Deafness as a Public Health Issue in the 1920s & 1930s (Part 1 of 2)

Today we have part one of a guest post written by Dr. Jaipreet Virdi-Dhesi, the 2016 Klemperer Fellow in the History of Medicine at the New York Academy of Medicine and a SSHRC Postdoctoral Fellow in the Department of History at Brock University in St. Catharines, Ontario. She is working on her first book, Hearing Happiness: Fakes, Fads, and Frauds in Deafness Cures, which examines the medical history of hearing loss and “quack cures” for deafness. Some of these cures are explored on her blog, From the Hands of Quacks. You can find her on twitter as @jaivirdi.

In 1935, physician Francis L. Rogers of Long Beach read a paper addressing the worrisome statistics of deafness. One study discovered nearly thirty-five thousand Americans were deaf. Another found that out of a million people tested for their hearing, 6% had significant hearing impairment. Yet another study reported three million people had some kind of hearing impairment. This “problem of deafness,” Rogers emphasized, “is primarily of public health and public welfare.” Not only were there too many people failing to adequately care for their hearing, but many cities, schools, and governments lacked the proper infrastructure to educate the public on the importance of hearing preservation. Indeed, as Rogers stressed: “Today the three great public health problems confronting the world are heart disease, cancer, and deafness.”[1]

The notion of deafness being statistically worrying as a public health issue actually dates to the late nineteenth century, especially to the work of otologist James Kerr Love of Glasgow. Love conducted several statistical studies of the ears of deaf schoolchildren, discovering that the majority of them were not completely deaf, but had some level of “residual” hearing. With proper medical treatment, the hearing could be intensified enough to warrant a “cure.” For other cases, children could be taught to make use of that residual hearing through invasive training using acoustic aids and other kinds of hearing technologies.

Love’s research concluded that many deafness cases could actually be relieved if the ears of children were examined early and
frequently—that is, deafness could be prevented. His “prevention of deafness” concept was influential for the new generation of otologists in America, especially those who were members of the New York Academy of Medicine’s Section of Otology during the first three decades of the twentieth century.

To raise awareness on the necessity of proper medical examinations and frequent hearing tests, these otologists collaborated with social organizations such as the New York League for the Hard of Hearing, which was established in 1910. The League was a progressive group catering to the needs of hard of hearing or deafened persons who were raised in a hearing society rather than in a D/deaf community and communicated primarily with speech and lip-reading rather than sign language. Composed mostly of white, middle-class, and educated members who lost their hearing from illness, injury, or progressive deafness, the League strove to construct hearing impairment as a medical issue. They argued hearing impairment was not an issue of education or communication, but rather a handicap.

The collaboration between New York otologists and the League eventually created a national network of experts, social services, teachers, physicians, and volunteers who banded together to address the so-called “problem of deafness.” That is, the problem of how to best integrate the hard of hearing, the deafened, and to some extent, even the deaf-mutes, into society. One key achievement of the League was the establishment of hearing clinics to properly assess hearing impairment, especially in children, to ensure medical care could be provided before it was too late. This project was primarily spearheaded by Harold M. Hays (1880-1940), who was recruited as president of the League in 1913, becoming the first active otologist collaborating with the League. After the First World War, Hays set up a clinic for treating hearing loss in children at the Manhattan Eye, Ear, and Throat Hospital.
Hays claimed that hearing impairment might be a handicap, but "the sad part of it is that 90 percent of all hearing troubles could be corrected if they were treated at the proper time." With regular hearing tests, this was possible. Yet, as Hays argued, regular hearing tests were not considered on par with other hygienic measures under public health services:

"We are saving the child’s eyes! We are saving the child’s teeth! Is it not worth while to save the child’s ears?"[2]

During the 1920s, Hays’ activism for regular hearing tests was so instrumental that in 1922, the League’s newsletter, The Chronicle, told its readers “we believe that the League would justify its existence if it did no other work than to prevent as much deafness as possible.” To achieve this mandate, the League launched a large public campaign to raise awareness on the importance of medical care. Indeed, in one report for the League, Hays remarked that with the increased publicity, there were 10,000 calls to the League in 1918 alone inquiring about aural examinations. A steady increase in patients would follow: 17 clinic patients in 1924, 326 in 1926, and then 1,531 in 1934.

Another publicity campaign spearheaded by the League was the establishment of “Better Hearing Week” in 1926, a week-long awareness program (later renamed “National Hearing Week”). Held in October, the campaign included symposium discussions on the “Problems of the Hard of Hearing,” including topics on the relationship between the physician and his deafened patient, how the deafened could build their lives, and even on newest technological developments in hearing aids. October issues of The Bulletin (the renamed League newsletter) and the Hearing News, the newsletter of the American Society for the Hard of Hearing (ASHH) included reprints of letters from prominent leaders supporting the mandates of “Better Hearing Week,” including letters from President Roosevelt and New York Mayor LaGuardia.
The 1920s publicity campaigns were primarily focused on fostering ties between otologists and the League, in cooperation with hospitals and schools. In 1927, the League purchased audiometers and offered invitations to conduct hearing tests in schools across New York, so children with hearing impairment could be assessed accordingly. Two years later, the League worked with Bell Laboratories to further substantiate the conviction that deafness was a serious problem amongst schoolchildren and that something needed to be done.

At the same time otologists across America established joint ventures between organizations like the America Medical Association and the American Otological Society. They formed committees to write reports to the White House on the national importance of addressing the “prevention of deafness.” Wendell C. Phillips (1857-1934), another president of the League and the founder of ASHH, particularly emphasized the need to address the “psychologic conditions and mental reactions” of the deafened patient, for the tragedy of acquired deafness meant it is a “disability without outward signs, for the deafened person uses no crutch, no black goggles, no tapping staff.”[3] It was an invisible handicap that needed to be made visible if it was to be prevented, if not cured.

References


Apply for our 2017 Research Fellowships

Do a one-month residence in The Drs. Barry and Bobbi Coller Rare Book Reading Room, immersed in resources on the history of medicine and public health, sound like a dream come true?

The Academy Library offers two annual research fellowships, the Paul Klemperer Fellowship in the History of Medicine and the Audrey and William H. Helfand Fellowship in the History of Medicine and Public Health, to support the advancement of scholarly research in the history of medicine and public health. Fellowship recipients spend a month in residence conducting research using the library’s collections.

Applications for our fellowships are being accepted now through late August for fellowships that may be used at any time during 2017.

Preference in the application process is given to early career scholars, although the fellowships are open to anyone who wishes to apply, regardless of academic status, discipline, or citizenship. While both fellowships are for researchers engaged in history...
of medicine projects, the Helfand Fellowship emphasizes the role of visual materials in understanding that history.

Applications are due by the end of the day on Friday, August 26, 2016. Letters of recommendation are due by the end of the day on Monday, August 29, 2016. Applicants will be notified of whether or not they have received a fellowship by Monday, October 3, 2016.

Prospective applicants are encouraged to contact Arlene Shaner, Historical Collections Librarian, at 212-822-7313 or history@nyam.org with questions or for assistance identifying useful materials in the library collections.

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**17th Century Recipes, Fit for a Gala**

**Posted on June 17, 2016 by nyamhistorymed**

By Arlene Shaner, Historical Collections Librarian

The New York Academy of Medicine hosted its annual fund-raising gala at the Mandarin Oriental on June 14. Gala attendees had the opportunity to sample two treats based on recipes from one of our favorite manuscript receipt books.

The Academy Library has 37 manuscript receipt books, most of which contain a mix of culinary, medicinal and household recipes. Some of them have been featured already on our blog (see earlier posts on *Mother Eve’s Pudding*, and *English Gingerbread*). The Recipes Project also featured an interview with Anne Garner, our Curator of Rare Books and Manuscripts, about the print and manuscript historical recipe books in our collection.

One of our favorite manuscripts is *A Collection of Choise Receipts* from the late seventeenth century. Inspired by a recipe for Black Cherry Water in the manuscript, Pietro Collina and Matt Jozwiak created a signature cocktail, the “Choise Cherry Crush,” for gala guests. You can try your hand at mixing one up if you are so inclined.
The drink was inspired by this 1680 recipe:
On their way out at the end of the evening, guests received bags with a pair of almond cookies also adapted from a recipe in *Choise Receipts*.

There are several recipes for cookies or little cakes made with almonds in the manuscript. My favorite, “The Lady Lowthers Receipt for to make Bean Bread” a cookie that very much resembles a macaron in texture, takes its name from the slivered almonds that look like little beans that are mixed into the dough.
The recipe for Almond Bisketts that we reproduced for the gala, however, seems to be missing a crucial ingredient: almonds!

—from “Lady Lowthers Receipt, for to make Bean Bread,” from A Collection of Choise Receipts, 1680.
Only when examining the full page of the manuscript, on which a very similar recipe for Almond Cakes appears directly above the one reproduced on the postcard, does it become clear that the “half a pound of fflower” referred to in this recipe would be made from ground almonds. The adapted recipe printed on the back of our card makes that clear.

If you make a batch of these tasty cookies, let us know how they turn out! Better yet, send us a picture and we’ll post it on Instagram.

Digitizing Medical Journals of State Societies

Posted on June 15, 2016 by nyamhistorymed

By Robin Naughton, Ph.D., Head of Digital

The New York Academy of Medicine Library is digitizing state society medical journals as part of a mass digitization project with the Medical Heritage Library (MHL), a digital curation consortium. The Academy Library is one of five collaborators on the project,
along with the College of Physicians of Philadelphia; the Countway Library of Medicine at Harvard University; the Health Sciences and Human Services Library, University of Maryland; the Founding Campus; and the University of California at San Francisco.

Together, the MHL team is actively working to digitize 48 state society journals, more than 3,800 volumes that span much of the 20th century. Digitizing the state medical journals will provide open access to quality historical resources in medicine for researchers and the general public, letting them explore connections between medicine and society.

Evenly splitting the volumes among the MHL team makes the process of mass digitization more manageable and very collaborative. The Academy Library has already digitized almost 50% of the state medical journals assigned to it since Fall 2015. The journals are scanned by the Internet Archive (IA) and are publicly available as part of the Library’s and MHL’s collections on the IA site. Our digitized assets are open for anyone to access and use. Thus far, we have digitized journals representing 24 states and almost 238,000 images.

The volumes are digitized in their entirety, showing the journals’ articles and advertising. For example, in *Alaska Medicine* (vol. 29, 1987), as you read the article “Alaska State Hepatitis B Program – Past, Present and Future” by Elizabeth A. Tower, you can’t help but notice the advertisement for medical transcription. It is hard to resist the “Hello … Museum of Primitive Civilizations and Hieroglyphs?”
State medical journals are valuable resources that should lead to many new and novel projects for researchers in the history of medicine. Look for more on the project as it progresses.

Explore our collection.

Get Crafty at the Museum Mile Festival on June 14

Posted on June 7, 2016 by nyamhistorymed

By Emily Miranker, Project Coordinator

When my office is perfumed by the smell of crayons and stocked with boxes of jumbo-sized sidewalk chalk, I know its Museum Mile Festival time. This year’s Museum Mile Festival takes place on Tuesday, June 14 from 6:00-9:00 pm, rain or shine.

Museum Mile (New York City’s Fifth Avenue from 82nd to 105th Street, which is technically three blocks longer than a mile) is one of the densest cultural stretches in the world! For the last 38 years, Fifth Avenue closes to traffic for a few hours on an early June evening. The eight major museums and their neighbors—that’s us!—throw open their doors and spill out onto the street in a block party.
The first festival was held in 1979, the brainchild of the Museum Mile Association, to increase cultural audiences and garner support for the arts in time of great fiscal crisis in the city. The festival has since brought many New Yorkers and tourists to upper Fifth Avenue for the first time, and total attendance over the years has surpassed one million visitors.

Besides free admission to the museums along the mile, street performers, chalk drawing, live bands, balloons, and family-friendly activities abound. Dedicated to improving the health and well-being of people living in cities, the Academy has partners from the East Harlem Asthma Center of Excellence and Shape Up NYC joining us for the evening.

The Library has planned some special crafts for the festival. We have the perennial favorite: coloring pages based on images from our collections. Feel free to download your own pages any time from #ColorOurCollections online.
Among the treasures of our collection are the anatomical flap books. These are detailed anatomical illustrations superimposed so that lifting the sheets reveals the anatomy and systems of the body as they would appear during dissection. We created a simple DIY version of a flapbook inspired by these remarkable figures from the 1559 edition of Geminus’ *Compendiosa totius anatomiae delineatio, aere exarata*. The sheets are quite delicate, so it’s rare to see intact versions like this 400 years after they were made. Make your own flapbook with us during the festival.
And there’s nothing like using your own body to create art—finger print art!
We look forward to seeing you at Museum Mile!

References


The Foresight of Trans-vision: An Innovative Anatomy of the Eye

Posted on June 2, 2016 by nyamhistorymed

By Anne Garner, Curator of Rare Books and Manuscripts

Early European anatomical lift-the-flap books made use of technologies available during the 16th century: woodcut and engraving, combined with manual cutting and pasting. Flap anatomies like Geminus’ Compendioso (1559) allowed readers to peel away the layers of the body to reveal different organs, but these flaps were made of paper and opaque, and didn’t allow the reader to view the strata of the body simultaneously.
Fast forward four centuries, when an innovation in printing technology let readers take a deep dive through the layers of the body all at once.

Anatomical illustrators used transparencies to show the layers of the body as early as the 1920s. J.E. Cheesman published *Baillière's Synthetic Anatomy*, a series of 14 booklets, in London from 1926 to 1936. The series used a set of glassine sheets to show what lay beneath the surface of the skin.
In 1942, Richard Lasker patented a new printing process for Milprint Inc., a Milwaukee-based company. He called this new method trans-vision. Trans-vision allowed for the printing of images on the inner surfaces of folded sheets of transparent acetate. These sheets could then be piled on top of one another so that they overlapped, enabling a multi-layered view with the top sheets depicting the most superficial layers of an object and the bottom sheets the deepest level.²

The patent application for Lasker’s trans-vision process used a cutaway illustration of a mattress, with different layers of acetate offering views of the mattress’ filling.³ Trans-vision’s medical applications proved significantly more useful: it made possible the representation of complex anatomical relationships to health professionals and public audiences alike.

In 1943, Peter C. Kronfeld, an ophthalmology professor at the University of Illinois, published  *The Human Eye in Anatomical Transparencies*. The book contains 34 color anatomical paintings printed using trans-vision.⁴ Each page offers a frontal and temporal view of the eye and its area, with transparent layers that can be peeled away by turning the pages. The paintings are printed on the inner side of the acetate to minimize damage from handling. The parts of the eye are numbered. Readers can use a bookmark key laid-in to identify the different parts by name.⁵

Kronfeld describes the project in *The Human Eye*’s preface:

It was at once obvious that the eye could advantageously be represented by this means, for it is a three-dimensional object in which great structural intricacy is combined with relatively small size. Ordinary drawings of its separate parts tend to isolate them too much from each other in the mind of the observer... The text has been so organized as to present not only a systematic account of ocular anatomy—taking up the various structures in a functionally logical order—but also a topographic treatment of the anatomy...which necessarily reveal the structures layer by layer in an order determined somewhat by the layers of dissection techniques.⁶

The paintings were made at twice the actual size by Gladys McHugh, an illustrator at the University of Chicago. The pioneering medical illustrator Max Brödel had been McHugh’s teacher and mentor at Johns Hopkins University, where she studied. It was
Brödel who influenced McHugh to make her own dissections.

McHugh augmented her dissections of human eyes with specimens from pigs and monkeys. She describes her extensive dissection work in her introduction:

Over a course of time I obtained from baby autopsies ten good cases, making a total of twenty eyes and orbits. These I dissected layer by layer, making color notes and drawings from the fresh specimens. To develop a technique for separating the layers of the eyeball as intact semispheres, pigs’ eyes were employed. Also, to supplement my observation of the muscles and other structures not fully developed in the infant, monkey orbits were dissected.

As Professor Shelley Wall has argued, turning the pages in *The Human Eye* mimics the dissection process. As the layers on the recto side of the book are more deeply revealed with each page turn, the layers build on the opposite verso, allowing for the eye’s reconstruction. With *The Human Eye*, the union of format, technology, and material is harmoniously in sync.
By 1958, the book had enjoyed five editions. Students and educators embraced the text and its ingenious illustrations. In 1946, the trans-vision process was applied again to McHugh’s paintings in for *The Human Ear in Anatomical Transparencies*. Initially conceived as a wartime project useful to the aviation industry, the book’s value, as with *The Human Eye*, was in its power to demonstrate to both lay and specialized audiences the inner workings of organs not easily seen.

The finest examples of trans-vision printing occurred when the coffers of the pharmaceutical companies who published them were at their fullest. After *The Human Eye* and *The Human Ear*, medical illustrator Ernest Beck used trans-vision technology to produce more than 30 anatomical transparency projects published by Milprint for encyclopedias, pharmaceutical companies and other commercial concerns. A decade after Kronfeld, Ciba Pharmaceuticals published a 13-volume collection of anatomical illustrations using anatomical transparencies between 1953 and 1989. The illustrator of these, was a native New Yorker, fellow of the Academy, and former member of the Art Students League of New York. His name was Frank Netter.

### References

1. For more on this, see Andrea Carlino’s excellent *Paper bodies: A catalogue of anatomical fugitive sheets, 1538-1687*.


3. Wall, 917.

20th-Century Teeth: Dentistry at the Turn of the Century

By Johanna Goldberg, Information Services Librarian

This is part of an intermittent series of blogs featuring advertisements from medical journals. You can find the entire series here.

“How did you learn to be a dentist? Did you go to a college?”

“I went along with a fellow who came to the mine once. My mother sent me. We used to go from one camp to another. I sharpened his excavators for him, and put up his notices in the towns—stuck them up in the post-offices and on the doors of the Odd Fellows’ halls. He had a wagon.”

“But didn’t you ever go to a college?”


Trina rolled down her sleeves. She was a little paler than usual. She fastened the buttons into the cuffs and said:

“But do you know you can’t practise unless you’re graduated from a college? You haven’t the right to call yourself, ‘doctor.’

In Frank Norris’ 1899 novel McTeague: A Story of San Francisco—better known for its depiction of greed than the professionalization of dentistry—the title character loses his 12-year-old dental practice after California requires practitioners to hold a degree in the field. The timing couldn’t be worse for McTeague: he’d only just fulfilled a long-held dream, obtaining and hanging an enormous golden tooth outside his dental parlor.

McTeague’s fictionalized struggle was based in reality: until the mid to late 1800s, dentistry in the United States was not a regulated profession. Alabama became the first state to regulate dentists in 1841, and other states followed suit through the end of the century. In 1885, California passed a law requiring practicing dentists to register with a board, which could call up registrants for examination. Diplomas from a licensed dentistry school—the University of California College of Dentistry opened in San Francisco in 1882—also qualified registered dentists to practice. In 1901, a new law made practicing dentistry in California even more restrictive, part of a nationwide move to tighter regulation. In the novel as it would have been in real life, McTeague’s practice was toast.

Advertisements in dental journals from the era depict the trend toward professionalization, along with other technological advances. In 1840, the Baltimore College of Dental Surgery opened its doors as the first dental school in the world; by 1895, it had some local competition, including the Dental Department of the Baltimore Medical College. This school advertised heavily in journals like the American Journal of Dental Science.
Intriguingly, not only dental schools advertised in dentistry journals: The February 1901 volume of *Dental Hints* includes an ad encouraging dentists to take up a correspondence course in optometry, “on account of the intimate relationship between the eye and the teeth.” Huh?
Dental journal advertisements also reflect anesthetic advances. William Morton, a dentist, performed the first public demonstration of ether as a surgical anesthetic in 1846. A similar demonstration of nitrous oxide in 1845 did not go so well: dentist Horace Wells extracted a tooth before administering the proper dosage, and the patient cried out in pain. The drug was tabled for about 20 years; by 1869, it was commonly used either on its own or in conjunction with ether for dental procedures.

Dental surgeries held less risk than other medical procedures, as they were commonly performed either in the patient’s or dentist’s home, locations less teeming with deadly microbes than operating theaters. After advances in antiseptic surgery by people like Joseph Lister, dental surgery became even safer—and Dr. Joseph Lawrence named an antiseptic mouthwash in his honor.
CODMAN & SHURTLEFF'S INHALER FOR GAS OR ETHER.

This inhaler (Figs. 105 and 115) has the following advantages over any other: The rubber hood covering both nose and mouth allows the patient to breathe easily and naturally through either organ without waste of gas. The instrument is easily managed by the operator with one hand, leaving the other at liberty to use as occasion may demand. With the Ether attachment, a saving of at least one-half of the Ether is effected, the desired result is produced much more quickly, and the operator inhales much less Ether himself.

Fig. 105 is the apparatus for Nitrous Oxide Gas. This has been used by a great number of dentists, and is pronounced by them entirely satisfactory. Fig. 115 represents the Ether attachment. At the sliding joint, E, the inhaler may be detached from the Gas apparatus, and the Ether chamber put on in place of it. This takes but a moment, and furnishes the best Ether inhaler ever made. The Ether chamber is tightly filled with sponge, upon which Ether is poured, and, leaving the cover, H, off, it is ready for use.

Price of Fig. 105, . . . . . . . . . . $13.00
" " 115, . . . . . . . . . . 5.00

We have a very full stock of Dental Instruments and material of our own manufacture and importation. Catalogues sent on application.

CODMAN & SHURTLEFF,
Nos. 13 & 15 Tremont St., Boston.
Local anesthetics also entered the market around the turn of the century. Some, like Mylocal, contained cocaine—though in the case of Mylocal, that cocaine was to be added by the practitioner prior to use. Perhaps unsurprisingly, the amount of cocaine used in local anesthetics was often poorly controlled, with sometimes dire results. Another local anesthetic, Eureka, proudly advertised that it “[avoids] that most dangerous drug that is known to the profession as COCAINE.” A third, Wilson’s Local Anaesthetic, notes that it is “non-secret and positively guaranteed.” Unfortunately, its ads don’t state what these non-secret ingredients are.
Eureka Local Anaesthetic for the Painless Extraction of Teeth.

The best known local anaesthetic, safe, absolutely painless, non-irritating, containing Bucaine, Menthol, Anise, Clove, Glycerine, Ether and Water, avoiding that most dangerous drug that is known to the profession as CCOCAINE.

Endorsed by the best known Colleges in the Country and leading men in the profession.

SEE TESTIMONIALS.


EUREKA CHEMICAL CO.,

Gentlemen:—For the last six months the Eureka Extracting Fluid has been in use in this school. During that time it has been applied in several hundred cases and I can say that it is a certain pain obliterator, and in no instance have I found injuries after effects. Very truly yours,

W. G. FOSTER,

Demonstrator.

J. Whitaker, D. D. S., M. D., Assistant Demonstrator University of Maryland.

EUREKA CHEMICAL CO.,

Baltimore, Md.

Dear Sirs:—I gladly give my testimony for your Local Anaesthetic. It has given perfect satisfaction in the extracting room at the University of Maryland.

J. WHITAKER, D. D. S., M. D.

EUREKA CHEMICAL CO.

Dear Sirs:—Your Eureka Local An, has proven highly successful at the D. D. of the Baltimore Medical College, and we find that it is worthy everything claimed for it.

K. W. EGERTON, D. D. S.


EUREKA CHEMICAL CO.

Gentlemen:—It gives me pleasure to state that your Extracting Fluid is all that is claimed for it. I most heartily recommend it to those who by necessity are obliged to extract. The extraction is positively painless without any after injurious effect.

W. R. FINNEY, D. D. S.

Very truly yours,

PRICES

2 ozs. $2.00; 6 ozs. $5.00, including all Metal Syringes, three Reinforced Needles with every $5.00 order. When money accompanies order, goods sent prepaid.

EUREKA CHEMICAL CO.

Wilkes-Barre, Penna.

[When writing, kindly mention Dental Hints]
Other turn-of-the-century advances include the development of tube toothpaste in the 1880s (previously, toothpaste had only been available in powdered form); awareness of microbial causes of tooth decay, leading to the promotion of flossing and brushing in the 1890s; and the use of gold foil as a cavity filling in the 1850s. The ads below reflect these advances and others, and were selected to show the relatively pain-free side of dentistry.
Dental Floss Silk advertisement in advertisements in the *American Journal of Dental Science*, vol. 33, no. 10, February 1900.
McConnell Dental Chair advertisement in Dental Hints, vol. 3, no. 4, April 1901.

A stump has some advantages as a Dental Chair in an emergency. It is strong and cheap, but it is heavy and unhandy to move, and would be more convenient and comfortable if it had less attachments and more adjustment. The same might truly be said of the majority of Dental Chairs excepting the high priced ones, and it takes from two to three years to adjust your finances after buying one.

"The McConnell" has none of these defects and all of the advantages, with the additional one that you can fold it up and walk off with it. The best Portable Dental Chair on earth, and your office is not complete without one or more of "The McConnell" Chairs. The only one in existence that can be elevated and adjusted while occupied. Lowest position 17 inches, highest 38 inches, and can be adjusted to any angle from a perfectly upright position to a reclining one. Head rest has back, forward and side movement. This Chair is fully guaranteed as represented, and will lend dignity to the best equipped office in the land, and is sold at the astonishingly low price of $16.50.

J. W. McConnell, D. D. S.
Cornelia, Ga.

(When writing, kindly mention Dental Hints.)
Teeth That Are Tested

“Twentieth Century” Teeth
TRADE MARK REGISTERED.
Made under 12 U. S. Patents covering method and machinery for manufacture.

PERFECT MOLDS.
PERFECT PORCELAIN.
PERFECT PINS.
PERFECTLY SECURED.

A Strong Rib Anchorage. Better than Cheap Pin Teeth. Large quantities used.

GIVING SPLendid SATISFACTION.
Try Them.

A dove-tailed rib, anchored in the rubber—never get loose—cannot be pulled off.

PLAIN ORLY—Prices, 1x14, 50c; 1½x14, 75c; 2x14, 1.00; 2½x14, $1.25; 3x14, $1.50; 4x14, $2.00; 6x14, $3.00; 100x14, $40.00; Terms Cash, or $1.00 with order, balance C. O. D.

GIVE THEM A TRIAL—They are ALL RIGHT.
Manufactured by
THE STANDARD DENTAL MFG. Co.

STANDARD PLATINUM PIN TEETH

Write for Prices if you want good value.

Standard Dental Manufacturing Co.

TOLEDO, OHIO

Wholesale and Retail Dealers.
(When writing, kindly mention Dental Hints.)
Dentacura toothpaste advertisement in *Dental Hints*, vol. 3, no. 11, November 1901.
Munson’s Standard Teeth advertisement in Dental Hints, vol. 3, no. 12, December 1901.

THIS OLD GOOSE
NEVER HAD ANY TEETH. BUT
NOW SHE IS GOING TO SEE...

DR. GANDER.
ABOUT A SET OF

Standard Teeth.
"CAUSE THEY ARE SO NICE."

MUNSON’S STANDARD TEETH
ALL THAT THE NAME IMPLIES.
FULL LINE. GOOD QUALITY. FAIR PRICES.

Standard Platinum Pin
Price, 1x14, $1.25; 10x14, $11.00; 25x14, $25.00.

Standard “P B”
Platinum 6 fronts PINLESS BACKS, call them “P B” for short. A fine combination, equal for service to all platinum pin. Very popular and serviceable.
Price, 1x14, $1.00c.; 12x14, $10.00; 30x14, $25.00; 50x14, $50.00; 100x14, $100; cash; plain only.

Price, cash, 1x14, $0.00; 11x14, $5.00; 28x14, $10.00; 100x14, $40.00; $75x14, $100; cash.

Standard Flat Backs
Large pins, fine moulds and shades; Price 15c each.

Twentieth Century.
Famous the world over. Price, 1x14, $1.00; 11x14, $10.00; 28x14, $25.00; cash.

TERMS:—Cash with order, or if C. O. D. $1 with order, balance C. O. D. Remit DRAFT or Money Order. Personal Checks Certified and Exchange added. ASK YOUR DEALER for these Teeth or order of me. FOR SHADE use Sibley or White.

Selling Agency
THE STANDARD DENTAL MFG. CO.
DENTISTS’ SUPPLY CO., and the
PORCELAIN TOOTH CO.
C. W. MUNSON.
Non-Combination.
Toledo, O.

nyamcenterforhistory.org
What's the Use of keeping him out of his rights? Every boy needs a Prophylactic toothbrush. (The child's or youth's size.) He ought to have one.

Urge upon all parents the necessity of using the Child's and Youth's sizes for their children—the little ones will soon use the Adult's size. Secure youthful trade—you secure the assurance of the adult trade, for habits are powerful. The Prophylactic won't take your place, but it will assist you tremendously in your good work. It is the people whose teeth are worth preserving who patronize you. It will pay you to recommend these toothbrushes—all 3 sizes. May we tell you more about them? Write at once.

FLORENCE MFG. CO., Florence, Mass., U. S. A.

3 sizes always sold in a yellow box by
Dr. Ransom & Randolph Co., Toledo, O.
Antikamnia and Odontoline advertisements in advertisements in the *American Journal of Dental Science*, vol. 39, no. 4, April 1908.
References


Many Anatomy Lessons at the New York Academy of Medicine

Kriota Willberg, the author of today’s guest post, explores the intersection of body sciences with creative practice through drawing, writing, performance, and needlework. She is offering the workshop “Visualizing and Drawing Anatomy” beginning June 6 at the Academy. Register online.

Different Disciplines, Same Body

I teach musculoskeletal anatomy to artists, dancers, and massage therapists. In my classes the students study the same raw material, and the set of skills each group acquires can be roughly organized around three distinct areas: representation of the body, kinesiology (the study of movement), and palpation (feeling the body).

As an anatomy teacher I am constantly on the prowl for images of the body that visually reinforce the information my students are learning. The Internet has become my most utilized source for visual teaching tools. It is full of anatomy virtual galleries, e-books, and apps. 3D media make it ever easier to understand muscle layering, attachment sites, fiber direction, and more.

In spite of the overwhelming volume of quality online cutting-edge anatomical imagery, I find myself drawn to historical 2D printed representations of the body and its components, once the cutting-edge educational technology of their respective centuries. Their precision, character, size, and even smell enhance my engagement with anatomical study. Many of these images emphasize the same principles as the apps replacing them centuries later.

The Essential Structure Of The Body

Different artists prefer different methods of rendering bodies in sketches. One method is to organize the body by its masses, outlining its surface to depict its bulk. Another method is to draw a stick figure, organizing body volume around inner scaffolding.
And what is a skeleton but an elaborate stick figure? William Cheselden’s *Osteographia* (1733) presents elegant representations of human and animal skeletons in action. These images remind us that bones are rigid and their joints are shaped to perform very specific actions. The cumulative position of the bones and joints gives the figure motion. In Cheselden’s world of skeletons, dogs and cats fight, a bird eats a fish, a man kneels in prayer, and a child holds up an adult’s humerus (upper arm bone) to give us a sense of scale while creating a rather creepy theatrical moment.

*Muscle Layering*

3D apps and other imaging programs facilitate the exploration of the body’s depth. One of the challenges of artists and massage therapists studying anatomy is transitioning information from the 2D image of the page into the 3D body of a sculpture or patient.
Salvage’s *Anatomie du gladiateur combattant: applicable aux beaux artes ...* (1812) is a 2D examination of the 3D Borghese Gladiator. Salvage, an artist and military doctor, dissected cadavers and positioned them to mimic the action depicted in the statue. His highly detailed images depict muscle layering of a body in motion. The viewer can examine many layers of the anatomized body in action from multiple directions, rendered in exquisite detail. Salvage retains the outline of the body in its pose to keep the viewer oriented as he works from superficial to deeper structures.
Bernhard Siegried Albinus worked with artist Jan Wandelaar to publish *Tabulae sceleti et musculorum corporis humani* (1749). Over their 20-year collaboration, they devised new methods for rendering the dissected body more accurately. The finely detailed illustrations and large size of the book invite the reader to scrutinize the dissected layers of the body in all their detail. Although there is no superficial body outline, the cadaver’s consistent position helps to keep the reader oriented. On the other hand, cherubs and a rhinoceros in the backgrounds are incredibly distracting!

*Fiber Direction*

Familiarity with a muscle’s fiber direction can make it easier to palpate and can indicate the muscle’s line of pull (direction of action).
The images of Jacopo Berengario da Carpi’s *Anatomia Carpi Isagoge breves*, *perlucide ac uberime, in anatomiam humani corporis*... (1535) powerfully emphasize the fiber direction of the muscles of the waist. This picture in particular radiates the significance of our “core muscles.” Here, the external oblique muscles have been peeled away to show the lines of the internal obliques running from low lateral to high medial attachments. The continuance of this line is indicated in the central area of the abdomen. It perfectly illustrates the muscle’s direction of pull on its flattened tendon inserting at the midline of the trunk.

*The Internal Body Interacting with the External World*

One of the most important lessons of anatomy is that it is always with us. Gluteus maximus and quadriceps muscles climb the stairs when the elevator is broken. Trapezius burns with the effort of carrying a heavy shoulder bag. Heck, that drumstick you had for lunch was a chicken’s gastrocnemius (calf) muscle.
Anatomists from Albinus to Vesalius depict the anatomized body in a non-clinical environment. One of my favorites is Adriaan van de Spiegel and Giulio Casseri’s *De humani corporis fabrica libri decem* (1627). In this book, dissected cadavers are depicted out of doors and clearly having a good time. They demurely hold their skin or superficial musculature aside to reveal deeper structures. Some of them are downright flirtatious, reminding us that these anatomized bodies are and were people.
I am so enamored of van de Spiegel and Casseri that I recreated page 24 of their book as a self-portrait. After my abdominal surgery, the image of this cadaver revealing his trunk musculature resonated with me. In my portrait I assume the same pose, but if you look closely you will see stitch marks tracing up my midline. I situate myself in a “field” of women performing a Pilates exercise that challenges abdominal musculature. And of course, I drew it in Photoshop.

**Narrative, Health, and Social Justice: Stories of the Body**

*Posted on May 19, 2016 by nyamhistorymed*

Annie Robinson, today’s guest blogger, holds a Master of Science in Narrative Medicine from Columbia University. As an eating disorder recovery coach, wellness educator, and workshop and retreat leader, Annie uses story to facilitate healing, self-reflection, and narrative competence. She will lead a Health and Social Justice Reading Group at the Academy six Wednesday afternoons from June 22 to July 27. [Find out more and register online](#).

In middle school I developed a severe eating disorder that persisted into my mid-twenties. I have told this story in so many ways over the years. Initially, I subscribed to the common narrative of disorder-as-enemy: “I am battling an eating disorder.” But ultimately, this story did not serve my healing. It made me feel like I was at the mercy of my symptoms. Perceiving my eating
disorder as a demon that I needed to fight against positions me as an enemy of myself, insofar as the eating disorder is inherently a part of me.

So I tried out a new story. What if my eating disorder is a wounded part trying to protect me from pain? It offers temporarily helpful—though ultimately ineffective—strategies to meet my needs for comfort and safety. It is young and naive, frantic and scared. It needs to be loved and listened to, not condemned and silenced. I took on the role of mother caring for a feisty, frightened child who needed firm but kind parenting. My mothering self and my eating disorder self engaged in frequent dialogues, both out loud and in writing, to rework the stories I’d been living for so long.

To truly enter recovery, I had to not only rewrite the story of my eating disorder, but to share it with others. As author instead of victim, I am freed from the secretiveness and shame that eating disorders thrive on. And by sharing my story, I make myself vulnerable, which allows me to connect authentically with others.

Renowned researcher Brené Brown studies the correlation between exposing shame, embracing vulnerability, and wellbeing. Her research also examines how the stories we tell about ourselves possess tremendous power—either to trap us, or to instigate radical change. She postulates: “When we deny the story, it defines us. When we own the story, we can write a brave new ending.”

By changing my story, I changed my behaviors, and by changing my behaviors, I changed my life. While stories can disempower, they can also generate agency. They can ascribe blame, or bestow forgiveness. At their best, I believe stories are some of our greatest tools for healing both individual pain and social injustices.

I realized the potency of language not only in recovery, but also in my role as a doula—someone trained to support individuals as they navigate pregnancy, abortion, birth, and fetal loss. In this role, I have witnessed how issues of social justice are deeply entwined with bodily experiences.

Maria, a quiet 16-year-old Hispanic girl living a foster care home for pregnant teens, was 36 weeks along when I met her. For the majority of her labor at a large hospital in the city, no one looked her in the eye. Family-less, jobless, degree-less, and soon to be responsible for a newborn, she seemed too much for her providers to bear. Her labor was blessedly short, her birth smooth, and her beautiful baby boy healthy. But no one showed up to celebrate with her. Though she spoke no words of disappointment, tears welled in her downcast eyes as she smiled down at her tiny child.

Pooja, a vibrant 30-year-old Bengali woman in her second trimester of pregnancy, came into my care at a public hospital. She had just learned that if she carried her pregnancy to term, her baby would be born with severe disabilities. She had no choice but to terminate the pregnancy, because she and her husband could not financially accommodate a child with expensive chronic medical needs. During the termination procedure, she wailed and dug her nails into my hand as I held fast, whispering soothing words in her ear. As her cries escalated, the doctors spoke louder to her in English (a language she barely understood) about what steps they were taking, as if they could extinguish her deep suffering with their voices and expertise.

The stories of Maria and Pooja, along with those of dozens of other women I have served, reflect how social injustice is so often based in the body. Their distinct cultural conditions, social vulnerabilities, and economic disparities all influenced the care they
In the world of medicine, the term “social justice” refers to the differences in how people experience health conditions and interface with the healthcare system. It is imperative to consider the roles these factors potentially play in the story of someone’s health experience, leading to inequities in resources, unique linguistic and cultural reference points, and distinct vulnerabilities and disadvantages.

While serving as a doula, I also was a graduate student at Columbia University studying an innovative discipline called narrative medicine. This approach endeavors to train clinicians to deeply hear and respond to their patients’ stories, not just their symptoms. Narrative medicine provides a way for patients and providers to co-create humanized stories of illness and embodied experiences, and offers strategies for studying the meaning of these experiences through telling, reading, and writing about them. I came to appreciate body-based stories as deeply vulnerable ones, as they concern both our physical selves as well as the parts of our identity that transcend biology.

I will be facilitating a six-week course at the New York Academy of Medicine from June 22-July 27, 2016 on how language can serve as a mechanism for social justice in health (register online). We will use narrative practices such as reading fiction and nonfiction texts, having group discussions, and writing self-reflectively for an in-depth exploration of how language influences our experiences of our bodies and can serve as a mechanism for enacting social justice in healthcare.

We will use narrative depictions to unpack how health, illness, and disability are issues of social justice. How do social justice and health relate to gender, sexuality, race, trauma, caregiving, privilege, disability, age, class, and geography? How can creative expressions of embodied experiences facilitate self-realization and healing? Whose voices are most often heard, and whose are not? Where do private matters of health, illness, and disability fit in the public arena? What are the effects of how they are politicized, for better and for worse? And how can social, cultural, and political change that benefits embodied experiences be instigated by individuals?

Sources will include (among others): poems by physician-poet Rafael Campo, stories by Sherman Alexie, essays by Eve Ensler, excerpts from Illness as Metaphor by Susan Sontag, first-person perspectives about gendered embodiment from Minding the Body, and pieces from Leslie Jamison’s The Empathy Exams.

Please join us to explore what social justice, story, and embodiment mean to you!

Questions? Please email culturalevents@nyam.org.

Have You Heard of the Lincoln Collective?
Today’s guest blogger, Merlin Chowkwanyun, is an assistant professor of sociomedical sciences at Columbia University’s Mailman School of Public Health. He will present “The Lincoln Collective: The World of New York City Health Activism in the 1970s” at the Academy on May 24. Learn more and register.

I’m really looking forward to visiting the New York Academy of Medicine next week, in no small part because the health activism I’m going to discuss took place in New York City itself. My talk will focus on a couple dozen physicians, fresh out of medical school, who decided to do their residencies at Lincoln Hospital in the South Bronx in the 1970s.

They arrived in the summer of 1970 and called themselves “the Lincoln Collective,” hoping to form a critical mass of politically conscious physicians who could effect change in one institution, and in the process, provide a model for other activists across the country to follow. In its recruitment pamphlet, the Collective’s founders wrote that they intended “to become part of the solution rather than part of the problem” and “affirm[ed] that we are in training to serve the community, and that we are committed to dealing with the problems of the urban ghetto community in a long-run way.” That commitment entailed not just ephemeral service projects that lasted a few weeks, but finding ways to facilitate more permanent community input into healthcare facilities’ operations.

Lincoln epitomized the overtaxed, under-resourced urban hospital. One official document described it as “a hopelessly inefficient and inadequate building” with “dirt and grime and general dilapidation [that] make it a completely improper place to care for the sick.” And locals had nicknamed it “The Butcher Shop.” By conventional standards, then, Lincoln was not exactly a desirable or prestigious choice for your typical medical graduate at this time. So what was it that set the Lincoln Collective’s members apart? Who were these people? And where did their values come from? What were they hoping to get by converging on one of the most dilapidated hospitals in one of the most resource-deprived areas of the United States? And most important of all, what did it all mean in the end, when the Lincoln Collective came to a close in the mid-1970s?
To answer these questions, I’ll place the Lincoln episode in a wider story about changes that wracked the healthcare sector during the 1960s and 1970s. Many Collective members had been involved in student organizing on medical campuses, not exactly known, then and now, as cauldrons of political foment. Others had come from community organizing. And some were not particularly political and simply looking for a place to serve the most indigent and medically deprived. They came to Lincoln when the health field was undergoing what I have called a “governance revolution”—multi-pronged efforts throughout the era to decrease hierarchy within medicine and increase the participation of professionals in healthcare governance.

The Collective arrived at a time of tumult around the hospital itself. Groups like the Black Panthers and the Young Lords had made healthcare equality a major tenet of their organizing. At times, the Collective’s relationship with these groups was cooperative and fruitful, at other times, tense and ambiguous. Much of that depended on Collective members’ individual ideological inclinations, which were hardly uniform throughout the group. Tensions undergirded the encounter between mostly white physicians and mostly non-white, non-professional activists, and I’ll explore these challenges throughout the talk.
I've been thinking about the Lincoln Collective for more than a decade now. The title of my talk is an utterance I heard repeatedly when I was a college student in New York City studying activist movements in public health and medicine. “Have you heard of the Lincoln Collective?” people would ask. Some who posed the question were in it (and some claimed to be but, I'd later discover, were not). When I went off to graduate school, I put the story aside for a long time. At the confused age of 22, I didn’t feel I had the political maturity to really write about some pretty politically fraught and emotional events. Now, with more distance, I've returned to it.

We’re now in an era when people in the health sector—in the wake of a wave of police brutality and the Flint disaster—are asking themselves serious questions about the role political activism should play in their work. Turning back the clock and looking at a group of health activists from 50 years ago is a way of moving that conversation forward.
#shophistory

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These books taught me how to make healthier choices. There are a lot of great books out there, but I thought my readers would prefer it if I listed my favorites and helped them set a course for their own healthy future. In the beginning, I would buy books from Amazon or sometimes at a local bookstore if something caught my eye while walking down the street. The History and Science of Our 2.5-Million-Year Obsession with Meat. It seems that almost daily, we learn more about the health risks of eating meat and the harm it does to our bodies and the planet. Yet it seems almost unfathomable for most folks to cut meat out of their diets entirely. Some have resorted to eating less (reducetarians). Others have turned a blind eye to the science and don’t believe the ‘hype.’ HISTORY OF PUBLIC HEALTH Public health was defined by the American public health leader, Charles-Erward A. This book served as a guide for decisions regarding the location of urban sites in the Greco-Roman world, and may be considered the first rational guide to the establishment of a science-based public health. The dark ages and the medieval period. During the Dark Ages (about 500 – 1000 c.e.), Western Europe experienced a period of social and political disintegration. Healthy Recipes FOR YOUR NUTRITIONAL TYPE Dr. Joseph Mercola with Dr. Kendra Degen Pearsall The Tao of Health, Sex and Longevity. 216 Pages·2012·3.66 MB·9,291 Downloads. The Tao of Longevity. NUDGE Improving Decisions About Health, Wealth, and Happiness Richard H. Thaler Cass R. Sunstein Nudge: Improving Pediatric Nursing and Health Care. 202 Pages·2007·443 KB·4,873 Downloads.