of subject formation is an area in which concepts such as "governmentality" and "bio-power", devised by Michel Foucault and his followers, come into their own and are already much used.[11] Grossly simplifying, we might say that these notions relate to Foucault's grand project of delineating the historical development of modalities of power, but they are also relevant to the field of health. Both "governmentality" and "bio-power" encompass the micro- and macro-level processes and technologies of subject formation – how people come to live by certain rules and norms, how such rules and norms are articulated, and what effects they have. These concepts revolve around the same issues as health citizenship, the shaping and governing of a certain kind of subjects from the 18th century, but they point to somewhat different notions of agency. By focusing particularly on the substantial dimension of citizenship, we perhaps gain more scope for the agency of discrete actors in the historical formation of subjects, because all participants in the tripartite relationship of citizenship – the state, the civic society and the subjects themselves – are allowed the possibility of contributing to the formation of both status and substance of citizenship. This enables us to trace how, for example, notions of 'the healthy citizen' are made, by whom, how they change and why. At the same time the notion of citizenship does not render irrelevant or uninteresting questions regarding the effects of such processes, the discrete technologies of governance involved and, more generally, the forms of knowledge and power within which agency is formed and may be exercised. Thus, I would like to suggest that the notion of health citizenship may function as a heading that brings together historians of different theoretical persuasions and empirical inclinations to a common field of interest, not divided by labels or methodologies but united in many differing but still fundamentally similar research concerns and interests.

Notes

1 Cf. Strømsnes, Kristin. Folkets makt. Medborgerskap, demokrati, deltagelse. Gyldendal Akademisk, Oslo 2003:15–21; Nagel, Anne-Hilde (ed.). Kjønn og velferdsstat. Alma Mater, Bergen 1998.

2 Marshall, T.H. "Citizenship and Social Class". In Marshall, T.H. and Tom Bottomore (eds). Citizenship and Social Class. Pluto Press, London 1992:18. The essay was originally published in 1950.

3 Cf. Marshall 1992 [1950]; Porter, Dorothy. Health, Civilization and the State: a history of public health from ancient to modern times. Routledge, London and New York 1999; Helén, Ilpo and Mikko Jauho. "Terveyskansalaisuus ja elämän politiikka". In Helén, Ilpo and Mikko Jauho (eds). Kansalaisuus ja kansanterveys. Gaudeamus, Helsinki 2003:13–33.

4 Nagel, Anne-Hilde. "Innledning." In Nagel 1998:10.

5 On the connection between recent debates about citizenship and multiculturalism, see Kymlicka, Will and Wayne Norman. "Citizenship in Culturally Diverse Societies: Issues, Contexts, Concepts." In Kymlicka, Will and Wayne Norman (eds). Citizenship in Diverse Societies. Oxford University Press, Oxford 2000:1–41; Kymlicka, Will. Multicultural Citizenship: a Liberal Theory of Minority Rights. Clarendon Press, Oxford 1995. On the claims of 'Citizenship-Plus' status from aboriginal groups in Canada, see Fleras, Augie and Jean Leonard Elliott. Aboriginal-State Relations in Canada, the United States and New Zealand. Oxford University Press, Toronto 1992:21–23; cf. also Brochmann, Grethe and Anniken Hagelund. Innvandringens velferdspolitiske konsekvenser. Nordisk kunnskapsstatus. Nordisk Ministerråd, København 2005:29–34.

6 On the concept of 'Indigeneity' see Maaka, Roger and Augie Fleras. The Politics of Indigeneity. Challenging the State in Canada and Aotearoa New Zealand. University of Otago Press, Dunedin 2005.

7 Cf. Brochmann and Hagelund 2005:29–31; Brubaker, Rogers. Citizenship and Nationhood in France and Germany. Harvard University Press, Cambridge, MA 1992:40–41.

8 Cf. Ahonen, Sirkka and Jukka Rantala (eds). Nordic Lights. Education for Nation and Civic Society in the Nordic Countries, 1850–2000. Suomalaisen Kirjallisuuden Seura, Helsinki 2001.

9 Cf. Baldwin, Peter. Disease and Democracy. The industrialized world faces AIDS. University of California Press, Berkeley 2005; Porter 1999.

10 Cf. Harjula, Minna. *Terveyden jäljillä. Suomalainen tervyspolitiikka 1900-luvulla*. Tampere University Press, Tampere 2007.

11 Foucault, Michel. *Security, Territory, Population. Lectures at the Collège de France 1977–1978.* Palgrave Macmillan, New York 2007; Dean, Mitchell. *Governmentality. Power and Rule in Modern Society.* SAGE Publications, London 2003. For a recent example of how these notions may be applied to the history of tuberculosis control in pre-Second World War Finland, see Jauho, Mikko. *Kansanterveysongelman synty. Tuberkuloosi ja terveyden hallinta Suomessa ennen toista maailmansotaa.* Tutkijaliitto, Helsinki 2007.

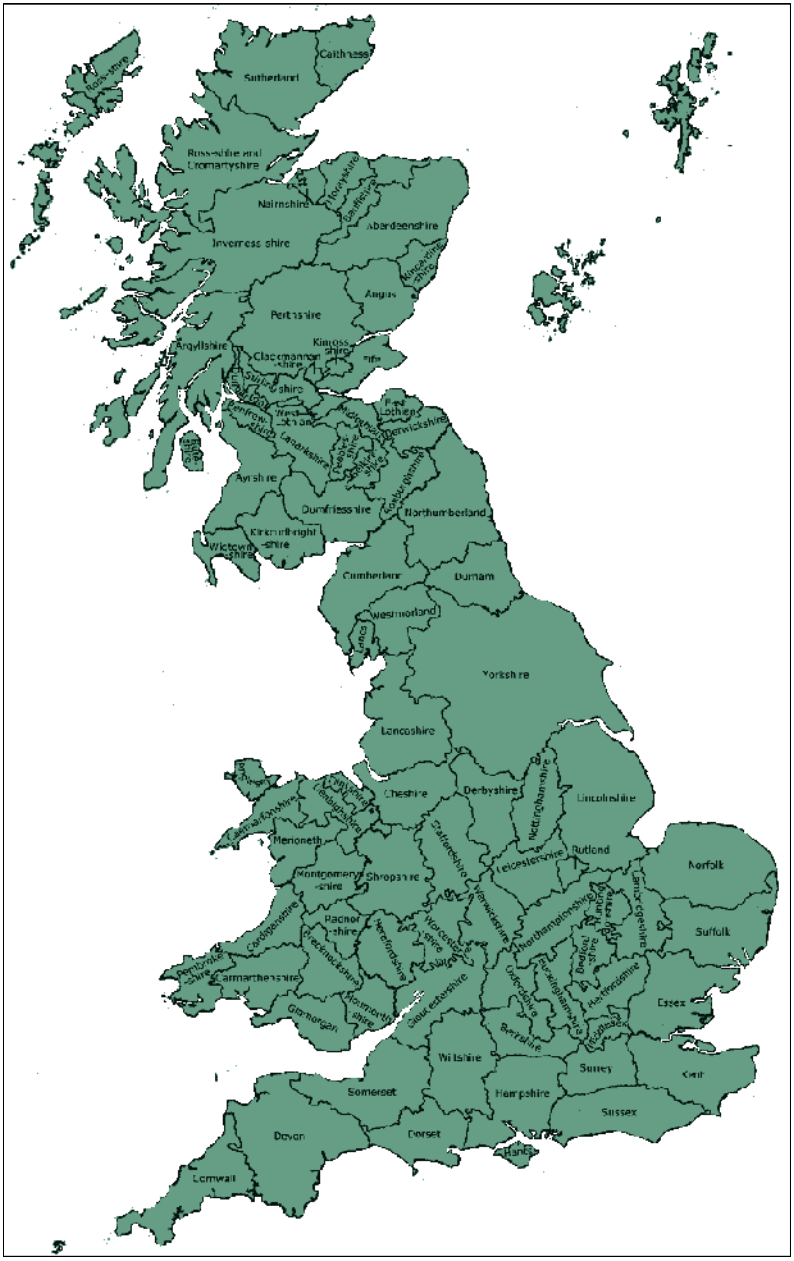
“The particular claim of a woman and a mother”: gender, belonging, and rights to medical relief in England 1800–1840s[1]

Steven King

Preamble

On 23 October 1824, John Taylor, overseer of the poor[2] for Kendal (Westmorland – See Figure one) wrote to his counterpart James Seed, overseer of the poor for Billington (Lancashire). He was concerned about the plight of Barbara Ingham, who had been abandoned by her husband, leaving her and a number of children destitute at a time (we subsequently learn) when Barbara herself was very ill. Reporting that the husband “is skulking around Bury or Burnley [two towns in Lancashire] but he has declared he will not do anything to support her”, Taylor went on to contrast the husband’s failure as a citizen with the wife’s exemplary behaviour. Thus, “he is a very bad fellow and your township ought to punish him – the poor creature [Barbara] is most industrious and maintains with your 4/ [shillings] her four small children by washing clothes *doing anything for a honest livelihood* and I can assure you she bears a *spotless reputation*”.[3] Barbara Ingham, in other words, was a well-regarded resident of the bustling market town of Kendal.

Figure 1



This letter arises because, while Taylor thought that Ingham was deserving of relief (and told his counterpart so), he had no power to order it and she had no claim to it in Kendal. Rather, if she had a claim on the communal welfare system that was the Old Poor Law, it was in the parish of her marriage and (in this case) birth, Billington.

Taylor could only pay relief if the Billington overseer gave permission and agreed to reimburse the town of Kendal; that is, if he recognised her as a settled citizen of Billington and was willing to transmit money across a large distance. The alternative was for Ingham to be brought back to her parish of settlement and belonging under a removal order.[4] In this case the overseer of Billington clearly thought the latter option too much trouble, and paid her a small allowance. This was not the last that Billington was to hear from the Inghams however. On 27 May 1831, John Mason, the overseer of the small rural town of Dent (Westmorland), wrote to Billington because Barbara Ingham was "laying ill at Dent and in a very poor state". Furthermore,

> she has been unable to follow her work since Christmas 2 of her children is with her and she says one is eleven years old and other 9 years old she says that her husband is at Kendal and doing nothing for their support and she is now with her sister for she *had stayed at Kendal till she was near lost*, at present she says that she is *maintained by her friends* but they are not able to do so any longer she therefore applies for relief which I hope you will send without delay.[5]

As a means of combating absolute destitution, Barbara had relocated some of her children (some of them were with her), moved to be near her sister, and called upon the resources of "friends" in the community. Like a model citizen, she had tried every resource in order to avoid troubling her settlement community. There is clearly a missing letter from the overseer of Billington asking for more detail, because on 6 June 1831 Mason wrote to his counterpart to assure him of the authenticity of the case. He reasserted his belief that Billington should offer relief and noted that Ingham demonstrated "The particular claim of a woman and a mother". By way of further postscript he added "She is seen by all who know her to be belonging here and fully deserving in her sickness".[6] In short, Ingham belonged, she was a citizen of Dent, and this – allied with her sickness and unblemished moral record – entitled her in the eyes of community and overseer to medical relief. While the imperative of economy might have swayed the overseer of Billington (a danger implicit in the texture of Mason's narrative, which clearly sought to head off thoughts of economy), custom, her agency, the particular claims of gender and above all the fact that she belonged to her host community should, in the eyes of the Dent official, move the borderline between deservingness and not in her favour.[7] In turn, the story of the Ingham family raises most of the key motifs of this article, starting with contested, blurred and overlapping notions of belonging.

Concepts of belonging and citizenship

Belonging, especially where it is elided with the narrower concept of citizenship, is a multi-layered and slippery term, and one that has a curiously patchy historiographical coverage in relation to women like Barbara Ingham. At a general level, there have been studies of the relationship between belonging or citizenship and the franchise, ratepaying, waging war, office-holding, and class formation, notably in the sense of the rise of the middling sorts.[8] Particularly for the late nineteenth, early twentieth and the seventeenth centuries there has also been provocative discussion of the citizenship position of the (largely male side of the) dependent poor.[9] Discussions of patterns and structures of belonging for and the citizenship credentials of women have been rather more muted. For the later nineteenth century the citizenship claims of women, usually middle-class women, have become elided with philanthropic work, the protracted campaign for franchise extension, local office-holding and political work, and campaigns against legislation such as the Contagious Diseases Act.[10] Astute work by feminist writers has also begun to unpick the subtle claims to citizenship and belonging deployed by women in debates over the biological life-cycle, the health of the nation and its armies, defence of Empire and the status of the different ethnic and social groups in the hierarchy of Empire.[11] And for a rather earlier period other feminist historians have also begun to explore the dynamic nature of women's reproductive citizenship, tracing a change in the sentiment and tone of advice manuals and pamphlet commentaries from seeing women's reproductive capacities as something that should confer a de facto citizenship, to seeing such capacities as a threat to the established order.[12]

Yet, and notwithstanding work on women in the church courts, as keepers of community knowledge and identity, and as agents of social stability,[13] little has been done on whether and how 'citizenship' and 'belonging' figured in the linguistic register of ordinary women. Nor is there much work on how the concepts (or their proxies such as service to others, neighbourhood visibility and place in community ceremonies) were understood and how they were used in shaping or justifying the day-to-day activities of working-class women. This is particularly true of the eighteenth and early nineteenth centuries, and is all the more surprising when set against Keith Snell's excellent new work on belonging, which has emphasised that a sense of attachment to place and parish (a de facto notion of citizenship) remained strong well into the nineteenth century.[14] For one group of women, the dependent poor, our understanding of the status, practice and impact of citizenship and belonging is very thin indeed. Such women are, as Alannah Tomkins points out, often assigned limited agency in terms of how they presented their case for relief. Ultimately, she concludes, "women had only narrow room for manoeuvre and the extent of their agency can at best be aligned with the 'imperfect empowerment'" described by Edward Thomson.[15] Perhaps unsurprisingly, then, these women have been tied by historians into a (problematic) model in which their claims to relief under an essentially paternalistic Old Poor Law system were founded on their dependent status and (linguistically) dressed up in the illnesses or desertion/death of major breadwinners and their roles as wives and mothers. In essence their belonging and citizenship was passive, almost second-class, rather than active like that of men, even poor men.

This article challenges the idea that female claims to relief were tied up with a passive and paternalistic rendering of belonging and citizenship. For now, it is important to remember that women were anything but invisible in poor-law-related sources.

Indeed, empirical studies have tended towards seeing women as the major recipients of welfare payments (regular doles, ad hoc monetary payments and payments in kind) even as the changing nature of family economies, regionalised economies of makeshift and the rise of poor law spending on family allowance and wage support policies tended to inflate the number of men appearing in the records from the later eighteenth-century.[16] Women were also in the majority amongst institutional populations, while it is becoming ever clearer that they also dominated lists of medical relief in cash and kind throughout England during the later eighteenth and early nineteenth centuries.[17] The latter observation is particularly important here. Under the Old Poor Law no one, no matter how old, sick or disabled, had an absolute right to relief. The overseer and the vestry had to balance their legal duties to prevent starvation and relieve the (never legally defined) "impotent poor", their customary duties to protect certain categories of poor, and their moral duty to the community to ensure that rates were not too high and that money was not wasted on the undeserving. Sickness, and in this article I will argue particularly the sickness of women, represented the keenest point of tension in achieving this balancing act. Relieving it could be expensive, not relieving it even more so. Offering medical aid might set a precedent, and yet in many places it is clear that the middling sorts in parishes and communities thought that sickness equated to deservingness. And for women in particular sickness could compromise morals, undermine the family and reduce the capacity of a man to work. Women's appearance on relief lists in general and relief lists for sickness in particular is thus freighted with symbolic significance, and the fact that women continued to dominate relief lists even in the toughest years of the 1790s means something. This is especially so if we believe Lynn Hollen Lees' rendering of the sentimental architecture of the Old Poor Law, which sees the poor generally lose their legitimacy (for which we might read their status as fellow citizens) in the eyes of the rate-paying classes at local level in the period between 1790 and 1840.[18]

Understanding why, against this backdrop, women were the major recipients of medical relief in the closing decades of the Old Poor Law is thus very important for our appreciation of the nature of health care for ordinary people and the symbolic significance of its provision. Did women occupy a disproportionate place as relief and medical relief recipients because a combination of law, custom and paternalism located women, especially sick women, as "deserving"? Alternatively, was there a more active process in which women lodged claims to a sort of health citizenship, systematically articulating the status and substance of belonging and yoking it to the language of deservingness? To be sure, the term "citizenship" rarely appears in any of the narrative information that we have about or by poor women, but, as Keith Snell has argued, settlement conferred a widely understood formal citizenship while various signifiers of belonging had the capacity to create a wider sense of citizenship independent of or building upon settlement.[19] This article will argue that sick women, far from being subsumed into a wider structure of paternalistic relations, used the rhetoric and strategy of belonging to a settlement or host parish as a de facto measure of citizenship in their claims-making for medical relief.[20] Such approaches were remarkably successful, testimony to the fact that both female paupers and (usually male) officials had a shared understanding of the nature, importance, linguistic register and accepted signifiers of belonging. Far from losing their status as fellow citizens in the eyes of ratepayers, in the closing decades of the Old Poor Law women became increasingly well cemented into common understandings of the deserving poor, particularly when they could evidence sickness.

To explore these matters, we will analyse letters written by poor and sick women as they sought medical relief either for themselves or their families, as well as correspondence written for or about such women. These sources pose very real methodological problems, and their usage is bound up with questions of reliability, representativeness and provenance. The re-telling of the self that lies at the heart of pauper letters may generate exaggeration, untruths, partial truths and a particular colouring of the experiences or causes of poverty, all crucial problems where belonging and citizenship are constructed and situational categories as much as or more than definitive and measurable states. Even if female paupers or their representatives told the truth and evidenced their rhetoric, it is unclear whether the proximately settled poor would use the same language, employ the same yardsticks and make the same sorts of claims to belonging and citizenship as their peers who were in receipt of out-parish relief elsewhere. Nor can we be clear that it was always the female pauper named in the letter who actually wrote the narrative, prompting the question of whose definition of belonging we actually detect in such sources.

Nonetheless, an increasing number of commentators have come to regard pauper letters in particular as opening a window on the socio-cultural lives of the English and Welsh poor that can generate portable lessons for all paupers and community types.[21] Thus, while modern historians might regard the employment of a scribe as automatically injecting bias into the process of writing, many contemporaries regarded use of a scribe as a way of both involving the community and evidencing their belonging. And while female paupers may have coloured their narratives, there is no evidence that they did so in different ways to the settled poor who delivered their appeals direct to the vestry. Indeed, it becomes ever clearer that the overseers of the poor in most parishes employed sophisticated mechanisms for checking the veracity of statements by both the in- and out-parish poor. Nor should we forget that while the proximately settled poor might have no need to make use of scribes, they often made use of proxies to appeal for them or to represent them before the vestry. As much as in pauper letters, the interactions between settled paupers and the overseer raises the question of whose voice we hear.

While these potential problems are in the end insoluble, what is certain is that earlier studies of pauper narratives and overseers' correspondence revealed the smallest tip of a large iceberg in terms of the survival and richness of such materials.[22] This article draws on a sample of 2,120 letters and associated pieces of correspondence from the counties (see Figure one) of Berkshire, Cambridgeshire, Lancashire, Norfolk, Northamptonshire, Wiltshire and Surrey, with a particular focus on the period between 1800 (the proximate beginning of the so-called crisis of the Old Poor Law) and the 1840s (the final emergence of the New Poor Law), when we might expect the tension between the perceived rights of paupers and the analogous duties of poor law officials to have been at their most severe.[23]

Establishing deservingness

The status of belonging that John Taylor ascribed to Barbara Ingham as she sought out-parish relief is by no means unusual in the sub-sample of letters written on behalf of either male or female paupers. Vicars, neighbours, poor law officials, doctors, employers, friends, relatives, tax collectors, military officers and even the gentry and aristocrats sometimes wrote to give a character to, and a sense of the deservingness of, out-parish paupers. They might do this either independently or (particularly in the case of doctors[24]) as an addendum to letters written by the pauper concerned. Indeed, there are 442 letters/addendum scripts of this sort in the underlying sample. Yet, if such narratives were constructed in support of both men and women, it is important to understand the subtle difference in the rhetoric employed for the different sexes and the different versions of belonging and citizenship to which they testified. For men, the narratives point to their industriousness or (if beyond work) a life of employed toil, clearly reflecting Tomkins' contention that for men citizenship, belonging and economic activity were yoked together forcibly.[25] Narratives in support of men also emphasised their susceptibility to negative external forces (high prices, the weather, underemployment due to trade downturn and so on), the extent to which their family economy was compromised by sickness of wives and children (particularly at times of lying-in), the hope that independence would be restored and, to a lesser degree, their compromised role as fathers. Those writing in support of men also (though infrequently) talked of nativity as the ultimate indicator of male deservingness. Narratives in support of women carried some of the same rhetoric, particularly their susceptibility to illness of or abandonment by husbands, but it was also much more common to detail their connectedness to, good standing in and unwillingness to leave a host community; in other words, to emphasise their belonging. Those written in support of sick women were particularly prone to adopt such rhetoric, and in turn narratives of this type were disproportionately likely to obtain a successful outcome when compared with those written in support of men. These observations apply to all community types and they become stronger over time, culminating in a substantial tranche of support narratives for sick women in the first decades of the New Poor Law. While we can still detect writers appealing to the paternalistic underside of the Old Poor Law, Barbara Ingham's status as wife and mother for instance, there was also a strong tendency to claim and evidence belonging as a reason for relief.

By way of example, Christopher Chapman, vestry clerk, wrote from Henley

(Oxfordshire) to Pangbourne (Berkshire) on 12 November 1829 to call attention to the case of the sick Widow Perkins who

> is very *industrious* when able to work, and carries a heavy load of cakes &c *round the neighbourhood* for her living, and I have no doubt when she is able to do so, with the 2/6 per week you allow her, she gains a comfortable livelihood. But during the greater part of the summer and more recently she has earned scarcely anything from her being unable to travel [because of sickness]. I am therefore of opinion that she stands in need of greater relief than the allowance.[26]

Like her male counterparts, Perkins was part of an economic community, but there was a qualitative difference in that belonging when compared to letters about men also in the Pangbourne collection. Thus, Widow Perkins' economic activities tied her into the neighbourhood rather than (as with many men) a relationship with a single employer, and the clerk embellished her work to show how arduous it was and how hard she had laboured. Her belonging was deeper than that portrayed by Chapman when he wrote on the subject of men from Pangbourne and other places. We see this rootedness played out in a further letter from Chapman on 27 June 1830 in which he suggested that Perkins be given an additional allowance "which would be the case here if she was a Parishioner". In other words, the only difference between the rootedness of Perkins and the proximate poor of Henley itself was a settlement certificate. She belonged, and in this case Pangbourne paid an extra £2 allowance.[27]

Other writers were more explicit about the nature of the connection to a host parish. Thus Joseph Keates, overseer of Egham, Surrey, wrote to his counterpart in Tilehurst, Berkshire, on 13 May 1806 with respect of Sarah Hamilton who was sick and

> I can assure you *you have not a Pauper more deserving than she* is she is over 70 years of Age and does a little washing and *the Neighbours are very good to Her* – otherways she must have been brought home before (…) *you have Gentlemen in the Parish that knows her well* Her Husband was a Collar maker at Thale and since that work'd at Egham as a Journey man.[28]

Hamilton had a functional link with her residence community, one that had saved her settlement parish money. And as well as having an identity where she lived, Hamilton and her husband were also well known to respectable citizens of Tilehurst. These two levels of belonging allied with her attempts to make do ensured that there was no more deserving pauper than she. Joseph Lawrence, overseer of St Peters parish in Nottingham, made a similar case when he wrote to Tilehurst seeking relief for Widow Wiggens on 4 February 1830. Noting that she was known in the neighbourhood and her settlement parish and that unemployment, sickness and the death of a daughter had drawn the widow low, he evidenced her rootedness and presence in the locality with the observation that "The Burial Expences [of the daughter] was Rec'd by a Subscription Raised at the mill ware she [Widow Wiggens] work'd".[29]

For some women sheer longevity generated a strong connection between belonging and deservingness in the minds of those writing in support, more so than in respect of long-resident men. By way of example, we first hear of Nanny Ormerod on 15 August 1825, when Richard Mason, overseer of the poor for Howick (West Yorkshire) wrote to his counterpart, James Seed, in Billington (Lancashire) to emphasise the deservingness of Nanny and her husband. They were deserving in part because they were "sorry that they have to trouble you but it is necessity that makes them apply to you and they hope you will help them at this time as they hope not to be regular paupers but will be able to do for themselves if Nanny gets better". The old couple aspired, in other words, to be independent and regular members of their host and settlement communities.[30] By 26 January 1829, when Richard Palmer, a new overseer of Howick, was writing on their behalf, Nanny was still "very poorly indeed". His signifiers of community embeddedness, belonging and citizenship were, however, more direct than his predecessor's because "the relief which they have had is thought by all who are acquainted with her situation to be quite insufficient" and Palmer declared his intention to give her 11s. per week whatever the overseer of Billington thought.[31] James Greenwood, another new overseer of Howick, was equally firm when he wrote on the subject of Nanny's continuing illness and afflictions of old age on 29 February 1832. Confined to her bed, Nanny "must have been removed had she not been relieved by some ladies". Pinned to the letter was a brief addendum "Nanny Ormerod is a *good and long citizen* of this place and her illness *requires* your favourable attention".[32] Here, then, we see both the status and the substance of citizenship evidenced. In none of the more than 150 letters written in support of sick, aged or unemployed men do we find such a bald expression of the community mandated link between belonging and deservingness.

In turn, we must understand that female paupers themselves used similar rhetorics of belonging when bargaining for medical relief with their settlement parishes. Thus Phoebe Giles wrote from Stroud (Gloucestershire) to Bradford-on-Avon, Wiltshire ("my parish"), on 9 June 1833 to say that she was sick and short of work. She noted that "My husband's Father had 10 Children and there is but we that have ever troubled you, neither will they, for all but us are become Parishoners here".[33] Simultaneously, Giles established a substantial family lineage in her (derived through marriage) parish of settlement, claimed a belonging in that parish and held out the hope that a little relief might, as with the rest of the family, create a legal and substantive belonging elsewhere. Her letter was followed by one from John Elliott, Vicar, who suggested that Giles "is a woman of good character".[34] When Ann Jones wrote from Freshford (Somerset) to Bradford-on-Avon on 18 September 1834, she used similar rhetorics of belonging. Clearly in response to a letter from the overseer doubting her circumstances and proposing to remove her entitlement to relief, a sick Ann Jones replied:

> Without Parochial relief I assure you Sir I have nothing else to Depend on Whoever informed you to the contrary was mistaken *Mrs Taylor the Lady to Whom you allude is a most kind and Benevolent character* and much very much am I indebted to her goodness *I have received a dinner from her bounty every day I have been able to go* for it but for the last ten Weeks I have been Very Ill and for five Weeks unable to do

> for myself and obliged to have a person to do for me *I am now nearly seventy nine years of age 40 of which I have lived in this Parish* and as long as I had Work and was able to do it *never troubled the parish for any thing* and am sorry to do it even now could I possibly avoid it As to my wearing as silk gown that is entirely Wrong I have never had One in my life the best gown I have is a cotton one I bought of Mr Watts seventeen years ago Mrs Taylor has been so kind as to give me many items of Wearing apparel far more useful to me than that but I am sorry to say the good Lady is about to leave Freshford And most severely shall I as well as many others feel the loss *if you Sir Will be good enough to enquire of Mrs Taylor or any other respectable person in this place Where I have so long been a resident they will satisfy you my necessitous condition* calls for relief from you.[35]

Ann Jones was thus cemented firmly into her host parish, partly by longevity but also by her membership of an economic community (she has worked all her life), her connections with Mrs Taylor and her visibility to other respectable people who would testify to her necessity. In turn, Jones had behaved like a good citizen to her settlement parish, never claiming relief, obtaining clothing from other sources so as not to burden her parish and only claiming relief after several weeks of illness. Belonging and good citizenship should, she argued, equate to deservingness for medical relief notwithstanding a slanderous attempt to blacken her reputation. Interestingly and importantly, neither Giles nor Jones played on their status as women or adopted particular linguistic gender stereotypes (for instance emphasising their submissiveness, dependence, inability to earn a living or their status as wives/widows), instead proposing more robust renderings of the status and substance of their belonging. Jones in particular inscribed her narrative with a framework that counterposed pride and shame, decline and rebirth, the fragility versus strength of belonging, friendship and loss, and dependency and independence.

Letters like these could be quoted at some length, and in contradistinction to those of men, who used different rhetorical and strategic devices to establish their deservingness. For men, any concept of citizenship centred round payment of rates, work and occasionally nativity, and yardsticks of citizenship were in general more muted and fewer than in the letters of their wives, daughters or female peers.[36] There is, however, an area of claims-making in which the writing of sick and poor women was particularly distinctive. Thus, such women were peculiarly likely to invoke the rhetorical concept of the poor law as "friend"; in other words to personify the poor law, to claim it as a substitute for friends and family, and to demonstrate personal connections to its officials. As Naomi Tadmor and others have shown, the concept of "friend" was an elastic one in the eighteenth and nineteenth centuries, and could include family, neighbours, business partners and genuine friends.[37] Evidently too it could include institutions and officials, and there are 214 letters in the underlying sample that deploy notions of friendship as a part of claims-making. One example, that of Mrs Barber who wrote from her host community in London to Pangbourne (Berkshire) at an unspecified date (but probably around 1831), can stand for many and is worth quoting in full:

> Mr Holmes
>
> I write these lines to say that *I took it very hard and unkind* [much perhaps as one would address a friend or relative] as you would not send us so much as a shilling yesterday as we are greatly destresed or else believe me *we would not trouble you but* my husband has been very ill since He came home and is legs are very bad at this time his oblidged to keep hisself as still as he can or his legs swells and are in so much pain or else he would have come to you yesterday and I do asure you he is very weak for he has been nearly starved this month and how can one [?] get strong when the have nothing to surport them was he able to work and could get it to do *believe me we would never trouble you again* so sir I beg you will consider of it and send us something and *I hope God will provide for us and send us a friend* for we have not one on earth. *I thought Mr Holmes you had a feeling for you know what affliction is as well as my self and how bad it is to be a cripple God grant you your health and may you never know the destress as we*.[38]

The letter is a strong one, though not outside the spectrum between passive and aggressive in the underlying sample, and some of the rhetoric (an unwillingness to trouble the parish, acknowledgement of the need for inspection of their state, recent physical presence in Pangbourne and hence an immediate identity with parish of settlement, a desire to be independent citizens) is familiar from consideration of letters elsewhere in this article.[39] However, the key rhetorical infrastructure of the letter is to be found in the last five lines. Here Mrs Barber emphasised their loneliness in the world, actively constructed the poor law as their only friend *and* personified her relationship with Mr Holmes, the overseer, drawing a direct correlation between his physical suffering and those of the husband and counterposing her wish for his health with the lack of a friend to ensure that (physical and financial) of the couple. Mrs Barber and her husband were not just settled in Pangbourne; they were known there, the poor law was their friend and their citizenship and deservingness of good health were as clear as they were for Mr Holmes the overseer.

Of course, it is possible to debate, and debate strongly, whether Mrs Barber took as much care with her narrative as this reading implies, and whether she freighted it with such underlying meaning. Whether she did or not, the issue of how to interpret the rhetorical tactic of claiming the poor law as friend remains. Thus, it could be suggested that Barber's letter had little to do with a rendering of belonging and citizenship and more to do with accepted conventions on how (linguistically, evidentially and practically) as a woman to approach a paternalistic local state. We might read her letter as representing a particular gender stereotype, highlighting the fact that she and her husband were alone in the world and appealing for protection as wife, mother and fellow human being to both the official and the poor law that he represented. There are, however, other readings. Thus, for many commentators the Old Poor Law, particularly in its later stages and local manifestations, would hardly be regarded as paternalistic. Overseers up and down the country regularly cut back relief lists, pruning the allowances or entitlement of those (the aged, children and the sick) who would lie at the heart of any model of paternalistic social relations. Nor does the gender stereotype – women writing what we would expect them to write because they were women – sit easily with the facts. Where women wrote multiple letters to the same parish, they ranged across the rhetorical and strategic devices used by men as well as adding their own, gender specific but not gender stereotypical, devices such as friendship. The preferred reading here is thus that neither paternalism nor poor law reactions to gender stereotypes explains why women remained the dominant recipients of poor relief in general and sickness relief in particular. Internal evidence from the letter series supports this view of a more active process of claiming and evidencing citizenship, of which the concept of friendship was a linguistic and practical part. Thus, friendship (not just of the poor law but also male and female parishioners in the host community) was an integral part of letters written by women in a way that it was not for men. Barber's more active use of the concept of friendship is duplicated in numerous other letters. Hence, Susan Waddington of Wisbech (Cambridgeshire) wrote to the overseer of her parish of settlement (Peterborough, Northamptonshire) on 23 November 1833 to state that

> On receiving my weekly allowance form Mr Mills which is our acting Overseer of Wisbeach he told me that he was not going to pay me any more after that day and that I must get you to send it to some *one friend* here Mr Chapman which is Mrs Peels father is so kind as to say if you gentlemen would be so good as to send it to him *he would take care that I should have it as I live at the farthest end of the town* I hoped you gentlemen would put me on a trifle more a week as I am so dreadfully afflicted with the Rheumatism on my hands shall be so much obliged to you to let me have it as often as convenient.[40]

Those women who characterised the poor law as friend were thus drawing on a wider narrative in female pauper letters.

Nor was the concept of friendship and its links to belonging, citizenship and deservingness solitary and static, as we see in series of letters by the same sick women. By way of example, we might devote some space to Elizabeth Howell, writing from her host community of Cheltenham (Warwickshire) to Bradford-on-Avon (Wiltshire). Her first letter of 26 March 1834 was a response to a letter from her settlement parish enclosing some relief, for

> I Resaved your laste leter with much plesher as I was much in want as I hame Note Habell To get My own living and I Hame a ferd I never shall I hame verey hill Note Habell to Ene [earn] work *Sur I have no other frend Besides you and I ope To god you will Remayn My frend* sur My Hies [eyes] his verey Bad I hame afraid I soon shall be Dark So No more at presante.[41]

Howell, then, was going blind and claimed other illnesses as well. At the centre of the letter was the idea of the poor law and official as a friend, her belonging (through friendship) as strong and her deservingness as clear. While she did not use the term "deserving citizen" it is clearly what she meant. Other letters followed on 29 June 1834 (when "I hame verey hill my selfe (…) I have no othe frend Bute you and I ope to God you well remaine so To a poor destered [distressed] wido"[42]), 28 September 1834 ("I Truste in god you well Remaine My True frend as I Have No other Bute god and you Sir (…) I hame a frayed So I have Nother frend to Fli To Bute you".[43]) and 26 December 1834 (when "my Hilth Contino verey offell (…) I Have nobadey to fle To Bute god and you for my Helpe".[44]). On each occasion, the appeal was successful. Her last letter under the auspices of the Old Poor Law was 29 March 1835, after which a New Poor Law union was structured. It said:

> Sur I have Taken the lebrty of riten To you as I have *No other frend* But you and *I ope you will ever Remaynm as such* I hame verey hill and My hise is verey Bad I hame all Moste Blind I Cannote Doo eney in ploymente. Sur I hame youre Moste Humbel Servante lesabeth Howell wedo.[45]

For Elizabeth Howell, then, the rhetoric of poor law and official as friend, both of which factors enhanced her strength of belonging and status as deserving, lay at the heart of her successful engagement with the poor law for medical relief. Lest we think that this is an overreading of the source, an undated note (presumably once pinned to a letter but now detached) from the overseer of Cheltenham states "Elizabeth Howell I am convinced is a deserving case and *would be treated much as the other citizens in this place did she but belong here* in a legal way".[46]

In one sense, the fact that sick and poor women used the elasticity of the term "friend" as part of their active claims-making should not surprise us, since they were drawing on an established conceptual and presumably linguistic register in the wider society. Yet, for the concept and its rhetoric to be so keenly attached to sick poor women rather than other groups amongst the poor is important. We might argue that claiming the poor law and (by inference) community as "friend" and personifying an institution with which one had to engage was an ultimate rhetorical tool to measure belonging and citizenship and to claim the deservingness that these two interrelated states conferred. While we must be careful not to read too much into pauper letters by way of intent and meaning, a careful consideration of individual letters and series of letters by the same women suggests that the concept and rhetoric of friendship were consciously used to change the ground on which the issue of deservingness was reconciled. That is, personifying the poor law and claiming links to its officials interposed personal citizenship and belonging into what would otherwise be a balancing act for the overseer between custom, law and the magistrate on the one hand and the (particularly in the crisis of the Old Poor Law between 1800 and the late 1830s) strong impetus to economy and rate-saving on the other. It would certainly be wrong to suggest that this was a process driven by models of paternalism. The fact that "friendship" was disproportionately used by women and by sick women in particular suggests that this interposition was only valid for a select group of paupers. It would be incorrect to regard this observation as confirming gender stereotyping in the structure, content and claims-making of pauper letters (after all, the most submissive letters in the underlying sample were written by men), but it does confirm that sick women were able to execute particularly hard-hitting and multi-stranded appeals centred around their belonging and citizenship. There is not the space in this article to extend our discussion of establishing deservingness, belonging and citizenship to the period of the New Poor Law. However, it is important to understand that paupers did not stop writing letters to overseers (who remained, though with different powers and responsibilities under the New Poor Law), poor law Guardians (the new elected people who run poor law unions under the New Poor Law) and government (an alternative avenue for petitioning once the New Poor Law was implemented) in 1834.[47]

Conclusion

Appeals framed by sick women were probably the most successful of any pauper narratives, explaining in part why sick women in particular retained their place at the head of the relief lists even as the theoretical impetus for more men to appear on them grew. Undoubtedly there was an element of paternalism in operation – it would not have been good form to abandon sick women to their fate. However, this article has argued that we also find an active construction of belonging claimed and evidenced in narratives from or about sick women. The fact that officials invariably responded by offering relief is testimony to a shared understanding of the importance of, and linguistic register for describing, belonging. Perhaps this should not surprise us. As Henry French, Margaret Hunt and other commentators have reminded us, the middling sorts used the language and rhetoric of belonging as they sought to construct their own citizenship credentials and thereby to share or accumulate power in the English parish.[48] Perhaps, against this backdrop, official and pauper genuinely were using a shared conceptual and linguistic corpus. True or not, it would be wrong to suggest that the women in this sample at least sought to establish deservingness by emphasising their dependency and lack of power. While Tomkins may be right that healthy poor women (and men for that matter) "were not just short of money; they were also short of influence", sickness introduced a new opportunity for agency which was, as this article shows, exploited through claiming and evidencing belonging and other de facto notions of citizenship.

Notes

1 This article is based upon data collected as part of a wider project funded by the Wellcome Trust. I am grateful to the Trust for their support.

2 For more on English and Welsh welfare structures and administration under the Old Poor Law (1601–1834) see King, Steven. Poverty and Welfare in England 1700–1850: A Regional Perspective. Manchester University Press, Manchester 2000; Hindle, Steve. On the Parish? The Micro-Politics of Poor Relief in Rural England 1550–1750. Oxford University Press, Oxford 2004; Lees, Lynn Hollen. The Solidarities of Strangers: The English Poor Laws and the

People 1700–1949. Cambridge University Press, Cambridge 1998; Patriquin, Larry. Agrarian Capitalism and Poor Relief in England 1500–1860. Palgrave, Basingstoke 2007.

3 Lancashire Record Office [hereafter LRO] PR2391/12, Letter. Here and hereafter all italics are added by the author.

4 On the mechanics of this "out-parish relief" system, see King, Steven. "'It is impossible for our vestry to judge his case into perfection from here': Managing the distance dimensions of poor relief, 1800–40." Rural History 16 (2005):161–189.

5 LRO, PR2391/31, Letter.

6 LRO, PR2391/36, Letter.

7 For the evolution of concepts of belonging in relation to the poor, see Snell, Keith. Parish and Belonging: Community Identity and Welfare in England and Wales 1700–1950. Cambridge University Press, Cambridge 2006, and Hindle, Steve. "Destitution, liminality and belonging: The church porch and the politics of settlement in English rural communities, c. 1590–1660." In Dyer, Christopher (ed.). The Self-Contained Village? The Social History of Rural Communities 1250–1900. University of Hertfordshire Press, Hatfield 2007.

8 Lees 1998; French, Henry. The Middle Sort of People in Provincial England 1600–1750. Oxford University Press, Oxford 2007; Hunt, Margaret. The Middling Sort: Commerce, Gender and the Family in England 1680–1780. University of California Press, Berkley 1996; Levine, Philippa. Gender and Empire. Oxford University Press, Oxford 2004; Harris, Jose. Private Lives, Public Spirit: A Social History of Britain 1870–1914. Penguin, London 1994; King, Steven. Women, Welfare and Local Politics 1880–1920: "We Might be Trusted". Sussex Academic Press, Brighton 2006.

9 Hurren, Elizabeth. Protesting about Pauperism: Poverty, Politics and Poor Relief in Late-Victorian England 1870–1900. Boydell and Brewer, Woodbridge 2007; Vincent, David. Poor Citizens: The State and the Poor in Twentieth Century Britain. Longman, London 1991. For longer run surveys see Fideler, Paul. Social Welfare in Pre-Industrial England: The Old Poor Law Tradition. Palgrave, Basingstoke 2005, and Horne, Thomas. Property Rights and Poverty: Political Argument in Britain 1605–1834. University of North Carolina Press, Chapel Hill 1990.

10 See King 2006.

11 See contributions to Bock, Gisela and Susan James (eds). Beyond Equality and Difference: Citizenship, Feminist Politics and Female Subjectivity. Routledge, London 1992, and to Canning, Kathleen and Sonya Rose (eds). Gender, Citizenship and Subjectivities. Blackwell, Oxford 2002. Also, Digby, Anne. "Women's biological straitjacket." In Mendus, Susan and Jane Rendall (eds). Sexuality and Subordination: Interdisciplinary Studies of Gender in the Nineteenth Century. Routledge, London 1989, and contributions to Koven, Seth and Sonya Michel (eds). Mothers of a New World: Maternalist Politics and the Origins of Welfare States. Routledge, London 1993.

12 Fissell, Mary. Vernacular Bodies: The Politics of Reproduction in Early Modern England. Oxford University Press, Oxford 2004.

13 Gowing, Laura. Domestic Dangers: Women, Words and Sex in Early Modern London. Clarendon Press, Oxford 1996; Botelho, Lynn and Pat Thane. "Introduction." In Botelho, Lynn and Pat Thane (eds). Women and Ageing in British Society since 1500. Longman, London 2001:1–12; Botelho, Lynn. "The old woman's home in eighteenth century England." In Botelho and Thane 2001:111–38.

14 Snell 2006.

15 Tomkins, Alannah. "Women and poverty." In Barker, Hannah and Elaine Chalus (eds). Women's History: Britain 1700–1850. Routledge, London 2005:154.

16 King 2000; Smith, Richard. "Ageing and well being in early modern England: Pension trends and gender preferences under the English Old Poor Law 1650–1800." In Johnson, Paul and Pat Thane (eds). Old Age from Antiquity to Post-Modernity. Routledge, London 1998:43–77; Patriquin 2007.

17 King, Steven. Sick Poor and Dead: Poverty, sickness and its Relief in England 1750–1860. Forthcoming 2009.

18 Lees 1998; Tomkins 2005:166;. Also Valenze, Deborah. "Charity, custom and humanity: Changing attitudes to the poor in eighteenth century England." In Garnett, Jane and Colin Matthew (eds). Revival and Religion since 1700: Essays for John Walsh. Hambledon, London 1993.

19 Snell 2006.

20 While there were variations in the tendency for women to draw on the rhetoric and signifiers of belonging according to community types from which letters were written (particularly the degree of urbanisation, with bigger urban areas generating a higher density of signifiers of belonging) and life-cycle stage (with older sick women more likely to use the rhetoric of belonging than their younger counterparts) there is not the space here to explore these issues.

21 For a review, see King, Steven. "Pauper letters as a source." Family and Community History 10 (2007):167–170.

22 Hitchcock, Tim, Peter King and Pam Sharpe (eds). Chronicling Poverty: The Voices and Strategies of the English Poor 1640–1840. Macmillan, Basingstoke 1997; King, Steven, Thomas Nutt and Alannah Tomkins. Narratives of the Poor in Eighteenth Century Britain. Pickering and Chatto, London 2006; Fontaine, Laurence, and Jürgen Schlümbohm (eds). Household Strategies for Survival 1600–2000. Cambridge University Press, Cambridge 2000; Sokoll, Thomas. Essex Pauper Letters 1731–1837. Oxford University Press, Oxford 2001; Sokoll, Thomas. "Writing for relief: Rhetoric in English pauper letters 1800–1834." In Gestrich, Andreas, Steven King and Lutz Raphael (eds). Being Poor in Modern Europe. Peter Lang, Bern 2006:91–112.

23 I have argued elsewhere, in common with earlier commentators, that the New Poor Law represented no decisive break with the Old. Most recipients in 1840 continued to be relieved outside the workhouse much as had been the case in 1820, while paupers and those acting for them continued to write letters in large numbers.

24 Space constraints prevent a wider discussion of the positive impact on deservingness and award size or composition of doctors writing in support of paupers. This will be the subject of future work.

25 Tomkins, Alannah. "Labouring on a bed of sickness: The material and rhetorical deployment of ill-health in Englishmen's pauper letters 1780–1840", in King, Steven (ed.). Narratives of Poverty and Sickness in Europe 1780–1938. (Forthcoming, Berghahn, 2008).

26 Berkshire Record Office [hereafter BRO], D/P 91 18/5.

27 BRO, D/P 91/18/11. Hindle 2007:69–70, discusses the dwindling of the symbolic and practical importance of the settlement system in the eighteenth century.

28 BRO, D/P 132/18/12.

29 BRO, D/P 132/18/12.

30 LRO, PR2391/18.

31 LRO, PR2391/29.

32 LRO, PR2391/34.

33 Hurley, Brenda. Bradford on Avon Applications for Relief from Out of Town Strays, 1832–1835. Wiltshire Family History Society, Devizes 2004:20–21.

34 Hurley 2004:21.

35 Hurley 2004:27–28.

36 Claims that men were deserving not just because they belonged to a place legally or by dint of long-residence, but because of their nativity are infrequent, but nonetheless noticeable. No woman in the sample ever writes about her nativity.

37 Tadmor, Naomi. Family and Friends in Eighteenth Century England. Cambridge University Press, Cambridge 2001.

38 BRO, D/P 91/18/4/2. Note the awareness of the duty to keep good health, in this case frustrated by lack of food.

39 Tomkins 2005:168, argues that letters from women become firmer and more rights-based in the last decades of the Old Poor Law.

40 Northamptonshire Record Office [hereafter NRO], 261P Vii/Bundle 244/22.

41 Hurley 2004:24.

42 Hurley 2004:25.

43 Hurley 2004:25.

44 Hurley 2004:25.

45 Hurley 2004:25.

46 I am grateful to John Todd for sight of his private collection of Cheltenham ephemera.

47 Hurren, Elizabeth. “The business of anatomy and being poor: Why have we failed to learn the medical and poverty lessons of the past?” In Gestrich, King and Raphael 2006:135–156.

48 French 2007; Hunt 1996.

Citizenship and venereal disease: legislation on STD in five northern European countries 1940s–1990s

Ida Blom

Precautions against some contagious diseases, such as leprosy, tuberculosis and sexually transmitted diseases (STDs), have been regulated in many countries by special laws, varying from one country to another. Consequently, national citizenship is important for the treatment a person could expect if suffering from a contagious disease. Citizenship gives access to certain rights, but also confers certain duties. The definition of who is included as a citizen and who is not regarded worthy of this status changes over time. So do relations between nation states and their citizens. The growth of democracy has led to increasing influence of political parties and of voluntary organisations. From the middle of the 20th century different forms of welfare states have emerged, at least formally giving citizens equal rights to health services. The welfare state aimed at eradicating class differences, but other differences, such as gender, ethnicity and sexuality have continued to be of importance.

During the last half of the 20th century expectations as to the proper behaviour of a good citizen have changed in some respects in a way that affects the question of contagious diseases. Around 1950 the good citizen was expected to follow rules and regulations established by a political process, but from the late 1960's, individual responsibility has gradually assumed greater importance.[1] With respect to STD, changing norms concerning the sexual behaviour have also been important. So were, of course, medical advances that from the 1950s introduced antibiotics as a relatively easy cure for the two STDs most feared, syphilis and gonorrhoea. But from the early 1980s HIV/AIDS became the main threat, and there was no cure for this new disease.

All these changes affected legislation on STDs. I shall concentrate on the impact of changing norms for sexual behaviour on STD legislation during the last part of the 20th century, focussing mainly on the Scandinavian countries, but also briefly comparing Scandinavian developments also with those in Britain and Germany.[2]

Main characteristics of STD legislation in five northern European countries

Looking first at Britain, it is remarkable that throughout the 20th century the Public Health (Venereal Diseases) Regulations, passed in 1917, continued to guarantee a British citizen free and voluntary treatment of STD. A network of information centres was constructed around the country to assist people suffering from STDs. However, during both world wars the need to protect soldiers from contagion resulted in some controlling measures that targeted young women. No doubt the need for healthy soldiers made the young men more worthy citizens than young women, who might expose soldiers to diseases. But otherwise every citizen was free to choose how to meet the threat of venereal diseases.[3]

This attitude reflects the understanding of Britain as a liberal welfare state offering every citizen basic security with a minimum of coercive measures.[4] British citizens are trusted to act to the best of the common good, in the interest of a healthy society. This attitude has also characterised British legislation on STD. At the same time, however, British society widely supported a moralistic approach that warned against extra-marital sexual relations and discouraged the provision of prophylactics.[5]

This individualistic approach continued after AIDS became the central problem. During the early 1980s vehement demands for compulsory notification and detention of persons afflicted by the disease were to no avail. The British Medical Association supported the country's tradition of liberal STD policies based on voluntary treatment and information and rejected the continental approach of compulsion, registration and control of certain social groups. Instead of enacting control and coercion to fight AIDS, British health authorities put more resources at the disposal of STD services. Until then these services had had a low status within the British National Health System. Now they were considered very important and attracted a number of gifted physicians. But when the predicted epidemic of AIDS failed to materialise, earlier policies of 'benign neglect' were resumed. Centrally allocated funds were discontinued for treatment and care, and reduced for prevention. As David Evans puts it, STD services again became "Cinderella services" within the National Health System.[6] The voluntarist approach adopted early in the century was seen as a success to be continued.[7] In Britain AIDS did not alter the widespread consensus on liberal relations between state and citizen. How did this compare with German and Scandinavian attitudes?

At the middle of the 20th century in Germany and the three Scandinavian countries, laws on STD, enacted at different times, assured all citizens free treatment. But in these four countries such treatment was mandatory, not voluntary as in Britain. Legislation also compelled STD-infected persons to name the potential source of infection (i.e. sexual partners) and allowed for the police to assist in bringing in carriers of infection for treatment. Knowingly infecting others with STD might result in imprisonment. By law all citizens were subject to the same constraints, but practice was often bent to conform to existing understandings of gender and sexuality. For the respectable citizen sexuality belonged within a heterosexual marriage. This was a widely accepted norm, although more important for women than for men. Women who did not follow this norm, prostitutes and what was termed 'frivolous young women', were regarded as less worthy citizens. They were seen as the main carriers of infection and consequently became the main targets for coercive measures.[8] Thus, around the middle of the twentieth century public health campaigns against STD had very different consequences for Scandinavian and German citizens than for British citizens.

Fifty years later, the primary concern in the fight to control STD was no longer syphilis and gonorrhoea, but rather AIDS. In Scandinavia and in Germany the mid-century laws on STD were repealed. Denmark and Germany followed the British example, permitting citizens voluntary choice of treatment. Sweden and Norway, however, elected to expand the purview of legislation on contagious diseases to include AIDS. Although Swedish and Norwegian legislation no longer prescribed punishment for non-compliance, in these two countries some of the coercive measures that had obtained in earlier STD legislation were continued. Why these different policies? In the following I shall suggest possible explanations, mainly for the differences between the three Scandinavian countries, but in the end I shall try to add Germany to the comparison.

Changes in Scandinavian legislation after 1947

In Denmark the law of 1947 was replaced in 1973. The main change was that punishment for non-compliance was cancelled, and information was made the main instrument to reduce the incidence of STD. The debates in the Danish Parliament showed that an important reason for this change was that the target group was no longer considered to be mainly prostitutes and frivolous young women, but now comprised the young generation as such, men and women alike. Several speakers referred to the importance of informing young people on how to avoid STD. Premarital sex had become more acceptable, and the young generation was seen as responsible citizens able to make sensible decisions. It does not seem a coincidence that this happened at a moment when popular movements, such as the students' movement and the feminist movement, protested public control and promoted ways of living that deviated strongly from traditional norms. While in the 1960s and 1970s the young generation organised to promote acceptance of new ways of living; in the 1950s prostitutes and frivolous young women had had no such possibility. Fifteen years later, in 1988, the Danish 1973 law on STD was repealed. When Parliament revised the country's legislation on contagious diseases in general in 1994, AIDS was not included. Consequently, since 1988 Denmark has had no laws that specifically targeted STDs.[9]

In Sweden the law of 1918 was repealed in 1968, but STDs were now included in a law on contagious diseases that continued the main provisions of the 1918 legislation. Twenty years later, in 1988, when AIDS had become the new threat, it was added to the list of diseases covered by this legislation.[10]

A similar change was made in Norway in 1994 when the STD law of 1947 was repealed. As in Sweden the Norwegian 1994 law on contagious diseases included AIDS. In both countries information was now seen as the main weapon to curtail AIDS, but treatment of the disease remained mandatory (though free of charge) and so did contact tracing. As a last resort compulsory medical examination of potentially infected persons was made dependent on a court decision in Sweden or on a decision in a special committee for protection against contagious diseases (*Smittevernkomiteen*) in Norway. There was no punishment for non-compliance in either country. Thus, some of the provisions from the earlier laws on STD were continued, but compulsion was relaxed and information was seen as important to avoid contagion.

Why did Norwegian and Swedish citizens who suffered from AIDS continue to be subject to some constraints by health legislation, while Danish citizens were exempted?[11] Signild Vallgårda has compared Swedish and Danish policies on AIDS and suggested that differences in the priority assigned to certain target groups might explain the differences in policies.[12] Expanding on Vallgårda's reasoning I shall include Norway in this comparison.

Target groups and path dependence

The fear of AIDS meant that target groups were no longer prostitutes or the young generation as such. Homosexuals and intravenous drug users were now seen as the most obvious carriers of infection. Vallgårda points to general attitudes towards these groups as important for legislation on AIDS, and she explains such attitudes as a result of path dependence, i.e. depending on earlier policies. How did homosexuals and drug addicts fit in with norms for responsible citizens? I shall look first at policies towards homosexuals.

Including homosexuals as respectable citizens has been a long and difficult process in Scandinavia as elsewhere. Homosexuality was punishable with imprisonment in Norway from 1842, in Sweden from 1864 and in Denmark from 1866. Denmark was the first to decriminalise homosexuality, in 1930; Sweden followed suit in 1944, while Norway waited until 1972 to follow the example of its neighbours.[13] It is indicative the differences in the three societies that discussions in ecclesiastical circles (national state churches) on homosexuality resulted in longer and more heated debates in Norway than in Sweden and Denmark and continued well beyond 1994.[14]

Organisations for homosexuals appeared at almost the same time in all the Scandinavian countries. The (Danish) Federation of 1948 (*Forbundet af 1948*) was organised a few years earlier than the parallel Swedish and Norwegian organisations (both 1950). During the 1980s and 1990s there was little difference in the timing of anti-discrimination laws and laws on cohabitation that placed homosexuals more or less on the same footing as heterosexuals.[15]

In all three countries homosexual organisations have been very active in spreading information about AIDS and attempting to influence the relevant legislation. Consequently, a policy of information and appeal to responsible behaviour seemed in tune with the growing acceptance of this group as respectable citizens on a par with heterosexuals.[16] Remembering that all three countries in 1947 shared similar policies on STDs, one might expect them now also to follow similar paths on AIDS. But as we have seen, this was not the case: Sweden and Norway continued some constraining policies, Denmark did not.

Signild Vallgårda has convincingly argued that the difference between Denmark and Sweden may be explained by the fact that in Denmark homosexuals were the main target group, whereas in Sweden intravenous drug users and drug-addicted prostitutes were perceived as the more dangerous carriers of infection.[17] Vallgårda proposes that the different definitions of target group were the main reason for differences in AIDS policies in the two countries.

It should be pointed out that nowhere did intravenous drug users have organisations that might promote their interests. This was a marked difference from the youth movements of the 1970s and from the homosexual organisations. Still, Denmark followed a decidedly more liberal approach to intravenous drug users than Sweden. Danish authorities exerted no coercion, and clean syringes could be bought from pharmacies or vending machines. In some counties clean needles were even distributed among drug addicts. This was also tried in two Swedish cities, but in Sweden it was feared that such a practice might be seen as a sign that drug addiction was acceptable.[18] Drug abusers were regarded as especially dangerous since they might spread AIDS to the heterosexual population, and they were perceived as little able to adopt precautions. In 1981 drug abusers in Sweden were included in the compulsory treatment programme already reserved for alcoholics; in 1986 an institution for compulsory treatment of drug abusers was opened. In 1988 a law imposed prolonged treatment on intravenous drug users.[19] In short, this group was certainly not regarded as respectable and responsible citizens. All this seems to pave the way to include AIDS in the Swedish law on contagious diseases in 1988.

Norwegian legislation on the use of illegal drugs built on attitudes that were closer to the Swedish than to the Danish approach. In 1964 and again in 1968 the Medicine and Drug Act was revised. The use of illegal drugs was now punishable by three months imprisonment, while the pushing of drugs could lead to a penalty of from two to five years imprisonment. The Health Director was allowed to inform the police about persons using narcotics.[20] As in legislation on contagious diseases, the aim was to protect society by attempting to limit drug abuse. Although clean needles were made available in Oslo and Bergen from 1988, in 1991 the Law on Social Services permitted coercive institutionalisation of drug addicts as a last resort.[21] Thus, Sweden and Norway chose different approaches to intravenous drug users than Denmark.

Vallgårda suggests that countries' traditions of controlling addictive behaviour in general also influenced measures adopted against AIDS. She points to the differences in Scandinavian policies on alcoholism. Compulsory treatment of alcoholics was not been uncommon in Denmark during the early twentieth century, but after the Second World War this was gradually replaced by voluntary therapy. Ellen Schrumpf maintains that from the 1960s the Danish capital became a hideaway for alcoholics, also those from Sweden and Norway.[22] In 1976 Denmark abolished all compulsory treatment of alcoholics and drug abusers.[23] Vallgårda argues that this liberal policy explains the subsequent liberal attitudes in Denmark towards intravenous drug users and consequently also helps explain policies towards AIDS.[24]

Swedish policies towards alcoholics, by contrast, were quite restrictive. In Sweden the so-called ‘Bratt-system’ from 1917 and a state sales monopoly regulated consumption of alcohol by allowing each individual citizen to buy only a certain amount of alcohol per month – unmarried women were allowed less than other people. In 1981 traditional policy of compulsory treatment of alcoholics was widened to include intravenous drug users, and this compulsion was strengthened in 1986 and 1988.[25] There is, therefore, good reason to agree with Vallgårda’s conclusion: the more restrictive Swedish policies on alcoholics and drug addicts translated into more restricted policies towards AIDS.

Control of alcoholics was an even stronger tradition in Norway than in Sweden. Schrumpf has pointed out that from the Danish perspective Norwegian policies towards alcoholics were brutal.[26] In 1926 a short period of prohibition was replaced by a state sales monopoly, followed in the 1930s by compulsory treatment of alcoholics. These policies won support from many organisations in Norwegian society. Teetotallers represented in Berge Furre’s words “one of the strongest popular movements in our history”.[27] No doubt, in this case voluntary organisations also influenced the relation between the individual citizen and the state.

But during the 1970s policies of compulsion were increasingly criticised. Alcoholism was now accepted as a disease, and its treatment became part of the public health system. Mandatory institutionalisation of alcoholics was now hardly used.[28] Despite continued restrictions on the sale of alcohol Norwegian policies towards alcoholics changed considerably. Still, they remained closer to the Swedish restrictionism than to Danish permissiveness. It seems reasonable to argue that the long-standing restrictive attitudes towards alcoholics were now transferred to support for constraining measures towards drug addicts. Together with a reserved attitude towards homosexuals, this may have coloured the Norwegian 1994 law on contagious diseases.

I would suggest that Vallgårda’s explanation for the differences between Danish and Swedish policies towards AIDS may also be valid for Norway. In both Sweden and Norway a long tradition of restrictive policies towards alcoholics was continued in the case of intravenous drug users. This may help explain why Swedish and Norwegian citizens, but not Danish citizens, were subjected to constraining measures against AIDS.

But I would also suggest that path dependence in the case of STD might quite simply mean continuation of some central elements of earlier legislation. This was what happened both in Norway and in Sweden. The countries’ laws on contagious diseases in fact featured some of the earlier regulations concerning STDs. A marked difference was, however, that constraints were now seen as a last resort, and compulsion was considerably weakened.[29] Different traditions regarding alcoholism and drug abuse would then explain why only Norway and Sweden, not Denmark, continued some of the earlier provisions.

Of course, path dependency is not the only possible reason for policy differences between countries. An alternative, or at least supplementary, explanation is found in what has been termed a country's 'reform capability'.

Reform capability

Klaus Petersen and Klas Åmark have applied the concept of 'reform capability' in their analysis of the history of old age pensions in the Nordic countries. They argue that possibilities for political reform – 'reform capability' – depend on the existence of strong interest organisations as well as on the character of the political party system prevailing in a country.[30]

Regarding STD legislation, the change in target groups may have been important for the existence of strong interest organisations. As long as the main target groups for provisions against STD were prostitutes and young flighty women, interest groups were non-existant. When in Denmark the young generation as such came into focus, one might speculate whether the youth revolt and the feminist movement of the late 1960s and early 1970s eased the passage of the 1973 law that established information and voluntary behaviour as the main tools against STD. By the 1980s homosexuals in all three countries were represented by strong interest organisations. They had newly been accepted as respectable citizens, and their initiatives to prevent the spread of AIDS were seen as highly effective. When these efforts turned out to be less successful in Sweden and Norway than in Denmark, the blame could be shifted to intravenous drug users. Like prostitutes this group did not have an interest organization and was not seen as being good citizens.

But differences in the political systems of the three countries may also have had importance. In both Sweden and Norway the post-war period until the 1970s was "the happy moment of Social Democracy", i.e. long periods of stable, social-democratic governments.[31] In fact, such periods also occurred during the 1980s and 1990s. The Social Democrats formed the Swedish government during the 1980s when the decisive legislation on STD was adopted. This was also the case for Norway in the 1990s. The Danish political system was less stable. Political coalitions shifted and at times even brought together Social Democrats and non-socialist parties (*Radikale Venstre*). Such coalitions never occurred in Norway and in Sweden only once.[32] It might be thus expected that the more flexible Danish party system would make compromises and changes easier in Denmark than in the other two countries where one party dominated government for longer periods.

One more point may be made. STDs were diseases that could be understood as resulting from immoral lives, and this raises the question of the importance of religion. In all three countries Christian circles were consistently against liberal practices to contain AIDS.[33] But these circles were much stronger in Norway than in Sweden and Denmark. Strong regional pietistic countercultures were well organised and gave the religious climate in Norway a different character.[34] Perceptions of alcoholism, drug addiction and STD as the products of deficient moral attitudes were especially strong within these religious circles.[35] Religion also influenced the country's party system. The Norwegian Christian Peoples Party (*Kristlige Folkeparti*), founded in 1931, attracted considerable voter support and formed part of coalition governments several times during the last half of the 20th century.[36] Although a similar party also existed in Sweden, the Christian Democratic Unity (*Kristen Demokratisk Samling*), this party only emerged in 1964 and had less support. The Danish counterpart (*Kristendemokraterne*) was weaker still and had almost no governmental influence.[37]

All this would support the assertion that a more liberal culture prevailed in Danish society and strengthened the reform capability of the Danish political system, whereas the opposite may have been the case in Norway and Sweden. One of the consequences was different perceptions of how best to combat AIDS. In Denmark all citizens were trusted as responsible individuals, able to make the right decisions concerning infection and disease. As in Britain, this seen as sufficient guarantee for the safety of society. In Sweden and Norway, however, the state continued to be seen as to some degree responsible for controlling recalcitrant citizens in order to safeguard society. Whether you were a Danish, a Swedish or a Norwegian citizen would be decisive for how you were treated if you contracted AIDS.

What about Germany?

There were clear similarities between German and Scandinavian legislation on STD. The West German law of 1953 built on Weimar Germany's policies (the law of 1927) that were very similar to those obtaining in Scandinavia at the time. A new penal code in 1962 also continued penalties for spreading STD. As well, in Germany the threat of AIDS during the 1980s led to extensive discussions on how to practise existing legislation. The result was a pronounced reduction in the use of coercion and a recourse to information as the main means to combat STDs. Why this change in German STD policies?

This question should be studied more thoroughly than I can do here. But it may not be without importance that in Germany as in Scandinavia there appears to have existed a strong interest group for homosexuals. According to Peter Baldwin, homosexuals were "equipped with impeccable intellectual and scholarly credentials" and their organisation dated back to the 19th century, much earlier than in Scandinavia. In West Germany homosexuality was decriminalised in 1969, much later than in Denmark and Sweden, but only three years earlier than in Norway.[38] The organisation German AIDS Help (*Deutsche AIDS Hilfe* or DAH), created in 1983 by gay men, gave advice and support on AIDS, and there was close cooperation between this organisation and the Federal Ministry of Public Health.[39] The Ministry followed an unaggressive policy towards AIDS, relying on information, education and research.[40] The existence of a strong interest group may have been important. This would indicate that, as in

Scandinavia, homosexuals in West Germany were seen as trustworthy citizens in the fight against AIDS.

German policies on drug addicts followed principles similar to those adopted in Denmark. Information and education were seen as the main defences against addiction. Possession of illegal drugs was prohibited, but using drugs was not criminalised.[41] To my knowledge there has been no German tradition of constraining policies regarding the use of alcohol.

Finally, it may be added that also West Germany, like Denmark, has a flexible political system. Since 1948 the federal government as well as most state governments have usually been political coalitions. The most frequent combination at the federal level has been the confessional Christian Democrats (*Christlich Demokratische Union Deutschlands* or CDU) and the liberal Free Democrats (*Freie Demokratische Partei* or FDP), although in the 1970s the Social Democrats (*Sozialdemokratische Partei Deutschlands* or SPD) and Free Democrats governed together. In 1988 these parties adopted new, liberal policies towards STDs over the opposition of the more conservative Christian Social Union (*Christlich Soziale Union* or CDU). Where this last party controlled government, i.e. in the state (*Land*) of Bavaria, public health authorities pursued much stricter policies regarding AIDs than in the rest of Germany.[42] It is no coincidence that this part of Germany is overwhelmingly Catholic. The Catholic Church strongly rejects homosexuality as a break with God's will of seeing sexuality confined to a faithful marriage, and Church leaders exercise considerable influence in governmental affairs in Bavaria. By contrast, leaders of the Protestant churches that dominate religious circles in northern and western Germany have accepted homosexuality and a liberal policy towards AIDS.[43] These factors may explain why where AIDS policies are concerned relations between the German state and the citizen have been close to those found in Denmark and in Britain.

Conclusion

During the last decades of the 20th century sexuality and drug addiction influenced legislation on STD, revealing different relations between the state and the individual citizen. In Britain since the First World War all citizens were seen as responsible for their own health, and the principle of voluntary and individual responsibility prevailed there throughout the century. During the 1980s this approach was also adopted in Denmark and in the Federal Republic of Germany. Part of the explanation may have been that strong and respected organisations representing homosexuals took responsibility for fighting AIDS. This was also the case in Sweden and Norway. But especially in Norway and in the German state of Bavaria traditional religiously grounded attitudes to homosexuality seem to have had a modifying effect. Intravenous drug addicts were the other target group. They had no powerful organisations and were seen as irresponsible citizens. Policies towards intravenous drug addicts were influenced by earlier traditions of measures to contain alcoholism. This led to liberal provisions in

Denmark and Germany but to restrictive legislation in Sweden and Norway. Finally, where cooperation across party boundaries was a recurring phenomenon, it was easier to adopt new, more progressive guidelines. Where one party, in this case the Social Democratic party, dominated the political stage for longer periods, reform capability was less pronounced. All this influenced legislation on STD and coloured the relationship between the state and its citizens.

Notes

1 Seip, Anne-Lise. Veiene til velferdstaten. Norsk sosialpolitikk 1920–1975. Gyldendal Norsk Forlag, Oslo 1994:381–383; Christiansen, Niels Finn, Klaus Petersen, Nils Edling and Per Haave (eds). The Nordic Model of Welfare. A Historical Reappraisal. Museum Tusculanum Press, Copenhagen 2006:17–29; Siim, Birte and Judith Squires. "Contesting Citizenship:Comparative Analyses." In Siim, Birte and Judith Squires (eds). Contesting Citizenship. Routledge, London and New York 2008:1–14; See also the contribution by Teemu Ryymin in this volume.

2 For an earlier version of part of this paper, see Blom, Ida. "From coercion to individual choice? Changing policies against venereal diseases in Scandinavia, 1940's to 1990's." In Johansson, Kenneth and Marie Lindstedt Cronberg (eds). Vänskap over gränser. En festskrift till Eva Østerberg. Författerna, Lund 2007:235–254.

3 Hall, Lesley A. "Venereal diseases and society in Britain, from the Contagious Diseases Acts to the National Health Service." In Davidson, Roger and Leslie A. Hall (eds). Sex, Sin and Suffering. Venereal disease and European society since 1870. Routledge, London and New York 2001:120–136.

4 Åmark, Klas. Hundra år av välfärdspolitik. Välfärdsstatens framväxt i Norge och Sverige. Borea Bokförlag, Umeå 2005:271–276; David Bradley, who has analysed British family law, finds that also this legislation is characterised by a strong element of individualism and a general antipathy to state intervention. See Bradley, David. "The Legal Dimensions of the Nordic Model of Marriage." In Melby, Kari, Anu Pylkkänen, Bente Rosenbeck and Christina Carlsson Wetterberg (eds). The Nordic Model of Marriage and the Welfare State. NORD, Copenhagen 2000:54–58.

5 Sauerteig, Lutz. Krankheit, Sexualität, Gesellschaft: Geschlechtskrankheiten und Gesundheitspolitik in Deutschland im 19. und frühen 20. Jahrhundert. Steiner, Stuttgart 1999:449–452.

6 Evans, David. "Sexually Transmitted Diseases Policy in the English National Health Service, 1948–2000." In Davidson and Hall 2001:237–252.

7 Baldwin, Peter. Disease and Democracy. The Industrialised World Faces AIDS. University of California Press, Berkeley-Los Angeles-London-New York 2005:229.

8 Laws to prevent STD were passed in Denmark in 1906 and 1947, in Sweden in 1918, in Germany in 1927 and in Norway in 1947. Sauerteig, Lutz. "'The Fatherland is in danger. Save the Fatherland!': venereal disease, sexuality and gender in Imperial and Weimar Germany." In Davidson and Hall 2001:76–78. For an extensive study of venereal disease in Germany, see

Sauerteig 1999; Blom, Ida. "Fighting Venereal Diseases: Scandinavian Legislation c. 1800 – c. 1950." Medical History 50 (2006):209–234.

9 Blom, Ida. "From Regulationism to the Scandinavian Sonderweg – legislating to prevent venereal diseases in Denmark during the long 19th century." Continuity and Change 20 (2005):265–286.

10 Vallgårda, Signild, "Problematization and Path Dependency: HIV/AIDS Policies in Denmark and Sweden." Medical History 51 (2007):99–112.

11 Vallgårda 2007; Blom 2007.

12 Vallgårda 2007. Vallgårda refers to the theory of path dependence set forward in Baldwin 2005:227–228. Baldwin points to traditions stemming from the fight against cholera in the middle of the nineteenth century as an explanation for compulsory measures in Swedish AIDS policies. Vallgårda convincingly argues that the path from a contagious water-borne epidemic to a sexually transmitted disease seems rather illogical.

13 Bradley 2000:43–44; Ahlberger, Christer and Lars Kvarnstrøm. Det svenska samhället 1720–2000. Böndernas och arbetarnas tid. Studentlitteratur, Lund 2004:321; Hennum, Rahnhild. "Lesbiske og homofiles rettsstilling." In Brantsæter, Marianne, Turid Eikvam, Reidar Kjær and Knut Åmås (eds). Norsk homseforskning. Universitetsforlaget, Oslo 2001:85–93.

14 Moxnes, Halvor. "Fra kulturelt hegemoni til ideologisk getto. Homofili-debatten i Den norske kirke fra 1950 til 2000." In Brantsæter, Eikvam, Kjær and Åmås 2001:57–84. A lively discussion of the question of how to approach homosexuality may be found in Kirke og Kultur 100 (1995), 4.

15 Antidiscrimination laws were passed in Norway in 1981, followed by Denmark in 1986 and by Sweden the following year. Denmark regulated cohabitation for homosexuals in the same way as for heterosexuals in 1986 and 1989, Sweden in 1988 and 1994 and Norway in 1991 and 1993. Vallgårda, Signild. Folkesundhed som politik. Danmark og Sverige fra 1930 til i dag. Aarhus Universitetsforlag, Århus 2003:247; Rydström, Jens. "Appendix." In Rydström, Jens and Kati Mustola (eds). Criminally Queer. Homosexuality and Criminal Law in Scandinavia, 1842–1999. Aksant, Amsterdam 2007:251–279.

16 Blom 2007.

17 Vallgårda 2003:252–258; Vallgårda 2007:102–106.

18 Vallgarda 2003:255–256; Baldwin 2005:145.

19 Baldwin 2005:151.

20 Fjær, Svanaug. "From Social Radicalism to Repression: The Construction of Norwegian Drug Policy in the 1970s." In Andresen, Astri, Kari Tove Elvbakken and William H. Hubbard (eds). Public Health and Preventive Medicine 1800–2000. Knowledge, Co-operation, and Conflict. Rokkansenteret, Bergen 2004:146.

21 Lov om sosiale tjenester m.v. 13. desember 1991, § 6; see Furuli, John. "Når det offentlige bruker makt." UIB-magasinet 2001/6.

22 Schrumpf, Ellen. "Berus eder!" Norske drikkekulturer i de siste 200 år. Unipax, Oslo 2003:258–259.

23 Vallgårda 2007:109–110.

24 Vallgårda 2003:250–258; Vallgårda 2007:109–110.

25 Vallgårda 2003:251, 258; Vallgårda 2007:109–110.

26 Schrumpf 2003:258–259.

27 Furre, Berge. Norsk historie 1905–1990. Det norske samlaget, Oslo 1992:118.

28 Hauge, Ragnar. Alkohollovgivning gjennom 1000 år. Rusmiddeldirektoratet, Oslo 1998:229–232 and 251.

29 <http://www.lovdata.no/smittevernloven>

30 Petersen, Klaus and Klas Åmark. “Old Age Pensions in the Nordic Countries, 1880–2000.” In Christiansen, Petersen, Edling and Haave 2006:145–188.

31 Sejersted, Francis. Socialdemokratiets tidsalder. Norge og Sverige i det 20. århundre. Pax forlag, Oslo 2005:201–360.

32 Edling, Nils. “Data on Population and Politics in the Nordic Countries.” In Christiansen, Petersen, Edling and Haave 2006:364–380. In the second half of the 20th century, Sweden had pure social-democratic governments in 1945–51, 1957–76, 1982–91, 1994–; In Norway, Social-democrats were in government in 1945–63, 1963–65, 1971–72, 1973–81, 1986–89, 1990–97. In Denmark there were social-democratic governments in 1947–50, 1953–57, 1964–68, 1971–73, 1979–82 (as well as three periods with coalitions including non-socialist parties.)

33 Vallgårda 2003:255–258. Blom 2006:231–232.

34 It seems no coincidence that freedom of religion was accepted in Denmark in 1849, about a hundred years before it happened in Sweden (1951). This came even later in Norway, in 1969. In Denmark liberal “Grundtvigianism” had characterised the Danish church since the middle of the 19th century. Overgaard, Frands Ove. “Vækkelse – kirke – samfund i efterkrigstidens Danmark.” In Schjørring, Jens Holger (ed.). Nordiske folkekirker i opbrud. National identitet og international nyorientering efter 1945. Aarhus universitetsforlag, Århus 2001:296–200; Lauha, Aila and Ingunn Montgomery. “Virkelighedsbilleder efter krigen.” In Schjørring 2001:47–52; Blom 2006:231–232.

35 Flessen, Rune. “Norsk alkoholpolitikk. Kjente virkemidler i over 150 år.” Online: http://unginfo.nt.no/wshows.aspx. Support for constraining expedients was widespread within the Norwegian public and has been explained by generally restrictive approaches to sexuality and critical attitudes to minorities. HIV/aids-forebyggende arbeid i Norge. En evaluering. Norges forskningsråd, Oslo 1995:98–99.

36 It gained 8.5% of the votes in 1949, increasing to 13.7% in 1997. Heidar, Knut (ed.). Nordic Politics. Comparative Perspectives. Universitetsforlaget, Oslo 2004:44–46; Edling 2006.

37 Heidar 2004:44–46; Ahlberger and Kvarnstrøm 2004:351–352.

38 Baldwin 2005:174; see also <http://en.wikipedia.org/wiki/Magnus_Hirschfeld>.

39 Frankenberg, Guenther. “Germany: The Uneasy Triumph of Pragmatism.” In Kirp, David L. and Ronald Bayer (eds). AIDS in the industrialized democracies: Passions, politics, and policies. Rutgers University Press, New Brunswick, NJ 1992:117–120.

40 Frankenberg 1992:114, 117.

41 Baldwin 2005:146.

42 Baldwin 2005:56, 216–217, 242, 253–254.

43 Frankenberg 1992:112–116.

Health citizenship and "Closing the Gaps": Maori and health policy

Linda Bryder

In 2000 New Zealand's Labour Government announced a new health initiative in relation to the country's Maori people. Called "Closing the Gaps", this was intended to reduce the disparities between the health status of Maori and non-Maori. Health inequalities were not new, nor was this the first time they had been acknowledged. What was novel, however, was the politically contested nature of the policy. In order to understand this policy and the subsequent furore it caused, it is necessary to place it in the context of broader social policies in New Zealand as well as changing relationships between the dominant Pakeha (European) population and the tangata whenua – "the People of the Land", the indigenous population of New Zealand, the Maori, who currently comprise almost 15 per cent of New Zealand's four million citizens.

For Norway, Teemu Ryymin recognised four phases in the relationship between state efforts of health enhancement of indigenous people (the Sámi) and the politics of citizenship from the mid-nineteenth century to the late twentieth century.[1] The first phase, from the 1880s to the 1920s, saw governmental attempts to construct a politically and culturally homogenous citizenry, which meant that minorities had to change their culture to become full (and healthy) citizens. The second phase from the 1930s to the late 1950s saw the growth of the welfare state and the attempt by the government to ensure equal access to health services. The third phase from the early 1960s saw an acknowledgement of cultural diversity. The final phase, arising from movements for self-determination, emerged from the 1980s. In New Zealand too, health citizenship of its indigenous people has been influenced by broader political, social and cultural movements, including changing ideas about the government's social responsibility and the changing status of Maori in New Zealand society. The four phases identified by Ryymin were played out in a broadly similar way in New Zealand in relation to Maori: the first phase (up to 1930) aimed at "Europeanisation" or "amalgamation", the second at "assimilation" (1930–60), and the third phase at "integration" (1960–80). The final phase, "self-determination", emerged from the late 1970s. The latter phase coincided with the "rolling back of the State" in welfare provision, with a targeted rather than universal approach, and also with the new understanding and heightened public discussion of the State's responsibility under the Treaty of Waitangi.

The four phases of health citizenship

The first phase can be illustrated by an 1884 school textbook called *Health for the Maori: A Manual for Use in Native Schools*, which urged Maori to live in a European manner for the sake of their health.[2] The early twentieth century saw the foundation of a new Maori activist group, the Young Maori Party, which sought to reverse the population decline which had occurred since colonisation (from 100,000 in the mid-nineteenth century to 40,000 by the 1890s). When the New Zealand Department of Health was established in 1900, Maui Pomare, the first Maori to graduate in Western medicine and a member of the Party, was appointed Health Officer to the Maori; in his first annual report Pomare described Maori as "just [having] stepped out of Neolithic darkness into the blazing, dazzling light of civilisation".[3]

The second phase occurred under the first Labour Government (1935–49), which promoted universal welfare from the cradle to the grave; Maori were to be treated equally with other citizens in access to health care.[4] The assimilationist approach to Maori health was encapsulated in a statement by Health Officer Dr Harold Turbott, who declared in 1938 that the aim of health policy relating to Maori was to turn them into "hardy, healthy, self-supporting, brown-skinned New Zealanders".[5] The Labour Government's adherence to assimilation can be seen in its housing policy of "pepper potting" – placing Maori families in predominantly Pakeha state house areas rather than keeping them apart.[6] The 1945 Maori Social and Economic Advancement Act was "designed to integrate Maori fully into the social and economic structure of the country". The Department of Maori Affairs established both a Maori Welfare Division to operate through tribal committees and the Maori Women's Welfare League, with the latter focusing upon promoting Maori health. The leaders of these organisations were to follow Maori tradition but in a way geared to modern conditions.[7]

These Maori-led organisations paved the way for a new official policy in the 1960s of "integration" as opposed to "assimilation". A wide-ranging 1960 Department of Maori Affairs report (commonly referred to as the Hunn Report), written within the context of growing urbanization of the Maori people, signaled this new initiative. "Integration" was defined as the attempt "to combine (not fuse) the Maori and Pakeha elements to form one nation wherein Maori culture remains distinct".[8] From 1962 Maori tohunga (healers), outlawed as part of the anti-quackery movement in the early twentieth century, were again sanctioned as health practitioners.[9]

Ironically, the new policy of integration coincided with the first systematic attempts to quantify disparities between Maori and non-Maori health status. Health researchers had taken a sporadic or occasional interest since the late nineteenth century, with the most detailed project being Dr Harold Turbott's 1930s survey of Maori tuberculosis rates.[10] When Turbott became Director-General of Health in 1960, he heralded a forthcoming report on the disparity between Maori and European as a first step towards "the enlistment of Maori interest and cooperation in the betterment of Maori health".[11] *Maori-European Standards of Health* appeared in April 1960, pre-dating the

Department of Maori Affairs report, and was quickly followed by *Maori Patients in Mental Hospitals* (1962), *Infant and Foetal Loss in New Zealand* (1964), *Diseases of the Ear, Nose and Throat in Maori Children* (1965), and *Maori Patients in Public Hospitals* (1965).

A generation later, Professor Eru Pomare, Maui's grandson and the foremost Maori doctor of his time, was commissioned by the Forward Planning Committee of the Medical Research Council of New Zealand to lead a study of Maori standards of health from 1955 to 1975.[12] Pomare was keen to bring Maori health issues to the fore, even though some commentators felt the statistics showed Maori in a negative fashion. A second report, updating the figures to 1984, was published in 1988 and the third appeared posthumously in 1995, following Pomare's untimely death.[13] All three reports formed a sound basis from which to discuss Maori health policy in the fourth phase of health citizenship.

"Integration" became "self-determination" from the 1970s as an increasingly urbanised and politicised Maori, influenced by the international civil rights movements, began to demand more agency in policymaking and implementation. In 1975 Matiu Rata, MP for Northern Maori, engineered the passage of the Treaty of Waitangi Act under which Maori complaints about breaches of the Treaty would be heard by a Tribunal. This Act has been described as "an enormously important milestone". As historian Graeme Butterworth explained, "For the first time the Treaty was given not only statutory recognition but became a yardstick against which government legislation, policies and actions could be measured."[14] The "principles of the Treaty of Waitangi" were incorporated into much subsequent legislation, including health legislation.

The Treaty of Waitangi

The Treaty of Waitangi was signed on 6 February 1840 between a representative of the British Crown and fifty Maori Chiefs of New Zealand. It ceded sovereignty to the British Crown (Article 1) in return for protection of lands, forests, fisheries and other property possessed by Maori, collectively or individually (Article 2). The Maori version included the word "taonga" (treasures) which could be, and subsequently was, interpreted to include health. Article 3 promised Maori "all the Rights and Privileges of British Subjects".[15]

There was considerable confusion about the relevance of the Treaty to health over the next hundred years. New Zealand was not alone in this. A study on the history of aboriginal health in Canada identified similar levels of uncertainty relating to the rights to health care under various treaties signed in the nineteenth century.[16] In early twentieth-century New Zealand one Native Health Nurse reported that local Maori believed they were entitled to medical services under "a certain treaty", but she could not verify it.[17] The Health Department's medical secretary, Dr Joseph Frengley, researched the implications of the Treaty for health policy, and concluded that there was no obligation to provide free medical assistance other than for indigent Maori.[18] This mirrored attitudes towards medical care for non-Maori, whose needs were met by a government-sponsored charitable aid system, New Zealand's equivalent to the English and Scottish poor law systems.[19]

The Health Department re-affirmed its interpretation of the Treaty in 1921, when it declared, "The Treaty of Waitangi, which is often quoted as implying some obligation on Government to give free medical treatment to the Natives, is absolutely silent on the point, and simply conveys the full right and undisturbed possession of their lands to the Maoris."[20] At the end of the 1920s the matter was raised again in the context of Maori inability to pay hospital fees. At a meeting between the Hospital Boards Association (HBA) and Prime Minister Joseph Ward (who had been New Zealand's first Minister of Public Health from 1900 to 1906), the HBA chairman observed that Maori "seemed to have an idea in their heads that there was something in the Treaty of Waitangi which entitled them to free hospital treatment". Ward told them that the government had no funds to finance their treatment but made no comment on the validity of the claims.[21]

In 1933 the Director-General of Health again argued that the Treaty did not include the right to free hospital treatment.[22] However, at least one external observer was not convinced. Professor Ivan Sutherland, an ethnologist, wrote in 1935 that all white New Zealanders should be ashamed of the current status of Maori health and, significantly, that the terms of the Treaty had not been honoured.[23] Sutherland's concerns about Maori health coincided with those of the first Labour Government, which sought to promote quality for Maori in New Zealand society in all respects. Following the introduction of hospital and other health benefits under the 1938 Social Security Act, however, there was little further interest in the question of specific Maori entitlement for almost half a century.[24]

The Treaty and late twentieth-century health citizenship

By the 1980s a view was emerging that the Treaty of Waitangi had direct relevance to Maori health. The catalyst for a change in perceptions was the 1975 Treaty of Waitangi Act, which afforded the Treaty greater status in law. However, the health implications of the new legislation were not recognised until the following decade. In 1984 a special health hui (meeting) was seen as a milestone; the Director-General of Health and the Director of the Medical Research Council declared, "The recommendations of this hui, coupled with the Government's increased commitment to honouring the principles of the Treaty of Waitanga and desire to develop a bicultural state sector are beginning to have an impact on the delivery of culturally sensitive [health] services".[25] The following year the Board of Health's Standing Committee on Maori Health recommended that the Treaty of Waitangi be regarded as a foundation for good health.[26] A decade later, the Public Health Commission's Strategic Plan for Maori Health affirmed that, "Any discussion on Maori public health must begin with reference to the Treaty of Waitangi."[27]

The new centrality of the Treaty to social policy arose largely as a result of Maori activism and heightened cultural awareness. The arguments that Maori were entitled to special consideration under the Treaty of Waitangi appeared to be accepted by the government and its departments and were incorporated into policy statements. Professor Mason Durie, a psychiatrist, widely respected Maori leader, and prolific writer on Maori health issues from the mid-1980s, was particularly outspoken.[28] He attributed health disparities to previous failures to implement the Treaty, pointing out that the government had not achieved the central goal of the Treaty: to protect Maori against the effects of colonisation.[29] He claimed that separation from the land had itself been a prescription for illness, citing recent health statistics to demonstrate that Article 2 of the Treaty (protection) had not been honoured. Others also stressed the importance of the Treaty. [30] Durie stated definitively that "good health is clearly an objective of the Treaty".[31] Honouring Article 2 involved the principles of decision-making and self-determination in health, and the government moved towards devolving health care provision to local iwi or communities. This could also be seen as a cutting-back of centralist services, and hence a policy suited to a government intent on dismantling the welfare state.[32]

Article 3 of the Treaty, which guaranteed Maori the rights and privileges of British subjects, was also invoked as integral to health policy. Durie pointed out, however, that "rights" did not just apply to "service delivery", and he believed it was a mistake to assume "the application of one law for all individuals can best be achieved by adopting a single set of standards, regardless of culture, class or gender."[33] Equality of access to health services was not enough, as it had been under the first Labour Government; equality was now interpreted as a demand for equality of health status. Whilst Maori health had improved steadily over the years, in all indicators of health status, they still lagged behind non-Maori.[34] Dr Paparangi Reid, a Maori public health specialist who is currently Maori Dean (Tumuaki) at the University of Auckland's Faculty of Health and Medical Sciences, critiqued the government's Maori health policy, pointing out while that Maori had assumed "equity" meant equity of outcome, the government talked only of equity in accessing health services. In her opinion the Crown had the "most immoral relationship with us as tangata whenua".[35] Health citizenship now meant equal access to health status not health services, something which required targeted as opposed to universalist services, which again suited a government intent on the dismantling of the universalist welfare state.

"Closing the Gaps" and "Privileged Citizens"?

As noted earlier, there was nothing new in the concept of reducing disparities between Maori and non-Maori health. Even the terminology was borrowed from previous generations. In 1961, for instance, the Hunn Report noted that the amelioration of Maori health dated from the 1890s, "but old ways persist enough to impede all efforts of the Health Department and Maori Affairs Department to close the statistical gap".[36] When the Medical Research Council of New Zealand investigated the country's health statistics in 1969 it stated that,

> Theoretically there should not be any disparity in mortality between the two races because all legislation, health and hygienic regulations and social welfare and medical care, are available to Maori and European alike (…). The explanation lies in a handicap, which all developing nations have to overcome, in their attitude to health and hygiene and in overall living standards.[37]

Politicians were slow to react to these findings. Aussie Malcolm, the National Government's Health Minister, freely admitted in 1983 that "we have always failed to bridge the gap",[38] but his government was ousted in a snap election in July 1984. The incoming Labour Government held a Maori economic development conference, which was heralded in a joint report of the Department of Maori Affairs, the Board of Maori Affairs and the Maori Trust Office as a new challenge for Maoridom, marking the start of a decade of challenge to "close the social and economic gaps that have existed between Maori and Pakeha since the Treaty of Waitangi". As ever, housing, unemployment, health and educational underachievement were regarded as the "hard issues".[39] There was little real change, however, during the fourth Labour Government's tenure (1984–90), as it concentrated on economic reforms. Nor did the National Party tackle the issue during its term of office (1990–9), when it concentrated on restructuring the health system, replacing the Health Department with a new Ministry of Health, introducing population-based funding, and devolving more responsibility to regional authorities.

During its short-lived tenure (1993–95) the Public Health Commission acknowledged there was a "special need to improve the health of Maori", and the second of its six goals was "to improve Maori health status so that in future Maori will have the opportunity to enjoy at least the same level of health as non-Maori".[40] To this end the Commission published a strategic plan.[41] Yet the disbanding of the Public Health Commission did open the way for greater self-determination in Maori health as health services were increasingly devolved. In 1997 the National Government created four Maori Development Commissions to oversee and implement policy relating to education, the labour market, economic business development, and health. The Maori Health Commission was intended, in the words of Maori Affairs Minister Tau Henare, "to do whatever it takes to reduce the disparities in health which exist between Maori and non-Maori". The Maori Health Commission chair, Wayne McLean, hailed its first report, issued in June 1998, as a milestone because this was the first body "to improve Maori health, controlled by Maori for Maori". Other contributors to the report were equally optimistic. Henare saw this as a grassroots solution to combat inequality in health and promised there was the political will within Cabinet to "make Maori aspirations a reality". Annette Dixon, Deputy Director General of Health Strategic Planning and Policy, argued that the reforms provided new opportunities for Maori health gains, and reminded readers of the priority given in the 1994/5 policy guidelines to "close the unacceptable gap" and the commitment to be responsive to the tangata whenua in line with the principles of the Treaty of Waitangi.[42]

A year after Labour returned to office in 1999 it set up a "Closing the Gaps" cabinet committee to tackle the perennial problem areas of Maori education, employment and health. To some extent this was a continuation of past initiatives but now caused an unprecedented public furore. Approximately half the policy strands were geared specifically towards Maori and Pacific Islander needs, with the remainder targeted on what Labour would later term the "general disadvantaged". [43] While a *New Zealand Herald* columnist noted that in some areas the gaps had been "seamlessly expanded to cover the whole of the rich-poor divide",[44] there was considerable public and political opposition to "Closing the Gaps' on the grounds it was biased in favour of Maori and Pacific Islanders to the exclusion of other low-income groups. The spark which ignited public debate was a speech by Maori activist and Labour MP Tariana Turia, who declared that Maori tribes had suffered a "holocaust" as a result of colonization.[45] Prime Minister Helen Clark was concerned that Turia's views would erode support for the policy (and the government) from middle (white) New Zealand.[46] Treaty of Waitangi Negotiations Minister Margaret Wilson denied that the "Closing the Gaps" policy would create apartheid in the health system.[47] However, Race Relations Conciliator Dr Rajen Prasad warned that the process would be divisive. National's health spokesman Wyatt Creech applauded Prasad's comments on the divisiveness of Labour's policy as a "sobering and courageous warning in a 'politically correct' world".[48] By January 2001 "Closing the Gaps" had disappeared from the political lexicon and been replaced by the phrase "social equity", with equivalent changes in the committee name.[49] The rhetoric around "Closing the Gaps" had been considered too politically loaded.

While the phrase "Closing the Gaps" was dropped as potentially racially-divisive, the concept underlying the policy was still in place and became subject to a vehement attack on Labour policies by the Leader of the Opposition, Dr Don Brash, in 2004.[50] He spoke of the "dangerous drift towards racial separatism in New Zealand (…) We are one country with many peoples, not simply a society of Pakeha and Maori where the minority has a birthright to the upper hand." He asked whether New Zealand was to be "a modern democratic society, embodying the essential notion of one rule for all in a single nation state? Or is it the racially divided nation, with two sets of laws, and two standards of citizenship (…)?" Further, he argued, "In both education and healthcare, government funding is now influenced not just by need – as it should be – but also by the ethnicity of the recipient." The speech dramatically raised National's popularity in the polls, although this was short-lived since Brash was unpopular in other ways.

However, targeting health inequalities has not only been defined by some Pakeha as privileging Maori and ignoring other disadvantaged groups, but also by some Maori as discriminatory and stigmatizing. Some earlier attempts at targeting had also been resented as racist, either at the time or in hindsight. In the 1920s Maori children were routinely inoculated against typhoid with the blessing of Maori leaders, who acknowledged the impact of the disease on communities which lacked the resources to improve sanitary conditions. In 1913, for example, the prominent Maori MP Apirana Ngata spoke out in favour of compulsory inoculation, if the medical profession believed this would act as a preventative.[51] While in the 1920s Maori still appeared enthusiastic about immunization,[52] by the 1940s some Maori were refusing to allow their children to be vaccinated against typhoid on the grounds that white children were not required to be vaccinated.[53] In the 1930s, following research which demonstrated that Maori tuberculosis rates were at least ten times greater than those for non-Maori, Ngata called for the introduction of BCG vaccination for Maori. The request was refused at that time, but Maori were classed as a priority group when vaccination began in the late 1940s.[54] One long-term consequence was that the Health Department maintained universal BCG vaccination of school children in the 1960s and 1970s, long after Maori had been identified as a particular at-risk group and TB had ceased to be a problem in the general population; they did so because of the fear that targeting Maori would be seen as racist and stigmatizing Maori as harbourers of the disease.[55] There were similar concerns with the Hepatitis B vaccine in the 1980s. On the one hand there were moves to target Maori children as having much higher rates than non-Maori, on the other some Maori claimed Maori were being experimented upon for the new vaccine.[56] There were also problems with targeted programmes to treat sexually transmitted diseases, since these could be interpreted as stigmatizing Maori as immoral, given the personal responsibility attached to those diseases.[57]

The concept of "Closing the Gaps" has been a part of New Zealand health strategy for many years. By 2000, however, it had became politicised and polarised as never before. Maori activists of the late twentieth century demanded not equality of access to health care, but equality of health status; health citizenship meant equal health status. This required affirmative and targeted public health programmes. To some extent this fitted the late twentieth-century political agenda of moving away from universalist to targeted welfare. Mason Durie saw positive benefits for Maori, despite a decrease in welfare funding, as they were given responsibility for their own health management.[58] However, others saw it as divisive, and as positively discriminating in favour of Maori. They argued that Maori were now privileged citizens. Some Maori saw targeted programmes as discriminatory and stigmatizing, as with it went the attribution of blame and a heightened perception of being "diseased" by virtue of being Maori. Strategies for achieving "health citizenship" and the meanings attached to it changed over the years; yet for all that, health inequalities persisted.

Notes

1 Ryymin, Teemu. "Health Policies, Indigenous People and Citizenship on the Arctic and Pacific Rim." Unpublished Research Proposal, University of Bergen, Bergen 2008.

2 Pope, James. Health for the Maori: A Manual for Use in Native Schools. Government Printer, Wellington 1884. The author was the Organising Inspector for Maori Schools.

3 "Report of Dr Pomare, Health Officer to the Maoris." Appendices to the Journals of the House of Representatives (AJHR) H–31, Wellington 1904:56.

4 See, for example, Tennant, Margaret. Children's Health, The Nation's Wealth: A History of Children's Health Camps. Bridget Williams Books, Wellington 1994:130.

5 Turbott, H.B. "Health and Social Welfare." In Sutherland, I.L.G. (ed.). The Maori People Today: A General Survey. Issued under the auspices of the New Zealand Institute of International Affairs and the New Zealand Council for Educational Research. Whitcombe & Tombs and Oxford University Press, Auckland and London 1940:268.

6 Ferguson, Gael. Building the New Zealand Dream. Dunmore Press & Historical Branch Department of Internal Affairs, Palmerston North 1994:168, 204.

7 Harris, Aroha. "Maori and 'the Maori Affairs'." In Dalley, Bronwyn and Margaret Tennant (eds). Past Judgement: Social Policy in New Zealand History. Otago University Press, Otago 2004:192, 194.

8 Dunstall, Graeme. "The Social Pattern." In Rice, G.W. (ed.). The Oxford History of New Zealand. 2nd edn, Oxford University Press, Auckland 1992:478.

9 See Dow, Derek A. "'Pruned of its dangers': The Tohunga Suppression Act 1907." Health and History 3/1 (2001):41–64.

10 See Dow, D., "Driving Their Own Health Canoe: Maori and Health Research." In Dalley and Tennant 2004:91–107.

11 AJHR H–31, 1960:10–11.

12 Pomare, E.W.H. Maori Standards of Health: A Study of the 20 Year Period 1955–75: A Report prepared for the Medical Research Council of New Zealand. The Health Research Council, Wellington 1980.

13 Pomare, E.W.H. and G. M. de Boer. Hauora: Maori Standards of Health: A Study of the Years 1970–1984, Department of Health Special Report Series Number 78. Wellington 1988; Pomare, E.W.H., V. Keefe-Ormsby, C. Ormsby, N. Pearce, P. Reid, B. Robson and N. Watane-Haydon. Hauora: Maori Standards of Health III: A Study of theYears 1970–1991. Wellington 1995.

14 Butterworth, G.V. and H.R. Young. Maori Affairs. Iwi Transition Agency, GP Books, Wellington 1990:110.

15 For a discussion of the different interpretations of the Treaty, see also Orange, Claudia. The Treaty of Waitangi. Allen & Unwin, Port Nicholson Press, Wellington 1987.

16 Waldram, J.B., D.A. Herring and T.K. Young. Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives. University of Toronto Press, Toronto 1995:141, 146, 149, 228–31.

17 "Native Health Nurse to District Health Officer", 28 October 1913, in Native Medical Aid: Johnsonville. H1 160/47 17665, Archives New Zealand, Wellington.

18 Health Department. "Annual Report." AJHR H–31, 1913:2–3.

19 Tennant, Margaret. Paupers and Providers: Charitable Aid in New Zealand. Allen & Unwin and Historical Branch Department of Internal Affairs, Wellington 1989.

20 "Patients' Payments." The New Zealand Journal of Health and Hospitals 4/12 (December 1921):348–9. For a discussion of Civil List payments see Dow, Derek A. Maori Health & Government Policy 1840–1940. Victoria University Press and Historical Branch Department of Internal Affairs, Wellington 1999.

21 Dominion, 6 September 1929.

22 Director-General of Health to Secretary of Waitaki Hospital Board, 5 July 1933, in Hospital Boards: General: Maori Patients in Hospitals 1922–35. H1 54/24 B.19, Archives New Zealand, Wellington.

23 Sutherland, I. L.G. The Maori Situation. Tombs, Wellington 1935:116–19.

24 For a fuller account of the discussions about hospital funding see Dow 1995:161–72

25 Salmond, George and J.V. Hodge. "Foreword." In Pomare and de Boer 1988:8.

26 Durie, M.H. "The Treaty of Waitangi and Health Care." New Zealand Medical Journal 102 (1989):203; Durie, M.H. Whaiora: Maori Health Development. Oxford University Press, Auckland 1998:81.

27 Public Health Commission. He Matariki: "A Strategic Plan for Maori Public Health." He Kaupapa Whainga Roa Mo Te Hauora Tumatanui Maori. The Public Health Commission's Advice to the Minister of Health 1994–1995. Public Health Commission, Wellington 1995:13, 34.

28 Durie 1998:vii, 3.

29 Durie, M.H. "The Treaty of Waitangi – Perspectives on Social Policy." In Kawharu, I.H. (ed.). Waitangi: Maori & Pakeha Perspectives of the Treaty of Waitangi. Oxford University Press, Auckland 1989:285, 287.

30 See, for example, Smith, Linda Tuhiwai. Decolonizing Methodologies: Research and Indigenous Peoples. Zed Books and University of Otago Press, New York and Dunedin 1998.

31 Durie 1989:205.

32 Rice, Geoffrey. "A Revolution in Social Policy, 1981–1991." In Rice 1992:482–497.

33 Durie 1989:288.

34 Durie 1998:55, 83, 88.

35 Brown A. (ed.). Mana Wahine: Women Who Show the Way. Auckland, 1994:58–61.

36 Hunn, J. K. Report on the Department of Maori Affairs with Statistical Supplement (24 August 1960). Wellington 1961:20.

37 Medical Research Council of New Zealand. Adequacy of Medical Statistics in New Zealand, Report of an Ad Hoc Committee … presented to Council in November 1969. Wellington 1969:26.

38 `Nurses Must Play Their Part in Shaping the Future' (Address by Aussie Malcolm to the New Zealand Nurses' Association Conference), New Zealand Nursing Journal 77/5 (May 1984):13–16.

39 AJHR E–13, 1985:3.

40 Public Health Commission. Our Health, Our Future: Hauora Pakiri, Koiora Roa: The State of the Public Health in New Zealand. Wellington 1994:13, 186.

41 New Zealand: Public Health Commission. He Matariki: "A Strategic Plan for Maori Public Health." He Kaupapa Whainga Roa Mo Te Hauora Tumatanui Maori. The Public Health Commission's Advice to the Minister of Health 1994–1995. Wellington 1995.

42 New Zealand: Maori Health Commission. Tihei Mauri Ora! / The Maori Health Commission. Wellington 1998:4–6, 84.

43 Pacific Islanders had come to New Zealand increasingly from the 1960s in search of jobs; with the economic downturn in the 1970s they, like Maori, became the under-class, and were also affected by the cutting back of welfare from the 1980s. See Boyd, Mary. "New Zealand and the other Pacific Islands." In Sinclair, Keith (ed.). Oxford Illustrated History of New Zealand. Oxford University Press, Auckland 1996:295–322.

44 New Zealand Herald, 16 June 2000.

45 New Zealand Herald, 30 August 2000.

46 New Zealand Herald, 30 August 2000; New Zealand Herald, 31 August 2000; Sandra Lee also used the term to describe colonisation at a national hui on child abuse: New Zealand Herald, 6 November 2000.

47 Sunday Star-Times, 17 September 2000.

48 New Zealand Herald, 26 October 2000.

49 Sunday Star-Times 10 December 2000; For a summary of events see Sunday Star-Times, 17 September 2000, 10 December 2000; "Next Generation to See Gaps Close." New Zealand Herald, 23 September 2000; "Closing the Gaps Divisive, Says Race Conciliator." New Zealand Herald, 26 October 2000; "Turia Supports Clark in Dumping "gaps' Phrase." New Zealand Herald, 12 December 2000; "Closing the Gaps." New Zealand Herald, 20 December 2000; Small, V. "Tarnished GAPs Goes – Social Equity Is In." New Zealand Herald, 10 February 2001.

50 "Don Brash's Orewa Speech, 27 January 2004." Scoop Media Group: http://www.scoop.co.nz/stories/PA0401/S00220.htm.

51 New Zealand Parliamentary Debates, 26 September 1913, 165:262.

52 Health Department. "Annual Report." AJHR H–31, 1922:5.

53 Day, Alison. "Child Immunisation: Reactions and Responses to New Zealand Government Policy 1920–1990." PhD thesis, The University of Auckland 2008.

54 Dow 1995:195–196.

55 Dunsford, Deborah. "Seeking the Prize of Eradication: A Social History of Tuberculosis in New Zealand from World War Two to the 1970s." PhD thesis, The University of Auckland 2008.

56 Jowitt, Deborah. "Hepatitis B: A History of Social, Ethical and Medical Issues in New Zealand 1970–2005." PhD thesis in progress, The University of Auckland.

57 Kampf, Antje. Mapping Out the Venereal Wilderness: Public Health and STD in New Zealand 1920–1980. Lit Verlag Dr. W. Hopf, Berlin 2007.

58 Durie, Mason. "Indigenous Transformations in Contemporary Aotearoa: J.C. Beaglehole Lecture." New Zealand Historical Association Conference: Future of the Past: Sovereignty and Dominion, People in Places. Wellington, 23–25 November 2007.

Citizenship and health – a dubious connection: the case of Australian Aboriginals

Judith Raftery

What does it mean to be a citizen of Australia? This is a complex question, as it is in other post-colonial societies. When in 1968 I became the proud owner of my first passport, that passport declared me – born in Australia, and with parents and grandparents also born in Australia – to be not only an Australian citizen, but also a British subject. I was not impressed. My passport seemed to suggest that Australian citizenship – whatever that was – was somehow deficient, and did not give me a complete identity. I had to be a British subject as well.

Indigenous Australians were also, and had been from the beginnings of colonisation, British subjects. Implicit or explicit allusions to this status are part of the heroic statements made by colonial governors at ceremonies to mark the establishment of British rule. For example, in South Australia, the first Governor, John Hindmarsh, apprised the colonists of his "resolution to take every lawful means for extending the same protection to the Native population as to the rest of His Majesty's subjects" since the Natives were "as much under the safeguard of the law as the Colonists themselves, and equally entitled to the privileges of British subjects".[1] When the Commonwealth Nationality and Citizenship Act of 1948 established the category of Australian citizen, Aboriginals became Australian citizens as well, in precisely the same way that I did, by virtue of being born in Australia. However, that is where the similarity ends. From the beginning, indigenous Australians were not treated as though they shared the same rights – legal, political, social and economic – as the rest of the population. Whether as British subjects or as Australian citizens, their rights have proved more fragile and more readily undermined and set aside by attitudes and practices of community and government than any conventional notion of citizenship would suggest. The incontrovertible historical fact is that indigenous Australian citizens have been treated differently from other Australian citizens, and that this different treatment has been a matter of law and formal policy, not merely public attitude. As I have argued in *Not Part of the Public: non-indigenous policies and practices and the health of indigenous South Australians, 1836–1973,* it is as though they have been *not part of the public* whose well-being governments are supposed to protect and maintain.[2]

In South Australia, by as early as 1860, regulations and practices which denied Aboriginals the opportunity to share fully in the life of the colony had been sanctioned by the findings and recommendations of a government inquiry. This inquiry had been established "to take evidence and report on the present condition of the natives and to suggest means by which that condition can be ameliorated."[3] Though it claimed to be concerned with "the advancement of the race", in fact it was merely about survival and about producing a level of conformity consistent with the Aboriginals not being any kind of burden or unsettling influence. Thus the inquiry established and legitimised an agenda of inequality, of non-inclusion, of lack of autonomy and of radically differential claims on civic goods. This was not consonant with what it meant to be a British subject. Furthermore, what we now know about the determinants of health in populations, and especially about the complex links between social and economic inequalities and health, reveals such an agenda to be a long-term recipe for poor health.

It may be useful, especially for those not closely acquainted with the Australian situation, to draw attention to some current markers of the health and well-being of indigenous Australian citizens.

- There is a life expectancy gap of 17 years between indigenous and non-indigenous Australians.
- The indigenous population is much younger than the non-indigenous: 40 per cent of indigenous Australians are under 15 years old, compared with 20 per cent of non-indigenous Australians.
- Leading causes of indigenous deaths are cardiovascular disease, with mortality rates in the 25–54 years age group at least 10 and perhaps as much as 15 times higher than for non-indigenous; injuries, from assault, self-harm and motor vehicle accidents, with mortality rates three times as high as in the non-indigenous population; and cancer, with mortality rates up to twice as high.
- Indigenous infant mortality varies from twice as high to four times as high as in the non-indigenous population, depending on region. Factors contributing to these high rates of indigenous infant mortality include the young age of mothers, poor nutrition, lower birth weights and a much higher prevalence of smoking.
- Other major causes of morbidity and mortality are type-two diabetes, end stage renal disease, respiratory disease and communicable diseases. Both the prevalence of and the mortality associated with these conditions are very much higher among the indigenous population.
- Other factors connected to the poor health of the indigenous population include inadequate and overcrowded housing; lack of educational achievement; high levels of unemployment, linked to educational failure and limited opportunities; drug use and misuse; interpersonal violence, including domestic and child abuse; very high levels of imprisonment; persistent problems of under-resourcing and discontinuity of services and programs, especially in remote communities.
- The small size of the indigenous population – 517,000 out of a total of 21 million, i.e. 2.5 per cent – and its pattern of distribution throughout Australia also detracts from indigenous well-being. In the sparsely settled Northern

> Territory, indigenous people constitute 31.6 per cent of the population, and in its remote communities and small towns they are a large majority. However, elsewhere in Australia, where the majority of Aboriginal people live, they vary from a mere 0.6 per cent of the population (Victoria) to 3.8 per cent (Queensland). This distribution distorts public perceptions and government responses. It is the highly visible endemic health and social problems of indigenous people in the Northern Territory's main population centres and remote communities, some of which are scarcely economically sustainable, blighted by dysfunctional leadership and exploited by non-indigenous opportunists, that capture the government's and the public's attention. The complex health problems of the much greater number of Aboriginal people who live in the main cities and rural areas of the rest of Australia are, by comparison, disregarded.[4]

The sorry situation of the health of Aboriginal Australians, most starkly illustrated by the 17 year gap in life expectancy, is a result of Australia's colonial and post-colonial history. Over time, the kind of inequality and differential treatment legitimised by the 1860 South Australian inquiry was legally reinforced across the country by a panoply of separate laws and regulations governing the lives of the indigenous population. These laws continued to keep Aboriginals sicker and dying younger than the rest of the population. They also made a mockery of Aboriginals' formal legal status as British subjects and later, Australian citizens, and assumed that their needs were different from, less than, and more easily and cheaply met than those of other Australians.

Simultaneous with this practice of treating the indigenous population as *not part of the public*, was a constant and contradictory refrain about the desirability of the Aboriginals becoming part of the community, being equipped, via education and training, to share its rights and responsibilities – in short being granted what was often referred to as 'full citizenship rights'. From the early colonial period, this was part of the rhetoric of politicians, bureaucrats, missionaries, newspaper editors and those members of the general public who were bothered about 'the Aboriginal question'. By the 1930s, it had become part of the rhetoric of some Aboriginal activists as well. For example, in 1933 the policy of the National Missionary Council was that while 'full bloods' were to be protected on inviolable reserves, different provisions were needed to allow 'half-castes' "ultimate absorption into full citizenship".[5] One church body "urge[d] that full citizenship rights be accorded to those of full aboriginal or mixed blood competent to exercise them."[6] Aboriginal organisations welcomed the assimilationist *Aborigines Act Amendment Act, 1939* and saw the attainment of 'civilisation' through education and training as the prerequisite for 'citizenship' and the escape route from the "degrading conditions under which we are at present forced to live".[7] The Aborigines Protection Board, the government authority empowered to implement the 1939 Act in South Australia, believed that "a considerable proportion of the native population in the settled areas is capable of enjoying the privileges and accepting the responsibilities of citizenship". However, it was concerned that "the development of exemptee[s] towards citizenship is definitely hindered if not entirely precluded" by their "continued association (...) with aborigines".[8]

Such talk of citizenship and citizenship rights employed the term 'citizenship' in a loose and legally imprecise way, but the commonsense meaning was pretty clear: citizenship, for Aboriginal people, was a kind of reward. Aboriginals could be 'citizens' when they had earned the right to be, by demonstrating assimilation to 'mainstream' Australian values, especially those to do with economic responsibility. For the rest of us, including the most feckless, improvident and anti-social it was easier: we just had to be born, white, under the Australian sky.

The differential treatment of Aboriginals confirmed them in a state of marginalisation and extreme disadvantage and maintained the circular, endlessly reiterated but never realised argument that the only way out of this situation was education or training for 'citizenship'.[9] From the 1960s, however, in response to complex changes in the global political climate, the formal, legal contradictions inherent in this situation were resolved. This occurred through the gradual abolition of separate and restrictive laws and regulations governing Aboriginals and through the development of policies that were, in theory at least, about integration rather than about segregation, protection or assimilation. Thus, the hitherto submerged and ignored status of Aboriginals as citizens re-emerged. They were citizens along with all other Australians. However, the gross disadvantage – apparent across all socio-economic indicators, including much lower life expectancy and radically undermined health – remained. And it was clear that contrary to the expectations of earlier policymakers and doom-sayers, the Aboriginals themselves were going to remain too. Aboriginality was not a thing of the past. Not only had the indigenous population not died out, but despite varying levels of assimilation to the dominant western culture it was persisting as a distinctive population. It is this fact that has brought the issue of indigenous citizenship to a new level of debate, and revealed the extent to which citizenship is a contested concept, one that entails struggle over the meaning of 'membership' within Australian society.[10]

Since the 1970s, increasingly politicised forms of Aboriginality have emerged to engage in this struggle and to challenge classic liberal notions of citizenship and of nationhood. Questions about what it means to 'be Aboriginal' in contemporary Australia are highly contentious, and they make many Australians nervous. Such nervousness is apparent in this 2007 statement of the then Prime Minister John Howard:

> We are not a federation of tribes. We are one great tribe; one Australia (...) while ever our indigenous citizens are left out or marginalised or feel their identity is challenged, we are all diminished.[11]

This statement, with its surface appeal to democracy and fairness differs little from the classic assimilation formulae of the 1950s and 1960s, which envisaged only one way of being Australian:

> All Aborigines and part-Aborigines are expected eventually to attain the same manner of living as other Australians and to live as members of a single Australian community, enjoying the same rights and privileges, accepting the same responsibilities, observing

> the same customs and influenced by the same beliefs, hopes and loyalties as other Australians.[12]

In fact, there is more than one way of being Australian. The dilemma which this poses for understandings of citizenship is examined in a very useful book edited by N. Peterson and W. Sanders: *Citizenship and Indigenous Australians: changing conceptions and possibilities***.** Following T.H. Marshall's analysis, Peterson and Sanders argue that the modern liberal democratic notion of citizenship grew out of class struggle and consists of three components: civil rights (such as property, contract, speech, assembly and religion), political rights (franchise) and social rights (provided by the state to guarantee living standards). According to this understanding, 'citizenship' defines the membership of a common society and the rights and duties of that society's members. It presupposes a society where there is strong emphasis on individual rights, as well as loyalty to an identity that subordinates other identities. Over time, we have seen this notion challenged in many societies on class and gender lines and more recently by claims from indigenous peoples, seeking recognition of their distinctive rights as 'first nations'. In Australia, this challenge has been manifest not just in demands for self-determination, and in the persistence of distinctive indigenous identity and 'indigenous social orders', but in legislation, especially that relating to indigenous land tenure.[13] All this has thrown into sharp relief the difficult question of how far recognition of and support for differences can be accommodated within a liberal democratic framework. In other words, how heterogeneous can the nation be while still being one nation?

In Australia, we are grappling with this question. In recent times some worrying answers have been suggested. A short-lived political party – tellingly called One Nation – exerted a good deal of influence between 1996 and 2004 by presenting recognition of indigenous distinctiveness, or any special response to indigenous need, as unfair, undemocratic, divisive, indeed *un-Australian*. With frightening ease, the One Nation party won votes, bred fear and resentment among many disaffected Australian 'battlers' who were vulnerable to the politics of envy, and encouraged ugly racist attitudes to surface. It encouraged the view that Aboriginals were privileged rather than disadvantaged and marginalised, and that support for distinctiveness was not to be tolerated within the Australian democracy. While the views of One Nation and its supporters were, to the majority of Australians, shocking in their crudeness and hostility, they should not have come as a complete surprise. They were an extreme and ill-informed variant of what has after all been a persistent element in our history, that is, on the one hand, an "attitude of ambivalence and inconsistency towards formally incorporating Aboriginal people into a common Australian society", and, on the other hand, "a failure by the settler society to come to grips with the persistence of indigenous traditions and social orders".[14]

A more worrying example of this ambivalence and failure – more worrying because much more mainstream and much more influential – has been the attitude of the conservative federal governments led by John Howard from 1996 to 2007. Howard, while claiming to govern for all Australians and to be committed to indigenous well-being, consistently opposed what he described as merely symbolic gestures – such as a more generous approach to native title to land, the idea of a treaty, a genuine embrace of self-determination, and a government apology for past wrongs, in particular child removal. These 'merely symbolic gestures' were the very things that many Aboriginal people have long sought and that they have valued highly as signs of the willingness of non-indigenous people to take them seriously. But Howard was afraid of such things, since they implicated the nation's history and the continuing tragic legacy of that history as the central issue at stake. Howard would have none of this. He did not even want the history to be told truly and derided what has been called 'the black arm band view of history', which, by critiquing aspects of colonial achievement and acknowledging past wrongs, points the way to a more just and compassionate future. Instead of 'symbolic gestures' Howard's government argued for 'practical reconciliation', that is projects relating to health, education, housing, employment and the like to alleviate indigenous disadvantage.[15]

One problem with this construction of the issues is that it does not fully acknowledge either their aetiology or their real character. In addition, remedial action springing from this construction has frequently been top–down, paternalistic, 'one size fits all', and has not modelled the kind of partnership between government and the indigenous sector that the indigenous sector wants – the kind of partnership implied by a commitment to self-determination and reconciliation. At their worst, these approaches have been coercive and dismissive of indigenous initiative. The most recent example of this is the Howard government's 2007 initiative against child abuse in the Northern Territory – an heroic, all-guns blazing, 'we've got the answers' campaign, that so far has yielded few positive results. Some critics detect, behind its laudable concern about a dreadful social problem, a newly invigorated assimilation agenda that, as in the past, undermines notions of autonomy and citizenship.[16]

It seems that the only thing that allows many Australians to overcome their discomfort with incorporating Aboriginal people into a common Australian society is the erasure of social difference and a clearly demonstrated cultural conformity. That is, for Aboriginals to be acceptable as Australian citizens they have to be like the rest of us, showing themselves to be 'as good as a white man'. Neither the persistence of indigenous distinctiveness nor any understanding of Aboriginal people as members of their own societies has been recognised as part of colonial and post-colonial citizenship.[17] And yet that distinctiveness persists, and Aboriginal people insist that it should continue to persist.

How can we move beyond the impasse this creates? Is it too much to expect that recognition of cultural distinctiveness can be accommodated within a liberal democratic framework? As several analysts have pointed out, Australia's federal system accommodates various levels and forms of government, demonstrating that shared sovereignty does not fracture the nation.[18] However, as a nation we have yet to accommodate the view that our sovereignty might be further divisible. So we are left with this core problem:

> How is it possible for people from different historical and cultural backgrounds to be members of a common society on equal terms?
>
> It is clear that (...) even with equal rights, the great majority of indigenous people in Australia are not members on equal terms, by any of the standard social indicators relating to health, education and general welfare. Governments of all political persuasions see it as fair and equitable to allocate increased resources to eliminate this disparity (...). However, when it comes to reshaping citizenship-related ideas and institutions in order to accommodate the persistence of indigenous social orders, and to do this by recognising additional indigenous rights, the achievement of any easy consensus evaporates.[19]

To achieve this consensus requires a degree of moral courage and political imagination that we have not yet demonstrated. As I have argued in this paper, and elsewhere, from the 1970s indigenous claims to the right to choose to be members of the Australian community as well as to maintain a distinctive indigeneity have become increasingly confident and politicised. They have aroused concerns and fears among other Australians about special dealing and social division, and have fuelled calls for a single, unified nation. Government reactions to the failure of assimilation, to the emergence of an assertive indigenous sector and to the tragic harvest of a history of exclusion and inequality have generally been to flounder and fall back on older patterns of segregation and protection. They have lacked the imagination to see that maintenance of identity, cultural renovation and choice, per se, might be productive of health and even be a means to social and economic integration, that is, to genuine citizenship.[20] Accommodating such a view of citizenship – "cultural citizenship for encapsulated minorities" that accords "real moral weight (...) to world views and practices that are at times inconsistent with predominant sentiments" – may be the only way in which we can break the nexus between 'being Aboriginal' and being marginalised. And it may be the only way in which citizenship can be positively linked to health.[21]

Notes

1 Governor John Hindmarsh's Proclamation, Glenelg, South Australia, 28 December 1836, South Australian Gazette and Colonial Register, 3 June 1837:1. State Library of South Australia.

2 Raftery, Judith. Not Part of the Public: non-indigenous policies and practices and the health of indigenous South Australians, 1836–1973. Wakefield Press, Adelaide 2006.

3 South Australian Parliamentary Papers, 1860, vol. 3, no. 165. State Library of South Australia. For a discussion on evidence before the inquiry and its conclusions and recommendations, see Raftery 2006:83–90.

4 A ready and respected source of indigenous health and illness data, which is regularly updated and accompanied by some explanation, is <http://www.healthinfonet.ecu.edu.au>. See also data collections of the Australian Census and the Australian Bureau of Statistics.

5 For more detail and context see Raftery 2006:167.

6 Resolution of Federal Conference of Churches of Christ in Australia, 1936. Churches of Christ in Australia Seventeenth Federal Conference, 1936, Programme: 17. Churches of Christ Archives, South Australia.

7 Raftery 2006:177.

8 Aborigines Protection Board Reports, 1946, 1948. State Library of South Australia. The term "exemptee" refers to the Board's power to exempt Aboriginal people deemed to be of suitable "character and standard of intelligence and development" from their legal status as Aboriginals. Exemptees were barred from consorting with (non-exempt) Aboriginals. For more detail and context, see Raftery 2006:181–183, 187–190.

9 Raftery 2006, especially chapter 6.

10 For an insightful analysis of this contestation in the area of land and resource use, see Trigger, David. "Citizenship and indigenous responses to mining in the Gulf country". In Peterson, Nicolas and Will Sanders (eds). Citizenship and Indigenous Australians: changing conceptions and possibilities. Cambridge University Press, Cambridge 1998:154–166.

11 John Howard, 11 October 2007, "A 'new reconciliation'? Speech to the Sydney Institute", reported in The Australian, 12 October 2007.

12 Statement adopted by the 1961 Commonwealth/States Native Welfare Conference. For further discussion, see Raftery 2006:183–184, and also Broome, Richard. Aboriginal Australia: black response to white dominance, 1788–1994. 2nd edn, Allen & Unwin, Sydney 1994:171–173.

13 Peterson, Nicolas and Will Sanders. "Introduction." In Peterson and Sanders 1998:1–3.

14 Peterson and Sanders 1998:3.

15 Kevin Rudd succeeded Howard as Prime Minister when the Australian Labor Party was elected to office on 24 November 2007. On the first sitting day of the new parliament, 13 February 2008, Rudd distinguished his stance from Howard's by offering a formal apology to the 'Stolen Generations' (victims of child removal practices) on behalf of the government and people of Australia. This action was acclaimed by indigenous and other Australians as a significant act of justice and a powerful contribution to national reconciliation. The ceremony was telecast live to 'Apology Day' celebrations across the nation.

16 For early analyses of the Northern Territory intervention see Altman, Jon and Melinda Hinkson (eds). Coercive Reconciliation: stabilise, normalise, exit Aboriginal Australia. Arena Publications, Melbourne 2007, and Scrimgeour, David. "Setting the agenda: neo-liberal think tanks and the government intervention in the Northern Territory". Paper delivered to Public Health Association of Australia, Annual Conference, September 2007. For an analysis of the first year of the intervention, see Toohey, Paul. "First Drinks: the impact of the Northern Territory Intervention". Quarterly Essay, 30 (2008).

17 Peterson and Sanders 1998:6–7.

18 Brennan, Frank. "Aboriginal Self-Government". Pacific Research 7 (August 1994):7–10; Sanders, Will. Towards an Indigenous Order of Australian Government. CAEPR Discussion Paper (230), Canberra 2002:11.

19 Peterson and Sanders 1998:27.

20 Raftery 2006:277.

21 Trigger, in Peterson and Sanders 1998:164.

Health citizenship and/as Sámi citizenship: Norway 1985–2007

Astri Andresen

In the late 1980s the Sámi in Norway gained formal status as an indigenous population. The Norwegian parliament adopted legal measures to protect and develop Sámi language, culture and way of life, and governmental bodies adjusted policies in a number of areas. The process is still in the making, but today Sámi citizenship in Norway clearly differs from the 'ordinary' Norwegian citizenship in that particular Sámi rights have been legally defined. This article discusses what this process of particularization has meant to notions of health citizenship. Health citizenship can be discussed in a number of ways (cf. Ryymin, this volume p. 00); my discussion will revolve around ideals, rights and obligations. What kind of rights is embedded in Sámi health citizenship; what are the duties of Sámi citizens regarding health; and who, in a health perspective, is the ideal Sámi citizen of Norway?

From assimilation via integration to particularization

Debates over and practical policies towards the Sámi in the late 20th and early 21st century, indeed Sámi citizenship in Norway, can not be understood without a knowledge about the past, for this is a field where history continues to influence current mentalities and policies. With one very significant exception, the Sámi population held the same formal rights as other citizens between 1814, the year the Norwegian constitution was adopted, and the 1980s.[1] Between c. 1850 until after the Second World War, however, the official Norwegian policy towards the Sámi was assimilation, which created a huge gap between formal citizenship and citizenship in practice.[2] Because of the assimilation policy access to the civil, social and political rights embedded in national citizenship was not the same for Sámi and non-Sámi citizens.[3] In the late 1940s and 1950s it was recognized that the low status of Sámi language and culture, indeed, the long-standing definition of the Sámi as a second-class people, hampered the Sámi in their functions as citizens.[4] Where health was concerned, social status and place of residence also had an effect. The largest portion of the Sámi lived in Finnmark and Troms, at the time among the poorest counties in Norway and also furthest away from the central government in Oslo. Moreover, many lived in inland Finnmark where long distances and a rather rudimentary communication system restricted contact with the rest of the country. A particularly noticeable indicator of the combined ethnic and geographically peripheral situation was that infant mortality rates in Finnmark after the Second World War were the highest in the country; within the county, certain Sámi districts topped the list with rates at a late nineteenth-century level, three times as high as the mean infant mortality rate.[5]

In the 1950s, inequalities were attacked along two different paths, universal welfare and recognition of Sámi language; the first was much more determinedly trodden than the second: universal welfare policies formed the backbone of post-war Norwegian society.[6] Georges Midré has argued that Norwegian welfare policies in this period demanded that everybody embraced a Norwegian lifestyle,[7] but this is a too one-sided a view. Sámi language was, for example, recognized as an official educational language in Sámi districts in 1959, and some limited acts of positive discrimination regarding access to higher education were passed.[8] There is no doubt, however, that universalism to some extent counteracted the recognition of difference, and it was not until the 1980s that a decisive break with assimilation policies took place, inspired by national movements to protect the environment and by international developments concerning indigenous peoples, but with Sámi agents playing a major part. Towards the end of the 1980s, a series of legal acts were passed that aimed at leveling inequalities between the Sámi and others not, as earlier, by universalization but by particularization. In this process four legal acts were particularly important. First, the 1987 Sámi Act entitled the population in what was defined as "the Sámi language area" to communicate in Sámi in all dealings with official authorities, including the health and social sector. Second, in 1988 the protection of Sámi culture and the Sámi way of life was enshrined in the constitution, thereby giving the Sámi population a special position among Norway's ethnic minorities. Third, pursuant to International Labour Organisation (ILO) Convention 169 (1989) concerning indigenous and tribal peoples in independent countries, Norway's Sámi were recognized as an indigenous population in 1990.[9] Article 25 of the Convention concerns health and social services. It states that governments are responsible for providing health services of "the highest attainable standard" in physical and mental health; that these shall be developed in cooperation with the peoples concerned; that consideration shall be given to economic, geographic, social and cultural conditions, and to traditional preventive and healing practices.[10] Fourth, an elected Sámi Parliament was established in 1989; for the first time the Sámi acquired an officially recognized institution that could speak to authorities on behalf of the Sámi. The Sámi parliament could negotiate with Norwegian authorities, for example, on issues pertaining to health care.

To understand the development of Sámi rights and obligations in issues pertaining to health and health care, it is important to realize that these have been formulated within this broad discourse on minority rights – be it culture, language or, most importantly, land and water resources – and that these broad issues have not yet been completely resolved. Thus, the debate over Sámi health citizenship may have derived its vocabulary from the particular minority rights' discourse more than from the parallel national discourses on health, health policies and individual responsibilities for health – but let us look more closely at what has actually been at stake in the period.

Health and access to health services

Equal access for all citizens to high quality health services has been an aim for all Norwegian governments since 1945, in fact, since the early 20th century.[11] Following the recognition of indigenous citizenship, Norwegian authorities, in collaboration with Sámi spokesmen and the Sámi Medical Association in particular, have emphasized that particular measures are needed to give the Sámi population equal access: 1) Sámi-speaking health professionals or, second best, professional translators in the health and social sector; and 2) health professionals attentive to and informed about Sámi culture and history.

The first measure is grounded in the 1987 Sámi Act, which gives the Sámi a right to use their own language, but language theory also stresses the importance of linguistic competence: even if most Sámi-speaking Sámi – of which the Sámi parliament estimates there are ca. 23,000 out of an estimated total Sámi population of 40,000 – are bilingual, many find that the mother tongue is better suited to communicate physical and mental problems, personal experiences and feelings.[12] One Sámi physician puts it this way: “To offer a service where the individual feels comfortable, both culturally and linguistically, is to grant greater and fairer accessibility to those who need it.”[13] That health personnel need to be familiar also with Sámi culture and history stems from the theory that culture and historical experiences influence sickness and health as well as the communication and interpretation of sickness and health. Thus, to diagnose and treat a Sámi patient correctly, a physician needs cultural and historical knowledge. This view finds support not only in research on multi-cultural societies elsewhere but also in empirical findings from Northern Norway. A recent doctoral dissertation has, for example, concluded that the treatment of mental disorders is more successful when the professional and the patient belong to the same ethnic group.[14] This does not mean, however, that simply belonging to the same ethnic group is sufficient; Sámi medical practitioners also “require an analytical approach to their own ethnicity and culture”.[15]

The number of Sámi-speaking health professionals and professionals with knowledge of Sámi culture and awareness of the medical meaning of culture has increased considerably over the last twenty years. Educational quotas and economic incentives that were established in the 1960s have been vastly extended. Aspects of ethnic medicine and trans-cultural knowledge have been integrated into the curriculum at the medical school in Tromsø and in the education of other health professions; specific courses are offered to those coming from other places to work in Sámi districts; and specialist, competence- and research centres have been established.

The demand for Sámi-speaking physicians in Sámi districts has not been met though, and it must be concluded that creating equality among ethnic groups is easier said than done – especially when taking into account such ‘modern’ measures as individual experiences and patient satisfaction.[16] In the 2002–2005 government plan of action for health and social services for the Sámi population, good communication was defined as meaning that the Sámi population should have an equally good encounter as others with the health and social services.[17] A recent survey of patient satisfaction with health services at community level in the Sámi language area discovered that the Sámi were less satisfied than their Norwegian neighbors; in particular Sámi living in the South Sámi area were dissatisfied.[18] One patient put it this way: "Norwegian physicians neither understand our heart-language nor our culture".[19] Even so, Sámi patients did not want to use interpreters.[20] It has been suggested that one reason for this negative attitude is that interpreter services many places have been somewhat disorganized, with relatives or other non-professionals functioning as interpreters. Another explanation put forward, however, is that using interpreters was considered degrading because it should not have been necessary: Health services in Sámi districts should have been staffed by Sámi health professionals.[21] This explanation indicates that the language issue is not only about difficulties in communication but about symbols. To be met by Sámi-speaking health professionals is emblematic of Sámi integration into the state, of being of equal value as other citizens. This attitude underscores the indelibility of the historical legacy: the long-standing assimilation policy looms over present Sámi–Norwegian relations and influences the way the Sámi interpret their encounter with Norwegian health services. If it does not function well, the inadequacy is seen in light of ethnic discrimination and as a confirmation that little has changed regarding Sámi status. In addition, there is a rights-perspective involved: history can be used, and is used, to shame or try to shame Norwegian politicians into making the reforms the Sámi actually want.

In view of the higher percentage of dissatisfactory encounters recently among Sámi patients than non-Sámi, the Sámi Parliament has argued that the Norwegian government lacks a strategy to look after the rights and needs of Sámi patients.[22] It emphasized that according to international law health services to the Sámi is an indigenous issue pertaining to the protection of language and culture. Thus, for the Sámi Parliament it is a question of rights more than of health. For similar reasons one of the largest Sámi interest organizations (*Norske Samers Riksforbund*) has suggested that a separate health service for the Sámi population only should be established.[23] Could this emphasis upon linguistic and cultural rights have come about because Sámi health is now basically the same as Norwegian health?

Health and health citizenship

When Sámi rights to health and health care on a par with other citizens were invoked in the 1940s and 1950s, there existed huge differences in health between various regions and ethnic groups. In particular infant mortality, normally held to be a fairly reliable indicator of health status, was high in Finnmark and even higher in some Sámi communities. When Sámi health and health care received new interest in the 1980s, the whole county of Finnmark showed somewhat higher mortality rates than the rest of the country, and it was assumed that Sámi health status was worse than that of their Norwegian neighbors.[24] What can be said about the more recent situation and, consequently, what the particularistic approach has meant for Sámi health status? Measuring health and what influences it is not a straightforward task, but where the Sámi are concerned, the additional problem is that there exist no simple criteria by which to categorize the population that is acceptable to everybody.[25] Research programs that have been launched to measure health inequality seem, however, more often than not to have been based upon a combination of self-defined ethnicity and the language spoken in the family over three generations. SAMINOR, a survey of Sámi health and living conditions carried out by the Centre for Sámi Health Research at the University of Tromsø, counted as Sámi individuals who considered themselves Sámi or who had at least one grandparent or parent who spoke Sámi language; thus, it may have included individuals who have only very weak ties, if any, to Sámi culture.[26] The reason for this broad definition is a suspicion that many Sámi avoid reporting their Sami background; thus, "classification based on self-reported ethnicity is shown to be misleadingly low".[27] What, then, about the results? A provisional SAMINOR conclusion was that there were no ethnic differences in self-reported health in disfavor of the Sámi, a conclusion that might be doubted if one questions the survey's definition of Sámi.[28] A similar definition of Sámi ethnicity was used in a doctoral dissertation that concluded that mental health among Sámi youth was as good as among non-Sámi, and in a another dissertation that claimed that use of illegal drugs was no higher in this group than among majority youth.[29] According to data gathered by Statistics Norway, life expectancy is slightly lower in the Sámi area than in others. It uses geographical criteria to identify the Sámi, but this approach is as imprecise as the "generational linguistic approach" since most communities in this region have an ethnically mixed population.[30]

Despite the fact that there is no straightforward way of defining the Sámi, the various investigations addressing the issue indicate that there are no or only very small differences in health status among the Sámi and others. Even so, we cannot attribute this result to the particularization of health policies; it might be a product of the regionalization of health care generally, the level of general welfare and/or the generally increased integration of the Sámi in Norwegian society. Worth noting in this respect are the Swedish experiences (even though the Swedish approach to measuring health has differed from the Norwegian one). In Sweden, no particularization of policies regarding health care has taken place, yet still it has been concluded that "the health situation of the Sámi show only minor differences in comparison with the general population".[31] For example, Swedish Sámi incur more accidents connected to reindeer herding, but that is after all a particularly Sámi livelihood. Finnish research indicates that the favorable health situation among Norwegian and Swedish Sámi is also present in neighboring Finland: "in the core Sámi area where 75% (…) are Sámi, life expectancy of men is five years longer than in the adjacent Finnish area".[32] Thus, it might be reasonable to question the effect of particularization upon health without, of course, disputing the reported dissatisfactory encounters between Sámi patients and the health care system. The fact remains: health differences between various groups nowadays seem to be small or even non-existant.

Furthermore, these results demonstrate that the Sámi hold a privileged position among indigenous populations of the world, who often display both higher infant mortality and lower life expectancy than the majority populations of the countries in question; some such populations are also reported to have more problems with substance abuse and mental disorders.[33] And with that in mind, let us turn to individual responsibilities for conducting one's life in a healthy way – or in other words the obligations of health citizenship.

Preserving culture, making identity, promoting health

Sámi individual responsibilities for health must be seen in light of the demands upon other citizens, and I would first like to suggest that there has been some reluctance in Norway –perhaps more reluctance than in many other Western states – to make individual behavior *more* important than social rights.[34] Here the conspicuous emphasis is on the *shared* responsibility between the individual and the society. That said, attempts to influence social behavior in numerous ways have occurred throughout the 20th century, and increasingly so during the last 20 years regarding eating, smoking and exercising. Where are the Sámi to be placed within this development? The picture that emerges is complex and ambiguous. On the one hand, information about what is healthy and what is not reaches the Sámi as well as others, in Norwegian and/or Sámi language; in that respect, the Sámi participate in the general Norwegian health discourse. Furthermore, epidemiological surveys since the 1970s have investigated risk factors for CHD, cancer, mental illness and so on among the Sámi, presumably because the Sámi themselves will benefit from this information and, if needed, will change their lifestyle, for example their dietary habits. On the other hand, however, in public policy documents concerning Sámi health there is a near-absence of references to individual responsibilities for making healthy choices. Instead, the discourse is embedded first in Sámi rights and duties of the state towards the Sámi and second in assumptions about the interrelatedness of Sámi health and cultural identity. The recurring topic in current medico-political discourse is that Sámi health is threatened not by some specific disease or a particularly unhealthy Sámi lifestyle, but by a weakened Sámi identity. It is the identity-angle that makes the discourse on Sámi health stand out from the general health discourse in Norway.

In the following I will try to uncover some of the assumptions about identity and health, but let me first emphasize that it is by no means particular to Sámi health discourse to postulate a connection between the two. The effects of acculturation upon mental and psycho–somatic conditions were acknowledged long ago, especially in American psychology.[35]

So, how is Sámi health perceived as threatened? Agreement exists that the impact of the past upon today's health is huge and, in particular, that the norwegianization process has had its price. In 1995, it was emphasized that Sámi health services were not only for those who identified themselves as Sámi, but also for individuals and communities who had changed from a dominant Sámi identification to a dominant Norwegian identification.[36] It was assumed that this group might be particularly vulnerable to stress and mental disorders – an assumption in accordance with theories of acculturative stress.[37] The norwegianized was not the only group in danger, though. In the 2002–2005 plan of action for Sámi health, two more vulnerable groups were identified. One was the large portion of the Sámi population living outside typically Sámi communities, in particular in coastal communities in Finnmark and Troms, who changed "back and forth between the language and norms of Norwegian working life and other public arenas and Sami life at home, with the associated conflicts of loyalty". This cultural shift was defined as a "major source of stress". But finally, "problems associated with restructuring and uncertainty in the reindeer husbandry and fishing industries have also been an additional cause of anxiety and mental illness in the Sámi population".[38] Being forced to leave reindeer herding and fisheries might result in a weakening of cultural ties and identity.

Thus, Norwegians who had Sámi forebears, Sámi living in culturally mixed societies, and Sámi who maintained what has often been seen as typical Sámi livelihoods like reindeer herding and coastal fisheries were all particularly vulnerable to stress, psychosomatic conditions and mental illness. This problematization encompasses, in fact, the larger part of the Sámi population, not to say all – based upon assumptions about identity, the relationship between identity and "traditional culture" and health. Thus, what is particular is the tendency to see the Sámi in themselves as threatened – along with the tendency in policy documents to see identity as closely intertwined with what is perceived as a 'traditional' Sámi culture. One could say that the first is a result of the second.

A telling indication of this 'traditionalization' is the changing status of folk medicine. In the 1980s, healing and folk medicine was hardly a topic, perhaps unsurprising given the fact that the Sámi medical profession was in the lead of Sámi health policy making. The 1995 plan for health and social services to the Sámi, however, was based upon the assumption that 'traditional Sámi knowledge' had to be incorporated in health policies.[39] To the Sámi, such knowledge was important to strengthen "a sense of belonging and Sámi individuality and character" and, furthermore, to give the Sámi the 'feeling' that other cultures had something 'to learn from them'. For those in health and social services, the knowledge would serve as a basis for working among the Sámi and also have preventive functions.[40] In 1995 'traditional knowledge' was spoken about as something that was hidden and needed to be brought into clear daylight through research, but it was assumed that traditional medicine played a more important role in Sámi society due to the group's late integration into the health care system. In particular it was assumed that Sámi societies depended upon personal networks in matters concerning health.[41] The 2002–2005 health plan stated that the health and social sector had to see such personal networks as resources, so that they could take on a complementary role in the treatment of Sámi patients – primarily to avoid sick people chosing their personal networks instead of professional health care.[42] Thus, the acceptance of traditional folk medicine seems to have been considered a necessity to confirm a specific Sámi identity based upon tradition and, furthermore, to make sure that sick people got in contact with professional health care. In 2002, this was not at all a big concession to the Sámi: alternative treatment had long since found its way into hospitals; in 2001 every fourth hospital in Norway offered some kind of alternative treatment.[43]

The Government action plan 2002–2005 for Sámi health also addressed identity-making in its chapters on children and adolescents. Health information for Sámi and Norwegian children and parents should include "information about cultural and cross-cultural issues relevant to the local Sámi district. Having an awareness of these issues would make the situation easier for children of bicultural families and would make a positive contribution towards strengthening Sámi children's sense of identity". Furthermore, Sámi children and adolescents should be more involved in the formulation and planning of measures in order to "minimize Norwegianization and alienation from their own culture".[44] The plan also specifically mentioned the theory that "a secure identity brings a gratifying life and good health". Obviously, it meant identity to be read as 'ethnic identity', for it referred to a current project aimed at preventing health problems by "passing on traditional Sami activities from generation to generation". [45]

In some of the scientific literature on identity and mental health, the findings are more nuanced than these statements in political documents. For example, in her doctoral dissertation *North-Norwegian adolescents in a multi-ethnic context* (1999), the Sámi child psychiatrist Siv Kvernmo concluded that a strong ethnic identity protected against mental disorders but only provided that the individual did not experience being in a minority situation.[46] Her findings indicated that the best protection was identification with both minority and the majority culture. Such a conclusion works in theory but not necessarily in real practice, which is probably why such a strategy is never promoted in political documents. In a more recent article Kvernmo has, however, emphasized that ethnicity is insufficient as an explanatory variable; ethnicity has to be contextualized.[47] She has also continuously pointed to the incompleteness of what is known, or accepted as knowledge: "the significance of cultural maintenance as a protective factor for emotional health in minority adolescents is still not settled".[48]

Even so, in policy documents dealing with the maintenance of Sámi traditional knowledge and culture Sámi lifestyle and, for the 'norwegianized', recognition of Sámi heritage are presented as a sort of a joint effort between authorities, medical services and the Sámi. To put it bluntly: authorities and health services shall make it possible to maintain 'traditional culture' – the Sámi shall maintain a Sámi identity based upon this culture. The most explicit demand upon the Sámi, however, is related to health education and where the Sámi should live and work. Public policy documents emphasize that Sámi youth has to be recruited to the health services and motivated to work in Sámi settlement areas; otherwise the various measures would obviously be ineffective.[49] But, in fact, this demand is also based upon essentialist assumptions about Sámi identity. It is implied that Sámi youth is more strongly connected to the place they were born than non-Sámi: “A concentration upon local recruitment is in line with the wish of most Sámi youth to live as Sámi also after having finished their education. That means they want to live in Sámi districts and use their education there”.[50] It is also implied that postings in rural Sámi districts is a way to preserve Sámi identity for professionally educated persons.

Policy documents leave a strong impression that Sámi identity is at the core of health promotion and, furthermore, that this identity is seen as intertwined with ‘traditional’ culture. This is not totally surprising given the political context of health and health promotion in the period under investigation. Lina Gaski has argued that because the Sámi find themselves in a position of building nationhood and demarcating a political community, essentialising culture is, if not the only option, the option closest at hand – and it is the option, or the strategy, employed by Sámi politicians. The result is that “despite insistence from the politicians (…) that the Sámi population is heterogeneous and the Sami society modern, they continue to focus on a ‘traditional’ and ‘common’ culture upon which identity should be built.”[51] It is my opinion that health issues are conceived as one more brick in the construction of Sámi nationhood; interestingly the rhetoric used by Sámi politicians is also accepted and employed by Norwegian health authorities.

The identity–tradition–culture-angle might make for conflicting signals in health promotion since Sámi culture, like any culture, doubtless includes elements that are not particularly healthy but simply traditional. In some cases, such elements have been interpreted in a positive way. Thus obesity in Norwegian children is problematized, but obesity in Sámi children, or rather in Sámi girls, has been represented as a positive thing, as a sign that the traditional ideal that women should be physically ample still exists; that Sámi girls are not suffering under a westernized and unhealthy beauty ideal and, consequently, that they are more satisfied with their bodies than other young girls and better protected against mental stress.[52] In this case, what might be physically unhealthy, might at least be mentally sound, but it is not always possible to mediate between the healthy and the cultural. One might, however, notice a slight tendency to present unwanted behavior as ‘modernized’, ‘westernized’ or simply ‘norwegianized’ – not ‘traditionally’ Sámi. For example, in her recent doctoral dissertation Anna Rita Spein argues that an increase in smoking among Sámi women might be the result of Sámi integration in Norwegian society. Similarly, youth who preferred assimilation into Norwegian society were reported to have a higher intake of alcohol than other Sámi; thus, norwegianization is presented as real source of behavioural problems.[53] In this case, what is unwanted and unhealthy is not part of an ‘original’ or ‘traditional’ Sámi culture and might be changed without consequences for identity or cultural ways. It is also opined that the protection against alcohol abuse might be found in ‘traditional’ culture, that is, in religion.[54]

Conclusion

What can one make of these findings from the perspective of health citizenship? Despite formal rights as citizens on par with others, long-standing discriminatory practices for a long time hampered Sámi access to political, social and civil rights in Norwegian society. In particular since the 1980s Sámi entitlement to the rights as citizens, including health and health care of the same standard as non-Sámi, has made for reforms to counteract discrimination and the effects of former discrimination. Today, language and culture are recognized as playing a prominent role in communications and encounters. Regarding health citizenship, a dichotomization between 'the Sámi' and 'other Norwegians' seems to be at play to the extent that ideal Norwegian and ideal Sámi citizens are conceived as behaving differently. The ideal Norwegian citizen is one who actively responds to health advice concerning eating, drinking, smoking and physical activities. The ideal Sámi citizen is one who actively responds to policies aimed at strengthening Sámi identity, in particular to emphasize what might be termed 'culture' and 'tradition'. It is implied that the Sámi has to choose not only what is healthy, but also what is closest to 'traditional' culture. In terms of health citizenship, one might say that it is demanded both more and less from the Sámi than from others; more, because preservation of Sámi identity and Sámi culture is so strongly emphasized; less, because the obligations otherwise resting upon citizens' healthy behavior are formulated with no particular address to the Sámi. Yet more, still again, since the Sámi as Norwegian citizens are also expected to handle advice about healthy living yet without 'disturbing' their culture and ethnic identity. Thus, the tendency to represent culture and identity as static and traditional – instead of continuously changing – adds to the dilemmas of health citizenship. In this case these dilemmas arise not from health citizenship, but from the fact that identity, tradition and culture are key concepts in present-day minority discourse.

Notes

The major exception relates to the 1902 Act on sale of land. The act indicated, even if it did not absolutely demand, that buyers of land should be in command of both oral and written Norwegian, and use Norwegian daily. Cf. Eriksen, Knut Einar and Einar Niemi. Den finske fare. Sikkerhetsproblemer og minoritetspolitikk i nord 1860–1940. Universitetsforlaget, Oslo 1981:78–81.

2 Eriksen and Niemi 1981.

3 A particularly revealing example is that as late as 1960, no Sámi youth had ever graduated from medical school. Discrimination of ethnic minorities was, however, the common practice in Norway, cf. Kjeldstadli, Knut (ed.). Norsk innvandringshistorie. bd. 2:I nasjonalstatens tid 1814–1940. Pax Forlag A/S, Oslo 2003:106–177.

4 Samordningsnemda for skoleverket oppnemd ved kongelig resolusjon 7. mars 1947. Tilråding om Samiske skole- og opplysningsspørsmål. Brødrene Tengs forlag, Oslo 1948. Innstilling fra

Komiteen til å utrede samespørsmål oppnevnt 3. august 1956. Indre Smaalenenes Trykkeri, Mysen 1959. Cf. also Aarseth, Bjørn. Norsk Samepolitikk 1945–1990. Målsetting, virkemidler og resultat. Forlaget Vett og Viten/Norsk Folkemuseums Samiske Samlinger, Oslo 2006.

5 Torgersen, Johan. "Noen populasjonsgenetiske data fra samene." Tidsskrift for den norske lægeforening 75 (1956):809–810.

6 On regional welfare and economic policies, cf. Grønlie, Tore. "Tiden etter 1945." In Danielsen, Rolf et al. Grunntrekk i norsk historie fra vikingtid til våre dager. Universitetsforlaget, Oslo 1991:330–338.

7 Cf. Midré, Georges. "Distribution, Recognition, and Poverty. Experiences from Guatemala and Norway." In Minde, Henry (ed.). Indigenous Peoples. Self-determination, Knowledge, Indigeneity. Eburon, Delft 2008:204–205.

8 Aarseth 2006:33, 67–68.

9 Aarseth 2006:347–445.

10 <http://www.unhcr.ch/html/menu3/b/62.htm>. Accessed 23 March 2007.

11 Andresen, Astri and Teemu Ryymin. "Effecting equality: The Norwegian Welfare State's Health Policy in Finnmark, 1945–1970s." Forthcoming, Acta Borealia 2009. Cf. also Medicinaldirektøren, Tidsskrift for den norske lægeforening 1917:876.

12 <http://www.sami-statistics.info/dafault.asp?nc=6969&id=46>. Accessed 13 May 2008.

13 Kvernmo, Siv. "Developing Sami health services – a medical and cultural challenge." In Gaski, Harald (ed.). Sami culture in a new era: the Norwegian Sami experience. Davi Girji/University of Washington Press, Seattle 1997:136.

14 Møllersen, Snefrid. "Mental health services and treatment in Sami and non Sami populations. A comparative study in a multiethnic rural area of Norway." Doctoral dissertation, University of Tromsø 2008.

15 Kvernmo 1997:136.

16 In 2007, a project was instigated to find out what actually happened to Sámi doctors: where did they go since, obviously, they did not take up positions in Sámi-speaking districts. Cf. "Hvor blir det av de samiske legene?" <http://www.forskning.no/artikler/2007/juni/1182507839.84>. Accessed 19 May 2008.

17 Mangfold og likeverd. Regjeringens handlingsplan for helse- og sosialtjenester til den samiske befolkningen i Norge 2002–2005. Sosial og helsedepartementet, Oslo 2001:3.

18 Nystad, Tove, Marita Melhus and Eiliv Lund. "Sami speakers are less satisfied with general practitioners' services." International Journal of Circumpolar Health 67 (2008):116–123.

19 Inga Karlsen, Tysfjord. NRK Sámi Radio. <http://www.nrk.no/kanal/nrk_sami_radio/1.3599756>. Accessed 3 March 2008.

20 Nystad, Tove, Marita Melhus and Lund, Eiliv. "Samisktalende er mindre fornøyd med legetjenestene." Tidsskrift for den Norske Lægeforening 126 (2006):740.

21 Cf. Nystad, Tove. NAKMI news, 13 December 2004. <http://www.nakmi.no/nyheter/artikkel.asp?SeksjonID=2&NyhetID=287&SpraakID=1>. Accessed 3 March 2008.

22 <http://www.samediggi.no>. 15 October 2006. Accessed 2 April 2008.

23 Nordlys, 24 April 2008.

24 Stortingsmelding nr. 16 (2002–2003) Resept for et sunnere Norge: 143.

25 Similar problems regarding how to categorize exist regarding other ethnic minorities as well, cf. eg. Tangata, Hauora. "Maori Health Status." In Durie, Mason. Whaiora. Maori Health Development. Oxford University Press, Oxford 2006 [1994]:123–127.

26 Actually, Sáminess was classified into three categories: Sámi I, II and III; presumably Sámi I indicating a strong Sámi identity, Sámi III the weakest. Cf. Hansen, Ketil Lenert, Marita Melhus, Asle Høgmo and Egil Lund. "Ethnic discrimination and bullying in the Sami and Non-Sami populations in Norway: the SAMINOR study." International Journal of Circumpolar Health 67 (2008):101–102.

27 Kvernmo, Siv and Sonja Heyerdahl. "Acculturation Strategies and Ethnic Identity as Predictors of Behavior Problems in Arctic Minority Adolescents". Journal of the American Academy of Child & Adolescent Psychiatry 42 (2003):59.

28 Næss, Øyvind, Marit Rognerud and Bjørn Heine Strand (eds). Sosial ulikhet i helse. En faktarapport. Folkehelseinstituttet, Rapport 2007:1:48.

29 Spein, Anna Rita. <http://www.nrk.no/kanal/nrk_sami_radio/1.2333219>; also Hætta Guttorm, Anna Anita, SANKS. "Unge samers rus- og røykevaner – ny forskning." <http://www.helse-finnmark.no/article41735-10180.html>. Accessed 17 June 2008.

30 Samisk statistikk. Forventet gjenstående levetid for utvalgte aldere. Hele landet og Norge nord for Saltfjellet 2004–2006. <http://www.ssb.no/emner/00/00/20/nos_samer/nos_d384/>. Accessed 17 June 2008.

31 Hassler, Sven. "The health conditions in the Sami population of Sweden." In Health Situation of the Indigenous peoples in the Barents region. Centre for Sámi Health Research, 2005:33. Another study has shown that male reindeer-herders score higher on physical function and lower on bodily pain than a Swedish reference population. Daerga, Laila, Anette Edin-Liljegren and Per Sjölander. "Quality of life in relation to physical, psychosocial and socio-economic conditions among reindeer-herding Sami." International Journal of Circumpolar Health 67 (2008):10–28.

32 Näyhä, Simo. "Disease patterns among the Sámi population in Finland." In Health Situation of the Indigenous peoples in the Barents region. Centre for Sámi Health Research, 2005:16. Cf. also Soininen, Leena and Eero Pukkula. "Mortality of the Sami in Northern Finland 1979–2005." International Journal of Circumpolar Health 67 (2008):45–57.

33 E.g. Bjerregaard, Peter, T. Kue Young, Eric Dewailly and Sven Ove Ebbesson. "Indigenous health in the Arctic: an overview of the circumpolar Inuit population". Scandinavian Journal of Public Health 32 (2004):390–395; Tangata 2006 [1994]; Waldram, James B., D. Ann Herring and T. Kue Young. Aboriginal Health in Canada. Historical, Cultural and Epidemiological Perspectives. University of Toronto Press, Toronto-Buffalo-London 2006:75–85. See also Judith Raftery in this volume.

34 Cf. eg. a recent white paper (Prescription for a more healthy Norway: public health policies, Stortingsmelding nr. 16, 2002–2003:7) that on the one hand states that "the individual is responsible for his/her health" and that "society can and should influence the choices made", but on the other hand emphasizes that "health is not least dependant upon trends and political choices outside the individual's own influence".

35 Cf. e.g. Berry, John W. "Psychology of Acculturation." In Berman, John (ed.). Cross-cultural perspectives: Nebraska symposium on motivation. University of Nebraska Press, Lincoln 1990:201–34.

36 NOU 1995:6:26

37 Berry 1990:224–231. Historians and educationalists have spoken of "cultural pain" to describe a similar process, cf. Minde, Henry. "Assimilation of the Sami – Implementation and Consequences". Acta Borealia 20 (2003):139–142.

38 Mangfold og likeverd. Regjeringens handlingsplan for helse- og sosialtjenester til den samiske befolkningen i Norge 2002–2005. Sosial og helsedepartementet, Oslo 2001:26.

39 NOU 1995:6:420.

40 NOU 1995:6:420.

41 NOU 1998:21.

42 Mangfold og likeverd. Regjeringens handlingsplan for helse- og sosialtjenester til den samiske befolkningen i Norge 2002–2005. Sosial og helsedepartementet, Oslo 2001:5–6.

43 Cf. Solhaug, Randi M. "Alternativ behandling ved hvert fjerde sykehus". Online: <http://www. forskning.no>. Accessed 12 March 2008. Also Salomonsen, Laila Johansdatter, Sameline Grimsgaard and Vinjar Fønnebø. "Bruk av alternativmedisinsk behandling ved norske sykehus." Tidsskrift for den Norske Lægeforening 123 (2003):631–633. In 2000 a centre for complementary and alternative medicine (Nasjonalt forskningssenter innen komplementær og alternative medisin) was established. Like the Centre for Sámi health research, this centre was also based at the University of Tromsø.

44 Mangfold og likeverd. Regjeringens handlingsplan for helse- og sosialtjenester til den samiske befolkningen i Norge 2002–2005. Sosial og helsedepartementet, Oslo 2001:19.

45 Mangfold og likeverd. Regjeringens handlingsplan for helse- og sosialtjenester til den samiske befolkningen i Norge 2002–2005. Sosial og helsedepartementet, Oslo 2001:28–29.

46 Høye, Ingrid M. "Nysgjerrigper i Sápmi." Tidsskrift for den norske legeforening 121 (2001):638–639.

47 Kvernmo, Siv. "Selvmord og akkulturasjon – minoriteter i kulturell endring." Suicidologi 7 (2002):14.

48 Kvernmo and Heyerdahl 2003:57.

49 NOU 1995:6:404.

50 NOU 1995:6:404.

51 Gaski, Lina. "Sami Identity as a Discursive Formation: Essentialism and Ambivalence". In Minde 2008:234; 228–29.

52 Cf. Høye 2001.

53 Hætta Guttorm, Anna Anita. "Unge samers rus- og røykevaner – ny forskning." <http://www.helse-finnmark.no/article41735-10180.html>. Accessed 17 June 2008. The author presents Cand. Med. Anna Rita Spein's doctoral dissertation "Substance use behavior among ethnic diverse young people in North Norway in the 1990s. The North Norwegian Youth Study: A cross-cultural longitudinal study comparing smoking and drinking rates and patterns among indigenous Sami and non-indigenous peers" (2007). Cf. also Spein, Anna Rita. "Substance use among young indigenous Sami – a summary of findings from the North Norwegian youth study." International Journal of Circumpolar Health 67 (2008):122–134.

54 Hætta Guttorm 2007.

Medicine in Court

Lord Gifford’s Oysters: State, trade and the courts in England 1895–1905

Anne Hardy

In the spring of 1899, escalating medical and public concern over the danger of acquiring typhoid infection from eating sewage polluted oysters led England’s Local Government Board to introduce a Bill into Parliament to regulate the practices of the oyster industry.

Oysters had been cultivated in Britain since at least the 16th century, and during the 19th century they were not regarded as a luxury foodstuff but rather as a popular treat among all social classes.[1] During the course of that century, the scale of the trade had greatly expanded, to reach an estimated capital value of £6–8 million by 1900.[2] By now involving the cultivation of both native oysters and imports from America and Portugal, the industry was spread out around Britain’s coastline wherever shores and river estuaries provided suitable sites for layings. It was a private industry, operating as so many industries then did, outside the rule of law, and like many other British industries relished freedom of trade and entrepreneurial licence to organise as its traders thought best. Yet the growth in urban populations that fuelled the demand for shellfish and brought prosperity to the industry came at a price. Urban populations increasingly dumped untreated sewage into the sea, by more or less obvious means. By the end of the century this dumping had become an environmental concern, at least in part as it affected fish stocks, and in 1898 a Royal Commission on Sewage Disposal was appointed, with a brief to inquire into methods of sewage treatment and disposal.

For many years Britain’s oyster growers had remained blissfully unconscious of any potential danger to their trade from urban expansion. It was a commonplace of fishery culture that oysters raised on sewer effluent fattened quickly and easily and were particularly well flavoured.[3] Beginning in the early 1890s, however, medical concern between shellfish consumption and the incidence of typhoid began to grow.[4] The country’s Medical Department – predecessor of the Ministry of Health – operated under the Local Government Board, and so it was that the LGB undertook the task of formulating a Bill to regulate the oyster trade in 1899.

The Bill was introduced into the House of Lords, and printed for public information, in mid May. It had three main aims: to provide for the inspection of oyster layings; to prohibit the removal of oysters from insanitary layings; and to regulate the import of foreign oysters from districts suspected of being polluted. Enforcement of the law was to be in the hands of the local administrative authorities and, in the final event, the Local Government Board.[5] Only a year previously, an in-trade proposal to institute a licensing system for the oyster beds had been opposed by traders "who did not want to be put under Government control".[6] The reaction of the trade to the Bill was therefore prompt. It was pointed out that the local authorities were responsible for the sewage, and that the new law would thus make "one of the parties to the dispute … the arbitrary inspecting authority and judge".[7] Appeals were allowed to the LGB, but, it was asked, were not the interests of the local authorities and the LGB the same?

Numerous other grievances were raised. The Bill took it for granted that sewer outfalls were not to be interfered with; and there was no suggestion of compensation to oyster growers, whose prospects might be damaged by conditions over which they had no control. It was pointed out that it was, in fact, much more difficult to close an oyster fishery than was assumed: only the removal of every oyster could ensure that that the beds would not regenerate, leaving the local authorities with the responsibility of constant inspection and policing to prevent people helping themselves. There was no suggestion of what was to become of oysters removed from insanitary layings.[8] Other raised the issue of the definition of risk: "How is the chance of 'serious risk' to be determined?"[9] Still others complained that the Bill gave no power over the shops where oysters were sold.[10] The main objection, however, was what was described as "the intrusion" of the LGB – after all, it had approved the sewerage schemes in the first place. "This Bill", it was declared, "puts the industry at the mercy of medical men, who have no practical experience of the oyster trade. The LGB will bungle this business as it has bungled others". The proper authority in this case, it was argued, was the Board of Trade, which had been "more or less intimately connected with the oyster industry for more than twenty years".[11] By late June, the National Fisheries Protection Association was pressing for the Bill to be withdrawn and for the appointment of a Select Committee.[12]

From the moment of the Oyster Bill's publication, therefore, the fish trades rallied to the defence of their own interests. They were now careful not to resist the prospect of regulation, which might cost public sympathy, but they did energetically resist imposition of the proposed policemen and other perceived shortcomings in the Bill. The older historiography of public health, as is well known, portrayed a relatively smooth progression of public health legislation moving 19th-century Britain towards a sanitary state. More recently, Christopher Hamlin and others have shown this process to be a more complex and contested affair than originally conceived. Two years ago, at this meeting, I offered a study of how the oyster traders adopted bacteriology as a strategy for combating the claims of the epidemiologists that oysters caused typhoid.[13] In this companion piece, I trace how the trades responded to the threat of regulation by attacking the position of the would-be regulators through the legislature and the courts from the position that, in all fairness, the polluters should pay the price of the clean up. The fish trades were a feisty and combative industry and their trade journal, *The Fish Trades Gazette*, the principal source for this paper, provides an unrivalled insight into the activities and attitudes with which they campaigned.

The initial offensive by the National Sea Fisheries Protection Association was successful. The Oyster Bill was referred to a Select Committee of the House of Lords, which began sitting in the third week of July.[14] The Committee was chaired by Lord Harris, well known cricketer, former civil servant and former Governor of Bombay. The medical witnesses included Richard Thorne Thorne, the Chief Medical Officer, and Medical Inspector Timbrell Bulstrode, whose report on the condition of English and Welsh oysters beds of 1895 had been the LGB's first move against the industry.[15] The trades were represented by J H Barber, Assistant Secretary to the National Sea Fisheries Protection Association, and by G H Baxter, President of the British Oyster Industries Association.[16] Their evidence was re-published by the *FTG* over a period of three weeks. The case made by the trades rested on their own innocence in creating pollution and their powerlessness in remedying the situation. The oyster beds were traditionally established, were private property, and provided their owners and the latter's employees with a livelihood. The local authorities owned the sewers and were responsible for the pollution; in justice it was they who should remedy the situation.

The trade case was articulated in the *FTG* by J M Tabor, scion of a family whose ownership of layings dated back to at least 1698. "This action of the sanitary authorities", Tabor thundered,[17]

> is A DIRECT AGGRESSION on the rights of property holders. The sanitary authorities contaminate the oyster beds, contaminate the oysters and ruin a man's property. They destroy public confidence in oysters, they reduce the oyster industry to one fourth of its previous dimensions, and finally they jeopardise public health. Yet when any attempt is made to saddle them with the expense of a remedy, the Government say it is impractical!

The appeal to property rights did not fail to enlist the sympathies of a Committee composed of hereditary peers. Indeed, when the Committee's report was published, the *FTG* was careful to note that "no one who studies it carefully can fail to recognise the service done to the trade by Lords Tweedmouth and Heneage".[18] The lords had suggested a critical amendment: that the LGB be replaced by the Sea Fishery Committees as the regulatory authority. Now the Sea Fishery Committees were largely composed of trade representatives, and were responsible for managing fishing along designated stretches of coastline. Their total local responsibilities by no means covered the whole length of the coastline, however, and excluded, for example, several important oyster grounds. Recognising that a stalemate had been reached, the LGB withdrew the Bill in early August, much to the disgust of the medical press. The *Lancet*, for example, noted bitterly that the Sea Fisheries Committees were "bodies concerned purely with fishing and licensing matters", half their members were engaged in the fishing industry, and they had "no concern whatever with the public health, and possess no advisers capable of guiding them in that direction".[19]

The Select Committee had given the initiative to the fish trades. Yet initially, it seemed as if they took little advantage of the opportunity. In October the *FTG* was fulminating against the policy of the British Oyster Association, which was to work to improve layings but to avoid publicity with a view to minimising the number of times the subject of oysters and disease was brought into the public eye.[20] This discretion, the *FTG* averred, was leaving "an open field to the faddists and opponents of the oyster trade to go to extremes in the denunciation of oysters".[21] Instead, the Gazette urged the trade "fearlessly" to place the "true facts" of the conditions of oyster culture before the public.[22] Obedient to the *FTG*'s prodding, the Association went public on its second annual report in an effort to publicise its own efforts towards improving oyster layings; "the work of watching the sanitary condition of oysters was zealously carried on", it was reported. The Secretary had, on the instructions of the Management Committee, inspected all oyster fisheries to which his attention was drawn and in each case "took the necessary steps to clear the fishery or laying from suspicion".[23] At the same time, local Sea Fishery Committees were also taking up cudgels. The Kent and Essex committee, indeed, was reported as having consistently opposed every sewage scheme liable to contaminate oyster beds since the Bulstrode report of 1895. In autumn 1900, it was objecting to a scheme at Margate jetty and appointing a sub-committee to consult with the sanitary engineer of another scheme at Burnham with a view to protecting interests of oyster bedders on the Crouch.[24]

At the end of the year the *FTG* was able to congratulate itself : "It is gratifying to note that the principles laid down in these columns for the rehabilitation of oysters in public estimation are receiving attention and practical support. Oyster bedders are awakening to the importance of energetic action".[25] The Helford fishery, it was noted, was now issuing all its customers, for distribution to the public, printed extracts relating to its own layings from the annual report of the British Oyster Industry Association, and from Bulstrode's report.[26] The *FTG* was now urging yet stronger measures:[27] "The attack must be carried right into the enemy's camp – the camp of the sanitary authorities – and the trade must insist that they be prevented from further polluting with crude sewage any oyster bed now or in the future."

Throughout 1901, the *FTG* grew bolder. Already in February it was asserting that nearly all oyster beds in England had been purified, and that almost no oysters from any polluted source were on the market: "as far as oysters are concerned no danger whatever is to be apprehended…".[28] In August, at the start of the oyster season, it denounced the "Rip Van Winkles" of the medical profession, who continued to issue dire warnings against a state of things "which they assume to exist but which … as everyone in the oyster trade knows, does not exist".[29]

Behind this publicity drive, however, private individuals were beginning to take action. In the summer of 1901, the third Lord Gifford, a hero of the Ashanti War, took the City of Chichester to court seeking to restrain its sewage pollution of Fishbourne Creek, which ran through the grounds of his estate, and which he claimed had damaged it as a fishery.[30] Although awarded damages of just £2.00, the City was made to pay the costs of the case and change its sewage arrangements. The case established an important precedent: in the event of damage through sewage discharge, the local authority could be made responsible and was liable to pay compensation.[31]

By resorting to the courts, Lord Gifford had moved the game on to a new level. By September, the Cornish Sea Fisheries Committee was moving to take action against the Truro Sanitary authority for contaminating the river and polluting the oyster beds.[32] A threat to take similar action at Falmouth was reported as having an effect by October,[33] and by May 1902 the *FTG* was claiming that of all the oyster beds liable to transmit disease only one, Penrhyn and Flushing in the county of Cornwall, remained polluted. "The warning against oysters, crammed into the heads of (medical) students," crowed the journal, "is about as reasonable as for a nation in 1902 to build a number of coast defences against Napoleon".[34]

Yet the *FTG* crowed too soon – or on the basis of incorrect information. In November that year the outbreaks of typhoid following the mayoral banquets at Winchester and Southampton brought down the whole, carefully constructed, edifice of positive publicity and legal action. Within a very short space of time it became known that the offending creatures had been supplied from beds at Emsworth, a few miles west of Chichester, and that they had for some time been suspected of causing a rash of sporadic typhoid cases in Portsmouth. By January 1903, the owner of the beds, James Duncan Foster, was suing the Warblington District Council for £15,000 in damages. In a scenario not unfamiliar in the annals of public health, it was claimed that the problem had been identified in 1895 (by Bulstrode), and that Foster had repeatedly attempted to get the Council to take action, even going so far as to get himself elected to it, but they "had done nothing but talk".[35] Warblington Council, it was reported, were determined to fight the case – they argued that the drains had been there before the oysters, but nonetheless were taking steps to improve the drains.[36] It was two years before proceedings reached the High Court, where Mr Justice Walton ruled in favour of the plaintiff.[37] The court found that when the local authority made the drains in 1872, the amount of sewage discharged had been "comparatively trifling". Moreover, use was then made of a sluice at the outlet, which prevented any discharge at low water, the sewage being carried out to sea. In 1892, however, the sluice was removed, after which the risk of contamination was greatly increased, as sewage deposits built up on the foreshore. Invoking the Sea Fisheries Act 1868, Judge Walton noted that the Act, "made it difficult to establish a right of discharged sewage so as to contaminate private beds. It was made criminal to do so, and there can be no prescription to commit a criminal act".[38]

The Emsworth case was just one of several at this time where a judge found for the plaintiff against a local authority on a pollution issue. In another important judgment, Lord Harrington was awarded £500.00 compensation from Derby Corporation for their pollution of the River Derwent with crude sewage that ruined an ornamental lake.[39] Action through the courts did not immediately restore public faith in oysters – the trade did not begin to show signs of recovery until October 1905 – it was effective in initiating a responsive movement among relevant authorities. The *FTG*, as a prime mover in the galvanising of trade interests, was certainly positive about the outcomes. In March 1905, for example, it was recommending to the 700-odd victims of a typhoid outbreak in Lincoln, resulting from contamination of the Corporation water supply, that they should each claim compensation from the City.[40] The administrative authorities, meanwhile, were beginning to get their act together: in January 1905, for example, the War Office began improving methods of sewage disposal at its sites at Gravesend, Sheerness and elsewhere.[41] "The excuse to avoid improvement, which was used before", the *FTG* noted, "viz., lack of funds, appears to have been remedied".[42] Cheaper, perhaps, to correct the sewerage than to pay costs and compensation in numerous court cases.

In conclusion, this case study finds the public health authorities assuming a paradoxical role: from being agencies of better health and environmental cleanliness for urban populations, they had become polluters of the natural environment whose activities needed to be controlled. At the same time, it is also clear that medical opinion, indeed the Central Medical Department itself, could not depend on any automatic support from within the legislature. Lord Harris's declaration that the Oyster Bill was more about the health of oysters than about the health of people ran directly – and perversely – counter to the explicit intention of the bill.[43] As late as 1900, the public health authorities operated in a world where such authority as they possessed was assessed and valued in the context of competing interests. The English peerage play an interesting role in this study. They appear as the ultimate defenders of private property, whether in the House of Lords or in the court cases which they instigated and which provided landmark judgments against those who defiled and despoiled private property interests. Lord Gifford and Lord Harrington may have been acting in their own self-interest, but they opened up a world of opportunity for the business community of the shellfish trades to take effective action against those whose activities rendered their products dangerous to human health, and threatened to undermine their prosperity and their livelihoods.

Notes

1 Neild, Robert. The English, the French and the Oyster. Quiller Press, London 1995.

2 Fish Trades Gazette 16 January 1904:18 (Hereafter FTG).

3 Hardy, Anne. "Exorcising Molly Malone: Typhoid and shellfish consumption in urban Britain, 1860-1960". History Workshop Journal 55 (2003):72-90.

4 Hardy 2003.

5 FTG 20 May 1899:11-12.

6 FTG 13 August 1898:13-14.

7 FTG 20 May 1899:12.

8 FTG 20 May 1899:12.

9 FTG 27 May 1899:14.

10 FTG 17 June 1899:18.

11 FTG 27 May 1899:14. See also letters FTG 27 May 1899:22.

12 FTG 24 June 1899:13.

13 Hardy, Anne. "The uses and abuses of science: Shellfish and the popularisation of bacteriology in England, 1890-1905". In Andresen, Astri, Tore Grønlie and Teemu Ryymin (eds). Science, Culture and Politics: European Perspectives on Medicine, Sickness and Health. Rokkansenteret, Bergen 2006.

14 FTG 22 July 1899:20.

15 Timbrell Bulstrode, H. "Report on an inquiry into the conditions under which oysters…are cultivated and stored along the coast of England and Wales", British Parliamentary Papers 1896 xxxvii. Appendix no. 1.

16 FTG 23 September 1899:16-17.

17 FTG 9 September 1899:18-19.

18 FTG 23 September 1899:17.

19 Annotation, "Mr Chaplin's Oyster Bill". Lancet 1899, ii:351-352.

20 FTG 3 November 1900:21.

21 FTG 2 October 1900:22.

22 FTG 3 November 1900:21.

23 FTG 8 December, 1900:. 25.

24 FTG 15 December 1900:23.

25 FTG 29 December 1900:17.

26 FTG 29 December 1900:17.

27 FTG 29 December 1900.

28 FTG 9 February 1901:27.

29 FTG 10 August 1901:35.

30 FTG 27 July 1901:35.

31 FTG 7 September 1901:15.

32 FTG 7 September 1901.

33 FTG 19 October 1901:30.

34 FTG 3 May 1902:27.

35 FTG 3 January 1903:21; 13 November 1904:22.

36 FTG 13 November 1904:22.

37 FTG 28 January 1905:18.

38 FTG 28 January 1905.

39 FTG 10 December 1904:21.

40 FTG 11 March 1905:17.

41 FTG 24 June 1905:17.

42 FTG 24 June 1905.

43 Editorial, “The abandoned Oyster Bill”, British Medical Journal 1899, ii:422.

Concepts of same sex-sexuality in Norwegian forensic psychiatry 1930–1945

Runar Jordåen

In my ongoing doctoral project about Norwegian medical discourses on homosexuality between 1880 and 1945, the practice of forensic psychiatry is one of the fields that I will focus on and analyse closer. This paper gives a preliminary outline of how to read varying concepts of same sex-sexuality in forensic psychiatric reports in relation to the more general question about the historical construction of homosexuality since the 19th century.

Constructionism and homosexuality

The breakthrough of a constructionist approach to the history of homosexuality in the 1980s established that "the homosexual" as a figure defined by its sexual attraction towards persons of its own sex was a product of modern times, most often dated to the late 19th century.[1] This has often been seen mainly as the result of the influence of Michel Foucault, and especially ascribed to the famous passage in the first volume of his *History of Sexuality* in which he contrasts the sodomy of the European law tradition of early modern times with "the nineteenth-century homosexual". Sodomy "was a category of forbidden acts", whereas the homosexual became a species: "a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology".[2]

Eve Kosofsky Sedgwick has addressed how the constructionist approach, although historiographically fruitful, sometimes lets the quest for "a great paradigm shift" overshadow the fact that different approaches and models have existed and exist at the same time.[3] The emphasis on a profound historical shift may, in other words, obscure the heterogeneity of understandings and experiences of same sex sexuality on a synchronic level; there is no such thing as one "homosexuality as we know it today" (nor was it at any given time in history). Sedgwick claims that although since the late 19th century increasingly there has been a tendency to perceive "the homosexual" as a species, different models have co-existed with this model. She therefore suggests to divide modern homosexual definitions into *minoritizing* views, that is, those that concern a minority of people (in this case, homosexuals), and *universalizing* views that formulate homosexuality as a topic that concerns the majority, as something that can develop in everyone and everywhere. This distinction means not only that different meanings and experiences of homosexuality are expressed and defended ideologically by different groups or persons, but also that in a wider and more complex sense different meanings might exist within the same discourse, including within a single text. Consequently, rather than looking for a single coherent figure, the historian should look for incoherencies and contradictions in their sources. Reading the history of sexuality since the end of the 19th century in this way, one will better grasp a situation in which the limits between normal and abnormal are far from settled and that is not only about the simple definition and exclusion of a homosexual minority in the figure of a species.[4]

Constructionist "orthodoxy" has been challenged also by recent studies that have demonstrated the existence of an understanding of homosexuality as something concerning a minority morphologically and psychologically characterized by this desire also in early modern Europe,[5] in this way questioning the historical uniqueness of "the modern homosexual". A historicist or constructionist approach to the history of homosexuality does not exclude, however, that similar phenomena and meanings can be found in different historical periods. Quite the contrary, emphasizing the different discursive effects these constructions have in different times, and the different epistemic contexts they exist in, might reveal how different they are.[6] In other words, a more nuanced and complex view of same-sex-sexuality on a synchronic level does not mean denying historical breaks or the fact that an important shift occurred in the understanding of homosexuality in the West in the second half of the nineteenth century; rather it makes possible a richer historical understanding of the conflict-ridden and heterogeneous ways (homo) sexuality is shaped and reshaped in time and space.

The discourse of forensic psychiatry

Following these lines of thought, my approach to forensic psychiatry will be to see it as a specific practice having specific effects both institutionally and discursively.[7] I will first present my corpus of forensic psychiatric reports (not assuming that it is representative of either "medical discourse" or "modernity" as such), thereafter I will make some suggestions about how to understand it in a wider historical context following the reflections above.

Since 1900 a Commission of Forensic Medicine has existed in Norway. It is a consultative body for the government and the courts, but first and foremost it is a supervisory body that oversees every forensic medical expert report (*rettspsykiatrisk erklæring*) presented to the courts in criminal cases.[8] This sanctioning makes it especially fruitful to approach the expert reports as one discourse, since they are standardized both by the rules of the outline of the examination, the structure of the report, and by the Commission's evaluation. The reports, of course, were designed to answer certain questions. According to Norwegian criminal law as revised in 1930, the reports should address specifically three questions: 1) the question of sanity; 2) the existence of "underdeveloped or permanently impaired mental faculties" (*mangelfullt utviklede eller varig svekkede sjelsevner*); and 3) the existence of a danger that the observed could commit new criminal acts.[9] To answer these questions an examination that included both psychological and physical aspects was to be performed. The reports based on these examinations shaped homosexualities that were specific for forensic psychiatric discourse, and had immediate effects on the homosexualities in courts and to some degree on the general juridical concepts and regulations of same sex-sexuality.[10] The forensic psychiatric way of shaping its objects, also when it comes to homosexuality, then, may have some structural coherence that makes it fruitful to approach it as a specific discourse, different from other discourses on homosexuality. [11]

The study is based on a sample of psychiatric reports from the Commission of Forensic Medicine during the period 1930 to 1945. The forensic psychiatric reports have a specific character as historical sources that has to be described before I go on. The psychiatric examinations were performed and the reports formulated by two doctors from the county were the accused lived – often a director of a mental asylum and the chief county medical officer. The Commission's task was to approve or not approve the reports before they were submitted to the court, thus making sure that they met established standards and answered the required questions mentioned earlier. From 1930 the ideal conclusion of an experts report should have the following structure:

1. We do not (do) consider N.N. insane.
2. We suppose (do not suppose) that his mental faculties are underdeveloped.
3. And because of that there is a (is no) danger [*fare for*] that he will commit new criminal acts.

If the Commission did not approve of the quality of the observation, the design of the report or the conclusions, it could return the report and require a new examination. The reports therefore contain hand-written comments from the Commission's psychiatric experts that finished with a judgement regarding acceptability; most reports were adjudged "may pass" (*får passere*), but in some cases it was deemed inadequate and a second examination called for (to be performed by the same two local doctors), with proposals/instructions about how to do it. Thus, in Svein Atle Skålevåg's words, the Commission became a "discourse police".[12] Even in the cases given "may pass", one frequently encounters comments that reveal discrepancies between the views of the Commission's experts and the sometimes fumbling approaches of the local medical examiners.

My sample comprises all reports in which homosexuality is a topic one way or the other, in all 38 expert opinons. Since 1902 Norway's Criminal Code had quite liberal provisions concerning same sex-sexuality; section 213 of the code made "immoral intercourse between persons of the male sex" illegal, but it also said that the regulation should be used only when "public interest demanded" it. In practice that meant that the section was very rarely enforced.[13] It is no big surprise, then, that we do not find many cases concerning section 213 among the reports. "Homosexuality" was an issue almost exclusively in cases where the charge was for a crime concerning sexuality; with few exceptions, these cases involved adult men who were charged with committing sexual acts or intercourse with minor boys (below 16 years). Today, such cases might be regarded as examples of paedophilia, but in my material this term is never used; homosexuality is the concept used to describe the actions and inclinations of the men charged.[14] I have only found one case involving a woman. She was accused of having sexual intercourse with a 15-year-old boy, but in the expert opinion it is also mentioned that she in a psychiatric institution had had sexual relations with other women in a psychiatric institution.[15]

My dissertation will cover forensic psychiatric reports between 1900 and 1945, but here I limit my analysis to the period of the new regime from 1930 when the question of danger and preventive detention was added to the earlier questions on mental illness and mental faculties. I will not focus much on diachronic developments within this period in this paper. It might be noted, though, that from the end of the 1930s the examinations tend to be more "technical" – the physical examination, for example, uses hormone testing for the first time in the 1940s – and the number of reports that link bodily features and homosexuality increases. The sample is so small, however, that I would not put too much weight on these tendencies.[16]

What kind of "homosexuality" is to be found in the expert reports? Significantly, the reports do not adhere to a uniform model of homosexuality. Instead we find different "homosexualities" that I have placed in three categories: 1) inborn homosexuality; 2) acquired homosexuality; and 3) situational homosexuality.

Inborn homosexuality

In 1925 a committee to reform the Norwegian Criminal Code proposed to lift the general ban on sex between men and instead to enforce an age limit of 21 years for homosexual sex (for both genders) in addition to a prohibition of homosexual prostitution (committed by persons over 18 years of age). Among the committee members were three medical doctors, among them Norway's first professor of psychiatry Ragnar Vogt. Presumably influenced by this medical presence, the committee referred to the sexual pathology of Magnus Hirschfeld arguing that a certain proportion of the population were homosexual due to inborn "abnormal gonads" that made them different from other people both physically and mentally, and concluded that a general ban on homosexuality therefore would be absurd.[17]

Homosexuality as inborn is also perhaps the most important figure to be found in the forensic psychiatric reports. The examination of the observed in most cases includes questioning them about childhood and youth, and many of the reports contain narratives about a feeling of otherness and "deviance" with respect to both sexual attraction and gender behaviour. But we also find the psychiatrist linking the *physical* examination to the person's sexuality: The search for a presumed homosexual body is quite frequent in the reports. An expert opinion from 1945, for example, mentions that the man has an appearance that is "distinctly feminine, when it comes to facial expressions, tone of the voice and posture [*holdning*]", but that his body is

"[...] well-built and without any kind of femininity concerning his secondary sexual characters".[18] This formulation indicates that one is looking for a homosexual body, and that one has certain expectations about the composition of this body that can be linked to femininity. Yet in most of the cases examined, however, one does not find this body.

One of the few cases that describes this homosexual body is from 1944. It concerns what is "[...] a mostly heterosexual person, with a certain homosexual element [...]". This element is described as a constitutional trait, and is said to characterize his body. He has "[...] slightly soft features, soft voice, with a certain soft appearance and character. [19] This example shows that the inborn homosexuality does not necessarily imply that the person is exclusively homosexual. Apart from this point, it is important to note how the limits between purely bodily signs and psychological signs are blurred: Soft features probably refer to a bodily condition, the soft voice is harder to locate, and the softness of character is referring to a psychological condition. But, as mentioned, there are actually few cases where the psychiatrists find the homosexual body they are looking for. The signs of femininity, then, are more often of a psychological character, despite the fact that one is looking for bodily symptoms.

Acquired homosexuality

The second model of homosexuality can be named "acquired homosexuality". Within psychiatric and forensic psychiatric discourse some kinds of homosexual behaviour were seen as more dangerous than others. During the first decades of the 20th century there was a growing concern among psychiatrists that homosexual experiences during teenage years could lead boys to become homosexual. Thus, one of the dangerous types of homosexuality was the homosexuality performed between adult men and boys up to 21 years; note that the boys' age was not defined by the general age of consent, which was 16 years in Norway at the time.

This thinking was expressed in the report of the committee on reform of the criminal code. It claimed that exposure to homosexual acts could lead to acquired homosexuality:

> […] the sexual instinct of some persons during the period of adolescence
>
> does not have any fixed direction; they are what one calls bisexuals. If their emotions are led in the right (heterosexual) direction, they acquire a normal sexual life. But if they are exposed to homosexual seduction, they can acquire lasting perversion.[20]

The proposal for an age limit of 21 years for permissible homosexual activity was based on this medical argument. In a statement attached to the proposal, the psychiatrist Ragnar Vogt elaborated the medical grounds for the proposal. He considered it proved that homosexuality in most cases was a constitutional condition whereas in other cases it was a result of seduction in individuals whose sexuality was thus led in the wrong direction. Homosexuality (especially in the latter version), then, was an anomaly of the normal development, a "[...] freezing of the sexual development at an unfinished, childish stage."[21] The proposal was rejected by the minister of justice, but the attorney general, probably influenced by the committee and Vogt, sent out an advice later in 1925 that section 213 should be enforced when one of the men involved was under 21 years of age (that is, between 16 and 21).

This kind of influence on boys is a major preoccupation in the forensic reports analysed. Apart from a more general concern about the damage such relationships could have on the health, morality and psychology of the boys, we find in most of the opinions an equally strong concern about how the boys could be led in a homosexual direction, or – as it is expressed in one report from 1944 – how the crime committed could "[...] awaken such feelings in the boys [...]".[22] In other opinions the biographies of the arraigned persons are interpreted in a similar way: early sexual experiences, whether with boys their own age or with grown men, have inevitably influenced the persons so that their adult sexuality has become mainly homosexual. The homosexuality described in such cases is about how a homosexual personality can be forged through an unfortunate development. In some of the expert opinions, this development is portrayed as a more or less universal danger, a question related to the nature of bisexual disposition: Does it concern everyone, or just a group of people? Whatever the case, adolescence is portrayed as crucial for the development towards homosexuality or heterosexuality.

More complex psychodynamic understandings of how homosexuality develops are absent from the reports, which means that the influence of psychoanalysis otherwise found in Norwegian psychiatry in the 1930s did not leave any profound mark on these expert opinions. The centrality of the category of "acquired homosexuality" in the reports indicates understandings of the psyche and sexuality as developed through childhood and adolescence, but the use of specifically Freudian analytic terms is hardly ever found.

Situational homosexuality

The models of inborn homosexuality and acquired homosexuality are both about homosexuality as an important and lasting part of the personality, whether constitutional or a result of a development. The third model, which I have called "situational homosexuality", is different in that the homosexuality is portrayed as an exception or a less important part of the personality. In a case from 1933, for example, the homosexual acts are described as provoked by drinking of alcohol, *without* the presence of a homosexual personality.[23] In a case from 1942, a man was charged for sexual relations with boys under 16 years; his actions were described as

> […] hardly caused by any inborn constitution or caused by hormones, but we understand his behaviour as an occasionally appearing sexual substitute act in an ethically and morally weakened, enfeebled person, apathetic as a result of alcohol consumption.[24]

This conclusion is drawn from the assumption that neither the acts nor the sexual attraction correspond to anything in his earlier biography, and was probably strengthened by the fact that the physical observation did not indicate any traces of a "homosexual body" ("masculine distribution of body hairs [...]nothing abnormal or striking about the tone of his voice" etc.).[25] One last example is the only woman in my sample of expert opinions. She is described as a promiscuous person, mainly having sexual relations with men. Her homosexual activities, that is her sexual relationships with women, are regarded as an extension of this general promiscuity.[26] What is common among these descriptions are references to weakness, immaturity and childishness. Alcohol is particularly referred to as a cause for the weakness and childishness.[27]

The deployment of sexuality: between minoritizing and universalizing meanings

Often Foucault's "chronological dichotomy" between sodomy and homosexuality is both taken too literally (it is more reasonable to read it as a dramatized contrast) and read out of context (it focuses on the discursive break with the understanding of sodomy as defined by canonical law, but has very often been read as depicting a general and total break between early modern and modern times).[28] This distinction is better seen as one of many examples of a transformation that is part of a more general *deployment of sexuality* (*dispositif de sexualité*) that gets an increasingly important regulatory role concerning intimate relations from the 18th century onwards, according to Foucault.[29] The term *dispositif* denotes an "apparatus" consisting of both discursive and non-discursive elements; the apparatus is the "relations that can be established between these elements".[30] The *deployment of sexuality*, then, denotes the process in Western societies by which the body and its sensations become the centre of focus, intervention, and efforts of reformation, whereas the decreasingly important *deployment of alliance* (*dispositif d'alliance*) had the links between families and reproduction of roles as its focal point.[31] The concept then shows how the transformation of power from a "juridical power" – with prohibition as its main method – to a productive, intervening and relational power works when it comes to intimate and erotic life.

Within forensic psychiatry a shift takes place during the 19th century that can be perceived as paradigmatic of this general transformation of power: The criminal act, which in itself is defined in terms of prohibition, gets its "psychologico-ethical double", which in my sample is "the homosexual". [32] As I have shown, this does not mean that forensic psychiatry merely identifies a homosexual species (persons with an inborn, deeply rooted homosexuality); the forensic "double" of the crime is far more ambivalent than that. The inborn category is important, to be sure, and a lot of energy is used to identify and diagnose it, but the existence of the other category, that of the acquired homosexuality, intensifies the quest for homosexual personalities (whether born such or grown up that way). Foucault suggests that *danger* and *perversion* are the "the essential theoretical core of expert medico-legal opinion": *Danger* constitutes both the justification of and theoretical foundation for the involvement beyond the juridical and the medical; *perversion* is the concept in which this connection between crime and disease is made.[33] Of course, the existence of a minority of inborn homosexuals constituted a medical problem, describable in medical terms, but homosexuality as a pathological status was disputed and in few cases did it lead to some sort of psychiatric intervention. Within Norwegian criminal law, as we have seen, homosexual behaviour in itself extremely rarely led to conviction. It is within forensic psychiatry, which cannot be reduced to either medicine or law, that homosexuality becomes a topic of focus.

To be sure, homosexuality in itself did not qualify as mental illness or indicate "underdeveloped or significantly impaired mental faculties" in forensic psychiatry. This aspect, the question of the status of *perversion* in relation to the questions of accountability, led to a lot of confusion among the local doctors who wrote the original reports. The policy of the Commission of Forensic Medicine was also confusing for many years, but in evaluating a report to the court in 1937 it formulated an opinion that can be considered its official position on the matter: Although a homosexual disposition was genetically deviant [*hører genetisk til utviklingsmangler*], it should not always result in decisions for preventive detention or judgements of underdeveloped mental faculties.[34] This opinion, which was also published in the Commission's annual report, ruled that homosexuality as an isolated trait in a person otherwise lacking symptoms of mental disease or underdevelopment should not lead to a conclusion that the said person was unaccountable; only in concert with other symptoms did homosexuality become a relevant factor to decide this question.

What really brought homosexuality to the foreground of discussion in the reports was the question added by the 1930 reform: that of the *danger* of the person committing new criminal acts. This question, combined with psychodynamic approaches to sexual development, justified the search for other homosexualities than genetically inborn homosexual disposition. Since, as we have seen, inborn homosexuality by itself was not regarded by the Commission as ineluctably perilous, it was thus acquired homosexuality that intensified the element of danger. This does not, of course, mean that congenital homosexuality was unproblematical and acceptable in Norwegian forensic psychiatry. Quite the contrary, its forensic relevance is reinforced after 1930 by the legal requirement to search for the potential of danger in the persons examined. Inborn homosexuals are considered carriers of contagion that they spread through the seduction of susceptible young persons whose homosexual potential is thereby triggered and realised. This seduction gives birth to the acquired homosexual, who is thus both a victim and a potential reproducer of deviance, ie a *danger* to society.

In other words, Norwegian forensic psychiatry during this period certainly "deploys sexuality", but it cannot be seen as an apparatus that merely strengthens and fixes the boundaries of the species, of the minoritizing understanding of homosexuality. Instead the problematic aspect of homosexuality in forensic psychiatry seems to be the tension, or even confusion, between minoritizing and universalizing conceptions. The danger of the inborn homosexuality – the minoritizing conception – is recognized to be limited, but the fear that homosexuality might spread throughout society – the universalizing conception – intensifies forensic psychiatry's concern with the potential link between homosexuality and criminal danger.

To write the history of same sex-sexuality since the 19th century, then, is not simply to chronicle the coming into being of a new species which can be described as a coherent entity clearly separated from others. Rather one has to identify how the concepts of homosexuality from the end of the 19th century have been constantly shifting, sometimes emphasizing the universalizing dimensions, other times the minoritizing definition. I will therefore claim that what is significant in modern understanding of same sex-sexuality still can be grasped as a search for "truth" in sex. But this does not mean that the only figure found is the "species"; what we find, rather, are different relations between minoritizing and universalizing conceptions varying from discourse to discourse, from text to text. The deployment of sexuality can be found in different contexts and discourses, with different goals (from diagnosis to emancipation to identification of risk), and obviously it has different power relations depending on time and place.

In closing, I emphasise that these remarks apply only to this specific analysis and are not a general claim about medical discourses about homosexuality. The construction of homosexuality is a complex and contradictory process; it takes place within different discourses, institutions, and fields, which also within themselves are filled with tensions, contradictions, and variations – just as we have seen here.

Notes

1 An analysis of the homosexual as a specific social role with a certain historical origin was already suggested by the sociologist Mary McIntosh in her influential article "The homosexual role" from 1968, reprinted in Seidman, Steven (ed.). Queer Theory/Sociology. Blackwell, Oxford 1996. The dating of the advent of such a role (or in Michel Foucault's words, "species") has been much discussed, and disagreement has sometimes evolved around what criteria to emphasise in the definition of this figure. There is consensus that a role that is mainly defined by the sexual attraction towards one's own sex is a product of the second half of the 19th century, which is also the time when autobiographical accounts and medical case histories describing such a role begin to emerge. The last three to four decades of the 19th century is also the time when new terms such as sexual inversion, conträre Sexualempfindung, and homosexuality are coined. Apart from this debate about the dating of the homosexual, the other great historiographical debate within the history of homosexuality concerns agency: Who constructs the homosexual? I will not go further into this debate here, and mention only that the emphasis has shifted from the conception of a (repressive) category invented by medical doctors to one of the interaction of different discourses and agents (autobiographical accounts, medical case histories and so on). See Silverstolpe, Fredrik. "Benkert was not a Doctor: on the Non-medical Origin of the Homosexual Category in the Nineteenth Century." In Homosexuality, which homosexuality? International conference on Gay and Lesbian studies. Free University, Amsterdam 1987; Oosterhuis, Harry. Stepchildren of nature: Krafft-Ebing, psychiatry, and the making of sexual identity. University of Chicago Press, Chicago 2000.

2 Foucault, Michel. The history of sexuality. Volume 1: An introduction. Vintage Books, New York 1990:43.

3 Sedgwick, Eve Kosofsky. Epistemology of the Closet. University of California Press, Berkeley 1990.

4 Sedgwick analyses the minoritizing/universalizing aspects in relation to the binarizing of homo- and heterosexuality. Chris Brickell, although finding her analysis of the internal dynamics of this dichotomy "extremely" useful, warns against an over-emphasis of the centrality of it as a cultural master term. Brickell, Chris. "Sexology, the homo/hetero binary, and the complexities of male sexual history." Sexualities 9/4 (2006). I will leave out this part of the discussion in this article, and focus on the constructions of homosexuality. Brickell also shows how central figures of sexology, like Richard von Krafft-Ebing, Albert Moll and Havelock Ellis, by no means limited same sex-desire to a minority and portrayed it as being a heterogeneous phenomenon in terms of etiology and appearance.

5 David M. Halperin bases his defence of historicism/constructionism to a large extent on an argument that there did not exist a configuration that resembles "the nineteenth-century homosexual" with its combination of a deviant morphology and a deviant sexual subjectivity in early modern times. Halperin, David M. How to do the history of homosexuality. University of Chicago Press, Chicago 2004. Recent research by e.g. Kenneth Borris, however, has made a strong argument that this is the case within some works of early modern physiognomy and astrology. Borris, Kenneth. "Introduction: the prehistory of homosexuality in the early modern sciences." In Borris, Kenneth and George Rousseau (eds). The sciences of homosexuality in early modern Europe. Routledge, London 2008.

6 The 16th-century palmistry, that is, the study of hands, which identified certain traits of the hands of persons involved in same sex sexuality (see Borris 2008), is not the same as Ernst Kretschmer's 20th-century science of Konstitutionstypologie, which describes traits of a homosexual body. Although both theories in some sense portray same sex-desire as constitutional, as inscribed on the body of the individual, the effects and influences of these discourses and their connection to cultural understandings of subjectivity and identity are obviously quite different.

7 On this point I agree with Ivan Crozier, who argues that one should focus on and isolate "[...] exact approaches in discourses that belong together, rather than focusing on a phenomenon as if it is the same for numerous different fields." (Crozier, Ivan. "Nineteenth-Century British Psychiatric Writing about Homosexuality before Havelock Ellis: The Missing Story". Journal of the History of Medicine and Allied Sciences 63/1 (2008):67.

8 See e.g. Aina Schiøtz. "Medisin og juss: Ambisjoner og ulikheter. Opptakten til Den rettsmedisinske kommisjon 1880–1900." In Benum, Edgeir, Per Haave, Hilde Ibsen, Aina Schiøtz and Ellen Schrumpf (eds). Den mangfoldige velferden. Festskrift til Anne-Lise Seip. Gyldendal, Oslo 2003.

9 This was due to changes in sections 39 and 44 of the Criminal Law of 1902 passed by Parliament in 1929, effective from 1930. Besl. O. nr. 7. In Stortingets forhandlinger. Innstillinger og beslutninger. Oslo 1929:5–7.

10 I use the concepts "same-sex sexuality", "homosexualities" (plural) and "homosexuality" interchangeably to break up the picture of one phenomenon explained and understood in the same way. Same-sex sexuality is a general term meant to be an analytic concept independent of the historical context; "Homosexuality" is mostly used as a more historically specific concept limited to certain discourses about same-sex sexuality from the end of the 19th century. I am also using the word in plural to demonstrate the variety also within these discourses. See Plummer, Ken. Modern homosexualities. Fragments of gay and lesbian experiences. Routledge, London 1992.

11 In a broad sense discourse may be defined as "practices that shape the objects of which they speak". Delaporte, Francois. "The history of medicine according to Foucault." In Goldstein, Jan (ed.). Foucault and the Writing of History. Blackwell, Oxford 1994:139.

12 Skålevåg, Svein Atle. Fra normalitetens historie. Sinnssykdom 1870–1920. Stein Rokkan senter for flerfaglige samfunnsstudier, Bergen 2003:171.

13 Between 1905, when the Criminal Code came into force, and 1945, fewer than five men were found guilty annually. Innstilling fra Straffelovrådet om forandringer i straffelovens §§ 213 og 379. 1954:4. It seems that from the mid 1920s the section was mostly/only used when one of the men involved was under 21 years of age (that is, between 16 and 21) and the other over 21. For a history of section 213 to its abolishment in 1972, see Halsos, Martin Skaug. "Norway 1842–1972: When Public Interest Demands." In Rydström, Jens and Kati Mustola (eds.). Criminally Queer. Homosexuality and Criminal Law in Scandinavia 1842–1999. Askant, Amsterdam 2007.

14 Some of the observed men, however, were being charged for violations against both sections banning sexual relations to minors and section 213. The term "Pädophilia erotica" was coined by Richard von Krafft-Ebing in 1896, but it was never used in the expert opinions I have examined. Krafft-Ebing, Richard von."Ueber Unzucht mit Kindern und Pädophilia erotica." Friedreichs Blätter für gerichtliche Medizin 47 (1896).

15 National Archives, Oslo. The Commission of Forensic Medicine, Dbb 1, Jnr. 8/1930.

16 There is no evidence of a change (that is, nazification) as a result of the German occupation 1940–1945 in the reports I have analysed.

17 Innstilling I fra Straffelovkomiteen. Oslo 1925:39.

18 "Hans vesen er tydelig feminint, både i mimikk, tonefall og holdning. […] Legemlig er han velbygget og uten noensomhelst feminine trekk ved de sekundære kjønnkarakterer." National Archives, Oslo. The Commission of Forensic Medicine, Dbb 43, Jnr. 145/1945:8.

19 "[…] en overveiende heteroseksuell person med et visst homoseksuelt islett. […] litt bløte ansiktstrekk, bløt stemme, med noe visst bløtaktig over fremtoning og vesen." National Archives, Oslo. The Commission of Forensic Medicine, Dbb 40, Jnr. 172/1944:39–40.

20 "For det første må man regne med, at kjønnsdriften hos enkelte personer i utviklingsperioden ikke har nogen bestemt retning; de er hva man kaller biseksuelle. Blir deres følelser ledet i riktig (hetero-seksuel) retning, får de et normalt kjønnsliv. Men blir de utsatt for homosexuell forførelse, kan de få varig perversjon." Innstilling… 1925:39.

21 "[…] stansning av seksualutviklingen paa et forholdsvis ufærdig primitivt, barnlig nivaa." Innstilling 1925:16.

22 "[…] vekke slike følelser hos guttene[…]" National Archives, Oslo. The Commission of Forensic Medicine, Dbb 42, Jnr. 456/1944:25.

23 National Archives, Oslo. The Commission of Forensic Medicine, Dbb 8, Jnr. 219/1933.

24 "Disse handlinger antar vi neppe skyldes noe medfødt anlegg eller at de er hormonalt betinget, men vi oppfatter hans opptreden som en leilighetsvis opptredende seksuell surrogathandling hos en etisk og moralsk svekket, debil person, som er sløvet av alkohol." National Archives, Oslo. The Commission of Forensic Medicine, Dbb 36, Jnr. 419/42:28.

25 "Maskulin kropsbehåring." […] "Intet abnormt eller påfallende ved talen." National Archives, Oslo. The Commission of Forensic Medicine, Dbb 36, Jnr. 419/42:20.

26 National Archives, Oslo. The Commission of Forensic Medicine, Dbb 1, Jnr. 8/1930.

27 In Vogt's account, alcohol reduces the person temporarily to a childish level, and its effect is therefore comparable to the more permanent freezing of the sexual development mentioned above. Innstilling… 1925:166.

28 See Halperin 2004:29.

29 Foucault 1990:106.

30 Foucault, Michel. Power/knowledge. Selected interviews and other writings 1972–1977. Pantheon, New York 1980:194–195; Agamben, Giorgio. Was ist ein Dispositiv? Diaphanes, Berlin 2008.

31 Foucault 1990:106–107.

32 "Psychologico-ethical double" is Foucault's term. Foucault, Michel. Abnormal. Lectures at the Collége de France 1974–1975. Picador, New York 2003:16.

33 Foucault 2003:34.

34 Hand-written response by Hans Evensen, forensic psychiatric expert at the Commission. National Archives, Oslo. The Commission of Forensic Medicine, Dbb 21, Jnr. 535/1937.

Homosexuality, psychiatry and legal medicine in Franco's regime and Democratic Transition in Spain (1936–1979)

Àlvar Martínez Vidal and Antoni Adam Donat

Introduction

In August 1970, the Francoist Cortes (Spanish parliament) passed the Dangerousness and Social Rehabilitation Law (DSRL), designed to impede and punish, but, allegedly, also to rehabilitate those people who displayed behaviour which the legislators considered to be an intrinsic threat to society, even in the absence of any kind of crime. This late Francoist law was an update of the primitive 1933 Layabouts and Delinquents Law, which had already been amended in 1954 in an atmosphere characterised by political and economic autarchy[1]. Certainly, the 1970 law was promulgated in order to defend the Establishment to the last in a context of political dictatorship and not at all, as its title could suggest, to rehabilitate those socially excluded[2]. Thus, hooligans, vagrants, delinquents, layabouts, drunkards, the mentally ill, homosexuals, prostitutes, pimps and other marginal individuals became increasingly bigger suspects in the eyes of the law. They became a target for the forces of law and order, regardless of whether they had committed an offence or not. The DSRL aimed to impose behaviour, beyond the terms of the penal code, according to the ethical principles shared by the legislators.

Following this law, social dangerousness was understood as an intangible concept related to menace and risk derived from the potential danger to morality, decency and coexistence. Undefined by the legislator, social dangerousness actually depended on the judge's own criteria and on his personal interpretation of the law[3]. In fact, implementation of this act was largely repressive and not rehabilitative, since no funds were provided by the government to carry out the measures of social rehabilitation laid down in the text of the law. The fact that no centres were fitted out to accommodate these supposedly dangerous people meant that, despite not being accused of any offence, those arrested under the terms of the DSRL were confined in ordinary prisons and other detention units[4]. Compared with the Layabouts and Delinquents Law of 1954, the new legal framework signified a substantial change because "this [1970] law was not related to delinquency" but to "a problem of social morality"[5]. In comparison with previous legislation, the DSRL, based on the principle of social defence, intensified repression and encouraged social exclusion in spite of the innovatory aim of socially rehabilitating potentially dangerous persons[6].

From the standpoint of medicine and sexual standards, the DSRL deemed any manifestation of homosexual behaviour to be explicitly dangerous not only because it was an offence against public decency but also because it carried the risk of spreading moral corruption for the rest of the population. In practice, the new law amounted to a consolidation of a pre-existing stigma and a reinforcement of the social exclusion of homosexuality. Paradoxically, this tightening up of the Spanish legal framework coincided, on the one hand, with the repeal of punitive anti-homosexuality laws in several European countries and, on the other, with the key debate in American psychiatry over the pathological condition of this sexual orientation[7].

Indeed, the late sixties and early seventies witnessed a long and heated controversy within the American Psychiatric Association (APA), which finally led to the declassification of homosexuality as a mental illness in 1973[8]. It is common knowledge that this modification of the pathological status of homosexuality in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was made after a referendum among psychiatrists who were APA members. To a large extent, this change was a response to the radicalisation, mainly in the United States but also in some European countries, of the struggle for sexual liberation and the consolidation of groups and networks of homosexual activists, such as the Gay Liberation Front[9].

In retrospect, the singularity of the formulation, promulgation and application of the Dangerousness and Social Rehabilitation Law with regard to homosexuality went against the mainstream in western countries. It also requires of historians a deeper analysis of a period marked by the development of a mass tourism industry and the massive savings which Spanish emigrants sent home to their families from France, Germany and other European countries. This article aims to explore the medical arguments, most of them taken from legal medicine, which could explain how, in respect to homosexuality, such a peculiar legal framework was produced at the end of the Francoist dictatorship.

Overlaps between psychiatry and legal medicine: Valentín Pérez Argilés and his *Discourse on Homosexuality* (1959)

In recent years a number of studies have dealt with the intersections between medicine and the regime of sexuality in Spain, focusing on the discourses of psychiatry in relation to homosexuality. One of the main results is the assertion that, in Spanish academic psychiatry of the time, there was no systematic discourse on homosexuality but that there was a good deal of prejudice and neglect framed by an attitude of ignorance and intolerance[10]. For example, Antonio Vallejo Nágera (1889–1960), the most representative figure of Spanish psychiatry during the first two decades of Francoism, insultingly labelled homosexuals "prison trash"[11]. In opposition to those who saw homosexuals as suffering from a medical condition, Vallejo postulated their criminalization and proclaimed: "it is not the job of doctors or biologists to decide on a punishment for such sexual delinquents, but that of jurists, and it is to them that we leave the problem"[12].

Nevertheless, *El libro de la vida sexual*, published in 1968 by psychiatrist Juan José López Ibor (1908–1991)[13] and a milestone in the popularisation of sexological literature in the last years of the regime, offered an interpretation of homosexuality which was closer to the medical model though without excluding the idea that such sexual practices derived from a degenerative nature[14] and represented a danger to society[15]. It should be noted that López Ibor headed the IV World Congress of Psychiatry held in Madrid in 1966, and from then until 1972 he presided the World Association of Psychiatry.

Unlike psychiatry, legal medicine of the period adhered to a deeper and more comprehensive approach to homosexuality, logically restricted to the ambit of crime and delinquency. Homosexuality was included in the chapter on forensic sexology, under sexual perversions and close to rape and abortion. The most outstanding example of this approach is, without any doubt, the *Treatise on Legal Medicine* by Leopoldo López Gómez (*fl.* 1945) and Juan Antonio Gisbert Calabuig (1922–2000)[16]. The handbook quickly became the standard in the discipline, inside and outside medical faculties, throughout the second half of the 20th century in Spain, and it continues to be the reference book on the subject.

This difference between psychiatry and legal medicine could probably be explained by the different level of academic institutionalisation of the two disciplines. The country's first chair of psychiatry was created only in 1946, and in the 1950s there were still very few of them in Spanish universities, whereas there were everywhere professorships of legal medicine, dating back to the middle of the 19th century[17].Moreover, the School of Legal Medicine, which was annexed to the University of Madrid, trained a number of physicians who had previously passed a specific entry exam. On completion of studies, they became members of the National Body of Forensic Physicians, created in 1862. Besides, every forensic physician was assigned to a regional Forensic Anatomic Institute, an auxiliary body established the Ministry of Justice in 1948 with offices in Madrid, Barcelona, Valencia and Seville[18].

In fact, during Francoism, there was a considerable overlap between the two disciplines: throughout most of this period psychiatry was taught by professors of legal medicine, especially in the peripheral universities. They occupied the professorships of psychiatry and were obliged to blend the exegeses of clinical and forensic psychiatry in their lessons on legal medicine. This is probably why during the Franco period and the Democratic Transition not just homosexuality but in fact all medical sexology was a territory which academic psychiatry could only claim to share with or inherit from legal medicine. In this respect, it is significant that the main contribution of a monographic nature – in fact, a doctoral thesis – about homosexuality came from the field of legal medicine in the years in which the Dangerousness and Social Rehabilitation Law (DSRL) was in force[19]. This study, published in 1981, was based on a sample of 205 homosexual inmates of different Spanish prisons and carried out between 1975 and 1977[20]. It is within this framework that we intend to analyse the medical and scientific foundations for justifying a law promulgated in 1970, the DSRL, which sent thousands of people of same-sex practices to jail.

Pursuing the hypothesis of the academic overlapping between psychiatry and legal medicine in Spain at the time, it is hardly surprising that a professor of legal medicine at the Universidad de Zaragoza (incidentally a peripheral university), Valentín Pérez Argilés[21] (1907–1988), should have delivered a *Discourse on homosexuality*[22] in 1959, in which he attempted to recapitulate all the platitudes about sexual perversions, even though he had made only passing reference to sexuality in his *Lessons of psychiatry: clinics and legal medicine*[23] published in 1941. This *Discourse*, as we shall now attempt to show, constituted the scientific basis which, conveniently re-elaborated and transferred from legal medicine to law (to jurisprudence and legislation), would confirm the alleged threat of homosexuals to society and justify the need to introduce repressive measures designed to isolate, restrict, treat and, paradoxically, rehabilitate them.

In his 1941 book *Lessons of psychiatry,* Pérez Argilés hardly mentioned homosexuality, not even including it among mental illnesses or instinct disorders, despite having reviewed – or so he claimed – "up to a total of over four hundred studies"[24] by different authors of varying persuasions. Homosexuality did get a mention, under the epigraph of psychopathies, in the classification of mental illnesses proposed by Pérez Argilés using Emil Kraepelin's nomenclature[25]. Yet in 1959, after making no further contribution to the field of sexology, Pérez Argilés dedicated his speech at the opening session of the academic year at the Real Academia de Medicina de Zaragoza to the subject of homosexuality. The *Discourse* was a markedly rhetorical text, apparently scholarly, full of authoritative though unreferenced citations, and expressly written to be delivered at a solemn academic event before university, military and civil authorities. It ranged over all sorts of considerations: homosexuality in animals; the punishments for sodomy laid down in medieval codes; "the practice of the Greek vice" in Antiquity; the extremely large proportion of homosexuals to be found in Germany and England compared with the "very low proportion" in Spain; and even the treatment of 'inversion' in the old collection of Spanish sayings. The *Discourse* also included an invective against so-called "defenders of homosexuality", authors such as Karl Ulrichs, Magnus Hirschfeld and, above all, André Gide. Implicitly, Pérez Argilés alluded also to Gregorio Marañón as one of the Spanish defenders.

Special mention should be made of the section in the *Discourse* that Pérez Argilés entitled "Penal configuration of homosexuality" in which he outlined its contagious nature, comparing it to tuberculosis:

> The postulators of the impunity of homosexuality, after the Napoleonic Code, are taking advantage of the evolution of medical doctrines to provide a basis for their position, and thus we come, in the immediately preceding contemporary era, to the concept of the so-called "intersexual stages", which appear to constitute a satisfactory explanation for the fact of homosexuality. At this point, the following reasoning is confidently put forward: 'The homosexual is not responsible for his homosexuality, just as the diabetic is not responsible for his diabetes'. The comparison is a fair one as the two concepts are both taken from the field of endocrinology, according

> to the prevailing theories at the time it was formulated; however, as with other comparisons, it is partially false. In fact, the diabetic carries no threat of contagion. The comparison would be fairer if I said: 'Nor is the tuberculosis sufferer guilty of his tuberculosis; but he will be gravely responsible if, out of hatred for the rest of healthy humanity (wilful misconduct), or neglecting the risk of his contagiousness (negligent misconduct), or out of ignorance etc. (culpably), he sets out to spread his bacillifer sputa'.[26]

According to Pérez Argilés, like the tuberculosis sufferer, the homosexual would be seriously responsible for the spread of his 'disease', making him a real danger to society. This threat would at times be wilful ("frequent proselytising zeal"), sometimes negligent misconduct ("when he makes his conquests without concern for the person he approaches"), and sometimes he would act culpably ("on those occasions that, in good faith, he mistakenly believes he is approaching one of his kind"). Pérez Argilés thus concluded: "the essence of the social threat of the radical invert lies in his contagiousness"[27].

This section, like the *Discourse* as a whole, was aimed at all those who saw in homosexuality a psychopathological condition, which at once medicalised and decriminalised it. In pre-Civil War Spain, the above-mentioned Gregorio Marañón (1887–1960), an endocrinologist, eminent clinician and prestigious essayist, had been the leading exponent of a medical sexology which had a huge influence not only in Spain[28] but also in many Latin American countries[29]. On the basis of an endocrinological conception, Marañón included homosexuality in the intersexual states and postulated that considering it a criminal offence "was not only foolish in the scientific domain, but also in social terms a tactic [that was], as well as [being] inhumane, notoriously counterproductive, given the peculiar psychology of homosexuals". In the eyes of this author, it was counterproductive because legal proceedings would be followed by "an intensification of homosexuality". He cited the case of Oscar Wilde as a clear example of "a large part of the current vogue for homosexuality"[30].

Without citing it explicitly, Pérez Argilés refuted the endocrinologically-based aetiology postulated by Marañón in defence of the decriminalisation of homosexuality; and, using an argument that was both surreptitious and fallacious, he likened homosexuality to tuberculosis, a disease which was contagious and socially stigmatised at the time. Moreover, according to Pérez Argilés, homosexuality involved in most cases, besides its contagiousness, "monstrous criminality". Hence, he insisted that, before "a quartered corpse", the investigation must always turn its attention to "the circles of the inverts". Among women, crimes of this kind were even more bizarre: "And these horrendous derivations from homosexual zelotypia involve sometimes even more cruel refinement in feminine homosexuality"[31]. This claim, slipped into an academic address, that homosexuality was at once contagious and dangerous was to prove decisive when a few years later an attempt was made to legitimise, using scientific arguments borrowed from psychiatry and legal medicine, the reform of the 1954 Layabouts and Delinquents Law, a reform which would eventually pave the way for the Dangerousness and Social Rehabilitation Law of 1970.

The immediate impact of Pérez Argilés's *Discourse* is indicated by the fact that in 1962 it was cited and described as a "documented study" on the subject of homosexuality by López Gómez and Gisbert Calabuig in their *Treatise on Legal Medicine*, in the section devoted to "Sexual Perversions" in the chapter on "Forensic Sexology":

> Homosexuality or sexual inversion comprises the genesic tendency towards individuals of the same sex, often linked to an intense repulsion for the opposite sex. Such an aberration has been observed in both men and women. It has recently been the subject of a documented study by professor Pérez Argilés.[32]

The influence of the *Discourse on homosexuality*, however, extended beyond strictly medical circles, and soon seeped into the domain of law. In 1963, for instance, it was quoted by Luis Vivas Marzal[33], president of the Provincial Court of Valencia, in his inaugural speech to the Academia Valenciana de Jurisprudencia y Legislación. More importantly, the *Discourse* became a paramount landmark for judge Antonio Sabater Tomás, the most prominent Spanish expert on social dangerousness at the time.

Homosexuality and the law: Antonio Sabater Tomás and the Dangerousness and Social Rehabilitation Law

In legal circles, the repressive approaches in the *Discourse on Homosexuality* by Pérez Argilés were noted and taken on board by Antonio Sabater Tomás (b. 1913), Magistrating Judge of Layabouts and Delinquents for Catalonia and the Balearics, who in the 1960s was one of the jurists responsible, though not as the ultimate authority, for preparing a draft text for a revision of the Layabouts and Delinquents Law. Author of a lengthy legal study, he advocated social defence in response to the certain danger which homosexuals represented[34].

Sabater Tomás was well known at the time for his dedication to the study of problems related to delinquency and marginality[35]. In 1962, he published *Hooligans, Homosexuals, Layabouts and Delinquents. A Legal-Sociological Study*[36] and in 1967 *Young Delinquents. A sociological and penal study*[37]. It is worth noting that in these two works, Sabater put forward different medical theories in an attempt to legitimise the legal arguments for applying coercive measures against all those individuals who might represent a threat in the eyes of the legal doctrine of social defence, dressing them up in a scientific cloak[38].

As regards legislation in Spain, neither the Penal Code of 1932 nor the so-called Layabouts and Delinquents Law of 1933 – both promulgated under the Second Republic (1931–1939) – mentioned homosexuality. This does not mean, however, that same-sex practices were commonly accepted at the time. The 1954 reform of the Layabouts and Delinquents Law, promulgated in a context of clerical dictatorship and political and economic autarchy, included homosexuals and defined them as dangerous subjects, along with "ruffians and pimps"[39].

The 1954 version of the Layabouts and Delinquents Law was very soon overtaken by the "developmentism" of the sixties, which led to what came to be known as the

"Spanish miracle". The economic boom that followed the Stabilisation Plan of 1959 brought wide-ranging social and economic changes: the entry of "technocrats" into government; mass exodus from rural communities; large remittances from millions of Spanish emigrant workers in the neighbouring countries of the European Common Market; and mass tourism of foreigners, who spread mores of greater sexual permissiveness. Overwhelmed by these changes, the 1954 Law became obsolete in little over a decade. It would appear that the Regime's most conservative sectors thought it necessary to amend the law in order to keep the values of the dictatorship intact within the ideological framework of National Catholicism.

In an order dated 4 October 1967, the Ministry of Justice appointed a commission to reform existing legislation[40]. One of the members of the commission was Antonio Sabater Tomás, who, as mentioned previously, was a prestigious jurist and considered an expert because he held the post of Special Magistrating Judge of Layabouts and Delinquents and was a member of the International Association of Penal Law; moreover, he had an advisory role in delinquency-related issues in various Latin American countries and had published widely on the subject**.** His court experience and, above all, his writings gave him unique authority in formulating the terms of the new legislation, and we shall examine his views on criminal law and homosexuality here in some detail.

Like most of his Spanish juridical colleagues, Sabater Tomás believed in the principle of social defence. As defined professor Octavio Pérez-Victoria Moreno in the prologue to Sabater's 1962 book *Hooligans, Homosexuals, Layabouts and Delinquents. A Legal-Sociological Study*, the principle of social defence meant the need to establish a system of penal and administrative security measures designed to prevent criminality[41]. In a forty-five-page chapter of the book, Sabater Tomás argued emphatically that homosexuality came under the principle's purview. He presented a markedly degrading vision of homosexuality, backed up with the main medical arguments necessary to prop up and legitimise the legal discourse with which he aimed to justify the inclusion of homosexual people among dangerous individuals in a future layabouts and delinquents law.[42] It should be pointed out that, with regard to the legal treatment of marginality, the whole book is full of quirks and prejudices and lacks the slightest critical appraisal of the adduced data and the sources from which they were taken.

According to Sabater Tomás, there were two types of dangerousness: pre-offence threat, referring to individuals who live in a dangerous state but who had not yet to commit an offence, and post-offence threat, in obvious reference to delinquents[43]. He thus placed "alcoholics, regular drinkers or habitual drunkards" in the dangerous individual category. Nor did he forget "the mentally ill, either because they have broken the law, they have shown symptoms of agitation, because of permanent insanity, cretinism or imbecility". He also included "the feebly minded of all kinds, those who seem to be prone to crime, individuals who behave in a disorderly and depraved manner or venereal contagious diseases [sic]". And, obviously, he did not omit “those who practise homosexualism” from this category[44]. Sabater claimed that homosexual practices were “a manifestation of psychopathic personality, of a pathologically-rooted defective personality, invincible and unmodifiable”[45]. Yet despite such deeply-rooted personality traits, he argued that the homosexual should receive treatment and medical–social care, as “scientific doctrine understands that the social problem of homosexuality should be resolved by medicine”[46].

Sabater Tomás went back to the classic works on medical sexology like *Psycopathia sexualis* by Richard von Krafft-Ebing to describe some examples of homosexual delinquents. His main reference, however, was *Discourse on Homosexuality* by Valentín Pérez Argilés, the previously cited professor of legal medicine at the Universidad de Zaragoza. Reproducing literally fragments from the *Discourse*, he attributed the homosexual with a capacity for contagion similar to that of the tuberculosis sufferer, who “out of hatred for the rest of healthy humanity, or neglecting the risk of his contagiousness, or out of ignorance etc, sets out to spread his bacillifer sputa”[47].

Furthermore, Sabater put forward the notion that homosexuals were characterized by an intense instinctive life, a fact which in his view meant there was no place for them in civilization. He went on to say that society could not tolerate these instincts, which crossed ethical, cultural and legal boundaries and also went against human progress. Echoing his mentor Pérez Argilés, he added: “… they are highly dangerous, displaying manifest ethical deviation, coldness and lack of feelings, which drives them, amongst other forms of aggression, to murder”.[48]

In Sabater’s view, some of these homosexuals were “jealous, sadistic, brutal individuals suffering from a persecution complex, who castigate, carry weapons, make death threats and sometimes kill, all of which is the product of their homosexuality, which they are unable to suppress”[49]. These characteristics led him to regard them as the group with the highest level of criminality and delinquency[50]. Their most habitual destiny was prison or a madhouse, since – to use his exact words – “it is not possible in our ambit to apply preventive measures to them”[51]. Based on these two inherent attributes of the homosexual – criminality and contagiousness – Sabater proposed special legislation – preventive, punitive and rehabilatory – which would tackle the great danger of homosexuals to society. Here in 1962 he was already anticipating the contents of some paragraphs of the future 1970 Law.

A year later, in 1963, he published an article specifically entitled “Homosexuality and the Layabouts and Delinquents Law”, which in addition to brandishing the same criminalising arguments of his book *Hooligans, Homosexuals, Layabouts and Delinquents* included the claim made by Juan Antonio Gisbert Calabuig, co-author of the *Treatise on Legal Medicine* (Valencia, 1962), that homosexuals “are not alienated and, being legally responsible, must be accountable before the courts for their actions”[52].

Thus, the jurist Sabater Tomás was in full agreement with the psychiatrist Vallejo Nágera and with the legal–medical experts Pérez Argilés and Gisbert Calabuig regarding the criminalisation of homosexuality. Accordingly, his advocacy in the reform commission that any new legislation should treat homosexuals as dangerous subjects simply because of their sexuality had the support of the three academic communities that carried most influence in such matters.

Such was the legal–medical framework of Spain's Dangerousness and Social Rehabilitation Law of 1970. It was promulgated during the waning years of the Francoist dictatorship in a context characterised by economical expansion and political sclerosis. It was based on the principle of social defence and incorporated the nominally innovatory aim of socially rehabilitating potentially dangerous people. Yet in practice the new law consolidated marginalisation by legal means, making homosexuality a behaviour considered potentially damaging to society as a whole and hence punishable by law. With regard to same-sex behaviour, Franco's Dictatorship was thus sanctioning what is known as 'an offence without a victim'[53].

Conclusion

We have tried to explain how in the last years of Franco's dictatorship, just when a gay liberation movement was starting in a number of Western countries, legal repression of homosexuality in Spain was reinforced. The combination of the discourse of psychiatrists and legal physicians and that of legislators produced legislation which allowed police to detain and imprison persons solely on the accusation of committing same-sex practices.

In the decade following its passage in 1970, the Dangerousness and Social Rehabilation Law led to the preventive detention of an uncertain number of homosexuals – thousands of young men, generally from poor social backgrounds and with low educational levels. After police roundups, those detained were taken first to big-city police headquarters before being transferred to general prisons, where they were held alongside all types of common criminals. Here they were classified, and a number of them were sent on to special penitentiary establishments in the cities of Badajoz and Huelva, which supposedly had facilities for providing them with medical and psychological treatment and also social rehabilitation programmes[54]. In practice, there were no specific programmes beyond aversive therapies (principally electroshock and induced vomits) and in a few cases lobotomy, too[55]. These people – "social inmates" – did not benefit from the general amnesty of 1977, a key year in the Democratic Transition, which was granted to all political prisoners. Although homosexuality was eliminated as a dangerous state from the Dangerousness and Social Rehabilitation Law in January 1979, legal proceedings against the victims and the police files on them were not annulled until the year 2000, and only after a long, hard legal battle fought on behalf of those persecuted. It should be added that, in December 2007, the Spanish State passed a specific law which recognised as victims all those people who had been subjected to persecution or violence during the civil war and the dictatorship for behaviour related to options including "sexual orientation"[56].

By way of epilogue, we would like to add that the promulgation of this Law prompted the organisation of the first clandestine groups of gay activists in Spain. In close cooperation with feminist collectives, these groups formed strategic alliances with political and trade union movements, also clandestine, although the latter took time to take on homosexuals' specific demands, in particular the repeal of the Dangerousness and Social Rehabilitation Law, which was the main aim of gay activism in the 1970s[57]. The activities of these groups would provide an interesting focus for future research, as would the number and characteristics of the victims who were imprisoned while this Law was in force. The current lack of information is overwhelming. More needs to be known about the circumstances of their detention, the forms and places of their confinement, the psychological handling and, especially, the medical treatments they suffered in order to be healed and rehabilitated. And, of course, the results of such a research should be located in a European comparative perspective, including especially those countries which have suffered from dictatorial regimes.

Notes

1 Campos, Ricardo. "¿Psiquiatría para los ciudadanos o psiquiatría para la represión? El problema de la peligrosidad del enfermo mental." In Campos, Ricardo, Olga Villasante and Rafael Huertas. De la "Edad de Plata" al exilio. Construcción y "reconstrucción" de la psiquiatría española. Frenia, Madrid 2007:15–36.

2 Terradillos Basoco, Juan. Peligrosidad social y estado de derecho. Akal, Madrid 1981:61–63.

3 Terradillos Basoco 1981:118–128.

4 Terradillos Basoco 1981:63.

5 Fiscalía del Tribunal Supremo. "Circulares relacionadas con la LPRS". Madrid 1972:10. Quoted by Terradillos Basoco 1981:125.

6 Terrasa Mateu, Jordi. "Estudio jurídico de la legislación represiva franquista." Orientaciones. Revista de homosexualidades 7 (2004):83–100.

7 Adam Donat, Antoni and Martínez Vidal, Àlvar. "Homosexualitat i perillositat social: bases mèdiques i científiques d'una llei tardofranquista." Actes d'Història de la Ciència [forthcoming].

8 Bayer, Ronald. Homosexuality and American psychiatry. The politics of diagnosis. With a new afterword on AIDS and homosexuality. Princeton University Press, Princeton 1987.

9 Terry, Jennifer. An American obsession. Science, medicine, and homosexuality in modern society. The University of Chicago, Chicago 1999.

10 Adam Donat, Antoni and Martínez Vidal, Àlvar. "'Consideraciones sobre tan repugnante tendencia sexual': la homosexualidad en la psiquiatría del franquismo." Orientaciones. Revista de homosexualidades 7 (2004):51–72.

11 Vallejo Nágera, Antonio. Higiene de la raza. La asexualización de los psicópatas. Ediciones Medicina, Madrid 1934:89.

12 Vallejo Nágera 1934:89; Vallejo Nágera, Antonio. Tratamiento de las enfermedades mentales. Sucesores de Rivadeneyra, Madrid 1940:26.

13 López Ibor, Juan José. El libro de la vida sexual. Danae, Barcelona 1968.

14 Mira, Alberto. De Sodoma a Chueca. Una historia cultural de la homosexualidad en España en el siglo XX. Egales, Barcelona-Madrid 2004:300–302.

15 Adam Donat and Martínez Vidal 2004:61–69.

16 López Gómez, Leopoldo and Juan Antonio Gisbert Calabuig. Tratado de Medicina Legal. Editorial Saber, Valencia 1962.

17 Corbella, Jacint. Antecedentes históricos de la medicina legal en España. Promociones y Publicaciones Universitarias (PPU), Barcelona 1995:295–297.

18 Royo-Villanova, Ricardo and Blas Aznar. Lecciones de medicina legal. Gráficas Benzal, Madrid 1954:15–21.

19 García Valdés, Alberto. Historia y presente de la homosexualidad. Akal, Madrid 1981.

20 García Valdés 1981:123–199.

21 Solsona, Fernando. "Centenario del nacimiento del Prof. Valentín Pérez Argilés (17.I.1907–11.XII.1988)." Boletín del Ateneo de Zaragoza 133 (2007):1.

22 Pérez Argilés, Valentín. Discurso sobre homosexualidad. Publicaciones de la Real Academia de Medicina del Distrito de Zaragoza, Zaragoza 1959.

23 Pérez Argilés, Valentín. Lecciones de psiquiatría (clínica y medicina legal). Librería General, Zaragoza 1941; Pérez Argilés, Valentín and Ramón Rey Ardid. Lecciones de psiquiatría (clínica y medicina legal). Librería General, Zaragoza 1957.

24 Pérez Argilés 1941:6.

25 Pérez Argilés 1941:91–94; Pérez Argilés and Rey Ardid 1957:117.

26 Pérez Argilés 1959:25–26.

27 Pérez Argilés 1959:26.

28 Glick, Thomas. "Marañón, intersexuality and the biological construction of gender in 1920s Spain." Cronos 8 (2005):121–137.

29 Ferla, Luis. "Gregorio Marañón y la apropiación de la homosexualidad por la medicina legal brasileña." Frenia 4 (2004):53–76.

30 Marañón, Gregorio. Los estados intersexuales en la especie humana. Javier Morata, Madrid 1929:125–126.

31 Pérez Argilés 1959:34.

32 López Gómez and Gisbert Calabuig 1962, vol. II:7.

33 Vivas Marzal, Luis. Contemplación jurídico-penal de la homosexualidad. Discurso de ingreso. Publicaciones de la Academia Valenciana de Jurisprudencia y Legislación, Valencia 1963:9–10.

34 Adam Donat, Antoni and Àlvar Martínez Vidal. "Homosexualitat i perillositat social: bases mèdiques i científiques d'una llei tardofranquista." Actes d'Història de la Ciència i de la Tècnica [forthcoming].

35 Pintó i Ruiz, Josep-Joan. "Contestació (…)." Revista Jurídica de Catalunya 93 (1994):398–418.

36 Sabater Tomás, Antonio. Gamberros, homosexuales, vagos y maleantes. (Estudio jurídico-sociológico). Editorial Hispano Europea, Barcelona 1962.

37 Sabater Tomás, Antonio. Los delincuentes jóvenes. Estudio sociológico y penal. Editorial Hispano Europea, Barcelona 1967.

38 Adam Donat, Antoni and Àlvar Martínez Vidal. "'Infanticidas, violadores, homosexuales y pervertidos de todas las categorías': la homosexualidad en la psiquiatría del franquismo." In Ugarte Pérez, Javier. Una discriminación universal. La homosexualidad bajo el franquismo y la transición. Egales, Barcelona-Madrid 2008:109–138.

39 Boletín Oficial del Estado, 17/07/1954.

40 Terrasa Mateu, Jordi. "La legislación represiva." In Ugarte Pérez 2008:79–107.

41 Pérez-Victoria Moreno, Octavio. "Prólogo". In Sabater Tomás, Antonio. Gamberros, homosexuales, vagos y maleantes. (Estudio jurídico-sociológico). Editorial Hispano Europea, Barcelona 1962.

42 Sabater Tomás 1962:175–219.

43 Sabater Tomás, 1962:25.

44 Sabater Tomás, 1962:26–29.

45 Sabater Tomás, 1962:176.

46 Sabater Tomás, 1962:176.

47 Pérez Argilés 1959:25–26; Sabater Tomás 1962:179–180.

48 Sabater Tomás, 1962:180.

49 Sabater Tomás, 1962:183.

50 Sabater Tomás, 1962:183.

51 Sabater Tomás, 1962:184.

52 Sabater Tomás, Antonio. "La homosexualidad y la Ley de Vagos y Maleantes." Revista Jurídica de Cataluña 62 (1963):470–475.

53 Ugarte Pérez, Javier. "Introducción." Una discriminación universal. La homosexualidad bajo el franquismo y la transición. Egales, Barcelona-Madrid 2008:13–47.

54 Gutiérrez Dorado, Antonio. "La voz de la memoria." In Ugarte Pérez 2008:247–256.

55 Gutiérrez Dorado 2008:251.

56 Boletín Oficial del Estado, 27/12/2007.

57 Petit, Jordi and Pineda, Empar. "El movimiento de liberación de gays y lesbianas durante la Transición (1975–1981)." In Ugarte Pérez 2008:171–197.

The trial of Ronald True (1922) and medical and psychiatric reactions to the M'Naghten rules

Ivan Crozier

Introduction

This paper addresses an important English trial in which psychiatric knowledge was central, and which fitted into a much longer debate between doctors, lawyers and psychiatrists on the status of psychiatric knowledge in law. To cut to the chase, one should note that a number of psychiatrists since the formulation of the laws of insanity in the M'Naghten Rules of 1843, and increasingly so since the 1890s, were dissatisfied with the perceived difference between their accounts of insanity and those supported by the legal profession.[1] The trial of Ronald True was seen by some to be an opportunity to test, and perhaps change, the laws of insanity and criminal responsibility that had been developed in the 1840s, before psychiatry was a particularly sophisticated discipline. This opportunity arose because four psychiatrists gave evidence for the defence that True was certifiably insane, and this evidence was not countered with psychiatric opinion from the Crown. Rather, the Crown relied upon a stringent application of the existing insanity laws to build its case.

To contextualise the issues of insanity and criminal responsibility (and thus the position of psychiatrists) in English law, it is necessary to give some background. The status of criminal responsibility was under a state of gradual change at the time of True's trial. To illustrate this point, in 1883 JF Stephen suggested in his *Digest of the Laws of England* that the M'Naghten Rules (which were used to determine criminal responsibility) be expanded, particularly by the addition of a third clause that would allow for so-called irresistible impulses to demonstrate madness and irresponsibility. Stephen's addition read:

> If it is not, it ought to be the law of England that no act is a crime if the person who does it is at the time prevented either by defective mental power or by any disease affecting his mind from controlling his own conduct, unless the absence of the power of control has been produced by his own default.[2]

This development had been supported by a number of judges, such as Bray J and Darling J, who had tried to implement some of Stephen's suggestions (although of course within the confines of the law). These suggested amendments had also been looked upon favourably by the Medico-Psychological Association (MPA), who sought to abandon M'Naghten, and by the British Medical Association (BMA), who it will be seen agreed with the suggested amendments of Stephen. Both medical organisations implemented committees to establish alternatives to or support for M'Naghten, and particular attention was given to the issue of irresistible impulse. After True, these documents were drawn upon as a part of a legal re-evaluation of the Lunacy Laws. Interestingly, the two medical bodies were at odds over these laws. While the MPA pushed to change these laws by seriously undermining the M'Naghten Rules,[3] the BMA resisted such changes and hoped to maintain the status quo with one significant amendment over irresistible impulse.[4] These differences are the focus of the antepenultimate part this paper. In order to get to this issue, I will give a quick outline of the legal point in query – the M'Naghten Rules – and then look at True's trial to examine the strategies employed by the defence and Crown to negotiate these Rules. It is really in the aftermath of the trial that these professional differences are made clear.

The M'Naghten Rules

The laws of insanity in 1922 had a number of axes. They controlled when the insane signed contract, wills, or married, and so forth. And for the purposes of this paper, they dealt with cases when a lunatic had committed a crime. This last issue was deeply entrenched in the law – for a crime to have been committed, the perpetrator had to be shown not only to have done the act, but to have been responsible for its commission. The law on this matter was formalised in 1843, after the trial of Daniel M'Naghten, a Scottish wood turner who had killed Sir Edward Drummond in the belief he was assassinating the Prime Minister, Sir Robert Peel. It was shown that M'Naghten was suffering from insane delusions of persecution, and on the request of Queen Victoria, a panel of Judges in the House of Lords was formed to sort out the law on the insanity defence. The formulation given by the panel stated: "… it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing was wrong."[5] This formulation has been the basis of over a century and a half of legal struggle in England and the colonies that took on the English legal system.[6]

After 1843, to be responsible meant that it had to be shown both that the accused had understood what they were doing, and that they understood the nature of this crime; they had to be compos mentis (in one's right mind), and had to understand that the crime was wrong (in the moral, not legal, sense is implied). To use an important seventeenth-century formulation, *actus non facit reum nisi mens sit rea*, an act does not make a person guilty unless (their) mind is also guilty.[7] For these reasons, children under six are considered to be criminally irresponsible, as they are assumed not to know the true nature of their crime. It is also the case that anyone who can be shown to have been so insane as not to know that they had done, or not to have understood its significance as a wrong act, was unable to be considered culpable, and should therefore be put under the appropriate care: that is, they were considered "not guilty by reason of insanity", and after the Trial of Lunatics Act of 1883 as "guilty but insane". It should be clear that these were questions of increasing significance to psychiatrists after the 1840s, and especially by the 1890s, when they suggested that changes in psychiatric knowledge required a re-thinking of the scientific basis for criminal responsibility. The "disease of the mind" that had been relied upon in M'Naghten had a much broader scope for psychiatrists. And more importantly, the cognitive aspect – knowing right from wrong – was concluded by many psychiatrists as being irrelevant to a person's mental state, in opposition to the Lockean foundations of English law. That is, psychiatrists held that delusion was no longer the hallmark that it had been at the time of Daniel M'Naghten's trial.

These issues were also of great import prior to 1957 Homicide Act, which greatly restricted capital punishment prior to the Murder (Abolition of the Death Penalty) Act 1965. If the perpetrator of a capital offence – as in the case of True – was found guilty, they would be hanged unless given reprieve or exculpated on the basis of their mental state. If they were found to be legally irresponsible, that is "not guilty by reason of insanity", they were to be incarcerated in a suitable mental institution or prison hospital, such as Broadmoor. This in effect meant a professional rivalry over disposal of murderers – the gallows or the prison hospital.

A further piece of information necessary to make sense of the trial of Ronald True was the long-standing legal issue of the carrying out of a sentence. A great many legal commentators in Britain, such as Lords Coke, Hale and Colerige, had suggested that there were grave problems with hanging the insane – as they would not be able to make their peace with God. This religious conviction meant that judges were unable to condemn an insane man. In effect, this meant that a reprieve could be given. After 1840, and maintained in the Trial of Lunatics Act of 1883, such a reprieve was to be served by the Home Secretary on the advice of two or more psychiatrists that the offender was certifiably insane. This situation would also add a dimension to the trial of Ronald True, and would be debated in the aftermath of his trial in the courts in England. In order to see this situation in action, it is necessary to turn to the trial of Ronald True.

Overview of the crime and capture[8]

At around 7 a.m. on the morning of Monday, 6 March 1922, Ronald True, the illegitimate son of Lady de Freyne, murdered a prostitute – Gertrude Yates, known as Olive Young – in her basement flat at 13a, Finborough Road, Brompton. He did so with extreme violence: after bringing her a cup of tea in bed, he hit her in the head a number of times with a rolling pin, asphyxiated her by stuffing a towel deeply into her throat, pulling back her tongue in the process, and then strangled her with the cord from her dressing gown. He dragged her dead naked body to the en suite bathroom, threw her dressing gown over her body, arranged some pillows in the bed to make it seem like Yates was sleeping, and then robbed her of her jewels and money. He did not leave her flat immediately. At around 9.30 a.m., Yates' maid, Emily Steel, came to start work, and noted that True's overcoat and scarf were in the lounge, and that some tea had been made. She put on some sausages for breakfast. True came out of the room, told Steel not to wake her mistress, as she was in a "deep sleep", and tipped her lavishly before leaving to take a cab. Steel recognised True as having visited Yates' flat the previous week – a time when he had been suspected of stealing £5.

People knew where True had been. Around 11 p.m. the night before, True's driver, Luigi Mazzola, had dropped him outside the flat after a number of reconnaissance visits to the area. True had made several other visits to Yates' flat during the week, and had stayed with her on the previous Saturday. People also knew that Yates was distressed about True; her friend, Mrs Dent, had been with her the evening of her killing, and Yates had told of her worry about True's persistent and annoying telephoning, and suspected him of the £5 theft the weekend before.[9] When Emily Steel entered her mistress's room and found the brutally murdered body in a blood-spattered room, True was the prime suspect.

The police had no trouble finding True. After a day's joy-riding in Mazzola's car with his new friend Mr Armstrong, with whom he had been spending time and money all of February, True was found where he had been dropped by his driver, at the Hammersmith Palace of Varieties. Before settling down for a night's entertainment, True had bought a new suit, and put his blood-soaked one in for cleaning (explaining its blood-sodden state by a fictitious air crash); he had pawned some of Yates' jewellery, and had bought a copy of the evening edition of the *Star*, which had details of the murder on the front page. He was taken into custody without fuss, although the police knew that he was carrying a loaded revolver. He pleaded not guilty, and insisted that the murder was committed by someone else also named Ronald True. He claimed to have forgotten the circumstances under which he obtained many of Yates' possessions.

Evidence gathered in the construction of the case can be used to understand True's conditions prior to the crime[10]

True's personal circumstances were in a complete mess at the time of the murder. He left his wife, ostensibly on business, and came back to see her once at the end of January. His whereabouts were unknown to his family for January and February. During this time, True stayed in hotels without paying the bill, or spent the night in the Turkish Baths on Jermyn Street, despite having a card that bore a false Mayfair address. At the beginning of February, True was introduced to a Mr James Armstrong, an unemployed man with whom True spent most of his time at restaurants and at night clubs, or driving about. Armstrong happily sold True his service revolver and a quantity of cartridges. Armstrong was apparently regaled by True's stories of his time in the air force, and his various escapades in Africa, America, and Latin America.

Although True was spending like a sailor, he actually had no money left from the annual £300 provided by his mother. He passed cheques that his mother had to pick up, and soon began forging further cheques. He also stole from Armstrong's mother on an occasion when they met for supper, although this did not deter Armstrong from spending further time with True.

At one of the night clubs frequented by Armstrong and True, Murray's, they made the acquaintance of a Mrs Wilson. It was in Mrs Wilson that True first confided his intention to kill someone, although he had joked about this topic with Armstrong previously. He told her of a person with whom he had been quarrelling, and showed Mrs Wilson his loaded gun. On another occasion, True told Mrs Wilson that he would call her, but on failing to do so and being chastised for his failure, told Mrs Wilson that his mother's flat had been broken into and that she had been severely battered around the head, and was in a grave state. When Mrs Wilson could find no evidence of this attack in the next day's papers, True replied that he was keeping it quiet, as it would lead to a big trial. Mrs Wilson also noted in her evidence that True would often become vague and despondent mid-conversation. True's delusions about being impersonated were also important material for the defence. True thought that at least one other person was impersonating him, and was writing cheques in his name. This person was pointed out to Mrs Wilson, but the 'impersonator' did not show any recognition of True.

These circumstances were the bases of both the prosecution's and defence's cases. For the Crown, there was an emphasis on the theft, and on the necessity of theft brought about by True's pecuniary circumstances. The ineffectual attempts to make alibis by conjuring up other people who were impersonating True were not seen as evidence of anything but ineptitude. For the defence, his irrational behaviour and delusional beliefs were evidence of insanity. Both thought that he had premeditated his attack, but their interpretations of this differed in motive. The various delusions suffered by True were considered to be symptomatic of insanity – and were tailored to meet the requirements of the M'Naghten Rules, which were predicated upon delusions and cognitive issues.

Evidence gathered in the construction of the case can be used to understand True's early mental conditions.

All of the preceding evidence pertained to True's current state. A number of facts emerged in the courtroom about True's early life that would be used by the defence as a basis for an insanity defence. This evidence was in the main tendered by his aunt, Grace Angus, and his wife, Frances True (née Roberts).

Childhood cruelty: True was reported by his aunt to have been cruel to his childhood pets. He let his rabbits starve to death, although he showed some considerable distress when he buried them – with their heads still sticking out of the ground so that he might visit them. He also beat his favourite pony mercilessly for no apparent reason. True's callousness was extended to his mother, who on being ill elicited no reaction from the young True, who simply told his aunt that should she die, and that he would give the aunt her jewellery.

Lying and bragging: True was a consummate bragger and liar. For instance, although he did crash his plane twice when undergoing training in 1916 (leading to severe concussion and a damaged leg, as well as being invalided out of service), he told various stories of exploits as a wartime runner of missions to France, which involved him crashing his plane. He also told of crashes in the States. Other incidents of bragging included his insistence that he was a wonderful billiards player (which he was not), and his various claims to be setting up a company, always somehow related to flying goods from France or Africa. Perhaps most outlandishly, and related to the common theme of homicide, True bragged about having killed a German in a squabble over mining rights in Mexico, only to sign a new mining lease in the dead man's blood.

Starring at a tree, starring into the sea – incidences of epilepsy?: one of True's earlier drivers, Mr Frank Sims, reported various occasions on which True would blank out. On one occasion, True was found sitting under a tree, starring out into space, although he did not know he had come to be there. Sims suspected that True was taking drugs, but also noted that these episodes were occasionally seemingly unrelated to anything other than True's mind going blank. On another occasion, at the Branksome Hotel at Bournemouth, True was found starring into the sea, but could not say how he got there. These episodes were drawn upon by the defence to suggest that the root of True's problems was epilepsy. Mrs Wilson's evidence of True's recent moments also suggested that he would go blank during conversations.

Morphine addiction: Since his crash that damaged his hip, True had been addicted to morphine. He had been treated for this condition previously. In 1920, he spent nine months in the home of Dr Parnham in Sussex. On another occasion, he spent a shorter episode in a different nursing home trying to recover from his addiction. The pharmacist of Parnham's home, Ernest Beckwith, gave evidence from his books that True required 100 half-grain tablets of morphine every few days. This quantity was enormous, especially as True seemed dissatisfied with this quantity of the drug. There is no hard evidence to suggest, however, that True had been taking morphine at the time when he committed the murder, or at all during February.

Impersonators: While being treated for morphia addiction at Dr Parnham's rest home, True also showed evidence of a delusion that he was being impersonated by insisting that all mail that came for him but was not wanted (such as bills, or news that he had lost on his horses) were in fact for another man called Ronald True, who had been writing out false cheques in True's name. This delusion would recur just before the time of Yates' murder.

These pieces of evidence were used by the defence to suggest that True was insane. His insanity had been exacerbated by vast abuse of morphine over a long period, but he had the germ of such behaviour in his childhood. Further, it was suggested by the defence that his delusions and especially his vacant episodes were the product of epilepsy that had not yet fully emerged – in that he had not had a proper seizure reported. This idea of epilepsy, which was most strongly put forward by Mr Stoddart, a psychiatrist for the defence case, was also used to explain the ferocity of the attack on Yates.[11]

Psychiatric evidence for the defence

It is worthwhile for the purposes of this paper to spend some more time with the defence psychiatrists, as it is their evidence that shows the place of psychiatry in the law, and the strategies used by both lawyers and psychiatrists to argue over the legal status of the insane. There were four psychiatrists called to give evidence for the defence; two of these were his prison doctors in Brixton, two were eminent private practitioners.

Norwood East MD, MRCS, LRCP, Senior Medical Officer at HMP Brixton, had seen True daily for six weeks before making his report. "I arrived at the conclusion, after a consideration of the history and observation and examination of the accused, that from birth or at an early age he had suffered from mental disorder, and that later this became complicated with morphia insanity."[12] After agreeing that True was certifiably insane, he added that True had homicidal tendencies, although under questioning by the judge, McCardie J, East noted that these were not the same as irresistible impulses,[13] but simply further symptoms of insanity. True suffered from insane delusions: "He said that he had been impersonated, and that appeared to be very persistent. I could discover no cause for it, and came to the conclusion it was general insane delusion. Delusions are one of the hallmarks of insanity."[14] This status of delusion relating to insanity underpinned the Lockean conception of sanity that underpinned English Law, and the M'Naghten Rules in particular. In addition, East drew attention to the "persistent untruthfulness, the persistent boasting, and the lack of appreciation he [True] has."[15]

East explained to McCardie J that the morphine addiction would "aggravate the condition", and that it would affect True's "perception of right and wrong."[16] From this position, East argued that True was legally insane – in that he could not distinguish right from wrong. East also cast doubt, on the basis of the episodes where he appeared to blank out, that True was able to appreciate what he was doing at the time he committed the crime.[17] This issue was confused, as East noted, "because he committed certain actions which appear to show that he knew what he did was punishable, but he followed them immediately with other actions which tend to show that he did not appreciate what he had done."[18] True had, in East's opinion, degenerated both morally and intellectually to this point. This led to East's conclusion that – following M'Naghten – True was suffering from a disease of the mind. As to whether True was epileptic, East responded that "I am not putting it above a bare possibility – I think it is possible, having regard to the episode which has been mentioned where the first memory lapse occurred" [under the tree].[19]

Of particular interest to the aims of this paper, East also gave his opinion of the M'Naghten Rules in response to the Crown's cross-examination by Sir Richard Muir.

He thought that the rules "ought to be relaxed."[20] East admitted that he could not see how the rules "could be relaxed safely", however, as he had "difficulty… to offer an alternative".[21] He did, however, believe that "moral wrong" was akin to "social responsibility", and that knowing that murder was wrong equated to knowing one's social responsibilities.[22]

East was recalled the following day by McCardie J to give further clarification on epilepsy. There were, according to East, two types: epileptic mania or fury, and epileptic automatism. Although these had not been precisely defined by medical science, "The epileptic mania would, if it existed, indicate that here was a nervous trouble of a permanent character, and this was an acute manifestation of it."[23] East did not want to reject this theory of the causes of True's insanity out of hand, but noted that apart from the lapses of memory, it was not evidenced.

Mr Young, Medical Officer at HMP Brixton, offered the following opinion of True: "Speaking as a doctor, in a medical sense I would consider him insane,"[24] meaning that True was certifiable. Young went on to suggest that True was nonchalant, care-free, and showed no remorse since being admitted to Brixton Prison. He largely agreed with East's diagnosis, and based True's insanity on his drug-taking. He also stressed that a "Disease of the moral sense is disease of the mind" and vice versa.[25]

As to the question of epilepsy, Young noted that "I have not seen about him any symptoms of epilepsy. Unless he had a fit or some seizure, one would see no symptoms of the disease; one might see signs of injury which would commonly occur during fits. These signs were absent. There is no reliable test. You cannot say with any certainty, except when a person is undergoing some sort of epileptic seizure, whether he is subject to it or not. I have heard details of his actions which may be attributed to epilepsy."[26] Young further stated that: "When in Brixton he [True] showed signs of vanity, excessive vanity. I have never seen him distressed with his position; quite pleased with it."[27] Additionally to True's prison doctors, two eminent private practitioners were called for evidence.

Robert Percy Smith, MD, FRCP, was an eminent private specialist. He had 13 years at Bethlehem Hospital, of which 10 years were as Medical Superintendent. At the time of the trial he now carried out a private practice in mental diseases, and worked as a consultant to various institutions. He had been a lecturer on mental diseases at Charing Cross Hospital and St Thomas' Hospital, and was examiner in mental diseases at Leeds University. He saw True twice at Brixton Prison. "I came to the conclusion that he was insane. I would certify him when I saw him, and now."[28] This decision was based on the signs of delusion that Percy Smith could ascertain, and on True's case history. Delusions included True's story about his mother being assaulted; Percy Smith thought that this indicated that murder was on True's mind. True's periods of unconsciousness were thought also to be symptoms of insanity.

In Percy Smith's opinion, True was "not capable of properly distinguishing right from wrong in the moral sense. I think he could not control his actions. I think they would be swayed by the passion or instinct of the man."[29] Further, Percy Smith noted:

"I have considered this case from the point of view of the possibility of epilepsy. As to whether I see any signs in the violent nature of the crime of an epileptic or maniacal attack, of course an epileptic who is in a state of epileptic fury may use the most extravagant violence, unreasoning violence."[30] The violence True had used was certainly evident, and Percy Smith thought that this might indicate epilepsy, as would the periods of lapse in consciousness.

Henry Stoddart, FRCP, set up private practice in Cavendish Square after seventeen years as resident Medical Officer at Bethlehem Hospital. He had seen True twice. He summed up these visits as follows: "I have formed an opinion about his mental state. My opinion is that he is insane, certifiably insane and certainly not safe to be at large. I regard him as having homicidal tendencies, delusions, disease of the mind, definite disease of the mind in a moral sense."[31] Not only did Stoddart agree with the views formed by Drs East and Percy Smith, but he asserted that True was not capable of controlling or directing his actions: "on occasions he cannot help doing wrong"; "he cannot control himself in such a way as to always act morally." In short, Stoddart strongly believed that True suffered from irresistible impulses, which were a part of the delusional insanity that True suffered.[32] Stoddart also held that these effects would be exacerbated by morphine abuse. In particular, he believed True's delusions of persecution were related to substance abuse.

On the matter of epilepsy, Stoddart held that it was "quite possible" that True suffered from this affliction. He thought that True's attempts to conceal his crime by moving the body and placing pillows in Yates' bed were not inconsistent with an epileptic fury. He also thought that the unnecessary violence employed (i.e. beyond killing with the rolling pin) were evidence of an epileptic fit. It was, however, impossible to ascertain True's mental state at the point when he committed the act against Yates.

The preceding psychiatric evidence showed a great deal of accord with regard to True's insanity. While epilepsy was hard to ascertain, there was general consensus concerning the suspect nature of True's vacant episodes. There was also complete consensus on the nature of True's delusions, and that these evidenced a disease of the mind that had been worsened by his morphine abuse. It would seem, on the face of it, that the defence had a strong case for preventing True being found guilty and going to the gallows.

The M'Naghten Rules and the prosecution's strategy

The Home Office thought that the evidence being tendered for the defence – particularly that of Norwood East – was outrageous. They certainly tried to counter this psychiatric evidence with their own expert testimony. Sir Ernley Blackwell, Director of the Department of Public Prosecutions, wrote to Guy Stephenson, the Undersecretary of State, that "It would be quite an omission on our part not to be advised [by a psychiatrist] in such a case. I do not think such a crime should be put down to insanity, with all the cunning, motive, deliberation, etc., merely because Dr East after 'interviews with relatives' thinks he is insane."[33]

As such, the Crown did try to get psychiatric evidence for their case. Undersecretary Guy Stephenson wrote to Dr R H Cole, asking him to examine True, and advising him that he was "unable to regard [the facts of East's report] as trustworthy".[34] Cole reported back with regard to True's delusions (which he thought might also be a "wilful fake statement"); on True's current state of remorse (which he believed was genuine); and on True's recent history.[35] His summation of the case was not exactly what the Home Office were after, however.

> I am of the opinion that the prisoner is a reckless individual, that he is wilfully untruthful to deceive and that he has genuine lapses of memory – that he is restless and unstable and devoid of moral sense, that some of his statements may be regarded as delusional or fabricated and from all evidence before me I take the later view. I consider the prisoner fit to plead and that he knows the nature of his acts.[36]

Cole added an important caveat, however: "…should evidence be found that the prisoner's defect of moral sense date from early life and that the history of morphinism and aeroplane crashes is true, which would undoubtedly aggravate such defect, I should feel obliged, if called to give my opinion at the trial, to modify my view as to his responsibility."[37]

Cole's report left the Crown with only one alternative in the trial. Rather than deny insanity, the prosecution relied upon a strong application of M'Naghten to achieve a guilty verdict. This approach had two parts, which followed the two axes of the M'Naghten defence: Did he know what he had done, and did he know that it was wrong? In order to argue affirmatively, the Crown drew attention to: 1) The fake body in the bed. 2) The fact that body was moved. 3) That True lied to Steel about Yates being asleep. 4) That True robbed Yates. 5) That True lied about the goods he was pawning and about his air crash.

All of this evidence suggested that he had a motivation for his actions – they were not the act of a wild beast, but those of a rational killer who was robbing a dead prostitute for his own gain. The trial then hung on one particular issue: did True know what he was doing was wrong? For the Crown, the answer was yes, or else, they argued, why would True try to hide the crime with lies and trickery? This position was used to explain away the delusions as deliberate lies and ruses, and True's inept attempts to cover his tracks. For the defence, the answer to these two questions was no, and they argued that True had no moral notions, and furthermore was deluded after years of abusing morphine and crashing planes. Anything True did or said was, according to the defence, essentially the random acts of an insane man.

The outcome of the trial

True was found guilty of the murder, and after the jury was (legally) directed to follow M'Naghten strictly, was not given the verdict of guilty but insane. An appeal followed, on the grounds that the weight of the evidence (and the fact that the Crown did not refute the scientific evidence with their own expert testimony) meant that the jury should have been directed to find True insane.[38] This appeal was denied. It was further suggested that M'Naghten could be extended to include irresistible impulse, but this also was denied. All was not lost for True's case, however. Despite being sentenced to death, he was given reprieve by the Home Secretary.

Under the 1883 Trials of Lunatics Act and the 1884 Criminal Lunacy Act, both of which followed the 1840 Insane Prisoners Act (3 + 4 Victoria c. 54), the Home Secretary could order the removal of the prisoner to an asylum (even if under the penalty of death) if, in the opinion of two or more expert medical practitioners, the prisoner was certifiably insane. This is what happened with True, after McCardie J suggested the idea to Edward Shortt, the incumbent Home Secretary. Not only had all four of the psychiatrist in the trial agreed that he was certifiably insane, but some of the most eminent alienists in London – Sir John Baker, former Medical Superintendent at Broadmoor, Dr Reginald Dyer, member of the Prisons Commission, and Sir Maurice Craig, lecturer at Guy's hospital – were called to the Inquiry, all of whom gave evidence of True's insanity and recommended reprieve. This submission was taken by Shortt, who reported to the Commons that "It was my statutory duty to set up that committee of inquiry, and when they reported to me that True was insane, and certified him to be insane, I was bound by the law of the land to reprieve him."[39]

The result of True's reprieve and removal to Broadmoor, where he would remain until his death 31 years later in 1953, was a public baying for blood in the newspapers. Nigel Walker has suggested that True's reprieve led to the last occasion on which the public wanted to see a man hanged when he was not.[40] This situation was made more difficult since at the same time another murderer, Henry Jacoby, who was tried by McCardie J only the week before, had been executed despite his young age of 18 (although there was no suggestion of insanity at Jacoby's trial).[41] What ensued was a great many articles and letters over the next 30 years concerning the injustice of reprieving True. This led to a public debate in the papers between psychiatrists and lawyers over the insanity laws (which will be the subject of another study). The public outcry also led to Shortt having to defend himself in the House of Commons further, and so he instituted a committee to examine the insanity laws and the Criminal Lunatics Act of 1884 (section 2 (4)). This was the Atkin Committee, which gave both the BMA and the MPA the opportunity to tender evidence on these questions in its reassessment of M'Naghten. Its aim was quite clear, to quote Lord Atkin: "There ought to be some change in the formula laid down in McNaghten's case… [but] it is no use criticising [that] formula… unless you can substitute some effective formula in its place which will not have the effect of removing all prisoners from a gaol to an asylum."[42] The Atkin Committee was therefore in a position to change English law substantially.

Professional reactions: the BMA and MPA

Underlying True's trial were disputes between the BMA and the MPA over the place of psychiatric knowledge in the courtroom. The Atkin Committee, which started meeting in 1922, tapped into a dispute that had been boiling away under the surface of both the BMA and MPA in previous years.

The MPA, 1896-resolutions: Ever since 1843, psychiatrists had been resisting M'Naghten. In 1896, a committee of the MPA had been set up to report on the state of the laws relating to criminal responsibility and insanity.[43] The committee's report was accepted by the MPA, and was the basis of the evidence they tendered to the Atkin Committee. This report noted that "The legal criteria of responsibility expressed in M'Naughton's case should be abrogated, and the responsibility of a person should be left as a question of fact to be determined by the jury on the merits of the particular case."[44] The second major finding of the MPA's committee was that "In every trial in which the prisoner's mental condition is in issue the judge should direct the jury to answer the following questions: a) Did the prisoner commit he act alleged? b) If he did was he insane at the time? c) If he was insane, has it nevertheless been proved to the satisfaction of the jury that his crime was unrelated to his mental disorder?"[45]

The MPA did not propose to offer a test of criminal responsibility, as was held in the M'Naghten Rules, because they thought that such a test failed to treat each case history on its own merits. The above criteria both necessitated psychiatric opinion given as expert testimony and also stressed that legal criteria for responsibility should not be the final authority – but that these questions were to be decided by the jury. This meant that proof of sanity was no longer the onus of the defence, a major suggested change to the existing law. It also meant that psychiatry would have the strongest role to play in the determination of the treatment of the insane criminal.

The BMA 1913-resolutions: The BMA's resolutions were reached by the medico–political sub-committee on crime and punishment in 1913, and their evidence tendered to the Atkin Committee was largely the same.[46] In short, the BMA subcommittee told the Atkin Committee that the M'Naghten Rules should be kept in substance, but that the clause concerning irresistible impulse first suggested by Stephen in 1883 should be added. This extra clause noted that a person should be held to be irresponsible if prevented by mental disease "from controlling his own conduct unless absence of control is the direct and immediate consequence of his own default."[47] This meant that cases of drunkenness and intoxication by drugs wilfully taken were not to be acceptable as excusing responsibility, but that long-term mental illness would be a factor in determining non-guilt. Disease of the mind was still to be the criterion for criminal irresponsibility, as it had been in the M'Naghten rules.

Committees and the Law

The Atkin Committee report of 1923 sided with the BMA, which in turn had adopted a very legal viewpoint in their medico–political subcommittee on crime and punishment that had addressed the issue of criminal responsibility in 1913, and again after the invitation to tend evidence to the Atkin Committee. It rejected the psychiatric position that general rules about insanity were useless as cases needed to be judged on their own merits and in the light of expert psychiatric opinion given as evidence in court. Nevertheless, psychiatric evidence was still incorporated into the Atkin Committee findings. They agreed with the evidence offered by East and his colleagues in the trial of True that mental disorders progressively erode the capacity for self control. They agreed with the psychiatrists that M'Naghten did not always capture the just response to insane cases (infanticide cases were a good example of this situation whereby one could know a deed was wrong, but still commit it under irresistible impulse, and the Infanticide Act of 1922 had taken this into account).[48] They fully accepted that mental disease excused guilt. But they were loath to turn this into a purely psychiatric decision, or one of the jury. Instead, they recommended that changes need be brought into the law by decision or statute. "We appreciate the difficulty of distinguishing some of such cases [where the act is not voluntary] from cases where there is no mental disease, such as criminal acts of violence or sexual offences where the impulse at the time is not merely uncontrolled, but uncontrollable. The suggested rule, however, postulates mental disease, and we think that it should be made clear that the law does recognise irresponsibility on the ground of insanity where the act was committed under an impulse which the prisoner was, by mental disease, in substance, deprived of any power to resist."[49] In other words, the Atkin Committee wanted to institute an irresistible impulse clause to the laws of criminal responsibility.

A report does not make the law, however. One judge who would have enjoyed the suggestions of the Atkin Committee was Darling LJ. Darling had already given judgments that anticipated the irresistible impulse clauses that the Committee wished to introduce. It was he who moved to have the recommendations of the Committee made into Statute. In his attempt to raise the Bill before the House of Lords in 1923, however, Darling was unsuccessful. The vehemence of the opposition is best shown in the following utterances by Lords: Lord Sumner: "if this Bill were passed very grave results would follow."[50] Lord Hewart: "What a door is being opened!"[51] Lord Cave: "This would be a dangerous change to make."[52] As such, the opportunity to change the laws of criminal responsibility, and to bring them up to date with some of the medical and psychiatric opinion of the day, was lost as the Lords would not acquiesce to a non-Lockean notion of mental illness. The will and cognition remained central to responsibility.

Conclusion

The trial of Ronald True and its aftermath is a useful vehicle through which to understand the criminal responsibility and insanity issue. This trial came at the time when many people were pushing for changes to the disposal of insane criminals. These changes had to take place within the law, and as we have seen, many parties were interested, from individual psychiatrists and lawyers through to medical organisations such as the MPA and BMA, up to the Houses of Commons and Lords. The issue was one that occupied newspaper editors as much as it occupied the members of the public who wrote letters to such publications. As such, this trial is also useful for gauging the status of psychiatric knowledge. Although it is not common nowadays, the *Evening Standard* felt it import to run an editorial explaining the theories of Sigmund Freud to the public in order to discuss the doctrine of irresistible impulses (regardless of the fact that these notions as were present in the trial were by no means Freudian).[53]

For the medical historian, it is interesting that there was a significant divergence between the two medical organisations – the MPA and the BMA. The BMA had always sided with the law on this issue, since its instigation of various subcommittees, whereas the MPA and its members had largely resisted legal definitions of criminal responsibility. This case exemplifies professional rivalry between two organisations, and further investigation into the strategies employed by these two organisations would shed light on the professional development of psychiatry in relation to regular medicine throughout the nineteenth and early twentieth centuries.

Finally, an important theoretical point can be gleaned from this trial with regard to considering how rules are social institutions. Following the elaborations of Ludwig Wittgenstein by David Bloor, we see that rules need to be maintained by social groups – they are not abstract entities, but everyday institutions.[54] Meaning comes from application of the rules, not their abstract formulation; or to quote Wittgenstein on language, "the meaning of a word is its use in the language."[55] In the above case, we saw a dispute over the nature of the M'Naghten Rules, an in particular we saw problems surrounding the correct application of these rules, and challenges to their very validity. One of the directions I will take this research is to further investigate the M'Naghten Rules as social institutions for a number of competing bodies of authority.[56]

Notes

1 For overviews of the state of English forensic psychiatric evidence, see Walker, Nigel. Crime and Insanity in England. Edinburgh UP, Edinburgh 1968. For English accounts that pre-date True's case, but are essential background for this study, see Smith, Roger. Trial by Medicine. Edinburgh University Press, Edinburgh 1981, and especially Eigen, Joel. Witnessing Insanity. Yale University Press, New Haven 1995, and Unconscious Crime. Johns Hopkins University Press, Baltimore 2003. The subject is also usefully, and philosophically, discussed in Smith, Roger. "Expertise and Causal Attribution in Deciding between Crime and Mental Disorder." Social Studies of Science 15 (1985):67–98.

2 Stephen, James F. A History of the Criminal Law of England. MacMillan, London 1883:168.

3 MPA. “Report of the criminal responsibility committee.” Journal of Mental Science, 42 (1896):863–866.

4 BMA. “Report of the Crime and Punishment Subcommittee on the present state of the law with regard to the legal responsibility for crime.” Transactions of the Medico-Legal Society, 12 (1915):110–126.

5 M’Naghten’s case is reported in House of Lords, 1843 10 Cl. & F. 200, 8 Eng. Rep. 718, and is reproduced at <http://www.audiocasefiles.com/acf_cases/8786-m-naghten-s-case> (August 2008). For more on the case, see Moran, Richard. Knowing right from wrong: The insanity defense of Daniel McNaughtan. Free Press, New York 1981.

6 For a recent evaluation of criminal responsibility, see Tadros, Victor. Criminal Responsibility. Oxford University Press, Oxford 2005.

7 Coke, Edward. The institutes of the laws of England. Part III, chapter 1, folio 10, Hargreaves and Butler, London, 1897.

8 This paragraph and the following description of the crime scene is taken from National Archive MEPO 3/1572.

9 The facts of Yates’ and Dent’s meetings are contained in Mrs Dent’s statement to police, National Archive MEPO 3/1572.

10 Details of the evidence given at the trial are taken from Carswell, Donald (ed.). The Trial of Ronald True. W Hodge, Edinburgh 1925 (volume 58 of the Notable British Trials series).

11 For a discussion of the place of epilepsy in English criminal responsibility trials, see Eigen 2003.

12 Carswell 1925:135.

13 Carswell 1925:145.

14 Carswell 1925:136.

15 Carswell 1925:136–37.

16 Carswell 1925:137.

17 Carswell 1925:139.

18 Carswell 1925:140.

19 Carswell 1925:141.

20 Carswell 1925:141.

21 Carswell 1925:141.

22 Carswell 1925:142.

23 Carswell 1925:171.

24 Carswell 1925:175.

25 Carswell 1925:177.

26 Carswell 1925:179.

27 Carswell 1925:180.

28 Carswell 1925:181.

29 Carswell 1925:184.

30 Carswell 1925:184.

31 Carswell 1925:189.

32 Carswell 1925:191.

33 NA/DPP/1/71, Blackwell to Stephenson, 21/4/22.

34 NA/DPP/1/71, Stephenson to Cole, 21/4/22.

35 NA/DPP/1/71, Cole's report, 25/4/22.

36 NA/DPP/1/71, Cole's report, 25/4/22.

37 NA/DPP/1/71, Cole's report, 25/4/22.

38 For True's appeal, see 16 Cr. App. R. (1922):164 et seq.

39 Carswell 1925:275.

40 See Walker 1968.

41 Ward, Tony. "A terrible responsibility: Murder and the insanity defence in England, 1908–1939." International Journal of Law and Psychiatry 25 (2002):361–377.

42 Lord Atkin. "Presidential address." Transactions of the Medico-Legal Society 15 (1960):1–13; on pp. 6–7

43 MPA. "Report of the criminal responsibility committee." Journal of Mental Science 42 (1896):863–866.

44 Carswell 1925:277. "The Atkins Committee Report" is reprinted in this volume, although it was also printed separately in 1923.

45 Carswell 1925:277.

46 BMA "Report of the Crime and Punishment Subcommittee on the present state of the law with regard to the legal responsibility for crime." Transactions of the Medico-Legal Society 12 (1915):110–126. There is also much material in the BMA archives of the medico-political sub-committee on crime and punishment, which I make use of in my forthcoming book on this trial.

47 Carswell 1925:281.

48 Jackson, Mark (ed.). Infanticide: historical perspectives on child murder and concealment, 1550–2000. Ashgate, Aldershot 2002. Ward, Tony. "The sad subject of infanticide: law, medicine and child murder, 1860–1938." Social and Legal Studies 8 (1999):163–180.

49 Carswell 1925:281.

50 57 H.L. Deb 443–76 (1924):459.

51 57 H.L. Deb 443–76 (1924):467.

52 57 H.L. Deb 443–76 (1924):475.

53 Rapp, D. "The reception of Freud by the British press, 1920–25." Journal of the History of the Behavioural Sciences 24 (1988):191–201.

54 See Bloor, David. Wittgenstein: Rules and Institutions. Routledge, London 1997.

55 See Wittgenstein, Ludwig. Philosophical Investigations. Trans. G E M Anscombe. 3rd edn, Blackwell's, Oxford 2001:43.

56 See Crozier, Ivan. The Trial of Ronald True: The Place of Psychiatry in a 1922 Murder Trial. Palgrave, Basingstoke (forthcoming 2010).

Between rule of law and the living life. The irresponsible criminal in Norwegian medico–legal discourse 1840–1929

Svein Atle Skålevåg

In the continental European legal tradition the question of criminal responsibility has, since the early nineteenth century, been construed as a well-defined legal problem. In a very concrete sense, the problem has consisted of phrasing a single clause in the criminal code regulating the matter of irresponsibility. But the question has at the same time been a much broader one, as a concept or responsibility has been fundamental for the legal order of the nineteenth century. Punishment has required two things: that a law has been trespassed, and that the trespasser has been of a state of mind that made him accountable or responsible. These two conditions were essential for establishing the rule of law in criminal law. What this "state of mind" implied, however, shifted through time and space, and was the subject of negotiations and fierce debates. The consequences of being held unaccountable also shifted in history. In a system practising capital punishment, the question of criminal responsibility could be a matter of life and death. In different circumstances it could be a matter of hospital or prison, arguably a matter of less urgency. The history of criminal responsibility, therefore, resides in the shifting definition of criminal insanity, but also in the environment in which this notion is embedded.

In this paper I examine the relationship between psychiatric and legal discourse in criminal law reforms in Norway from *c.*1840s to *c.*1935. At the centre of the analysis lies the question of how to define criminal *ir*responsibility, but I will also seek to place this question in a wider context of the construction of the subject in criminal law.

From at least the second half of the 19th century, the matter of responsibility was framed by a medico–legal discourse, i.e. a discourse that was simultaneously medical and legal. The history of such a discourse is in many ways framed by the history of the relationship between law and medicine.[1] From the mid-19th century representatives of the emerging medical profession challenged the sovereignty of legal discourse in the courts in the role of expert witnesses. And yet, the history of the medico–legal discourse should, at least analytically, be distinguished from the history of the legal and medical professions.[2] The inter-professional battle should of course not be disregarded in a historical analysis of the problem of criminal responsibility, but the one should not too easily be identified with the other; the legal and medical discourses should not a priori be taken to follow accurately the trenches of inter-professional battles.[3] My discussion of the law–medicine relationship and the question of criminal responsibility is based on a reading of policy documents, legal drafts, minutes from debates, court rulings and forensic medical reports from the 19th century up until the criminal law reforms of 1929.

The first criminal reform (1842)

The first major reform of Norwegian criminal law passed the parliament in 1842. Until this time, the valid law had been forged under the absolutist rule of the Danish kings, who had incorporated significant elements of medieval law in their legislation.[4] In 1842 the Norwegian parliament adopted a law book modelled on the Kingdom of Hannover's criminal code of 1840, which was itself based on the Bavarian code of 1813, written by the leading legal scholar Paul von Feuerbach under the influence of the French Napoleonic *code pénal* of 1810. The very idea of a coherent law book was a reformatory idea. The new Norwegian law book incorporated the principle of *nullum crimen, nulla poena sine lege* (no crime or punishment without legislation), and inscribed Norway in the genealogy of post-revolutionary reformed states.

The subject of criminal responsibility of the insane was addressed in one dedicated article, as in the French code. This article has the form of an absolute exclusionary rule, though not expressed as unequivocally as in the *code pénal*. Whereas Napoleon's code stated with simple elegance that "where there is *démence* there is no crime", the Norwegian code ruled that "an act shall not be punished when committed by a mad (*galne*) or demented (*afsindige*) person or someone derived from their senses by illness or old age".[5] The terms put in operation here are traditional legal terms with roots going back to Roman law.[6] The only concession to a medical discourse in this case is the intrusion of illness as one cause among others that may produce such an exculpatory state.

We see that even without the assistance of physicians, the lawmakers included references to illness and to somatic causality in the law book. These references were combined with a conceptualisation of the exculpating state as a *state of mind* (*Forstandens brug*). All in all, this rather vague formulation constituted an exception in a code that predominantly sought to punish *acts* rather than states of mind and that gave the judges relatively narrow margins for measuring out the punishment, compared with ensuing legislation. However, we should be careful not to read this code as a pure expression of what Foucault termed the "sovereign power", a form of power working predominantly through the rule or prohibition.[7] Anton Martin Schweigaard, the leading expert on criminal law in Norway in the second third of the 19th century, delivered the authoritative exegesis of this code in a commentary first appearing in 1842.[8] In his commentary he stressed the significant expansion of the range of available choices for the courts in measuring out the *intensity* of punishment as well as to the *kind* of punishment in the then new law book. [9] Furthermore, this flexibility was now expanded so that it included even the most common of crimes. For Schweigaard the criminal code of 1842 expanded the court's possibilities to individualize punishment.[10] Even though later criminal reform activists came to read the law differently, Schweigaard saw in it the very same impetus towards individualization of the societal response to criminal offence that came to be much more prominent in the next code.

The country's lack of physicians explains the absence of medico–legal debate on the matter of criminal responsibility in the early 1840s. Following the code's adoption, however, there was occasionally some discussion. Here, I want to just point to one such debate, which was firmly rooted in the legal practice. It concerned the case of an imprisoned man who had slaughtered a prison warden with an axe, a horrific deed that attracted quite a lot of attention at the time, that is in the early 1870s.[11] The director of the major insane asylum in the country, O.R. Aa. Sandberg, acted as a medical expert in the case. According to Sandberg the defendant suffered from "monomanie de persecution". The term monomania proved to be very controversial, also among medical experts. It evoked the figure of the dangerous madman, who seemed perfectly normal for the untrained eye, but who might at any time explode in a burst of violence. This eruptive character served to bolster the psychiatrists' claim to specialist knowledge. The imagery of the dangerous monomaniac was pungent, but it soon faded. In the 1890s the monomaniac is only a receding shadow, ousted by the new and more modern figure of the pervert.

The second reform (1902)

In 1887 the Norwegian criminal law system was again refoprmed through the introduction of juries into legal proceedings. In the latter part of the 19th century legislative reform no longer meant to construe a rule of law as a bulwark against the threats of absolute sovereignty, but to secure a broader popular participation in the public life; the notion of a state of law (*Rechtsstaat*) ceded preeminence to the notion of a state of the people (democracy). These changes of the *forms* of law in turn pressed for a wider reform of the *substance* of law, as the existing law book was considered to be too technical and complicated to serve the new non-legally trained juries.[12] The result of the democratization of criminal law was the Criminal Code of 1902.

The main agent of this reform was the brilliant and prolific Bernhard Getz (1850–1901). Getz became professor in criminal law in 1876 and Director General of Public Prosecution in 1889. In 1885 he was appointed the chairman of an expert commission to reform the criminal proceedings, and another commission to reform the criminal law accordingly.[13] Getz was well acquainted with the international criminalist movement and with Francis Hagerup, a fellow legal scholar and professor at the university, a leading conservative parliamentarian and for some years prime minister. In 1892 Hagerup founded the Criminalist Association in order to establish a dialogue between criminal law and the emerging "sciences of crime". In the first instance this meant physicians, predominantly those with experience from psychiatry. The association, headed by Hagerup, and for several years customarily presided over by the Minister of Justice (also invariably a lawyer), became an important workshop for criminal reform, a semi-official arena for the forging of a new reformed criminal law, fusing elements from law and the sciences. Here representatives of both the executive powers and the legislative bodies met with the foremost academic expertise and men of science to discuss crime and punishment. The physicians were always few in number, and yet very outspoken at the meetings. The association organised meetings with debates on topics considered crucial for the advancement of the criminal law reforms; generally these meetings were annual in periods of considerable parliamentary activity in the field, but infrequent in periods with insignificant activity.[14]

The reformers of the 1890s recognized that the criminal code of 1842 already had established a principle of individualization of punishment. This fact was, for example, pointed out by Dr. Paul Winge, a specialist in forensic psychiatry and a vigorous campaigner for criminal reforms in the 1890s.[15] However, all things being relative, the most important demand of the reformers close to the criminalist movement was, again: to individualize punishment. But this time it was interpreted differently: individualization of punishment was perceived as requiring the assistance of representatives of the sciences of man, more specifically the most ubiquitous representatives of these sciences, the physicians. A new alliance was thus called for in order to achieve what was considered a more *efficient* criminal law, and the most concrete expression of this alliance was the Criminalist Association.

The problem of mental illness and criminal responsibility was a focal point in the discussions in the Criminalist Association in the 1890s. The question attracted an immense attention inside and outside the association. At least eleven different drafts were proposed by parliamentary and extra-parlamentary groups; during the final deliberations in Parliament, a handful of parliamentarians with medical background set aside party affiliation to join force and negotiate with the criminalist Hagerup. These negotiations ended in a compromise between the physician–parliamentarians and the majority of the parliamentary committee, a compromise in which also Paul Winge played a role as an extra-parliamentary player.[16] To put it simply, the problem was whether the border between law and medicine should be drawn on medical grounds or on legal grounds. Schematically speaking, two models were available at the time: one that stated that mental illness was a general ground of exculpation; and one that stated that mental illness often but not always resulted in exculpation. The controversy, of course, also had a sociological dimension: in the first model the medical expert would become the true arbiter of the case, invested with the power to tell if a criminal should be tried or not (in Norway the matter was rarely settled by a jury). In the second proposed solution, the medical expert would have the more limited authority of a legal advisor of the court.

On this matter the actors tended to take positions in accordance with their professional affiliation. The physicians/psychiatrists called for a phrasing of the law that was in harmony with medical discourse. The leading lawyers inclined towards a phrasing that was independent of medical discourse and therefore required the judge to be the discursive arbiter. Even so, it is less clear that these professional positions had much to do with professional *interests*. Why would physician have an interest in a greater share in the often muddled and uncomfortable negotiations of the court?[17]

The discussions on criminal responsibility that took place in the Criminalist Association in 1896 revolved around abstract principles rather than concrete examples. It is in a way striking that so few examples were presented to visualize the consequences of a specific principle. One example, however, was discussed in some detail. The example was hypothetic and regarded a thief stealing women's shoes. It was introduced in the 1896 draft of the expert commission of 1885, chaired by Bernhard Getz, that prepared the proposal for a criminal code – and it was passionately discussed in the Association's meeting.

In the motives for his draft of 1887, Getz seems to be careful to avoid employing the term mental illness (*sinnssygdom*). His discussion of the question of responsibility is framed by the notions "will" and "understanding" – can the one be impaired while the other remains intact? In concluding he briefly touches on the question of the relationship between mental illness and criminal responsibility, but even then he prefers the term "vanvittige", a term occuring in the criminal code of 1842, to the term "sindsssyge" that was employed in the Mental Illness Act of 1848. At this time Getz held the opinion that the code should establish the unaccountability of the "vanvittige" in order to "avoid misunderstandings."[18]

In the motives for the commission's draft of 1896, however, the question of the relationship between mental illness (*sindssygdom*) and criminal responsibility is tackled head on, and the text recognizes that this question is a very complicated one that has been the object of fervent discussions in Norway as in other countries.[19] The commission opposed admitting irresponsibility to the mentally ill as a rule on the grounds that this would turn the question of criminal responsibility into a medical question, to be resolved by physicians, instead of a legal question to be decided by the courts of law (p. 67). If that was to be the case, the relationship between the mental state and the criminal act would be left completely unaddressed. In this context the pervert was introduced in the discussion to back up the claim that mental illness existed in many forms, which did not all exclude criminal responsibility.

The Getz commission posed the problem in this manner: Consider a person suffering from a periodically recurrent drive (*drift)* to steal women's shoes, a drive considered irresistible. Should such a man be held responsible for crimes he might commit? The commission's answer was threefold: If the man committed the crime of stealing women's shoes, he should be absolved from criminal responsibility and from punishment, even if he was otherwise normal. But if he committed some other crime, he should be punished as a normal, accountable citizen. If, however, the drive in question was considered to represent a danger to society, then the man should be hospitalised in an asylum, to defend society. For Getz and the commission, the derangement of such a man – "suffering from a relatively innocent perversity" – would be restricted to a delimited region of his mind and have no relevance for the misdeeds committed in other regions. In such a case the commission believed that the question of responsibility could not be left to a medical decision of whether or not a drive to steal women's shoes qualified as an illness. By introducing this ambiguous figure, the pervert, the commission departed from the strict duality crime/illness and moved towards a triptych of criminal/insane/dangerous.

As a random example of a crime, the crime of stealing women's shoes strikes one as an odd choice. The example seems to have been collected from foreign medico–legal literature, as the draft has a reference to the German psychiatrist Eduard Ritter von Hoffmann's *Lehrbuch der gerichtlichen Medizin* from 1878 (and the draft further includes Hoffmann's references to Maudsley, Krafft-Ebing, Schüle and Legrand du Saulle). Through this secondary reference the commission calls on the emerging discipline of sexual psychology, a novel discipline at the time.[20]

In the debate in the Criminalist Association in 1896 the issue was raised again by Paul Winge, who ridiculed the commission's exposé and spelled out the sexological subtext of the example.[21] Thieves have a variety of specialities, remarked Winge, which can be seemingly eccentric, and if one of them specializes in the theft of women's shoes, then he should be appropriately punished for it, provided he is not insane. (Winge's point must have been to demonstrate the absurdity of the example lest the sexual theme is spelled out). However, it just might be the case that this man's reasons for stealing women's shoes is that he thereby secured the means for "satisfying a sexual abnormity". "The man might be a masochist, and steal women's shoes in order to satisfy his masochistic inclinations, or he might be fetishist, for also a fetishist may use women's shoes in order to satisfy an abnormal sexual drive."[22] Winge provides a reinterpretation of the example whose sexological connotations were only hinted at by the commission. For Winge, identifying a man as a masochist or a fetishist would be only the beginning of solving the problem of responsibility. It opened a number of possibilities: If one considered masochism/fetishism only to exist as symptoms of insanity, then such a man should not be punished. If one considered that also sane people could demonstrate these symptoms, then a new set of questions are opened up: does the state have reasons to fight masochism/fetishism? And if so, is imprisonment an effective means of fighting such perversities? If both questions are answered in the affirmative, then the man should be punished for the theft *and* for the perverse act. If the answer to the first question but not the second is yes, then one must look for other means of fighting the perversity. For Winge, the thief's perversity – being an irresistible impulse – should be reckoned an attenuating circumstance but not a condition that suspended his criminal responsibility.

The commission never referred to a sexual dimension of the theft in the example used. For them the case appeared to exhibit a kind of monomania, and they therefore treated the man's derangement as something that could be isolated from the rest of the person. For Winge the psychiatrist, well acquainted with the writings of von Krafft-Ebing and others, the example was really about sexual pathology. The medical expert was obliged to interrogate the causes of the man's drive. The disputed point was whether it should be expected from the medical witness to consider the specific relationship between the state of mind and the unlawful act ("the anglo-saxon model") or to make strictly a statement on the state of mind ("the continental model"). For Paul Winge, the forensic psychiatric specialist, the question was to determine the relationship between this drive (towards perversity) and a possible mental illness. What mattered for him was not so much whether one chose to regard the man as criminally responsible or not, but that the case called for a thorough psychiatric investigation and a personalized approach. For Getz the legal scholar, the question was to determine the relationship between the drive and the criminal act. Hence, both sides referred to an idea of causality, but this causality was positioned differently on the spectrum from mental state to criminal act. The crucial point was no longer the defendant's ability to know right from wrong, i.e. his intellectual capacity, but his ability to resist the drive situated in his body.

Paradoxically, Getz's introduction of the drives and the question of the mind's sovereignty over the body implied the need for the kind of closer scrutiny of the offender that only medicine could offer. Hence, the heated disagreement between Getz and Winge hid an agreement on a deeper level on the desirability of a criminal law that took into account the individual criminal's body and that penetrated and sought to reform his very mind. The flexibility of the law and the possibility for individualization of punishment that Schweigaard had found already in the 1842 code was radically reinforced in the Criminal Code of 1902. The nature of a criminal offence was no longer simply to be determined according to the fixed taxonomy of the law book; its very individuality was to be acknowledged by the court.

The third reform (1929): social defence

The Criminal Code of 1902 had been prepared by a committee of lawyers and politicians. Only relatively late in the process did a number of physicians engage in the process, mainly through the Criminalist Association, but also through the (relatively) newly formed Medical Association and through direct participation in the parliamentary deliberations. These physicians rallied around one particularly contested issue, namely the phrasing of the paragraph that listed the conditions of exculpating states of mind, an issue with obvious consequences for the inter-professional division of labour in courts of law. In the shadow of this delicate question, the physicians joined forces with the legally trained criminalists on other matters, such as the use of non-delimited incarceration (*ubestemte straffer*).

At the time the Criminal Code of 1902 (effective from 1905) was celebrated, also internationally, as a progressive, modern criminal code. For Adolphe Prins, the distinguished Belgian professor of criminal law, the code was a landmark in the history of criminal law.[23] For the no less distinguished Austrian-German professor of criminal law Franz von Liszt, Getz had "shown the way to the future".[24] Yet the new legal apparatus apparently created problems when put into practice. As early as 1913 the authorities considered a revision, and in 1922 an expert committee was appointed.[25] A long list of issues, in part derived from practical problems in enforcing the 1902 law, required revision. In addition, as a result of the dramatic expansionion of the electorate following the promulgation of universal suffrage for women in 1913, extra-parliamentary circumstances framed the reform of the 1920s. A kind of moral panic, partly issuing from women's rights organizations, allegedly contributed to putting the sexual offenders on the agenda and pushed the demand for a tougher line in criminal law.[26] The expert committee delivered its report in 1925, and Parliament adopted the reformed code in 1929.

This time physicians were well represented in the reform process. Three out of nine members of the preparatory committee, which was chaired by professor of criminal law Jon Skeie, were trained in medicine. Another novelty in the composition of the committee was to introduce an expertise emanating from the prisons, represented by Arne Omsted. Omsted had a decade of experience as a prison director, and by 1925 he had risen to the summits of the prison bureaucracy as a Director General in the Department of Justice.

The question of criminal responsibility was on the list of issues to be revised, but originally only insofar as it involved the intoxicated criminal.[27] Alcohol was widely regarded as a factor in a huge and increasing proportion of all crimes committed, and this factor slightly altered the terms of the old debate on principles of responsibility. The intoxicated offender clearly did not know the nature of his acts, nor was he in control of himself, and still he was clearly blameworthy. Hence, the drunken criminal constituted a specific problem, confusing the line between law, medicine and morality.

The restricted mandate notwithstanding, the preparatory committee decided on its own to revise also the clause on criminal responsibility. The discussion of this clause in the committee's report echoes the arguments of Paul Winge from two decades earlier, and the perspective had arguably shifted towards a medical perspective. The committee shared Winge's description of the two available options: a biological and a psychological principle. And they shared Winge's opinion that in Norway the biological principle had prevailed at least since 1842. They even shared Winge's politicized point of view that what was at stake was the division of work in the courts of law, "the diagnosis of the physician against the judgment of the judge".[28] The committee in the end proposed what would be a long-lasting solution of the problem, putting aside the compromise of 1902 and giving prominence to the medical point of view. Mental illness would henceforth automatically absolve the accused from criminal responsibility: "An act is not punishable if the perpetrator was insane or unconscious."[29] Thus, the duality of cognitive and volitional capacities (the ability to know right from wrong and the ability to be in control of oneself) apparently disappeared from the law. As regards the intoxicated criminal, this disappearance made it possible to punish the act committed under the influence of alcohol, even though the offender lacked both understanding and volitional control, because – whatever his state of inebriation – he would hardly be considered to be insane.

In addition to reformulating the rule of criminal responsibility, the committee put sexual crimes (*sedelighetsforbrytelser)* on the agenda, apparently as a response to a popular demand articulated through the women's movement. The committee's report gave prime importance to the figure of the sexual offender, stating initially that "it is a widespread understanding that rape and sexual offences have been on the rise in recent times, and that those crimes have been judged too leniently by our judges."[30] The committee considered "a more effective defence" against sexual offenders the most pressing task of criminal law reform at the time.[31] The sexual offender represented a danger to society, being beyond reach of the regular forms of discipline and punishment and aiming at women and children, the weakest members of society. The sexual offender was the scourge of society, a person against whom society must be defended.

The idea of social defence was already very visible in the criminalist movement of the 1880s and 90s. Already Cesare Lombroso's highly controversial idea of "the delinquent man" from the 1870s is a case in point; a criminal species, if such a species exist, is not something to be healed or cured, but rather something society legitimately should defend itself against. The idea of a social defence was then forged into a program of criminal law by the Belgian legal scholar Albert Prins in his book *La Défence sociale et les transformations du droit pénal* from 1910.[32] Prins was one of three founding members of the International Criminalist Association, and hence a well-known figure for Getz and Hagerup. It was, however, in the reforms of the 1920s that the idea of social defence rose to prominence in Norway and legitimated a more rigid, less individualized, criminal law.

For the Norwegian preparatory committee of 1922 a number of related criminalist problems followed from the new agenda: the question of criminal responsibility for acts committed under the influence of alcohol (see above); safety measures against the irresponsible criminals and criminals of diminished responsibility; detention of dangerous criminals and recidivists; and the use of suspended sentences. All of these problems highlighted the importance of areas that escaped the dichotomies of responsible/irresponsible, criminal/insane, prison/hospital and law/medicine. Arguably, this indicates that the very clause on criminal responsibility, when finally formulated in 1929, already had lost much of its previous significance.

In its quest for alternative methods for defending society, the committee explored the option of using surgical interventions as a weapon against sexual offenders. Eugenic thinking came to the fore with reference to the "inherited weakness" of many sexual offenders.[33] Specifically, the menace from the sexual offender became the occasion for lifting the existing ban on sterilization. Sterilization was proposed not as retaliation, but as a preventive measure in defence of society. Two of the physicians on the 1922 committee (professor Ragnar Vogt and dr. Ingeborg Aas) gave separate expert opinions on the question,[34] and in 1932 the committee proposed legislation permitting sterilization. Adopted three years later, in 1935, the Sterilization Act sanctioned sterilizing of specific individuals on "eugenic", "social" or other "worthy" grounds.[35]

Finally, Arne Omsted, member of the 1922 committee, delivered a separate proposition advocating the implementation of flexible sentences (*ubestemte straffer*) on a broad scale. He opposed the proposed rise in minimum punishments, as he perceived such a measure as an expression of the popular demand for revenge and a revival of the retribution principle in criminal law. Instead Omsted proposed to increase the malleability of the law by introducing sentences that would leave to the prison authorities to decide when the inmates would be ready to return to extramural society.[36] Omsted represented the disciplinary perspective in the criminal law debate of the 1920s and 30s. The ideal he propagated was a supple criminal law that was outcome oriented, taking as its task to transform the criminal after the model of medicine. In 1925 Omsted's consistent articulation of this perspective was a minority position, outvoted in the preparatory committee as well as in the parliamentary discussions based on the committee's work. He represented in some ways a radicalized version of the guiding principles from 1902, but he also is a testimony to the extent that these principles had been institutionalised in the expanding disciplinary apparatus of the prisons and correctional institutions. In his memoirs from 1949, Omsted bemoaned the "reactionary laws" that had been passed against his advice in 1929. By rejecting the idea of non-delimited punishment the laws of 1929 represented a missed opportunity to forge a criminal law that took into consideration the "immense variation in the ways that living life presents itself".[37] The almost lyrical expression with its reference to the "living life" is echoed in Foucault's idea of a biopower, a power that sets out to do its work on life it self.[38] The idea of making life itself, and its various forms, into an object of criminal law is found in Omsted's proposals of a more malleable law, as it is in Vogt's and Aas's explorations of sterilization as a tool for criminal policies.

Conclusion

The paper has followed the discussions of criminal responsibility related to criminal law reforms from the 1840s to the 1920s. In these debates we can identify two significant shifts. First, the previous emphasis on cognitive faculties, the criminal's ability to know what he was doing, was in the late 1800s challenged by the concept of controlling one's actions. This shift, from cognition to volition, was underpinned by developments in psychiatric knowledge, implying the emergence of the pervert as a new object of knowledge. But it was not brought into the Norwegian debate on criminal responsibility *by* psychiatrists. The psychiatrists were far more concerned with pushing for the adoption of the term "mental illness" in the criminal code, thereby restructuring the division of labour between the two professions, jurists and physicians, in criminal law. Thus, and this is the second significant change harboured in this debate, through the fight to introduce the notion of mental illness in the criminal code, the reforms of the early twentieth century witness the rise of the medical profession as a corps of experts on man and society. The successful outcome of this fight by 1929 eliminated the whole question of knowing versus willing, and psychiatric medical expertise had gained new recognition.

The three stages of the debate were dominated by voices that spoke from different positions in the penal apparatus, positions increasingly close to the criminals. The first phase was dominated by lawyers who spoke the language of the law. The second phase was dominated by a small number of psychiatrists who knew criminals through their practice as experts to the courts. In the third phase an expertise emanating from the prisons took on greater confidence and challenged the former expertise by presenting a radicalised version of the program that had been first presented a hundred years earlier in the project of a prison reform in the 1820s.

Notes

1 See e.g. Goldstein, Jan. Console and classify. The French psychiatric profession in the nineteenth century. University of Chicago Press, Chicago & London 2001 (1987); Smith, Roger. Trial by medicine. Insanity and responsibility in Victorian trials. Edinburgh university press, Edinburgh 1981.

2 For a discussion on the relationship between a profession oriented perspective and a discourse oriented perspective, see Goldstein 2001:168ff. and Skålevåg, Svein Atle. "The matter of forensic psychiatry." Medical history 50 (2006):49–51.

3 See especially Afterword in Goldstein 2001.

4 See Skålevåg 2006.

5 The art. 64 in the code pénal of 1810 read: « Il n'y a ni crime ni délit, lorsque le prévenue était en état de démence au temps de l'action (…) » (quoted in Innstilling Fra Den Av Justisdepartementet 11. Mai 1922 Opnevnte Komité Til Revisjon Av Straffeloven. Oslo, 1925:58.) For a discussion of this clause, see Foucault, Michel. Les Anormaux. Cours au Collège de France. 1974–1975. Gallimard Le seuil, Paris 1999:29 ff.

6 The etymology of galne and afsindige indicates their roots in Latin legal terminology, afsindige being an early literal translation of dementia. Winge, Paul. Samfundet og den sindssyge lovovertræder. Alb. Cammermeyers forlag, Kristiania 1898.

7 Foucault, Michel. Sécurité, territoire, population. Cours au Collège de France, 1977–78. Gallimard Seuil, Paris 2004.

8 Schweigaard, A. Commentar over Den norske Criminallov. 3rd edn, vol. 1. H. Aschehoug & Co., Christiania 1882 (1842).

9 "Rettens valgfrihed har ved den nye lov modtaget en mærkelig udvidelse." Schweigaard 1882:273.

10 Interestingly, for Schweigaard this individualization was a task for the magistrates, who required no assistance from physicians. Even when the law mentions specifically that the mental and physical state of the prospective prisoner is of relevance for the choice of adequate punishment, Schweigaard stresses that this only on rare occasions requires the assistance of a medical expert.

11 I have discussed this case in more detail in Skålevåg, Svein Atle. "Sykdom og tilregnelighet – fra sakkyndighetens historie." Tidsskrift for den norske lægeforening 139 (2002).

12 Mandatet var en omredigering: "en enklere, præcisere, for Spørgsmaalsstillingen til Juryen mere egnet Redaktion af Strafeloven". Hagerup in Hagerup, Francis (ed.). Forhandlinger ved Den norske kriminalistforenings sjette møde i januar 1901. H. Ashehoug & Co, Kristiania 1901:4.

13 It is worth emphasizing the fundamental role Getz played in this work. He was the chairman of the commission for criminal law reform, but the work the commission performed was a kind of a dialogue with the chairman. Getz singlehandedly drafted a new criminal law code, which were subsequently discussed in the commission; then Getz redrew his draft before having a new discussion. In 1896 the commission issued its joint proposal, a revision of Getz's last draft.

14 Skålevåg 2006.

15 "(…) ogsaa den nugjældende straffelov har jo allerede taget stærke Hensyn til Kravet paa Individualisering af Straffen." Winge in Hagerup, Francis (ed.). Forhandlinger ved Den norske kriminalistforenings fjerde møde, oktober 1896. H. Aschehoug & Co., Kristiania 1897:61.

16 Innstilling… 1925:57.

17 Cf. the discussion in Goldstein 2001.

18 Getz, Bernhard. Foreløpig udkast til Almindelig borgerlig Straffelov for Kongeriget Norge. Første Del med Motiver. Det Steenske Bogtrykkeri, Kristiania 1887:86.

19 Straffelovkommissionen. Udkast til Almindelig borgerlig straffelov for kongeriket Norge. II. Motiver. Kristiania 1896.

20 The first edition of Richard von Krafft-Ebing's famous Psycopathia sexualis appeared in 1886, Alfred Binet's groundbreaking article "Le fetichism dans l'amour" in 1887 in Revue philosophique de la France et de l'etranger 24 (1887):141–275. Winge was himself to contribute to the sexological literature years later when he published a small book entitled "Psychiatric and sexological remarks on totem and taboo." Winge, Paul. Psykiatriske og sexologiske bemærkninger om tabu og totem. Videnskabsselskapets forhandlinger, Kristiania 1915.

21 Hagerup 1897:61–63.

22 Winge in Hagerup 1897:62.

23 "la loi norwégienne [sic] marque une date dans l'histoire du Droit pénal." Prins, Adolphe. La Défence sociale et les transformations du droit pénal. Misch et Thron, Bruxelles and Leipzig 1910:97.

24 Hagerup, Francis. "Strafferetsreformen." in Hagerup 1901:5.

25 The process is described in the commission's report. Innstilling…1925.

26 Arne Omsted in Den norske kriminalistforenings ellevte møte i november 1935. Nationaltrykkeriet, Oslo 1936:44. Two of the physicians on the committee were women, and at least one of them, Ingeborg Aas, seems to have perceived herself as a representative of the women's movement. Aas, Ingeborg. "Revision av straffeloven. Hvilke forandringer i loven maa kvinderne kræve likeoverfor sedelighetsforbrydere?" Nylænde (1922).

27 Innstilling… 1925:.

28 Innstilling…:63.

29 §44 in the commission's proposal, which became law in 1929. Innstilling…1925.

30 Innstilling…1925:3.

31 Innstilling…1925:2.

32 Prins 1910.

33 Nielsen, Torben Hviid, Arve Monsen and Tore Tennøe. Livets tre og kodenes kode. Fra genetikk til bioteknologi. Norge 1900–2000. Gyldendal akademisk, Oslo 2000:91.

34 Innstilling…1925:2.

35 See e.g. Nielsen et al. 2000.

36 It is important to note that Omsted did not advocate a more criminal-friendly approach to crime. In his later critique of the legislation of 1929 he claimed that whereas the intention of these reforms had been to punish (sexual offenders) harder, their consequence was that a great number of these offenders were never punished at all. Omsted, Arne. Fra Mangelsgården til Sing Sing. Aschehoug & Co, Oslo 1949:139.

37 Omsted 1949:138.

38 Foucault 2004.

Travelling Knowledgde and Science

Chasing knowledge: The Norwegian physicians Christen Heiberg and Christian Wisbech touring Europe 1823–1824

Øivind Larsen and Arvid Heiberg

Two doctors on tour

On Sunday 1 June 1823, a small sailing ship left the Norwegian west coast harbour of Bergen and headed for Copenhagen with two young physicians on board. Christen Heiberg (1799–1872) and his younger friend and colleague Christian Wisbech (1801–1869) had both graduated as medical doctors at the new university in the Norwegian capital Christiania in 1822 and 1821 respectively; since Heiberg's schooling had included the study of Latin, he had graduated as *candidatus medicinae,* whereas Wisbech was awarded the degree title of *examinatus medicinae.* After finishing university, they had returned to their native city of Bergen, and now they wanted to undertake a study tour to continental Europe. Through financial support from the Bergen merchant Albert Henrik Krohn (1776–1843) and the Bergen surgeon Wilhelm Johannes Schwindt (1766–1826), they were able to realize their travel plans. During the first part of the trip, until arriving in Bamberg on 2 October 1823 Heiberg wrote a detailed diary, consisting of three booklets. Later, these notebooks were taken care of in his family; in 1933 they were gifted to the Norwegian Medical Society in 1933 by a relative, the Stavanger general practitioner Christian Andersen Heiberg (1882–1970).[1]

Heiberg and Wisbech were abroad until September 1824. During those fifteen months they visited Copenhagen, and passed through Kiel, Lübeck, and Hamburg on their way to Berlin. Their stay there was somewhat disappointing because the university term had ended and few of the medical personalities they had hoped to see were available. So they proceeded over Wittenberg, Leipzig, Meissen, Dresden, Pirna, Tölpitz and Prague to Karlsbad, Eger and Marienbad. From here they travelled into Bavaria and visited Bayreuth, Bamberg and Würzburg. Lacking time to go further, they went back to Berlin, visiting en route Meinigen, Liebenstein, Satzungen, Eisenach, Gotha, Erfurt, Weimar, Jena and Halle. By the time they arrived in the Prussian capital, the famous professors were again in place, and they had a very rewarding stay until returning to Bergen.[2] The available information on their travel reveals detailed observations and a deep commitment to what they heard and learned. For details here one should go to the original sources, for a wide range of topics was covered. Their dedication applied especially to the medical contacts they established, but they also took seriously the encounter with continental culture.

Back in Bergen, the two companions established medical careers and family lives. In 1825 Heiberg married Johanne Marie Wilhelmine Alida Heiberg (1803–1869). In 1826 he moved to Christiania, where he took over a position at the new National Hospital (*Rikshospitalet*), which had been established the same year. His career flourished; in 1836 he was appointed professor and became one of the foremost representatives of Norwegian ophthalmology and surgery, friendlily nicknamed "Christen Kniv" (Christen "the Knife) by contemporary students.[3] Wisbech married Alida Georgine Brunchhorst (1803–1860) in 1827. He held various positions as a physician in Bergen until 1848, when also he moved eastwards with his family and settled near Christiania as a district physician and had other public commitments as well. Both brides were step-daughters in the rich merchant family Krohn, and the two travellers were protégés of the wealthy surgeon Schwindt. In his biography of Schwindt,[4] Torstein Bertelsen suggests that the motives of the two sponsors of Heiberg's and Wisbech's study tour differed: for the merchant Krohn and his wife the motive was social – to mature the two young men as future husbands of their step-daughters, whereas for Schwindt the advancement of the young medical graduates' scientific preparation was a more likely motive. The diary sheds light on this question, assuming that the contents reflect what the writer perceived as the most important outcome of every day described, but we shall take up this issue later.

The birth of medical scientific travelling in Norway?

In general, travelling in order to search for skills and knowledge has been an integrated part of professional medical life at least since the 19th century. However, this statement needs a modification: Earlier, the field of work of a modern medical doctor belonged to two vocational groups, the non-academic, handicraft surgeons who dealt with injuries, skin diseases and other mainly external issues, and the university-trained physicians who treated internal diseases through a more academic approach to ailments and illness. Like other craftsmen the surgeons had years of travelling as a traditional part of their training. Their later service, for example as military surgeons, often included a substantial degree of mobility.

Biographies of famous academic physicians also often inform about visits and stays in foreign hospitals and universities. In such cases there may have been a greater resemblance to the grand tours of the nobility and the wealthy – to see the world before settling in at home – than to the apprentice travelling of the surgeons.

The medical profession in Europe changed its image and practice following the introduction of the surgical academies in the later decades of the 18th century (Vienna and Copenhagen 1785). From that time onwards, the medical students passed through a curriculum which combined the theoretical training formerly taught in the universities only with the practical craftsmanship obtained under the leadership of an older surgeon. The industrial revolution, the build-up of large armies and naval forces, urbanisation, the embarking on the process which later was named the demographic transition, and the increase and spread of epidemic diseases that flourished in the upheaved communities – all this generated a new demand for more and more effective medical services.

A national, Norwegian university – the Royal Frederik's University – was opened in Christiania in 1811 with the clear intention to educate national elite to take over core positions in the Norwegian state. A task which was given priority was to educate physicians for the national health services. The curriculum introduced was in many ways a copy of the one used in the institution where the new professors themselves had been trained, namely the Royal Surgical Academy in Copenhagen.[5] The establishment of the new university was a complicated venture in a country where demands were numerous and finances scarce.[6] The obligation to teach was prominent, and so were the burdens laid on the professors to give advice in the build-up of the new society. As a consequence, professorial research did not really take off until the 1870s. In the field of medicine, for example, the establishment of a national body of knowledge to a considerable extent had to rely on experiences and scientific literature from abroad. This created a special need for study tours.

The number of doctors in Norway in 1814 has been calculated at 100. At the end of the century, the number was tenfold, and all of them had been trained in Norway. The health services had developed from being almost non-existent to a European standard during the same period, and so had the University. This growth implies that the number of doctors who might have considered embarking on a study tour was ever increasing, so that any conclusions about such tours – their frequency, itinerary, activities and preferences – must be cautiously drawn. The physical context of study travel also changed considerably. Transportation, for example, was made easier and quicker by the coming of steamers in the 1820s and railways in the 1830s. As well, international medical meetings and congresses started up in the 1830s and provided new opportunities for the acquisition and exchange of scientific knowledge.[7]

Bent Olav Olsen[8] and Hanne Winge Kvarenes[9] have studied Norwegian medical travelling in the 19th century based on the biographies of Norwegian doctors and on travel accounts published in the national medical journal *Norsk Magazin for Lægevidenskaben*. Their investigations revealed a vivid travel activity among 19th-century Norwegian doctors, confirming the notion of a norm of refreshing and developing one's own competency as one of the special traits of Norwegian medical professionality[10]. The tour undertaken by Heiberg and Wisbech in 1823–1824 occured at an early stage of this activity. Did it belong to the very beginning of Norwegian medical travelling for educational purposes, or were there different underlying motives?

Financing of studies and travels – the case of Schwindt

Until modern times, indeed in Norway up to the mid 20th century, education was not easy to finance. Money for studies and subsistence had to be sought among family members and benefactors, often supplemented by one's own earnings in spare time and during vacations. This made the recruitment to higher education, and of course to non-institutional ways of knowledge acquisition such as study tours, dependant on access to the necessary means. Thus, the social composition of students was skewed, a consequence of – among other things – cultural background and family ties. At the same time there were persons who were willing to share their resources with others who needed assistance, for example orphaned children or poor students.

The biographies of Heiberg and Wisbech tell that their study trip abroad was paid for by the Krohn family and the surgeon Wilhelm Johannes Schwindt. Schwindt played a quite remarkable role as a benefactor for the still tiny number of physicians in Norway at the beginning of the 19th century. Bertelsen's biography[11] relates that Schwindt acted as a mentor for several young men who later became physicians.[12] Schwindt must have been a quite special personality. A surgeon born and initially trained in Germany, military service had brought him to Norway, and he had settled in Bergen in 1789, immediately after having taken part in the 1788–1789 military campaign against Sweden. He became a Danish-Norwegian citizen in 1790 and went to Copenhagen, where he pursued further studies and passed the examinations at the Royal Surgical Academy in 1793. His behaviour is sometimes described as somewhat odd,[13] but his favourable reputation as a surgeon enabled him to establish himself in Bergen society. His marriage in 1796 to Sophie Marie Heiberg (1760–1814) made him a wealthy man. The couple had one son, who died only one day after birth. They had no more children of their own, and instead fostered and supported several other children and youngsters in a generous way.

Heiberg, Wisbech and the love story

Christen Heiberg grew up in Bergen under difficult conditions; his father, a ship's captain, died in 1811 when the boy was twelve years old. He had to work to support himself and his family while still attending secondary school. In 1817 he matriculated in the university in Christiania and completed his medical studies in 1822. During these years Heiberg had also benefited from the support of Schwindt, who had become a distant relative by marriage. Heiberg's friend Christian Wisbech was son of the city surgeon of the same name.[14] The family economy was not the best, especially in his father's later years. This situation undoubtedly led to Wisbech junior being taken into the group favoured by Schwindt.

Heiberg and Wisbech were at that time courting two young ladies, who subsequently became their respective wives. It belongs to the story of their study tour that these women also had complicated childhoods. Johanne Marie Wilhelmine Alida Heiberg (the later Mrs. Heiberg) and Alida Georgine Brunchhorst (the later Mrs. Wisbech) were cousins. They had both lost their parents at a young age, and had been taken into the household of mutual relatives, the merchant family Else Margrethe and Albert Henrik Krohn,who had no children of their own. Thus, the two young men were courting two young women from a very well-off, upper-class home, cared for by step-parents who wished them all the best.

According to Bertelsen the Krohns and Schwindt decided to jointly support the study tour of the two doctors in order to enhance their social qualifications, so that they could remain in Bergen as good spouses for the step-daughters.[15] In order to avoid arousing the suspicions and misgivings of the two suitors, however, the trip was planned as "a privately supported study tour abroad". If Bertelsen was correct in his interpretation that the prime objective of the study tour was to secure a socially acceptable future job situation for two prospective family fathers, the general historical interest which has been attached to this venture fades. The pioneer status of Heiberg and Wisbech in Norwegian scientific travelling would be undermined if social considerations had been the prominent driving force. But was Bertelsen right?

Pleasure or professionalism?

Travel accounts may be analysed in light of different theories. One of these, presented by Dean MacCannell,[16] focuses on the dynamics of how tourist experiences arise. The essence is short and simple: tourists see what they expect to see; the promotion of touristy satisfaction depends on the development of expectations. The tools for this development are so-called *markers*: *off-site markers* inform about what is waiting for the traveller to see, and *on-site markers* tell the tourists that now they have arrived at where their expectations are to be fulfilled.

In an earlier paper on Heiberg and Wisbech in Copenhagen,[17] we have described the diary from this point of view, and it fits well into the MacCannell framework. Many parts of the text are purely touristy. After having endured the long and dramatic voyage from Bergen to Denmark, Heiberg meticulously described how he experienced Denmark in light of what he already knew and in comparison with conditions at home. His perceptions obviously were formed through *off-site markers* conveyed to him at home, and upon encountering the *on-site markers* he was satisfied that he had experienced by himself what he had expected.

The same response applied to the professional encounters. Together with his colleague and comrade he visited the medical institutions in Copenhagen which he had heard about back in Norway: The Royal Frederiks Hospital, The Royal Surgical Academy and others. They also established contacts with famous professors whose names were well known to them. The diary contains personal comments, sometimes positive, sometimes negative. The travellers made their own observations. And their expectations were fulfilled.

However, MacCannell's theory can also be used as a tool for analysis the other way round. Instead of looking at the traveller's on-site experiences as the objective, one might shift the study to the basis of the expectations, that is, to the *off-site markers* and see to what extent the outcome of the travel fits in with what would be a sensible result. And in this case, to shed light on to what extent Heiberg and Wisbech's *grand* *tour* touched on new and upcoming issues in medicine and imminent problems at home, for example the build-up of health services. A clear connection here would indicate that the intentions of the travel were oriented towards a future in Norwegian medicine, rather than the author's future situation in Bergen society.

Medical markers

It has to be kept in mind that the beginning of the 19th century still was a time when the communication of knowledge was limited, albeit increasing. In medicine, dissemination of knowledge and skills by means of books and journals was just beginning the development which took off later in the century.[18] Nevertheless, books and journals were already the most important *off-site markers.* Publishing in a dedicated medical journal in Norway started with the journal *Eyr* in 1826.[19] *Eyr* continued publication until 1837, when its editors gave up in the face of a chronic shortage of manuscripts.[20] Even its first issues, according to Bertelsen,[21] depended on material that had appeared in the Danish periodical *Bibliothek for Læger*, established in 1809, and in German medical journals. Perhaps just this trait confirms its role as an *off-site marker* for foreign medicine among Norwegian readers?

Obviously, for Heiberg and Wisbech the most important *off-site markers* to the outside medical world must have been acquired at the University in Christiania, in particular from teachers and colleagues. These had their scientific background in Copenhagen, the first destination on the study tour. A passage on Copenhagen in the diary, relating that contact between teachers and students was much closer in Christiania[22] than in the Danish capital, may have bearing for the historical perception of teachers as conveyors of information from the outer medical world.

An additional, important inspiration for Heiberg and Wisbech was probably the activities of Frederik Holst (1791–1871). After passing his doctoral degree in 1817 (the first in Norway) on the typical Norwegian phenomenon, the "radesyge", a disease which was a real problem in the 18th century,[23] Holst undertook extensive study tours abroad. From 1824 he was professor in hygiene at the University and in time one of the most renowned doctors in Christiania. Among his many duties Holst was also a public health officer in Christiania. He wrote extensively on public health issues, for example the reform of care for the mentally ill. New medico–political attitudes towards psychiatric patients had emerged in the wake of the French Revolution, and it was quite clear that Norway's institutions in this area required major reform. In this context Heiberg and Wisbech's visit to Roskilde and St. Hans Hospital takes on particular relevance for their subsequent work, and this is corroborated by their later visit to the asylum in Pirna outside Dresden.[24]

On-site observations

The contents of the diary which deals with touristy observations fit well into the MacCannell relation between expectations and satisfaction, and so do the notes on professional matters. The presence of touristy matters in the text confirms its status as a diary, that is, the recording of day-to day-events. The people they met, the parties they attended and so forth are all mentioned. However, if the tour's objective had been predominantly social and the trip more like a general *Bildungsreise*, undertaken to make the two young men more suitable members of the Bergen bourgeoisie on their return, one would have been expected such social commentary to have appeared more frequently in the notebooks.

Since the diary from the first part of the trip and the two letters dealing with the latter part cover a wide range of medical topics, a comparison of what they had heard and learnt in Christiania – the state of the art in the different disciplines, so to speak – and their observations and comments abroad on these issues must lie outside the scope of the present study. The status of their *on-site observations* as reflections of *off-side markers* must be studied by looking at the different topics one by one. However, the general impression is that the two companions were well informed in advance. They obviously had made plans which they pursued as far as possible, but also modified when new information, new contacts and new advice came up. Cost was not least an important factor in determining activities; for example, a fee was required to attend clinics in Berlin.

Bertelsen[25] claimed that there is no evidence that Heiberg and Wisbech had previously known the professors and physicians they met on their tour.[26] He also noted that they had not sent introductory letters in advance.[27] Schwindt, he argued, could not have given them much concrete advice on where to go and whom to visit because he had left Germany 34 years earlier and never returned. Bertelsen found it peculiar that Heiberg and Wisbech did not visit Schwindt's home town, the village Wachenheim in the Palatinate. But why should they? It was an insignificant, distant spot of no touristy or medical interest. They had their own professional agenda.

It is difficult to draw any other conclusion than that professional off-site markers originally achieved at home through their medical training, practice, and concern for the needs of the Norwegian society served as their leading stars. Heiberg and Wisbech knew what they were looking for. The passages on the relationship between students and teachers mentioned above are an example that clearly shows the comparative approach in the text.[28] And their visits to psychiatric institutions also reflected contemporary discussions at home.[29]

Knowledge brought home

Heiberg and Wisbech became more than ordinary medical practitioners. Both took part in the build-up of Norway's national health services. Whereas Heiberg made his career in the capital, Wisbech stayed for many years in Bergen, where from 1825 he worked at the civic hospital. During these years a new psychiatric hospital, the so-called *Mentalen*, was planned, and it opened in 1833. Both Heiberg and Wisbech had been instrumental in its establishment,[30] which makes the professional part of the diary even more interesting.

In 1826, the same year that the journal *Eyr* was born, a reading club for doctors was established in Christiania.[31] In 1833 the reading club was converted into The Norwegian Medical Society, which became a central institution in Norwegian medicine for many years. Heiberg was a central person both in *Eyr* and in the Society.

The study of Christen Heiberg and Christian Wisbech – their background, scientific travelling, later careers and impact on Norwegian medicine – confirm that they were pioneers in bringing international medicine to Norway. Their study tour in 1823–1824 is an important part of this contribution – the venture may have had some social intentions at the outset, but these were overshadowed by the professional outcome. Moreover, in spite of their many activities in Norway, neither Heiberg nor Wisbech lost interest in gathering knowledge by travelling; both of them embarked on study tours also in later years.[32]

Notes

1 The originals are in the possession of the Norwegian Medical Society. In 1920, prosector Halfdan Hopstock (1866–1925) at the Institute of Anatomy of the University in Kristiania published a comprehensive summary of these notebooks (Dagboksoptegnelser fra en utenlandsreise av daværende korpslæge Christen Heiberg. Tidsskrift for Den Norske Lægeforening 1920, 40:89–97, 130–36.) The first part of the travel, including the stay in Copenhagen, has been described and discussed in Larsen, Øivind and Arvid Heiberg. "Å legge ut på studiereise – med legene Christen Heiberg og Christian Wisbech til København i 1823." In Michael, 2008, 5:11–23. Further references to sources and literature on the travellers and their trip have been given in these papers.

2 Although the diary ends in Bamberg, two letters to their mentor in Bergen, the wealthy and influential surgeon Wilhelm Johannes Schwindt (1766–1826), give further information. These letters have been transcribed and published in Bertelsen Torstein Inge. Regimentschirurgen. Forlaget Regius, Bergen 2003. The first letter was dated August 19, 1823 and written in Hamburg. It ends with the signatures of both travellers, but Bertelsen assigned the handwriting of the letter to Wisbech. This letter mainly covers the stay in Copenhagen and the onward travel to Hamburg. The second letter was dated five months later, i.e. in Berlin on January 19, 1824. Also this letter is extensively written, and the handwriting is that of Heiberg. It covers adventures and medical experiences ending with the first part of their second visit in Berlin.

3 See his biography and further references to his activities and achievements in Grande Jan. "Christen Heiberg." In Arntzen, Jon Gunnar et al. (eds.) Norsk biografisk leksikon, Vol. 4. Kunnskapsforlaget, Bergen 2001:195–96 og Larsen, Øivind (ed.) Norges Leger, Vol. II. Den norske lægeforening, Oslo 1996:586–88.

4 Bertelsen 2003:173.

5 For the Norwegian situation, see Larsen Øivind, Ole Berg and Fritz Hodne. Legene og samfunnet. Den norske lægeforening, Oslo1986; Larsen, Øivind (ed.) The shaping of a

profession. Science History Publications/USA, Canton/MA1996; Larsen Øivind. Legestudent i hovedstaden. Gyldendal Akademisk, Oslo 2002.

6 See Collett Jon Peter. Historien om Universitetet i Oslo. Universitetsforlaget, Oslo 1999.

7 See Olsen, Bernt Olav. "Recreation and professional necessity – the study tours of nineteenth century physicians." In Larsen (ed.) 1996:258–75.

8 Olsen 1996.

9 Kvarenes, Hanne Winge. "Travel accounts in the Norsk Magazin for Lægevidenskaben." In Larsen (ed.) 1996:276–93.

10 See discussion in Larsen (ed.) 1996 and in Nylenna, Magne and Øivind Larsen. "Finnes det en egen norsk medisinsk identitet?" I Tidsskrift for Den Norske Lægeforening 2005,125:1813–16.

11 Bertelsen 2003. This book renders a vivid, detailed and well-documented description of Schwindt and his time. However, in places where sources are scarce, the author often presents assumptions which may allow for other interpretations.

12 Bertelsen (203) mentions as pupils and protégés Ludvig Holberg Arentz (1796–1836), later company physicians at the cobalt mining plant in Modum; Ontong Wiese (1799–1860), military surgeon; Frederik Schübeler (1795–1856), general practitioner in Copenhagen; Johan Fritzner Heiberg (1805–1883), surgeon general for the Norwegian army; Marius Heiberg (1809–1883), district physician; Albert Mathias Brock (1805–1950), district physician; Andreas Halsten Larsen Istad (1790–1862), district physician; in addition to the two doctors covered in the present paper, Christen Heiberg (1799–1872), the later professor of surgery; and Christian Wisbech (1801–1869), physician in chief in Bergen and district physician near Christiania.

13 In addition to Bertelsen 2003, see his biography in Larsen, Øivind (ed.) Norges Leger, Vol. V:13–14.

14 Christian Wilhelm Wisbech (1740–1822).

15 It might be that the situation for the young ladies was not that simple. At least for the future Mrs. Heiberg, we learn that after having stayed in the Krohn family she came into the house of Christen Heiberg's father Christopher Heiberg (1767–1811), at a time when she must have been ten years old or younger. (See Larsen and Heiberg 2008 and references.) The conditions there seem to have been rather humble, as the breadwinning father died in 1811 In his travel diary Christen Heiberg gave a rather private description from the early morning in 1823 when he departed for the travel, of how she got on to her feet and kissed him goodbye. These lines leave no doubt that she lived in the Heiberg home and probably had done so for several years.

16 MacCannell D. The tourist. A new theory of the leisure class. Schocken Books, New York 1976. Revised dedition 1989.

17 Larsen og Heiberg 2008.

18 It is possible to get an impression of the extent and contents of medical writing and its development at this time, as there were some attempts to establish bibliographic surveys of existing literature. One of the last works of this type, obviously because thereafter lack of time made such ventures impossible, is the large Callisen, Adolph Carl Peter. Medicinisches Schriftsteller-Lexicon der jetzt lebenden Aerzte, Wundärzte, Geburtshelfer, Apotheker, und Naturforscher aller gebildeten Völker I–XXXIII. Königl. Taubstummen-Institut, Schleswig. Copenhagen 1830 – Altona 1845.

19 See Larsen, Øivind and Magne Nylenna. "Medisinsk sakprosa som samfunnsbygger." In Johnsen, Egil Børre og Trond Bergh Eriksen (eds.). Norsk litteraturhistorie. Sakprosa fra 1750–1995. Vol.

1, 1750–1920. Universitetsforlaget, Oslo 1998:302–13; Nylenna, Magne. "Scientific literature and the shaping of a medical profession in Norway." In Larsen, Øivind (ed.) 1996:229–57.

20 Eyr was already in 1840 replaced by the influential medical journal Norsk Magazin for Lægevidenskaben, which held the hegemony as the national scientific journal covering medicine in general. It was published as an independent journal until 1939, when it merged into the Nordic journal Nordisk medicin, which kept its scientific profile until 1972, when it was converted into a sort of political periodical and finally disappeared in 1998.

21 Bertelsen 2003.

22 Citation in Larsen and Heiberg 2008.

23 See Lie, Anne Kveim. Radesygens tilblivelse. "Historien om en sykdom." Det medisinske fakultet, Universitetet i Oslo, Oslo 2008. (doctoral thesis).

24 The visit to St. Hans Hospital in Roskilde took place on Sunday, July 1823, and is described in detail in part II of the handwritten diary, and the whole weekend trip, including touristic adventures, covers the pages 14–26. Heiberg was especially interested in how everything has been arranged here in this new asylum, opened in 1816. During the visit in the wards a female patient committed suicide by hanging herself, and this made a deep impression on the guests. Two hours of resuscitation were in vain. Heiberg notes without further comments that the wardens expressed their content at having gotten rid of this demanding patient. The information on the visit in Pirna is taken from the letter to Schwindt from Berlin of January 19, 1824, (referred to by Bertelsen 2003) and contains no details. It confirms that reforms in psychiatry were needed also in other countries, and shows that travels to psychiatric institutions to gather information was quite common. For first-hand impressions of German and European impressions of contemporary psychiatry, see e.g. Zeller, Gerhart (ed.) Albert Zellers medizinisches Tagebuch der psychiatrischen Reise durch Deutschland, England, Frankreich und nach Prag von 1832 bis 1833. Bd. Reisatagebuch, Bd. 2 Erläuterungen. Zwiefalten:Verlag Psychiatrie und Geschichte der Münsterklinik, 2007. Although written a decade after the visit by Heiberg and Wisbech, comparisons should be allowed. In Norway, Frederik Holst had studied psychiatry and the related prison systems by travelling abroad and submitting reports upon return, see e.g. Larsen, Øivind. "Holst, Frederik". In Arntzen, Jon Gunnar et. al. (eds.) Norsk biografisk leksikon, Vol. 4., Kunnskapsforlaget, Oslo 2001:358.

25 Bertelsen 2003:188.

26 In the transcript of the letter from Berlin in Bertelsen 2003, the name Huseland must be a misspelling for Christoph Wilhelm Hufeland (1762–1836). Probably Heiberg should not be blamed for a possible misunderstanding here, for in gothic handwriting the letter "f" and the short "s" can easily be mixed up in transcription.

27 If they exist, such letters should be sought in the archives of the recipients.

28 See Larsen and Heiberg 2008.

29 See note 26.

30 See Harris, Christopher John. ""Mentalen" i Bergen." I Bergensposten 2003:47–56. (Published by the State Archive in Bergen.)

31 See Larsen, Øivind. "Det norske medicinske Selskab som kunnskapsformidler." In Michael 2008,5:96–101.

32 See Larsen and Heiberg 2008.

The creolization of medicine: Perceptions and policies of health and medicine in the Danish–Norwegian West Indies, 1750–1850*

Niklas Thode Jensen

Introduction

To researchers of colonial medicine the problem of “travelling knowledge”, or rather the question of what happened when European medical knowledge travelled to the colonies, is essential. More than 20 years ago, the late medical historian Roy Porter framed the problem in a single question. He asked: “What is colonial about colonial medicine?”[2] How, and if so, why was colonial medicine different from European medicine? This is not the place to try to answer this complex question, but it points to the fact that medicine in the very different environments and societies of the colonies is a particularly instructive place to look for what happens when medical knowledge travels. The stranger the colonial environment and society the more they reveal the fundamental ideas of European medicine and what happened to these ideas in the process of transplantation. Accordingly, I will try to approach the issue of travelling knowledge by investigating what happened to European medical knowledge and policy when it was transferred to the tropical West Indian colonies. As a case, I will use the Danish–Norwegian West Indies (now the US Virgin Islands) in the period 1750–1850.

My main argument will be that European medicine engaged in a process of “creolization” when it met with and had to adapt to the different problems of environment, culture and power in the West Indies. The concept of creolization originates in the word “creole”, a term of Caribbean origin referring either to a white person of European descent born and raised in the Caribbean colonies or to indigenous natives and others of non-European origin born in the Caribbean. In post-colonial theory, creolization is used to signify the process of intermixing and cultural change that produces a creole society. In this process, concepts and objects are selected and given new meaning in the construction of new cultures and identities. The term “hybridity” used by theorists Mikhail Bakhtin and Homi Bhaba covers about the same meaning.[3]

European medicine in the “Torrid Zone”

In the period 1750–1850 European medicine was still founded on the theories of humoral pathology and “airs, waters and places” dating back to Hippocrates. The theory of “airs, waters and places”, and later developments of it, stated that external physical factors in the environment determined individuals' physical and mental constitution and even their physical characteristics. Any imbalance between the individual constitution and the environment could cause imbalance in the four humours of the body, which again caused disease. The most important environmental factor was the climate. The hot tropical climate was considered to cause disease in Europeans because their constitution had been determined by their native cold or temperate European climate and thus did not fit with the tropical environment.[4]

However, tropical diseases were not seen as fundamentally different from those known in Europe. They were just much more severe in character. Yet because these so-called "tropical diseases" were more severe, doctors agreed that they had to be treated differently.[5] Nevertheless, doctors and surgeons coming out of Europe were not trained to deal with tropical diseases. It was not a part of the curriculum in European universities and medical schools.[6] All that existed were a few handbooks with medical advice for Europeans travelling in the so-called "Torrid Zone", that is the tropics.[7] The pharmaceuticals and therapy used by European doctors and surgeons to cure the diseases of the hot climate were also generally the same as the ones used in Europe.[8] According to West Indian doctors, this lack of training among the numerous physicians in the West Indies was an important factor behind the high morbidity and mortality that wrecked havoc among all newcomers to the islands.[9]

Based on this brief sketch, it would appear that European medical theory and practice travelled to the West Indies without much adaptation. Even if the tropical climate was seen to change the character of the diseases, therapy did not change. However, this scenario is only true for the treatment of the European minority in the West Indies. The majority of the inhabitants in the islands were enslaved labourers, and their treatment unfolds a different scenario.

Medicine for and of the enslaved

The idea of the incompatibility of European constitution and tropical environment was not just a medical problem in the West Indies but also a problem of how to get a healthy, productive workforce for the plantations. Fortunately, the solution was right at hand, as European medicine viewed the constitution of Africans to be perfectly adapted to the tropical climate. Africans were born in a hot climate and consequently regarded as well suited to work on the plantations of the West Indies. In this way, European medical perceptions were a strong foundation for the establishment of the plantation economy in the West Indies based on enslaved Africans.[10]

However, the enslaved labourers were also prone to illness, yet not to the same diseases or to the same degree as Europeans. Some diseases were specific to the enslaved, for instance Yaws (Pian) or Dirt eating (Geophagy, Pica). For this reason slave medicine became a specialism among the many surgeons employed to ensure the health of the enslaved labourers on the plantations of the West Indies. Like tropical diseases in general, this special discipline was not taught in any university or medical school. It had to be learned by experience and through the few handbooks and manuals published by doctors experienced in the field.[11] If we contrast the treatment of Europeans in the West Indies with slave medicine, it seems that European medicine did in fact develop when it travelled to the West Indies because it branched into the specialism of slave medicine. Yet, the basic concepts of humoral pathology and "airs, waters and places" remained the same.

The practice of slave medicine is especially interesting for an investigation of what happened when medical knowledge travelled to colonies because it involved encounters with the enslaved labourers and the very different medical theories and practices they had brought with them from Africa. When European surgeons or doctors treated enslaved patients, there were striking differences in the interpretation of both the cause of disease and the possible cure.[12] The following are three examples from the Danish–Norwegian West Indies. First, an enslaved labourer might believe his illness to be caused by an evil curse. Since the medical theories of the enslaved included the actions of spirits and other supernatural agents, this interpretation was perfectly sound. However, the plantation doctor would always dismiss the idea of sorcery and treat the illness in accordance with standard therapy in European humoral pathology (i.e. with a laxative, diaphoretic, salivant and so on).[13] Second, the introduction of ether as an anaesthetic in the 1840s turned out to be a mixed blessing in the then Danish West Indies. The enslaved patients perceived the unconsciousness produced by ether as a magically induced sleep, which gave the doctor a power over them akin to the powers of an "Obeah man", i.e. a sorcerer.[14] Accordingly, they were terrified and resisted the ether mask so violently that the anaesthesia hardly had any effect during operations.[15] Third, according to the beliefs of the enslaved, a newborn infant had to spend the first 8–9 days after birth with its mother in a tightly sealed hut. This was to prevent the infant's soul from being stolen by witches.[16] The doctors blamed the staggering infant mortality on this "superstitious" practice because they believed the sealed huts to contain "impure air". Instead, they recommended that enslaved mothers and children were moved to special airy maternity wards build in accordance with European medical theories.[17]

These examples all point to the connection between knowledge and power. Of course, when dealing with West Indian society the asymmetric power relations between Eurocaribbeans and Afrocaribbeans are obvious and inescapable. However, the West Indian case emphasises the fact that any kind of travel involves encounters with something new, different or strange. New knowledge, even within the same general frame of theory, will not just be accepted when it arrives in a new place but will be tested and exposed to various political and practical concerns. Thus, the introduction of new knowledge involves some kind of negotiation of power, of what elements of the new knowledge to accept, and how to integrate them into existing structures.

Returning to the West Indian case, it is now clear that the transplantation of medical knowledge from Europe was more complicated than the use of European medical therapy for West Indian diseases initially indicated. Doctors, plantation owners and administrators of the Danish–Norwegian colonial government did not succeed in transferring and transplanting their own medical theories into the minds of the enslaved labourers – despite the power these Eurocaribbeans held over the bodies of the enslaved. On the contrary, the enslaved managed to actively select some parts of European medicine as useful and to reject other parts. One example of the first instance is that enslaved women in labour asked specifically for the European drug Secale cornutum to speed up a slow birth (it stimulates muscle contractions in the womb).[18] The second instance is exemplified by the fact that the treatment of venereal diseases and dental problems were the domain of the enslaved, which European doctors did not usually interfere with.[19] So, one might say that European medical knowledge was creolized, mixed into a new medical culture, by the enslaved labourers when they misunderstood some parts of it and chose or rejected other parts.

Transplanting medical policy: vaccination against smallpox

In the last part of the paper, I will move the focus once more to a more general level and give an example of the creolization of medical policy. In general, the medical system in the Danish–Norwegian West Indies was modelled on the medical system in Denmark–Norway. It was a strict hierarchical pyramid with the landfysikus, the royal physician, at the top. Most of the medical policies in the Danish–Norwegian West Indies were founded on Danish–Norwegian medical policy, but they were rarely imposed by decree from the capital of Copenhagen. Usually, the medical authorities in Copenhagen asked the opinion of the West Indian government and landfysikus to devise a legal solution suited to the special conditions in the islands. This was a wise and natural approach under the guiding principles of "airs, waters and places".[20]

A good example of how a European medical policy was transferred and adapted to the conditions in the Danish–Norwegian West Indies is the establishment of the system of vaccination against smallpox. After Edward Jenner's publication of the method of vaccination in 1798, the procedure spread rapidly throughout Europe and the European colonies. In January 1803, the first successful vaccination was carried out in the Danish–Norwegian West Indies. In fact, dried vaccine matter had already arrived in 1802 from Copenhagen and the USA, but as was usually the case with the dried matter, it was useless when it arrived. The vaccine matter consisted of scabs from the pustules of patients vaccinated with cowpox and during the long sea voyage the cowpox virus in it died out. The only reliable way to transport the living vaccine over long distances was in the bodies of patients and in January 1803, a local physician succeeded in bringing the vaccine from North America to the islands using his own two children as live carriers.[21] Thus, the transfer of medical knowledge and therapy could also be obstructed by very practical difficulties.

In Denmark–Norway, vaccination of the entire population had been a major concern for the government since the law of vaccination issued in 1810. In 1817, the authorities in Copenhagen extended this concern to the West Indies by ordering the local government to find the best solution for the propagation of the vaccination in the islands. In response, the local government designed a unique system of vaccination – a sort of colonial hybrid of the Danish–Norwegian system.[22] What was new in this system was that the landfysikus was given the sole responsibility for the vaccination of all enslaved individuals on the island. He was to keep a record of all vaccinated and unvaccinated individuals and travel around the island following a fixed schedule, vaccinating enslaved children at fixed locations along the way. If the children did not meet for vaccination and the following control of vaccination at the specified time and place, the owner would be fined. Furthermore, no enslaved person could be sold without a certificate of vaccination issued by the landfysikus. The landfysikus was also put in charge of securing vaccine matter for the many doctors in private practice on St. Croix who catered to the vaccination of all free individuals. Free people could choose any doctor they liked as their vaccinator, but they could not choose not to have their children vaccinated since no one could be confirmed in church or go to school without a certificate of vaccination. Finally, inoculation with human smallpox was prohibited, and all citizens were ordered to report cases of natural smallpox to the landfysikus.[23]

If we compare the vaccination systems of the Danish–Norwegian West Indies and Denmark–Norway, it is evident that the former was modelled on the latter. The requirement that free people must present certificates of vaccination before being confirmed in church and before going to school was similar. Yet, the regulations pertaining to the enslaved were obviously not present in the Danish–Norwegian model, nor was the central position of the landfysikus. These differences show that the system of vaccination in the Danish–Norwegian West Indies was designed to target the enslaved workforce.[24] In other words, it was a European medical policy adapted to a very different colonial society by choosing some elements of the original policy and rejecting others. It was a creolized medical policy.

Conclusion

To conclude, it is now evident that when medical knowledge travelled to the Danish–Norwegian West Indies it did engage in a process of creolization. However, this process of adaptation did not take place in all spheres. European medical theory and therapy remained the same despite the transfer to a different climate, and even though it branched into the new field of slave medicine, the fundamental concepts stayed the same. Yet, at the same time European medical knowledge was both creolized *by* the enslaved labourers themselves in their choices of which elements to accept and *for* their sake by the colonial government when it adapted the medical policies of the metropole to fit West Indian society.

Notes

1 This article is based on the author's unpublished PhD thesis "For slavernes sundhed. Sygdom, sundhed og koloniadministrationens sundhedspolitik blandt plantageslaverne på St. Croix, Dansk Vestindien, 1803–1848", University of Copenhagen 2006.

2 Ernst, Waltraud. "Beyond East and West. From the History of Colonial Medicine to a social History of Medicine(s) in South Asia." Social History of Medicine 20/3 (2007):506, 508.

3 Ashcroft, Bill et al. Post-Colonial Studies. The Key Concepts. Routledge, London 2000:58–59, 118–121.

4 Harrison, Mark. "'The Tender Frame of Man': Disease, Climate, and Racial Difference in India and the West Indies, 1760–1860." Bulletin of the History of Medicine 70/1 (1996):74.

5 Harrison 1996:69.

6 Harrison 1996:71. Rosner, Lisa. Medical Education in the Age of Improvement. Edinburgh University Press, Edinburgh 1991.

7 Sheridan, Richard B. Doctors and Slaves. A medical and demographic history of slavery in the British West Indies, 1680–1834. Cambridge University Press, Cambridge 1985:16–28.

8 Higman, B.W. Slave Populations of the British Caribbean, 1807–1834. Johns Hopkins University Press, Baltimore, MD 1984:269.

9 Sheridan 1985:42–48, 69–71. Mallerbach, Carl Adolph. Diss. Inaug. Medica complectens observatines de morbis advenas in America vexantibus speciatim in insulis St. Thomæ et St. Crucis. Copenhagen 1745:2–3.

10 Kiple, Kenneth F. The Caribbean Slave. A Biological History. Cambridge University Press, Cambridge 1984:165.

11 Sheridan 1985:28–41.

12 Sheridan 1985:77–82.

13 Danish National Archive (hereafter DNA), West Indian Local Archives, West Indian Medical Service, Archives of Private Doctors, Dr. Lawrence Grundel's account book, no. 10.17.1, p. 174.

14 Handler, Jerome S. "Slave Medicine and Obeah in Barbados, circa 1650 to 1834." New West Indian Guide/Nieuwe West-Indische Gids 74/1+2 (2000):57–90.

15 DNA, Board of Health, Medical reports, Danish West Indies, 1847.

16 Schmidt, Johan Christian. Various Remarks collected on and about the island of St. Croix in America. The Virgin Islands Humanities Council, US Virgin Islands, St. Croix 1998 (originally printed Copenhagen 1788):29.

17 DNA, Danish Chancellery, Common Department, The commission concerning legislation on a medical police, 1802–1814, Incoming cases, negotiation and correspondence. No G125C. Medical report, 1804, doctors Stedman and Lang.

18 DNA, Board of Health, Medical report, Danish West Indies, 1842.

19 DNA, Danish Chancellery, Common Department, The commission concerning legislation on a medical police, 1802–1814, Incoming cases, negotiation and correspondence. No G125C. Medical report, 1804, doctors Charles Smith & James Walker, Andrew Kenny and Royal Physician (Landfysikus) Johan Mathias Frederik Keutsch.

20 Jensen, Niklas Thode. “For slavernes sundhed. Sygdom, sundhed og koloniadministrationens sundhedspolitik blandt plantageslaverne på St. Croix, Dansk Vestindien, 1803–1848.” PhD thesis, University of Copenhagen 2006:65–75.

21 Jensen, Niklas Thode. “‘…hvor negere og plantagernes dyrkning er alt…’ Om kopperne, vaccinationen og slaverne på øen St. Croix i Dansk Vestindien, 1803–1848.” 1066 – Tidsskrift for Historie 37/3 (2007):28–29.

22 Jensen 2007:30.

23 Jensen 2006:238–242.

24 Jensen 2007:30.

Medical auxiliaries, colonial fieldwork, and sleeping sickness research in the Lake Victoria and Lake Tanganyika basins before 1914: preliminary findings

Mari K. Webel

This article presents preliminary conclusions from recent doctoral dissertation research on the history of sleeping sickness research in Germany and East Africa.[1] The dissertation project examines the history of sleeping sickness research during the years between 1901, when Europeans in East Africa first recognized epidemic sleeping sickness, and 1914, when anti-sleeping sickness measures were disrupted by the outbreak of World War I. Within this period, I explore how collaboration, competition, the organization of labor, and changing ideas about disease prevention shaped sleeping sickness work in Europe and Africa.

In the following discussion, I present preliminary findings from two different sections of my current research. The first section addresses communication between German and British doctors and colonial officials in the Lake Victoria basin, and relates especially to collaboration and competition in the early phase of sleeping sickness research (1902–1908). Efforts to keep current on one another's work, initiated by both British and German scientists, indicate that inter-colonial and inter-imperial contacts were a key part of tropical medicine research, and specifically research on sleeping sickness, in the pre-war period. Significant scientific research activity concentrated on Lake Tanganyika and Lake Victoria as sleeping sickness spread along the lakeshores. The disease appeared in communities along the lakeshore, in the bodies of migrants as they moved across and around the lakes, and in the disease's fly vector, harbored in the dense vegetation of the lakeshores and nearby waterways.[2] African mobility along and across each of the vast lakes made sleeping sickness an international and inter-colonial problem.[3] Belgian, British, and German colonial administrators, doctors, and public health staff rapidly became involved in different strands of research and anti-disease work. Colonial officials, particularly medical staff in stations or clinics on the lakes, also made contact with one another in their efforts to determine the extent of the epidemic's spread, establish mortality and morbidity rates, identify useful chemotherapies, and chart a path for anti-sleeping sickness campaigns in their respective territories.

The second section turns to the work of African auxiliaries in anti-sleeping sickness campaign work specifically in Bukoba District and Usumbura District, and opens up an analysis of shifts in German recruitment of and dependence upon local labor throughout the anti-sleeping sickness campaign. Local African auxiliaries played a crucial and complicated role in sleeping sickness work in the lakes region. Sleeping sickness not only caused colonial officials to come into more regular contact with local populations and their leaders, but also spurred the movement of local Africans across colonial borders, and, importantly, brought many people into new or altered relations with colonial authorities. Local engagement with colonial anti-sleeping sickness work, as well as flight from and avoidance of anti-sleeping sickness measures, led to adjustments and shifts in German policies. The campaign involved constant German adaptation to African approaches to sleeping sickness, as local communities in turn responded to the changing goals of the colonial medical authorities. Employing local auxiliaries was one strategy in the campaign; by doing scientific and medical work with German doctors, local auxiliaries occupied a place of mediation and negotiation between the doctors, local chiefs, and the affected population. German anti-sleeping sickness measures aimed, through the use of local auxiliaries, at a greater incorporation of Africans into the colonial medical system and colonial administration, while also delegating an ever-increasing amount of work to those auxiliaries.[4]

Taking a broader view, briefly, I locate sleeping sickness research and anti-sleeping sickness campaign work during a transition in the colonial administration of the lakes region by German officials, and also amid debates about anti-disease measures in the field of tropical medicine. These two changes overlapped in the period prior to World War I.[5] Within this period of transition and development, the epidemic attracted – rapidly and urgently – the attention of metropolitan European academies and governments, of colonial administrators and medical officers, and of local people and Europeans researching in the affected regions.

In the context of the sleeping sickness epidemic, Lake Victoria and northern Lake Tanganyika were particularly distinctive regions. People, goods, vectors, and diseases circulated vigorously around, across, and between the lakes in the pre-colonial period, and trade and mobility increased in the years before World War I.[6] In German East Africa, epidemic sleeping sickness meant the accelerated movement of people across borders with British Uganda and Belgian Congo, as well as movement within the German protectorate.[7] This study considers the lakes as zones of historical analysis, as home to distinct political and ecological situations, and also as linked pieces of a larger system of trade and migration; it attends to mobility that persisted from pre-colonial patterns of migration and trade, and that then came to cross new colonial borders. Four specific areas in German East Africa were centers of sleeping sickness work and also sites of intense mobility: Bukoba and Shirati districts on the western and eastern shores of Lake Victoria, respectively, and Ujiji and Usumbura districts on the eastern-central and north-eastern shores of Lake Tanganyika, respectively. Scientific research and anti-sleeping sickness measures initially targeted settlements along Lake Victoria, but those along Lake Tanganyika – especially north, on the border with Belgian Congo – soon assumed parallel importance. More generally, these four districts on the two lakes also reflect the focus of concern for German colonial medical officials after 1903.

Connections within British and German sleeping sickness research, 1902–1907

The rich historiography of tropical medicine and of medical research in East Africa has largely retained the boundaries established by European colonial regimes to define its subjects of analysis.[8] Privileging these borders has colored our understanding of continuities between pre-colonial and colonial Africa, but has also separated public health interventions, and their subjects, across territorial boundaries. Further, nationalist and social historical narratives in both African history and the history of medicine and science – though a necessary corrective of preceding work that focused largely on European elites and their activities – have placed less importance on instances of communication and collaboration. Research was not a singular endeavor, however, and scientists tapped into the expertise of a network that included European peers and subordinates, and local Africans leaders and populations. Particularly in the Lake Victoria and Lake Tanganyika regions, colonial boundaries were permeable, and the nature of the sleeping sickness epidemic brought this permeability, and movement of people and information it enabled, to the forefront.

Borders remained a key point of focus, as movement of Africans infected with sleeping sickness around and across the Lake Tanganyika and Lake Victoria regions was a primary concern for scientists and administrators involved in research, and in subsequent campaigns to prevent sleeping sickness. The movement of European scientists themselves – and their ideas – in the same geographical field also shaped sleeping sickness work. The colonial situation around Lake Victoria brought scientists from Germany and Britain into close proximity, mirroring a key aspect of tropical medicine in Europe, where scientists maintained contact with their domestic and foreign colleagues in a variety of ways: through personal correspondence, by taking courses in and otherwise visiting each other's institutions, and publishing and commenting in a range of field-specific journals.[9] Collegiality and rivalry went hand in hand. But while rivalry spurred by nationalist feeling was certainly an issue, competition largely revolved around scientific concepts and practices. Competition in tropical medicine in this pre-war period aimed at prestige and recognition among a field of researchers that was vibrantly international. However, just as research funding and support largely came primarily from national governments and scientific institutions, rewards for achievement registered first domestically, and colonial research in Africa was thus inextricably linked to national competition in Europe.

Still, the importance of a national scientific school or school of thought, as opposed to an international community of peers, was mutable; sleeping sickness work in East Africa benefited from a widespread desire to take advantage of new laboratory and experimental methods, to test and re-test new findings, largely without respect to the national origin of the scientist in question or to the colonial borders that separated scientists. In the Lake Victoria basin, German and British scientists corresponded with and visited one another at their respective administrative posts and research sites. The higher concentration of scientists conducting research in the area, achieved through posting of additional colonial staff and the arrival of expedition teams, was part of a broader increase in attention to sleeping sickness. Between 1901 and 1909, eight different expeditions sponsored by European governments and tropical medicine institutes fanned out across sub-Saharan Africa, each lasting at least a year and some resulting in permanent laboratories or research stations in their region of research.[10]

One of the first of these diverse expeditions did its work in Uganda. The sleeping sickness epidemic broke out on the northern shore of Lake Victoria in mid-1901, and a British research expedition, the Royal Society's Sleeping Sickness Commission, arrived in spring of 1902. The East African and metropolitan presses covered the epidemic, and both British and German administrations worked initially to gather information – an epidemiological survey by mail and telegraph.[11] This also involved researchers traveling around Lake Victoria, crossing colonial and district boundaries, and traveling among different local chiefdoms. The mobility of colonial officials reflected the mobility of the local population, as migration into and out of areas where sleeping sickness was newly present took on increased importance. In November 1902, Dr. Feldmann, of the *Schutztruppe* (the German colonial army) medical staff reported meeting with Cuthbert Christy, a member of the Royal Society's Sleeping Sickness Commission. The two conducted examinations and collected blood samples together from the local population of Kifumbiro (in Bukoba District of German East Africa, near the border with Uganda).[12] In December 1902, on the opposite shore of Lake Victoria, a German colonial officer traveled to the colonial border with Uganda to investigate the presence of sleeping sickness cases – not to meet with the British, but to observe Africans crossing the border in Shirati District.[13] In May 1903, a few months prior to confirming cases of sleeping sickness in German East Africa, Feldmann wrote to David Bruce, head of the Royal Society's research commission, requesting further information about the extent and the speed of the disease's spread in British territory, about the nature and speed of the disease's progress, as well as notification of its southernmost boundary.[14]

Medical officials first reported cases of sleeping sickness in German territories in Shirati in July 1903, and at Bukoba in November of the same year. Cases were believed to have been imported from Uganda, and, indeed, German officials took great pains to argue that no endemic or epidemic sleeping sickness had originated in their territory. Despite this, the reality of frequent movement of individuals as well as larger groups around the lake meant that sleeping sickness presented a major problem in containing the disease for the medical officers of the *Schutztruppe*. Traffic to and from Uganda also required that German officials be aware of British research and any concurrent anti-sleeping sickness measures. Sharing of information included sharing of research methodologies and technologies, particularly after the confirmation of a trypanosome as the cause of sleeping sickness and of the fly *Glossina palpalis* as the disease's vector in 1903. Communication facilitated sharing techniques and skills among researchers and medical officers around the lake. Investigating the spread of the disease and diagnosing it required a solid command of microscopy and a knowledge of bacteriology and parasitology – the fundamentals of the new tropical medicine.[15] Specific knowledge of entomology was also key in identifying and differentiating between various species of the fly vector.[16]

The epidemic required that those not trained in the necessary research methods acquire them quickly. Sometime between May and October 1903, *Schutztruppe* physician Lott, stationed at Mwanza, traveled to Uganda for a crash course in the laboratory and clinical methods needed to investigate and diagnose sleeping sickness.[17] As scientists continued to research the spread of the disease and consider different anti-disease strategies, communication continued. British doctors, correspondingly, wrote to German doctors around the lake inquiring about the presence of the disease, and in at least one later case, visited a German station to observe disease control and treatment measures in place.

This initial communication served largely as a fact-finding effort, and, judging from letters and reports between the officials and scientists involved, was generally open. Given the acute nature of the epidemic, the nature of this communication – directly between individual scientists at work in East Africa – occurred largely without mediation from metropolitan authorities or any formal diplomatic introduction. Official diplomatic introductions may also have been deemed unnecessary because, apart from David Bruce and the two other members of the Sleeping Sickness Commission, all of the men investigating the disease were members of the colonial medical service in some capacity and were required to report to the colonial administration. Inter-colonial communication was also important in later cases where metropolitan and colonial governments negotiated details of cooperation, however, and smoothed the way for the arrival of a high-profile peer of David Bruce in the Lake Victoria area in 1906. Robert Koch, considered the German expert in bacteriological research, returned to East Africa, arriving in 1906 and traveling to Lake Victoria by July of that year.[18] Finding no cases to work with in German East African territory around the lake, Koch secured the support of British authorities in Uganda, where a larger number of people ill with sleeping sickness lived, and did the majority of his research with sleeping sickness in British colonial territories beginning in August 1906.[19] There, Koch also visited and consulted with A.D.P. Hodges, a British medical officer, discussing prevention methods in advance of beginning his own work (much to Hodges's apparent delight).[20] He also took advantage of the resources of the White Fathers (Missionaries of Africa) mission at Bumangi on the Sese Islands in Uganda, using their buildings and constructing a sleeping sickness camp close by.[21]

Further analysis of governmental, institutional, and personal manuscript sources will indicate how inter-colonial relationships, such as those between German and British scientists, affected sleeping sickness research and the development of ideas about both the disease and its control. Several preliminary conclusions are, however, possible. First, whereas nationalist allegiances and scientific rivalries were important factors in research in East Africa, coordination between administrators and scientists suggests that the influence of national scientific schools or national-colonial styles of disease prevention should not be overstated. Both metropolitan institutions and colonial administrations were subject to internal divisions and policy disagreements, and scientific academies were rife with intra-national jockeying for power and clout. Particularly in the early stage in sleeping sickness work in East Africa, sharing of information occurred, and went hand-in-hand with the protection of individual scientific achievements and appeals to wider transnational professional networks. Second, in looking at communication among doctors, we can also start to identify common approaches or practices, methodological, theoretical, and ethical continuities, and an array of differences in ideas about the disease. Sleeping sickness work presents interesting possibilities from a comparative perspective, particularly with regard to the development of early chemotherapy.[22] Given extant literature addressing sleeping sickness work from the perspective of medical ethics, it remains to examine to what extent information about experimental chemotherapies traveled, and if so, how?[23] Experimentation with different anti-trypanosomal chemicals, as discussed in British and German sources, indicates the potential for strong continuities across colonial administrations in their approaches to their African subjects as well as the potential fruits of an analysis of how medicine fit into these approaches.[24] Third, despite the novelty of sleeping sickness as an epidemic disease in East Africa, prior experience with domestic and colonial epidemics shaped administrative and scientific approaches to sleeping sickness. Sleeping sickness researchers referred frequently to their experience in malaria research and anti-malaria campaigns, both in terms of disease epidemiology and public health interventions.[25] Plague, smallpox, cholera, and typhus were also points of reference with regard to designing both research methods and anti-disease campaigns.[26] Sleeping sickness research, then, affords a view into the transit of ideas and practices between Africa and Europe, as well as between European colonies globally.

African medical auxiliaries in the German anti-sleeping sickness campaign, 1907–1914

Sleeping sickness research, as with most colonial work in East Africa, depended on African labor and materials. The anti-sleeping sickness campaign was carried out by doctors and sanitary officers who were members of the *Schutztruppe*, but who were under the command of a central medical authority, Prof. Dr. Friedrich Kleine (Koch's chief assistant during his 1906–07 expedition). As such, the campaign had special funds and reported directly to Kleine, the central government in Dar es Salaam, and the Reichs-Kolonialamt and Reichs-Gesundheitamt, but not to district administrators. The campaign's twinned priorities of arresting the epidemic and continuing research on its transmission and treatment required local labor not only to build clinics and camps, but also to collect tsetse fly specimens and manage test animals. The campaign would also come to depend on local labor to survey local populations for signs of the disease and to bring the sick to camps for treatment. The necessities of research and of disease prevention led German doctors to create a cohort of local African medical auxiliaries, eventually called *Drüsenfühler* (lit., gland-feeler). Their knowledge of local languages and populations was to be coupled with training to find suspected cases of sleeping sickness by detecting the presence of swollen cervical lymph glands. Charged with finding sleeping sickness sufferers and delivering them into treatment, *Drüsenfühler* would also, doctors hoped, help to explain the nature of the disease and what Europeans were doing to fight it – to calm fears, and instill trust. *Drüsenfühler* were not a straightforward solution to the sleeping sickness campaigns needs, however, but rather introduced an additional degree of complexity and variability into interactions between German doctors and local Africans.

Anti-sleeping sickness measures were, by and large, contingent on strict enforcement by campaign doctors, local leaders, district officers, and, if necessary, military troops. They also depended on the ability of medical staff to reach, examine, and treat the sick. The problem of reaching, examining, and treating the sick was not only one of resources and manpower, but also of differing approaches to European biomedicine and its associated methods and technologies among colonial doctors and local Africans. Defining who was sick with the disease, particularly given its sometimes chronic nature, was a key point of difference between European and local approaches to the disease. Studies of similar instances of interaction between colonial European and local African definitions of illness and wellness, and systems of healing and curing, inform my analysis of material from German records.[27] Rather than explore how such interactions between colonial and African ideas affected how sleeping sickness was defined as a disease and the meaning of that disease for both local communities and colonial officials, I instead focus here on the initial organization and implementation of anti-sleeping sickness work and the employment of African auxiliaries.[28]

As medical auxiliaries, *Drüsenfühler* occupied an intermediary position between local chiefs, colonial doctors, and local populations.[29] The process of negotiation and adaptation by which they were introduced into the sleeping sickness campaign reveals the limitations of the campaign and the incommensurability of Robert Koch's original plans with local African responses to the German colonial presence and to the disease itself. The intended work of *Drüsenfühler* also provides a view into the organization of colonial medical work, as well as into the reciprocal impact that colonial doctors and local populations had on the ultimate shape of research and disease prevention.

The anti-sleeping sickness campaign in German East Africa began in earnest in late 1907, following a period of initial research, and also overlapped with British anti-sleeping sickness measures. German sources describe the intention to implement a highly centralized and unified campaign, developed in the Imperial Health Office, largely according to measures provided by Robert Koch. Koch's guidelines for a sleeping sickness campaign, based on his experience in East Africa and drawn up in Uganda before his return to Berlin in late 1907, included: moving populations from "infected" areas into fly-free areas; collecting and isolating the sick in camps; treating the sick long-term with regular doses of atoxyl; border closures and regulation of traffic to and from "infected" areas; clearing of vegetation at boat landings and populated stretches of the lakeshore; and eradication of crocodiles to eliminate fly vector blood meals.[30] The anti-sleeping sickness campaign would focus on two sites around Lake Victoria (Bukoba in the west and Shirati in the east) and on various areas along the eastern shore of Lake Tanganyika (beginning with Usumbura, in the north, but including Ujiji and locations further south).

In 1907, German energy in the anti-sleeping sickness campaign was mainly devoted to organizing new isolation camps[31] in areas where the disease had been identified and to fanning out further into the countryside to identify any other "sources of infection", including people with signs of trypanosomiasis and the flies carrying the parasites. Localized measures also focused on limiting traffic, trade, and migration to Uganda, in the Lake Victoria basin, and on monitoring traffic from the Belgian Congo, in the Lake Tanganyika area. These measures also required treating patients with atoxyl and the systematic management and reporting of cases; isolation in collective camps was compulsory, and enforced by *askari* (African soldiers in the *Schutztruppe*) if necessary.

This new, systematic approach also included the use of local African labor. German colonial officials had relied heavily on African and Afro-Arab functionaries for the administration of areas on the Swahili-speaking coast and the fertile northern highlands of eastern Tanzania.[32] But auxiliary labor in this case now involved specific training oriented toward scientific collection and experimentation. *Fliegenfänger* (lit., fly-catcher) had been a regular part of Koch's expedition work, and were also used in the course of sleeping sickness research in Uganda and Belgian Congo.[33] Generally young men, they were now constant participants in campaign work. African assistants also performed other types of work necessary for sleeping sickness research, such as the management of animal specimens and experimental feeding of flies. Station budgets for anti-sleeping sickness work in German East Africa included outfitting and wages for *Fliegenfänger* as well as for general laboratory assistants.[34]

The recruitment and employment of further African personnel indicate that the expansion of anti-sleeping sickness efforts led to new forms of work and different arrangements between German colonial officials, local chiefs, and their subjects. As of late 1907, a doctor manned each of the four main stations at Shirati, Bukoba, Usumbura, and Ujiji, and each either had, or had requested, an additional sanitation officer. Local circumstances quickly exceeded the capacity of the limited European staff of the campaign. In their reports to the campaign's coordinator Friedrich Kleine, doctors mention identifying suspected cases of sleeping sickness in a given village, but being unable to confirm the diagnosis for lack of time or lack of proper equipment.[35] Much of the initial survey work of local populations and of the environment remained to be done, and resources and manpower were limited.

In October 1907, Robert Kudicke, the doctor responsible for the campaign at Bukoba, faced the prospect of a large number of unidentified or unconfirmed and untreated cases in the nearby chiefdoms of Bugabu and Kiziba. Kudicke reported that, in order to treat these populations as soon as possible, he would attempt to have several villages searched by "natives, who were trained in the palpation of glands." The Haya ruler Mutahangarwa, near the Uganda border in Kiziba, had sent him 10 young people whose instruction Kudicke had already begun. He would later refer to these people as *Drüsenfühler*.[36] *Drüsenfühler* were paid a wage per month, and, within a few months, were also paid a premium per positive case identified; their wages and premiums would fluctuate throughout the campaign.

In addition to examining a given population for signs of sleeping sickness, Kudicke also advocated using *Drüsenfühler* to monitor caravan traffic around Bukoba District and toward Lake Kivu and Urundi.[37] They would also work alongside a *katikiro*[38] in villages to identify and note those suspected of having sleeping sickness, then bringing those people to the nearest isolation camp for treatment.[39] Campaign doctors also suggested offering a premium to *katikiro* and to family members who brought their sick relatives in for treatment at isolation camps. Wages and premiums provided an incentive for cooperating with the German campaign, though determining the weight of those incentives requires further research into local economies.

In May 1908, Dr. Feldmann, now leading the campaign in Ujiji on Lake Tanganyika, commented on relations with local people with regard to sleeping sickness internment camps, asserting the need for a strong government-backed compulsory internment system combined with material incentives (such as clothing, *pombe* [banana beer], tobacco) to bring people into isolation camps for treatment. [40] Provision of material goods, like sleeping mats, to camp inhabitants, and for other goods as incentives for treatment was earmarked in campaign funding.[41] But Feldmann's comments belied a serious problem for the campaign: hiding from examination and flight from treatment. Both made surveying the population and treatment or isolation in camps difficult. Reports from other posts discussed problems in simply finding and examining the sick – let alone moving them to a camp for treatment and keeping them in isolation for a extended period of time and treatment with anti-trypanosomal drugs. In 1908, just a few months into the formal campaign, doctors from all stations reported people hiding from examinations conducted in their districts, and their quarterly reports document a steady stream of patients removing themselves from treatment.[42]

Hiding from examination and flight from treatment indicate, in my reading of the sources, a desire to avoid or refusal to engage with colonial medical activity. Apart from removing oneself from the purview of sleeping sickness work, talking about it could also have an impact.[43] German doctors linked their problems in attracting and retaining patients to perceived misunderstandings of medical procedures and deliberate spreading of rumors and misinformation. Station chief Göring at Ujiji reported detailed rumors about medical examinations in the area:

> Das Haupthindernis bildet das unvernünftige Verhalten der Bevölkerung selbst, hervorgerufen durch die Unkenntnis mit dem Wesen der Krankheit, die grosse Gleichgültigkeit, die abergläubigen Vorstellungen und die falschen abschreckenden

> Gerüchte über die Untersuchungs- und Behandlungsweise des Arztes. So wurde z.B. vor kurzem das Gerücht verbreitet, dass der untersuchende Arzt den Leute zunächst einen grossen Nagel in den Kopf treibe, ihnen dann das Blut in Flaschen abzapfe und ihnen schliesslich das Fell über die Ohren ziehe. Haut und Blut würden nach Europa gebracht und dort verkauft.[44]

Similarly, Dr. Kudicke reported unspecified rumors from his work in Bukoba on Lake Victoria, several hundred miles away, relayed to him by *Drüsenfühler* monitoring caravan traffic and border crossings at Kifumbiro to Uganda. He compared these to rumors that had circulated in a neighboring area, which involved Africans becoming sick through examination or blood-taking. Kudicke placed these new rumors in the context of local "magicians" active in the area and who created the difficulties that the campaign had encountered there. Kudicke recommended spreading information about medical activities and their scientific bases, primarily through local auxiliaries, which he called "farbige Hülfsarbeiter," to respond to what he perceived as misinformation.[45]

The grounds for flight, hiding, and rumor-spreading were certainly manifold, and motivations for these and other actions cannot necessarily be apprehended through colonial reports. Rumor and flight were cited as the primary reasons for a more aggressive effort to communicate better with local populations – often cast as a process of winning trust or of education. *Drüsenfühler*, as auxiliaries familiar with local languages and perhaps also members of the local elite, were seen as the key means of educating the broader population in Bukoba District, alongside administrative efforts to compel the cooperation of local chiefs. More extensive research on their position between local chiefs and German officials – and the engagement of local chiefs with the colonial medical officials – is necessary.[46] Further, though amalgamated by German doctors for the purposes of designing a centralized anti-sleeping sickness strategy, rumors in Ujiji and rumors in Bukoba cannot be presumed to have had equivalent meaning or valence in their respective local contexts. An exploration of local symptomologies and nosologies could provide a means of comparing disparate diseases and rumors, and working toward their contemporary meaning.

What practices were *Drüsenfühler* expected to explain or translate, and into what medical system did they bring the trypansomiasis-positive people they found? Blood and lymph extractions were, in 1908, standard procedures for diagnosing sleeping sickness. Scientists drew blood from ear lobes and finger sticks, but quite often also required examination of lymph extracted through a puncture of the cervical nodes to diagnose the disease. In some advanced cases, they performed lumbar punctures to search for trypanosomes in the cerebro-spinal fluid. The epidemic in German territories was such that the majority of patients was considered *Leichtkranken* (lit., lightly sick) and had minimal, if any, symptoms of disease. In addition, local symptomologies may not have identified the same signs of illness, or connected them with a discrete disease, sleeping sickness, as German doctors did. The primary drug used to treat sleeping sickness, and particularly to decrease parasitemia in these *Leichtkranken* was atoxyl, which was painful to inject and could cause serious side effects, including blindness. In the initial phase of the campaign, the expanded use of atoxyl, as well as other experimental drugs, often involved the presence of a new "camp" or treatment center, tailored specifically to a local epidemic. Camps were guarded by *askari* and meant to be self-sustaining, but also often were surrounded by an accompanying settlement of relatives, who provided and cared for their sick.

While German colonial medical officers offer a version of local African oral sources distilled to fit into written reports, the rumors they recounted and the activity these rumors triggered suggests a complex picture of African engagement with colonial medicine. Rumor and flight (alongside recruitment and employment as auxiliaries) are here active engagement or disengagement rather than misunderstandings or misinterpretations of biomedical practices. These actions became a part of a dynamic and productive situation wherein public health interventions were developed. The deployment of *Drüsenfühler* was an effort to combat misinformation through auxiliaries fluent in the local language and who were assumed to be perceived as less foreign to local people. But the job itself also established an intermediary role for Africans trained to recognize symptoms of sleeping sickness, and provided a monetary incentive for bringing the sick into camps, sometimes forcibly. Sleeping sickness was, however, difficult to diagnose, and even with microscopic examination of the blood or lymph of suspected cases, many cases remained only "suspected". A margin of error in identifying sleeping sickness existed, acknowledged by doctors at work in the campaign and by researchers in Europe. It was precisely this margin of error that placed *Drüsenfühler* in such an interesting position between a local population and German medical staff, and their expertise – and ability to compel a person's removal from home and family – which became itself a source of fear and reason for flight.[47]

The training of *Drüsenfühler* was one adaptation in the strategy of the anti-sleeping sickness campaign to local circumstances, a recognition of the inadequacy of German manpower for the vast territory concerned and a tacit acknowledgment of the need for African intermediaries to interact with local populations. Further adaptations in German policy took shape in response to African reactions to it and, specifically, to withdrawal from its tactics. Friedrich Kleine, the leader of the campaign, reported in 1908 that the "local circumstances" that the campaign encountered demanded a shift in strategy and also a move toward uniformity in the German implementation of prevention and treatment measures. In August of 1908, he wrote to the government in Dar es Salaam:

> In einem früheren Berichte gab ich auf Grund meiner Beobachtungen bei den Wagaia [sic] der Ansicht Ausdruck, dass es ein Ding der Unmöglichkeit und vollkommen nutzlos ist, in einem halbwilden Lande mit Gewalt und mit Askari die erkrankten Einwohner zusammenfangen und gegen ihren Willen aus ihrer eigenen Heimath in ferner gelegene befestige Lager versetzen zu wollen. Einmal mag es gelingen, zum zweiten Male kaum. Sobald der Arzt mit bewaffneter Macht erscheint, entfliehen die durch abenteuerliche Gerüchte geängstigen Eingeborenen in weiten Umkreise

> [sic]. Die verhältnismässig geringe Zahl Kranker, die beim ersten Mal eingefangen sind und zwangsweise interniert und behandelt werden, kann bei der Ausdehnung der Seuche eine Rolle nicht spielen. Insbesondere die Leichtkranken bleiben in überwiegender Mehrheit unbehelligt und tragen die Seuche weiter...Wie im Bezirk Schirati, müssen wir deshalb in gleicher Weise am Tanganika auf die Anwendung von Gewalt verzichten, die nur geeignet ist, unsere Absichten ernstlich zu hindern.[48]

When campaign tactics shifted away from internment and toward ambulatory treatment with atoxyl, the use of *Drüsenfühler* did not end, rather it continued alongside the employment of laborers in bush clearing work and monitoring trade and traffic. Their work fitted with the goal of reaching people through ambulatory treatment and the use of small and more widely dispersed treatment stations. *Drüsenfühler* were employed in other areas as the campaign went on, with different levels of involvement with local authorities and shifting levels of autonomy in the conduct of their work. They were seen as an essential extension of German medical manpower, able to reach and reach out to people sick with sleeping sickness. They simultaneously filled the role of translator, interpreter, surveyor, caravan inspector, and, in later cases, may have administered atoxyl injections to treat the sick. The blending of social, political, and medical factors, visible in both the creation of the position of *Drüsenfühler* and in the widely varying responses to their work, adds a new element to our appraisal of the colonial labor dynamic. The employment of medical auxiliaries at this time indicates another degree of complexity in the political and economic relations between German colonial officials and local populations and their leaders, fitting alongside better-known histories of porterage, military service, and plantation labor.

By 1911, according to the Reichs-Kolonialamt's medical report on the colonies, strict isolation and enforced treatment had been abandoned in favor of environmental measures aimed at controlling the fly vector, and ambulatory treatment with atoxyl. In German East Africa, a public report stated:

> Wie bereits in früheren Berichten ausgeführt wurde, haben wir das ursprüngliche Prinzip der Bekämpfung: Konzentration der Schlafkranken in feste Lager, mehr und mehr aufgeben müssen und statt dessen das Hauptgewicht auf die Sanierung der infektiösen Landschaften gelegt. Soweit es sich aber ermöglichen ließ, wurden daneben doch die Kranken, meist ambulatorisch, mit Medikamenten behandelt.[49]

This shift accorded with a more general move away from drug treatment or internment and an increasing emphasis on environment and vector control in sleeping sickness prevention. This was also, at the time, because each new attempt at chemotherapy had failed to varying degrees, and atoxyl now proved to be subject to relapses. Experimental drug therapies were controversial in the metropole, difficult to administer consistently in East Africa, and, with frequent negative side effects and sometimes high mortality, also had the potential drawback of further damaging local trust in colonial doctors.[50]

The employment of *Drüsenfühler*, and the context in which they functioned, reminds us that colonial power was not comprehensive and that, in the German case, administration of East Africa depended on the use of auxiliaries. Doctors working on the anti-sleeping sickness campaign were not working with a stable situation – even as they were organizing internment camps and directing clearing, they were also traveling around their districts, surveying populations, and documenting environments. This instability, combined with the near-constant requests from all doctors involved in the campaign for more support staff and more funding, brought local auxiliaries into the sleeping sickness campaign because the German staff and supporting military were simply too thin on the ground to manage the campaign as it was designed. But auxiliaries were also intended for cultural work as well – to make colonial medical procedures and strategies more familiar and to bring ever-larger portions of local populations into the colonial medical system.

Conclusion

This article aims neither to describe European scientific networks to the exclusion of their African members nor to examine local African political and social circumstances with colonial officials kept at arm's length. Indeed, the sleeping sickness epidemic in the Lake Victoria and Lake Tanganyika regions remains a compelling historical and epidemiological problem because its impact was so wide and varied upon both Europeans and Africans concerned. I have focused on communication and adaptation, and on the ways sleeping sickness research and prevention work changed in accordance with local contexts. Analysis of the epidemic also captures a transitional period, between 1901 and 1914, in the colonial administration of western areas of German East Africa as well as in the development of the scientific field of tropical medicine. Sleeping sickness was significant for inter-colonial administrative and public health strategies and shaped by efforts at international coordination. In both its African and European contexts, sleeping sickness research attracted competing interests and built necessary alliances. The work of research – who would do it and who could benefit from it – here involved enthusiastic scientists, budget-conscious administrators, local African auxiliaries, and potential patients, among countless others.

The initial phase of sleeping sickness research in Lake Victoria brought scientists across colonial borders into communication, neither eschewing competition and rivalry completely nor being hobbled by it. German and British scientists communicated about sleeping sickness out of necessity, and also within a framework of collegiality established within the transnational discipline of tropical medicine. Communication between colonial administrations and the scientists working for them recognized the realities of contiguous populations, fly-belts, and, at a basic level, of a linked fate when it came to disease control and prevention. Subsequent sleeping sickness treatment and prevention efforts after 1907 further entangled local Africans in this scientific network. *Drüsenfühler* constituted a new position within the anti-sleeping sickness campaign and within the local political and social contexts where they worked. The problem of mediating between local and European approaches to sleeping sickness, between doctors, chiefs, and the population – in addition to their scientific responsibilities – placed *Drüsenfühler* at the center of anti-sleeping sickness work in the lakes region. How local Africans became employed in laboratory labor and epidemiological survey work indicates the adaptations and negotiations required in sleeping sickness research work.

This article has examined how research work in East Africa was understood, as well as how it depended on and interacted with local political and economic situations, in order to shift the level of historical inquiry from laboratories and experts to the contexts in which they functioned. With regard to writing the history of medicine and African history, this requires an attention to pre-colonial connections in the Lake Victoria and Lake Tanganyika regions, and to what continuities persisted. It also requires an eye to reciprocal impacts, to feedback loops, in examining the adaptations and translations that occurred in colonial medical research. In examining the ways that the officials, scientists, auxiliaries and others who lived with and worked on sleeping sickness were connected to one another, within and across colonially created borders, and how and why this changed over time, a more comprehensive history of sleeping sickness is attainable.

Notes

I wish first to thank the Department of Archaeology, History, Cultural Studies and Religion, University of Bergen, and the Rokkan Centre for the opportunity to participate in the workshop. I thank the Tanzanian Commission for Science and Technology (COSTECH) for supporting my dissertation research. Research has been conducted with the generous support of the Council on Library and Information Resources Mellon Fellowship for Dissertation Research in the Humanities in Original Sources, the International Dissertation Research Fellowship Program of the Social Science Research Council, with funds provided by the Andrew W. Mellon Foundation, and the Berlin Program for Advanced German and European Studies, jointly administered by the Freie Universität Berlin and the German Studies Association with funds provided by the Freie Universität Berlin. Many thanks to Professor Volker Berghahn, Professor Marcia Wright, and Aimee Genell for their comments; my gratitude also to Max and Kathryn Webel and to Joshua Kobrin. The dissertation will be submitted for completion of a doctorate in History at Columbia University, New York. The conclusions in this article are the author's alone.

2 Sleeping sickness (Human African Trypanosomiasis) is caused by a protozoan parasite (Trypanosoma brucei rhodesiense or gambiense) and spread by the bite of the tsetse fly (commonly Glossina palpalis or G. morsitans). The parasitic infection initially causes fever, edema, weakness, and loss of appetite; the later stages of the disease are characterized by tremors, lethargy and sometimes dementia, coma, and ultimately death. Cases are diagnosed through identification of trypanosomes in the peripheral blood, lymphatic fluid, or cerebrospinal fluid; swollen cervical lymph glands, known as Winterbottom's sign, were considered an early presentation of the disease at the turn of the century. See Burri, C. and R. Brun. "Human African Trypanosomiasis." In Gordon C. Cook and Alimuddin I. Zumla. Manson's Tropical Diseases. Saunders, London 2003. No cure existed in the early twentieth century. At that time, in Central and East Africa, the disease's scope and scale changed drastically. Regarding the debate on the expansion of sleeping sickness at the turn of the century, see Iliffe, John. Tanganyika Under German Rule, 1905–1912. Cambridge University Press, Cambridge 1969; Ford, John.

The Trypanosomiases in African Ecology: a Study of the Tsetse Fly Problem. Oxford University Press, Oxford, 1971; Kjekshus, Helge. Ecology Control and Economic Development in East African History: The Case of Tanganyika, 1850–1950. Ohio University Press, Athens, OH 1996; Koponen, Juhani. Development for Exploitation: German Colonial Policies in Mainland Tanzania, 1884–1914. Lit Verlag, Münster 1994; Giblin, James. "Trypanosomiasis Control in African History: an Evaded Issue?" Journal of African History 31 (1990).

3 Hundreds of thousands are believed to have died in the Congo River watershed epidemic that began in 1896, as well as during the Lake Victoria basin epidemic in the first decades of the twentieth century. Estimates for the Congo epidemic are 500,000 dead; in Uganda, between 250,00 and 300,000. Figures for the epidemic along Lake Tanganyika remain vague, but were likely in the tens of thousands. See also Hoppe, Kirk. Lords of the Fly: Sleeping Sickness Control in British East Africa, 1900–1960. Praeger, Westport, CT 2003:27; Lyons, Maryinez. The Colonial Disease: a Social History of Sleeping Sickness in Northern Zaire, 1900–1940. Cambridge University Press, Cambridge 1992.

4 Administratively, sleeping sickness prevention also involved district officers and tax agents, which I will not discuss in the following section.

5 See Eckart, Wolfgang U. Medizin und Kolonialimperialismus, Deutschland 1884–1945. Schöningh, Paderborn 1997.

6 My research focuses on the colonial territories of the Uganda Protectorate, German East Africa, and the Congo Free State/Belgian Congo; the areas in question are located in present-day Uganda, Tanzania, Burundi, and Democratic Republic of the Congo.

7 With regard to settlements around Lake Victoria, Uganda was of special reference for local trade and migration. Uganda was also relevant for the Lake Tanganyika basin, especially for communities on the northern lakeshore, as were areas across the lake in the Belgian Congo and caravan trade to the Indian Ocean coast.

8 Worboys, Michael. "The comparative history of sleeping sickness in East and Central Africa." History of Science 23 (1990); Tilley, Helen. "Ecologies of Complexity: Tropical Environments, African Trypanosomiasis, and the Science of Disease Control in British Colonial Africa, 1900–1940." Osiris 19 (2004); Tilley, Helen. "Africa as a 'Living Laboratory: the African Research Survey and the British Colonial Empire: Consolidating Environmental, Medical, and Anthropological Debates, 1920–1940." Dr. Phil. thesis, University of Oxford 2001; White, Luise. "Tsetse Visions: Narratives of Blood and Bugs in Colonial Northern Zambia." Journal of African History 36/2 (1995); White, Luise. "'They could Make Their Victims Dull': Genders and Genres, Fantasies and Cures in Colonial Southern Uganda." American Historical Review 100/5 (1995); Bell, Heather. Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899–1940. Oxford University Press, New York 1999; Lyons 1992; Hoppe 2003.

9 Regarding similar events in the history of bacteriology, see Mendelsohn, Andrew. "Cultures of Bacteriology: Formation and Transformation of a Science in France and Germany, 1870–1914." PhD dissertation, Princeton University 1996. Thanks also to Anne Hardy for her comment regarding tropical medicine publications during the workshop discussion.

10 See Dutton, John E. and John L. Todd. "First Report of the Trypanosomiasis Expedition to Senegambia (1902) of the Liverpool School of Tropical Medicine." Thompson Yates and Johnston Laboratories Reports V (1903); Dutton, John E. and John L. Todd. "Reports of the Trypanosomiasis Expedition to the Congo 1903–1904 of the Liverpool School of Tropical Medicine and Medical Parasitology." Thompson Yates and Johnston Laboratory Reports VI (new series) (1905); Martin, Gustave, Emile Roubaud, and Alexis Leboeuf. Mission d'études de la maladie du sommeil au Congo Français. Masson, Paris 1909; Royal Society. Reports on the Sleeping Sickness Commission. Harrison and Sons, London 1903–19. Robert Koch's

reports were published serially in the Deutsche medizinische Wochenschrift, and are collected in Gaffky, Georg and Edward Pfuhl. Gesammelte Werke von Robert Koch. Georg Thieme, Leipzig, 1912.

11 Clippings in British and German colonial and foreign office records as well as from the medical and scientific press indicate that analysis of press attention to the disease would be a fruitful area for further research.

12 Feldmann. "Bericht: Arbeiten der englischen Kommission zur Erforschung der Schlafkrankheit." 11/26/1902. Bundesarchiv-Lichterfelde (hereafter BA-Li), R 86/2622. Christy was working on surveying populations for Filaria perstans, while his colleagues researched the pathogen causing sleeping sickness.

13 Lott. "Bericht über das Auftreten der Schlafkrankheit im Bezirk Schirati." 1/11/1903. BA-Li, R 86/2622.

14 Feldmann to Sir David Bruce. 5/20/1903. Wellcome Collection, Archives and Manuscripts [hereafter WCAM] WTI/RST/G26/24.

15 Worboys, Michael. "Tropical Diseases." In Porter, Roy and W.F. Bynum (eds). Companion Encyclopedia to the History of Medicine. Routledge, London 1993; Cunningham, Andrew and Perry Williams (eds). The Laboratory Revolution in Medicine. Cambridge University Press, New York 1992; Burri and Brun 2003, p. 1303.

16 German colonial and public health officials were also concerned with providing a primer, or further training, for medical officers in the field through this period, which I will also address elsewhere in my dissertation.

17 The exact date of Lott's visit is unknown, but it was likely in April or May 1903. See David Bruce to Sir Michael Foster/Royal Society, 5/16/1903, CMB 15, Archives of the Royal Society, London. Lott's report was sent to the colonial administration on 10/6/1903, and extracts published in the Medizinal Berichte für die deutschen Schutzgebiete für das Jahr 1903/04, herausgegeben von der Kolonial-Abteilung des Auswärtigen Amts. Ernst Siegfried Mittler und Sohn, Königlich Hofbuchhandlung. Berlin 1905.

18 On Koch's work in tropical medicine, see Brock, Thomas. Robert Koch: a Life in Medicine and Bacteriology. ASM Press, Washington, DC 1999; Gradmann, Christoph. Krankheit im Labor: Robert Koch und die medizinische Bakteriologie. Wallstein Verlag, Göttingen 2005; Webel, Mari. "Cosmopolitan Science, International Problems: Robert Koch, Tropical Medicine, and Sleeping Sickness Research, 1893–1908." Master's thesis, Columbia University 2006.

19 Koch, Robert. "Bericht über die Schlafkrankheits-Expedition während des Aufenthalts in Muansa." 7/31/1906. BA-Li, R 86/2613.

20 Diary of Aubrey Dallas Percival Hodges, entries dated 8/8/1906 and 8/16/1906. Archives of the London School of Hygiene and Tropical Medicine (hereafter LSHTM), GB 0809 Hodges/01/10.

21 Koch to Dr. Milne, draft letter, 6/22/1907, Archives of the Robert Koch Institute (hereafter RKI) AS/b2/160; Koch, draft letter, no recipient, 6/22/1907, RKI AS/b2/161. Koch's research on sleeping sickness will be discussed in greater detail in subsequent sections of my dissertation.

22 For a comparative analysis of sleeping sickness work in German and French colonies in West Africa, see Neill, Deborah Joy. Transnationalism in the Colonies: Cooperation, Rivalry, and Race in German and French Tropical Medicine, 1880–1930. PhD dissertation, University of Toronto 2005.

23 See Gradmann 2005; Eckart, Wolfgang. "The Colony as Laboratory: German Sleeping Sickness

Campaigns in German East Africa and Togo, 1900–1914." History and Philosophy of the Life Sciences 24 (2002); Gradmann, Christoph. "'It Seemed About Time to Try One of Those Modern Medicines': Animal and Human Experimentation in the Chemotherapy of Sleeping Sickness 1905–1908." In Maio, Giovanni and Volker Roelcke (eds). Twentieth Century Ethics of Human Subjects Research: Historical Perspectives on Values, Practices, and Regulations. Steiner, Stuttgart 2004.

24 Marks, Shula. "What is colonial about colonial medicine? And what has happened to imperialism and health?" Social History of Medicine 10 (1997).

25 Regarding the development of tropical medicine, see Worboys 1993.

26 See, for instance, Evans, Richard J. Death in Hamburg: Society and Politics in the Cholera Years, 1830–1910. Oxford University Press, New York 1987.

27 See Feierman, Steven. "Struggles for Control: The Social Roots of Health and Healing in Modem Africa. " African Studies Review 2/3 (1985); Hunt, Nancy Rose. A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo. Duke University Press, Durham, NC 1999; Vaughan, Megan. Curing Their Ills: Colonial Power and African Illness. Stanford University Press, Stanford 1991.

28 Regarding research and medical work, see Iliffe, John. East African Doctors: a History of the Modern Profession. Cambridge University Press, Cambridge 1998; Jacobs, Nancy. "The Intimate Politics of Ornithology in Colonial Africa." Comparative Studies in Society and History 48 (2006); Schumaker, Lyn. Africanizing Anthropology: Fieldwork, Networks, and the Making of Cultural Knowledge in Central Africa. Duke University Press, Durham, NC 2001; Hunt 1999.

29 I here follow Iliffe 1998 and Hunt 1999 regarding auxiliaries.

30 "Aufzeichnung über die Sitzung des Reichsgesundheits-rats (Ausschuß für Schiffs- und Tropenhygiene und Unterausschuß für Cholera)." 11/18/1907, BA-Li, R 1001/5876, p. 10–11; see also Koch, "Entwurf zu einem Ergebnis-Bericht über die Expedition zur Erforschung der Schlafkrankheit." Undated [1907?], RKI AS/w6/008, p. 9. Atoxyl is an arsenic compound.

31 Koch referred to camps as "Konzentrationslager, wie sie die Engländer nennen" in his remarks for the Reichsgesundheitsamt's Reichsgesundheits-Rat. "Aufzeichnung über die Sitzung des Reichsgesundheits-rats..." 11/18/1907, BA-Li, R 1001/5876, p. 10. Sleeping sickness camps were also called variously "Isolationslager", "Sammlungslager", "Krankenlager", or "Schlafkrankheitslager" by Koch, colonial medical officials, and colonial administrators

32 Here, I emphasize "local" to highlight the potential difference from askari, who provided additional labor for the campaign, and auxiliaries recruited from communities where sleeping sickness was present. Askari, African soldiers, were not necessarily from the areas where they were stationed. By "local", I mean people who resided in a given district or returned there after periods of, for instance, seasonal migration, trade, rubber collection, or fishing. See Austen, Ralph A. Northwest Tanzania Under German and British Rule: Colonial Policy and Tribal Politics, 1889–1939. New Haven, Yale University Press, 1968; Iliffe, 1979; Iliffe, 1979; Kilaini, Method M.P. The Catholic Evangelization of Kagera in North-West Tanzania: the Pioneer Period, 1892–1912. Rome, 1990.

33 See Koch, Robert. "Bericht über die Tätigkeit zur Erforschung der Schlafkrankheit im Jahre 1906/07 nach Ostafrika entsandten Kommission." In Gaffky and Pfuhl 1912; Todd, John L. Congo Expedition Diaries, vol. 1, 12/10/1903, WCAM MS.4792 ; Dutton, Joseph E. Photograph undated (1904). Archives of the Liverpool School of Tropical Medicine (hereafter LSTM), TM14/5/Dutton/8; Hamerton, Albert E. "Album of photographs taken by Hamerton

during the Sleeping Sickness Commission investigations." 1908–13. WCAM GC/18/A.2; Hamerton, A.E. and David Bruce. Photographs. Undated (1908–13). WCAM WTI/RST/G30, Box 20.

34 Feldmann. "Bericht: Die Schlafkrankheit im Bezirk Schirati." 9/8/1907. BA-Li, R 86/ 2622.

35 Lack of proper scientific equipment was also a complaint of British researchers in Uganda.

36 Kudicke. "Bericht über das Schlafkrankenlager Kigarama für die Zeit vom 1.6. bis 1.10.1907 und Vorschläge zur Bekämpfung der Schlafkrankheit in den Sultanaten Kiziba und Bugabu." 10/1/1907. BA-Li R 86/2622, p. 3.

37 Kudicke. "Bericht über die Bekämpfung der Schlafkrankheit im Bezirk Bukoba 1. Mai bis 31. Juli 1908." Undated. BA-Li, R 1001/5898. See Eckart 1997.

38 German officials used "katikiro" to describe a local elder, or an official subordinate to a sultan, or chief, different than its meaning in the Uganda context, of Prime Minister.

39 Kudicke. "Bericht über die Schlafkrankheit im Bezirk Bukoba für die Zeit vom 1.1. bis 31.3.1908." 5/13/1908. BA-Li, R 1001/5897.

40 Feldmann. "Bericht." 5/20/1908. BA-Li, R 1001/5898.

41 It is also important to situate the giving of goods within pre-existing traditions of patron-client relations. There is a rich literature in East African history which deals with this social and political dynamic. See Glassman, Jonathon. Feasts and Riot: Revelry, Rebellion, and Popular Consciousness on the Swahili Coast, 1856–1888. Heinemann, Portsmouth, NH 1995; Iliffe, 1969; Maddox, Gregory, James L. Giblin, and I.N. Kimambo. Custodians of the Land: Ecology and Culture in the History of Tanzania. James Currey, London 1996.

42 Breuer. "Menschliche Trypanosomiasis." 3/30/1908. BA-Li, R 1001/ 5897.

43 While I do not address oral histories here, Luise White's work, in dialogue with that of Nancy Rose Hunt, has shaped current thinking about rumor and colonial labor. See White, Luise. Speaking with Vampires: Rumor and History in Colonial Africa. University of California Press, Berkeley 2000; Hunt 1999. See also Mann, Gregory. "An Africanist's Apostasy: On Luise White's Speaking with Vampires." International Journal of African Historical Studies 41 (2008).

44 Göring. "Bericht." 4/28/1908. R 1001/5897. Translation: "The unreasonable attitude of the population itself creates the chief obstacle, caused by their ignorance of the nature of the disease, great apathy, superstitious imaginings and the false, frightening rumors about the examination and treatment methods of the doctors. So, for example, a rumor was recently spread that the examining doctor first drives a large nail into the head of people, collects their blood into bottles and then finally skins them. Skin and blood would be brought to Europe and sold there."

45 Kudicke. "Bericht über die Bekämpfung der Schlafkrankheit im Bezirk Bukoba 1. Mai bis 31. Juli 1908." 7/31/1908. BA- Li R 1001/ 5898, p. 2. Translation: colored assistants.

46 Austen 1968.

47 Later reports indicate that populations fled from Drüsenfühler as well, see Ullrich. "Vierteljahrsbericht für Kigarama/Kishanje." 7/1/1909. BA-Li, R 1001/5903.

48 Kleine, Friedrich. "Bericht." 8/30/1908. BA-Li, R 1001/5898, p. 3. Translation: "In an earlier report I expressed the opinion, on the basis of my observations of the Wagaia [sic], that it is a thing of impossibility and totally useless, in a half-wild land, to collect the sick inhabitants together by force and with askari and to remove them against their will from their homes to a faraway fortified camp. It can be done once, but rarely a second time. As soon as a doctor appears with armed power, the natives, frightened by fantastic rumors, flee into the wider area.

The relatively small number of sick who are caught the first time and forcibly interned and treated cannot play a role in the spread of the epidemic. The vast majority of the lightly sick in particular remain unhindered and carry the epidemic further. ... As in Shirati district, we must therefore in the same way in Tanganyika renounce the use of force, which is suited only to impede our aims severely.“

49 Kleine, Friedrich. “Schlafkrankheit: Bericht über die Schlafkrankheitsbekämpfung im Jahre 1911/12.” In Reichs-Kolonialamt. Medizinal Berichte über die Deutsche Schutzgebiete. Ernst Siegfried Mittler und Sohn, Berlin 1913:94. Translation: “As was already stated in an earlier report, we have more and more given up the original principle of the campaign, concentration of the [sleeping] sick in fixed camps, and instead of this laid the chief emphasis on the sanitation of the infected landscape. As far can be made possible, the sick have, at the same time, been treated with drugs, mostly ambulatorily. “

50 Deborah Neill’s current work on chemotherapy discusses the metropolitan background to the use of experimental drug treatments in the colonies. Neill, Deborah. “Paul Ehrlich’s Colonial Connections: Scientific Networks and Sleeping Sickness Drug Therapy Research Networks, 1900–1914. “ Social History of Medicine (forthcoming, 2009). At the time, station doctors noted a problem with losing the trust of their patients. See Breuer. “Vierteljahrsbericht für Usumbura.” 10/28/1909. BA-Li, R 1001/5903; Kudicke. “Vierteljahrsbericht für Kigarama/Kishanje.” 10/25/1910. BA-Li, R 1001/5905.

Man and cattle in a laboratory. Robert Koch and tropical veterinary medicine

Christoph Gradmann

Introduction: The father of tropical veterinary hygiene?

There is a certain danger in approaching a familiar subject from an unfamiliar angle: This raises the suspicion that one is talking about more or less irrelevant side strains of otherwise important historical events and giving preference to one's curiosity over objects of study that have more significance in the larger historical context. In its own decidedly modest proportions the subject of my paper certainly falls into that category: Robert Koch as a tropical vet? This is not what seems to be central to his biography or the history of medical bacteriology he was one of the founding fathers of.[1] The German physician Robert Koch (1843–1910) is usually remembered for innovative work on pathogenic bacteria and hygiene. This would include laboratory technology such as solid culture media, micro-photography of bacteria or animal experimentation, and most notably the elucidation of the bacterial aetiologies of common infectious diseases such as tuberculosis and cholera.

Historiography on the 'father of microbes' has in that sense largely followed the evaluation of his work by the Nobel Foundation that awarded him with the prize bearing its name in 1905 for his work on tuberculosis – which by that time was more than 20 years old.[2] Yet, if we look into the years surrounding the awarding of the Nobel Price, we find a lot of research that hardly fits the picture of the pioneer of medical bacteriology and experimental pathology. Koch, whose fame rested and still rests on work done on common human infections prevailing in the cool north, from about 1895 on largely focussed on tropical infections and for that purpose travelled extensively in Africa, India or New Guinea. In parallel, he moved his interests away from bacterial infections in the technical sense of the word and with a few exceptions focussed on vector-borne diseases, caused by unicellular parasites rather than bacteria. Finally, next to classical tropical infections of humans such as malaria or sleeping sickness we find a surprising number of veterinary pathologies such as rinderpest, horse sickness, East coast fever, surra and so on. In his later years Robert Koch seems to have developed a propensity for veterinary diseases that all had one thing in common: they affected the livestock of farmers in so-called settler colonies.[3]

Another common feature seems to be that most of this work – in stark contrast to his earlier studies – was inconclusive or even erroneous, even by contemporary standards. On top of this, there were accusations that Koch was cannibalising the work of other researchers while failing to give due credit.[4] So there is certainly a point in Thomas

Brock's biographical interpretation that the turn to tropical veterinary infections has to be seen in the context of a certain isolation on the part of an ageing researcher[5] who failed to live up to his earlier successes and who had also been involved in some private and professional scandals at home.[6] Andrew Mendelsohn, however, has come up with another interpretation of Koch's later years. In his view, certain observations that Koch had made in the context of the Hamburg cholera epidemic of 1892 triggered an epidemiological turn in his work which culminated in the formulation of concept of healthy carriers of disease. This concept relates to infected, yet healthy individuals that carry pathogens and who are suited to dispense them into their environments. Such a concept, for example, facilitates an explanation for the endemic character of infectious diseases in areas where no acute cases of such diseases can be detected. Mass screening of local population is suitable to trace such carriers. The concept was developed on the occasion of directing a typhoid campaign in 1902 – in fact one of the rare occasions when Koch conducted, or rather directed, work in Europe.[7]

A question to be asked here is if these studies were a rare spark of creativity in the later stages of the career of a scientist who otherwise failed to live up to his reputation. My answer here is "no", and I propose that the epidemiological turn in Koch's work should better be seen as the icing on the cake of a research program on tropical infections. It had a particular focus on veterinary infections and was pursued from about 1896. To substantiate this thesis, I will proceed in three steps: First, I will give a short introduction in which I will elucidate some of the biographical background of Koch's turn to tropical infections. Second, I will talk about relations of veterinary medicine and bacteriology in Koch's work. Third, I will have a closer look at his epidemiological and veterinary research in Africa. Here I will in particular focus on his studies on East Coast fever and sleeping sickness.

A colonial traveller

Regarding the biographical dimension, it is useful to step back and take a look at Koch's career as it evolved over time. In 1885 he could look back on a successful period of work. At the age of just over 40 he had been made deputy director of Germany's Imperial Health Office and appointed Director of the Institute of Hygiene at Berlin University. At the same time, however, medical bacteriology was changing. From a scientific branch for experts it developed into a huge discipline. The tubercle bacillus of 1882 could in a way be regarded as a "Berlin parasite": its identification required the application of methods that – for the time being – could only be learned in Koch's laboratory at the Imperial Health Office. Around 1890 the exclusive status of those methods had come to an end. The small group of scientists had mushroomed and was transformed into a heterogeneous group of colleagues and critics. Concurrent opinions had to be considered more and more, and this was something that the pioneer Koch found hard to learn. In 1904 he sulkily wrote to an old friend:

> Whatever I undertake these days, there will a bunch of the envious and jealous at hand. The will try to challenge me, and if they don't succeed, try to make me turn away from my work in disgust. I believe that in my studies I have been particularly unlucky and have met more and totally unjustified arguments than anybody else.[8]

Moreover, the discipline of medical bacteriology differentiated as a whole: immunology, serology, parasitology, and tropical medicine were emerging as independent fields of research.[9] The attitude of a pioneer who governed the entire field, an attitude that Koch had cultivated so efficiently, became increasingly problematic. The unexplored pastures of microbial life, which he ploughed so happily around 1880, had been transformed into something that reminded him of a battlefield. In 1904, answering congratulations of his own pupils on his 60th birthday, Koch gave a grumpy comment on what medical bacteriology had become:

> Those happy days are gone when the number of bacteriologists was small, and each of them could research wide areas in an undisturbed manner. [… Today], there is no way to escape that even with a modest and most careful demarcation of your field of work you will step on the first colleague's toes or bump into a second one unintentional, or come too close to the third's field of work. Before you even realise it, you are surrounded by opponents.[10]

All this can in way be mirrored in the course of Koch's research after 1885, which did not progress in the way it had done until then. As a consequence, he gave his studies some new directions during the 1890s and took to the study of tropical infectious diseases. That such research required travelling was one of the attractions of doing it. "I have seen and learned so much new, when I first came to Africa!", Koch wrote to a colleague.[11] While travelling, he could go about his work in the style of a pioneer, detached from his colleagues and critics in Berlin. He could modify his traditional research style on new objects, and he enjoyed doing so. In a certain way his orientation followed the development of hygiene and microbiology at that time. By working on parasitic, vector-borne diseases of the tropics, he found a possibility to link up to an up-to-date field of research – while showing little interest in other "hot fields" of the day such as immunology.

Animal and human pathologies in medical bacteriology

Let me come to my second point concerning the relations of veterinary medicine and medical bacteriology in Koch's work. In this context it is important to realise that even before Koch started to study veterinary infections in their own right, there had been an undercurrent of interest in such pathologies in his work. Being, after all, a pioneer of the use of animal models in the study of human infectious disease, Koch was convinced that there was no principal barrier between human and animal pathologies and that one could be employed to elucidate the other. Differences that existed in relation to susceptibility and clinical symptoms of diseases were acknowledged but were considered to be of little relevance since in the all-decisive microscopic picture pathologies were assumed to be identical.[12] In this sense, it is not surprising that Koch's first object of study, anthrax (in 1876), was predominantly a veterinary infection of sheep and cattle, which he succeeded in studying in yet another animal, the guinea pig. Koch also carried out that study in a somewhat veterinary style; that is, he combined basic research into the aetiology of the condition with practical and cost-efficient proposals on its prevention. In his paper on anthrax, next to the arguments about the aetiology of the condition and the bacteriology of the *Bacillus anthracis* we find a down-to-earth recommendation on the proper disposal of the cadavers of cattle that have fallen victim to the disease.[13]

That transferability between species was a presumption that became ever more obvious when Koch studied septic infections just two years after his anthrax studies. In this case he did not even try to find an animal model for human sepsis. Instead he established experimental models for various types of such infections in mice and rabbits and concluded that upon closer inspection human sepsis would turn out to be principally identical to what had been elucidated in animals. The pathologies, which he had produced in his laboratory animal, Koch concluded, "had the greatest resemblance to human septic infections"[14].

Again a few years later, when working on tuberculosis in 1881, Koch did explicitly address possible differences, but only to refute the prevailing conviction that they existed and to insist that substantially they did not. His work on that condition started with an experimental demonstration that bovine and human tuberculosis are identical. Infective matter taken from both directions would induce identical pathologies in laboratory animals and could eventually be attributed to one and the same pathogenic bacterium, which was responsible for all human and bovine forms of the condition.[15]

Thus, the fact that Koch in the early years of his career showed little interest in veterinary medicine as such was due less to a lack of interest or knowledge, than to his conviction that differences between animal and human pathologies were a matter of detail, not of principle. When working with laboratory animals, Koch sought to imitate the microscopic picture of human pathologies in susceptible animals, rather than thinking that one was a model for the other in a more elaborate sense. Co-operations with veterinarians were not very frequent but could be intense, such as in the case of tuberculosis, when the above-mentioned series of infection experiments was conducted together with Wilhelm Schütz, a Berlin professor of veterinary medicine.[16]

The years around 1900, however, created new impetuses for a more specific approach to such issues. I am not thinking here of Koch's ill-fated announcement of the non-identity of human and bovine tuberculosis, which he made in 1902.[17] Based on his long-standing co-operation with Wilhelm Schütz, this was classical bacteriological work aiming at differentiating species or types of bacteria rather than their hosts. What I refer to is Koch's growing interest in epidemiology in these days. Triggered by certain observations in the context of the Hamburg cholera epidemic, Koch came to pay rather more attention to host reaction and specificity in the context of understanding infections and epidemics.[18] Earlier, bacterial infections had been understood as bacterial invasions of a passive human body, which would be uniformly receptive to infection and respond as passively as a culture medium. Now it became clear that infection was not automatically followed by disease and that infectiousness of a host could also last much longer than its illness.[19] What first appeared as an attempt to stabilize Koch's established thinking on infections by taking into account some variability on the side of the host (such as subclinical infections, latency, immunity and so forth) turned out to be rather productive in research. It resulted in the formulation of the fundamental epidemiological concept of the carrier state of an infected, yet healthy individual that would, for example, be suited to explain how infections could be endemic in places where no acute cases could be detected.

Tropical carriers

It is in this context that Koch's turn to tropical medicine and veterinary medicine acquired more than the biographical significance that I have described above. Of course, the carrier concept as such was laid down while working on typhoid, but the attraction that tropical and, more specifically, veterinary infections offered are obvious. Veterinary medicine provided the opportunity to do infection experiments in whole populations, since groups of cattle, for example, could easily be transferred from endemic to non-endemic areas. The economic constraints that characterise veterinary medicine coincided with Koch shifting focus away from individual infections towards the understanding and control of infections in populations. Also, as Koch noted, some things were decidedly easier in veterinary medicine; for example, vaccines could be developed on the affected species itself.[20]

The tropical diseases of humans and animals that were researched in that period were usually so-called vector-borne diseases, in which the pathogen is transmitted by some intermediary host, such as a fly or a tick. Many of these pathogens were not bacteria but unicellular parasites, offering the researcher host-pathogen relationships that were "complicated, sometimes even intricate"[21], as Koch commented enthusiastically in a letter to a colleague. Africa was in that sense for him a laboratory of possibilities of infections and their control, a place where, as he put it in another letter, "the streets are still paved with the gold of science."[22]

Right from the beginning of his African travelling from 1896, he showed a pronounced interest in vector-borne, parasitic infections of cattle. Travelling in East Africa in 1896/97, his main focus was on surra, which later on turned out to be an animal form of trypanosomiasis, and on a widespread haemorrhagic fever of cattle, which he identified as the African form of Texas fever. It was transmitted by ticks infected by a pathogen, which had recently been identified as a unicellular parasite, a piroplasm.[23] Studying infectious processes of such complexity on cattle provided opportunities to do experiments that would otherwise be considered difficult, if not unethical, if performed on humans. We need not go into detail here, but Koch's strategy consisted in combining affected and non-affected cattle with affected and non-affected ticks in infection experiments; it included a fair amount of moving the respective experimental subjects between coastal regions, where the fever was prevalent, and highlands, where it was not to be found.[24] One important result of these experiments was that cattle from coastal regions – although seemingly unaffected by the disease – were nonetheless infected and infectious. Discussing the contemporary research on Texas fever, Koch commented:

> I can furthermore fully confirm observations on the very strange behaviour of this disease […]. The essence is that in regions where Texas fever is endemic, cattle have become more or less immune and do not suffer from the disease to a noticeable degree. Such cattle may look perfectly healthy and well fed. However, when they are brought into contact with other cattle which are not immune to Texas fever, […] an epidemic will break out after a few weeks amongst the non-immune animals.[25]

Although the animals were immune to the disease due to an earlier infection, the blood of such cattle still contained the parasite, which could be transferred via the ticks. If fresh cattle were imported, an epidemic might break out among them. Likewise, the disease could travel elsewhere; if healthy but infectious cattle were brought to regions where the tick existed but the disease had not been endemic before.[26]

While such observations contained a number of factual errors in relation to the diseases under study and their impact on contemporary medical science therefore limited[27], Koch drew two conclusions that would influence his future work. One is that areas in which no cases of acute infections were occurring could still be considered dangerous. Such dangers could be checked by strict control of movement of cattle[28] or – more radically – by eradicating hosts, which would typically also include big game.[29] While failing to propose mass screening for the parasite (as he would do later on), Koch drew a second conclusion. Though by no means novel, it still laid out the directions of his work in veterinary medicine in the years to come. It shows how he reacted to the economic constraints that characterise veterinary medicine by which the health of the individual animal counts little as compared to the wealth of the owner of the herd. Cattle farmers usually preferred vaccination to hygienic practices that limited travel and trade, let alone the killing of livestock, and Koch responded to this preference. Attempting to artificially reproduce natural immunity where it was the outcome of certain infections, Koch – who had shown little interest in this previously – now produced a whole series of vaccinations, all of them for veterinary infections of cattle such as surra, rinderpest or East Coast fever.

When called upon by British colonial authorities to study a mysterious deadly infection among cattle in Rhodesia from 1903, Koch had the opportunity to repeat and deepen the above-mentioned observations. What had alarmed everyone and led to the employment of the German doctor had been the outbreak of a massive, deadly haemorrhagic fever among newly imported cattle destined for Rhodesia in the port of Beira on the shores of the Indian Ocean. From there the disease had travelled inland and caused havoc among Rhodesian cattle. For Koch, this was intriguing.

"Because it is in a certain sense a continuation of the work I began in 1896, I could hardly refuse"[30], he commented to an old friend on the offer to work in East Africa which he had received from British authorities. This time Koch distinguished between Texas fever and what became known as East Coast fever, but otherwise he described the epidemiology of the outbreak in pretty much the same terms as he had done in 1897.[31] Upon inspecting some of the very few cattle that had survived the infection, Koch observed that "even though they appeared to be perfectly healthy and displayed not the slightest variation in temperature, their blood contained a small number of parasites."[32] East Coast fever, which broke out among cattle recently imported from Australia, had been endemic yet invisible along the East African coast in the form of immune stock, acting as healthy carriers of the disease. On the nature of a certain group of tropical infections, he noted in his diary:

> This is characterised in that way that those diseases that belong to it, of which I will only mention Texas fever and tsetse, are not immediately infectious. Instead they are transmitted by way of a vector, a tick in our given case, and after survival of that disease the parasites do not vanish entirely. Such animals may appear to be perfectly healthy, but they may be dangerous for healthy animals of the same species. The keeping of livestock under such circumstances will always be subject to limitations in the sense that animals can only be exported after being slaughtered and that healthy animals, which are supposed to be imported from other countries, will have to be immunized artificially.[33]

Two strategies followed from that type of evidence. The first involved screening, stamping out and isolation/eradication with the aim of eliminating the pathogen from the population. This was what Koch would have preferred as a scientist, but it could not be put in place because of several obstacles. While white farmers could be expected to agree to screening, they resented the idea of transport restrictions and/or mass killings of livestock. Indigenous farmers, however, could not be expected at all to comply with the necessary screenings of cattle and pastures for pathogen and vector. As Koch somewhat grumpily conceded in his report:

> If no objections are to be raised against the instance that by way of artificial immunisation a disease will not be exterminated but preserved – admittedly preserved and spread in an attenuated and harmless form, unsuitable to cause considerable losses – then one has to consent to that form of the control of plagues.[34]

In a letter to Paul Frosch, who was one of his assistants handling the typhoid screening in Germany on his behalf, he commented:

> The ticks cannot be exterminated; we also cannot follow the protocol of malaria, because animals that have recovered from the disease and become immune will carry parasites in their blood for a long time, most likely for years and they cannot be removed entirely. Given that, the only thing that we can do is to immunise. But how? Given the high virulence of the disease this is particularly difficult.[35]

The second strategy was vaccination. So Koch walked in the footsteps of his pupils Emil Behring and Paul Ehrlich and developed an antitoxic vaccine for East Coast fever.[36] The development of that vaccine was done in veterinary style, that is, by working on the affected species immediately rather than developing the vaccine on some other host and by making use of a large number of specimens for experiments and testing.[37] Lengthy field trials also served to seek answers to certain open questions regarding the aetiology of the disease and to convince sceptical farmers that the vaccine was safe and efficient to use. As it turned out pretty soon, that scepticism had been quite justified. Koch's vaccine proved ineffective, and his work on African Coast fever soon came to be remembered for its factual errors in relation to aetiology, wishful thinking in relation to the efficacy of his vaccine, for cannibalising work done by the South African veterinarians, and finally for the enormous bills that Koch and his assistants charged for their work.[38] As the Inter-Continental Veterinary Conference held in Salisbury in summer 1904 concluded

> […] this Conference, after considering the reports of the Scientists [sic] who have practical experience of the effects of the inoculation proposed by Dr Koch, is reluctantly compelled to the conclusion that it will be vain to trust to inoculation to arrest the spread of African Coast Fever.[39]

Undeterred by such (and other) failures, Koch stuck to his methods, and two years later we see a strategy of the above described fashion being followed on the example of a condition that was neither a veterinary disease nor had a pathology containing any sort of a carrier state. That disease is human trypanosomiasis, better known as sleeping sickness. In this case, Koch tested means for control on a long expedition in British and German East Africa.[40] Like most of his contemporaries, he was convinced that the disease was 100 per cent lethal, and thus there could be no such thing as a carrier state. Still, in his concept of the disease and in the measures proposed to combat its spread, his epidemiological understanding, which focussed on the containment and eradication of diseases in populations rather than the treatment of individuals, resurfaced in a remarkable way. In his work Koch highlighted some of the peculiarities of the disease. For example, that following infection there was normally a rather long period of latency in which the patient – although infected and infectious – would feel healthy and not develop a lot of clinical symptoms. Yet, he or she was suited to transmit the parasites via a vector, in this case the tsetse fly, to others. Since the responsible pathogen, the *Trypanosoma gambiense*, had been identified recently by David Bruce, such a latent stage could now be detected by diagnostic means.

To treat the disease Koch, like others and most notably British researchers in the Congo, experimented with arsenicals, atoxyl in particular. Following initial successes, however, it became clear that the therapeutic value of atoxyl was limited. It produced severe side-effects, and its curative value was dubious. All it brought about was a temporary recession of clinical symptoms and a disappearance of parasites from peripheral blood vessels. Even though this was not fully revealed to the public at home, Koch and his team were in no doubt about it. Thus, it is surprising that in his final report he forcefully advocated a grand-scale campaign to combat sleeping sickness in German East Africa that was based on the application of such medicine.

Yet it is precisely here that he followed his epidemiological and veterinary experiences. Koch's recourse to arsenicals was less motivated by the expected improvement of the individual's state of health than by seeing it as a means to fight the epidemic as far as the population as a whole was concerned. Treated with this drug, the patients could not transmit the disease for months, even they personally profited little from it:

> In this way we are capable of keeping people who suffer from trypanosomiasis free from parasites in relation to their blood for at least 10 months and to bring about the result that they are unsuited, i.e. harmless, in relation to infecting tsetse flies and as a consequence for the propagation of the disease.[41]

Following this idea, Koch planned serial examinations and the establishment of so-called "concentration camps" for those infected with sleeping sickness on German colonial territory. Inside these camps the patients were to be isolated and treated, if necessary against their will. This proposal certainly had consequences, since it stood at the beginning of a campaign against sleeping sickness in the German colonies that was to follow in the years until the First World War – to be carried out by Koch's most important assistant at the time, Friedrich Karl Kleine.[42] By giving priority to the fight against the epidemic instead the therapeutic treatment of individual patients, Koch brought his veterinary experience to bear, but the strategy's motivation was moreover strengthened by the racist ideological background of "colonial human economy" (*koloniale Menschenökonomie*), which treated indigenous patients in Africa like economic commodities or livestock and applied ethical double standards to them and patients in Germany. As Koch spelled it out, the value of campaign would not be the healing of individuals but the maintenance of the population's workforce as a whole.

Man and cattle in a laboratory

Let me try to summarise quickly what I see as a still incomplete analysis. In his years as a tropical hygienist after 1896, Koch, for the first time in his career, developed a more than accidental interest in veterinary infections. Yet, as I would like to argue, distinctions between human and veterinary infections were still largely disregarded in his work. Instead, studying tropical infections of humans and cattle was part and parcel of the epidemiological turn in his work. Pathologies of men and cattle that could be studied at ease under the conditions of a colonial laboratory were suitable to develop epidemiologically inspired measures for the control of diseases in populations and the cleansing of spaces.[43] The dehumanizing potential of this approach has been shown by Paul Weindling in particular in the example of early 20th-century epidemiology and bacteriology.[44] Yet, as I hope to have shown, the approach also draws on a legacy in tropical and veterinary medicine. As Koch himself wrote, it was really tropical epidemiology that had set him on the trail of screening for healthy carriers of typhoid:

> What has been demonstrated here is identical to what I have found in my studies on malaria. The first attempt to control malaria in New Guinea has in fact only been undertaken with the aim to give evidence that there is no other source of malaria infection than people themselves. And this same proof I believe to have established […] for typhus.[45]

Seen from this angle, the carrier state was a spin-off from tropical medicine to European pastures – or in this particular case to the designated deployment areas of the Schlieffen Plan alongside Germany's western border. However, in order for its potential to evolve for better and for worse, the concept also needed to be transferred in a certain sense. While Koch's colonial laboratory offered unique possibilities to develop epidemiological models, the lack of infrastructure in the colonies also made their application there difficult. In this sense Europe was far better suited. Talking about the extermination of hosts as a measure to control veterinary infections, Koch commented:

> Under European conditions, where this is applicable, the extermination of such a disease would be the best method of treatment, even though such an approach would be costly and would require a couple of years to be put in practice. Here in Rhodesia, however, conditions are very different from those in European countries, because the cattle owned by the indigenous people cannot be brought under surveillance.[46]

To give another example, the efficacy of the atoxyl treatment of sleeping sickness could hardly be evaluated under the given conditions in Koch's travelling laboratory in East Africa. Patients would enter and leave the camp more or less as they wished, and Koch – being outside German-controlled territory – had no means to secure compliance to the degree that made that evaluations reliable.[47] His former assistant Kleine, while carrying out the above-mentioned campaign on German terrain a few years later, resorted to the customary measures of barbed wire and armed guards, and still did not make much headway.[48]

For a host of reasons much of Koch's research on tropical veterinary infections was ill-informed in parasitological and immunological matters and on that account was widely disregarded. Still, it should be seen as the major source of inspiration for the much praised concept of carrier state which Koch developed from the example of typhoid.

Notes

1 For an introduction to Koch's work, see Brock, Thomas D. Robert Koch. A Life in Medicine and Bacteriology. Science Tech Publishers, Madison, Wisc. 1988; Gradmann, Christoph. Krankheit im Labor. Robert Koch und die medizinische Bakteriologie. Wallstein Verlag, Göttingen 2005b.

2 At least as far as the undisputed parts were concerned. Koch unveiled the aetiology of tuberculosis in 1882, and his fame rested in part on the tubercle bacillus. His later work was less fortunate.

3 In the latter parts of his biography Möllers lists the diseases Koch had worked on. Möllers, Bernhard. Robert Koch. Persönlichkeit und Lebenswerk 1843–1910. Schmorl und von Seefeld, Hannover 1950.

4 He was accused in relation to that when working on malaria. The correspondence of Ronald Ross and Patrick Manson contains a number of sometimes seriously sarcastic hints in that direction. Bynum, W.F. and Caroline Overy (eds). The Beast in the Mosquito: The correspondence of Ronald Ross and Patrick Manson. Rodopi, Amsterdam-Atlanta 1998. In relation to tropical veterinary medicine it seems that Koch denied due credit to Arnold Theiler, a South African veterinarian. Cranefield, Paul F. Science and Empire: East Coast Fever in Rhodesia and the Transvaal. Cambridge University Press, Cambridge-New York 1991.

5 Brock 1988:286–302.

6 The scandal in relation to his tuberculosis medicine, which became known as tuberculin, may serve as an example: Gradmann, Christoph. “Money and Microbes: Robert Koch, Tuberculin and the Foundation of the Institute for Infectious Diseases in Berlin in 1891.” History and Philosophy of the Life Sciences 22 (2000):51–71.

7 Koch, Robert. “Die Bekämpfung des Typhus” (1902). In Schwalbe, Julius (ed.). Gesammelte Werke von Robert Koch. Bd. 2.1, Thieme, Leipzig 1912:296–305; Mendelsohn, John Andrew. “Cultures of Bacteriology: Formation and Transformation of a Science in France and Germany, 1870–1914.” PhD dissertation, Princeton University 1996.

8 Koch an Karl Weigert. 22.1.1904. SBPK Berlin, Slg Darmst., 3 b 1882 (2). The catalogue names Ruge as addressee. Möllers 1950:282, who printed a shortened version, names Weigert, which is a lot more plausible.

9 Arnold, David (ed.). Warm climates and western medicine. The emergence of tropical medicine, 1500–1900. Rodopi, Amsterdam 1996; Worboys, Michael. “The Emergence of Tropical Medicine: A Study in the Establishment of a Scientific Speciality.” In Lermaine, Gerard, Roy MacLeod, Michael Mulkay and Peter Weingart (eds). Perspectives on the Emergence of Scientific Disciplines. Vol. 4, Mouton & Co, The Hague-Paris 1976:75–98; Silverstein, Arthur. A History of Immunology. Academic Press, San Diego et al. 1989; Gradmann, Christoph and Volker Hess (eds). “Vaccines and sera as medical, industrial and administrative objects 1880–1930.” Science in Context 21(2) 2008.

10 Printed in Möllers 1950:289.

11 Koch an Gaffky, 10.10.1903, printed in Möllers 1950:272.

12 Koch, Robert. “Vorläufiger Bericht über das Rhodesische Rotwasser oder ‘Afrikanische Küstenfieber’” (1904b). In Gesammelte Werke. Bd. 2.2:748–757.

13 Koch, Robert. “Die Ätiologie der Milzbrand-Krankheit, begründet auf die Entwicklungsgeschichte des Bacillus Anthracis” (1876). In Gesammelte Werke. Bd. 1:5–25.

14 Koch, Robert. “Untersuchungen über die Ätiologie der Wundinfektionskrankheiten” (1878). In Gesammelte Werke. Bd. 1:61–108 (here 101). Cf. Gradmann, Christoph. “Das Maß der Krankheit – das pathologische Tierexperiment in der medizinischen Bakteriologie Robert Kochs.” In Borck, Cornelius, Volker Hess and Henning Schmidgen (eds). Maß und Eigensinn. Versuche im Anschluß an Georges Canghuilhem. Fink, München 2005a:71–90.

15 The work was documented in detail in Koch, Robert. “Die Ätiologie der Tuberkulose” (1884). In Gesammelte Werke. Bd. 1:467–565.

16 In the files on Koch’s initial work on tuberculosis there is a series of experiments with Schütz (RKI-Archive). On Schütz and bacteriology, see Koch 1884:396–7.

17 Rosenkrantz, Barbara Gutmann. "The Trouble with Bovine Tuberculosis." Bulletin of the History of Medicine 59 (1985):155–175.

18 Mendelsohn 1996, ch. 7.

19 Mendelsohn 1996, ch. 9.

20 Koch, Robert. "Reiseberichte über Rinderpest, Bubonepest in Indien und Afrika, Tsetse- oder Surrakrankheit, Texasfieber, tropische Malaria, Schwarzwasserfieber" (1898). In Gesammelte Werke. Bd. 2.2:689–742 (here 698–9).

21 Koch to Gaffky, 10.10.1903. In Möllers 1950:272.

22 Koch to Gaffky, 10.10.1903. In Möllers 1950:272.

23 Koch 1898:726, by Smith and Kilbourne.

24 Koch 1898.

25 Koch 1898:727.

26 Koch 1898:727 (Cf. Cranefield 1991:91).

27 If we follow Cranefield 1991, Koch focussed on a brown tick that transmits Texas fever rather than the blue tick that transmits East Coast fever. While the brown tick does pass the parasite to its offspring, the blue tick does not. In this case fresh ticks need to be infected on the blood of cattle. In that sense he was also wrong in relation to epidemiology. Koch's critics in the South African Veterinary service were more in line with today's knowledge on this issue.

28 Koch 1898:729.

29 Koch proposed this in relation to surra. Koch 1898:696.

30 Koch to Libbertz, 29.12.1902. In Möllers 1950:265.

31 Koch 1904b:752. In fact, he insisted in having made that distinction in 1886 (Koch to Dönitz, 27.3.1903. In Möllers 1950:265). However, as Cranefield 1991 has shown, that this was clearly wrong. In his travel report of 1898 he barely mentioned a few open questions and otherwise identified the cattle disease as Texas fever.

32 Koch 1904b:754.

33 RKI-Archive, AS/W4/006, Bl.43.

34 RKI-Archive, AS/W4/006, Bl.44.

35 Koch to Frosch, 2.4.1903. In Möllers 1950:267. In the first sentence it is unclear also in the German text whether Koch is arguing about the removal of parasites or affected cattle.

36 The development is described in detail in Koch, Robert. "Dritter Bericht über das Rhodesische Rotwasser oder 'Afrikanische Küstenfieber'" (1904a). In Gesammelte Werke. Bd. 2.2:764–773; "Zweiter Bericht über das Rhodesische Rotwasser oder 'Afrikanische Küstenfieber'" (1904c). In Gesammelte Werke. Bd. 2.2:757–763. For a short account see Koch, Robert and Friedrich Karl Kleine. "Die Ergebnisse der Forschungen Robert Kochs über Küstenfieber der Rinder und über die Pferdesterbe gelegentlich seiner letzten Expedition nach Südafrika" (1905). In Gesammelte Werke. Bd. 2.2:799–805. He even devised an assay (Wertbestimmungsverfahren) for it. This sort procedure had been designed by Ehrlich for testing therapeutic vaccines. See Gradmann und Hess 2008.

37 Described in detail in Koch 1904a. Original documentation is to be found in RKI-Archives AS/W4.

38 Cranefield 1991. On the work of the South African veterinarians, Arnold Theiler in particular, see Gilfoyle, Daniel. “Veterinary Immunology as Colonial Science: Method and Quantification in the Investigation of Horsesickness in South Africa, c. 1905–1945.” Journal of the History of Medicine and Allied Sciences 61 (2005):26–65.

39 RKI-Archives, AS/W4/00x, Bl.1.

40 On sleeping sickness: Lyons, Maryinez. The colonial disease: A social history of sleeping sickness in northern Zaire, 1900–1940. Cambridge University Press, Cambridge 1992; Worboys, Michael. “The comparative history of sleeping sickness in East and Central Africa, 1900–1914.” History of Science 32 (1994):89–102. For the following on Koch’s expedition Eckart, Wolfgang U. Medizin und Kolonialimperialismus in Deutschland 1884–1945. Schöningh, Paderborn 1997:340–349; Gradmann 2005b:297–336.

41 Koch, Robert. “Schlußbericht über die Tätigkeit der deutschen Expedition zur Erforschung der Schlafkrankheit” (1907). In Gesammelte Werke. Bd. 2.1:534–546 (here 543).

42 Eckart, Wolfgang U. and Meike Cordes. “‘People too Wild’? Pocken, Schlafkrankheit und koloniale Gesundheitskontrolle im Kaiserlichen ‘Schutzgebiet’ Togo.” In Dinges, Martin and Thomas Schlich (eds). Neue Wege in der Seuchengeschichte. Steiner, Stuttgart 1995:175–206.

43 Cf. Anderson, Warwick. “‘Where Every Prospect Pleases and Only Man is Vile’: Laboratory Medicine as Colonial Discourse.” Critical Inquiry 18 (1992):506–529.

44 Weindling, Paul. Epidemics and Genocide in Eastern Europe, 1890–1945. Oxford University Press, Oxford 2000.

45 Koch 1902:303–304. Cf. Eckart 1998.

46 Koch 1904a:770.

47 Gradmann 2005b:328.

48 Eckart 2002.

Health policy and welfare regimes in Western Europe, 1945–1973

John Stewart

In 1963 the independent British research organisation, the Office of Health Economics, published a report on the health services of Western Europe. This was timely, it noted, because of the "current interest in continental affairs" – a rather coy reference to Britain's growing, but at this point unsuccessful, interest in joining what at the time was called the European Common Market. Specifically with regard to health services, it was observed that almost all European countries had "accepted the provision of medical care as a community responsibility". There were, nonetheless, differences in how these schemes were financed and run. At one end of the spectrum was the British National Health Service (NHS), available to all citizens, more or less free at the point of delivery, and funded out of general taxation and with social insurance having an almost imperceptible role to play.

At the other end of the spectrum were those systems funded through various types of social insurance, often integrated with other social insurance schemes and with the state playing a much less direct part – usually a supervisory role – than was the case in Britain. These social insurance schemes might be organised and run by provincial or local governments, a prominent example of the former being West Germany; or even by completely non-state bodies such as private insurance companies or voluntary bodies, as in the Netherlands. In principle at least, these schemes were autonomous. The nearest arrangements to the British system were to be found in countries such as Sweden where, although funding was still roughly on a social insurance model, the programme embraced such as large proportion of the population as to be effectively universal. Aside from its discussions of individual countries, the report also urged the need for further information gathering and exchange across national boundaries with the aim of throwing "light on many controversial issues, about which only hypothetical conclusions can be reached within Britain itself".[1]

Just over ten years later, another British report from the voluntary sector – written by the former Liberal MP Donald Wade – again drew attention to the fact that most European countries saw providing "arrangements for sharing the cost of medical care as a community responsibility". The British system nonetheless differed from that to be found elsewhere and an "increasing number of people from overseas…interested in the study of health services ask to come to the United Kingdom". This report too drew attention to the comprehensiveness of the Swedish system with its "guiding principle…that everyone should have medical care without regard to the ability to pay…". Rather, it "should be treated as a 'right' and some would say 'an obligation'".

A notable contextual difference was, of course, that by the time of this second report Britain had joined the European Economic Community. This, though, had had no impact on the recent reorganisation of the NHS as such administrative changes were not covered by the Treaty of Rome. Moreover there was, at present, no concerted move towards social policy co-ordination. Nonetheless, no country could live in isolation. As the author noted:

> Scarcely a month goes by without some conference being held at which delegates from different countries study some aspect of health care or health service administration. There is a movement towards mutual recognition of qualifications, a greater exchange of information, an expansion of research and a closer study of the economics of health care. All this should be welcomed, and yet the interchange of experiences alone is bound to have some influence on future developments.[2]

These reports draw attention, explicitly and implicitly, to a number of issues pursued in the rest of this essay: first, the idea that across Europe it had come to be accepted that the provision of health care was a "community responsibility"; second, that this general trend notwithstanding, there were differences between European nations and, indeed, in some cases within particular nations themselves; and third, that it is possible to combine the first two points by acknowledging national and sub-national differences, but nonetheless to see a form of convergence taking place across Europe during its "Golden Age" of the late 1940s to the mid 1970s. The ambition for information-sharing and policy-learning evident in the two reports quoted might be seen as contributing to this process. Arguably, although it is not something dealt with here, such convergence continued in the face of the common European experience of economic downturn and attempts at welfare retrenchment during the 1980s and 1990s. As one way into this, we look briefly at the analytical tool of "welfare regimes".

The "Golden Age"

It is necessary to place European health policies in their broader economic context. We have already encountered the idea of Europe's "Golden Age", a period of rapid economic growth which occurred from the late 1940s to the early to mid 1970s. The data in table 1 clearly buttress this idea:

Table 1. *Average annual growth rate of gross domestic product (GDP) in selected countries*[3]

	1870–1913	1913–1950	1950–1973	1973–2000
Germany	1.6	0.3	5.0	1.6
Italy	1.3	0.8	5.0	2.1
Sweden	1.5	2.1	3.1	1.5
United Kingdom	1.0	0.8	2.5	1.9
Average of 12 “advanced” European countries	1.3	0.8	4.0	1.8
Portugal	0.5	1.2	5.7	2.5
Ireland	1.0	0.7	3.1	4.3
Average of 5 “peripheral” European countries	1.1	0.5	5.1	2.5

Accompanying this historically unprecedented economic growth was an associated expansion in social transfers (that is, expenditure on welfare not including education):

Table 2. *Social transfers as per cent of GDP in selected countries*[4]

	1930	1960	1970	1980	1990*
Germany	4.82	18.10	19.53	25.66	19.85
Italy	0.08	13.10	16.94	21.24	21.34
Sweden	2.59	10.83	16.76	25.94	32.18
United Kingdom	2.24	10.21	13.20	16.24	18.05
Portugal	0	N/K (but ⇢ 0)	N/K (but ⇢ 0)	10.10	12.62
Ireland	3.74	8.70	11.89	19.19	18.05
Median OECD	1.66	10.41	14.84	20.09	24.00

*Method of calculation differs from that used in earlier years.

Examining the composition of these transfers reveals a widespread growth in expenditure (public and private) on health, in some cases very rapid growth indeed.

Table 3. *Total expenditure on health as per cent of GDP in selected countries*[5]

	1960	1970	1980	1990
Germany	4.8	5.9	8.4	8.3
Italy	3.6	5.2	6.9	8.1
Sweden	4.7	7.2	9.4	8.6
United Kingdom	3.9	4.5	5.8	6.2
Portugal	N/A	3.1	5.9	5.4
Ireland	4.0	5.6	9.2	7.0

The expansion of health services

The overarching point is, therefore, that expenditure on health rose extremely rapidly during the Golden Age, indeed in advance of actual economic growth, although this is not to suggest that it expanded as much as it might have done or as was necessary.[6] Such growth was not necessarily what proponents of health reform had envisaged. In

France, for example, Pierre Laroque, a key architect of the social insurance system, predicted in 1944 that although both the costs of and the population covered by the health care scheme would certainly rise, this increase would be at no greater a rate than economic growth as a whole. But in fact, as Paul Dutton notes, "health care has consumed a larger and larger proportion of France's national income every year since 1947".[7] One reason why this might be so is the growth in health service employment across Europe. Again to use a French example, the number of registered doctors doubled between 1950 and 1970, and during the 1960s the number of doctors per thousand of population the increased from 97 to 125.[8] The British NHS, meanwhile, had become the largest single employer in Europe by the 1980s.[9] It was also the case that, increasingly, all European nations felt the impact of various social and scientific changes, ranging from the health care implications of an ageing population through to the scientific and technological advances which both increased health costs and further stimulated the demand for health care. In certain societies, notably the Scandinavian countries, labour market policies promoting female employment also had a crucial impact on the expansion of health and welfare expenditure.[10] While none of this of itself is overwhelming evidence for the notion of convergence in health care policy, it is nonetheless suggestive of broader, transnational trends. The issue of convergence is also dealt with at the end of this paper.

It is perhaps worth noting here, incidentally, that again for the most part this expansion on expenditure on welfare and health was carried out by governments of different political persuasions which, again on a broad European level, were nonetheless united in their scepticism about the efficacy of unbridled free market capitalism and its ability to promote social stability. Social Democracy was, of course, important in the Scandinavian states. But, equally, it is worth bearing in mind that, as van Kersbergen points out, by the late 1950s in "Germany, Austria, Switzerland, the Netherlands, Belgium, France and Italy, fully organised Catholic, Protestant and inter-denominational parties had come to power" – that is, parties which for the most part could be described as Christian Democratic and which saw welfare policy as, inter alia, a means of promoting the institution of the family while fending off godless communism and socialism.[11] One obvious example of this broad political approach can be found in the health insurance programme issued in France in 1945. This came from a government which was led by General de Gaulle – nobody's idea of someone of the Left – and which nonetheless included socialists, members of the Social Catholic political body the MRP, and indeed also godless communists.[12] The communists were soon to out of government, but all the rest were to play a crucial part in post-war French politics and thus welfare policy.

Summarising the position, and taking the long view, one commentator, Richard Freeman, remarks that: "By 1980, almost all European states guaranteed access to health care to almost all of their citizens. In 1880, none of them did". As he further observes, if we take access to publicly-funded hospital care as the core of a socialized health service, then by 1970 this was available to nearly all citizens in all Western

European states.[13] While it remained the case that in some countries charges could be levied at particular points or in particular circumstances – in Italy in the early 1970s, for example, free hospital care was only available for 26 weeks – nonetheless Freeman's point is well made. [14] The idea of taking the long view is worth a brief comment. Given that social insurance was a central component of many European health care systems after 1945, it is important to bear in mind that many of these had deep historical roots. The Office of Health Economics report cited earlier noted that, for example, Luxembourg's social insurance scheme had started in 1901; that of Switzerland in 1911; and, most famously, that of Germany in 1883, with the current German scheme still being based largely on the Social Health Insurance Act of 1911.[15] While these historical precedents are extremely important, not least in explaining national differences and welfare regimes, it nonetheless remains the case that it is after the Second World War that state-sponsored and controlled health services really expand, and we now turn to look at how this took place in selected European nation states.

While it is true that the health services of the Western European nations after 1945 expanded – with varying degrees of state direction, control, and provision – they did not do so uniformly, at least in the first instance. Finland, for example, was a relatively late developer. It was certainly the case that, under an Act of 1943, municipalities had responsibilities for hospital provision and the 1950s saw a period of hospital construction. One consequence of this was that Finland had more hospital beds per capita than any other Scandinavian country. Nonetheless it was not until the rapid economic expansion of the 1960s that health expenditure really took off. The growth rate for health service expenditure during this period was nearly double that of Gross Domestic Product and 1964 saw the passing of the Sickness Insurance Act, Finland's entry into the world of relatively comprehensive health insurance. The previously under-developed primary care system was upgraded through the 1972 Primary Health Care Act. So from comparative "backwardness" the Finnish system had been revolutionized, on the back of outstanding economic performance and a more pro-welfare political climate, and had become, arguably, one of the most advanced in Europe.[16]

In France, meanwhile, we have already seen evidence in the rapid rise in the number of doctors and the increasing proportion of national income devoted to health care expenditure. Addressing the French medical profession in 1960, President Charles de Gaulle argued: "I saved France on a colonel's pay. For the billions I pay you, surely you can give me better health care!".[17] France as a nation thus had aspirations for its medical system. As Timothy Smith points out, as the result of a 1958 ordinance university-hospitals and research centres were created alongside the reform of medical education. During the 1960s and 1970s the French "constructed dozens of avant-garde hospitals…and the Pasteur Institute…began to re-establish the nation as a medical powerhouse". Moreover, a nation "once tolerant of widespread health problems, including one of Europe's highest tuberculosis rates into the 1950s, became a nation of widespread medical consumption". "Medical inflation", Smith continues, "…was higher than in most OECD countries: 22% (gross) during the 1970s".[18] This was the case even though the French insurance system, in principle at least, usually only allowed for partial reimbursement of patients' costs.[19] It is also noticeable that a recent French history of the nation's health services refers to the period 1945 to 1975 as "Les "Trentes Glorieuses" de la Santé", a clear echo of the more general perception of France's glorious thirty years.[20]

Across the English Channel, meanwhile, Britain's NHS had been introduced, through two pieces of legislation, in the late 1940s. As we have seen, unlike its continental counterparts it was primarily financed out of general taxation rather than social insurance. It was also free at the point of delivery for most services and available to all citizens. Funding and other differences notwithstanding, the British system – which was actually an English and Welsh system and a Scottish system and thus in a small way an instance of divergence within a nation state – experienced a number of common issues with those of the rest of Europe. A World Health Organisation report on the Scottish NHS, for instance, noted that because the service "offers services rather than goods, most of the current expenditure is on pay: 70% of all operational spending in hospitals is on salaries". This was unsurprising since, for example, the number of nurses had grown by 43 per cent between 1964 and 1973, albeit that some of these were part-time. As to doctors, their numbers had grown by 17 per cent in the same period – 1964 to 1973 – with growth especially concentrated in hospital services.[21] The point here, as with the French example, is the rapid expansion of service provision.

These three national examples illustrate a point made by Freeman. In the course of his description of the arrival of universality of European health care by the last third of the twentieth century he argues that: "Two routes to universalisation are distinguishable. The first was instrumental, achieved by the piecemeal expansion of social insurance…. The second was more radical, in which universal access was instituted at a stroke by creating national health services…". One exemplar of the former was France, with Britain a key instance of the latter route.[22] Freeman also acknowledges the possibility of variants on this basic scheme, and the Finnish example briefly discussed above might be seen as one instance of this – relatively slow progress and then a sudden, fairly radical, shift.

Health services and "welfare regimes"

This leads into what will be a tentative and exploratory discussion of whether post-war health policy in Western Europe maps very easily with the notion of "welfare regimes" and how this relates, if at all, to another analytical position, that of the convergence of welfare systems. With regard to welfare regimes, the starting point is the work of Gøsta Esping-Andersen. This work, it is reasonable to acknowledge, has been the subject of much criticism and modification. Nonetheless, the welfare regimes he describes remain a useful starting point for how we might better understand social welfare systems outside the confines of national boundaries or histories.

Put very crudely, what Esping-Andersen argued in his groundbreaking work *The Three Worlds of Welfare Capitalism* was that welfare could be classified in one of three ways. [23] First, there was the "liberal" regime in which state provision was residualist – that is designed to cater only to the most needy; which saw the market as the ultimate provider of welfare; and which continued to display characteristics such as means-testing. Revealingly, he occasionally describes this regime as "Anglo-Saxon". Esping-Andersen famously had a lot of trouble classifying the British welfare state. Quite correctly, he saw much of British welfare provision as falling into the "liberal" category but, although he does not specifically mention it, it is virtually impossible to argue that Britain's National Health Service – universal, comprehensive, and free at the point of delivery – can be seen in this way. Indeed by the mid-1960s it is difficult to see any of health systems of at least the advanced West European nations in such a light, and for present purposes we shall leave this type of regime to one side.

Esping-Andersen's second category was the "corporatist" regime, examples of which could be found in Italy, France, Germany, and Austria. Often driven, at least in the first instance, by religious ideas such as social catholicism, these regimes rejected reliance on the market and emphasised instead "subsidiarity". What this meant was that the state would support non-state organisations and structures which could provide welfare in situations where the family – a central institution in such regimes – was not able to do so. This, in fact, is quite a useful way of seeing health policy in certain West European nations during the Golden Age. So, for example, it was noted of France in the mid-1970s that there were a plethora of health insurance schemes operating at different levels and with different functions, including "special schemes for civil servants, servicemen, miners, seamen, railwaymen, and the employees of the gas and electricity industries".[24] The central point is, though, that such welfare regimes very explicitly separate out financial support for health care services from actual provision.

Esping-Andersen's third analytical category was, of course, the social democratic – or Scandinavian – regime. This involved universalism; high standards of service promoting equality; and a rejection of the market as a provider of welfare in the form of services. In short, these welfare regimes seek to promote social solidarity through the welfare system. This is an interesting way of viewing Britain's National Health Service, not least given the historic circumstances of its creation. In this context it is revealing, moreover, that by the early 1960s Britain had reciprocal health care arrangements with both Denmark and Sweden.[25] But it also maps rather well with the Finnish situation discussed earlier, if only because the rapid advance of the health services in Finland in the mid-1960s was largely coincident with the coming to power of a Social Democratic Party with a coherent and well-worked out welfare agenda; and with the Scandinavian situation more generally. So, for example, the Swedish "Seven Crowns" legislation of 1970 is notable here, a consciously egalitarian measure which sought, inter alia, to significantly reduce private practice in medicine.[26]

Conclusion

So does this mean that the notion of welfare regimes has purchase when we are looking at health systems in various Western European nations during the Golden Age? On one level, that of administrative arrangements – by which is meant how the system is organised and how it is financed – the answer to this question appears to be unequivocally "yes". It is possible, for instance and as we have seen, to contrast the British NHS, funded out of general taxation, with the social insurance schemes of the continent. But were the situations really so different? Social insurance schemes were purportedly autonomous, albeit also under, to varying degrees, the direction of the state. But this is a bit more problematic than it at first appears. In its 1963 report, for example, the Office of Health Economics noted that in Belgium the "rising cost of medical care has severely embarrassed the sick fund, which has attempted to restrict expenditure by curtailing the range of services available. The substantial deficit which the fund incurs is met by the state." Similar, if less severe, problems were noted for France and Germany.[27] It is notable too that, over the long term, many of the voluntary insurance bodies, which had started out as schemes involving worker and contributor participation, had been depoliticized and, as Starr and Immergut put it, "incorporated into state bureaucracies".[28]

The point being made here is that the central state can, in such circumstances, be seen as playing a much more crucial and indeed necessary role than an account of administrative arrangements might superficially suggest. This argument is, it could be suggested, reinforced by the Swedish example cited earlier whereby the social insurance scheme was so comprehensive that to all intents and purposes it was little different from the general taxation scheme operating in Britain. All this returns us to Freeman's analysis noted earlier on – that there are two ways to universalism, but by the 1970s both had converged to bring about not dissimilar systems across Western Europe most notably, but not exclusively, in terms of access to hospital care. To put it another way, by this time the patient experience was relatively uniform. When taken together with the rise across the Western European nations in health care expenditure over the period under consideration, which in turn was to drive health care provision to the top of the political agenda in the post-Golden Age era of economic difficulty, does all this not suggest at least some form of convergence?

These considerations in turn bring us to our final point. If we are looking for evidence for convergence, we might also think about policy learning. Two examples suggest themselves here. First, until the mid-1970s the Italian health system was insurance-based and a classic example of a "corporatist" welfare regime not dissimilar to that of Germany. In 1978, however, it was radically reformed and a "unitary and universal scheme" modelled on the British NHS introduced.[29] The second example takes us back to Finland. In our earlier discussion of the development of that country's health system the work of two Finnish scholars was extensively drawn upon. In their analysis of the 1972 Primary Health Care Act they observe that this was "justified by domestic reasons" but also "greatly inspired by the comprehensive, rational planning systems introduced in most of the OECD countries during the early 1970s".[30] This is an intriguing remark and one which bears more examination. We might think here, for instance, of Britain's somewhat earlier Hospital Plan – an attempt at rationalisation and more coherent management of the health services – and, in the 1970s, the same country's health service reorganisation. It is also possible to see France's reforms of its hospital system in the 1960s and thereafter in this sort of light. More generally, these remarks chime closely with the points made, as we saw at the beginning, by the Office of Health Economics and by Donald Wade regarding the need to understand, study, and possibly learn from other health care systems. And, of course, the very notion of "welfare regimes" of itself implies commonality of purpose in regime clusters and thus, in real practical and political terms, some measure of policy learning.

As is no doubt evident from this essay, comparative work on health care policy in post-war Europe is a field in need of considerably more investigation and analysis. What has been attempted here is to suggest some ways in which this might happen and some of the issues which might fruitfully be addressed.

Notes

1 Office of Health Economics. Health Services in Western Europe. Office of Health Economics, London 1963:3–7.

2 Wade, Lord. Europe and the British Health Service. National Council of Social Service, London 1974:15, 31, 61, 87.

3 Extracted from Eichengreen, Barry. The European Economy since 1945. Princeton University Press, Princeton NJ 2007.

4 Extracted from Lindert, Peter. Growing Public: Social Spending and Economic Growth since the Eighteenth Century, Volume I, Cambridge University Press, Cambridge 2004.

5 Extracted from Lindert 2004.

6 For the British case, see Stewart, John. "The Political Economy of the British National Health Service, 1945–1975: Opportunities and Constraints?" Medical History 82, 4 (2008) which also contains comparative data.

7 Dutton, Paul V. Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France. Cornell University Press, Ithaca 2007:156.

8 Fillaut, Thierry. Le Système de Santé Français, 1880–1995. L'Ecole Nationale de Santé Publique, Rennes 1997:42, 44.

9 Pierson, Christopher. Beyond the Welfare State? The New Political Economy of Welfare. 3rd edn., Polity, Cambridge 2006:136.

10 See the references in Huber, Evelyne and John D. Stephens. Development and Crisis of the Welfare State. University of Chicago Press, Chicago 2001.

11 van Kersbergen, Kees. Social Capitalism: A Study of Christian Democracy and the Welfare State. Routledge, London 1995:48.

12 Starr, Paul and Ellen Immergut. “Health Care and the Boundaries of Politics”. In Maier, Charles S. (ed.). Changing Boundaries of the Political. Cambridge University Press, Cambridge 1987:227–8.

13 Freeman, Richard. The Politics of Health in Europe. Manchester University Press, Manchester 2000:14, 22.

14 Maynard, Alan. Health Care in the European Community. Croom Helm, London 1975:260 Table 4.

15 Office of Health Economics 1963:12, 15, 11.

16 Martikainen, Tuomo and Petri Uusikylä. Reforming Health Policy in Finland: A Critical Assessment. Saarijärvi, Helsinki 1997:14–22.

17 Dutton 2007:134.

18 Smith, Timothy B. France in Crisis: Welfare, Inequality, and Globalization since 1980. Cambridge University Press, Cambridge 2004:142.

19 Maynard 1975:252.

20 Fillaut 1997:42.

21 World Health Organization Regional Office for Europe. The Planning of Health Services: Studies in Eight European Countries. World Health Organization, Copenhagen 1980:29.

22 Freeman 2000:24.

23 Esping-Andersen, Gøsta. The Three Worlds of Welfare Capitalism. Polity, Cambridge 1990. For a further discussion, see also Huber and Stephens 2001.

24 Maynard 1975:250.

25 Office of Health Economics 1963:9, 15.

26 Starr and Immergut 1987:236.

27 Office of Health Economics 1963:9, 10–11.

28 Starr and Immergut 1987:31.

29 Freeman 2000:17.

30 Martikainen and Uusikylä 1997:22.

Contributors

Astri Andresen, Professor, Department of Archaeology, History, Cultural Studies and Religion, University of Bergen
Ida Blom, Professor Emerita, Department of Archaeology, History, Cultural Studies and Religion, University of Bergen
Linda Bryder, Associate Professor, Department of History, University of Auckland
Ivan Crozier, Lecturer, Science Studies Unit, University of Edinburgh
Antoni Adam Donat, Agència Valenciana de Salut
Christoph Gradmann, Professor, Institute of General Practice and Community Medicine, University of Oslo
Anne Hardy, Professor, the Wellcome Trust Centre for the History of Medicine at University College, London
Arvid Heiberg, Senior Hospital Physician, Rikshospitalet University Hospital HF
Niklas Thode Jensen, Postdoctoral Fellow, Department of History at the Saxo Institute, University of Copenhagen
Runar Jordåen, PhD Student, Department of Archaeology, History, Cultural Studies and Religion, University of Bergen
Steven King, Professor, Assistant Dean (Resources), School of Arts and Humanities, Oxford Brookes University
Øivind Larsen, Professor, Institute of General Practice and Community Medicine, University of Oslo
Judith Raftery, Visiting Senior Lecturer, Discipline of Public Health, University of Adelaide
Teemu Ryymin, Senior Researcher, Stein Rokkan Centre for Social Studies, University of Bergen
Svein Atle Skålevåg, Senior Researcher, Stein Rokkan Centre for Social Studies, University of Bergen
John Stewart, Professor, School of Law and Social Studies, Glasgow Caledonian University
Àlvar Martínez Vidal, Professor Titular d'Universitat, Departament de Filosofia, Universitat Autònoma de Barcelona
Mari Webel, PhD Student, Columbia University

Report series Rokkansenteret

(ISSN 1503-4844)

The publications can be ordered from Rokkansenteret, tel +47 55 58 97 10,
e-mail: post@rokkan.uib.no, http://www.rokkansenteret.uib.no

No	2008
1-2008	Hans-Erik Ringkjøb, Jacob Aars og Signy Irene Vabo: *Lokalt folkestyre AS. Eierskap og styringsroller i kommunale selskap.* Februar 2008.
2-2008	Dag Arne Christensen og Jacob Aars: *Valg av ordfører ved supplerende stemmegivning. En empirisk analyse av ordførervalgene i 48 norske kommuner i 2007.* Februar 2008.
3-2008	Gry Brandser og Ole Andreas Brekke: *Veien mot et Innlandsuniversitet. Om interne utviklingstrekk og eksterne rammebetingelser 2001–2008.* Juni 2008
4-2008	Kristin Hope, Hans-Erik Ringkjøb og Lise Hellebø Rykkja: *Evaluering av styring og ledelse ved NTNU*. August 2008.
5-2008	Tom Christensen: *«En felles etat» – en analyse av prosessen som ledet frem til opprettelse av ny arbeids- og velferdsforvaltning (NAV).* August 2008.
6-2008	Dag Wollebæk, Per Selle og Kristin Strømsnes: *Endringsprosesser i norsk frivillighet: En kunnskapsoversikt.* September 2008.
7-2008	Rune Ervik: *Bruk av skift og turnus i ulike virksomheter: En kartlegging.* Oktober 2008.
8-2008	Anne Homme og Håkon Høst: *Hvem pleier de gamle i Oslo? Om hjelpepleiernes og helsefagarbeidernes posisjon i pleie- og omsorgstjenestene i hovedstaden.* Oktober 2008.
9-2008	Dag Arne Christensen, Tor Midtbø, Hans-Erik Ringkjøb og Jacob Aars: *To valg med ny personvalgordning – Kontinuitet eller endring?* Desember 2008.
10-2008	Astri Andresen, Tore Grønlie, William Hubbard, Teemu Ryymin, Svein Atle Skålevåg (eds): *Citizens, Courtrooms, Crossings.* December 2008.

No	2007
1-2007	Hans-Erik Ringkjøb, Bjarte Folkestad, Audun Offerdal og Jacob Aars: *Demokrati heile vegen. Gode styringsgrep og metodar for folkevalte*. Mai 2007.
2-2007	Astrid Andresen and Tore Grønlie (eds): *Transferring Public Health, Medical Knowledge and Science in the 19th and 20th Century.* December 2007

No	2007
1-2007	Hans-Erik Ringkjøb, Bjarte Folkestad, Audun Offerdal og Jacob Aars: *Demokrati heile vegen. Gode styringsgrep og metodar for folkevalte*. Mai 2007.
2-2007	Astri Andresen and Tore Grønlie (eds): *Transferring Public Health, Medical Knowledge and Science in the 19th and 20th Century.* December 2007
3-2007	Knut Grove: *Historikarar i randsona. Historieforskinga ved Rokkansenteret, LOS og SEFOS.* Desember 2007.

No	2006
1-2006	Arnhild Taksdal, Jan-Kåre Breivik, Kari Ludvigsen og Bodil Ravneberg: *På randen av å bo. Erfart kunnskap om livet og flyttingene mellom psykiatri, rusomsorg, gater, hospitser og egne* **boliger. Mai 2006.**
2-2006	Morten Dyrdal, Per Lægreid og Kristin Rubecksen: *EU i norsk sentralforvaltning*. Oktober 2006.
3-2006	Kaia Christina I. Grahm-Haga: *Institusjonalisering av forvaltningsrevisjon. En studie av utvikling i policy og praksis hos Riksrevisjonen i perioden 1994–2005.* November 2006.
4-2006	Astri Andresen, Tore Grønlie og Teemu Ryymin (eds): *Science, Culture, and Politics. European Perspectives on Medicine, Sickness and Health. The Fourth Bergen Workshop of the History of Health and Medicine. Conference Proceedings.* December 2006.
5-2006	Camilla H. Glückstad: *Revitalisering av Riksrevisjonen. En prosesstudie av Riksrevisjonens nye rammeverk.* Desember 2006.

No	2005
1-2005	Bjørn C. Ekeland, Ingrid Lundeberg og Svein Atle Skålevåg (red.): *Studier av dommen. Konferanserapport*. Mars 2005.
2-2005	Stein Kuhnle (ed.): *Social Policy Development in South Eastern Europe: Outside Influences and Domestic Forces.* March 2005.
3-2005	Sturle Næss: *Omsorgens vilkår i de kommunale pleie- og omsorgstjenestene.* Juli 2005.
4-2005	Eirinn Larsen: *Invisible Strategies. Gender in French and Norwegian Business Education, 1870–1980.* September 2005.
5-2005	Nina Berven: *National Politics and Cross-National Ideas. Welfare, Work and Legitimacy in the United States and Norway.* September 2005.
6-2005	Hans K. Mjelva: *Tre storverft i norsk industris finaste stund. Ein komparativ studie av Stord Verft, Rosenberg mek. Verksted og Fredrikstad mek. Verksted 1960–1980.* November 2005.
7-2005	Rune Ervik: *Active Ageing and the Norwegian Pension System*. December 2005.
8-2005	Even Nilssen: *Fag, rett og politikk. Rettsutformingen angående bruk av tvang overfor voksne rusmiddelmisburkere og psykisk utviklingshemmede i de skandinaviske landenes sosialrett.* Desember 2005.
9-2005	Arne Ramslien: *Fra ritual til verktøy. Mål- og resultatstyring av Utlendingsdirektoratet 1998–2003.* Desember 2005.
10-2005	Astri Andresen, Kari Tove Elvbakken and Tore Grønlie (eds): *Politics of Prevention, Health Propaganda, and the Organisation of Hospitals 1800–2000. Conference Proceedings.* December 2005.
11-2005	Even Nilssen: *Fag, rett og politikk. Rettsutformingen angående bruk av tvang overfor voksne rusmiddelmisbrukere og psykisk utviklingshemmede i de skandinaviske landenes sosialrett.* Desember 2005.
12-2005	Kirsti Malterud og Kari Tove Elvbakken: *Sunnhet og sykdom i kulturelt perspektiv. Bidrag fra Helsekameratenes avslutningsseminar.* Desember 2005.

No	2004
1-2004	Astri Andresen, Kari Tove Elvbakken and William H. Hubbard (eds): *Public Health and Preventive Medicine 1700 – 2000. Knowledge, Co-operation, and Conflict.* March 2004.
2-2004	Anne Lise Fimreite, Yngve Flo, Tommy Tranvik og Jacob Aars: *Tillit mellom forvaltningsnivåene – sentrale aktørers oppfatninger av og holdninger til kommunene.* Juni 2004.
3-2004	Rune Hallingstad: Regional styring i lys av foretaksorganiseringen. *En sammenlignende studie av Helse Vest-Norge RHF og Helse Midt-Norge RHF*. September 2004. ATM.
4-2004	Håkon Høst: *Kontinuitet og endring i pleie- og omsorgsutdanningene. En studie av utviklingen innenfor utdanningene til hjelpepleier og omsorgsarbeider.* Oktober 2004.
5-2004	Sturla Herfindal: *Veien frem til sykehusreformen – En studie av beslutningsprosessen bak lov om helseforetak.* November 2004.
6-2004	Astri Andresen, Tore Grønlie and Svein Atle Skålevåg (eds): *Hospitals, Patients and Medicine 1800 –2000. Conference Proceedings.* November 2004.
7-2004	Stig Helleren: *Kontrollør eller veileder? En studie av policyendring i Arbeidstilsynet 1989–2002*. November 2004.
8-2004	Dag Arne Christensen, Tor Midtbø, Hans-Erik Ringkjøb, Lars Svåsand og Jacob Aars: *Ny personvalgordning og hva så? En analyse av kommune- og fylkestingsvalget i 2003.* Desember 2004.

No	2003
1-2003	Sturle Næss*: Ikke helt etter planen. Dokumentasjonsrapport om hjelpetrengende eldres erfaringer før og etter Handlingsplan for eldreomsorgen*. Mars 2003.
2-3003	Kim Ove Hommen: Tilsynsroller i Staten. En studie av Luftfartstilsynet og Statens Jernbanetilsyn. Mars 2003.
3-2003	Stein Kuhnle and Dzemal Sokolovic*: The Balkans: Searching for Solutions*. March 2003.
4-2003	Anne Lise Fimreite (red.): *Styringssystem i storby. Evaluering av styringssystemet i Bergen kommune*. April 2003.
5-2003	Ingrid Helgøy og Bodil Ravneberg: *Byråkrat, sosialarbeider eller innovatør? Organiseringens betydning for utvikling av yrkesroller i sosialtjenesten*. Mai 2003.
6-2003	Anne Homme: *Skolen som styringsarena? Lokalt handlingsrom og gjennomføringen av Reform 97*. Mai 2003.
7-2003	Dag Stenvoll: *Politisk argumentasjon. En analyse av norske stortingsdebatter om seksualitet og reproduksjon 1945–2001*. Juni 2003.
8-2003	Anne Lise Fimreite: *Der hvor intet er, har selv keiseren tapt sin rett! Om lokalt folkestyre og rettigheter.* Juni 2003.
9-2003	Sturle Næss: *I tøffeste laget? Dokumentasjonsrapport om arbeidsituasjonen til ansatte i pleie- og omsorgstjenesten.* Juni 2003.
10-2003	Sven Atle Skålevåg: *Fra normalitetens historie. Sinnssykdom 1870–1920*. Juli 2003 .
11-2003	Simon Neby: *Interessekonflikt, kommunikasjonssvikt og kulturkollisjon. En studie av fusjonen mellom Telia og Telenor*. Juli 2003.
12-2003	Birte Bjørkelo: *The Power of Learning in the Global Age – The World Bank and Environmental NGOs.* October 2003. The Globalization Program.

13-2003 Ingrid Hagen: *Global konkurranse og lokal fleksibilitet. Omstillinger og fleksibilitetsstrategier i en norsk elektronikkbedrift.* Oktober 2003. Globaliseringsprogrammet.

14-2003 Mariann Moberg: *Engasjement og trygghet i et mer globalisert arbeidsliv. En studie av endringsprosesser i et multinasjonalt konsern i lys av trekk ved den nye kapitalismens ånd.* Oktober 2003. Globaliseringsprogrammet.

15-2003 Harald Grimen and Kari Tove Elvbakken (eds): *Cultural Perspectives on Risk, Preventive Medicine and Health Promotion.* October 2003.

16-2003 Synnøve Serigstad: Samordning og samfunnstryggleik. *Ein studie av omorganiseringa av den sentrale tryggleiks- og beredskapsforvaltninga i Noreg i perioden 1999–2002.* Desember 2003.

17-2003 Kurt Brekke, Astrid Grasdal, Tor Helge Holmås, Frode Steen og Kjell Sunnevåg: *Evaluering av ny apoteklov og indeksprissystemet.* Desember 2003. HEB.

No 2002

1-2002 Agnete Vabø: *Mytedannelser i endringsprosesser i akademiske institusjoner.* November 2002.

2-2002 Svanaug Fjær og Liv Johanne Syltevik: *Omsorg, tid og penger for likestillingens frontløpere. Sluttrapport fra evalueringen av reformen for enslige forsørgere.* November 2002.

3-2002 Hege Søreng: *Revitalisering av Stortingets kontrollaktivitet? En studie av oppmerksomhet i Stortinget mot kontroll med forvaltningen 1989–1999.* Desember 2002.

Report **10** 2008

Citizens, Courtrooms, Crossings

Conference Proceedings

In April 2008 scholars from Australia, New Zealand, United States, Spain, Great Britain, Sweden, Denmark and Norway gathered for the sixth Bergen workshop on the history of health and medicine, made possible through funding from the Bergen Research Foundation. This volume contains a selection of the papers presented at the workshop under three different subheadings: *Health and citizenship*, *Medicine in court* and *Travelling knowledge and science*. A number of papers discuss the dynamic relationships between states and their citizens, in a variety of geographical and historical settings, from New Zealand to Norway, in relationship to a broad range of health concerns and health care policies. A second set of papers discusses the multifaceted relationship between medicine and the law, with a particular attention towards forensic psychiatry, related to cases from Norway, UK, and Spain. And a third set of papers discusses the role of organisations, state representatives and individuals in transfer processes, from creolization of medicine in the Danish West Indies in the 18th century to western welfare regimes in the latter half of the 20th century.

The contributors are Teemu Ryymin, Steven King, Ida Blom, Linda Bryder, Judith Raftery, Astri Andresen, Anne Hardy, Runar Jordåen, Àlvar Martínez Vidal, Antoni Adam Donat, Ivan Crozier, Svein Atle Skålevåg, Øyvind Larsen, Arvid Heiberg, Niklas Thode Jensen, Mari K. Webel, Christoph Gradmann and John Stewart.

ISBN 978-82-8095-062-8

ISSN 1503-4844

ROKKANSENTERET · NYGÅRDSGATEN 5 · N-5015 BERGEN · NORWAY
TEL. +47-55 58 97 10 / FAX +47-55 58 97 11 · E-MAIL: POST@ROKKAN.UIB.NO · WWW.ROKKANSENTERET.UIB.NO

www.mastertrykk.no