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Politics, ideology, and medical theory: interview with Christopher Hamlin

Política, ideologia e teoria médica: entrevista com Christopher Hamlin

Interview with:

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Abstract

An interview with Christopher Hamlin in November 2020 in which he explains how he became interested in the history of public health. He talks about the outcomes of epidemics, the relationship between trust in science and moral imagination, why historians use previous public health experiences to think about the present, the role of discipline and ideology in problem-solving arrangements to deal with public health issues, and his new article on legal medicine.

Keywords: moral imagination; history; liberalism; medical police; legal medicine.

Resumo

Entrevista com Christopher Hamlin, feita em novembro de 2020, na qual ele explica como se interessou pela história da saúde pública, fala sobre as consequências das epidemias, sobre a relação entre confiança na ciência e imaginação moral, por que historiadores levantam experiências passadas de saúde pública para pensar a respeito do presente, sobre o papel da disciplina e da ideologia nos arranjos para resolução de problemas de saúde pública e comenta a respeito do seu novo artigo sobre medicina legal.

Palavras-chave: imaginação moral; história; liberalismo; polícia médica; medicina legal.

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Christopher Hamlin, born in the US state of Vermont, is a historian whose studies are both rigorous and inspiring. After studying Earth Sciences at Antioch College and pursuing a short career working as a chemical researcher and development technician, he took up graduate studies in the History of Science Program at the University of Wisconsin-Madison, studying with the historian of chemistry Aaron J. Ihde. On receiving his PhD, in 1982, he took a post teaching science studies at Michigan State University, moving to the University of Notre Dame in 1985, where he taught in the Department of History and the Program in the History and Philosophy of Science before retiring in 2021.

His works on the history of public health demand intense research, and his writing engages us in stories with political plots about decisions as diverse as institutional reform or the installation of drains. His objects of study and research problems involve complicated networks of philosophical thought, political science, and urban engineering, among other issues raised by policymakers during disputes about the implementation of their programs or the consolidation of their own state positions.

He has argued that the work of the historian must help answer important current affairs questions. Nevertheless, adept to the rigor in historical research, he criticizes Erwin Heinz Ackerknecht[1] (1906-1988) for his oversimplification in dichotomizing anticontagionism as a tool for liberal governments and contagionism as a facet of "moribund bureaucracies" (Hamlin, 2009a, p.22). Regarding the connection that some people began to make in the 1990s between cholera epidemics and health reforms, he wrote that if we use threats of disease to generate fear and thus induce good outcomes, some might say that it doesn't matter if the historical point of view lacks veracity. Nonetheless, he believes that "the costs of indulging oversimplification outweigh the benefits of a more qualified look" (Hamlin, 2009b, p.1947).

In eight books and numerous articles, Hamlin goes through the history of medicine, public health, ecology, the environment, natural theology, urban theology, technology, expertise, and science, as well as covering topics such as agriculture, development, and science and technology policy. In 2010, his book *Cholera: The biography* was one of the British Medical Association's highly commended books.

In this interview, we talk about epidemics and pandemics and how history can explain them; the relationship between science, charismatic authority, and moral imagination; the role of liberalism in the search for a fair public health system in the United States; the boundaries of medical theory, discipline, and ideology in nineteenth-century Europe regarding sanitation concerns; and novelties about important aspects of the foundations of public health which are totally contrary to what the literature says.

The discussion present since the beginning of modern public health debates about the biological and social aspects of health and public health pervades the whole conversation. To the Brazilian readership, in addition to the novelties mentioned above, this interview may be particularly interesting because it provides a remarkably interesting understanding of the differences in governance and public health administration between Germany, England, and the Iberian world that may have greatly influenced the way American governments understood their own way of administering public health. Although Michel Foucault is not mentioned, Hamlin offers an important insight into the differences between discipline

and ideology (or municipal administration on the one hand and government and social movements on the other) that could be of great service for Brazilian studies about the history of medicine and public health.

Why did you become interested in the history of public health and medicine?

Well, it was a long time ago and it was an accident. I was originally an earth scientist, part geologist, part geographer. When I was in graduate school, in history of science, I was interested initially in the history of sciences, but then I also became interested in the history of environmental sciences and particularly in the places where environmental sciences and earth sciences intersect. Among them are issues of pollution, and in this case it was river pollution. So, I began to look into the question of how rivers are polluted and then become pure again. That led to questions about wastewater treatment, and in turn to questions about water-borne diseases, like cholera, and to questions about how towns and national polities took steps to deal with those problems. So, I became very interested both in the side of public health that concerns knowledge about diseases, and in the side that concerns how knowledge about diseases is translated into actions of local bodies of government. I continued to follow both those directions: I think they can't really be separated. The former was all about how we explain disease, who gets diseases and things like this. In the case of the latter, I became very interested in how difficult it is for communities to make changes, in building things like waterworks and sewer networks that cost a lot of money. So, in the early period of these technologies there were a lot of options and they had to choose which designs to follow up and things like this. There were lots of starts and stops; things did not happen quickly. Those were the main interests, probably, of the first fifteen or twenty years of my career.

We notice a political inclination in your writing. Where does it come from?

I don't believe you can think about public health without considering politics, because choices are always made to deal with some kinds of public health problems and in certain kinds of ways and not others. As a historian you begin to see these choices being made. I was particularly struck (and still am struck) that the sanitarian reformers, for all the wonderful things they did, were also looking away from certain kinds of health problems that they didn't want to deal with, because they were ideologically problematic at that time. They were emphasizing things that they thought were more politically possible. But again, if you compare public health programs in different places, you'll see that the route taken in one place is quite different from the route taken in another place, because the politics are different. I don't see myself as bringing a political position to this so much as it arises when I see people who are focusing on one issue at the cost of other issues and pretending that the other issues don't exist.

But you chose the side of social justice.

When I wrote that book (Hamlin, 1998), I didn't have a title. By the time I finished it, I said, "What am I going to call it?" and asked myself, "What is it about?" And then I said, "My goodness, it's about social justice! It's about just ways of accessing things people need." I think at that time it was looked upon as a strange title and I thought it was a strange title. But as I began to work with that title, I began to focus quite a lot on what were called "necessaries[2] of life:" things that people need to maintain health and how they access those "necessaries." Water and sanitation are some of those "necessaries," but so is food and work that does not debilitate. At that point I began to see what Marx had to say about these issues. He did say some things, but he was not a doctor and had limited access to contemporary medical views. We don't commonly realize how limited that access was; and fuller medical knowledge might have changed his views quite significantly. I began to look at places and medical traditions where there had been a more holistic notion of human welfare that included recognition of psychological and emotional issues that arose as part of the hardships of making a living. I was very interested in questions like "What do people do when they are in cold and wet places and they have no shelter?" We all know we've been very uncomfortable in an environment that is too hot or too cold. It affects our health, our wellbeing. And yet very little of that has registered in the history of medicine or of public health. When you look at the primary sources, you do find these concerns, but they are often left out of modern reconstructions.

You argued that cholera epidemics didn't lead to improvements in public health or good water supply and that the idea of a "good epidemic"[3] is a myth (Hamlin, 2009a). Were there any good outcomes from the cholera epidemics? What about the covid-19 pandemic?

I don't think I'm arguing that it's impossible for there to be good outcomes. What I was arguing against was a notion that you find in some places, a claim that epidemics will spur people to make progressive changes. They are viewed as good epidemics because people will presumably act rationally to make whatever changes are necessary to prevent them from happening again. In terms of sequence, cholera epidemics do precede sanitation infrastructure. But if you try to say that sanitation infrastructure comes very directly as a response to the cholera epidemic or that it comes to places where the cholera epidemic is the worst, the answer is no. Basically, there are lots of reasons for people to build these kinds of infrastructure. In the case of water supplies, industrial uses of water were very important. So, industrialists would try to make the public buy the water supply, so the industrialists could use it, and they sometimes used the argument that the water would benefit the public health, which of course it did, too. In some ways, this is a kind of progressive political sensibility. We like to hope that a crisis will strengthen us, but often at the end of a crisis we are so exhausted and demoralized that we may not have the ability to act to prevent the next crisis. I'm struck, when I see plague and cholera epidemics, that when they are over, often the response is just relief. People want to forget as quickly as possible; they want to go back to the old ways of living. So, twenty years later, the same situation may happen; the earlier epidemic hadn't produced an effective response. When covid started,

some editorial writers were treating it as the wakeup call that would lead us to improve our public life. Maybe that will happen – I hope it happens –, but I don't yet see any signs it is.

Recently you wrote about the "moral imagination" that results from experiences of debility and epidemic (Hamlin, 2020) as a way to make them intelligible. As you have mentioned race and racism in the US, I thought of "moral imagination" because the experience is different for the rich or the poor, and for white or black people. What are the elements of the moral imagination of black people and Trump voters in the country?

The article that you are referring to came in a strange way. Last spring, the journal *Isis,* published by the History of Science Society, asked several historians of public health to go back and look at an important book in the field. They were asking us to think about the relevance of such a book in the time of covid. I picked a book by Julie Livingston (2005). It's very different from the kind of work I usually do. She is an historian of modern Africa and, like many African historians, she does much of her work as oral history. I had been intrigued when I first read it by her concepts of "debility" and "moral imagination." A lot of my work has been about the concept of debility, because in eighteenth- and early-nineteenth-century medicine, before the sanitary revolution took off, it had been the most general concept of harm to health. It was (and is) a concept that integrates the mind and the body. If you are hungry, you are debilitated; if you are tired, you are debilitated; if you are depressed, you are debilitated. When these earlier writers used the term "depression," for example, they were using it – just as we do – for a biological condition and a subjective one. "Moral imagination" is a nice term too, because it refers to the way people think about how their lives "should be," and about the changes in health that occur during their lives and about whether those changes are expected and acceptable or represent outrages. I think historians know too little about these matters, though some medical anthropologists study these kinds of things. Julie Livingston is attuned to these matters, because much of her work is done by interviewing people and getting a sense about how they read their own lives. I have been trying to do a lot of that kind of work historically, working on the seventeenth century, for example, on the broad issue of theodicy: how we explain why the universe sometimes harms us, if God is good. It's a question that occurs for all people at all times. In the seventeenth century, for example, you find people wondering if they are living in end times. You asked me how this fits into race and current politics in the United States: I think these issues of moral imagination are very important parts of our politics, but I certainly don't know the answers to your question. The approach to understanding the epidemic simply in terms of numbers ignores how people perceive their access to medical care and the magnitude of the epidemic threat in comparison to other risks and priorities.

But isn't it interesting that, for example, safety and what is acceptable or not may involve issues about the police and mass incarceration in the case of black people?

It's interesting that during covid a separate set of issues of racism became very central. This recalls a central concern of the older historians of cholera: that an epidemic will expose

social divisions that people normally overlook. In America, the epidemic exposed the depth of racism that many people hoped had been left behind.

In 2001, you wrote that "whether people find in science a compelling reason to act depends more on who brings the science to the public than on the quality of the science" (Hamlin, 2001, p.111). I understand your sentence as meaning that people will adopt an idea depending more on charismatic authority than its internal logic. In Brazil, it's quite interesting because we have a potentialized version of Donald Trump.[4] Is the current denial of science an extrapolation of this logic or do you think something has changed throughout this century?

I am not suggesting that this is the way it should be, first of all. There is a lot of research in science and technology studies that is concerned with "stakeholders" or users in matters of public health or environmental science, where scientists' findings are either ignored or heard differently. So, the question is not so much "Is this happening?"; the more important question is "What do you do about it?". One response sees the problem as inadequate science education and says, "The problem is ignorance. People need to be better educated to appreciate the work of science." But this is difficult because always the problem will remain of how to invest one's trust in complicated issues that affect one's life. A lot of my teaching has been about precisely that issue. I try to teach people skills of scientific literacy, but I don't think the community of historians of science has engaged well enough with the problem of how people allocate trust. This goes back again in some ways to the moral imagination issues: we have to understand what the moral imagination is if we are going to answer that question, and that is an historical question and sometimes one with roots that go back for centuries.

About George Rosen's studies of medical policy, you wrote that "seldom has an historian apologized so profusely for a subject to which he was so plainly attracted" (Hamlin, 2008, p.63), because he wanted to introduce Rudolph Virchow to the American discussion about public health. And at the end of your article, defending knowledgeable management, you ask, "Must common good be inherently coercive? Is 'regulation' invariably a dirty word?" (p.68). In the text about Ackerknecht (1948), you assert that "Ackerknecht wants to say, but cannot quite, that the anticontagionists' descendants still wear the white hats" (Hamlin, 2009b, p.26), because he understood that from the "filth theory" to a social concept of medicine was a short step. But he linked anticontagionism to economic liberalism. In Brazil or in many other countries, if you call a progressive person a "liberal," they will think you are insulting them, but in the United States it seems that you have to show that an idea is market-friendly or well-adapted to economic liberalism for it to be considered. How is it to defend ideas about the common good in a country where it is almost always portrayed as antifreedom, where any idea that does not fit the economic rationale seems immediately disposable?

First of all, I just want to say that your conception of liberalism in Brazil is much more coherent than the one that exists in the United States. I sometimes tell my students what liberalism meant in 1830, which is not what it means to them now. Let me go back to the Rosen and Ackerknecht issues and I'll try to connect them together. This period in which

Rosen and Ackerknecht were writing was a really interesting period in the intersection of the history of medicine with American medical politics. It's the period after the Second World War, from the late 1940s to the beginning of the Cold War. Rosen (1979) had been thinking about the foundations of social medicine. He had a very positive conception of it as it had existed in Germany in the beginning of the twentieth century among social-democrats and progressives. In going back, he ran into Johann Peter Frank, who had written this huge book, with many volumes, called *The system of medical police*, mainly in the 1780s. What Rosen found was a very impressive and comprehensive conception of public health and state medicine. But it was in service of an absolutist state, with human beings being seen as instruments of state production. That horrified him, but while he admired the institutions of public health Frank outlined, he rejected both the motives and coerciveness. He was looking for a framework of medical citizenship within a liberal and later within a social democratic ideology that would not be coercive. So, he put a lot of faith in the fact that somehow between the 1780s and the early twentieth century that had happened, perhaps through an interaction of the growth of science with social progress. But he never really dealt with the problem of how to reconcile public health and liberty other than making clear that many of the things Frank wanted to do were obviously warranted because they improved any and all lives and that as citizens we owed to others the goods we desired for ourselves. Many things that we customarily do contribute both to our own and the public's health, but we don't feel coerced in doing them; instead, we just say "that's the way decent people behave." While the campaign against spitting was once a means to combat tuberculosis and was resisted by some, it's now simply a matter of public decency. So we don't. Hence the coercion issue can be misleading in that it ignores the fact that there always will be community standards and that these evolve partly to maintain health. Both Rosen and Ackerknecht were trying to push for a more communitarian social medicine in America at a time when it did seem there might be national health coverage. They were using history to shift the focus from singular scientific discoveries to a more general approach to the improvement of health and welfare.

Do you agree with Ackerknecht that the "filth theory" is close to the social approach? Chadwick used it to avoid the "social theory of epidemiology" (Hamlin, 1998, 2006).

The anticontagionism that attracted both Ackerknecht and Chadwick is not a theory, it's an opposition to another theory. What goes under the heading of anticontagionism varies enormously. For Chadwick it meant some essence from rotting matter and he did use it against views that were more social, though those views often used explanations that relied both on contagion and on debility in the way I mentioned earlier. Ackerknecht was thinking about contagionism as a view in which contagia are the only explanation. If we take anticontagionism to mean that something other than contagia matters in health outcomes, then Ackerknecht is absolutely right.

You also told me that contrary to what has been said, the original idea of medical police could be Iberian, due to Moorish influence. How would such a hypothesis impact the history of public health?

Often the roots of public health have been seen to be ideological. For a long time, public health was seen as an English achievement, associated with the Benthamite utilitarianism of the beginning of the nineteenth century. The assumption was that what applied in England would apply everywhere else. That assumption ignored a much longer tradition that can be called pragmatic urban management. That tradition was represented in the German medical police (the kind of thing that Frank was dealing with), but it had many roots, and most of them appear to come from southern Europe, the Mediterranean region. Some of them were Italian, some of them were Iberian. In Iberia their roots were in Islamic municipal administration, but we shouldn't think of them as uniquely Islamic, because other places too developed public approaches to the problems of urban life. The vision of a medieval city as a site of filth, chaos, and anarchy overlooks the many kinds of regulations, and the decision-making bodies that enforced public standards etc. Did they work as well as we would like them to do? Not always. They were not based on very much scientific knowledge, but they certainly were based on the recognition that people living together needed to regulate what is common among them. This enormous and neglected foundation has nothing to do with ideology, it really has more to do with people finding ways to live together. These then get instantiated with the Italian legal codes coming to Germany and representing one of the foundations of Frank's thinking about public health.

You told me that the concept of disciplinarization could work better in an analysis of the Iberian world, but maybe not of England, where ideology had greater impact. Could you talk a bit more about this?

One question to ask about public health is how much it depends on disciplinary expertise as opposed to social movements (ideology) or public problem-solving. The medical jurisprudence that came to exist in Italy and in Germany was learned and disciplinary, and anti-ideological. It assumed a single best answer to each technical question and saw public health as a matter of training people and putting them in charge. While this outlook had come to England by 1900, as Tom Crook (2016) has shown, before then public health had been largely anti-disciplinary, the achievement of amateur groups of citizens or sometimes magistrates who had to deal with every kind of conflict that came before them. They were not experts on any of the issues, they just dealt with these matters as well as they could.

Lately you've been working on a paper about the state and legal medicine. Could you tell us a bit about it?

In this country – and probably in Brazil too – popular culture is fascinated by forensic sciences. So, one way we learn to think about the relations of states and bodies is in terms of crime scene investigators: these people who come around after someone is murdered and they find the clues. At the same time there is little fascination with ordinary public health, which is also a matter of states and bodies. What I have been thinking about is how those poles – and I think they are very opposite bases for thinking about health citizenship – come out of a unified conception of legal medicine that existed in Frank's time in Germany in

the eighteenth century. The authors of medico-legal handbooks are concerned with forensic anatomy and poisoning, for example, but they are also concerned with the quality of the air, water, and food supply. So, what has occurred is a splitting of what was once a unified approach to public medical matters. In America, I think it starts in the 1930s. A lot of the work I am doing involves comparing the history of health citizenship in Germany, France, Scotland, and the United States in an effort to historicize that bifurcation.

In Germany, in France, in England, the treatises of medical police are divided between, on the one hand, public hygiene and, on the other hand, legal or forensic medicine. In Portugal, it's public health or legal medicine; it's very much about punishment.

This division is artificial. If you think about it in terms of the way I'm presenting it, both are involved in the relations of states to bodies; there is a lot in between. In Germany and France any divisions of the overall subject were mainly matters of convenience. In both, the main question was something like: "Look, in running a state, issues of bodies come up in various sorts of ways and you have to have experts who know about how bodies work and how they intersect with states, so you can administer in some rational way." In both, there is specialized training in universities in this matter of medical jurisprudence. It just seems to me that it is a much more useful way to think about these things comprehensively than to try to split them apart, which is what almost all the historians have done. Even Ackerknecht (1950), in an old article on the history of legal medicine, puts these things apart.

But the authors of these treatises separated these things, probably because they assumed that taking care and punishing were very different things.

They sometimes separated them for some practical purposes, but they also very frequently unified them. There is one chapter and another chapter, but they are all part of the same thing.

NOTES

[1] Ackerknecht was trained as a physician and as a medical historian in Leipzig in the 1920s and as a social anthropologist in Paris in the 1930s. He had to flee Europe due to Nazism and arrived in New York in 1941. In 1946, he became a professor at Wisconsin University. He helped to professionalize the field of the history of medicine in the United States, "using medical history as a vehicle for instilling ethics and what his generation termed sociology – a mix that included social history and social policy – into the medical curriculum" (Rosenberg, 2007, p.513). His generation understood that society is embedded in medicine, disease is determined socially, and social conditions and health are profoundly related, and was responsible for introducing "social medicine" to the United States.

[2] In his article and here in this interview, Hamlin uses the term used in the nineteenth century: "necessaries."

[3] In "'Cholera forcing': the myth of the good epidemic and the coming of good water," Hamlin argues that the cholera epidemics did not force improvements in public health, although a lot of people have claimed that they did. According to him, this is an unfounded historical generalization.

[4] Jair Bolsonaro, president of Brazil, is arguably more obscurantist, science-denying, and authoritarian than Donald Trump.

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