

# Book Reviews / Comptes Rendus

## **Influenza 1918: Disease, Death and Struggle in Winnipeg**

Esyllt Jones

Toronto: University of Toronto Press, 2007, ix + 248 p., \$27.95

In the wake of the Great War, Spanish influenza swept across the globe from March of 1918 to June of 1920, killing tens of millions of people. More people died from this flu than in the previous five horrific years of war. Given the enormity and sheer scale of the epidemic, the 1918 Spanish influenza pandemic has generated a great deal of scholarly attention. Nevertheless, Esyllt Jones' highly acclaimed book, *Influenza 1918*, breathes new life into this topic, offers innovative dimensions, and suggests further avenues of inquiry.

In the fall of 1918, Winnipeg faced enormous challenges. Considered to be the Chicago of the North and the Gateway to the West, the landscape of Winnipeg reflected the social and economic inequities produced by rapid urbanization, industrialization, and immigration. Appropriate housing remained a real concern for the majority of Winnipeg's working class, a reality that was exacerbated by the nascent state of public health facilities and the fact that accessible, affordable, and effective medical care was beyond the reach of the average citizen. Indeed, on the eve of the influenza epidemic, Winnipeg was a city whose citizens were physically separated between the south and the north, the haves and the have-nots.

Focusing on the working class and Winnipeg's "ethnic north," Jones traces the devastating path of the disease through Winnipeg, concentrating on how the intersection of ethnicity, class, and gender shaped people's lives during the outbreak. In particular, she seeks to re-centre the experience of the epidemic as faced by "members of families, neighbourhoods, and communities," rather than "isolated individuals and patients" (p. 7). Jones does not see the timing of the Winnipeg General Strike as incidental to the influenza outbreak. She links the experience of influenza to growing working class solidarity in a series of important historical steps: from the first general strike in October 1918, to the municipal elections where labour was strongly represented, and finally, to the general strike of 1919. Careful to avoid suggesting that the pandemic produced the strike, Jones proposes instead that the epidemic brought into stark relief the inequities inherent within Winnipeg's economic system. As a result, the Spanish influenza crisis helped to forge a working class identity as it fostered co-operation and collaboration among those whose economic standing left them with few options and without adequate health care. For Winnipeg's working class, the disease was a social construction that emerged out of the city's social relations, and the General Strike was their attempt to act out that understanding.

The failure of city officials to act decisively or to provide medical care for the thousands of victims of influenza created a public health disaster in Win-

nipeg. As a result, stories of entire households dying without medical aid or young children standing vigil over the bodies of their dead parents were not uncommon. In the absence of ameliorative or even coherent action by the state, the majority of care and assistance in the city was offered by middle- and upper-class women through volunteer and philanthropic organizations. The nursing care and social service work made available by these women formed an informal health care and social service system in Winnipeg. Participation in the operation of nursing services, daycares, and soup kitchens forced upper- and middle-class women to transgress social and geographical boundaries, exposing them to new people and situations. At the same time, however, the healing and care giving labour of middle- and upper-class women also served to reassert and normalize pre-existing gender and social norms. In valorizing these women's work, the press characterized such activities as the realization of women's social and maternal responsibilities. Thus, the volunteerism of non-working-class women was perceived by society as bringing order to the chaos produced by the outbreak and reinforcing gender, class, and ethnic divisions. Outlining this "feminine" work is one of the major contributions of Jones' book. By tracing women's volunteerism, she takes the discussion of illness and care-giving out of the realm of the domestic and makes it part of a larger social concern, blurring the divisions between home, work, and community.

Significantly, Jones does not end her study of the disease with the cessation of reported cases. Instead, Jones extends her investigation to include the long-term effects of the disease as a result of death or loss of income. The devastation produced by the influenza epidemic had lasting consequences for both the material and physical well-being of families. Given the high mortality rates, family disintegration was a regular occurrence. Children were left to be raised by extended family, friends, or orphanages. Wives and husbands were forced to cope without the support, financial or domestic, of their spouses. The death of a wife or husband had the potential to transform people's lives and to render those formerly comfortable completely destitute. Jones reveals a too frequently overlooked segment of the population: widows, widowers, and orphans.

In conclusion, Jones' study artfully weaves together different historiographical trends from medicine to nursing to labour to urban studies to gender and produces a sophisticated analysis of the epidemic's effect on the social fabric of Winnipeg. As such, *Influenza 1918* is a monograph that is an essential read for more than just historians of medicine.

KRISTIN BURNETT *Lakehead University*

### **The Making of a Tropical Disease: A Short History of Malaria**

Randall M. Packard

Baltimore: Johns Hopkins University Press, 2007, 296 p., US\$24.95

When a book is written by one of the leading historians of medicine, and in a series edited by Charles E. Rosenberg, arguably the pre-eminent specialist in the field, readers' expectations are justifiably high. This book does not disappoint, even when the daunting task is to provide a global overview of the history of an extremely complex disease such as malaria. Packard is clearly an expert malariologist and has been, as he says in his preface, preoccupied with this killer ever since contracting the disease in southeast Uganda while serving with a team of

Peace Corps Volunteers sent to eradicate trachoma, an infectious eye disease, in the late 1960s.

Packard's strength is to keep his argument as simple as possible. He stresses the importance of social and economic conditions that have turned a curable disease into a killer. Malaria is, in fact, not a tropical disease. As recently as 1922-23, it struck Archangel, Siberia, just below the Arctic Circle. Advances in sanitation, housing, and public health surveillance have reduced malaria to a rare disease outside the tropics. But it is Packard's thesis that agrarian transformations have altered the human ecology of malaria time and again as it first emerged in African antiquity, and that environmental changes can again unleash malaria outbreaks virtually anywhere in the world if conditions permit.

This book also guides novices and specialists alike through the intricacies of malaria's origins and evolution, and the evolving scientific breakthroughs associated with the various malaria parasites, its many mosquito vectors, and quests for a successful method of control. Packard contends, however, that malarial science has lost sight of, or has ignored, lessons from the history of malaria. A narrow biomedical focus has contributed to the persistent failures of science to this day to control and contain malaria, let alone eradicate this horrible disease.

Packard cleverly distinguishes between what he calls malaria dreams and realities. Mankind's dream of controlling this scourge took a potential leap forward during the great breakthroughs in epidemiology and biology in the late 19th century. International giants like Laveran, Manson, Ross, and the Italian malariologist Angelo Celli, gave scientific shape to the dream. Celli especially understood that malaria was also linked to the economic and social conditions of people in a region such as Sardinia or the Roman Campagna. Unfortunately, the human dimension was overwhelmed by the technical and biomedical. Technical experts like the Rockefeller Foundation's Frederick Soper and the epidemiologist George Macdonald lacked Celli's sensitivity to human and environmental variables, and their successes against malaria proved temporary. As one ambitious eradication program after another failed, international funding from the WHO and elsewhere began finally to pay lip service to the neglected human dimensions by the 1990s.

The realities of malaria can be grasped only if attention is paid, and lessons learned, about how past communities have, in Packard's phrase, "grown out of malaria." Malaria's spread in Africa and then globally, has been closely linked to changes in agriculture. Whether in El Salvador or Sardinia, the agricultural colonies of South Carolina or the upper Mississippi Valley, agriculture provided opportunities for the growth of the malaria parasite and its vectors. But capitalization of agriculture improved land management and altered farming practices which could also drive out malaria. Malaria gradually receded from the Northern hemisphere, but kept its grip on colonial and other populations in the 19th and 20th centuries, when it became a "southern disease."

Africa, the original home of malaria, remains to this day the continent where malarial control has been the most fragile. Packard's case study shows how debt and poverty in Zambia have made malaria much worse. Its annual incidence rose from 121 per 1000 in 1976 to 376 per 1000 in 2000. In 2001-02, malaria accounted for 50,000 deaths annually and 40% of all infant deaths. During this period, Zambia's debt rose alarmingly as world prices for its primary export, copper, fell. Turning in desperation to the World Bank and the IMF, Zambia accepted loans contingent on the now discredited neo-liberal ideology of "structural

adjustment." Food availability, housing, and labour conditions deteriorated as the cotton industry was privatized. Bank-mandated cuts to the health sector saw skilled professionals flee to better paying positions in South Africa or abroad. Rural clinics were either closed or deprived of drugs for malaria treatment as well as other needs. On top of all this, the HIV/AIDS pandemic only added to the health burden.

A new international initiative, "Roll Back Malaria" (RBM), launched in 1998, has been active in Zambia. RBM stresses wider issues of education, environment, and the economy, as well as biomedical applications such as combination drug therapies, bed nets, and the elusive and costly quest for an effective vaccine. Whether or not RBM can meet its goal of a 75% reduction in malaria in Zambia by 2008, one good sign is that G8 countries have reduced Zambia's external debt so that the country could drop user fees for health services in rural areas.

Packard remains pessimistic, however, about the Zambian case and the malaria dream in general. Zambia still needs many more trained health workers and faces higher costs involved for drug treatment using the new generation of antimalarial drugs. Politicians will need to remain supportive of anti-malarial programs as the disease recedes into the poorest part of the population. Finally, narrow private interests will have to show understanding, as in the case of Texas cotton growers' willingness to accept American government limits to prices to help Zambian exports.

Packard's painful conclusion is worth quoting: "Failure to link ecology and policy has prevented the elimination of malaria as a serious public health problem in many areas of the globe and will continue to restrict the success of malaria control programs, such as Roll Back Malaria (247)." This fine book should be compulsory reading not only for generalists, but for those malariologists and their financial supporters who are still dreaming.

MYRON ECHENBERG *McGill University*

### **Alberta's Medical History: Young and Lusty and Full of Life**

Robert Lampard

Red Deer, Alta.: R. Lampard, 2008. ill, 732 p., \$69.95

This large and timely volume by western Canada's foremost medical historian brings to life the unique and continuing spirit of the West. Here Robert Lampard traces the development of medical practice and administration in Alberta and reveals the significant influence the "Young and Lusty" west has had on medical practice in Canada as a whole.

The book is in two sections. The first contains biographies of 35 pioneering and leading physicians beginning with those first to visit the area. John Rae, the "Great Pedestrian" who searched for Franklin's lost expedition in the 1840s, and James Hector of the Palliser Expedition who investigated passes in the Rockies, one of which bears remembrance to his being kicked by his horse. These were highly intelligent and very tough men. The doctors who came later with the North West Mounted Police play their part, soon to be followed by Dr. Brett of Banff who, although busy as the first surgeon, found time to establish the North West Territory Medical Council, the Alberta Medical Association, and the Alberta

College of Physicians and Surgeons, prototype of the Medical Council of Canada of which he later became president. He cared for workers building the Canadian Pacific Railway line through the Rocky Mountains, dealt with epidemics of typhoid, built the Banff hotel and sanatorium, and became Lieutenant Governor of Alberta. Dr. Frank Mewburn, a surgeon, "completely patient centered, first last and always a joyous doctor" was too old at 58 to enlist for the Great War so he went to England at his own expense to join the Canadian Medical Corps and in 1919 became the first Professor of Surgery at the University of Alberta. Dr. Harry G. MacKid, a man of many talents, measured Sir Ernest Waterloo for his coffin because the CPR lawyer from London would not let a "colonial" operate on his appendix, a feat which Dr. MacKid later performed successfully. Dr. E. A. Braithwaite treated NWMP casualties of the Riel rebellion and Dr. G.H. Malcomson brought the first X-ray machine to Alberta in 1906.

Dr. J. S. McEachern is dealt with at length, as he deserves. He arrived in Calgary in 1905 as a general surgeon but achieved fame first by saving the Canadian Medical Association from bankruptcy in 1921 and by legally binding the CMA with the provincial medical associations in the 1930s, leading the Alberta Medical Association to be the first to join with the CMA. He led the CMA to form a National General Council for the Control of Cancer, known since 1944 as the Canadian Cancer Society and linked the Alberta Health Insurance proposals of 1932 with the CMA plans for health insurance in Canada. "A persister, a prodder with crisp clear precise language," he was a great leader and worthy recipient of the 1938 F.N.G. Starr award, described as the Victoria Cross of Canadian medicine. Yet his story was the most difficult to trace as he left almost no personal records.

The years roll by. The University of Alberta is created with its fledgling medical faculty and the brilliant Dr. J. B. Collip comes to join the original four member faculty in 1915. In 1921, he was seconded to Macleod's laboratory in Toronto where he isolated and purified insulin for Banting and Best. Later, in Edmonton, he isolated parathyroid hormone. Not many doctors command infantry battalions, but Dr. E. G. Mason did just that and captured the two highest points on Vimy Ridge, afterwards becoming a psychiatrist treating returning soldiers.

The first voluntary prepaid community medical insurance program in Canada began in Cardston, Alberta in 1932. Dr. W. A. Wilson and Dr. A. E. Archer organized the Alberta College of Physicians and Surgeons health insurance briefs, which were enshrined in the *Alberta Health Insurance Act* passed in 1935, which became the basis for the CMA's proposal for a national health insurance plan in 1943. Contrary to most accepted views, Alberta was the root of Medicare in Canada. This was undoubtedly aided by there being only two Alberta Ministers of Health between 1921 and 1957.

One is almost overwhelmed by the achievements and personalities of the people described. Dr. Mary Percy-Jackson came from England in 1929 for a six-month contract (women doctors were cheaper than men) and remained in her remote northern practice for 70 years. And we are brought up-to-date by Dr. Lorne Tyrrell, still very active, who developed the first effective oral anti-Hepatitis B drug after experimenting with ducks on his family farm. Space does not permit discussion of the other remarkable men and women portrayed but the pace does not slacken: all people who, as Dr. MacKid said in 1912, "think boldly and act boldly, by necessity first then by conviction, and ultimately by habit."

The second part of the book consists of articles covering a wide range of topics ranging from mercy flights in bad weather, the Alberta Foundation for Medical Research, the roots of Medicare in Alberta, the history of laboratory and radiology services, and an enlightened essay on the *Sexual Sterilization Act* of 1927 among others, and the book ends with an historical quiz and an useful list of Alberta medical milestones between 1668 and 2006. There is also a huge list of references.

Enough has been said of this interesting book to show how vividly it brings before our eyes not only the personalities and achievements of these doctors who were leaders as well as carers in Alberta, but also the great and lasting influence they had on the development of Canadian medicine as a whole. So much recent history is forgotten and buried too soon but the author has done a great service to these forgotten worthies with almost obsessional devotion to detail and accuracy.

BRIAN LOOSMORE *Edmonton*

### **Vitalizing Nature in the Enlightenment**

Peter Hanns Reill

Berkeley: University of California Press, 2005, x + 388 p. US\$60.00

Did the Enlightenment happen? An interesting question—quite unlike asking the same thing about, say, the Industrial Revolution or World War I. That is the elusive nature of an idea like Enlightenment. Arguably, all characterizations of intellectual ages have this malleable quality. In Peter Hanns Reill's formulation, a key aspect of the period long overlooked is "Enlightenment vitalism," a "natural philosophy" that "respected natural variety, dynamic change, and the epistemological consequences of skepticism." His project here is ambitious: attempting to reframe the Enlightenment and highlighting what were previously seen as secondary features of its intellectual landscape. By emphasizing vitalism, Reill adds an unconventional perspective to understandings of the "Age of Reason."

Reill's prologue explores the lives and writings of the famed Humboldt brothers, paying particular attention to the way these two natural scientists "mystified" nature, further unwilling to divorce their understandings from more patently moral concerns. Buffon is the subject of Reill's first chapter, which is a mixed bag exploring mid-18th-century visions of natural history. His emphasis is on the historicist sensibility of biology in the Enlightenment, showing how in the hands of a writer like Buffon, whose influence was widespread, there is a clearly dichotomous relationship between the qualitative (history, biology) and the quantitative (mathematics). Elaborating on how Buffon envisioned the life sciences, Reill argues he advocated a methodology amenable to vitalist thought.

The bulk of the book—chapters 2, 3, and 4—are devoted to specific discussions of Enlightenment vitalism in chemistry, physiology, medicine, and developmental biology. There are brilliant insights in this dense material, whether in Reill's identification of a move in chemistry from "solid" to "fluid" conceptions of the universe or in his discussions of how the concept of "death" in the late-18th century shed light on vitalist understandings of natural philosophy. He produces a masterful history of ideas here, full of textual analysis and a deep familiarity with secondary source arguments. There is nary a quibble with this

rich content. It is in one of Reill's tropes, however, a central argument in his text, where he falls short.

Reill's introduction dissociates his notion of Enlightenment vitalism from *Naturphilosophie* (and its romantic analogues), seeking to create a deep divide between the two. This perspective leads to a series of related assumptions about characterizations of the Enlightenment and its critics. Reill asks, for example, whether a figure like Johann Gottfried Herder, with his clearly historicist inclinations, can be seen as properly anti-Enlightenment, as intellectual historian Isaiah Berlin argues. Instead Reill suggests Herder was "anti-mechanist, not anti-Enlightenment."

In continuing to assert this thin line of distinction, Reill makes it clear he sees Enlightenment vitalism and *Naturphilosophie* as unique paradigms. Not only are the romantic scientific practitioners asking different questions, they are pursuing answers using a different method. Reill explores the way gender and sexuality are constructed in the two eras to illustrate this difference, and while his discussions are fascinating, the argument seems tenuous.

Paralleling other recent treatments of vitalism, Reill creates an a historical conception of the idea and its manifestations in the last half of the 18th century. This is problematic, overlooking that vitalism actually flourished after the Enlightenment, in the early 19th century, and that the issues it dealt with and the questions it raised were inextricably linked to the development of biology as a discipline and the rise of the laboratory as a seminal epistemological framework. Vitalism burgeoned in the medical sphere because it promised alternatives to the narrow paradigm of the "particular" in respect to the healing arts. Much as Reill's discussions of Enlightenment vitalism are compelling, they are also misleading, reflecting a time when all scientific thought was, by definition, less scientific, intertwined with moral philosophy, and even theology.

This does a disservice to the idea of vitalism, born largely as a critical stance; a challenge to the overwhelmingly reductionistic and mechanistic approach to science that emerged post-Enlightenment. That science was not defined by these characteristics in the Enlightenment is a given, for it was a time when the process of definition was still occurring—when negotiations had yet to be completed. To understand vitalism and its historical meaning is to reflect on a polarized world of ideas, and realize how different the views of a German laboratory patriarch like Justus von Liebig were from, for example, the philosopher Arthur Schopenhauer.

It is difficult to criticize Reill for introducing nuance into our understanding of the Enlightenment, a task he rises to with excellence and aplomb. It is his use of the idea of vitalism, however, that is historically problematic. For if vitalism is "a unique epistemological position based on the imperative to mediate between extremes"—an ideal description—then it should be properly placed in a later age, when the fissures between materialism and spiritualism became like a chasm—wide, deep, and unbridgeable. In this sense the Enlightenment did happen, but not in the way that Reill suggests. Vitalism was not a part of Enlightenment in any real sense, for its worldview flowered in the 19th century, when concerns about the meaning and impact of science became more intensely polemical and politicized.

**British Military and Naval Medicine, 1600-1830**

Geoffrey L. Hudson, ed.

Amsterdam/New York: Rodopi, 2008, ill, 290 p., €60/US\$84

This collected work is the eighty-first volume issued for *Clio Medica* (The Wellcome Series in the History of Medicine). The purpose of the volume is to present research on a range of topics relating to health issues within the English/British armed forces between 1600 and 1830. Editor Geoffrey L. Hudson points out in his introduction that British military medicine is a subgenre emerging from a past of relative scholarly neglect. With some notable exceptions, previous works frequently retained a hagiographic focus on miracle cures once attributed to "great men," such as Dr. James Lind with regards to scurvy. The essays in the current volume offer more comprehensive treatments of the subject in an effort to connect the sick or wounded soldier and sailor with the increasing institutionalization of early-modern military medicine.

Hudson places the various essays in several broad categories: the imperial context, aspects of health and nursing in Britain, naval medicine, and state and society. J.D. Alsop begins with a survey of medical literature related to the armed forces published during the survey period. The decentralized nature of medical services and their diffusion throughout the empire did little to facilitate professional writing on the subject. Continuing with the imperial theme, Paul E. Kopperman and Mark Harrison, respectively, examine army medicine in North America and the West Indies and India from the 1750s onward. Each outlines the institutionalization of army medicine; one originating from the government, the other from the East India Company. Both argue that contemporary perceptions of idiosyncratic climatic conditions influenced the thought and direction of health care overseas. The care of the sick and wounded in England receives treatment from Eric Gruber von Arni during the era of the Civil Wars. Gruber von Arni gleans parliamentary accounting records for the care of wounded soldiers, especially for the Savoy and Ely hospitals in London. Philip R. Mills examines treatments of that common servicemen's ailment, the hernia, to illustrate how prescribed treatments by medical professionals clashed with the labour demands of the service.

With regards to the Royal Navy, Patricia Kathleen Crimmin examines changes in health and care regimens within the navy's Sick and Hurt Board. The navy's decentralized policy of leaving the prevention and treatment of disease within the individual ship and private recuperative contracting coalesced with increasingly systemic care in response to naval expansion during the 18th century. Margarette Lincoln then examines public perceptions of naval health, medicine, and the care of seamen by examining the print media between 1750 and 1815. In the final category, Christine Stevenson focuses on the architecture of the purpose-built military hospital, both at home and abroad. The design and construction of these buildings incorporated current medical thinking into the final product. Meanwhile, Geoffrey L. Hudson employs the operational records of the administration board of the Royal Greenwich Hospital for sailors to recreate the often tense relationship between extended care pensioners and administrative staff early in the 18th century.

A suggested editorial theme for the volume questions whether or not army and navy medicine could be described as a "good thing" (p. 1, 18). Indeed, in the Harrison essay on the treatment of fevers in India, for example, physicians in the

Indian army debated the merits of purging and bloodletting versus doses of mercury. The benefit of hindsight allows us to see how such treatments thrust the patient into an institutionalized no-win situation. But another common feature identified as uniting the various essays has perhaps wider implications for early-modern institutional development. This concerns the growth of the early-modern state, especially the fiscal-military variety beginning in the 17th century and greatly expanding following the American Revolution. These essays illustrate how the growing administrative organization and resources necessary to field large armies and navies fostered a corresponding need to successfully treat increased numbers of sick and wounded and improve the overall health of the armed services, if only for the sake of operational efficiency. Furthermore, most of the essays in this volume issue passing, but direct, challenges to the temporal boundaries of Foucault's *Birth of the Clinic*, alluding that institutionalized medicine occurred within the expansion of the English/British military in Europe and overseas much earlier than in the aftermath of the French Revolution.

Both popular and scholarly perception can still marginalize early-modern soldiers and sailors resulting from their exotic working environment. Examining the institutionalization of military medicine, in conjunction with the health of seamen and soldiers, provides a useful link between the world of the armed services and mainstream society.

WILLIAM R. MILES *Memorial University of Newfoundland*

### **Medicine by Design: The Architect and the Modern Hospital, 1893-1943**

Annamarie Adams

Minneapolis: University of Minnesota Press, 2008, xxv + 169 p., US\$27.50

In his architectural history of the Hapsburg Empire, *When Buildings Speak*, Anthony Alofsin "investigates the assertion that architecture is a language" that can tell us much about the social, political, and cultural contexts of which it forms part. Alofsin also emphasizes that "the languages of architecture can say some things well and others less well, or not at all"<sup>1</sup> Annmarie Adams' book is a welcome addition to a growing body of literature that explores these languages of architecture. *Medicine by Design* addresses the complex forms of architectural expression manifested in turn of the century hospitals, including the social and cultural hierarchies that these buildings encompassed, the dynamic architectural tensions created by competing professional perspectives of the modern hospital, and the historical layering of architectural elements resulting from successive additions. One also gets the sense that the buildings explored by Adams "speak" clearly about some aspects of historical change and less clearly about others.

Adams starts her book with a chapter on the Royal Victoria Hospital which opened its doors to dynamic and bustling Montreal in 1893. Designed by Henry Saxon Snell, this pavilion plan hospital was in many respects the perfect manifestation of late 19th-century Montreal culture. As Adams notes, this hospital was underwritten by heavyweight philanthropists Donald Smith and George Stephen, its exterior resembled a "Scottish castle" linking it aesthetically to McGill University, it was strategically situated against Mont Royal, and it was meticulously designed to evoke its dual functions as a "philanthropic enter-

prise" and an exemplar of modern "healing technology" (p. 3). This chapter sets the tone for Adams' more in-depth exploration of how the architectural design of the Royal Victoria and similar hospitals elsewhere anticipated and responded to two important social groupings: patients (chap. 2) and nurses (chap. 3).

Chapter 2 evaluates how four "new groups of patients" were incorporated into turn of the century hospital architecture: "paying patients, out-patients, pregnant women, and children" (p. 34). Adams shows how, in accommodating these groups, hospital architecture reflected the increasing purchase of orthodox institutional medicine, at the same time that it highlighted the relationships of class and gender embedded in the social structure of industrial Montreal. For example, for the wealthy, the architectural features of the Ross Pavilion of the Royal Victoria Hospital emphasized comfortable domesticity and privacy, with grand entrance ways, elite interiors and luxurious landscapes. The working-class markers of the outpatient facilities were also built into hospital architecture, emphasizing public spaces, proximity to urban industrial neighbourhoods, and frugality of interior design. Adams likewise shows how paying and non-paying obstetrical patients were separated architecturally within the hospital, even as the hospital's technology emphasized to both rich and poor women that birth had become a dangerous medical procedure requiring institutionalization. Adam's chapter on nursing adds a nice layering of gender analysis to the mix, demonstrating the shift from the domestic and spatially distinct built-in nurses' residences that protected nurses from the dangers of urban life, to more autonomous and removed residences that reflected "the social advancement of women in general" (p. 78).

Chapter 4 of *Medicine by Design* explores changes in hospital architecture resulting from an increasing emphasis on medical expertise, medical technology, and the tensions arising between architects and doctors. Adams tackles these issues mainly through an analysis of the flourishing career of architect Edward Fletcher Stevens. Although not abandoning the domestic features of hospital exteriors, the central focus for Stevens and others was on the integration of modern medical technologies into the plan of the hospital. This new focus on "the plan" increasingly led architects to work in collaboration with an emerging cadre of expert medical consultants. However, strong minded successful architects like Stephens could come into conflict with hospital physicians who had their own ideas about design. This, Adams notes, can be seen in Stephen's insistence on hydrotherapy facilities and on natural lighting for surgical suites, to the chagrin of physicians. Adams' last chapter analyses the curious insistence on "historicist" architectural exteriors for hospitals that, by the 1930s and 40s, had clearly become institutions of cutting edge technology.

In a study replete with insights, it is a pity that this book does not include a concluding chapter that considers, at a broader remove, the several lines of argument drawn here by Adams. Nevertheless, *Medicine by Design* is a significant contribution to historical studies in architecture, health, medicine and history.

JAMES E. MORAN *University of Prince Edward Island*

**Meyer : le radici e l'orizzonte. Storia dell'Ospedale Pediatrico Anna Meyer di Firenze (1884-1950)**

Esther Diana

Firenze, Milano: Giunti Editore, 2008, 159 p., €5.79

Les événements institutionnels et l'enchevêtrement de questions médico-sanitaires relatives à l'histoire de la fondation, à Florence, de l'Hôpital pédiatrique Anna Meyer (1884-1950), bien qu'ils ravivent une histoire locale, n'éclairent pas le lecteur sur la relation majeure entre micro-événement et clinique moderne. Le fil rouge qui relie l'histoire sanitaire embrouillée de cette institution à son sens historique n'est pas la *pietas* bourgeoise, ni l'initiative philanthropique (p. 24), mais une histoire plus importante : celle de la médecine hospitalière, de la reconfiguration des lieux sanitaires au cœur du tissu urbain et des nouvelles conditions d'apparition et d'investissement de la *valeur d'usage* de la vie (santé) au sein de la population. L'absence de ces trois niveaux de lecture réduit la création de l'« *Ospedalino* » à la pure histoire locale ; cela ne donne pas à voir, notamment, la transformation anthropologique qui inséra la partie infantile de la population florentine dans la pléthore de discours et de pratiques relatives à la santé dans la société de masse du XX<sup>ème</sup> siècle. Comme pour l'histoire de la fondation d'autres types d'hôpitaux, celle de l'hôpital pédiatrique de Florence trouve sa genèse dans un lieu sanitaire moderne (p. 19), déjà inscrit dans le tissu urbain de cette ville toscane : l'Hôpital de Santa Maria Nuova, dont la transformation s'est faite, comme l'explique l'auteure, grâce à la réforme sanitaire voulue par le directeur de l'hôpital, Francesco Maggio, en 1754, puis par le commissaire Marco Girolami Covoni en 1783 (p. 17-18).

Ce travail, certes riche en faits divers et mis en valeur par une remarquable documentation iconographique, n'appréhende pas comme il le faut la genèse historique et donc échoue à saisir le sens anthropologique de la fondation même de l'Hôpital Meyer. La mise en place de la clinique moderne, sous la pression de facteurs sanitaires et sociaux, a déterminé l'implosion de l'organisation interne des mégastructures hospitalières florentines, par un *clonage* de cette dernière, à l'extérieur, dans des lieux sanitaires cliniquement différents des précédents et placés stratégiquement dans le tissu urbain en expansion (p. 27). Le nouveau discours sanitaire concernant la population infantile était en gestation dans l'Hôpital de Santa Maria Nuova où, comme dans de nombreux autres hôpitaux européens, la question d'un « département pédiatrique » s'est posée en termes de « promiscuité » entre adultes et enfants (p.18). Cela fut, apparemment, la raison de fondation d'un hôpital destiné aux enfants. En réalité, ce ne fut pas la promiscuité, source de désordre et d'immoralité, qui a déclenché la fondation d'un hôpital pédiatrique, ni le décalage entre les thérapies pour adultes et celles pour enfants qui a attiré l'attention de la médecine sur la population infantile. Ce ne fut pas non plus la modernisation sanitaire, facteur de progrès et de civilisation. C'est parce que toute la population citadine s'est trouvée impliquée, voire « investie », dans les pratiques anthropologiques de la clinique en fonction de la pathologie moderne qu'une *population sanitaire infantile* a émergé. C'est parce que la *valeur d'usage* de la vie de la population a concerné progressivement des groupes d'âges plus jeunes que, à un certain moment, la population infantile est devenue objet de pratique sanitaire. Ce fut cette pratique, qui fit émerger au sein de l'organisation citoyenne communale l'exigence – philanthropique ou non,

peu importe – d'un hôpital pour les « enfants malades » nécessitant des soins. La clinique s'est insérée dans le projet philanthropique souhaité par Giovanni Meyer et a fait une place, dans cet espace sanitaire apparemment né de la charité bourgeoise, aux maladies infantiles et aux problématiques inhérentes à une pathologie de l'enfance.

L'introduction de la *valeur d'usage de la vie* au sein de la population infantile a eu pour résultat, dans les pratiques sanitaires, la perception obsessionnelle de la mortalité et de la morbidité infantiles ainsi que, dans les hôpitaux généraux, l'aménagement d'un espace réservé aux maladies propres à l'enfance. Ce ne fut donc pas une « histoire linéaire ». Penser les conditions historiques liées à la possibilité d'un hôpital pédiatrique à Firenze implique de tenir compte d'une fracture, d'une discontinuité plutôt que d'une linéarité ou d'une évolution. Une fracture qui se situe *en amont* des motivations philanthropiques. Ce fut la réforme de 1783 qui remodela l'organisation médico-sanitaire et didactico-pédagogique à travers le renforcement du lien entre enseignement et soins au malade, principe qui deviendra, au siècle suivant, comme le dit l'auteure, le credo de la transformation moderniste. L'évolution de cette réforme ne renvoie pas tant aux axiomes d'une culture hygiéniste qu'à la nouvelle anthropologie sanitaire, où la clinique inscrira la population en termes comptables, conformément aux exigences de la société de masse et de l'économie de marché du XX<sup>ème</sup> siècle. L'histoire de l'Hôpital Meyer est un événement qui s'insère dans une histoire plus importante : celle de la problématisation de la valeur d'usage de la vie au sein de la population florentine, celle de l'histoire hospitalière inféodée à la clinique moderne – transformation des espaces embryonnaires en élargissements spécifiques, transformation des conditions sanitaires, salles réservées aux opérations chirurgicales, laboratoires d'analyse, espaces destinés aux convalescents, isolation des personnes contagieuses, salles d'autopsie, morgue, service consacré à la nosographie des pathologies, organisation d'une équipe médicale, spécialisations, écoles d'obstétrique, de gynécologie et de pédiatrie. L'Hôpital Meyer? La clinique en effacera l'histoire philanthropique en posant comme objectif incontournable de sa propre pratique la direction de l'Institut d'Études Supérieures (p. 42).

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**D'Avignon médecin, patriote et nordiste, suivi des lettres de Joseph-François D'Avignon à son fils Eugène pendant la guerre de Sécession**

Jean Lamarre

Montréal, VLB éditeur, 2009, 189 p., \$23.00

Jean Lamarre fait partie du groupe des historiens qui ont travaillé, ces dernières années, sur l'important phénomène de l'émigration des Canadiens français aux États-Unis au XIX<sup>e</sup> siècle. Dans *Les Canadiens français et la guerre de Sécession, 1861-1865*, paru en 2006, il s'intéressait à ceux qui ont choisi de s'enrôler dans l'armée nordiste, soit plus de 12,000 d'entre eux. Son nouveau livre porte sur l'un de ces engagés, Joseph-François D'Avignon (1807-1867), qui dut

s'exiler aux États-Unis après avoir participé aux Rébellions de 1837 et 1838. Le livre comprend trois parties : le rôle politique de D'Avignon durant les années 1830 au Bas-Canada; ses activités comme officier-chirurgien durant la guerre de Sécession; et sa vie à Ausable Forks après la guerre.

D'Avignon, comme plusieurs autres médecins de son temps, a joué un rôle important durant les Rébellions de 1837 et 1838; il a même joint le mouvement dès les débuts. Originaire de la vallée du Richelieu, il travailla d'abord à l'organisation des réunions politiques qui furent tenues dans cette région. À partir des Résolutions Russel de 1837, ses positions se radicalisèrent et il opta pour la révolte armée. Il était présent les 23 et 24 octobre 1837 lors de la grande réunion de Saint-Charles qui rassembla plus de 5000 personnes. Plusieurs résolutions furent alors adoptées dont l'une, proposée par le docteur Wolfred Nelson et appuyée par D'Avignon, qui s'inspirait largement de la déclaration d'indépendance américaine rédigée par Thomas Jefferson en 1776. Le 17 novembre 1837, il était à Longueuil lors des premiers échanges de coups de fusil entre Patriotes et militaires. En 1838, il participa aux opérations dirigées par le docteur Robert Nelson, le frère de Wolfred, afin d'envahir le Bas-Canada à partir des États-Unis. Ce fut de nouveau un échec et D'Avignon dut s'enfuir aux États-Unis où il choisit d'y faire sa vie car il ne voulait pas « vivre sous le régime colonial de l'Union » (p. 86). D'Avignon s'établit à Ausable Forks, près de Plattsburg, où il ouvrit un cabinet médical. En 1840, il se maria à une Irlandaise catholique; le couple eut 10 enfants dont sept survécurent.

L'aspect le plus nouveau de ce livre concerne la participation de D'Avignon à la guerre de Sécession (le chapitre II). En 1861, D'Avignon avait 54 ans et il n'était pas obligé de s'enrôler. On pourrait penser qu'il le fit pour des raisons politiques ou de principe. Mais cela ne sembla pas la principale explication. D'Avignon avait plusieurs enfants, une propriété qu'il n'avait pas fini de payer et sa situation financière n'était pas très bonne, malgré une clientèle fidèle et qui l'appréciait. Il pensa donc pouvoir améliorer ses affaires en allant servir la cause nordiste comme officier-chirurgien. On l'assigna au 96<sup>e</sup> régiment d'infanterie de l'État de New-York. Stationné en Virginie puis en Caroline du Nord, il assuma diverses fonctions dont celle de « chirurgien médical en chef de l'hôpital de la 2<sup>e</sup> Division, Département de Virginie et de Caroline du Nord ». Il a aussi été fait prisonnier et détenu pendant quatre mois à la prison de Libby, un pénitencier pouvant accueillir 1200 détenus. Démobilisé en mars 1865, D'Avignon a donc vécu trois années au front. Il revint ensuite à Ausable Forks où il reprit ses activités de médecin, mais sans avoir vraiment amélioré sa situation financière. Il mourut deux ans plus tard. Ce chapitre sur D'Avignon le Nordiste s'appuie essentiellement sur 68 lettres que D'Avignon a écrites à son fils aîné, Eugène, qui faisait alors des études de pharmacie à Montréal et qui s'occupait, à distance, des affaires de la maison à Ausable Forks, car la femme de D'Avignon décéda peu après le début de la guerre.

Le livre est intéressant surtout en ce qui concerne l'histoire personnelle de ce médecin et de ses choix de vie dans le contexte de l'époque. La partie sur les activités de D'Avignon comme officier-chirurgien et chirurgien-chef d'un hôpital aurait pu être plus étayée. Plusieurs aspects de la vie de D'Avignon durant ces années sont esquissés de façon trop rapide. Même si D'Avignon parle peu, dans ses lettres à son fils, des difficultés qu'il rencontre au quotidien dans son travail,

on s'attendrait à ce que l'auteur décrive, d'une façon plus concrète, ce qu'a pu être la vie de ce chirurgien au front. On ne sent pas les horreurs de cette guerre qui a fait plus de 600,000 morts. Cela aurait pu être fait assez facilement en faisant référence à l'une ou l'autre des nombreuses études parues récemment sur la médecine sur les champs de bataille durant cette guerre civile.

Cela dit, l'histoire peu banale de ce personnage oublié méritait évidemment d'être connue.

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