Narrative of HIS 414 – History of Health and Medicine – Application for Diverse Communities-designation

The history of medicine discipline studies the contested efforts of medical practitioners to gain the authority to define health and illness, and to determine the acceptable range of medical interventions that they can enforce upon persons deemed to be ill. To bring better coherence to my history of medicine course, HIS 414, I organized the inquiry into those contested topics around a narrower thematic focus concerning the interrelationship of medical knowledge and the preservation or disruption of social order, especially in respect to the experiences of historically marginalized persons. For that reason, since its creation a few years ago I always envisioned HIS 414 as a course suitable for the diverse communities "J" designation.

In HIS 414 students evaluate how and why dominant cultures consolidated authority as creators of medical knowledge, and how they marked and marginalized certain types of bodies as "deviant" or "inferior" through professional medical concepts and practice. The class further explores how the designations of some bodies as inherently better than others legitimized and reinforced structural inequalities by making inequality seem a "natural" fact of biology and scientific medicine. Because I center the course around the contested nature of medical authority, I also explore the history of how historically marginalized and vulnerable people challenge and seek to build alternate sources of medical authority. In doing so, historically marginalized persons have reimagined, subverted, and modified the dominant culture's definition of sick bodies and the medical interventions used upon those bodies. In HIS 414 I focus on how these themes have affected the experience of health and illness for several historically marginalized groups. In approximate, descending order of emphasis, the course explores the experience of medical knowledge and practice for women, persons of African ancestry, immigrants to new countries, children, persons in poverty, LGBTQQA and gender non-conforming persons, prisoners, and non-human animals. For purposes of this application I will limit my discussion mostly to the first two groups, though the syllabus will indicate the substantive engagement students in HIS 414 have with each community.

Medical theory and practice and medical institutions as agents in structural inequality

The traditional historical perspective concerning scientific medicine presumes that the scientific method is a privileged, superior, perhaps exclusive approach for understanding the physical world. Better medical outcomes supposedly demonstrate the superiority of scientific medicine when compared to other models for diagnosing and treating illness and maintaining health. Historians invested in this perspective generally argue that scientific medicine practiced by physicians in hospitals and research laboratories came to dominate the medical landscape because its manifestly superior methods and evidence base resulted in better medical practices and better health outcomes. In HIS 414, I introduce students to this traditional historical perspective, but also to two additional theoretical frameworks that are more useful for helping students analyze the role of

medicine in creating and perpetuating structural inequality. Those frameworks are social constructivist and post-modernist theory.

Among historians of science and medicine, "social construction" refers to the set of theoretical tools that help scholars identify and understand the ways in which medical and scientific knowledge are human constructs: beliefs and practices that are embedded in society and therefore reflect the social conditions in which they are made. Post-modernist theory, when applied to the historical study of science and medicine, generally refers to the study of how scientific and medical authority are embedded in and dependent upon language. Constructivist and post-modernist approaches, then, examine how medical authority is a result of political, cultural, and discursive battles fought on unequal political grounds inside of systems of oppression that give favor to some forms of medical knowledge over others.

HIS 414 uses these theoretical tools to help students understand why physicians succeeded in defining lay practitioners from historically marginalized communities as outside the boundaries of legitimate medicine, long before physicians could claim to have access to manifestly superior medical theory or practice. In this move to delegitimize and marginalize other medical traditions, physicians claimed the exclusive right to perform certain medical treatments, generally without regard to informed consent by the patient.

Much of this history is told in HIS 414 through the complex and often contentious relationship between "folk" and "learned" medical traditions. Learned medicine generally refers to medical knowledge and practices gained from formal learning done in credential institutions and rooted in theoretical principles, which typically are used to control and limit persons who can claim membership in the profession. It is, today, virtually synonymous with scientific medicine practiced by physicians who possess terminal medical degrees. Folk medicine, by contrast, is the medicine of experience-based, practical, and locally situated knowledge. Think, for instance, of the popular folk remedies advertising the therapeutic powers of different elixers, or the "medicine man" or woman found in virtually all cultures and eras. From Hippocrates to HIV, students in HIS 414 explore how and why the learned medical community limited its membership to men from the dominant cultural groups, and thereby accumulated great social, economic, and political prestige. With it came great power to marginalize competing forms of medical knowledge and practice, their practitioners, and persons or groups whose bodies became sites for medical intervention and the exertion of professional medical authority. From ancient times to at least the 1880s c.e., folk medicine likely was as or more effective in treating illness as learned medicine, and yet the history of medicine is in large part a history of learned medical practitioners delegitimized the medical knowledge of folk practitioners, and relegated folk medicine to socially and economically marginalized groups.

Employing these theoretical tools allows students to examine how structural inequalities are built and maintained. For instance, among the foremost ways that learned medicine signaled its professional exclusivity and stature was by restricting and eliminating women's access to the profession. The result of this structural inequality in access to

formal medical education, perhaps unsurprisingly, is that physicians increasingly medicalized women's bodies as fundamentally deviant and lesser than men's, which in turn justified additional systems and forms of oppression.

Among the more famous examples that illustrate this dynamic is the history of witchcraft persecution in Europe. HIS 414 analyzes the topic through the lenses of contested medical authority and gender-identity, revealing how professional medical knowledge combined with the legal system to advance the economic interests of physicians against those of women practitioners of folk medicine. Legal records indicate that many, perhaps most witchcraft trials were initiated over disputes about the causes of sickness and/or the prescribed remedies. The stereotypical profile of a witch – an older, unmarried woman living by modest means in a home at the periphery of the community, one filled with cauldrons and vials – is also the profile of a practitioner of traditional folk medicine. A person unable to afford a physician or rightfully doubtful that the physician's theoretical knowledge resulted in better outcomes than the folk practitioner's practical knowledge might seek out the woman for help with an illness. Failure might mean accusations of witchcraft. So too, an illness or death in a family that did not consult with the folk practitioner might also result in the family's physician blaming the death on the witchery practiced by the vulnerable, marginalized woman practicing folk medicine as one of the few sources of income available to older, single women.

The history of smallpox inoculation and then vaccination – a discovery that likely has saved more lives than any other single development in human history – similarly is a story of how learned medicine captured and appropriated folk medical practices in ways that further marginalized already vulnerable and oppressed groups. West African and Middle Eastern folk medical practitioners had known how to inoculate against smallpox for centuries, before an aristocratic Englishwoman introduced it to Europe, where it was at first dismissed as unscientific superstition, before eventually being appropriated by American physicians. Once appropriated, smallpox inoculation served, ironically, as proof of the intellectual and cultural superiority of Western (white, masculine) scientific medicine. We explore similar stories in the histories of midwifery, gynecology, and nursing.

HIS 414's use of post-modernist theory also empowers students to examine the rhetorical and literary tools scientists and doctors use to gain the power to define the "natural." That insight in turn enables students to examine how the exclusive medical authority invested in learned medicine worked to mark historically marginalized groups as different, abnormal, and inferior, and thereby perpetuate systems of oppression. In deconstructing what scientists and physicians mean when they call something "natural," students learn that it often is as much a normative statement as a scientific one. Race, gender, class, region, religion, and able-bodiedness (to name just a few) all inform presumptions of what is "natural," and, therefore, of what it means to be healthy or sick, and how to maintain health and treat illness.

Students learn of how Aristotle famously rejected women as unfit for public life due to their propensity for hysteria: literally a mental and physical illness caused by a displaced uterus.

HIS 414 follows the incredible lasting power of this idea across millennia: Students learn how Philadelphia physician S. Weir Mitchell gained an international following in the 1880s for his theory and treatment of hysteria. Mitchell posited that ambitious, educated women over-taxed their nervous system, and prescribed weeks and even months of complete submission to (masculine, scientific) medical authority and a withdrawal from all intellectual and civic exercises. Reading S. Weir Mitchell's thoroughly misogynistic theories and therapies regarding hysteria through a post-modernist lens helps students identify and understand the discursive tools physicians used to maintain traditional gender norms, to medicalize intelligent women as sick and deviant, and thereby maintain a system of structural inequalities that kept women out of civic life. Mitchell's work only makes sense when read in a social context in which physicians sought to distinguish themselves from popular folk remedies and quacks by textual and therapeutic strategies that emphasized the manly, masculine nature of the physician, in contrast to the feminine qualities of folk remedies and their practitioners. In text and in practice Mitchell presented his treatment of hysteria as an argument for the complete submission of patients to doctors, while signaling that patients coded as feminine and doctors, masculine. The eugenic sterilization movement of the 1890s through 1940s similarly drew on gendered and racial anxieties about the feminization and dilution of while male identity. Eugenicists drew on the cultural authority of physicians and psychologists to mark poor and especially bi-racial persons, and persons who did not conform to the dominant culture's sexual mores, as not just socially deviant, but also medically deviant. This in turn justified the forced institutionalization and/or forced sterilization of hundreds of thousands if not millions of persons in Europe and the United States. I could go on in documenting the content with which we explore learned medicine's complicity in systems of oppression against historically marginalized groups, but the syllabus hopefully suffices.

Marginalized Communities' Modes of Resistance and Negotiation with Medical Authority

Marginalized communities historically have employed a variety of strategies to resist the medicalization of their identities and subsequent claims of medical authority over their bodies. These forms of resistance include challenging the theoretical underpinnings as well as the forms of practice of learned medicine, forming economic and professional associations to advance the interests of folk medical knowledge, and constructing alternative theoretical frameworks and medical practices grounded in other sources of knowledge, often religious and based in the collective wisdom of the marginalized group.

The set of healing practices often described as witchcraft, discussed above, are one example of resistance and negotiation with the dominant medical culture. HIS 414 also gives considerable attention to the creation and growth of Seventh Day Adventism and Christian Science. Both are examples of religions founded by women who had problematic interactions with the dominant medical culture and, in response, turned to the authority of religious revelation, the founders' identities as women, and common-sense folk medical practices to construct alternatives to the predominant religious and medical practices of the time.

Most notable, students read, in their entirety, two of the most famous historical studies of cross-cultural conflict in modern medical practice: *The Spirit Catches You and You Fall Down* by Anne Fadiman, and *The Immortal Life of Henrietta Lacks* by Rebecca Skloot. *The Spirit Catches You* is a "canonical text for burgeoning efforts to impart "cultural competence" to health care practitioners and regularly assigned to entering medical school students, as it illustrates problems for effective communication with patients who come from cultures that are both historically marginalized and that understand health and sickness through cultural perspectives other than scientific medicine.[1] Fadiman documents efforts by a Hmong immigrant family living in southern California as it tries to treat a child's epilepsy through traditional spiritual rituals. The local hospital and child protective services agencies, oblivious to the premises of these rituals and limited in their abilities to communicate with the family, misunderstood the practices, which resulted in a series of decisions that abused their legal and cultural positions of authority over the family, and adversely affected the child's long-term health. The book, however, also shows how both the family and a couple of allies at the local hospital worked to preserve the role of the family's traditional medical practices and even to incorporate them into how the hospital and government agencies worked with the local Hmong community.

In *Immortal Life of Henrietta Lacks*, Skloot recounts the history of an impoverished southern African American woman whose cervical cancer cells were taken without her consent and became the basis for virtually all genetic research in the biomedical industry, ever since. In particular, Rebecca Skloot documents the history of how the Lacks family at first sought control of the intellectual property-rights of their genetic information, and, barring that, at least some form of economic compensation, before settling on a push for proper historical recognition of Henrietta's contribution to medical research. Through *Immortal Life*, students explore how the history of the idea of informed medical consent emerged in the 1960s out of the Nuremberg trials and revelations of Nazi medical testing on concentration camp prisoners, as well as political activism by women and racial minority patients and some allies within the learned medical community.

In exploring historically marginalized communities' efforts to resist non-consensual use of their bodies for medical research, HIS 414 also explores the history of pain, and the efforts by which historically marginalized groups challenged learned medicine's presumption that non-white racial groups, were, like animals, less sensitive to pain than white people and therefore received fewer and weaker pain-killers and more invasive surgeries. (A presumption that, ironically, informs the present Opioid epidemic in white communities: white doctors *still* manage white patients' pain more aggressively than they do for African American patients.) In addition to exploring the issue of palliative care for pain in the history of people of African ancestry in both Europe and the Americas, HIS 414 also looks at the first efforts of HIV-positive individuals and gay-rights activists to organize and demand better treatment of AIDS patients. The examination of pain extends further, to animal rights activists who pursued similar efforts to end medical testing on mammals. Studying first the creation of the anti-vivisection movement in the 1800s and then the effort to end

[1] Janelle S. Taylor, "The Story Catches You and You Fall down: Tragedy, Ethnography, and "Cultural Competence"," *Medical Anthropology Quarterly* 17, no. 2 (Jun. 2003) p. 159.

psychological testing on primates, HIS 414 also explores how women successfully created the SPCA for the purpose of ending live animal dissections, and in doing so challenged the ethical and scientific consensus of academic medical researchers.

Fostering Informed and Reasoned Openness to and Understanding of Differences

My students generally arrive in HIS 414 with opinions about health and medicine that are both strongly held and only modestly understood. Even students who normally recoil at essentialist language are prone to accept what they think are "natural," biologically-based differences in how women and men experience health and illness in the learned medical community. While students bring a diverse set of beliefs about the medical efficacy of prayer, virtually none arrive with sympathetic predispositions to Seventh Day Adventist or Christian Science medical beliefs and practices. Similarly, students from more advantaged economic backgrounds, especially white students, struggle to understand and accept the skepticism that poor rural communities—especially poor rural and predominantly black communities—possess for scientific medicine. Virtually none of my students, at first, show patience or an interest in understanding the origins of anti-vaccination beliefs. I have shown videos of traditional Hmong healing rituals in several of my history courses, and reactions typically range from polite amusement to contempt.

HIS 414 does not attempt to change any student's personal health regimen or medical choices, but it does attempt to help students understand the historical conditions, social contexts, values and perspectives that lead different groups—especially historically marginalized groups—to promote and practice different ideas about wellness. After having studied the history of women's exclusion from learned medicine and persecution of women's folk medical practices, students are positioned to be more open to the curious mix of religious, feminist, and traditional principles that inform Seventh Day Adventist and Christian Science medical practice. Similarly, while I take care to work students through the unrivaled importance and efficacy of vaccines in saving lives and the lack of evidence that would connect vaccination to autism, my students also are able to better appreciate contemporary anti-vaccination groups in the context of nearly three centuries of historically marginalized communities' opposition to learned medicine's efforts to secure compulsory vaccination laws. Anti-vaccination groups look different to students, when considered after spending a semester looking at the efforts of historically marginalized groups to win the right to give informed consent before being subjected to medical interventions. We use both *The Spirit Catches You* and *Immortal Life of Henrietta Lacks* as launching points for in-class exercises where we consider all the historical and socio-economic circumstances that inform each family's distrust of medical science, then pivot to identify other instances where we see the contemporary American health-care system perpetuating inequalities. Finally, we brainstorm all the places where we have seen different communities of historically marginalized Americans pursue a variety of responses to challenge those inequalities.

Informed Action

The professional association for teaching the social studies, the National Council for the Social Studies, recently updated its curriculum standards in order to clarify that pursuing social justice is integral to teaching the social studies disciplines, including history. As the NCSS outlines the process of student inquiry in history, it only is complete when the students arrive at a point where they are able to "take informed action" within their community to address a problem in an evidence-based manner. In my Social Studies Education Methods course, SSC 331, I teach our social studies education teacher-candidates research-tested methods for integrating social justice projects into their inquiry-based curriculum. In efforts to practice the same pedagogical principles that I teach to others, I have added an "informed action" assignment in HIS 414.

In my informed action project, I first ask students to evaluate how their intersectional identities affect their experiences in medicine as patients, consumers, and self-advocates. Students are asked to identify where their own medical beliefs come from and consider how those beliefs relate to the folk and learned medical traditions they study in class. Students then are asked to examine where in their daily media consumption they see expressions of medical authority, and to evaluate the historical and social influences from which that authority is constructed. Finally, students are asked to more precisely identify a medical issue, belief, practice, or attitude they have encountered in one or more of the communities with which they identify, and then identify how that issue fits within our examination of how medicine can either reinforce or challenge systems of oppression and inequality. The assignment culminates with students identifying ways they might work to address this inequality in medicine, and where possible to document steps they have taken to advocate for more equitable and just attitudes and practices concerning health and medicine. This assignment reinforces and draws upon more traditional historical written assignments in my course, which, as the Course Objectives and attached assignment sheets will indicate, all ask students to use the theoretical tools of our course to think about the relationship between historically marginalized people and medical theory and practice.

I always have taught my HIS 414 History of Medicine course as a vehicle for exploring themes of oppression, resistance, and diverse perspectives in medicine. This application is an effort to formalize my teaching of HIS 414 as a "diverse communities" course. I thank you for your consideration and look forward to your feedback.