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ADDRESS FOR CORRESPONDENCE
ADRESSE
J. S. G. Blair,
The Brae,
143 Glasgow Road,
Perth, PH2 OLX,
Scotland, United Kingdom.

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Editorial, Vesalius, X, I 1, 50-51, 2004

Editorial

This is our first communication through the editorial of ***Vesalius.*** Hopefully we will have numerous such opportunities in the future. As you may know via your National Delegates, elections for the Bureau of the ISHM were held in September, during our 39th Congress in Bari, Italy. I had the honour of being elected to serve as President of the Society for the following four years, while Professor Shifra Shvartz from Israel and Dr. Pedro Chiancone from Chile were elected Vice-Presidents. Hence, I feel the need to share some thoughts about the Society, the History of Medicine and several forthcoming events with you.

First of all, I would like to express my gratitude to the current President, Professor Jean-Pierre Tricot, for his efforts in running the Society during his four years of office. I realize the strong personal commitment required for the successful fulfillment of such a task. The same feelings are expressed towards another two of my predecessors, the Honorary Life President of the Society Dr. John Cule and the previous President, Prof.Ynez O'Neill. Due to their combined efforts, as well as those above, as well as those of all the members of the Executive Board, our Society continues to thrive. The General Secretary Dr. Philippe Albou is the efficient engineer who keeps the wheels of ISHM turning smoothly, while the Treasurer and the Assistant Treasurer, Prof. Alfredo Musajo-Soma and Prof. Cynthia Pitcock respectively, secure the financial status of the Society.The work of Drs. David Wright, Alain Lellouch and John Blair, editors of ***Vesalius*** also deserves special mention.Through their labours our Journal is steadily improving. I thank them all.

Although we revel in the study of the past, we now have to face the challenges of the future. The fundamental questions we ask ourselves during various *rites de passage* (entering adulthood, starting married life, changing jobs, at the beginning of each new year or just reading a newly elected President's address), remain the same :Who are we, what are our goals and how are we going to achieve them ? I will try to give some - incomplete - answers merely as stimuli for your own thoughts.

We are a multinational community of cultured adults, with a medical mainly background, although there are welcome exceptions from the fields of History, Ethics and Sociology. Most of us as are at least middle-aged - although, happily, the younger generation is also represented. Naturally, all of us share an interest in the history of medicine. But why ? Some continue the time-honoured tradition of the doctor-gentleman-collector who, as the epitome of the upper middle class, contributed thus to general education and enlightenment. Others find in the History of Medicine a stronghold to support the love for their homeland, their university or their hospital, while a minority uses the field to gain a living and promote their academic interests as full-time historians and/or ethicists of the caring professions. In practice, everyone in the Society is a mixture, in varying percentages, of all three categories because we believe that apart from its aesthetic value, the Society acts as a hot house for ideas on medicine.

What then are our goals ? A single answer covering the whole range of interests of the various groups within the ISHM, scattered as it is in five continents, is almost impossible to find. However, a common dream is the spread of knowledge about the past of our profession to as wide an audience within the biomedical community as possible and, simultaneously, the proliferation of serious research on the subject. But how we are going to achieve these ? I am afraid I do not have a miraculous solution. Being an historian of Medicine I shall only suggest some old home-made recipes.

The first is to persist in our love for the subject.We need to continue the unselfish pursuit of our dream. A second guideline is the adherence to an objective historical methodology. Although I realize it is an oxymoron to speak of History and Objectivity in the same sentence, I still think that we have the obligation to suppress the urge to "prove" that our national medicine was historically the best, the most scientific, the most humanistic and suchlike.This tendency to claim historical "orthodoxy" on biomedical matters is not an exclusive characteristic of the romantic gentlemen doctors and their nostalgic approach. It can be equally strong amongst the new breed of progressive "pure scientists" in the medico-historical field, who thus try to establish a niche for their profession. If we want the voice of the Society to be heard by medical unions, academia and policy-makers, we should show a satisfactory degree of objectivity.

The last remedy in my suggested therapeutic trilogy is to continue building amicable relations between all of us. The sincere appreciation of all members and their ability to assist is of vital importance. Each of us contributes in their way. Sharing the same goal is a permanent source of encouragement. I understand that many other ways may be suggested to promote our goals and I will be happy to hear any new ideas via the correspondence pages of ***Vesalius,*** snail mail and e-mail or through participation in various fora.

Concluding my address, I am pleased to invite all of you to the forthcoming 3^{d} International Meeting of the Historians of Medicine which will take place in my hometown, Patras, Greece, from the I Ith to the 14th of September 2005. More details are published in another page of this issue of ***Vesalius.***

Ass. Prof.Athanasios Diamandopoulos,
Nephrologist -Archaeologist
President Elect, ISHM.

Editorial, Vesalius, X, I I, 50-51, 2004

Editorial

C'est la première fois que je communique avec vous, via un éditorial de ***Vesalius.*** J'espère qu'une telle occasion s'offrira encore à moi, dans l'avenir. Comme vous devez le savoir, grâce à vos délégués nationaux, un nouveau Bureau de la SIMH a été élu, en septembre dernier, pendant notre trente-neuvième congrès international de Bari, en Italie. J'ai eu l'honneur d'être élu président de la Société pour les quatre années qui viennent tandis que le professeur Shiffra Shvartz d'Israël et le Dr. Pedro Chiancone du Chili ont été élus vice-présidents. Je ressens désormais le besoin de partager avec vous quelques pensées concernant notre Société, l'histoire de la médecine, en général et plusieurs événements prochains, en particulier.

Tout d'abord, je voudrais exprimer ma gratitude au président sortant, le professeur Jean-Pierre Tricot, pour les efforts qu'il a déployés durant ses quatre années d'exercice. Je réalise combien a dû être fort son engagement personnel en vue de l' accomplissement réussi d'une telle tâche. Les mêmes sentiments sont exprimés envers deux autres de mes prédécesseurs, le président d'honneur de la Société, le Dr.John Cule et la précédente présidente, le Pr.Ynez O'Neill. Grâce aux efforts combinés des personnes que je viens de citer et grâce aussi aux membres du Bureau exécutif, notre Société continue de prospérer. Le Dr Philippe Albou, secrétaire général est l'ingénieur efficace tenant les roues d'une Société internationale qui doit tourner sans à-coup, tandis que le trésorier et le trésorier adjoint, respectivement, les professeurs Alfredo Musajo-Somma et Cynthia Pitcock garantissent le statut financier de notre organisation. Le travail des Drs David Wright, Alain Lellouch et John Blair, rédacteurs de ***Vesalius*** mérite également une mention spéciale. Grâce à leurs efforts, notre journal s'améliore constamment. Je les remercie tous.

Prendre plaisir à l'étude du passé ne doit pas empêcher de relever les défis du futur. Les questions essentielles qui nous sont posées pendant les divers « *rites de passage* » que nous traversons au cours de notre vie (entrée dans l'âge adulte, début de la vie conjugale, changement de travail, au début de chaque nouvelle année ou, simplement, lors de la lecture du discours d'un président nouvellement élu), restent fondamentalement les mêmes : Qui sommes-nous ? Quelle est la finalité de notre Société et comment allons-nous nous y prendre pour atteindre les objectifs que nous nous sommes assignés ? J'essayerais de donner quelques réponses, bien sûr incomplètes, à ces questions, surtout pour stimuler vos propres pensées.

Nous sommes une communauté multinationale d' adultes cultivés avec, derrière nous, une formation principalement médicale, même si quelques uns d'entre nous constituent d'heureuses exceptions qu'il nous faut accueillir chaleureusement, en provenance des champs de l'histoire, de l'éthique et de la sociologie. La plupart d'entre nous ont déjà atteint le milieu de leur vie - même si, heureusement, une génération plus jeune est également représentée au sein de notre Société. Naturellement, nous partageons tous le même intérêt pour l'histoire de la médecine. Mais pourquoi ? Certains continuent la tradition des *«docteurs-gentilhommes-collectionneurs»,* quintessence d'une classe sociale, la grande et moyenne bourgeoisie. Ces médecins cultivés contribuent à l'éducation et à l'instruction du grand public éclairé. D'autres trouvent dans l'histoire de la médecine un moyen de défendre l'amour qu'ils témoignent à leur patrie, leur université ou leur hôpital. Une minorité utilise le champ de l'histoire de la médecine comme moyen de gagner sa vie et d'être promu au plan universitaire, comme historien ou comme éthicien plein-temps des professions de soins. En pratique, chacun d'entre nous constitue dans la Société un mélange alliant, dans des proportions variables, ces trois catégories d'historien de la médecine. En effet, nous croyons qu'en plus de son utilité esthétique, la Société agit comme une serre chaude, aidant à mieux faire pousser les idées sur la médecine.

Quels seront donc nos objectifs? Vouloir donner à cette question une réponse univoque est impossible. Il est bien difficile de pouvoir prendre en compte la totalité des intérêts qui se manifestent dans les divers groupes internes de la SIHM, dispersés dans les cinq continents de la planète. Cependant, un rêve nous est commun diffuser, au sein de la communauté biomédicale, les connaissances consacrées à l'étude du passé de notre profession et, dans le même temps, développer des recherches sérieuses sur ce sujet. Mais comment parvenir à réaliser ces objectifs ? Je crains de ne pouvoir offrir des solutions miracles. Historien de médecine, je ne ferais que suggérer quelques vieilles recettes domestiques.

La première de ces recettes consiste à persister dans notre amour du sujet. Nous avons besoin de poursuivre ce grand rêve altruiste. Une deuxième recommandation est de s'en tenir à une méthodologie historique « *objective* » . Je suis bien conscient que combiner dans une même phrase les mots d' « *histoire* » et d' « objectivé » peut paraître contradictoire, à la fois « *piquant* » et « *absurde* » (« *oxymoron* ») .Je pense cependant qu'il nous faut, de façon urgente, cesser de vouloir « *prouver* », de toutes nos forces, la supériorité de notre médecine nationale : elle serait historiquement la meilleure, la plus scientifique, la plus humaniste etc. Ce mode de pensée historique « *orthodoxe* », clamé dans nombre de sujets biomédicaux, n'est pourtant pas l'apanage exclusif des médecins cultivés, (nos romantiques « *gentlemen-doctors* ») et de leur approche nostalgique du passé. La pensée historique « *orthodoxe* » sévit tout aussi fortement au sein de la nouvelle espèce née du champ médico-historique, les « *scientifiques purs* ». Trop souvent, ces derniers entendent défendre une place au soleil pour leur profession. Si nous voulons que la voix de notre Société soit entendue par les syndicats médicaux, dans le milieu universitaire et par les politiques-faiseurs d'opinions, il nous faudra montrer un degré d'objectivité satisfaisant.

Le dernier remède que je suggérerais dans cette trilogie thérapeutique est de continuer entre nous à construire des relations amicales. L'appréciation sincère de tous nos membres et leur capacité d'aide est d'une importance primordiale pour la vie de la Société. Chacun de nous y contribuera à sa façon. Partager le même but est une source permanente d'encouragement. Je sais que bien d'autres moyens peuvent être suggérés pour promouvoir notre but. Je serai donc à l'écoute de toutes les nouvelles idées qui pourraient être proposées, que celles-ci émanent du courrier des lecteurs de ***Vesalius,*** qu'elles proviennent de vos lettres et courriels , ou encore qu'elles résultent de votre participation à divers forums de discussion

Je conclurai cet éditorial : je suis très heureux de vous convier à la 3eme Réunion Internationale des historiens de la Médecine. Elle se tiendra dans ma ville natale, à Patras, en Grèce, du II au 14 septembre 2005. Plus de détails vous sont donnés dans les pages qui suivent ce numéro de ***Vesalius.***

Prof.Ass.Athanasios Diamandopoulos,
Néphrologue -Archéologue.
Président élu de la SIHM.

Medical History for the Medical Student, Vesalius, X, I I, 52-54, 2004

Medical History for the Medical Student

John Cule

Summary

The modern medical student is necessarily heavily burdened with instruction in Medical Science.When the teaching of Medical History is added to the university course, it is first necessary to stimulate student interest in that discipline and show its clinical relevance.

Résumé

L'esprit de l'étudiant en médecine d'aujourd'hui se trouve lourdement surchargé par un volume considérable de connaissances médicales et scientifiques nouvelles qu'il lui faut acquérir. Si l'enseignement de l'histoire de la médecine est ajouté, en plus, au cursus universitaire de cet étudiant, il faut avant tout stimuler son intérêt pour cette discipline et lui en démontrer la pertinence clinique.

The number of specialist disciplines in medicine and surgery today grows with exponential increase. Patients may be sent from department to department in search of someone else believed to know more about their illnesses. It has been likened to care by a committee without a chairman. In order to appreciate current reality the student needs a balanced view of the history of medicine and surgery. Active treatment is not always desirable. Heroic surgery has been replaced by heroic chemotherapy. The student needs to learn that medical treatment is ephemeral: its dangers may be worse than the disease.

The nature of the patient's dependence on the doctor has changed. The growth of a technological medicine, extending beyond strictly clinical medicine, has led to a new sort of medical practitioner; a medical scientist often not holding a clinical medical degree. Such practitioners make an essential contribution to diagnosis and treatment, but without a personal social function in relation to the patient. In teaching medical history to the medical student, this needs to be evaluated. An ethical dilemma exists when the ability to diagnose or predict the possibility of serious disease precedes the ability to treat it.

To medical students, at the outset of their years of medical education, the status quo seems an enduring reality. Medical history reveals that this is not true. What we are looking at in the present is not something which was, and is, and shall be evermore. Our forefathers' time was their own present. Acceptance of its dogma was just as easy to them as belief in the natural order of things. The contemporary climate of opinion influences behaviour.

Confidence in the doctor brought and brings comfort to the patient. Empiricism does the same for the doctor. Before the cause of a specific disease was known its treatment remained empirical. Students learn from history the temporary nature of a panacea. Osier said "Give the medicine now, whilst it is still curing".

The strengths and weaknesses of empiricism in medical and surgical practice are reflected in the relief of symptoms, which is synonymous in the minds of many patients with the cure of disease.

Reported "discoveries" of medical "cures" still provide popularised data of varying accuracy. The call for "evidence based medicine" seeks to displace the old empiricism. Patients are encouraged to question any disliked diagnoses and to threaten financial penalties for treatment failures. Increased caution has fostered the growth of "defensive medicine", with its own dangers; Medical History helps perspective.

Doctors had been wrongly regarded as comfortingly omniscient by a generation of patients living at a time when there was less understanding of the nature of disease. The doctor's experience brought comfort in personal relationships. Competence was sought in the search for a recognisably"safe doctor" as a requirement before registration to practise; a commendable but unachievable aim.

The patient has always sought the quality of experience in his medical adviser. But the wisdom of the clinician is not in that of his own experience alone; such an isolated learning process can be expensively acquired from its punishing mistakes. The most important lesson of experience may be that of the recognition of probability. John Locke (himself physician to the first Earl of Shaftsbury) said that this lesson "supplies the defects of our knowledge and guides us when that fails and is conversant about things of which we have no certainty".

It is the quality that supports the comfort of "the tried remedy", but it may have a spurious claim to be evidence based. Yet, if the doctor does not prescribe his own remedy confidently, the patient will seek solace elsewhere.

What constitutes evidence? It was Eric Freeman, when Librarian and Director of the Wellcome Institute, who first alerted me to the apparently cynical, but realistic view that "History is not what happened, but is what is written about what happened".

Credibility is a necessary but difficult concept, requiring experience and understanding of probability. A

common difficulty of assessment, well known to the clinician, is the unpredictability of human behaviour.This needs teaching in the history of medicine. The instinctual reactions inherited from Neanderthal Man influence us more than that learned from the Greek civilisation.

How much historical writing need students do themselves? Writing medical clinical histories is not unlike writing medical historical essays. As an exercise it should improve student literacy, not always evident when a university career begins.

The clinical account begins with past and present signs and symptoms, the social background and anything of family relevance. Case records are thus made in historical terms. The primary source is the patient. "Listen to the patient. He is telling you what is wrong"!

Primary sources in the history of medicine are sought in personal or original documents in the history of medicine. Confirmation or refutation is tested by comparison with other relevant contemporary documents.

The clinician considers a differential diagnosis. The prudent doctor will refer to what has been written about the subject in the journals, testing theses and diagnoses against the views of colleagues. Scientific tests confirm or refute the diagnosis. Academic historians also seek evidence from laboratories and technical specialists. Medical students are already burdened with the task of learning the vast amount of clinical and technical information necessary to teach them the care of patients. The ability to interest students is of the greatest practical importance in a crowded curriculum. A medical history course should show the student its relevance for a medical or surgical career. It may restore neglected ideas of holism and universitas.

We should not be concerned in training the medical student as a specialist medical historian. The value of Medicine being concerned with humans and the ills that befall them, it is not surprising that for many of us the pleasurable introduction to history has been via biographies. The narrative form is the usual style, of which AL Rowse says "first rate biography will lead you straight into the atmosphere, the thoughts will give you the very pulse of the period."

Biography can be used imaginatively in the medical curriculum to illustrate, in an interesting and easily remembered manner, the health care of a period, the signs and symptoms of an illness of one of the characters, as well as the importance of a therapeutic discovery. Heroes remain memorably attractive despite the dread criticism of veneration by hagiography.

A study of the history of Scientific Medicine reveals that what is now known as Alternative Medicine has close similarities with an earlier empirical stage in the development of Modern Medicine. Explanations of the nature of disease govern diagnostic methods.

Improvements in diagnosis anticipate improved treatment. Even so, herbal medicine played an important historical place in the development of pharmacy.

The patient is the common factor in all medical and surgical care and the tradition of listening and taking a clinical history extends from Hippocratic times. Kindly naturopaths and aroma-therapists were not the begetters of *caritas.* An intelligent interest in the history of medicine can alert the medical student to cultivate wisdom and remember to "comfort always". Scientific technology is guiltless of the charge of dehumanising a medical concept of the patient.

In practical terms the medical student should be taught the basic rules of writing a medical historical essay. My own teacher, the late Professor David Williams, Professor of Modern Welsh History at Aberystwyth, was a great communicator. His simple advice for historical writers was to start at the beginning, finish at the end, include no error and acknowledge your sources. To do the last, one must keep accurate notes of what one reads. The thoughts of others may rapidly become regarded as one's own. To state them as one's own was regarded by David Williams as the unforgivable historical sin.

The student needs to learn of the perils in the interpretation of historical writing. Eric Freeman's warning, which I have already given, bears repetition. " History is not what happened, but is what is written about what happened"; revised by Alan Bullock, in his Leslie Stephen lecture at the University of Cambridge in 1976, "History can only in truth be how people today interpret what people have written about what has happened in the past". This admonition needs also to be observed by the medical student in interpreting case notes written by others. Historical and clinical method requires the discovery of truth, which needs an understanding of experience, not limited to one's own.

Clinical medical historians have an ally in Bullock. He warns of the dangers of looking at the past "in ways similar to those in which social scientists look at contemporary society." And in social science he includes "anthropology, ethnology, sociology, economics, statistics, demography, social psychology, even psychoanalysis". The relevance of his criticism is understood by both the clinician and the clinical historian.

Bullock then continues that "most historians ...find no difficulty in discriminating between the solid

achievements of historical demography on the one hand, and the inflated claims of psychohistory on the other".

Contemporary medical historical writing and clinical practice provide examples. The historian Elie Kedourie feared that eventually "the efforts of the historian would be directed toward making history into a kind of event-free social science, the task of which is to discover the norms of human behaviour".

In relation to the introduction of statistics and numeracy into historical accounts, Bullock quotes Robert Fogel:

"by all means count when counting is possible and useful", but adds Arthur Schlesinger's caution "almost all important questions are important because they are not susceptible to quantitative answers".

In clinical practice it is difficult to quantify illness, or to predict the outcome of illnesses with anything more than probabilities.

Bullock appreciates the importance of "the irregularities as opposed to the regularities of history, the discontinuities as opposed to the continuities. The accidental and the unforeseen have to be taken into account".The clinician is well aware of similar pitfalls in anticipating human responses.

It is important, for those now teaching medical history, to tell students how doctors of the past cared for their patients: of their having to make decisions, of life-long consequence to the patient (sometimes resulting in immediate dramatic death) on very inadequate evidence.

In summary and in conclusion; medical students should be given the opportunity to appreciate the continuing possibility that some new discovery may yet destroy the most cherished current teaching as it often has in the past. They may best learn this from those clinicians who themselves can appreciate the value of historical perspective.

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Dr John Cule Is Honorary Life President of the International Society of the History of Medicine and Founder Editor of Vesaiius. This paper was given as a master lecture in the Faculty of Medicine at the University of Bari as part of the 39th International Congress on the History of Medicine.

The editors would be interested to hear comments, both from teachers and students, on the philosophy of teaching which this article raises.

Encouraging debate on this subject (and any other subject) is stimulating for us all and is something that we are keen to develop in Vesaiius.

From L: Dr J Blair, Dr J Cule, Prof A Musajo-Somma

Renkioi: A Forgotten Crimean War Hospital and its Significance

CP Silver

Summary

Renkioi Civil Hospital was built late in the Crimean War (1854-6) in Turkey on the Dardanelles. Designed by Isambard Kingdom Brunei, its prefabricated structure was a brilliant engineering innovation. As a civil hospital for military patients, it was staffed by experienced civilian doctors, thereby relieving the shortage of military doctors.

Renkioi is remembered as an astonishing early prefabricated structure. However the war was soon to end and it was never used to near capacity.Thus, its other successful features are largely forgotten. It demonstrated the advantages of a doctor, rather than a military officer, being in complete command of a hospital and this was later accepted by the army. Renkioi also showed how infection could be reduced by able staff in a well administered, properly designed hospital with good sanitation. After the war, Dr Edmund Parkes, its Medical Superintendent, became the first Professor of Hygiene at the new Army Medical School, ensuring that "the prevention of disease and the promotion of health" became the first function of the Army Medical Services.

Résumé

L'hôpital civil d'Erenkoy a été construit en Turquie, dans les Dardanelles, peu avant la fin de la guerre de Crimée (1854-1856). Sa structure préfabriquée marqua les mémoires. Cette brillante innovation technique (la première du genre) fut l'oeuvre d' Isambard Kingdom Brunel. Comme il s'agissait d'un hôpital civil destiné aux patients militaires, on y plaça des médecins civils, dotés d'une bonne expérience et capables de remédier au manque de médecins militaires.

Pourtant, la guerre touchant à son terme, les ressources de l'hôpital ne furent jamais pleinement utilisées et on oublia vite les autres qualités de cette institution qui méritent pourtant d'être rappelées. C'était un médecin et non pas un officier militaire qui dirigeait l'hôpital - un indéniable avantage que l'armée finit par reconnaître. Erenkoy apporta ainsi la preuve qu'un personnel compétent, travaillant dans un hôpital bien conçu, judicieusement administré et respectant les règles d'hygiène était à même de lutter efficacement contre les infections. Après la guerre, le docteur Edmund Parkes, fort de son expérience acquise en qualité de responsable médical d'Erenkoy, fut tout désigné pour devenir le premier professeur d'hygiène de la nouvelle Ecole médicale de l'Armée. A Erenkoy furent ainsi instituées «la prévention des maladies et la promotion de la santé» deux fonctions premières des services médicaux de l'Armée.

Renkioi Hospital, existing during the second half of the Crimean War (1854-56), is now almost completely forgotten save in one respect. It was the work of Isambard Kingdom Brunei, the great Victorian engineer. He designed it as one of the first large prefabricated buildings and arranged its transport and erection in Turkey, an extraordinary and rapidly completed engineering feat. Over the course of eight months, 23 ships carried I 1,500 tons of hospital parts to be erected on the shores of the Dardanelles, near the town now known as Canakkale: the first ships arrived on May 8th 1855.

The civil hospital had skilled experienced civilian staff but military patients. It was first proposed in the darkest days of the war, January I855[12], to relieve the strains on the army medical services exposed by the disasters at Scutari. It was made up of huts, each a ward for 50 patients, and could be extended indefinitely, eventually becoming large enough to take 1500 patients.

With its skilled medical staff, it was seen as additional to, or replacing a base hospital. Such intentions were appropriate in January 1855, but by the time the hospital opened, beds for convalescence were the greatest need. Far from the Crimea and never fully accepted by the army medical services, it remained underused. In all 1408 patients were admitted, with 642 the largest number in hospital at any one time. Only as the Redan fell and the siege of Sevastopol was over did the hospital become fully operational. Fighting died away that autumn and the war ended before the hospital could take its place as an important military hospital of the campaigns[3].

The Report[4] by Dr Edmund Parkes, the Medical Superintendent, which included a supplement by Brunei, comprehensively covered the medical aspects of the hospital, but most subsequent accounts have concentrated on the engineering and architectural achievements[58]. The "Wooden Hospital" was the third large prefabricated scheme to be undertaken and was entirely built of wood, unlike the glass and iron of the previous giant prefabricated constructions, the Great Exhibition of 1851 and Paddington Station, opened in 1854. It was an industrial building, prepared off-site in England and then assembled after a journey of 3000 miles. In 1861, after the start of the American Civil War, Florence Nightingale was asked for help by the American Government to which she responded[9]. Details of Renkioi must have been sent, for prefabrication as a building method in hospitals was used by both sides[10], and since then prefabrication has become a common building practice.This was to be Renkioi's most important legacy. However, there were other successful innovations of medical and military significance which deserve attention.

After the war, a Royal Commission" studied the disaster caused by disease rather than by battlefield casualties. It was a meticulous investigation, under the chairmanship of Sidney Herbert, Secretary of State for War, which owed a great debt to Florence Nightingale and those associated with her for its pertinence and its important consequences. Concerning the "civil element", only Renkioi received much attention and the verdict there went no further than the evidence presented by Sir John Hall, Inspector General of Hospitals, the most senior medical officer at the "seat of war". It was his responsibility to direct patients to Renkioi, but in all other ways the hospital was independent and Dr Parkes, reporting to the War Office, bore the whole responsibility for it. Hall's evidence was confined to his adverse view of the value of Renkioi. He thought the Civil Hospitals very expensive and that Renkioi was built too late, when upwards of 3000 empty beds were available elsewhere, and that it was too far from the Crimea. Hall was strongly averse to the civil hospitals but this summary is not unfair[12].

From the military viewpoint, Renkioi was adjudged a failure and, with the war over, little further reference to it was made.Yet Renkioi must have been freely discussed at the Commission, which was made up of influential people[13] and it had lessons for those who listened.The War Office, with Sidney Herbert, the Minister and, in particular, Benjamin Hawes, the Under Secretary, (Brunei's brother-in-law), knew every detail of the hospital. The Report of the Commission ends with a note from Andrew Smith, Director-General of the Army Medical Department, dissenting from the Commission's conclusions over three matters, one of which was the command of a military hospital. Smith preferred the arrangement which had been uniquely demonstrated at Renkioi, of a doctor in complete charge. The Renkioi arrangement was accepted by the army much later and the command of a hospital passed completely to a medical officer.[M]

Renkioi demonstrated, by its example, the advantages of an up-to-date, properly designed, well administered hospital. At that time, permanent military hospitals on British soil were little better than Scutari, though not under the same duress.The excellence of Renkioi Hospital, which had been visited by Stafford and Sutherland, both members of the Commission, contrasted with the nuisances at the permanent army hospital at Fort Pitt, Chatham. These had been very adversely reported upon by Andrew Smith in 1843, but were unchanged at the time of the Commission. Acceptance of that standard had resulted in catastrophe at Scutari.

Renkioi's worth was also well-known to another member of the Commission, Sir James Clark, who had played a major part in commissioning the hospital. Florence Nightingale, not herself a member of the Commission, though submitting written evidence, never visited the hospital but referred to those "magnificent huts" at Renkioi[15]. Five Renkioi huts were diverted to Scutari and this must have allowed her to make her comment first hand. The many witnesses at the Commission, among them Parkes himself, who had the ear of the medical profession, had ample opportunity to discuss Renkioi amongst themselves. At Renkioi medical staffing was organised as in a civil hospital and difficulties which junior doctors experienced in military hospitals, under the orders of seniors whose duties were administrative and who had ceased to have direct care of patients, did not arise. Visible reminders of Renkioi were the patent siphoning water closets which had been shipped back from Renkioi and which were soon installed in the new military hospital at Netley[16].

Intended as a temporary hospital only, Renkioi Hospital was purpose built. By contrast, the general hospitals in the Crimea, the base hospitals at Scutari and the Civil Hospital at Smyrna, relied on old, converted buildings, often augmented by tents or later huts; these were smaller than those at Renkioi. Overcrowding was frequent and sanitary conditions appalling. As the war continued, conditions in these hospitals, at first so bad, improved greatly and death rates, when Renkioi and Scutari were simultaneously open at the end of the war, would have been about the same and low[17], had not patients with cholera been admitted to Scutari. It is quite wrong to compare, as has been done more than once, the very high death rate during the first winter of the war at Scutari, with that at Renkioi at the end of the war.

Even in comparison with civil hospitals, Renkioi possessed advantages. One hundred and fifty-four civilian hospitals and dispensaries had been founded in England, Scotland.Wales and Ireland between 1700 and 1825 and in many the buildings had, by the time of the Crimean War, been in use for at least fifty years[18]. A thorough survey of British civilian hospitals, undertaken in I860-63[19], emphasized the value of ventilation - especially ventilation - drainage, cleanliness and space, much as Brunei had done. Many hospitals were considered satisfactory, especially in London, but a number of provincial and rural hospitals, particularly those with water supply from wells, water closets at the corner of a ward and cesspits, fell short of the standards set at Renkioi. At Renkioi, the only ward design features called into question were the absence of a lobby outside the water closets, (made less necessary by their modern design), the desirability of increasing ventilation by making use of the roof ridges, (an improvement introduced in the larger huts of the American Civil War hospitals), and beds arranged in two

rows, not four. The system of forced ventilation which Brunei installed was however never used or needed in Turkey.

Brunei's buildings represented the best practice of the time and Parkes found them entirely satisfactory. Though intended to be temporary, Renkioi was a modern hospital representing a big advance in design. Brunei's guiding principle was to ensure the comfort of the soldier patients. He showed an extraordinary grasp of the situation, knowing that the burden of sickness far exceeded that of caring for the wounded. It is not known from which medical authorities he sought advice[20], though he was in close touch with Dr Parkes. Brunei's brother-in-law Benjamin Hawes, as Under Secretary of State for War, had access to every sort of official information. Brunei's proposals were in accord with the views that Florence Nightingale expressed in her book," Notes on Hospitals", which was, however, not published until after the war. He knew the importance of diarrhoeal diseases and his provision of water closets of the latest design was a striking example of his foresight.

The three great groups of illness during the campaign were diarrhoeal diseases, cholera, (so specific as to be classified separately), and fever, with scurvy always in the background. Diarrhoea was a universal scourge and diarrhoeal diseases caused the highest overall mortality even without cholera, a terrifying diarrhoeal disease which was regarded as 'the most fatal disease known in the annals of medicine'. To deal with all these circumstances Brunei had insisted upon a good water supply, effective sanitation, ventilation, proper cooking facilities, and warmth and shelter in clean surroundings but, unfortunately, meeting some of these strict requirements also determined the site of the hospital. An ideal site could only be found, not on the Bosphorus as had been hoped, but far from the battlefield, at best 72 hours from the Crimea, so that the military effectiveness of the hospital was reduced.

The buildings at Renkioi were set out on a pavilion plan, with single storey buildings separated by ample space, the plan which was soon to become the favoured disposition of hospital buildings. At that time, only the Royal Naval Hospital at Plymouth, (1764-65) had been built on this plan, which allowed the free passage of air past buildings and encouraged their ventilation, circumventing the miasmatic or primarily atmospheric spread of disease, then considered the most likely manner of spread of many diseases. Renkioi preceded the next British hospital built on the pavilion plan, the Blackburn Infirmary (1858). The water supply, completely uncontaminated and allowing up 30 gallons (136 litres) per head each day, was brought by earthenware pipes from springs high in the hills[21].Taps and running water and a little hot water available in the wards meant that the staff could wash their hands easily, patients could wash or be washed, while efficient laundries ensured clean linen. Soyer stoves were installed in the kitchens and kitchen practice was transformed by a liberal water supply. Renkioi was the first overseas military hospital to have modern sanitation with siphoning water closets, the same principle used today. On disembarkation, patients were carried on horse-drawn trolleys on a rail track to the wards, obviating all the difficulties experienced elsewhere.

The hospital had a very capable medical staff and was well administered. These favourable circumstances must have had a significant effect upon infection, making its contraction in hospital less likely and hastening recovery. The Times reported that "there has been no epidemic, no spreading of disease from bed to bed, no case of indigenous disease"[22]. The most common illnesses were fevers and it was apparent that few of the hospital staff caught infectious diseases (in comparison, for instance, with the staff at Smyrna [23]). Among the staff, there were three cases of typhus, a doctor, a nurse and an orderly; the orderly died. Without knowing of its transmission by lice, Parkes recommended that patients with typhus should be isolated[24] and, that on steamers with typhus about, knapsacks should be separated from their owners. Isolation had a value, but more effective must have been the baths for patient in the ward, together with the drying cabinet in the laundry reaching 400° F, for clothing often swarming with lice. Diarrhoeal diseases were common; Brunei sent instructions to be displayed by the water closets, (which were often unfamiliar to their users), to forbid rubbish being thrown down them, a common occurrence elsewhere. Discipline, despite Renkioi being a civil hospital, was good and these instructions would have been obeyed. Hall, on his way back to England in July 1856, noted that all but two of the patent WC.s at Scutari, installed on the instructions of the Sanitary Commission, were out of order[26]. In the previous November, an epidemic of cholera had occurred at Scutari among troops stationed in the east wing of the hospital buildings and the outbreak was attributed to cholera in nearby villages: 138 died including several of the hospital staff. The cause of cholera was as yet unknown, though the possibility that the disease could be waterborne was beginning to be considered. At Scutari, the water supply was considered satisfactory. There was never cholera at Renkioi, but had there been, in view of the excellent sanitary arrangements, would the staff there have escaped infection?

Only one death was due to wounds and surgical patients accounted for rather less than one quarter of all patients at Renkioi. Spencer Wells, Senior Surgeon and later a pioneer of abdominal surgery, was very concerned

with cleanliness and the spread of disease [27,28]. Erysipelas and pyaemia, easily recognised complicating features of wound infection, were unusual and treated by isolation; this practice was not always followed elsewhere.

Besides moving towards cleaner, if not aseptic surgery, Wells used bulldog clips at Renkioi to control haemorrhage; from these he later developed the Spencer Wells forceps, still in use today[29].

Renkioi has two other reasons for being remembered, one conjectural, the other undoubted. The first concerns cremation, just coming to the fore in Britain because of scandals arising from the lack of space for burials in increasingly overcrowded cities. Dr Parkes, commenting on the giant burial grounds close to Renkioi, on returning to England, put forward the merits of cremation as a method of saving space in great cities[30]. Spencer Wells, the Senior Surgeon, later President of the Royal College of Surgeons of England, became one of cremation's greatest advocates. William Eassie, Assistant Engineer at Renkioi went further, later becoming the first Secretary to the Cremation Society.These three influential men were only too aware of shallow Turkish graves, hasty burials on the battlefield, and the common sight of dead horses and cattle left by their owners at the roadside.Though this can only be conjecture, the idea of cremation on a greater scale may have come from their proximity to Troy and their awareness of the burning of the dead in the Ancient World. The hospital itself was perceived as close to Troy though the exact site ofTroy was yet to be established[31].

Renkioi has one further reason to be remembered, in its undoubted influence on the subsequent career of Dr Parkes, its Medical Superintendent. Parkes, exceptionally gifted, was, early in his career, an army medical officer in India and Burma. On leaving the army, he soon became Professor of Clinical Medicine at University College Hospital, London. Renkioi gave him the opportunity to create an enormous hospital overseas, to exercise administrative skills, and to learn something of the wider world of government, all of which fitted him for his next move. After the war the Royal Commission recommended the establishment of an Army Medical School and in Dr Parkes was found the ideal first Professor of Hygiene. He went on to become a world authority on hygiene and his career at the School ensured that, "the prevention of disease and the promotion of health" became the first function of the Army Medical Services[32], the most fundamental change in their history. After Parkes' death in 1876, Florence Nightingale was to say of him, when referring to his work at the Army Medical School, that' he was the mainspring of that watch'[33].

The story of Renkioi is one of enterprise and excellence; had the early horrors never lessened and the war continued, Renkioi, instead of being forgotten, would have been an outstanding success. Macleod.a Civil Surgeon though not at Renkioi, wrote, "I have no hesitation, in saying, it is a very great loss to the advancement of surgery, that this war has so soon come to a close"[34]. The same could have been said about Renkioi.

Acknowledgement

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Department), Thomas Alexander, (a serving medical officer who followed Andrew Smith as Director General but died soon after taking office), Sir John McNeill, (Surgeon in India, Diplomat, Chairman of the Supplies Commission. 1855), Sir Thomas Phillips, (Lawyer), James Ranald Martin, (Inspector General of Army Hospitals), Sir James Clark, (Physician), John Sutherland, (Leader of the Sanitary Commission 1855) and Dr Graham Balfour, (Secretary).

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31 The village now known as Pinabarci was considered the most likely site of Ancient Troy when Renkioi was open. When the hospital was due to close, John Brunton the Engineer, took his work force to Hisarlik, 12 miles (19 km) from the hospital, and had them dig there for perhaps only a day. This almost fortuitous excavation was the first made at the site which Schliemann later established as that of Troy.

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Author

Dr Christopher Silver qualified in Medicine at Oxford in 1942, and served in the RAMC in Italy and India from 1943-6. He later became Consultant Geriatrician at the Royal London Hospital and is now retired. His interest in Renkioi came as a result of visiting Moscow in 1996 to see the Trojan Gold, excavated by Heinrich Schliemann and then rediscovered in the basement of the Pushkin Museum where it had lain since its removal from Berlin, at the end of the Second World War. He visited Turkey and Troy itself and nearby, came on the site of Renkioi Hospital.

Fig. I : Map. Black Sea. Sea of Marmara and Dardanelles

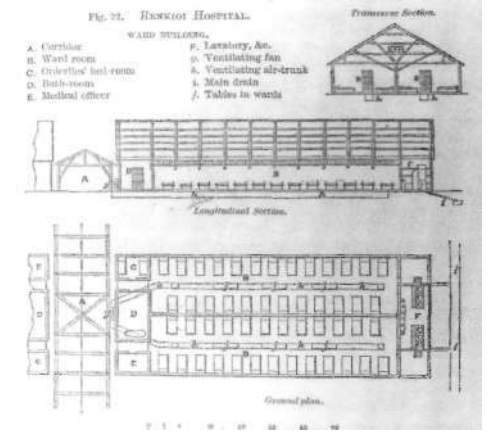
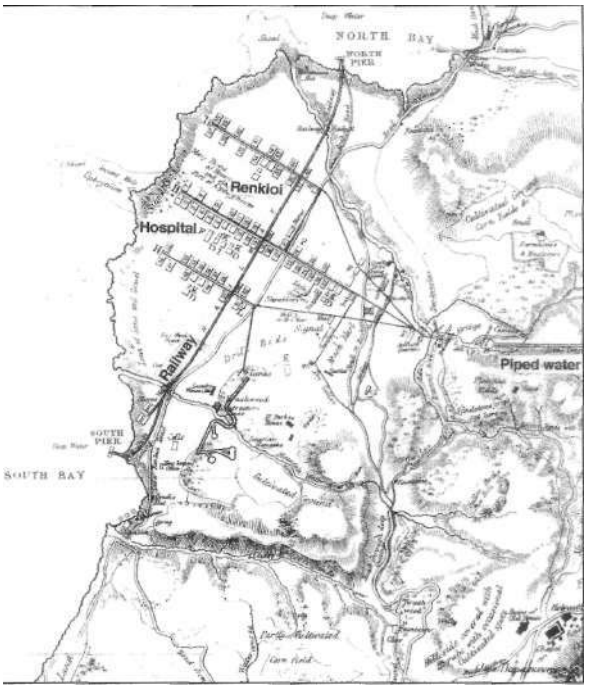


Fig. 2 : Plan of Ward Hut [From: Brunei I.The Life of Isambard Kingdom Brunei. London: Longmans Green, 1870]

Fig.3 : Map. Renkioi Hospital.Three rows of ward huts (each similar to that shown in Figure 2) appear as they would have if the hospital had been completed. Also shown is the pipe bringing water 21/2 miles (4km) from springs high in the hills and ending at the reservoir, and the railway, also never completed, running between the two landing piers. [Acknowledgement] Courtesy of the Wellcome Institute Library. London.

Fig.4 : Renkioi Hospital in 1855. Beyond the hospital are the Dardanelles and, faintly visible in the distance, the Gallipoli Peninsula.This view was taken by Dr John Kirk, later knighted, who was to accompany David Livingstone, as naturalist and physician, and ultimately to be responsible for securing an end to the slave trade in Zanzibar. [Acknowledgement] By permission of the owner and courtesy of the Scottish National Portrait Gallery. Edinburgh.



The physician Romolo Spezioli (1642 -1723) and his private library in the Public Library of Fermo

Summary

The Public Library of Fermo in the Italian Marches, houses an almost unknown treasure for historians of medicine, the personal library of Romolo Spezioli. Spezioli was born in Fermo in 1642 and died in Rome in 1723. He was the personal physician of Cardinal Decio Azzolini junior, Queen Christina of Sweden and Pope Alexander VIII.
There are almost 12,000 books, dating from the sixteenth to the early eighteenth centuries, almost all of them on medicine or science. They are housed in the Globe Room, whose creation was made possible by the generosity of Cardinal Azzolini.The library was opened to the public in 1688.

Résumé

La Bibliothèque municipale de Fermo, est située dans la région des Marches, au centre de l'Italie. Elle héberge un trésor presque inconnu des historiens de la médecine : il s'agit de la collection personnelle du médecin Romolo Spezioli. Spezioli naquit à Fermo, en 1642 et mourut à Rome, en 1664. Il était docteur en Médecine et en Philosophie de l'Université du lieu. Il s'installa ensuite à Rome où il fit une brillante carrière, devenant médecin personnel de la reine Christine de Suède, du cardinal Decio Azzolino junior ; il fut aussi l' archiâtre du pape Alexandre VIII. Spezioli légua sa collection personnelle à sa ville natale, la destinant ainsi aux étudiants de médecine de l'Université de Fermo.

Le fonds contient plus de 12.000 volumes imprimés, datant des XVème., XVIème. et XVIIème. siècles. La plupart de ces ouvrages sont des traités de médecine ou de science. Cette collection, entreposée dans la Bibliothèque municipale de Fermo, contient les catalogues manuscrits ; elle peut être consultée dans la salle dite « de la Mappemonde ». La création de la collection est due à la générosité du cardinal Azzolino. Depuis 1688, la Bibliothèque de Fermo est ouverte au grand public.

The Public Library of Fermo in the Italian Marches houses an unknown treasure for historians of medicine : the personal library of Romolo Spezioli[1] (Fig I, Romolo Spezioli's portrait, Fermo, Palazzo dei Priori, Mayor's room) who was the personal physician of Queen Christina of Sweden.

It is preserved in a room that was created in 1688 as the first part of the Library and was intended to be open to all scholars.Today, it is called the Globe Room (Fig 2, The Public Library of Fermo.The Globe room), because of the presence of a large terrestrial Globe that was made, in 1713, by the cartographer and instrument maker Silvestro Amanzio Moroncelli. Behind the old main door of the Globe Room, the unique atmosphere of the room, with its splendid baroque ceiling and woodwork, is completely unexpected. Its original wooden bookcases contain about twelve thousand books from the sixteenth, seventeenth and early eighteenth centuries, almost all of them on medicine and science. But how and why did they find their way to the Public Library of Fermo ?

Over the main entrance to the Globe Room, there is an old, wooden, coloured medallion, upon which is written simply: *"Chhstinae"*. This important name explains the whole history of the library. The room is dedicated to the memory of Queen Christina of Sweden (Stockholm, 1626 -Rome, 1689) who was linked to Fermo in the seventeenth century by two important personalities :the cardinal Decio Azzolino *junior* and her personal physician Romolo Spezioli[2]. Cardinal Azzolino (Fermo, 1623 - Rome, 1689), one of the most powerful personalities at the papal court in Rome[3], was a member of a noble family that dominated Fermo, in the seventeenth century. As a result of his great skills in politics and diplomacy (he was nicknamed the "Eagle"), the cardinal became a great friend of Queen Christina of Sweden after her abdication and move to Rome, helping and protecting her until the very end of her life. He was also the patron of the people of Fermo who came to Rome and it was he who, in 1675, introduced the newly arrived Romolo Spezioli to Queen Christina[4] as a possible new personal physician. Spezioli was particularly fortunate because Christina's personal physician Cesare Macchiati had just died and she was looking for a suitable person to fill this position. Cesare Macchiati too, had come from the county of Fermo, a further proof of the importance of Fermo for the study of medicine in the Papal States. Its university, founded in the XIV century, had gained a solid reputation for its graduates in medicine, theology and philosophy and Spezioli, himself, had graduated there on 22nd April 1664.

Queen Christina was fascinated by the broad culture and the serious intelligence of the young physician from Fermo, appointing him as her personal physician and arranging for him to teach practical medicine at the University "La Sapienza", in Rome. Spezioli enjoyed spectacular success throughout his whole career in Rome. He taught practical medicine at the University from 1675 until 1722, a year before his death, as well as being the private physician of Cardinal Azzolino and of the noble Ottoboni family, in Rome. When the cardinal Pietro Ottoboni was elected Pope as Alexander VIII, in 1689, Spezioli was appointed also as his personal

physician, the highest and the most prestigious office for a physician in Rome, in the seventeenth century. He also took care of Cardinal Azzolino and Queen Christina until their deaths, in 1689.

Shortly before he died, Cardinal Azzolino decided to make a special gift to his native Fermo : a Public Library. Although there had long been a university at Fermo, there was no public library for its students. It was Cardinal Azzolino who gave the money to change the Globe Room, (which had been used as a little theatre for performances of religious works), into the first room of the Public Library of Fermo. He probably wanted to dedicate the room to Queen Christina, in memory of the most educated and intellectual woman of the seventeenth century, but he died in 1689 before he could see the completion of the work on the Globe Room and Christina, herself, followed soon after.

Although Spezioli lived in Rome, from 1675 until the year of his death in 1723, he never forgot Fermo and, like the Cardinal, he left to his birth-place a most precious legacy, his personal library. It offers an insight into his life and his thought and holds up a mirror to the scientific and medical culture in baroque Rome. At the time when Spezioli first decided to leave his library to Fermo, in 1705, he was in Rome. Since he wanted to help the library, as Cardinal Azzolino had done before him and, in particular, the students of medicine[5], the first part of his library to be sent to Fermo was entirely composed of medical books. In his autograph testament[6], dated 25th November 1722, shortly before his death, the next year, he left orders for the rest of his library, with books about "all other subjects", and his manuscript catalogues to be transferred to Fermo. In this way, the Public Library of Fermo houses a substantial number of other books about theology, philosophy, literature and all other matters considered essential to the education of a physician, in the seventeenth century. Spezioli himself was very religious and belonged to the order of canons regular of St. Peter's, in Rome. He made the monastery of the Jesuits at Fermo his main heirs, ordering the erection of a new altar, in the church of San Martino, the monastery church, to be dedicated to his three patrons, Cardinal Decio Azzolino, Queen Christina of Sweden and Pope Alexander VIII.

The whole world of seventeenth-century Rome is reflected in his library. It shows his links with religion and, in particular, with the scientific culture of the Jesuits, the scientific world of the Queen Christina's court, the conservative and the new "progressive" medical theories of the university, the formal, practical medicine of a papal court and the informal' medical knowledge that had been placed on the Index *Librorum Prohibitorum.* His library is like a baroque picture, full of contrasts.The most useful keys to decoding this complicated world are the seven manuscript catalogues of the library, which are like seven different photographs. The most important is Spezioli's own autograph catalogue of the first part of the library[7], dedicated entirely to medicine and dated 6th February 1706.The volumes are organised firstly by size and, secondly, by the name of the author. In this catalogue, one can find all the major authors of the Renaissance, like Adrian van der Spiegel, Conrad Gessner, Thomas Sydenham, Thomas Willis, William Harvey, Gaspar Hoffmann,Thomas Bartholinus, Marcello Malpighi, Bartolomeo Eustachi, Girolamo Mercuriale, Girolamo Fabrizi D' Aquapendente, Giambattista Delia Porta, Fortunio Liceti, Paracelsus, Jean Riolan and Athanasius Kircher, as well as many commentaries on Galen and Hippocrates.

There are two copies of the first edition of Vesalius' "De *humani corporis fabrica",* printed in 1543, in one[8] of which some of the illustrations have been coloured in by hand (Fig 3 Andreas Vesalius, De *humani corporis fabrica,* Basileae, 1543, p. 174). In particular, this copy of the Fabrica is very interesting because the watercolour of the illustrations has not only an artistic significance but also a scientific purpose. In fact, different colours are used to paint the anatomical parts : the red is used for the muscles and for the heart, light yellow for the bones and green for lymphatic ducts. Spezioli's library includes other important books on anatomy[9]: a copy of the *Opera omnia* of Adrian van der Spiegel printed in Amsterdam in 1645, the *Opera Chirurgica* of Girolamo Fabrizi D' Aquapendente (Padova, 1666, *in folio),* the *Opera omnia* of Gabriele Falloppio (Frankfurt, 1600, in folio), the *Tetras anatomicarum epistolarum de lingua, et cerebro* of *Marcello Malpighi* (Napoli, 1665). There are some important incunabula in Spezioli's library too : a copy of *Canon medicinae,* Avicenna (Lyons, Johann Trechsel e Johann Klein, 1498) with rubricated capital letters, the volume of *Hortus Sanitatis* (Mainz, Jacob Meydenbach, 1491), with rubricated capital letters and woodcut illustrations of plants and animal, three different copies of *Libellus de conservation'^ sanitatis,* Benedetto da Norcia — the oldest copy is printed in 1475, in Rome — , a copy of De *aegretudinibus et remediis infantium,* Paolo Bagellardo[10] (Padova, 1487).

While the presence of incunabula and manuscripts is important for showing the medieval medical knowledge represented in Spezioli's library, the most important part of the library is formed by the printed books of the sixteenth and seventeenth centuries. Spezioli's library includes not only medical treatises, but other fundamental books for different scientific subjects

closely linked to medicine, like natural history.The library has a copy of *Historia animalium* of Konrad Gessner : it is composed of three volumes that belong to different editions, printed in Germany (Frankfurt, Heidelberg), from 1586 until 1606. It was easier to catalogue Ulisse Aldrovrandi's works because they are all collected in *Opera omnia,* printed in Bologna, in l599.The linking of Spezioli's library with the scientific culture of Jesuits is well documented by Athanasius Kircher's works : there are copies of *China Monumentis* (Amsterdam, 1667, in *folio), Mundus subterraneus* (Amsterdam, 1678, in *folio), Ars magna lucis* et *umbrae* (Roma, 1646, in *folio), Musurgia universalis* (Roma, 1650).

The classification system used in the seven catalogues of Spezioli is extremely interesting for showing the scientific and bibliographic models of a medical library of the seventeenth century. The oldest manuscript among the seven, a manuscript with an old parchment binding, is listed in my first book as "Bibliography", after the reconstruction I made of the *stemma codicum* of the seven manuscripts. It has the bibliographical references without the classmarks, so it has to be studied as a bibliography, rather than as a catalogue. Its importance lies in the probability that this was the bibliographical model that guided the growth of Spezioli's library. It can be collated with those books of Spezioli's library that still have both their original classmarks and Spezioli's autograph signature, on the inner part of the binding, to help reconstruct the original library. So far we have succeeded in identifying the books on alchemy, seventeen in all, and the thirty-seven books that were in the *Index.* Alchemy is a very important scientific feature of Spezioli's library for biographical and scientific reasons ; Queen Christina of Sweden and Cardinal Decio Azzolino were both interested in alchemy and they probably had an influence on Spezioli's scientific thought, but alchemical knowledge was a hermetic philosophical component of medicine, in the seventeenth century too. This explains the presence of works by Jean Pierre Fabre and Gerhard Dorn, as well as four different editions of the famous De Re *Metallica* by Georg Agricola. Two are translated in Italian, being published in Venice in 1550 and in Basle, in 1563 and both, have illustrations about the extraction and working of metals, the copy of 1563 having an interesting manuscript note about the features of some metals. The other two were published in Latin, in Wittemberg in 1612 and in Basle, in 1657. The copy printed in Wittemberg is important because it has the original numerical signature and the manuscript note of the class "Alchemy", in front of the binding.

It is important to emphasize that Paracelsus's *Opera omnia,* published in 1659, is not listed among the alchemy books but among those on the *Index.* Spezioli identified these forbidden books in his autograph catalogue of the library, with a symbol like an asterisk or a cross and with a double zero, on the binding. The classmark of forbidden editions also has a particular symbol written on the binding : a double zero. It is not difficult to explain how he could find these books. He lived in Rome where the trade of books was well developed in the seventeenth century but he probably had a lot of contacts with booksellers of Northern Europe, for many of his books were printed in Germany, England, Holland and Belgium, although few books were printed in France.This North-European origin might be explained by Spezioli's cultural relationship with Queen Christina of Sweden. Not only did Spezioli live in Christina's palace in Rome and look after her until her death, but in her will, Christina granted him an annuity for life. Very unusually, Spezioli rejected this annuity in exchange for some of the Queen's precious books and manuscripts". This was perhaps the only way to get books from Christina's library which he would never have been able to buy himself, and shows his passion for books and culture. The most beautiful of all his acquisitions is a devotional Book of Hours, an illuminated manuscript[12] of the early sixteenth century, that had belonged to Queen Christina.

Ongoing research to identify Christina's books and manuscripts in Spezioli's library has still much to reveal about the history of this library and its links with Christina's court. It is also an important index of medical and scientific culture in baroque Rome, comparable only to that of the physician Giovanni Maria Lancisi, now preserved in the Roman hospital of Santo Spirito, in Sassia. The comparison is valuable not only because Lancisi and Spezioli were contemporaries and colleagues at the Sapienza and at the Papal Court. Spezioli was born in 1642 and died in Rome, in 1723 ; Lancisi was born in 1654 and died in 1720.

The architectural structures of both old libraries are very similar. They both have their original wooden bookcases and old globes. The comparison of their manuscript catalogues is very interesting because it shows the scientific originality of Spezioli's library, with its many editions printed in Northern Europe. The two libraries have some different features: Lancisi's library includes more medical manuscripts, especially letters of physicians, but Spezioli's library is more complete for the medical and scientific printed books of the seventeenth century. The libraries used different systems of classification, showing the philosophical difference between the system adopted by Lancisi[13] and that of Spezioli's library[l4].The first is more specific with more medical subdivisions, while the second is more universal, from a bibliographical point of view, and is very close to Gessner's bibliographical model.

The reasons for this difference may be two : Lancisi's library was built in a hospital to educate the young physicians who practised medicine there ; whereas Spezioli's library was a private medical bibliographical collection without at first the features of a "public library". Above all, Queen Christina's influence on Spezioli's scientific knowledge is the most important clue towards the correct reading of Spezioli's library. A preliminary census of the scientific and medical editions printed in Northern Europe shows that Spezioli's library displays a very particular feature : it is far closer, from a bibliographical point of view, to a German or English private medical library. Christina could be the link with the new scientific culture. Her palace on the river Tiber was home to a marvellous library as well as to many intellectuals from all over Europe. She probably had a lot of contacts with booksellers of Northern Europe who informed her librarians about new publications.This could explain the presence of the numerous forbidden editions in Spezioli's library too. It is important to highlight that the most important of the editions printed in Northern Europe are books of medicine and philosophy.

These include the works of Bacon[15] and Descartes, atomism, as represented by Godsend's Opera *omnia*[16] and the hermetical neo-Platonism of the *Opera omnia* of Marsilio Ficino[17]. The study of these philosophical editions allows us to understand the position of Spezioli in the philosophical and scientific discussion of the seventeenth century, especially in the complicated cultural universe of Queen Christina.This is only one of the aspects still to be studied in a comparison between the libraries of Spezioli and Queen Christina, not least because the manuscript inventory,Vat. Lat. 12637[18], offers a good deal of interesting information about both of them.

Much research will still be required to uncover the real face of Spezioli's library. But, once achieved, the complete reconstruction of this almost forgotten library will not only offer new sources of information on medicine, in the seventeenth century to historians of medicine, it will also illuminate the life and work of a leading figure, in Baroque Rome.

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Notes

I .This article is based on F. Zurlini, *Romoio Spezioii (Fermo, I642-Romel723)* : un medico fermano nel XVII secolo a Roma, Manziana (Rome),Vecchiarelli, 2000.

2. See :V Nigrisoli Warnhjelm, / *Fermani alia corte della regina Cristina di Svezia,* in, *"Cristina di Svezia* e *Fermo",* Atti del Convegno Internazionale "La Regina Cristina di Svezia, il cardinale Decio Azzolino junior e Fermo nell'arte e la politica della seconda meta del Seicento", Fermo, Auditorium S. Martino, 3-4 ottobre 1995, (a cura di) VNigrisoli Warnhjelm, Fermo, Fondazione Cassa di Risparmio di Fermo, 2001, pp. 105-121.

3. See: M.L. Roden, *Church Politics in Seventeenth-Century Rome: Cardinal Decio Azzolino, Queen Christina of Sweden and the Squadrone Volante,* Stockholm, Almqvist & Wiksell International, 2000.

4. See: F. Zurlini, *Romoio Spezioii...,* p. 16.

5. See: F. Zurlini, *Romoio Spezioii..* .pp. 84-85.The transcription of Spezioli's autograph letter of I Ith July 1705 explains very clearly his plans for the future of the library.

6. See: F. Zurlini, *Romoio Spezioii...* p. 16, pp. 73-80.

7. Idem, p.83-l02.Thefirst results of the complicated study of the catalogues are published in chapter 2.Vera Nigrisoli Warnhjelm was the first to study the catalogues of Spezioli's library. See : V Nigrisoli Warnhjelm, *Romoio Spezioii, medico di Cristina di Svezia,* in,"Settentrione", nuova serie(l994),pp.25-38.

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10. See: N.Tizi, *La cura e l'assistenza all'infante malato nei libri del medico Romoio Spezioii,* in, F. Zurlini, *Romoio Spezioii...* pp. 221-228.

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14. F. Zurlini, *Antonio Cocchi, medico, bibliotecario e bibliografo del secolo XVIII,* in, "Culture del testo e del documento, le discipline del libro nelle biblioteche e negli archivi", 8/maggio-agosto 2002, p. I 16-126.This a first comparative study about the different systems of classification of Spezioli's library in Fermo, Lancisi's library in Rome, Cocchi's library in Florence.

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Author

Fabiola Zurlini has been a librarian in the Public Library of Fermo, in the Italian Marches since 1995, with specific responsibility for manuscripts and rare-books cataloguing, preservation, and study. In 2000, she published her thesis on *"Romolo Spezioli (Fermo, 1642 - Roma, I 723) :a physician between Fermo and Rome in Seventeenth century",* Manziana (Rome), Vecchiarelli publisher. In 2001, she joined as a formal researcher the Studio Firmano, Institute of Research for the History of Medicine and Science, in Fermo. She has published on the physician Antonio Cocchi and his private library in the journal "Culture of the Text", edited by the Department of History,Text and Document culture, University ofViterbo.

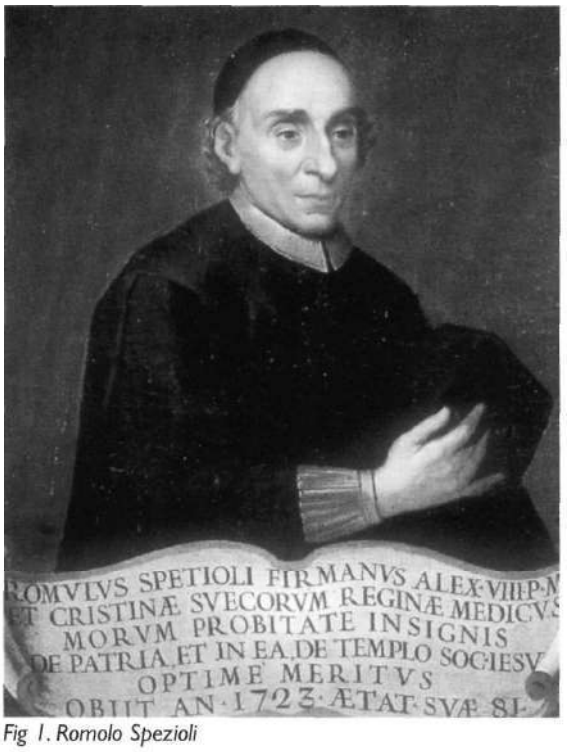

Fig 1. Romolo Spezioli

Fig 2. The Globe Room, The Public Library, Fermo

Fig 3. de humani corporis. Andreas Vesalius

Disease in Africa: a Medical Perspective from the 1950s, Vesalius, X, 11, 67-73, 2004

Disease in Africa: a Medical Perspective from the 1950s

J D Macgregor

Summary

So much attention is focused on the current HIV/AIDS epidemic in Africa that there is a tendency to overlook the grievous burden of disease from which the peoples of that Continent have suffered for centuries. This paper, based on letters sent in 1953/54 by a young doctor in Sierra Leone to his parents in Scotland, together with extracts from Makeni Hospital records of the same period, provides a factual account of front-line medicine in West Africa half a century ago.

Résumé

De nos jours, on se préoccupe bien plus de l'épidémie de SIDA, dueauVIH, en Afrique que du pénible fardeau, souvent négligé, dont les habitants de ce continent souffrent, depuis des siècles. Cette étude tire ses sources des lettres qu'un jeune médecin, résidant en Sierra Leone, envoya à ses parents habitant l' Ecosse, en 1953-1954. Cette étude s'appuye aussi sur les extraits du registre de l'Hôpital de Makeni, durant la même période. Ces registres nous fournissent ainsi une contribution factuelle de ce que fut l'état de la médecine d'Afrique de l'Ouest, il y a maintenant un demi-siècle.

Introduction

Following graduation from St Andrews University Medical School in June 1950, there was a legal requirement to obtain a year's hospital experience before being called up, like all male medical graduates, for two years National Service. This was satisfied by six months as House Physician at Perth Royal Infirmary, followed in 1951 by six months as House Surgeon at the Royal Northern Infirmary, Inverness.

Unlike most medical graduates who were drafted into the medical branch of one of the British armed services, a few doctors were given the opportunity to spend this time with H.M. Colonial Medical Service. My posting to Sierra Leone duly arrived, but pending departure by sea for West Africa in December 1951, a few months were spent as Surgical House Officer at Scartho Road Infirmary, Grimsby.

Freetown, Sierra Leone

Along with a few other young doctors I arrived in Freetown, Sierra Leone, in mid December 1951, and spent the whole of my first tour of duty, lasting some 14 months, working either at the Connaught Hospital in the capital, or at one of the peripheral clinics in the Peninsula, or as medical superintendent at Kissy Mental Hospital, where some 200 patients from Sierra Leone and The Gambia were confined. Many such patients were detained by virtue of a Court Order, having been found guilty of a serious crime, but insane. Several others had previously been studying overseas, and were well-educated, but had succumbed to the stresses involved by developing a major psychosis, and had been repatriated. Unfortunately, the therapeutic modalities available in those days were exceedingly limited and generally not obtainable in West Africa at the time.

Some of the clinic facilities also left much to be desired. At the Clinetown railway workshops, for example, the clinic had an earthen floor traversed by railway lines, and was separated from the sheet metal workshop by a corrugated iron partition. Consequently, the noise level was such that it was often impossible to conduct a conversation, let alone use a stethoscope. It is pleasing to record that representations to the Director of Medical Services and the Manager of the Railway effected a swift improvement.

The daily routine was not without its compensations. Thanks to the interest and encouragement of the senior consultant surgeon in Freetown, a good deal of practical experience was obtained in the management of many of the surgical emergency situations commonly encountered in tropical Africa, and this was to stand me in very good stead when I returned to Sierra Leone for my second tour of duty in mid 1953.

In earlier times Sierra Leone was indeed "The White Man's Grave" as was evident from the European cemeteries which existed at places such as Makeni and Batkanu,as well as in Freetown itself. Examination of the headstones confirmed that a high proportion of the officers concerned had succumbed within the first few months of arrival in the country, often from Blackwater fever (a complication of malaria) or from Yellow Fever.

Makeni, Northern Province

Shortly after returning to Freetown in May 1953, I was posted upcountry to Makeni, then the headquarters of the Northern Province of the Protectorate. I arrived there after a 12 hour train journey on the Sierra Leone Government Railway, in itself an interesting experience. This was a relatively narrow gauge railway, though the passenger compartments were wide enough to provide a single seat on each side of a central aisle. Powered by a wood-burning steam locomotive which produced an abundance of smoke and sparks, it also required frequent stops to replenish the firewood supply. Consequently,

progress was slow, averaging about 13 mph, and it was not uncommon to see children running alongside the track and keeping up with the train!

The Medical Officer at Makeni, like all such district medical officers, was responsible for all aspects of the medical and public health care of the population of his district, which in this case was the largest in the country and was estimated[1] to contain some 360,000 people in the two sub-districts of Bombali andTonkolili.

Clearly this was a task of some magnitude, given that the total medical staff in the district consisted of himself plus a missionary doctor based at the American Mission Hospital at Kamakwie, some 40 miles northwest of Makeni. There was also a doctor in charge of the Endemic Disease Control Unit which, with assistance from WHO and UNICER was endeavouring to control and hopefully eradicate Yaws from the country. The EDCU was administered by Medical Department Headquarters in Freetown.

Subordinate staff at Makeni Hospital included one Dispenser who was essentially the hospital manager, several nurses and various male orderlies, two of whom, Pa Raka and Pa Mende, were illiterate yet very competent at sterilising instruments and setting up the theatre. A clerk and Sanitary Inspector completed the local departmental personnel. (Fig I)

Makeni Hospital had 27 beds, consisting of male and female wards plus two small mud huts, together with a small operating theatre, an office with clerk and typewriter, and an outpatients department. Rainwater catchment tanks outside the hospital provided the water supply except for a month or two during the dry season, when water was carried from the nearby river in buckets. There was no electricity supply, so only natural lighting was available in the operating theatre, where the windows consisted of insect screening. A kerosene pressure lamp was of course used if an operation proved essential during the hours of darkness.

While Malaria was undoubtedly the most important endemic disease, and no doubt still is, Yaws (Fig 2), Trypanosomiasis.Tuberculosis, Leprosy (Fig 3) and Filariasis were prevalent, as was the disfiguring elephantiasis (Fig 4) resulting from the latter condition. Smallpox outbreaks (Fig 5) occurred periodically, often associated with illegal diamond mining, increasingly prevalent in the area at the time. A small outbreak of cerebro-spinal meningitis occurred at Makali during December 1953, and I recorded that "I have several patients in the hospital rather more ill than is good for my peace of mind".

Gonorrhoea and other sexually transmitted diseases were widespread, though laboratory confirmation was seldom available, and the consequences including urethral stricture in men, salpingitis in women, and purulent conjunctivitis in infants were common. Hookworm infestations were common, as were other helminths including Guinea worm. Large intramuscular abscesses were frequently seen, requiring incision and drainage, but often with no very obvious cause.

Outpatient attendances were at first unremarkable, complaints being mostly about ill-defined fevers, but within a few days of the first successful surgical procedure, attendances increased, rising within a short time to some 80 to 100 new outpatients every day. (Fig 6)

Local confidence was further boosted when a Paramount Chief had his hernia repaired, an event which was reported in the "Weekly Bulletin" published by the Public Relations Office in Freetown.

Again, one of the dozen or so expatriate government officers based at Makeni had to undergo surgery (by the light of a hurricane lamp) when he developed acute appendicitis late one evening after the ferries were closed, preventing his evacuation to Freetown.The patient made a good recovery, and after a day or two was transferred to Hill Station Hospital in Freetown to convalesce.

Hernias of all kinds were prevalent, no doubt associated with the hard physical labour demanded by subsistence farming, and possibly compounded by the relative lack of protein in the local diet. Many of these cases presented at a late stage, either strangulated or as bulky sliding hernias, a typical example being shown in Fig 7.

When the village of Binkolo was visited in 1953 at the request of the local Chief, it was found that he had lined up a total of 76 men from his area and reported that they were all suffering from hernias. On examination it was confirmed that the great majority were indeed so afflicted. The pool of hernia sufferers in the country as a whole must therefore have been quite staggering, and well beyond the resources of the Medical Department to manage in any comprehensive way.

Surgical procedures during the period included 108 hernia repairs (12 bilateral, 85 right and 31 left), 9 femoral hernia repairs and 7 hydrocoele operations. In addition, two inguinal hernias and several hydrocoeles were repaired in

the course of operations for elephantiasis of the scrotum. Some of the other surgical procedures carried out during the period are listed in the Appendix.

It is interesting that the ratio of right to left inguinal hernias in this series (9:4) is substantially higher than the 4:3 ratio referred to byAird[2]. No hypothesis is advanced to explain this discrepancy.

As will be seen from the foregoing and the Appendix, (extracts from the Makeni Hospital Operations Register from June 1953 to September 1954), a surprisingly wide range of emergency and other conditions were seen and treated. In the great majority of cases anaesthesia, (spinal, regional or local anaesthetic block), was administered by the single-handed surgeon. General anaesthesia was rarely employed, open ether being the only form available.

In addition to those procedures in the Operations Register, many minor procedures were also carried out. For example, in September 1953, minor procedures totalled 39 in addition to the 18 listed in the Register. These included suturing of lacerations, incision of abscesses and dilatation of urethral strictures.

Such surgical drapes as were available were laundered in the usual way, but of course there were no facilities for sterilisation. Surgical gowns for the operating theatre were not available, and in any event the heat and humidity precluded their use.

Despite these somewhat primitive arrangements, it was remarkable that wound infections were so uncommon, most surgical incisions healing by first intention. This applied even in hernia case no. 234, which had involved resection of bowel and anastomosis. I recorded that "much to my surprise, this man made an uninterrupted recovery".

I had to conclude that this remarkable resistance to infection stemmed from the fact that this community represented the survivors of a lifetime's exposure to all manner of micro-organisms, parasites and disease.

There was a good deal of trauma, including a substantial number of gunshot and related injuries, many associated with locally made muzzle-loading firearms which tended to burst at the breech if the powder charge was excessive, or the firearm old and worn, causing irreparable damage to the hunter's hand. Several mid-forearm amputations were required as a result of this kind of injury, with three in one week during March 1954.

Mercifully, deaths in this series were unusual and mostly predictable. Only one patient, no. 254 who had peritonitis from a gangrenous ileum, died during the course of an operation to relieve his strangulated hernia. No. 44 died later following gunshot wounds to his abdomen and chest; and no. 212 died seven days after appendicectomy for acute phlegmonous appendicitis leading to portal pyaemia. Finally, one man died unexpectedly several days after an operation for haemorrhoids, probably from a pulmonary embolus.

Apart from the infectious endemic diseases mentioned above, there was a recognised pneumonia season in May/June when hospital beds were filled with a significant number of very ill patients suffering clinically from a lobar pneumonia. In the absence of x-ray and microbiological facilities, however, it was not possible to characterise this syndrome more accurately.

Obstetric emergencies generally presented late on in labour, often with the baby already dead or seriously distressed, and the mother exhausted. Seldom was it possible to intervene at an early enough stage to save both parties, but occasionally Caesarean Section or forceps delivery secured a favourable outcome, as in case no. I 13. This resulted in an interesting letter being received from a missionary nursing sister some six weeks later (Fig 8). Unfortunately, other cases (e.g. nos. 129 and 183) required the use of destructive instruments long since relegated to obstetric museums in more developed countries.

The late results of difficult childbirth were also all too commonly seen, usually in the form of vesico-vaginal fistulae, a very distressing condition for all concerned.

Particularly interesting cases included no. 91, where a live baby of approximately seven month gestation was delivered at laparotomy in a case of right tubo-ovarian pregnancy; and no. 270 which was a direct consequence of female circumcision. This had resulted in the injured labia healing together almost perfectly, leaving only a tiny introitus, which, on presentation, was being distended by one of the baby's heels. It was therefore necessary to rectify this situation before continuing the breech delivery. This case may also be considered as a remarkable testimony to the vigour and tenacity of at least one local spermatozoon.

Discussion

It is hoped that this description of the range of diseases and injuries encountered in a single-handed medical practice in Sierra Leone during the 1950s will help to balance the emphasis currently being placed on the tragic HIV/AIDS epidemic sweeping through Africa.

The facts must surely be that this epidemic exists in addition to all the other illnesses and trauma afflicting African society at this time, with the exception of course of smallpox, (eradicated as a consequence of a massive worldwide smallpox eradication campaign mounted by the World Health Organisation and culminating in total eradication by 1979).

Indeed, it may be said that HIV/AIDS in Africa has taken the place of smallpox as a major endemic disease in that continent, and it is perhaps not too fanciful to speculate that the eradication of smallpox may somehow have tipped the delicate ecological balance enjoyed until then by myriad pathogens interacting with each other and with human and animal society.

Could it be that the eradication of smallpox in the 1960/1970s created favourable conditions for the HIV virus to emerge and infect humans in the 1980s? That the first cases of HIV infection were reported from New York and California in 1981 suggests that the chronological sequence is not incompatible with the suggestion.

Conclusion

It is hoped that this brief account of the wide range of medical, surgical and other conditions observed and treated during the early 1950s will contribute in some small measure to the medical history of Sierra Leone during its final years as a British Colony and Protectorate.

It was certainly a period which placed the author in a unique position of responsibility and gave him a range of experience far beyond what might have been expected had he not been given the opportunity of practising medicine as a National Service medical officer in West Africa.

References

1) Sierra Leone Protectorate Handbook, 1954

2) Aird, Ian. 1950, Companion in Surgical Studies, page 528, Livingstone, Edinburgh.

Footnote

The Figures were prepared from colour slides taken at Makeni in 1953/54. A few have deteriorated considerably in the interim but are the best now available. Verbal permission to take these photographs was obtained from all patients portrayed in Figs. 2 to 5 and 7.

The author still possesses the walking stick with the carved ivory head which was presented to him by the Hospital staff on his departure from Makeni, not for himself be it noted, but for his father who, according to local perception, was clearly responsible for much of the activity described in this paper.

Author.

Dr Macgregor graduated in medicine in 1950 from St Andrews University. He served in HM Colonial Medical Service from 1951 to 1975, initially in Sierra Leone as a general duty medical officer and then from 1957 in the South Pacific Health Service, retiring in 1975 as Director of Medical Services of the British Solomon Islands Protectorate.

He was a WHO Consultant in Malariology, and gave advice to the Governments of Papua New Guinea and Malaysia in connection with their malaria control programmes. He was appointed OBE in 1971.

From 1975 he was Chief Administrative Medical Officer for the Shetland Health Board in Scotland, until 1981 when he became District Medical Officer for Perth & Kinross. He retired from the National Health Service in 1992 at the mandatory age of 65, but continued in part-time medical work for the next 10 years.

Fig. I : Hospital Staff Makeni 1954

Appendix

Makeni Hospital, Northern Province, Sierra Leone
Extracts from Operations Register 1953-54

		DIAGNOSIS	PROCEDURE
1	06/06/53	Cpd frac R tib & fib	Excision & skin graft
2	07/06/53	Ruptured mesentery	Laparotomy
5	20/06/53	Gunshot R thigh	Excision & removal FBs
11	11/07/53	L cataract	Extracapsular extraction
14	18/07/53	L panophthalmitis	Evisceration L eye
22	13/08/53	Dystocia etc	Classical Caesarian Section
24	21/08/53	Elephantiasis of scrotum	Excision
26	21/08/53	Dystocia etc	Forceps
30	28/08/53	Hepatic neoplasm	Laparotomy: biopsy
38	12/09/53	Abdominal injury: prolapsed gut	Laparotomy: reduction of prolapse
41	18/09/53	Fibroids & R chronic pyosalpinx	Subtotal hysterectomy
44	23/09/53	Gunshot injuries colon & lung	Laparotomy & repair; drainage
45	27/09/53	Retention of urine	Bougies & dilatation
48	29/09/53	Cervical fibroid & teratoma ovary	Myomectomy & excision teratoma
55	09/10/53	Recto-vaginal fistula	L Inguinal colostomy
76	10/11/53	Thyroid adenoma	Enucleation
91	05/12/53	R tubo-ovarian pregnancy	Abdominal delivery of live infant
92	08/12/53	Elephantiasis of vulva	Vulvectomy
93	08/12/53	L otitis media	Paracentesis tympani
97	24/11/53	Dystocia; dead baby	Mid-pelvic forceps
108	16/01/54	Urethral stricture & extravasation	Supra-pubic cystotomy
113	22/01/54	Dystocia; Foetal distress	Classical Caesarian Section
129	14/02/54	Dystocia; dead foetus	Craniotomy; cranioclast extraction
130	15/02/54	Explosive injury R hand	Mid-forearm amputation R
151	03/03/54	Gunshot wounds	R orchidectomy; wound toilet & suture
183	05/05/54	Impacted shoulder presentation	Decapitation; forceps head; manual removal
184	07/05/54	Acute appendicitis	Appendicectomy
187	07/05/54	Large Lipoma R shoulder	Excision
194	14/05/54	External haemorrhoids	Haemorrhoidectomy
198	18/05/54	Elephantiasis of penis	Plastic repair
212	11/06/54	Acute phlegmonous appendicitis	Appendicectomy & drainage
223	29/06/54	Fungating tumour L buttock	Excision
234	13/07/54	R Sliding Hernia & R Haematocele	Excision of Mass. Ileo-colostomy
235	16/07/54	Vesico-vaginal fistula	Repair
245	27/07/54	Wound L foot	Skin grafting
246	27/07/54	Bush cow lacerations R arm & leg	Wound toilet & suture
254	01/08/54	Strang. IH & Peritonitis	Herniotomy. Excn of ileum. Died during Op.
259	07/08/54	Infertility	Dilatation & curettage
260	07/08/54	Haemorrhoids & rectal stricture	Haemorrhoidectomy. Died later.
270	20/08/54	Fusion of labia; breech presentation	Vulvotomy & repair; breech delivery
275	26/08/54	Elephantiasis of scrotum; L hydrocoele	Excision, Jaboulay s operation
278	31/08/54	R ovarian cyst	Laparotomy; ovarian cystectomy

Fig. 2 :Yaws

Fig. 3 : Leprosy

ippp

Fig. 4 :Elephantiasis

Fig. 5 : Smallpox

Fig. 6 : Out-patients department Makeni 1954

Fig. 7 : Sliding Hernia

the baby. The baby is getting along very well.
This incident has been a marvel to the people here at Kamabai, they just can't believe it. You may be interested to know that they named the baby Sere na which in Limba means wonders of wonders.
Again thank you.

Sincerely,
Lois E. Sheridan R.N.

Fig. 8 : Part of a letter 1954

Georges Dieulafoy (1839-191 I), Vesalius, X, 11, 74-77, 2004

Georges *Dieulafoy (1839-1911)* et *l'enseignement* de *la médecine à Paris à la charnière du Second Empire* et de *la Ille République.*

Jean Jacques Peumery

Résumé

Elève favori d'Armand Trousseau, Georges Dieulafoy (1839-1911) s'est montré digne de son maître. Sa grande liberté d'allure et son orgueil ostensible ne choquaient point car ce comportement s'accordait parfaitement avec sa valeur médicale. Il fut professeur de pathologie interne à la Faculté de médecine de Paris et, à ce titre, il peut-être considéré comme l'un des practiciens les plus représentatifs de l'enseignement de la médecine en France, à cette période de jonction entre le Second Empire et la IIIème République. L'oeuvre qu'il a laissée et notamment, son *"Manuel de Pathologie Interne",* se lit avec intérêt encore aujourd'hui.

Summary

Armand Trousseau's favourite disciple, Georges Dieulafoy (1839-191 I), proved a worthy successor to his master. Although he was an obviously proud person, this did not detract from his outstanding medical merit. He was Professor of Pathology at the Faculty of Medicine in Paris and can be regarded as an outstanding exponent of medical teaching, at that phase of transition between the Second Empire and the Third Republic. The works that he left, in particular the "Manuel de Pathologie Interne", are still easy to read today.

Il nous a semblé que l'un des médecins les plus représentatifs de l'enseignement de la médecine en France, à cette phase de transition entre le Second Empire et de la IIIème République, était Georges Dieulafoy.

Elève d'Armand Trousseau, il fut professeur de pathologie interne à la faculté de médecine de Paris et l'un de plus grands cliniciens de son époque (I). Originaire d'une famille bourgeoise de négociants toulousains, son oncle Paul Dieulafoy qui était le chirurgien en chef de l'Ecole de médecine de Toulouse, lui communiqua la passion de la médecine. Il demanda alors à cet oncle une lettre de recommandation pour Armand Trousseau, devant lequel il était tombé en admiration, après avoir lu ses écrits. Puis, il vint a Paris, au début des années 1860, pour s'inscrire à la faculté de Médecine (2).

Il était né à Toulouse, le 18 novembre 1839.

Sous le Second Empire.

Jeune et avide de renommée, Georges Dieulafoy se rapprocha aussitôt d'Armand Trousseau qui était titulaire de la chaire de clinique médicale de l'Hôtel-Dieu de Paris.

Externe des Hôpitaux de Paris en 1864, interne en 1865, il attira très vite l'attention de Trousseau par son érudition. Alors que celui-ci, perplexe devant un cas clinique embarrassant, citait un vers d'Ovide puis, s'arrêtait court au beau milieu de texte, on entendit s'élever la voix de Dieulafoy pour achever la citation latine dont la fin avait échappé à la mémoire du maître. Dieulafoy en profita pour lui remettre la lettre de recommandation de l'oncle Paul. Et c'est ainsi que Dieulafoy devint l'élève favori de Trousseau (3).

En 1869, il soutint sa thèse de médecine, à Paris. C'était une thèse conforme aux interrogations de son époque, " De *la mort subite dans la fièvre typhoïde ".* En moins d'un an, Dieulafoy fut à même de colliger, pour son sujet, 14 observations cliniques. La même année, il inventait un appareil d' aspiration pour évacuer les liquides pleuraux. Il proclamait que son " *illustre et vénéré maître* "Trousseau avait tellement vulgarisé la " *ponction de poitrine* " qu'on pût le considérer comme l'inventeur de cette technique. *"Mais - dit Dieulafoy - lorsqu'en 1869 j'eus appliqué la méthode de l'aspiration au traitement des épanchements de la plèvre, le manuel opératoire de la thoracenthèse fut si simplifié qu'on abandonna graduellement l'ancien procédé ".* A cette époque, l'Hôtel-Dieu était le centre médical de la Maison impériale. La comtesse Tascher de la Pagerie, fille du grand chambellan de l'impératrice Eugénie et parente de l'empereur, fit appeler Dieulafoy au palais de Compiègne. Elle souffrait d'un asthme et il parvint à l'en soulager. Mais c'étaient surtout la silhouette élégante de Dieulafoy, ses belles manières, le charme de sa conversation et même ses qualités sportives-(il tirait à l'escrime comme un maître) - qui le firent apprécier. Il devint un familier de la Cour, à Compiègne comme à Fontainebleau (4).

Le 27 novembre 1869, en Egypte, lors de l'inauguration du canal de Suez par l'impératrice Eugénie, Georges Dieulafoy figurait dans la suite impériale.

Durant la guerre franco-allemande de 1870-1871, il dirigea un service d'ambulances dans l'église de laTrinité, à Paris (5).

Sous la IIIème République.

Après la chute du Second Empire, dès la proclamation de la IIIème Republique, le 4 septembre 1870, la carrière de notre médecin changea.

Agrégé en 1875, chef de service à l'hôpital Tenon en 1879 puis, à Saint-Antoine, en 1881, à Necker en 1886,

Dieulafoy obtint la chaire de pathologie interne en 1887, à la suite de Sigismond Jaccoud, appelé à d'autres fonctions.

Ses cours dispensés, le samedi, à I0h.30, au grand amphithéâtre de la Faculté de médecine de Paris (auquel il avait donné le nom d' amphithéâtre Trousseau) obtinrent un prodigieux succès.

En plus des étudiants, le tout-Paris accourait. Les auditeurs prenaient place dans le grand amphi, eu égard à l' âge et à la notoriété de chacun. Mais tous venaient écouter religieusement la belle voix du maître qui pontifiait, élégant et sûr de lui.

" *// est d'usage, il est de tradition a la Faculté de médecine qu'en prenant possession de la chaire où il vient d'être appelé, le nouveau professeur inaugure son enseignement par une première leçon qui est, en quelque sorte, un programme et une profession de foi..."* C'était en ces termes que débuta la leçon inaugurale, le 25 janvier 1887.

Paul Bourget fut parmi les auditeurs les plus assidus. Il eut Fernand Widal pour élève.

Grand admirateur de Pasteur, dont il sut appliquer les découvertes à la médecine, il assista au jubilé de l'illustre chimiste et biologiste français, en 1892. On le voit sur une toile du peintre Rixens, situé derrière le fameux physiologiste et chirurgien anglais Joseph Lister, lequel accueille Pasteur entrant au bras de président de la République.

La présence de Joseph Lister (1827-1912) à ce jubilé s'explique par son enthousiasme et son amitié pour Pasteur. On sait que Lister fut le principal promoteur de l'asepsie, et ses éminents travaux, dans ce domaine, lui valurent des honneurs exceptionnels, ainsi qu'une renommée mondiale: il devint Lord Lister. La médecine ne doit pas rester une science isolée et ses progrès dépendent du niveau acquis dans d'autres disciplines scientifiques.

Avant Lister, en 1847, l'obstétricien et chirurgien, Ignace-Philippe Semmelweis (1818-1865), avait bien entrevu l'antisepsie, à l'occasion de ses observations sur la fièvre puerpérale mais il n'avait pu démontrer expérimentalement que les " *particules putrides* " qu'il incriminait en étaient sûrement à l'origine.

La découverte de Lister se fondait elle sur celles de Pasteur : il concluait ainsi que l'infection compliquant les interventions chirurgicales était due à des micro-organismes et, pour les détruire, il utilisait l'acide phénique, appelé aujourd'hui " *phénol* " (6).

Les leçons de Dieulafoy contribuèrent, dans une large mesure, à parachever l'oeuvre de Pasteur et celle de Lister. Elu à l'Académie de médecine en 1890, Dieulafoy en deviendra le président en 1910.

Le service de clinique, à l'Hôtel-Dieu de Paris, laissé libre par le départ deTrousseau en 1886, revint à Germain Sée. Napoléon III avait nommé ce dernier à cette fonction, *"sans limite d'âge ".* Dieulafoy fut donc promu à ce poste, en 1896, à la mort de Sée.

Georges Dieulafoy finit par devenir l' une de nos célébrités nationales. L'écrivain français Marcel Proust en parle en termes élogieux dans son oeuvre *"A la recherche du temps perdus " (" Le côté de Guermantes ")* , à l'occasion de la maladie et du déclin de sa grand-mère : *Avez-vous fait venir Dieulafoy ? Ah ! c'est une grave erreur...*

" Grand médecin, professeur merveilleux... Son nom déjà présageait la dignité avec laquelle il tiendrait l'emploi...

" A la dignité de l'attitude concourait, sans se laisser voir, la souplesse d'une taille charmante. Son visage en lui-même trop beau se modelait, par convenance, selon les circonstances douloureuses...

" Il était le tact, l'intelligence et la bonté mêmes. Cet homme éminent n'est plus " (7).

Fier d'avoir acquis une telle réputation, Dieulafoy faisait, chaque matin, une entrée spectaculaire- fouette cocher! , sous le porche de l'Hôtel-Dieu , dans son coupé à deux chevaux (8). Et lorsqu'il quittait son service, tout son personnel, disposé en rang selon les fonctions hiérarchiques occupées, l'accompagnait jusqu'à sa voiture.

En 1909, il dut quitter ses fonctions à l'Hôtel-Dieu, mais il continua ses consultations et son enseignement au dispensaire Léon-Bourgeois, dépendance de l'hôpital Laennec, peu d'années avant sa mort.

George Dieulafoy mourut à Paris, le mercredi 16 août 191 l,à son domicile, 38,avenue Montaigne. Ses obsèques furent célébrées le samedi 19 août, en l'église Saint-Pierre-de-Chaillot, au milieu d'une affluence considérable. Armand Fallieres, Président de la République, et Théodore Steeg, ministre de l'Instruction publique, s'étaient faits représenter à la cérémonie.

Georges Dieulafoy était le frère de l'explorateur bien connu, Marcel Dieulafoy, dont l'épouse, née Jeanne Magre, était aussi une célèbre archéologue.

Son oeuvre

Georges Dieulafoy nous a laissé un " *Manuel de Pathologie Interne ",* dont six éditions furent publiées de 1880 à 1890, des " *Cliniques médicales de l'Hôtel-Dieu* " (1897), à l'exemple de son maître Armand Trousseau ainsi que de nombreuses publications et communications (9).

Son " *Manuel* " comprend la description de toutes les affections connues à son époque et classées de façon claire et précise. Dès l'introduction, une grande place est accordée à l'anatomie pathologique. La lecture de cette longue série d'entités nosologiques reste encore

aujourd'hui riche d'enseignement. Entre autres arguments, il fit ainsi valoir que le clinicien anglais Richard Bright avait compris (1827) que l'albuminurie et les hydropisies persistantes étaient des troubles associés à une lésion des reins :

" Je *vais décrire sous le nom de maladie de Bright des néphrites chronique* et *des néphrites mixtes, diffuses, qui représentent la forme la plus commune du mal de Bright "* écrivait t-il, ainsi , dans son " *Manuel ".*

Pour Dieulafoy, le terme de " *phtisie "* n'était pas synonyme de " *tuberculose ";* il l'utilisait pour désigner la phase ultime de la maladie, caractérisée par une période de consomption et des lésions phtisiogènes.

Dieulafoy sut encore différencier *"hématémèse"* et *"gastrorragie"* : celle-ci était définie comme une hémorragie de l'estomac, fréquente dans l'ulcère et le cancer de l'organe , tandis que celle-là (l'hématémèse) ne constituait qu'un symptôme désignant un vomissement de sang, que ce sang provienne ou non d'une hémorragie stomacale : " *// peut y avoir hématémèse sans gastrorragie et gastrorragie sans hématémèse."*

Dieulafoy sera le premier médecin français à donner de l'appendicite une description mémorable : " *L'appendice vermiculaire du caecum peut participer aux lésions de la typhlite* et de *la périty phlite, ou bien être le siège de lésions indépendantes. Les ulcérations tuberculeuses, corps étrangers, pépins, noyaux de fruit, grains de plomb, calculs biliaires et intestinaux, etc., déterminent l'inflammation, la perforation, la gangrène de l'appendice. Quelquefois même, la perforation et la gangrène de l'appendice ne sont précédées d'aucun symptôme, et les accidents terribles de péritonite suraiguë éclatent brusquement Dans d'autres circonstances, la perforation se fait vers le tissu cellulaire rétro-caecal, et un phlegmon gangreneux en est la conséquence. "*

Il faut cependant remarquer que Dieulafoy, dans son *"Manuel",* ne mentionne jamais le terme d' *"appendicite".* L'inflammation aiguë de l'appendice est désignée par le mot de " *typhlite ".* Rappelons que le substantif *"appendicite"* avait été créé en 1886 par le physiologiste américain Reginald Fitz (1843-1913), de Boston,. *("appendicitis "* du latin " *appendicis ").* Le mot apparaît dans son ouvrage : " *The diagnosis and médical treatment ofacute intestinal obstruction " ,* publié en 1889.

La dénomination " *appendicite "* n'apparaitra en France, dans les dictionnaires, qu'à partir de 1898, à l' instar de sa création par R Fitz en 1886.

Par contre, l'usage du terme " *appendicectomie "* est plus ancien puisqu'il remonte à l'année 1872. Dieulafoy a donné, à ce sujet, l'un des premiers exemples d'une nécessaire et fructueuse collaboration médico-chirurgicale.

A son époque, en effet, médecins et chirurgiens ne s'ignoraient que trop souvent. Dieulafoy eut le mérite d'insister sur le caractère d'urgence chirurgicale que représentait l'inflammation aiguë de l'appendice. En ce qui concernait l'appendicectomie, il s'opposait fermement aux ablations inutiles de l'organe , pour de fausses appendicites qui risquaient de transformer les patients en " *balafrés "* revendicateurs. En revanche, il se montra fervent partisan de l'appendicectomie dans les *"vraies"* appendicites, dont il sut faire le diagnostic correct.

C'est cependant à Charles Mac Burney (1845-1913), de New York (et non à Dieulafoy) que reviendra le mérite de décrire, en 1889, la douleur provoquée à la pression en un point situé à un pouce et demi (4 à 5 cm) de l'épine iliaque antéro-supérieure droite, sur le trajet d'une ligne menée de cette épine à l'ombilic. C'est la douleur au " *point de Mac Burney* "qui , on le sait, signe cliniquement l'appendicite.

En ce temps-là, deux clans s'affrontaient à propos de l' appendicite : les partisans de l'opération " *à chaud "* et ceux de l'intervention " *à froid ".*

Dieulafoy comprit que l'une ou l'autre de ces attitudes comportait des risques : il fut ainsi le premier adepte de l' " *opportunisme ".* Une première crise appendiculaire pouvait certes être calmée par un traitement purement médical (repos, diète, glace sur le ventre); mais cette guérison apparente n'était que trop souvent une *"accalmie traîtresse ":* aussi, préconisait-il, l'opération chirurgicale d'urgence dès la moindre reprise de la douleur. Cette attitude contribua largement â son succès, tant dans le monde médical que dans le monde extra-médical.

La vie privée de Georges Dieulafoy nous reste mal connue. Travailleur infatigable, il se levait vers 4 ou 5 heures, mais il était toujours couché avant I I heures. Il écourtait - à regret- les soirées mondaines, les représentations théâtrales ou artistiques, pour ne pas rompre avec son mode de vie.

Très reconnaissant envers ses maîtres, non seulement envers Trousseau (dont il fut, pour ainsi dire, le fils spirituel) , mais aussi vis-à-vis de ceux dont il fut l'élève et le disciple, Peter, Jaccoud et Potain, qui l'avaient précédé dans la chaire de pathologie. Toute sa vie, Dieulafoy chercha à les égalerai y parvint :" *ils ont semé la graine, je n'ai fourni que la terrain",* écrivait-il, non sans modestie.

On ne connaît pas d'épouse à Georges Dieulafoy. Il est probable qu'il mourut sans laisser de postérité, tout comme son frère et sa belle-soeur, les Dieulafoy-Magre. Il reste aujourd'hui l'une de ces figures légendaires de *"mandarins"* imposant le respect par leur

comportement, leur savoir et, peut-être même aussi une certaine humanité (10).

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Docteur en médecine (Paris), docteur en histoire-philosophie des sciences (Paris I -Sorbonne), trois fois lauréat et médaille d'argent de l'Académie nationale de médecine, Jean-Jacques Peumery est l'auteur de plusieurs ouvrages et de nombreuses publications sur la pneumologie et sur l'histoire de la médecine.

Peumery Jean-Jacques.
392 avenue Maréchal de Lattre deTassigny, 62100 Calais - FRANCE

La Bibliothèque Interuniversitaire de Médecine (BIUM), la Société Française d'Histoire de la Médecine (SFHM) et l'Ecole Pratique des Hautes Etudes (EPHE) organisent le colloque : "Jean-Baptiste BAILLIERE, éditeur de livres médicaux et scientifiques" au Grand amphithéâtre de l'ancienne faculté de médecine de Paris, Université René Descartes, 12 rue de l'Ecole de Médecine, 75006 Paris, le samedi 29 janvier 2005 (journée complète).
Ce colloque sera articulé autour de trois thèmes: I l'exceptionnelle carrière d'éditeur de Jean-Baptiste Bailliere (1797-1885); 2 Bailliere et ses auteurs ; 3 l'internationalisation précoce de la maison Bailliere.
Une exposition de livres illustrera la dimension internationale des Editions J-B. BAILLIERE.
Renseignements : Dr. Christian RÉGNIER, 9 rue Bachaumont, 75002 Paris, dr.christian.regnier@wanadoo.fr

A symposium devoted to Jean-Baptiste Bailliere (1797-1885), the famous publisher of medical books, will be held on Saturday 29th of January 2005, 9.30 am to 6 pm, at the Faculte de medecine de Paris, Universite Rene Descartes, 12 rue de l'Ecole de Medecine, 75006 Paris. There are three themes: I) the career of J-B Bailliere, 2) Bailliere and his authors and 3) the international nature of his enterprise.
Information : Dr. Christian REGNIER, 9 rue Bachaumont, 75002 Paris, dr.christian.regnier@wanadoo.fr

Le service dentaire de l'armée américaine, Vesalius, X, 11, 78-82, 2004

Le *service dentaire de l'armée américaine pendant la Seconde Guerre Mondiale*

Xavier Riaud

Résumé

Le service dentaire de l'armée américaine, d'existence récente, a dû faire face au recrutement massif des troupes, après l'agression japonaise de Pearl Harbour.

Très vite dépassé par les événements, ce service a comblé progressivement son déficit de personnel, par la formation massive de dentistes militaires, ceci en étroite relation avec les écoles dentaires américaines et, par l'engagement des dentistes civils en grand nombre. La pénurie de matériels et de matériaux dentaires a été comblée par la production nationale qui a pu, ainsi, équiper les équipes soignantes de façon tout à fait satisfaisante. Dès lors, une organisation d'une réelle efficacité s'est mise en place, tant sur le front par ses unités mobiles que sur les arrières, par les cliniques dentaires affectées aux différents régiments en fonction de l'importance des effectifs.

Summary

U.S. Army Dental Corps in World War II

The newly created U.S. Army Dental Corps, had to deal with a huge recruitment of troops after the Japanese attack of Pearl Harbour.

Initially quickly overtaken by events, they gradually made up their lack of staff by the massive training of army dentists, in close co-operation with the American dental schools and by taking on many civil dentists.The lack of dental equipment and material was made up by the increased national output.

With these advantages, both the mobile units at the front and the dental clinics in the rear guard, appointed to the many regiments of differing size, proved to be well organised and successful.

Bref historique.

Le Major Général Joseph Warren[1] succombe d'une balle dans la tête à la bataille de Bunker Hill, petite ville du Massachusetts, le 17 juin 1775. C'est un dentiste de la jeune armée américaine, Paul Révère, formé par John Baker[2], un praticien anglais, qui identifie le corps du Major Général, dix mois après, en 1776, grâce à deux dents artificielles qu'il a faites pour lui. C'est le premier fait marquant, recensé du service dentaire de l'armée américaine.

En 1778, le Comte de Rochambeau[3] débarque à Newport. Un dentiste français,Jean Gardette est venu avec lui.Jusque là, l'odontologie du nouveau-monde est sous l'emprise de clergymans puritains et de « *tooth breakers* ». Les soldats étant tenus de s'occuper eux-mêmes de leurs soins dentaires, Gardette contribue à la formation de dentistes civils, pendant la Guerre d'Indépendance.

Le 4 avril 1872, William Saunders[4] devient le premier soldat reconnu comme dentiste de l'armée américaine.

Le I I février 1901, le Dr John Sayre Marshall, père fondateur du corps dentaire de l'armée, devient officier supérieur et est le premier dentiste sous contrat.

Le 20 avril 1906, le Dr Léonie von Meusebach-Zasch devient la première femme dentiste à travailler pour l'armée.

Le 3 mars 191 I, le Corps Dentaire de l'Armée américaine est officiellement établi.

Avec la Première Guerre Mondiale, le nombre d'officiers dentaires en activité atteint 4620, le 30 novembre 1918, dont 1864 stationnés en Europe, la première unité ayant débarqué le 20 août 1917, en France.

Le 6 janvier 1922, l'Institut pour la Recherche Dentaire[5] de l'Armée est créé. Le Colonel Siebert D. Boak en est le premier commandant.

Le I er juillet 1934, le Registre des Pathologies Dentaires et Orales voit le jour au Musée Médical de l'Armée, avec l'aide de l'Association Dentaire Américaine.

Le 29 janvier 1938, le rang de Brigadier Général est accordé par le 75ème Congrès au directeur de la Division Dentaire. Le 29 juin 1938, Leigh Fairbank devient le premier dentiste à occuper cette fonction. Il restera en poste jusqu'au 16 mars 1942.

Ainsi, le service dentaire qui voit les Etats-Unis[6] entrer en guerre le 7 décembre 1941, après l'agression japonaise de Pearl Harbour, est un tout jeune corps d'armée.

Le I I décembre 1941, Hitler, allié du Soleil Levant, déclare la guerre aux U.S.A.

Quelques grandes dates du service dentaire de l'armée américaine, de 1941 à 1945.

Dès 1941,2000 dentistes de réserve sont appelés sous les drapeaux.

Le 17 mars 1942, le Brigadier Général Robert Mills[7] est le neuvième chef du Corps Dentaire d'Armée. Il se retirera, le 17 mars 1946, au grade de Major Général. Il est le premier dentiste militaire de ce rang.

Le 9 avril 1942, le Major Roy Bodine est capturé par les Japonais, lors de la prise de Bataan, aux Philippines. Il y passera trois ans et demi comme prisonnier de guerre aux Philippines, au Japon et en Corée, avant d'être libéré le 7 septembre 1945. Son abnégation, sa camaraderie et son soutien dévoué à ses compagnons d'armes seront cités, par la suite, en exemple.

En 1943, l'Armée est confrontée à une véritable pénurie en œil artificiel en verre. Des officiers dentaires, de l'Institut Dentaire de Recherches de l'Armée, étendent leur domaine d'activité à toute la sphère maxillo-faciale et étudient le problème dans trois centres différents. Ils réussissent à fabriquer un œil en plastique, avec une résine synthétique claire, adopté aussitôt et ensuite, utilisé très

fréquemment. Le personnel dentaire sera aussi déterminant dans le développement d'audiophones et dans la fabrication de techniques de consolidation de crânes endommagés.

Le 6 juin 1944, les Alliés débarquent en Normandie[8]. Pour la préparation du D-Day[9], des montagnes d'armes et d'équipements, jusqu'aux amalgames dentaires, ont traversé l'Atlantique infesté de sous-marins ennemis, pour être acheminés en Grande-Bretagne.

Le I er novembre 1944, le Corps Dentaire[10] d'activé atteint le chiffre de 15 292 officiers, ce qui constitue un record.

Le 8 mai 1945, le Maréchal Wilhelm Keitel" signe la reddition sans condition de l'armée allemande qui se soumet ainsi aux exigences de l'armée américaine. Le 2 septembre 1945, une délégation japonaise signe l'acte de capitulation du Japon : la guerre est finie.

Un héros de guerre ou l'histoire du Capitaine Ben L. Salomon.

Il naît à Milwaukee, dans le Wisconsin[12], le 1er septembre 1914. En 1937, il est diplômé de l'école dentaire de l'Université de Caroline du Sud.

Quand les U.S.A. entrent en guerre, il s'engage aussitôt comme simple volontaire, en 1940. Avant un an, il devient sergent et dirige une section de mitrailleuses. En 1942, il rejoint le Corps Dentaire et devient officier. C'est à Hawaii, le 14 août 1942, qu'il devient premier lieutenant. Après plusieurs mois de travail dans un hôpital, Ben Salomon est affecté, en mai 1943, comme officier dentaire de régiment, au 105 ème d'Infanterie de la 27 ème Division d'Infanterie. Bien que n'ayant pas exercé depuis deux ans, Ben Salomon est reconnu comme un excellent dentiste par ses pairs et ses patients. Mais, il ne se contente pas de cette reconnaissance. Il participe aussi à toutes les simulations de combat et à toutes les courses d'obstacles. Il gagne toutes les compétitions au sein de son régiment.

En 1944, il est promu capitaine et part pour Saïpan, dans les Iles Mariannes, avec le I05ème. Il devient polyvalent et supplée le chirurgien de sa division, dans les interventions. Il se porte bientôt volontaire pour remplacer le chirurgien du 2ème Bataillon qui a été blessé.

Le 7 juillet 1944, tôt le matin, une attaque massive[13] déborde le 2ème Bataillon aux alentours du village de Tanapag. Les Japonais enfoncent les lignes américaines. La station médicale est très vite débordée de blessés qui affluent. La situation est désespérée. Salomon ordonne l'évacuation des blessés et du personnel soignant. Il décide de couvrir leur retraite et s'empare d'une mitrailleuse dont les servants ont été tués. C'est la dernière fois qu'il sera vu vivant[14].

Tôt, le 8 juillet, les positions perdues sont reprises par les Américains.

Le Capitaine Edmund G. Love accompagne alors ceux qui reviennent sur les positions du 2ème Bataillon. Il se souvient : *« Nous marchons sur un amas de soldats morts. Tout à coup, le Général se met à courir vers le visage d'un homme allongé sur une lourde mitrailleuse. Le Général prend alors un couteau et coupe le brassard de la Croix Rouge sur le bras de Ben Salomon. Aussitôt, il se redresse et regarde autour de lui. Il constate que 98 soldats japonais sont étendus face à la position que défendait Ben Salomon. Ce dernier a tué tellement d'hommes qu'il a été obligé de déplacer son arme à quatre reprises, pour avoir un champ de tir dégagé. On constate autre chose. Le corps de Ben Salomon est criblé de 76 balles ».*

Le 1er mai 2002, le Président George W. Bush lui décerne, à titre posthume, la Médaille d'Honneur pour son *«extraordinaire héroïsme et dévotion à son devoir »* dans cette campagne. Cette distinction lui avait été refusée, dans un premier temps, après la guerre. En effet, un article de la Convention de Genève interdit à un médecin d'une armée d'un pays signataire de prendre les armes. Le Capitaine Ben Salomon est le premier dentiste de l'armée américaine à avoir obtenu la Médaille d'Honneur. De plus, le Corps Dentaire d'Armée a honoré sa mémoire en donnant son nom à une clinique dentaire, à Fort Brenning.

Organisation du service dentaire de l'armée américaine, pendant la Seconde Guerre Mondiale.

Le Corps Dentaire de l'Armée américaine[15] est organisé en deux services :

- le premier suit le mouvement des troupes, à l'aide de véhicules aménagés ;
- le second, en arrière du front, est développé dans des cliniques spécialisées.

Avant la phase de débarquement en France, un grand effort de préparation des forces alliées est fait par les services dentaires, pour éviter les problèmes sur les fronts. Par la suite, pendant de longs mois, 50 % des chirurgiens-dentistes servent comme assistants aux bataillons chirurgicaux ou dans d'autres services médicaux, non dentaires.

Une fois la situation des armées alliées devenue plus sûre, l'organisation des services dentaires de l'avant ainsi que de la zone intérieure, est rendue possible.

Depuis le début de la guerre[16] jusqu'à la fin de celle-ci, le nombre de chirurgiens-dentistes passe de 250 à un peu plus de 15 000. Le nombre d'hommes et de femmes dans l'armée américaine pendant cette période est d'approximativement 8 000 000 d'individus. L'objectif du Service de Santé américain est d'arriver à une proportion de I dentiste pour 500 hommes.

L'objectif sera atteint en 1943. En décembre 1942, il aurait fallu 30 000 chirurgiens-dentistes pour respecter cette proportion quand près de 500 000 hommes entrent dans la guerre, en un mois. Cette situation[17] est rétablie dès l'année suivante, alors que l'arrivée des troupes est plus étalée dans le temps.

Une grande pénurie de matériel touche le service dentaire à l'entame de la guerre, mais *la production nationale américaine rattrape très vite ce retard qui n'existe plus au moment du débarquement.*

Les équipes mobiles.

L'armée américaine dispose de 33 camions aménagés *en cabinet dentaire* qui se déplacent sur toute la ligne de front, en Europe. Elle dispose aussi de 30 camions aménagés en *laboratoire* de *prothèse,* qui suivent les premiers.

Des unités volantes, composées d'un dentiste et de son assistant, peuvent intervenir avec un matériel urgentiste à tout moment, dans les zones d'affrontements. Ces équipes disposent, le plus souvent, de *matériel transportable en kit* comme un fauteuil démontable et un tour dentaire à pieds. Tout le petit matériel est en caisses, de même que le matériel nécessaire à la fabrication des prothèses dentaires. Ces ensembles sont utilisés *dans des positions avancées de première ligne.* Au cours du conflit, quelques modifications sont faites, à la demande des dentistes, pour apporter davantage de confort au patient et au praticien, comme l'apport d'une lumière artificielle et d'un tour électrique.

L'approvisionnement[18] se fait à partir de matériels et matériaux stockés dans des entrepôts situés dans des endroits sécurisés, en arrière des zones de combats.

Le service dentaire des zones arrières

Ce service est *organisé en cliniques* qui ont pour but de centraliser et d'optimiser les possibilités de soins dentaires. En fonction des régiments basés sur place, ces cliniques disposent de différentes capacités d'accueil, cotées de I à 6 :

- dental clinique (DC) I : elle est équipée de 25 fauteuils. Elle est prévue pour des camps divisionnaires ou d'autres formations, regroupant environ 15 000 hommes. Cette clinique est pourvue du matériel le plus moderne (un appareil radio, laboratoire de prothèse), réparti sur deux étages. Elle mesure 40 m de long, pour 12 m de large ;
- DC 2 : la clinique DC 2 n'a pas d'étage et est prévue pour 15 fauteuils. C'est une réplique de la première, en plus petite. Elle est adaptée à des formations de 10 000 hommes et retrouvée dans des hôpitaux de 250 lits ou plus ;
- DC 3 : elle contient 8 fauteuils. Ce type de clinique apparaît au milieu de l'année 1941, pour des camps de 3 000 à 6 000 hommes ou pour des hôpitaux ayant 100 à 200 lits ;
- DC 4 relie comprend 3 fauteuils et apparaît au milieu de l'année 1943. Elle est conçue pour les petits cantonnements. Elle fait partie intégrante du dispensaire. Elle est équipée de matériel de base (un appareil radio et un laboratoire de prothèse miniature) ;
- DC 5 : elle ne présente qu'un seul fauteuil. Elle répond à des besoins qui ne sont pas assez grands pour une DC 4. Elle ne possède pas de radio, mais est équipée de matériel de base pour un laboratoire de prothèse ;
- DC 6 : c'est une version simplifiée de la DC 5, avec également un seul fauteuil. Elle est *conçue pour les camps de prisonniers* dont les américains se souciaient.

La formation de chirurgiens-dentistes militaires, aux U.S.A.[c]

Avec l'entrée en guerre des Etats-Unis, un nouveau programme militaire est mis en place et appliqué dans les écoles dentaires du pays. Les étudiants qui ont passé l'examen d'aptitude physique sont déférés au service actif, jusqu'à leur complète formation. Ils reçoivent aussitôt le grade de second lieutenant dans l'armée ou une classification d'enseigne de vaisseau, jusqu'à leur diplôme.

Statistiques

Du début jusqu'à la fin de la guerre, l'armée américaine comprend approximativement 8 000 000 de soldats.

Chaque année, pour 1000 hommes reçus en consultation[21], sont comptabilisés environ :

109 appareils dentaires réalisés ;
- 32 réparations prothétiques ;
- 8 bridges,

soit un total de 149 actes prothétiques pour 1000.

Ainsi, durant la période du I er janvier 1942 au 31 août 1945, le Corps Dentaire de l'Armée américaine[22] effectue 16 231 264 extractions, 69 546 560 restaurations, 579 473 appareils dentaires complets, 2 032 684 appareils dentaires partiels et 206 500 bridges.

Ce service perdra I 16 officiers dentaires, sur tous les fronts : 20 décéderont au combat, 5 succomberont de leurs blessures, 10 mourront en captivité et 81 perdront la vie, suite à une maladie ou à des blessures reçues loin des affrontements.

Conclusion

Le service dentaire de l'armée américaine a occupé une place prépondérante dans les services médicaux, en délivrant des soins dentaires aux marines, leur évitant des « *rages de dents* » handicapantes au combat, en participant aux multiples interventions chirurgicales délivrées dans les hôpitaux comme chirurgien, assistant opératoire ou infirmier, se dévouant pour leurs camarades blessés ou agonisants ou enfin, comme soldat dont le courage et l'abnégation ont souvent été cités en exemple.

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Biographie

Xavier Riaud a fait ses études à Nantes. Docteur en chirurgie dentaire en 1997, lauréat de l'Académie Nationale de chirurgie dentaire en 1998, il est également titulaire d'un Diplôme universitaire d'expertise bucco-dentaire en 2000, à Montpellier. Son champ de recherche et d'investigation couvre l'histoire de la pratique dentaire avant et pendant la seconde guerre mondiale. Il est enfin l'auteur d'un livre qui vient d'être publié et qui s'intitule : "la pratique dentaire dans les camps du IIIème Reich "

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Fig 1. Mobile dental truck. Unité mobile dentaire

Fig 2. DC-1

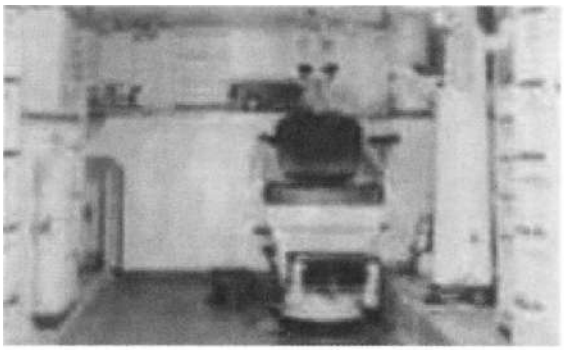


Fig 3. Interior mobile dental truck[23] Intérieur d'une unité mobile dentaire

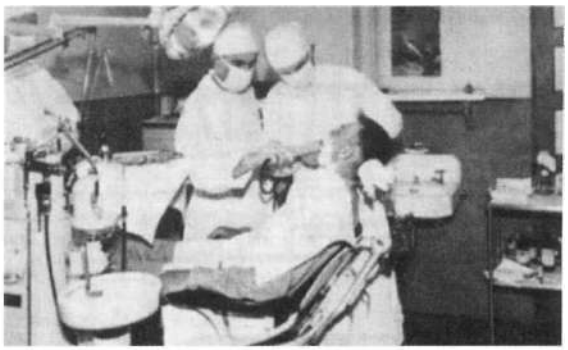
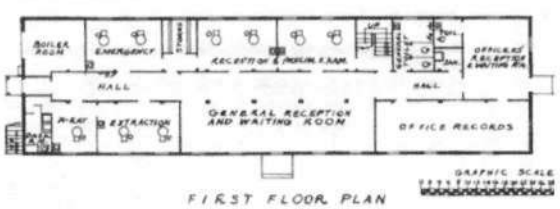


Fig 4. DC-1



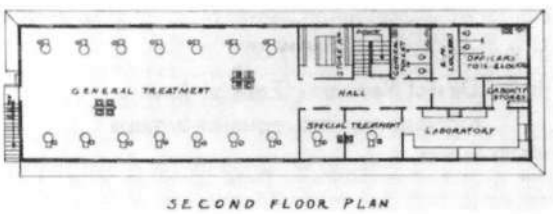


Fig 5 & 6. Dental clinic type DC-1. Clinique dentaire DC-1.

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Fig 7. Waiting room of dental clinic 1945[24]
Salle d'attente d'une clinique dentaire 1945

Fig 8. On L CptJ Lyten (dentist - 8th Armoured Division) outside a hospital for concentration camp survivors[25].
Sur la gauche, le capitaine J Lyten (dentiste de la 8ème division blindée) à l'extérieur d'un hôpital pur les survivants du camp de concentration.

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Israel-Tïberias. I st International Conférence on Medicine and Ethics	20-25 March 2005	www.ortra.com/maimonedes
Iceland- Reykjavik. XXth Nordic Médical History Congress	10-13 August 2005	www.icemed.is/saga contact conference@icelandtravel.is
UK-Exeter 21 st Congress of the British Society for the History of Medicine. Centre for Médical History, University of Exeter.	1-4 September 2005	www.ex.ac. uk/shipps/medhist/BSHM Miss Claire Keyte, Centre Co-ordinator e-mail c.c.keyte@Exeter.ac.uk
Greece-Patras 3rd International Meeting of the History of Medicine Water and Medicine	11-14 September 2005	"Ermineia", Odos Gounary 37, Patra 26 221 Tel and fax 0030 2610 226 530 email ishmgreece@hotmail.com
Hungary-Budapest 40th Congress of the International Society of the History of Medicine	26-30 August 2006	Congress Organiser: Hungarian Academy of Sciences Office for International Co-operation, Mrs Klara Papp, 1051, Budapest, Nador u.7 HUNGARY Tel 36-1-327-3000/2538 Fax 36-1-41 1-6370 e-mail info@ishm.2006.hu

39th *International Congress of the History of Medicine*

JSG Blair. A Musajo Somma.

This year's Congress was in Italy, in Bari, Metaponto, from 3rd to I Oth September, and was the first Italian Congress to be held in this southern part of the country. Every land brings its own national heritage and flavour to its Congress, and Bari was no exception. Here was all the cheerful efficiency and breadth of activities, as well as the wonderful weather, that Italy offers so well. Our thanks are due to the Organising Committee, with Professor Musajo-Somma Congress president, G Acete secretary, to Professor Musajo-Somma's International Scientific Committee, L Medullo and A Porro their secretaries, and to the Congress Organisers, B and C Servizi Integrati and their staff.These together put in an enormous amount of time, energy, and skill to make it a success.To produce such an outstanding quality of Proceedings so early was a unique achievement.

Participants were accommodated at the newly built Village Calane Hotel and Conference Centre. Well-appointed lecture rooms (Pitagora, Alcamene, and Milone) with first-class facilities were on the first floor and a short distance away in the Valentino Hotel (named after Rudolf Valentino, a famous local son) was the Clarke room.

Themes of the Congress included Medicine and Archeology, the Scientific Method in Experimental Medicine, a Grmek Memorial Tribute, History of Arabic-Islamic Medicine, Oncology and Epistemology, Medicine and Mathematics for Health Devices, History of Medicine in Health Sciences Education, History of Plastic and Cosmetic Surgery and of Sports Medicine, and Varia of a wide range. 261 papers were in English, 51 in Italian, and 20 in French. A round table discussion on editing History journals confirmed the need for the written and printed word as well as for new web sites.

Poster sessions were especially large and varied. Master lectures began each day — Bone disease in ancient peoples, Bringing together History of Medicine and Science, European concepts of medical ethics in the 13th and 14th centuries, Patients' and doctors' views about plastic surgery in the 16th and 17th centuries, and History, art, and the patient-physician relationships in headache.

A significant number of delegates did not appear to give their papers, which was unfair to the organisers. The Vesalius Editorial Board meeting (editors A Lellouch, D Wright and JSG Blair) heard of good progress in production and publication of the Journal to a record number of members, and good suggestions for new ideas to be considered.

It would be invidious to select any lecture from the total, but one outstanding lecture must be recorded: 'Medical History for the medical student', by Dr John Cule, ISHM Honorary Life President, on the evening of Wednesday 3rd September in the Great Hall of the Faculty of Medicine in the University of Bari. Those who failed to hear this lecture missed an experience. So significant was the lecture that it was later repeated in the Italian national news.

The Social Programme was full and varied.The Opening Ceremony was as impressive as always, with speeches by the International Society President JP Tricot, the Italian Society President G Armveida, and the Congress President A Musajo-Somma.

On the morning of Monday 6th, there was a visit to the Policoro Archaeological museum and in the evening there was a visit to the Temple of Hera (although bad light detracted from the hoped-for view of a Mediterranean sunset). This was followed, at the Pantanello Agro-archaeological Centre, by the Metaponto lecture, 'Medicine and the Olympic Games', given by A Diamandopoulos to a large audience. There was a short cruise to the island of S.Pietro, and visits to the Theme Park at Felifonte on Tuesday 7th, followed by an Ethno-music party that evening. On Thursday 9th we all went to the UNESCO world heritage site. That evening Professor Diamandopoulos was elected President of the International Society for the History of Medicine at the Administrative Council meeting.

The Gala Dinner on the 9th was a happy occasion and the Congress ended after the Annual General Meeting on Friday I Oth. The departing president, JP Tricot, was thanked for his contribution during his four years in post. After the majority of participants and accompanying persons had left, some stayed on to enjoy post-congress trips to Pompei,Trani/ Castel del Monte, and Alderobello and the Grotto of Castellana and the friendly Italian atmosphere.

JSG Blair. A Musajo Somma.

Photographs of past congresses. Les congres passes (photographies)

J. Honti, A. Lellouch

35th ISHM congress Greece, Cos: 2-8 September 1996
35eme. Congres Grece-Cos: 2-8 Septembre 1996

Fig I Dr £ Lomax (left) and Prof YV O'Neil (right)

Fig 2 From left Hindrik Strandberg (Finland), Maria Vida (Hungary), Mrs.Strandberg, Balint Boga (Hungary),Arpad Szallasi (Hungary)

Fig 4 1st left Prof J-PTricot (Belgium), 2nd left R Price (UK), 1st right DrJ Cule (UK)

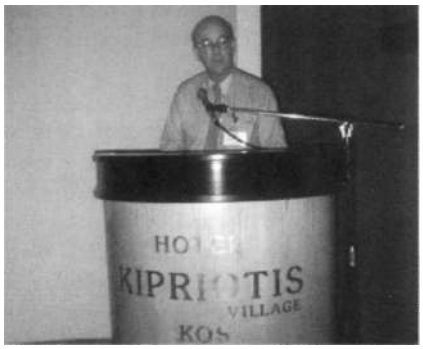

Fig 3 Professor J Pearn (Australia)

Fig 5 DrJ Honti (Hungary)

Fig 6 Professor and Mrs C Burns (USA)

Nouvelles des pays membres
News from member countries

Algérie

Le jeudi 29 janvier 2004, à la Bibliothèque nationale d'Alger (El Hamma), s'est tenue avec succès la 1ère Rencontre Scientifique de la Société Algérienne d'Histoire de la Médecine (SAHM), sur le thème « *Histoire de la médecine, pourquoi* ? ».

La cérémonie d'ouverture s'est faite devant une centaine de professionnels intéressés : médecins, dentistes, philosophes, sociologues, islamologues, mathématiciens, historiens, etc. Après les allocutions du Dr Mahmoud Aroua (Président actif de la SAHM), du Pr. Saïd Chibane (Président d'honneur et 1er Président de la SAHM) et du Pr. Mohamed Drif (Doyen de la Faculté de Médecine d'Alger), plusieurs conférences sont venues illustrer le thème principal de cette journée:

« *Expérience de l'enseignement de l'histoire des sciences dans le Département de Philosophie à l'Université d'Alger* ». (Pr. Cheikh Bouamrane, Professeur en Philosophie et Président du Haut Conseil Islamique).

« *L'histoire de la médecine, pourquoi ?* ». (Dr. M. Aroua, Médecin Anesthésiste Réanimateur, Président de la SAHM).

« Le *larynx et ses affections en médecine arabo-islamique* ». (Dr. MTchikou, Médecin Spécialiste en ORL,Trésorier de la SAHM).

« *Histoire de la déontologie médicale en Algérie* ». (Dr. B. Merad-Boudia, Directeur de la Publication de la « *Revue Médico - Pharmaceutique* »).

« *Historique de la responsabilité médicale* ». (Dr. M. Bekkat Berkani, Président du Conseil de l'Ordre des Médecins de la Région d'Alger)

« *Médecine dentaire et éthique en Occident Musulman: fragment d'une histoire occultée* ». (Dr. El Hadi Baba Ali, Président du Conseil de l'Ordre National des Médecins).

« *Ibn Sina et l'ophtalmologie* » (Pr.A. Stambouli, Professeur en ophtalmologie à l'Hôpital de Blida).

Les travaux se sont déroulés dans un climat convivial suivis de débats fructueux permettant l'échange des expériences en matière de recherche bibliographique et de traitement de l'information, médicale en général. On notera la présence de l'Attaché culturel de l'Ambassade de Belgique et la représentante du Centre Culturel Français d'Alger.

A l'occasion de cette journée, la SAHM a édité le I er numéro (n° : 0) de sa revue semestrielle Tarikh Ettib (Histoire de la Médecine) qui comprenait les articles suivants : « *La médecine arabe dans l'Espagne musulmane à travers l'œuvre d'Ibn Zuhr* » (F. Bouamrane) ; « *La mémoire d'aujourd'hui dans l'histoire de la médecine de demain* » (J-P Tricot) ; « *La santé et les facteurs d'environnement d'après le Canon de la Médecine d'Ibnou Sina* » (A. Aroua); « *L'histoire de la médecine, mérite-t-elle d'être enseignée* ?» (M. Sendrail) ;« *Le guide en ophtalmologie* » (S. Chibane) ;« *La paralysie faciale selon Ibn Sina* » (M.Tchikou) ; « *La douleur dans le Colliget d'Ibn Rushd* » (M. Aroua).

Le deuxième numéro de Tarikh Ettib (n° : I) est paru au mois de juillet 2004, et porte sur les sujets suivants : «*L'approvisionnement en eau et l'assainissement de la ville d'Alger à l'époque ottomane* » (N. Aroua) ; « *Histoire de la médecine aéronautique* » (EB. Rahal) ; « *Le larynx et ses affections en médecine arabo-musulmane* » (M.Tchikou) ; « *Histoire de la déontologie médicale de 1962 à nos jours* » (B. Merad Boudia) ; « *Histoire de la médecine, pourquoi ?* » (M. Aroua).

Mahmoud AROUA
Délégué National de l'Algérie
Mahmoud.aroua@laposte.net

Iceland

The XXth Nordic Médical History Congress will be held in Reykjavik, Iceland from August 10-13, 2005.The meeting will be at the University of Iceland in Reykjavik, which is located near the center of Reykjavik, and will be organised by the Icelandic Médical Historical Society.

The meeting topics are The Patient and Society, Epidémies in Northern Countries,

Medicine and Common Knowledge, The General Practitioner in Historical Perspective, The History of Dentistry, The History of Pharmacy.Viking and Médiéval Medicine, Women in Medicine. There will also be Open Sessions.

The congress language will be English, but Danish, Swedish and Norwegian are allowed.

Detailed information on the scientific programme, invited speakers, field trips, meeting registration, abstract submission and accommodation is available on the Conférence website: www.lis.is/saga.

The Congress secrétariat is Iceland Travel (Conférence Department), Lâgmûli 4, PO Box: 8650, IS-128 Reykjavik. Tel.: +354 585 4300. e-mail: conferences@icelandtravel.is.

It is important to notice that low-cost airfares are often available to Iceland and that there will be a variety of accommodation at différent prices.

Atli Olason

3rd International Meeting of the Historians of Medicine
Patras, Greece, 11-14 September 2005

First **Announcement**

We are pleased to announce the 3rd International Meeting of the History of Medicine to be held in Patras, Greece, from Sunday I Ith till Wednesday 14th September 2005.The Meeting is the formal biennial event of the International Society for the History of Medicine, organized for the year between two International Congresses.The last meeting, which took place in Mexico, was unquestionably a success.The theme of the forthcoming Meeting is:

Water and Medicine

It is a well-known fact that water is an essential element of life and the major component of the Earth's surface. Consequently, it has always played an important role in medicine, either as a therapeutic agent or as a corporeal element that required urgent restoration to equilibrium. At the same time, the aquatic route (sea, rivers, lakes) was the most efficient way for the traffic of goods, knowledge, ideas, civilization, regimes and, obviously, people. Given the above, we thought it only proper to devote the forthcoming Meeting to the historical relationship between Water and Medicine. As Greece is an ancient maritime state and the city of Patras, its main port to the West, we already had good reasons for the subject. As the boundaries of the subject are vast, the Meeting will be devoted to two particular aspects.

1) The History of Medicine in the countries surrounding the Eastern Mediterranean

The history of Western Navigation started exactly here. Phoenicians, Egyptians, Minoans, Greeks, Romans, Byzantines, Ottomans, Italians, Austrians, Balkan People, Russians and many others whose names and nationalities have changed through the centuries, crossed these waters. Consequently, they exchanged their knowledge on medicine, they imported and exported medicinal substances and they organized hospitals and asylums. Sadly, they were also the carriers of pestilences, initiating epidemics. We invite our colleagues from all countries surrounding Eastern Mediterranean and its extensions, like the Adriatic, the Libyan Sea, the Cyprian Sea, the Aegean, the Propontis and the Black Sea to come together and discuss their accumulated knowledge on these subjects.

2) Hydrotherapy ail over the World

Water treatments were perhaps the most ancient means for restoring health and preventing disease. Either via its external use in hot and cold baths, showers, hammams in plain, mineral or rain water, or via its internal use by drinking curative or miraculous waters, the union of hydrogen and oxygen has marked the practice of medicine in every era and area. Hence, medical doctors of various specialties, physiotherapists, physicists, hydrotherapists and all others who are interested in hydrotherapy are welcome to contribute to the subject.

Above all, meetings are to meet people. We plan a "homely" gathering.Visits to private neoclassical mansions, garden parties in private eclectic villas, meals served at the refectory of monasteries still in use and accommodation in some refined old buildings are but a small sample of the social program. On top of that, participants and the accompanied members will visit the mythical locations of Olympia, Delphi and Epidaurus, all within one and a half hours from Patras. After all, you have to know the way of life of all sorts of people you meet.This was the goal of a sailor whose story was written three thousand years ago:

"Many cities did he visit, and many were the nations with whose manners and customs he was acquainted"

The sailor's name was Ulysses and the poet who immortalized his adventures "in the many cities and nations" was Homer.

Last, but not least, we have focused on an equally "homely" price.The registration fee will be 450 euros, whereas hotel accommodation will cost between 300 to 400 euros for four nights.This includes all events in the social program.

Cordially,

A.A. Diamandopoulos
President Elect - ISHM,
President of the Organizing Committee

For more information, please contact the President of the Organizing Committee:

Dr.Athanasios Diamandopoulos
Odos Agiou Andreou
Chorio Romanou
Patra 26 500
GREECE
Tel: 0030 2610 641 364

OR

The Conference Organisation:

"Ermineia"
Odos Gounary 37
Patra 26 221
Tel. & Fax: 0030 2610 226 530
e-mail: ishmgreece@hotmail.com

3ème réunion internationale des historiens de la médecine. Patras, Grèce, 11-14 septembre 2005

Première Annonce

Nous sommes heureux d'annoncer la 3 ème réunion internationale des Historiens de la médecine qui se tiendra à Patras, en Grèce, du dimanche I I au mercredi 14 septembre 2005. Cette réunion de la société internationale d'histoire de la médecine, est celle des années impaires, intercalée entre deux congrès internationaux organisés, les années paires. La dernière réunion de ce type eut lieu au Mexique et fut, de l'avis de tous, un succès. Le thème de la prochaine réunion à Patras s'intitule :

L'eau et la médecine

L'eau, c'est un fait bien connu, représente le constituant essentiel de notre matière vivante ; c'est aussi le principal composant de la surface de notre terre. L'eau a donc toujours joué un rôle important en médecine et comme agent thérapeutique et comme élément corporel dont l'équilibre doit être impérativement maintenu. En même temps, l'eau des mers, des fleuves et des lacs a constitué, dans le passé, le moyen le plus efficace pour acheminer les marchandises d'un lieu à un autre. Ce fut encore un vecteur de connaissances, d' idées et de civilisations et aussi un moyen de circulation des personnes. Compte-tenu de ce qui précède, nous avons pensé approprié de consacrer notre prochaine réunion SIHM des années impaires à l'étude des relations historiques tissées entre l'eau et la médecine. Durant l'Antiquité, la Grèce a été une région maritime et la ville de Patras a constitué son port principal, sur la côte ouest. Cette situation géographique nous a sensibilisé à ce thème. Pour bien le délimiter, la réunion sera consacrée plus particulièrement à deux aspects principaux.

Premier thème : L'histoire de la médecine des pays de la Méditerranée orientale

C'est au pourtour de la Méditerranée orientale qu'a débuté l'histoire de la navigation occidentale. Ce sont ces eaux qu'ont traversé Phéniciens, Egyptiens, Cretois, Grecs, Romains, Byzantins, Turcs, Italiens, Autrichiens, peuples des Balkans, Russes et de nombreuses autres populations dont les dénominations ont changé au cours des siècles. Ici, on a échangé des connaissances médicales, importé (et exporté) des substances à usage médicinal et aussi organisé des lieux servant d'hôpital et d' asile. Ces mêmes peuples furent encore vecteurs d'épidémies pestilencielles terriblement dévastatrices. A Patras, nous invitons tous nos collègues originaires du bassin méditerranéen oriental et de ses prolongements (mer Adriatique, mer de Libye, mer du Levant , mer Egée, mer de Marmara, mer Noire) à venir ensemble discuter de toutes les connaissances accumulées sur ces sujets.

Second thème : L'hydrothérapie dans le monde

Les traitements à base d'eau ont été peut-être les thérapeutiques les plus anciennement utilisées pour reconstituer la santé et empêcher la survenue de maladie. L'eau administrée par voie externe (bains chauds ou froids, douches, hammams d'eaux plate, minérale, de pluie) ou par voie interne (ingestion d'eaux curatives ou miraculeuses), a ainsi marqué la pratique médicale de nombreuses époques et aires géographiques. En conséquence, les spécialistes médicaux de diverses disciplines (physiothérapeutes, spécialistes de médecine physique, hydrothérapeutes) et, de façon générale, tous ceux qui s'intéressent aux vertus de l' hydrothérapie sont les bienvenus et leurs contributions seront appréciées.

Surtout, ces réunions nous fourniront l'occasion de nous retrouver simplement, dans une ambiance accueillante . Les visites de châteaux et de manoirs privés, de style néo-classique, les garden-parties, les repas servis dans les monastères et l'hébergement dans quelques vieilles demeures raffinées sont un échantillon du programme social. En plus, participants et accompagnants visiteront les lieux mythiques d'Olympie, de Delphes et d'Epidaure, situés à proximité de Patras. Après tout, il vous faut connaître le mode de vie des différentes catégories de personnes que vous serez amenés à rencontrer. C'était le même but que s'assignait un marin dont l'histoire a été écrite voici trois mille ans:

" *// visita* de *nombreuses cités et nombreux furent les pays dont il fut à même de mieux connaître,* de cette *façon, le mode de vie* et *les coutumes* ".

Pour ces différentes prestations, nous nous sommes efforcés d'obtenir des prix également « simples » . Le montant de la participation s'élève à 450 euros et celui de l'hébergement varie de 300 à 400 euros (pour quatre nuits). Ces sommes incluent aussi toutes les manifestations prévues dans le programme social.

Cordialement,

A.A. Diamandopoulos, Président élu - SIHM,
Président du Comité d'organisation:
(Alain Lellouch a aidé à cette traduction en français)

Pour plus d'information, svp contactez le Président du Comité d'Organisation:

Dr Athanasios Diamandopoulos
Odos Agiou Andreou, Chorio Romanou
Patra 26 500, GREECE
Tel: 0030 2610 641 364

OU

Les organisateurs de la Conférence :

"Ermineia"
Odos Gounary 37, Patra 26 221
Tel. & Fax: 0030 2610 226 530
Courriel: ishmgreece@hotmail.com

Book Reviews, Vesalius, X, 11, 88-93, 2004

Book *Reviews*

Yesterday's Anaesthesia

Ernest Kern, Jean Lassner, Guy Vourc'h

Three men who joined General de Gaulle

Preface by Professor Jean-Marie Desmonts
Glyphe and Biotem editions. Paris. 2004 pp 336
29 euros ISBN 2-911119-50-9

This book recounts the history of anaesthesia in post-war France and the most interesting aspect of it is that the history has been written by those who also created it. On the first page, the reader will see a signed tribute by no less than Jacques Chirac, the President of France, to Professor Jean Lassner, one of the three French doctors who joined General de Gaulle to fight for the freedom of their country. After winning freedom, all three started building the specialty of anaesthesia in France, which was almost totally destroyed due to devastation caused by the war. In order to be able to lead they designed their own post-graduate training in Britain and America, selecting those departments that were headed by pioneers in their own right. The high level of service they offered after starting their own departments in France can be judged by the fact that one of them anaesthetised General de Gaulle and then looked after him in intensive care. The chapter written by Professor Lassner, with some historical photographs, is a valuable record of the social history of anaesthesia in France. Even after retirement, Jean Lassner remained active and helped to establish the European Academy of Anaesthesiology in 1978. Almost all the photographs published in the book are fascinating illustrations of history and record captivating moments that most historians will find of great interest.

The book was originally published in French; the English translation offers an opportunity to English speaking historians of medicine to benefit from it. Whoever took this wise initiative must be congratulated on their far sightedness.

There are few minor flaws in this soft cover publication, which is otherwise excellently produced. It suffers from the slightly disorganised way in which the material is presented. This is obviously due to the lack of editorial control; there is no named compiler or editor. Similarly the names of those who translated are lacking. More importantly the book has no index. Despite these minor shortcomings the book is an important addition to medical history, recording the academic contributions and achievements of the three anaesthetists who in the face of great difficulties quickly established high standards of anaesthesia.

Nasim H Naqvi

The History of Moorfields Eye Hospital, Volume III, Forty Years On

by Peter K. Leaver.

RSM Press ISBN 1-85315-580-2

This is the third book of a series, the others having been published in 1929 and 1975. The overlap occurs because 1963 marked the appointment to the Chair of Clinical Ophthalmology of Barrie Jones whose strategic vision and its legacy has guided the modernisation of the hospital technically and politically to the threshold of its bicentenary. During this period two separate hospitals have amalgamated and general ophthalmic clinics and some day surgery sessions have been planted in peripheral hospitals in London. Relationships with the Institute of Ophthalmology, a centre of research and teaching, have also seen changes.

The book is divided into four separable sections of which the first, on changes in medicine, technological, socio-economic and political, is of wide general interest to those with experience of the National Health Service in action. The other sections on clinical and clinical support services, education and research and management and infrastructure are more specialised, describing the complex of hospital activity and some of the relational difficulties which occurred.

Lessons in the management of innovation are there to be learned, Moorfields being fortunate in having enough staff with the rare but necessary skills, supported by endowment funds allocated by enlightened trustees. An extreme example is the clearance of former air-raid shelters from the basement using a controlled explosion to create more space for clinical use. The text is interspersed with such recollections from members of several departments. The author, who was both trainee and consultant at the hospital, manages to convey a comprehensive moving picture in an easy style and there are numerous illustrations, some in colour. This finely presented history deserves reading by more than those with direct links with Moorfields. It offers an insight into the way many hospitals work and what it is like to work in them.

Geoffrey Millar

Miguel Serveto or Miguel de Villanueva

(Commemoracion del 4S0 aniversario de la muerte de Miguel Servet)

Editor: Navarre Government
Issues about History of Medicine
ISBN: 84-235-2503-1
Price: 7 €

This book is the first number of a new collection devoted to « History of Medicine ». The issue contains lectures given in 2003, by several authors, in Tudela and Pamplona to commemorate the 450th anniversary of the death of Michel Servetus.

The title of the book gives us an overview of his life when we consider his name. He used his better-known surname « *Servetus alias Reves* » from Aragon, informally when he needed a nickname or when he was in danger, for instance in Basel or in Geneva. By contrast, the surname « de *Villanueva* » was used in official or recorded documents. He was born in Navarre, at that time an independent kingdom in Spain, whose last Jews were exiled in 1498, six years after those from Aragon. He came from the rebellious city of Tudela, conquered in 1512, but containing at this time, a very important refugee population of crypto-Jews including several members of the « *deVillanueva* » family. This fact allows a better understanding of Servet's hebraism and of his theological views which were so different from his contemporaries.This is one of the ideas developed in this book.

The book starts with, « *In Servetus death* », by Jose Javier Vines, Public University in Pamplona, which discusses the exhibition of original books by Servetus, Renaissance music and other events in Pamplona and Tudela , in October and November 2003.The second author, Manuel de Fuentes Sagaz, of the Spanish Society of Cardiology, has written about « *Servetus, works, personality and time* » .The third author is Francisco Javier Gonzalez Echeverria (the ISHM Spanish national delegate) . His topic is « *The relationship between Servetus and Navarre* ». D. Antonio Paniagua Arellano, emeritus in History of Medicine in University of Navarre took the subject of « *Servetus as a doctor of the Renaissance* ».A theological side was displayed by Alfredo Lopez Vallejos in « *Theological and philosophical trends in XVIth century Christianism* ». Two further documents bring the book to a close ; a dramatic work, in one act , written by Javier Munarriz Sanjuan and Francisco Gonzalez Echeverria, performed in Tudela, on October 25,2003 and a reprint of the 1933 first edition by D.J. Goyanes entitled « *Michael Servetus, theologian, geographer and doctor* ».

The book of 266 pp. has 36 colour and black and white illustrations, showing the various celebrations which took place in Navarre, together with other material including protocols, documents, Servetus's works, and art work by Picasso .

In summary, this book, written in Spanish, is of great interest for those keen to see new aspects of a very famous physician, astrologist philosopher and theologian.

Alain Lellouch

Journal de *Santé* de *Louis XIV,*

écrit par Vallot$_9$ Daquin et Fagon (édition établie par Stanis Perez), précédé de « La lancette et le sceptre »,

par S. Perez.Jérôme Million éd., Grenoble 2004, 445 pp., 27 €

Ce livre comporte trois textes différents. Le premier (55 pp.) « *La lancette et le sceptre* » est signé Stanis Perez . Il est suivi d'un lexique commode, re-définissant les formes médicamenteuses courantes de l'époque. Cette entrée en matière, enrichie de notes et de références érudites, rapporte aussi les impressions d'historiens ou de critiques littéraires du XIXème siècle : Michelet, Sainte Beuve (étudiant en médecine) et Daremberg (historien de la médecine) s'expriment face à la description des tracas de santé de Louis XIV. Cités encore par S. Perez comme ouvrages de référence la synthèse de Dégueret, *Histoire médicale du Grand Roi* (1924) et le livre documenté de J.-J. Peumery : *Les mandarins du grand siècle* (Les empêcheurs de penser en rond, 1999) .

Le second texte (15 pp.) ici publié est l' introduction rédigée en 1862 pour l'édition dactylographiée princeps, en français à l'orthographe et à la ponctuation modernisées, des « *Remarques sur la santé du Roy* ». Son auteur est un bibliothécaire nommé Le Roi. Son texte détaille les noms et les dates d'exercice des cinq médecins de Louis XIV : Cousinot (déjà son médecin comme Dauphin , à la mort de Louis XIII, en 1643 ... jusqu'à sa mort.. en 1646) ; Vaultier, (de 1646 à sa mort, en 1652) ; surtout Vallot (de 1652 jusqu'à sa mort en 1671) ; d'Aquin (de 1671 à jusqu'à sa disgrâce, en 1693) et, bien sûr Fagon (de 1693, jusqu'à la mort de Louis, en 1715.). Les rédacteurs des « *Remarques sur la Santé du Roy* » sont ces trois derniers médecins de Louis XIV. D' âpres conflits d'origine, de personnes et de doctrines

opposaient férocement entre eux ces médecins courtisans : les montpelliérins (Vaultier.Vallot et Daquin) étaient plutôt partisans d'une médecine chimique, inspirée de la médecine arabe ; ils utilisaient souvent opiacés, antimoine et quinquina. Les parisiens (Cousinot et Fagon), représentaient la très galénique Faculté de Paris et défendaient plutôt purgations et saignées.

Les « *Remarques* » proprement dites, rééditées par St. Perez, constituent la dernière partie, la plus importante (372 pp.) du livre En dépit du titre de couverture, disons d'emblée que ce *«Journal de Santé* » n'en est pas un : rien à voir avec celui Héroard qui, par exemple, notait méticuleusement, jour après jour, voire heure après heure, l' hygiène et l'alimentation nécessaires au développement du petit Louis XIII. Les *«Remarques sur la santé du Roi* » décrivent, année par année, les « *accidents ... survenus au Roy* » et les thérapeutiques prescrites par ses « *premiers médecins* ». Le choix et le moment des traitements sont justifiés et chaque fois que le traitement réusssit, c'est l'occasion de se faire valoir aux yeux de la postérité.

Louis XIV nait en 1638 et meurt en 1715. Cinquante-huit ans (1653-171 l) de pathographie sont égrenés : la vie, les faits et gestes, petits et grands, ainsi que les troubles d'un long règne nous sont ainsi contés . « Le *roi, de page en page, est purgé et chanté* », écrivait Michelet. Remarquons que les dernières années de la vie du Roi et ses derniers moments face à l'imminence de la mort ne nous sont pas décrits . De la riche sémiologie qui nous est présentée, on extraira d'abord les très fréquents troubles digestifs : bouche amère, mauvaise haleine, avulsion de dents cariées, douleurs d'estomac, « *colique venteuse* », « *flux de ventre* », « *dévoiement* ». Il y a aussi les émissions fréquentes, par les selles, de vers morts.Vers la fin de sa vie, le monarque nous apparaît anxieux et, somnambule : agité de cauchemars et il se rend, parlant tout haut, à la « *garde-robe* » pour exonérer. Tous ces ennuis digestifs sont favorisés par l'incorrigible boulimie de Louis. Il faut encore mentionner les très fréquentes « *vapeurs* », « *lourdeurs de tête* », « *étourdissements* » et « vertiges », dont souffrait le Roi. Les affections vaporeuses étaient décrites dans les ouvrages de l'époque comme des maladies épidémiques affectant surtout l'aristocratie et la riche bourgeoisie oisives de la Cour. Louis souffrait encore de fréquents « *rhumes* », « *refroidissements* » et « *enrouements* » de sa voix. Les « *Remarques* » signalent, de même, les maladies infectieuses de sa jeunesse : petite-vérole (1647), blennorrhagie (1655), « *maladie du Roi, à Calais* » (qui faillit l'emporter en 1658), rougeole (1663) ; le monarque est atteint aussi par les fièvres palustres, dues à l'environnement insalubre des marais de Versailles et de Marly, sans doute à la suite des travaux entrepris d'assèchement et de terrassement. D'Aquin, surtout entre 1686 et 1688, préviendra et soulagera habilement, par la prescription de quinquina, ces « *fièvres* ». On voit ensuite apparaître, au fil des années, les pathologies chroniques de l'âge mur et de la vieillesse : la goutte articulaire qui finira par faire boiter le Roi, limiter sa marche l'obligeant à rester plus souvent assis ; il sera alors gêné par des hémoroîdes, des rectorragies certes indolores mais répétées ; les incommodités viendront encore de la « *fistule* » : elle sera finalement opérée par Félix ; la lithiase rénale, sans doute urique, avec ses fines émissions calculeuses et sableuses répétées et surtout sa gangrène feront aussi beaucoup souffrir le Roi. Pour tous ces troubles, la saignée sera , en définitive, assez peu utilisée. L'émission de selles nombreuses, complaisamment décrites par Fagon est l'indice d' une purge réussie. Les multiples formules des lavements ou des bouillons purgatoires varieront et certaines formules seront signées de la main même du premier médecin Vallot. Plus que la saignée, c'est la purge qui constitue la thérapeutique maîtresse, la panacée, bien souvent capable de trouver une issue heureuse aux déplacements dangereux des humeurs. Elle sera donc inlassablement répétée au fil des ans et des pages.

Pathographie et prescriptions médicamenteuses intéresseront plus directement médecins et pharmaciens. Mais les « *Remarques* » nous donnent aussi l' image d'un corps royal souffrant ;on perçoit bien ici les réactions du patient, face à certaines recommandations médicales et les rapports tissés par le Roi, au fil des années, avec ses « *premiers médecins* ». Les « *Remarques sur la santé du Roy* » passionneront aussi l'historien et l'anthropologue. Le livre de Stanis Perez a donné lieu à l'enregistrement d'un CD-ROM, après une émission à France —Culture. On saura gré à son auteur, historien de la santé et du corps , spécialiste du Siècle de Louis XIV, d'avoir eu l'idée et pris le soin de rééditer et d'annoter ce texte majeur de l'histoire et de l'anthropologie médicales du XVIIème siècle.

Alain Lellouch

Book Reviews, Vesalius, X, 11, 88-93, 2004

Le *Regard de Panatomiste. Dissections et invention du corps en Occident*

Paris, Seuil, 2003.

Le livre de Rafaël Mandressi est de ces ouvrages qui, de prime abord, traitent de sujets déjà bien connus des spécialistes et qui, de plus près, révèlent, en les comblant peu à peu, les failles de la bibliographie disponible. Ceci, au départ, parce que l'histoire de l'anatomie et, plus particulièrement, de la dissection est déjà ancienne. A rebours de bon nombre d'études, Mandressi pose, en priorité, la question de la constitution et de la diffusion d'une discipline (l'anatomie) qui a construit son objet d'étude (le corps segmenté) au bénéfice d'une méthode d'analyse reposant sur la dissection. Ce n'est donc pas une collecte des avancées historiques de la fouille des corps à des fins médicales qui est engagée mais, au travers du dépouillement d'une quantité considérable de références, classiques ou non, une enquête sur un dispositif de connaissance du corps et sur ses influences intellectuelles et sociales.

Le lecteur débute son parcours par un étonnement, celui que l'auteur provoque lorsqu'il montre que c'est par l'émergence d'un regard spécifique que le corps des anatomistes s'est dessiné, et non l'inverse. Ainsi, tout le savoir anatomique ne serait que le résultat d'un processus complexe de désignation et de définition des parties du corps humain auquel ont été associés le regard et la manipulation. A cet égard, comme l'introduction du livre le rappelle, le clitoris est une invention relativement récente - au XVIe siècle - du discours médical. Pourtant, ni l'évolution de la nomenclature anatomique, ni celle des protocoles liés à la dissection ne sont vraiment au cœur de l'ouvrage. C'est davantage la complexification du regard porté sur le corps par les chirurgiens ou les médecins qui retient l'attention de l'auteur. On se remémore alors les thèmes chers à Michel Foucault, ceux développés notamment dans Naissance de la clinique. Mais l'héritage foucaldien s'arrête là, au détour d'une méthode qui en conserve les qualités critiques ainsi qu'une transdisciplinarité bien tempérée, sans verser toutefois dans l'élucubration ou le raccourci de précipitation.

Sur cinq siècles s'est organisé un regard médical fouillant dans les plus petits recoins du corps humain. La segmentation obtenue n'a été retardée ni par une éventuelle interdiction pontificale, ni par une hypothétique sacralisation du corps d'anonymes soumis, après leur mort, au bistouri des chirurgiens. La problématique est toute autre puisque c'est la vision traditionnelle, héritée de l'Antiquité, qui semble avoir exclu l'idée d'une étude des organes et des tissus à des fins d'innovation ou d'expérimentation médicale. La médecine hippocratique n'avait pas besoin de la dissection, bien au contraire. Les traités contenaient l'essentiel du savoir sur le corps. L'âge de la clinique et de la dissection changera la donne.

Ce n'est qu'avec l'avènement du recours à la vue et au toucher dans les procédures d'expérimentation et d'observation que l'étude des différentes parties du corps prendra son envol. Il s'agit dès lors de mener l'enquête dans la masse des chairs en élaborant un nombre croissant de distinctions entre les éléments s'offrant au regard au-delà de la confusion apparente du contenu de l'enveloppe charnelle. L'apparition des premières dissections publiques, à Bologne, cité-phare des études juridiques dans l'Occident du XIIIe siècle, ne relève pas du hasard. Un même état d'esprit, conforté par la similitude des postures intellectuelles,guidait de concert le découpage du corps et de l'objet du droit.

L'auteur n'hésite pas non plus à insister sur la fonction de vérification qu'a rempli la dissection en témoignant, par exemple, en faveur de la théorie de la circulation sanguine. Avec l'avènement de la dissection, le corps s'est changé en un réservoir de vérité qui ne demande qu'à être épuisé par le jeu d'un regard méthodiquement posé sur ses parties les moins faciles et les moins agréables à regarder. Sagement, Mandressi distingue les dissections des autopsies et des autres opérations destinées au prélèvement de futures reliques. La nouveauté ne consiste pas dans l'ouverture d'un corps quelconque, comme les bourreaux le font quotidiennement devant des foules de badauds, mais dans la transformation de cette « manipulation oculaire » en un moment, aussi éphémère que privilégié, de connaissance et d'enseignement comme Rembrandt l'a dépeint avec talent.

Le deuxième grand volet de cette étude est consacré aux ramifications nouées autour d'une pratique considérée a priori comme marginale. Il apparaît que ces corps dépecés avec une méticulosité d'horloger sont l'objet d'un divertissement savant au moment où, dans tous les savoirs, s'insinue la métaphore anatomique comme schéma de pensée. Modèle d'enquête à part entière, l'anatomie cesse d'être un savoir confiné aux marges de la médecine pour définir et imposer son propre régime de vérité. Elle franchit aussi la frontière entre les sciences et les arts en dépoussiérant, au passage, les classifications contemporaines. La mise en évidence des extensions de cette méthode ne se contente pas de répéter ce que fut, à la Renaissance notamment, la profondeur du dialogue entre les sciences et les arts, les meilleurs artistes endossant à l'occasion le costume de l'anatomiste.

A partir de cette époque, une place de choix est réservée à l'anatomie en tant que moyen privilégié dans la connaissance de soi. Au-delà d'un emploi exclusivement métaphorique, l'auteur observe l'intrusion de la méthode anatomique au sein de chaque réflexion cherchant à mettre de l'ordre dans la pensée et l'expérience sensible. De là, ce constat de Mandressi à propos d'une « civilisation de l'anatomie » qui a évacué le dégoût provoqué par la vision des parties d'un corps sans vie et valorisé le découpage méthodique d'une liste infinie d'objets. La promotion de l'expérience critique et du raisonnement méthodique, avant Bacon et Descartes, a sans doute

contribué à la vulgarisation de l'anatomie et des séances de dissection. Ceci rappelle que, de Jean de Salisbury à Hobbes, le corps a constitué un support privilégié de la conceptualisation de notions aussi complexes que celle de « royaume », les crises politiques étant assimilées à des maladies.

Cette mode de la dissection serait-elle une manière d'exorciser, d'un simple coup d'oeil, l'horreur de la mort en transformant le regard ? Mondanité ou non, cette curiosité pour le corps et ses ressorts, goûtée par l'élite éclairée et, indirectement, par une large partie de la population moins familière des amphithéâtres, pose beaucoup de questions sur l'impact auprès de ceux qui assistent aux dissections. C'est peut-être à cet endroit que le texte est le moins prolixe. Cet attrait pour le répugnant, quoique soutenu par une interrogation de type philosophique, artistique ou scientifique, participe peut-être d'un dispositif distinct de représentation du corps et de l'intime en général. L'investigation médicale a sans doute servi de prétexte à nombre de curieux tout autant attirés que révulsés par la vision de ce qui n'est pas longtemps regardable en-dehors de l'enceinte d'un lieu aseptisé par sa vocation scientifique. Cette apparition d'un regard aussi attentif que distancié aurait mérité de plus amples développements, même si l'auteur se devait de respecter la problématique définie dans l'introduction.

Les questions laissées en suspens sont nombreuses. Quel fut l'impact de ces séances de dissection sur les différents types de public ? L'image de son propre corps sort-elle forcément modifiée à l'issue de cette entrevue du sordide et de l'admirable ? Quelle conception du corps permet-elle, au-delà des variations de sensibilité, d'assister stoïquement à pareille cérémonie ? Un changement de définition de la vie et de la mort a-t-il accompagné l'émergence de cet incomparable miroir des vanités ?

Analyse historique d'un point de vue et d'une objectivation, étude de dispositifs construisant leur propre objet, interdisciplinarité critique, inspiration distante des premiers travaux de Foucault et de ceux, plus récents, de Thomas Laqueur : le lecteur averti aura reconnu dans les pages de Mandressi l'influence diffuse du post-modernisme ambiant dans les travaux d'histoire des sciences. Mais point n'est besoin de chercher ici ou là une quelconque école à laquelle rattacher le propos d'un auteur aussi inspiré qu'indépendant. Cet essai épistémologique représente enfin une précieuse mise en garde contre les études synchroniques qui fleurissent à propos du corps et de ses permanences les moins avérées. Voilà un chapitre supplémentaire dans l'histoire du regard médical en Occident.

Stanis Perez

La pratique dentaire dans les camps du IIIè Reich.

Xavier Riaud

L'Harmattan éd. 2002, coll. Allemagne d'hier et d'aujourd'hui, imp. Barnéoud, 290 pp., 24,40 euros.

Le livre de Xavier Riaud doit être lu pour les détails médico-historiques qu'il nous révèle et pour les horreurs dont il témoigne. L'auteur est chirurgien dentiste de la Faculté de Nantes. Son ouvrage, fruit de sept années de labeur, est dédié « en hommage à ces confrères déportés qui firent le choix de sauver des vies plutôt que la leur ». C'est une enquête historique, au sens étymologique que donne Hérodote à ce mot. Fondée sur des documents originaux (recueils), des sources d'archives et divers témoignages (chirurgiens-dentistes, médecins, déportés) , l' enquête personnelle de X. Riaud est dédiée à la « pathologie bucco-dentaire dans les camps de concentration nazis, 1941 -1945 ».Tel fut le thème de sa thèse de doctorat soutenue, à Nantes, en 1997. Grâce aux associations de déportés puis, avec l'aide du centre de documentation de la Bibliothèque Universitaire de la Faculté de médecine de Nantes, l'auteur étend bientôt ses recherches aux centres d'archives de France et des pays limitrophes. Trente et un camp, de Dachau à Ellrich , témoignent pour montrer « dans quelles conditions et par qui les soins, les prothèses et surtout les extractions dentaires étaient effectuées.. » L'office central de gestion économique de la SS (SS-WVHA) classait les camps en trois catégories : I °) les « camps de travail » (Dachau); 2°) les « camps de concentration » dans lesquels s'aggravaient les conditions de vie et de travail, (Auschwitz, Buchenwald) ; 3°) enfin, les « camps d'extermination » (Mauthausen, et aussi en Pologne que Lublin-Maïdanek, Treblinka, Sobibor, Chelmo, Belzec et bien sûr, Auschwitz-Birkenau) réservés eux aux Juifs, Tziganes, homosexuels, criminels et à certains détenus politiques. Un médecin du livre, le Dr. G. Soubirous témoigne : « On peut s'étonner... du souci des SS à soigner les dents des détenus alors que le plus grand nombre était exterminé dans des conditions épouvantables. . En fait, l'univers concentrationnaire était un univers hiérarchisé avec ses privilégiés... Pour eux, couture, bibliothèque, terrain de sports, bordel et cabinet dentaire. Les autres, main d'oeuvre d'esclaves, pouvaient être récupérés par le travail .. .participant à l'économie de guerre nazie. (Il fallait donc)

traiter les dents douloureuses susceptibles de perturber le rendement du travail ». Ainsi, dans la SS-VWHA, le Département D, en charge des camps de concentration comporte, en son sein, un troisième bureau (DIII), le « Service de santé et d'hygiène des camps », dirigé par le SS Obersturmbannfûhrer Dr. Lolling. C'est ici que travaillent 17 ou 18 dentistes. Ainsi, à Buchenwald, durant un peu plus de deux ans, de mi-mars 43 à fin mars 45, 37 536 détenus sont traités et la nature des actes et examens pratiqués méticuleusement détaillée. Riaud analyse encore le circuit de la « récupération de l'or dentaire », au travers d'une organisation « extrêmement contrôlée et hiérarchisée par des décrets et des ordonnances » : Qu'on en juge : « A Maïdanek, (les SS) arrachaient les dents des prisonniers, à la recherche de diamants qu'ils disaient pouvoir être cachés dans des dents dariées . . . . . A Belzec, une fois retirés des chambres à gaz, les cadavres étaient examinés par un dentiste. Il enlevait les bagues et arrachait les dents en or. Il jetait les objets de valeur ainsi recueillis dans un carton... des caissses entières de dents en or et de prothèses dentaires étaient ainsi récupérées sur les cadavres avant leur incinération... A Sobibor, avec les dents en or récupérées sur les cadavres, les nazis faisaient faire par des orfèvres juifs, des chevalières en or, gravées SS et d'autres objet. A Chelmo, des SS se livrèrent à de véritables supplices dentaires Les « expérimentations nazies bucco-dentaires » furent rares. Riaud signale pourtant les recherches histo-bactériologiques du Dr. Weber, voulant retrouver une cause infectieuse au Noma, cette maladie perforante buccale frappant les enfants tziganes. Sont encore mentionnés le travail du Dr. Munch qui « prétendait que l'origine (des) douleurs rhumatismales provenait de granulomes dentaires (infections) et qu'en faisant des injections de filtrats streptococciques ... à des malades rhumatisants , on devait assurer leur guérison » ou les recherches du « Dr. Rascher, médecin nazi qui réalisa des expérimentations sur la coagulation au camp de concentration de Dachau » à partir d'un anticoagulant, le Polygal 10. « La question de l'or dentaire » fait l'objet du chapitre X : les nazis furent des prospecteurs d'or acharnés et trois hommes sont particulièrement cités : le général Pohl (qui, le premier, rationalisa, sur des bases massives, l'utilisation des cadavres des camps d'extermination) ; Walter Funk (ancien collaborateur de Goebels au Ministère de la Propagande) et le Reichsfuùhrer Heinrich Himmler qui ordonna aux médecins SS la récupération des dents en or sur les cadavres.

Une iconographie (qu'on aurait souhaité parfois d'une meilleure lisibilité), un « lexique concentrationnaire » et « dentaire » , une bibliographie et un index complètent cet ouvrage qui contribue, ainsi que l 'a écrit Hérodote, à « ... empêcher que ce qu'ont fait les hommes, avec le temps ne s'efface de la mémoire ». En ces temps de négationisme et de résurgence antisémite, ceci n'est pas le moindre mérite du livre de Xavier Riaud.

Alain Lellouch

Arterial Aneurysms - A Historical Review

Raphael M.ESuy

MD.Vascular Surgeon, Emeritus Professor, University ofLeuven. 2004, ISBN 90-9018493-7.
Printed by Demol Printing, Krommeweg 31, 1640, Sint-Genesius-Rode, Belgium.

This is an excellent book. In his introduction, the author writes: 'I was very disturbed about the very meagre knowledge of history among medical students and surgical residents. You cannot hold it against them : their ignorance is being fostered by the curriculum ....and by their nature the youth are interested primarily in the future.'

Professor Suy's book is a complete answer. He covers the subject of arterial aneurysms from pre-historic times - where he finds the contribution of ancient Indian medicine superior to that of both Greece and Egypt - with later facts about the studies of medieval surgeons and physicians, their ideas of aetiology, pathology, and treatment. Chapter 2 describes the story from 16th to 19th centuries in considerable detail, but nowhere is the detail overdone or irrelevant. Chapter 3 tells of changing pathologies from the 19th century till the present, and surgical treatment and its progress, from early ligations to resections and open repairs. Finally we have the present day and his story becomes the present - an Ian Aird of aneurysm surgery which all Fellowship candidates must study. In his epilogue, Suy writes :' It is tempting to smile condescendingly at the ideas and the practices of our predecessors, as our successors will doubtless smile on ours. Such an attitude to the history of medicine in general and to the history of the arterial aneurysm in particular is uncalled for as well as misleading' He then quotes Anatole France who said 'let us not lightly cast aside things that belong to the past, for only with the past can we weave the fabric of the future.'

Throughout the whole book the standard of scholarship, of choice of diagram, picture, and painting of those who strove to solve problems of this condition, of choice of treatments to describe the solutions, are first-class.

The book is available from Fonteyn, Science and Medicine, www. Fonteynmedical.com

JSG Blair

In celebration of a life

(Current work in the history of medicine, 1954-2004)

Cathy Doggrell,
Editor,Wellcome bibliography for the history of medicine

With apologies to Harriet Beecher Stowe, like Topsy, "I 'spect I grow'd".

50 years ago, the very first issue of *Current work in the history of medicine* was produced. It was the brainchild of the then new librarian of the Library of the Wellcome Institute for the History of Medicine in London, Dr. F.N.L Poynter.

Up until then no printed bibliography was available which concentrated on the listing of articles found in journals, primarily those found in the Wellcome Library but also in the libraries of local institutions, which related to the history of medicine and allied sciences. In simple terms, the printed *Current work,* as it came to be known, comprised an author address list and a single sequence of articles arranged under subject headings. The first few issues underwent a variety of alterations and enhancements, including the addition of an annual new books list published in the final issue for each year.This arrangement of articles was to exist for some 37 years, under the stewardship of Miss P.M. Hully, who took over as editor in early 1957. During this time, *Current work* grew to be one of the most respected international bibliographies in the field of the history of medicine and allied sciences.

Miss Hully retired in 1991, after which *Current work* entered a new phase - online access, under my editorship. Up until then, citations had been created on cards. These cards were then sorted to create the printed list and were then interfiled into the Library catalogue drawers. In the late 1980s the Library had been developing its online in-house cataloguing system, and in 1991 it was thought that it would be sensible to produce the citations for *Current work* via this system, thereby still creating a printed product, but also supplementing the Library's holdings. An extremely wide-ranging database on the history of medicine was thus created, bringing together the Library's holdings and the *Current work* bibliography in one searchable tool.

In 1998, to make the *Current work* listings available to an even greater readership, the Library (soon to change its name to the Wellcome Library for the History and Understanding of Medicine) signed a contract with RLG (Research Libraries Group, a cooperative organisation in the USA providing online bibliographic tools), to supply citations to articles and new books in the history of medicine. These citations were then included in a database called HST (History of Science.Technology and Medicine). In 1999, after discussion, it was decided that there was no longer a need to produce a separate printed version, as it was fully and freely available online via the Library OPAC (Online Public Access Catalogue). Instead, monthly lists were created and hosted on the OPAC for readers to use and/or download as they wished. An online Archive of these files is also available (http://library.wellcome.ac.uk/resources/cw.shtml).

For the past five years there has been a staff of two producing the records for Current work (now renamed the *Wellcome bibliography for the history of medicine)* with the aim of including around 350 citations per month, ranging from such titles as 'Safety belts on stamps' to The quality of drinking water: some lessons from history', from such mainstream medical journals such as *The Lancet* and BM/,to such less well-known items as *Butlleti de la Societat d'Amics de la Historia de la Ciencia Farmaceutica Catalana.* In the 12 years since it went online, *Current work* has added something in the region of 70,000 records to the Library catalogue. Since its humble beginnings, it has come to be **the** major international bibliography specifically covering the history of medicine and allied sciences.

Unfortunately however, all good things must come to an end. Not only will 2004 be *Current work's* 50th anniversary, but it will also be its last, as structural changes in the staffing of the Library have unfortunately led to its demise. We can still be proud though, of the achievements of this unassuming but greatly respected resource, used throughout the world by generations of historians of medicine.

Letter to the Editor

Heart Clinic
University Hospital, University of Lund
SE-205 02 Malmo, Sweden

Dear Editor

I was fascinated by Emily Wittmann's paper in Vesalius Xijune 2004, pi 6-19.

Today it is very easy to forget how the idea of eugenics penetrated peoples' way of thinking and not only in the Academies. It was certainly so in Sweden, with the establishment of our "Institute of Racial Hygiene". But what was new to me is how these ideas were so widely distributed, not only in Britain but also in the United States- a very stimulating and informative article that clearly shows how important medical history knowledge is.

Yours sincerely
Bengt Johansson

International Society for the History of Medicine

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Date of birth :

Address :

Phone :

Fax :

E-mail :

Languages spoken fluently :

Languages read :

Your experience in the History of Medicine

Historical Field of Interest

Periods studied :

Current research :

Published works :

Do you teach the history of medicine ?
O No
OYes:

Are you affiliated with another institution associated with the history of medicine (e.g. museum, library) ?
If so, which one?

Would you be available for translations for Vesalius or for the Internet site ?
If so, from which language to which language ?

Date:

Signature :

This application form should be sent to the General Secretary :
Dr *Philippe ALBOU, 13 Cours Fleurus, 18200 SAINT-AMAND (FRANCE)*
E-mail: philippe.albou(a)wanadoo.fr Fax : 00 33 2 48 96 27 98

Vesalius, X, 11, 95-96, 2004

Société *Internationale d'Histoire de la Médecine*

FORMULAIRE D'ADHESION

Titres : M. Mme. Dr Pr

Nom :

Prénoms :

Date de naissance :

Adresse :

Téléphone :

Fax :

E-mail :

Langue (s) parlée (s) couramment :....

Langue (s) comprise (s) en lecture :....

Votre expérience en Histoire de la Médecine

Points d'intérêt historiques :

Epoques étudiées :

Recherche actuelle :

Travaux publiés :

Fonctions d'enseignement en histoire de la médecine
O Non
O Oui :. . . . . .

Autres fonctions en rapport avec l'histoire de la médecine
(musée, bibliothèque, etc.) :

Seriez-vous disponible pour des traductions (pourVesalius ou pour le site Internet) ?
Si oui : de quelle langue en quelle langue :

Date :

Signature :

Ce formulaire doit être adressé au Secrétaire Général :
Dr *Philippe ALBOU, 13 Cours Fleurus, 18200 SAINT-AMAND (FRANCE)*
Courriel : philippe.albou(a)wanadoo.fr Fax : 00 33 2 48 96 27 98

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