Of Medicine and Men

Biographies and Ideas in European Social Medicine between the World Wars

Edited by Iris Borowy
and Anne Hardy

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Of Medicine and Men – Introduction

Iris Borowy

Biography is a popular genre. We like stories about people, whose courses through life we can follow and understand. In reassuring ways the lives of even the most extraordinary persons, the heroes, the saviours and the monsters, unfold in categories we can relate to: hopes and ambitions, successes and failures, friendship, trust, deceit, love and hate. Biographies on Hitler, Stalin or the Soong siblings sell very well and are widely read. They have a prominent place in historiography, and justifiably so. Since by history we axiomatically assume the history of humans at its simplest level, all history is biography: an account of how people have experienced their environments, how they have reacted to them, what decisions they have taken and how these decisions have influenced the people and the world around them. Even mass phenomena consist of the aggregate individual fates: famine means many people suffering hunger, demographic growth means many people having three and more surviving children and living long lives, industrial revolution means many people making inventions, working in factories and living in an increasingly urban and technological environment. While we need statistics to grasp the quantitative component of reality, we need an understanding of individual fates to make sense of the numbers.

However, the dangers of biographies are equally obvious and well known: an overgeneralization of individual experiences i.e. accepting a few cases with their idiosyncratic aspects as representative of the large picture, overrating the impact of specific individuals in relation to cultural and political development beyond their control, the danger of filling in gaps of people's lives by speculations or imagination, concentration on seemingly important people and an uncritical or unbalanced assessment of their achievements, in short, neglecting analysis for the sheer story. Besides, the very popularity of biography presents a problem for scholarly analysis. In Austria, the issue has been considered sufficiently important in 2005 to establish an institute for the history and theory of biography, which justifies its existence by the fact that its genre has long been underestimated by professional scholars because of its murky place between fact and fiction. It defines its object of study as: 'Biography forms an intersection point between academia, art and entertainment.'[1] Today, biography can hardly be considered a neglected area. Several other institutes between the Netherlands and Australia devote all or part of their resources to the study of biography,[2] and at least seven journals focus on biography.[3] They can rely on and will no doubt add to an already impressive body of books relating to science/art and craft of writing biography.[4]

In fact, the genre is sufficiently extensive to allow the medical biography as a sub-field, including its own Journal of Medical Biography, dedicated to the study of 'lives of people in or associated with medicine…'[5] However, medical biography offers particular difficulties, derived from generations of historiographic baggage. Traditionally, the history of medicine has been perceived as the history of discoveries of physicians and scientists. Indeed, it is difficult to imagine how any history of medicine or health could possibly be written without mentioning personalities like Edward Jenner, Louis Pasteur or Robert Koch, not to mention Hippocrates. Thus, biographical data inevitably must be considered for the interpretation of past conceptualizations of disease, therapeutic traditions, the social repercussions of health and disease and a host of other facets, and justifiably, collections of doctors' biographies are considered important projects in the history of medicine.[6] But the very attention historiography grants them, and has to grant them as essential players in all matters regarding medicine and health, risks overrating them. For too long classic narratives granted medical men the role of heroes as selfless helpers of the sick and infirm or as similarly selfless researchers, who put their genius to the use of science for the benefit of mankind, as 'medical history … seemed to celebrate medical science, glorify the role of physicians, and project a positivist view of scientific progress…'.[7] Such a view is no longer tenable, as revisionist analysis has revealed the profound involvement of physicians and science in general in all phenomena that have accompanied human history, the good, the bad and the ugly, including imperialism, colonialism, racism and genocide.[8] Also, at least since Thomas McKeown demonstrated that falling mortality rates in Europe pre-dated therapeutic competence, the relative importance of physicians for public health has had to be viewed critically.[9] Not surprisingly, a growing amount of scholarship addresses the particular problems surrounding biographies of scientists, trying to identify strategies that do justice to the ambivalence of the genre.[10] But at the moment, this theoretical interest is not borne out by successful practice. As Thomas Söderqvist shows in his recent overview, scientific biography merely represents a pointed version of biography in general: a large number of scientific lives face a dearth of scholarly treatments.[11]

Patrick Zylberman's paper in this volume is one attempt to bridge this gap by reconciling the complex historical baggage of professional ritual within the science community with a modern scholarly view. As his analysis makes clear, medical biographies have long existed in a multifaceted cultural context and have carried a variety of subtle meanings, which are near impossible to detach from present-day perspectives. Inevitably, the legacy of this context colours all subsequent memory of individuals, including the choice of who is remembered favourably, often, or even at all. Bearing these cautions in mind, this book aims to understand the health experience of a period through a small group of physician-scientists. For a number of reasons, the early twentieth century is a particu-

larly rich period for biographical analysis. The important role medicine played in Nazi Germany has served to direct attention to doctors' interaction with National Socialism.[12] In other countries, important developments such as the introduction of the welfare state and the evolution of social hygiene have sparked interest in prominent proponents.[13] But as medicine and public health became international, one of the main themes of this volume, an increasing number of people have been perceived as international personae. Thus, a number of personalities that marked the international health scene have already been the object of publications. In recent years Heinrich Zeiss has attracted substantial attention for the clear political repercussions of his position between Weimar Germany, Soviet Russia and Nazi ideology and his ambivalent concept of 'geomedicine.'[14] Maxime Kuczinsky-Godard's activities in several continents have been examined exhaustively.[15] Similarly, with Alan Gregg, Jacques Parisot and René Sand, some of the influential men of the international public health scene of the period have been described.[16]

So what has determined the selection of men in this volume? Zylberman's sharp analysis makes it impossible to ignore the extent to which the framework of organisational structure and memory context has also affected the preparation of this volume. Thus, the selection of personalities was partly dictated by institutional affiliation to the League of Nations Health Organisation (LNHO), arguably the centre of international health in Europe at the time.[17] It was also the only international health organization to develop a clear social hygienic approach to public health and to forge ties between scientists along those lines. While the Rockefeller Foundation, which likewise plays a significant role in the story of this volume, remained committed to a vertical, disease-centred view of public health, and the *Office International d'Hygiène Publique* focused on an older epidemiological paradigm, the LNHO organized comprehensive projects regarding the social determinants of health and thus became the natural point of reference for work of social medicine at the time.[18] This context connected a social and political to the medical-scientific agenda of the people involved. Social medicine was then a major conceptual framework of health. It derived from a growing awareness of the detrimental repercussions of industrialisation on the health of the worker population, often overworked and underfed and crammed into dismal housing.[19] An increasing realization of the serious health effects of such conditions gave rise to an international movement of health experts, who never organised into a coordinated pressure group, but who were vaguely united in 'a critical approach to health care that stressed the social determinants of disease.'[20] These determinants included working and living conditions and their contexts. A social medical approach to public health typically was horizontal, addressing not specific diseases but the general measures needed to prevent the outbreak of an array of diseases. Thereby, social medicine combined descriptive and normative components: the former sought to determine the conditions that

led to specific diseases or increased morbidity among special risk groups, a process that necessitated comprehensive statistical evidence, while the latter aimed at identifying structures that would prevent these diseases and result in good health among all parts of society, notably the underprivileged. Increasingly, it formed part of the mainstream of medical and societal discourse. While the exact meaning of social medicine remained vague and adaptable to local circumstances, the central idea informed crucial welfare legislation as well as contemporary understanding of public health.[21] Originally, the focus on the need for social reform as a prerequisite of improving public health identified social medicine with left-wing, socialist positions. However, ideological lines were not that clearly defined. The preventive element of social hygiene could be interpreted as a prevention of disease in future generations, forming connections to eugenics and racial hygiene.[22]

By the 1930s, a social medical approach to public health had found forceful institutional endorsement in the League of Nations Health Organisation (LNHO). The impact of the LNHO on the international discourse can hardly be overestimated. It attracted international cooperation because it offered funds, professional expertise, a safe framework for open discussion and, to many, a promise of modernity. In several fields of work, it elicited the enthusiastic cooperation of some of the best minds of the time.[23] In some way our subjects were all connected with it, though Selskar Gunn never belonged to it or cooperated in LNHO projects. But his unwavering support for the institution within the Rockefeller Foundation was of substantial support. The importance of the interconnection of people affiliated with the LNHO has been pointed out before. Martin Dubin coined the expression of a 'biomedical/public health episteme' that characterised international cooperation among a group of medical and public health experts, who framed the discourse from within various international organisations.[24] A similar point has been made by Bridget Towers.[25] As both emphasise, strong, determined and sometimes brilliant individuals were the driving forces of the interwar health scene, but they gained their impact only through an informal yet effective network of colleagues. In some instances, as for Andrija Štampar or Franz Goldmann during World War II, this network may have been life-saving. Of the people in this volume, Andrija Štampar is probably the best known internationally. He and Selskar Gunn have been described in the English language.[26] Bela Johan has attracted substantial and controversial attention in his native Hungary. Franz Goldmann and Fritz Rott have both been the object of lengthy biographies but are otherwise little known outside of, or even in, Germany. Gustavo Pittaluga, Thorvald Madsen, Melville Mackenzie, Emil Roesle and Otto Olsen have received little attention before, and in some cases unearthing sufficient information about them has proved difficult. The story of many men who made up the vibrant international public health scene during the formative period after World War I is still untold, among them Oscar Velghe (Belgium), Al-

berto Lutrario (Italy), Hugh Cumming (USA), Antoine Lasnet (France), and Witold Chodzko (Poland). Regrettably it was not possible to include them in this volume because material or authors or both could not be found. The full story of international social medicine during the early twentieth century is still to be written. This book is meant to be one contribution to it.

At first sight, the men of this volume appear to be experts in different fields with only limited overlap. Pittaluga was by training a malarialogist, Johan a pathologist, Gunn a biologist, Štampar a social hygienist, Goldmann a public health expert, Mackenzie a general practitioner, Madsen a serologist, Olsen a clinician, Rott a paediatrician and Roesle a statistician. But a closer look reveals that they had more in common than seems immediately obvious. All devoted all or part of their attention to the conditions that determined the health of groups of people; all were active in the field of public health structures, often with a focus on rural areas. They were also all interdisciplinarians, combining two or more fields of work by mixing medical practice, scientific research, academic teaching and public health administration. The degrees to which they engaged in these respective duties differed. Some were primarily scientists (Roesle, Pittaluga, Madsen), others were more prominently public health officials (Johan, Štampar, Gunn), some spent prolonged periods as practicing physicians (Mackenzie, Pittaluga, Štampar) and others were long-time lecturers (Goldmann, Roesle). Several made significant contributions to conceptual developments in public health (Štampar, Johan, Goldmann, Rott), others contributed to it through diplomacy (Madsen, Gunn, Mackenzie). But all of them mixed duties, and it is remarkable how much they saw the various facets as complementary. To them, experience with patients inter-acted with theoretical knowledge (requiring as much as generating it), the collective experience with individuals needed to be enriched by laboratory findings and transformed into statistical evidence, and the understanding thus gained should feed back into health benefits via public health arrangements and training for new generations of doctors. Thus, they clearly agreed on several key issues:

- that individual health depended on public health policies and therefore there was a need for an active public health agenda,
- that prevention was at least as important as therapy,
- that in the interest of the general good some parts of society, notably children and rural populations, needed special attention;
- that effective efforts needed to be rational, holistic and science-driven, incorporating bacteriology and social hygiene,
- that public health was a collective responsibility of many, including governments, insurance funds, scientists and physicians, whose respective input required cooperation and coordination,
- that all progress depended on the international exchange of information.

The internationalism of this group was a formative component of their activities, and, by the same token, their and their colleagues' activities shaped the nature of

international medico-scientific discourse at the time. For some of them, internationalism came naturally. Olsen's origins in the Danish minority in northern Germany automatically provided him with a bi-national background, and Pittaluga entered a transnational sphere when he left his native Italy for life and work in Spain. Several worked in foreign countries (Štampar, Mackenzie, Gunn, Madsen, Goldmann) or at least considered it (Johan). Such personal factors spurred these men's international outlook, but even those, whose work remained inside their native country (Rott, Roesle) appreciated the value of experience beyond its borders. This exchange was noteworthy because it was not limited to science, whose flow is inevitably international, even if and when scientists and governments try to put it to nationalist use. To an unprecedented degree, these people exchanged ideas about what constituted health and how societies could and should be organised to safeguard it. Collectively, they made use of this small window of opportunity where the breakdown of an old world order encouraged social experimentation before the advent of World War II, and subsequently the Cold War, froze a free flow of ideas. Although the interwar era was certainly rich in contradictory ideology, these ideological rifts did not divide public health theory into distinct and neatly packaged concepts.

The significance of the LNHO in the lives of these men has been noted. But there were other avenues of contact, both organizational and geographical. While they were most likely physically to meet in Geneva at meetings of LNHO committees many of them depended, financially and professionally, on the support of the Rockefeller Foundation (RF) for at least part of their careers. RF fellow Gunn helped negotiate the terms under which the RF underwrote some of the health reforms undertaken by Štampar in Yugoslavia and Johan in Hungary. Pittaluga likewise profited from RF funds, though to a lesser extent. Geographically, first Russia and then China turned out to be formative locales for interwar public health. Even before the First World War, Russia provided a key experience for Madsen. His observations during the 1908 cholera epidemic shocked him for the intensity of helpless misery that an infectious disease could still cause in a European country at the time, and it opened his eyes to the need for international cooperation in science as well as in issues of public health. Years later Mackenzie would undergo a very similar experience when acting as the only foreign doctor in a Russian province. While Russia acted as a catalyst for international public health efforts, it also provided illustration of the effects of the first – and only – communist administration, its radical break with conventional social policies and the effects on public health. As always, people's conclusions tended to reflect individual perspectives. While Mackenzie was appalled by what he perceived to be blatant abuse of healthcare in the interest of inhumane politics, Roesle was fascinated and Štampar clearly impressed. Only a few years later, the new National Government of China offered a second testing ground for the creation of a new public health system. But this time, there was

no question of learning from Chinese experiments. Western health experts, who had invested considerable efforts in improving clearly inadequate health structures in their own countries, now turned to China with missionary zeal. While Gunn and Mackenzie undertook the coordination of modernization efforts for their respective institutions, Johan and Štampar provided conceptual cues, and after his forced departure from Croatia, Štampar strove to implement his ideas in China. Even Goldmann, desperate for a new professional home after German politics had made him a refugee, tried to save his own livelihood by working for China. The importance of these two countries was hardly coincidental. The nascent Soviet Union and China naturally attracted international physicians: as places of turmoil and the extensive prevalence of epidemic diseases with a clear need for medical help, but also as countries that were establishing new health systems in processes that offered both demonstration material and jobs. With their mixture of hygienic misery and promise, these two countries epitomized the feeling within medical circles of the time.

The world of international health was small, allowing for paths to cross frequently. Already in 1910-11 Štampar was impressed by the lectures of Ludwig Teleky in Vienna, some fifteen years before the latter would argue with Emil Roesle about the correct use of medical statistics.[27] Later in Croatia, Štampar used references by Alfred Grotjahn, who was also a formative influence on the careers of Franz Goldmann and Fritz Rott in Germany. Madsen was the driving force behind the connection of Germany to the LNHO and possibly both he and Grotjahn were directly involved in the employment of Otto Olsen at the LNHO Health Section in Geneva. Meanwhile, Štampar was one of the important contacts for Gunn during the latter's stay in Europe, another being Bela Johan in Hungary. In 1936, Štampar toured Europe with Pittaluga and in the same year he met Charles Winslow during a mission to the USSR. Winslow was then instrumental in opening doors to employment for Goldmann, who had taken refuge from Nazi Germany in the United States.

These contacts were facilitated by the characteristics they had in common. They came from comfortable, middle to upper middle class backgrounds, with Štampar, whose father was a village teacher, occupying the relatively lowest rank of the social ladder. Born between 1870 and 1895, they came of age before World War I. They were old enough to have experienced the world of the long nineteenth century with its scientific and social progressivism and its political conservatism. They had qualified as doctors and had gained various degrees of work experience when they witnessed the breakdown of the political order, often that of their own countries, notably the Habsburg Empire (Štampar, Johan) and the German monarchy (Goldmann, Rott, Roesle, Olsen). And even for those, who came from relatively stable societies in Denmark or the USA (Madsen, Gunn) World War I proved the pivotal event that radically transformed the conceptual conditions of their work. But they were also young enough to appreciate

the opportunities inherent in the post-war crises. For them, the combination of reformist currents in science and social theory, medical needs and political options translated into tangible efforts towards new, improved health systems.
In retrospect, it is the ambivalent relation to politics which is most intriguing about the intertwined careers, portrayed in this volume. At all times, medicine and public health are political issues. As numerous publications have amply demonstrated in recent years, a plethora of decisions about the social construction of patients and diseases, about sanitary measures, and access to measures of prevention and cure are distinctly political.[28] None of these men could have been unaware of the close nexus between political decisions and public health output, since they were subjected to evidence of the process on a daily basis. Few countries enjoyed political stability. Madsen, Gunn and Mackenzie were among the lucky few, whose lives were based in countries with stable political regimes. But Pittaluga, Johan, Štampar and, obviously, their German colleagues experienced changes not only of government but of political system which threw into question the entire fabric of the social order. They knew that politics could overnight wipe out structures that had been built up over years.

Above all, the catastrophic First World War affected public health, both data and discourse, in all European countries, and in this context medical science entered political conceptualisations to a degree unknown before.[29] The war left scars everywhere, but it proved traumatic for the defeated. In Hungary, resentment over the treaty of Trianon gave birth to a psychological need to demonstrate Hungarian cultural superiority, a mindset that Bela Johan duly took into account when he portrayed public health work as part of a national-conservative policy for cultural assertion and when he made sure to stress real or imagined Hungarian origins of his plan for a major health reform. In Germany, widespread indignation about the treaty of Versailles restricted the possibilities of cooperation with the LNHO. And, similar to Hungary but with more devastating results, defeat was compensated by a search for perceived racial superiority. Scientific racism was hardly new, but it gained deadly strength in a climate in which the society eagerly sought this chance to repair their sense of victimization, and in which doctors eagerly sought this chance to improve both social standing and job opportunities.[30] In Spain, the experience of defeat in the 1898 Spanish-American War led not to introspection but, on the contrary, to an opening up to 'Europe," an imagined place of modernity and reform, which would allow the country to regain its rightful place in the international arena. Thus, while Johan, Goldmann, Roesle or Rott sometimes had to find ingenious ways to connect their work to outside influences, Pittaluga, by seeking international contact, merely met widespread expectations about his role as scientist – at least until civil war and the fascist rise to power turned political coordinates upside down. Meanwhile, Madsen, Mackenzie and Gunn enjoyed the luxury of stable systems that weathered the challenges of economic crisis and international political crisis

through democratic changes of government within democratic order. In a sense, they even benefited from the war, which broadened their bio-political horizon and opened up new career opportunities to them. Madsen, while not having sought this path, gained international stature as a shrewd businessman, who combined economic opportunity with impartial – and life-saving – help to combatant troops, and as a diplomat in humanitarian mission. Mackenzie positively enjoyed his war experience, which he spent far away from frontline bloodshed and which introduced him to another life than that of a provincial GP. In dealing with people and administrations in turbulent places, these men could hardly afford to ignore political sensitivities. Gunn, as mediator between American and European public health efforts, and Mackenzie, temporarily responsible for public health decisions in Liberia and China, had to take cognizance of the politics of these countries in their charge. Thus, the lives of the people in this volume serve as illustrations of how interwar political thinking diffused into scientific work. Only Madsen seemed able to switch effortlessly between the complicated politics of his international engagement at the LNHO and the scientific retreat of his serological institute in peaceful Denmark. The neutral status of his country doubtlessly helped, but so supposedly did his calm bearing. Even so, politics caught up with him after the outbreak of World War II. Unlike most in the international scene, he apparently translated his loyalty to his German colleagues into pro-Axis sentiments, or so at least it seemed to French observers.[31]

The issue of Germany and German politics eventually forced the deepest rifts within the group. In some cases, the World War II position was a continuation of long-term ideological development, in which medical beliefs constituted a formative component. Thus, Fritz Rott began his career as a conservative side and inexorably veered further to the extreme right. His views on child welfare – perfectly in line with LNHO work during the 1920s – increasingly took on eugenic overtones. After 1933, Rott embraced racial hygiene and continued a successful career in National-Socialist Germany. For others, living with National Socialism appeared a matter of political compromise without conceptual connection to their bio-medical agenda. Faced with the demands of dictatorships Bela Johan and Otto Olsen tried to manoeuvre their way through difficult times in ways that evade simple moral judgment. Such ambivalence was not open to all. Jewish Franz Goldmann was forced to leave Germany because staying was tantamount to a death sentence. Štampar's life was no less in jeopardy. After losing his position due to nationalist intrigue in his country and spending several years on temporary assignments, he was imprisoned by German occupation forces and forced into an internment camp. He probably survived only because of the intervention of a 'German professor,' whose identity remains obscure. Not all men endured such a dramatic, life-threatening turn of events, but several experienced political difficulties of varying degrees. Pittaluga had to leave Spain when a workers' committee removed him from his office, and he then found himself dismissed

twice, first by the Republican and later again by the Francoist government. Johan was detained for a few days by Communist authorities in 1950, probably under suspicion of overly close contact with Western scientific circles. He was released unharmed, but worked for the rest of his life in pharmaceutical research, outside the field of public health administration. Roesle probably owed his relative safety during National Socialism to the usefulness of his expertise, despite his pro-Soviet sympathies. Attitudes to the Soviet Union divided the group almost as much as those to Germany. Štampar was dismayed by the growing tide of fascism he witnessed in Europe and found reason to admire developments in Communist Russia, apparently blind to the genocidal starvation its policies caused in the Ukraine (and elsewhere). By contrast Mackenzie, while never in danger of turning fascist, was repelled by his experience with Communism in the Soviet Union and retained a conservative outlook that effortlessly reconciled internationalism with loyalty to the British Empire. The group's views on the US health system were correspondingly diverse. While Johan looked towards the USA as a model to learn from, Štampar considered it backward and in need of progressive reform. Gunn tried to distance himself from the tendency of the Rockefeller Foundation to export its American system throughout the world but never doubted that it was a model worth exporting when adapted to local circumstances.

Between them, these men represent the entire range of politics on offer during the period. Inevitably, these differences placed them on different sides of the political divides, defined by those in power in their countries during and after World War II. Johan, Rott and to some extent Olsen were on the 'right' side of power during the war and unable to cleanse themselves of the political stain afterwards. Štampar, Goldmann and, though in a different way, Roesle were on 'wrong' side before or during the war, but exonerated afterwards. Those who were blessed by the absence of dictatorship, Gunn, Mackenzie and Madsen, were consistently on the 'right" side or, in the case of Madsen, at least escaped further scrutiny of his wartime attitude. Relatively the saddest case may be Pittaluga, who never managed to establish himself in a place with whose politics he was fully in harmony. He was survived by dictatorship.

There remains the paradox that people with such contrasting political beliefs could, at one time, work together within a framework of organised international cooperation and could hold very similar bio-medical views. Part of the explanation may be that to a substantial extent they acted under the express credo of the apolitical character of health. Indeed, several of them flatly denied the political nature of their work. Pittaluga tried to organise malaria commissions in ways that kept them independent from government influence. Both Štampar and Mackenzie ostensibly aimed at keeping their health work separated from 'politics.' This attitude is non-sensical not only because of the evident political com-

ponent of public health concepts and strategies, but because several of the men themselves were active in politics. Johan was political secretary in the Ministry of the Interior from summer 1935 until October 1944. Štampar was chairman of the Department of Racial, Public and Social Hygiene in the newly founded Ministry of Public Health. Rott was deputy director of the new Imperial Centre for Health Matters, and Goldmann worked at the Imperial Health Bureau. Pittaluga joined the newly founded Reformist party and won a seat in the last democratically elected parliament before the military dictatorship of Primo de Rivera, and later he held several public service positions under the short-lived Second Republic. Ironically, the person who most emphatically rejected a political component of medicine, Mackenzie, accepted the most clearly political twist in his career. On behalf of the League he repeatedly engaged in missions, which had only scant connection to medical affairs, such as his missions to Liberia or his responsibility for League work in China. Still, although these people's lives in themselves belied the idea of non-political health, the concept nevertheless held true in the understanding of a basic humanity, common to all people, which transcended political considerations. And, as Zoe Sprigings points out, this belief was certainly held dear by some experts in ways that were self-delusive as much as they were idealistic. And without doubt it paved the way for their direct or indirect cooperation across ideological divides.

On a practical level, however, cooperation was often less complicated than ideological differences might suggest. As indicated above, many ideas about best practice in public health were shared across belief barriers, which only later became ideologically prohibitive. At the time, numerous measures (mass screenings and mass vaccinations, health propaganda, the control of water quality and the establishment of a rational infrastructure of health institutions) were compatible with fascism, communism or liberalism. In a remarkable congruence of thought the health centre epitomizes this shared pool of ideas. Virtually all the men portrayed in this volume endorsed, recommended, established or worked in a health centre type of institution at some point or other. The concept clearly had broad appeal, possibly for a combination of elements: the idea a central place of reference for health matters, mainly but not exclusively preventive, where people from different disciplines cooperated or its embeddedness in the social fabric of a people. Not surprisingly, they made common enemies among practicing physicians, who defended their status as a liberal profession, the group whose status was most threatened by broad based public health activities.

As individuals, all these men had periods of success and failure, but in the end their fates took distinctly different turns. Madsen, Mackenzie and Štampar ended their lives as highly respected personalities, whose expertise was sought and whose contribution to the international health scene was valued at renowned research institutes or at the World Health Organization. By contrast, Pittaluga

spent his last years in exile in Cuba with most of his work destroyed by the dictatorship that prevented his return. Several continued their careers in unspectacular ways. Roesle and Madsen, the two oldest of the group, approached retirement in their professional environment. Goldmann had a prestigious position at Harvard but suffered from seeing his ideas ignored. Those who were tainted with Nazi collaboration continued on a more subdued level. Johan was discredited through his temporary connection with the occupation forces, but he was nevertheless able to gain a scientific foothold in pharmaceutical production. Rott evaded scrutiny of his role in the Nazi administration through an unglamorous but solid private practice, and Olsen apparently remained loosely connected with the general field of public health without, however, being able to regain secure employment.

The result of their work is difficult to define, both collectively and individually, and assessment invariably depends on whether one chooses a short- or long-term perspective. As the controversy around Bela Johan in Hungary proves, evaluation also depends on political circumstances and is far from over. But some people's legacy seems comparatively clear. Štampar's significance as a formative figure in the establishment of public health structures in Yugoslavia and as cofounder of the WHO is uncontested. Madsen is justifiably remembered as a long-time Director of the Danish State Serum Institute and a central personality in serological standardization. Roesle's contribution to medical statistics is recognised among statisticians. The achievements of Pittaluga, Gunn, Goldmann, Rott, Olsen and Mackenzie are known only to a small group of specialists, and clearly their significance is limited. Gunn, Olsen and Mackenzie were mainly organisers, important in their times for the functioning of international cooperation but with little conceptual input into the overall discourse to leave as legacy. Goldmann's ideas still have their place in today's discussions of modern public health systems, while Rott's writings have dated and are to a large extent discredited by his Nazi connection. Pittaluga has left his mark on the development of public health in democratic Spain and on malariology.

In the end, the collective significance of these men is more than the sum of their individual successes and failings. They were influential – though not the only – pioneers of a culture of international, interdisciplinary and holistic commitment to public health. Their cooperation was made possible by the existence of international organisation, above all the LNHO, but by the same token these organisations existed only through their activities. They were the first generation of bio-medical experts who perceived health issues in their medical, scientific and social shape as challenges for international engagement, to which they contributed and from which they drew support. With their visions, their differences among themselves and also their shortcomings, they drove a process towards an approach to global health which now appears natural, almost self-evident, to us. Though their immediate goals were usually much more modest, and often more

self-serving, together they were essential contributors to the efforts of humanity towards a global civil society.

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2 Including the Biografie Instituut at the University of Groningen; The Center for Biographical Research at the University of Hawaii, the Biography Institute at the Humanities Research Centre of the Australian National University.

3 a/b: Auto/Biography Studies; Auto/Biography; Biography, BIOS, Journal of Historical Biography, Life Writing and Life Writing Annual.

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28 See e.g. A.T. Price-Smith, *The Health of Nations* (Cambridge, Mass.: MIT Press, 2002); R. Cooter and J. Pickstone (eds.), *Companion to Medicine in the Twentieth Century* (London and New York: Routledge, 2003); E. Rodríguez-Ocaña (ed.), *The Politics of the Healthy Life* (Sheffield: EAHMH Publications, 2002); R.B. Proctor, *The Nazi War on Cancer* (Princeton: Princeton University Press, 1999).

29 See chapter three in Mark Mazower, *Dark Continent: Europe's twentieth Century* (London: Penguin Books, 1998).

30 See P. Weindling, *Health race and German politics between national unification and Nazism, 1870-1945* (Cambridge: Cambridge University Press), 1993.

31 Ministre des Affaires Etrangères to Ministre de la Guerre, stamped 26 October 1939, and response, AMAE, Serie SDN. IL – Hygiene. Nr. 1562. Composition du Comite d´Hygiene; Report, untitled, unsigned and undated, AMAE, SDN, IL-Hygiène, 1561, 193-6. The description of Madsen is credible in as much as he did, indeed, have close personal ties to Germany. It is, however, strange to imagine him turning against Poland, the home of his long-time friend and LNHO partner, Rajchman.