COMMENTARY

Introduction: Health and Medicine in Historical Social Contexts

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The theory and practice of Western medicine emerged from the Enlightenment project to gain mastery over the universe—including the human body—through the principles of scientific empiricism. The 19th and 20th centuries marked a period during which many of the distinguishing features of the biomedical paradigm were developed and elaborated, and in which scientific focus on human variation contributed to pathologizing various forms of difference. It is impossible to understand the present-day landscape of inequalities in healthcare and their social, political, and economic effects without tracing their origins to this time period, when such inequalities were formalized and ossified in the medical system.

Bringing theory from medical anthropology together with historical case studies, the articles in this collection explore the complex interaction between the biomedical paradigm and individual practices of consumption and bodily care during the critical late 19th- to early 20th-century era. As doctors and medical practitioners are members of society (and are often from highly privileged groups), they are influenced by socially normalized understandings of bodies and difference. Conceptualizing the relationship between medicine and society as dialectical, Osherson and Amarasingham (1981:218) adopt a perspective wherein “the growth of modern medicine is viewed not as autonomous but as an evolving institution with a changing culture, with its own functions and interests, but responsive to, and productive of, the ideas, stresses and interests of the larger society.” Differentiating between prescribed use and individual practice, medical anthropologists have complicated conceptualizations of medical knowledge as monolithic and unidirectional, advocating for centering patient perspectives and experiences (Good et al. 1994; Harvey and Adolphs 2014; Seligman 2018). Archaeological data are valuable tools for further studying the development of cultural medical practices in the historical United States. Bringing these concepts together with historical case studies, the articles in this collection add time depth to anthropological discussions of the interconnections among society, science, and individuals. How are individual relationships to bodies and selves influenced by biomedical paradigms? How are these paradigms complicated or resisted through patterns of practice?

The late 19th to early 20th centuries featured an escalation of scientific and medical attention to racial difference, same-sex attraction and gender nonconformity, and neurological variation, seeking biological origins and explanations for differences in behavior and appearance. During this time period, cities became increasingly segregated, and lawmakers passed Jim Crow regulations across the U.S. As morality movements, such as the temperance movement and prohibition party, garnered increasing support, medical attention turned to questions of “sexual deviance” and “gender inversion,” and sought to identify and correct biological causes of criminality,
mental illness, and poverty. The field of gynecology developed, and the treatment of “women’s conditions” shifted from the domain of (female) midwives to (male) doctors. One of many such examples, gynecology was built on the work of J. Marion Sims, who is known to have conducted brutal and inhumane medical experiments on several enslaved women, including Lucy, Betsey, and Anarcha; see Snorton (2017) and Washington (2008). As cities began to implement centralized water filtration, trash collection, and sewage management, urban residents had varying and unequal access to these essential services. While these services ushered in a new emphasis on hygiene, doctors concurrently railed against midwifery with untrue claims that midwife-assisted birth practices were unhygienic and therefore dangerous. Centering the able-bodied heterosexual white male as the ideal of which all other bodies fell short, scientists and doctors sought to understand what made others lesser, weaker, or more prone to disease, criminal behavior, or chronic pain. In doing so, racism, sexism, homo- and transphobia, classism, and ableism were biologized through scientific logics.

Rachel Watkins writes that “our understanding of race as a social construct must consider the sustained role that biology plays in making race appear to be real” (Watkins 2012b:196). Scholars have discussed present-day racial disparities in medicine, but admit that the root causes of these disparities are not well understood (Smedley et al. 2003; Egede 2006; McCarthy et al. 2016; Williams et al. 2016). Biological anthropologists studying DNA and genetic variation have argued that racial categories do not have clear roots in genetic differences (Benn Torres and Kittles 2007; Gravlee 2009; Goodman et al. 2012; Watkins 2012a; Kuzawa and Gravlee 2016). Rather, these categories are created and enacted socially, with biological repercussions that come about through repeated exposure to discrimination, inadequate medical treatment, restricted labor opportunities, segregated housing, and other factors, leading to “a growing body of evidence [that] establishes the primacy of social inequalities in the origin and persistence of racial health disparities” (Gravlee 2009:47).

Race and other social categories are inextricable from social power relations and are enacted in historically specific ways (Mullins 1999; Singleton 1999; Orser 2002; Gravlee 2009). In order to understand modern American social categories, it is essential to understand their antecedents. The relationship between social inequalities and biological embodiment is dialectical and cyclical because “social inequalities shape the biology of racialized groups, and embodied inequalities perpetuate a racialized view of human biology” (Gravlee 2009:48). Because race is a social construct with biological impacts, Mack and Blakey (2004:11) and others have advocated for a biocultural/biohistorical approach to archaeological and anthropological research whereby “human biology is interpreted within historically specific, sociocultural contexts.” The articles in this collection provide case studies highlighting how social categories—race, gender, social class, immigration status, and other factors—have carried different material implications and changed over time. Historically situated medical and scientific understandings of bodily difference can act to validate and replicate systemic social inequalities with profound and lasting impacts.

The present-day COVID-19 pandemic prompts attention to medical access and structural barriers to access over time. Regardless of technological advancements, public health relies on individual and household practices of bodily care and illness treatment. Measures of health in the U.S., particularly mortality rates, show marked racial disparities, and nowhere is this starker than in recent statistics on COVID-19. The COVID Racial Data Tracker, an initiative partly organized by the Boston University Center for Antiracist Research, explains that “COVID-19 is affecting Black, Indigenous, Latinx, and other people of color the most. ... Nationwide, Black people are dying at 1.4 times the rate of white people” (COVID Tracking Project 2021). Pandemics highlight the structural inequalities and failings in U.S. medical and social systems, as, historically and in the present, Black and poor communities face increased transmission and mortality rates due to a variety of factors related to structural barriers to healthcare access, the physiological costs of systemic racism, and housing and environmental inequalities. Disease and medical care are not apolitical; rather, they provide an essential site for studying social inequalities and their effects.

Through understanding the past in relation to the present, continuities and ruptures can be observed, elucidating patterns and assumptions that continue to be taken for granted. The United States spends more per capita on healthcare than any other developed nation, but ranks among the lowest of these in measures of health, including life expectancy, infant-mortality rate, and rate of preventable deaths (Reinhardt et al. 2004; Nolte and McKee 2008; Papanicolas et al. 2018). Within medical statistics, racial and gender disparities are pronounced,
even after controlling for other factors, such as socio-economic status and access to insurance (Smedley et al. 2003; Achenbach 2017). The articles in this collection seek to better understand the historical developments of these trends in order to highlight possibilities for improving present-day health systems and outcomes.

**Medicine and Archaeology**

As a discipline that examines how meaning is formed in the interfaces among objects, bodies, and spaces, archaeology is uniquely positioned to trace the emergence and development of modern biomedicine. While some archaeological studies have analyzed sites or topics related to healthcare and medicine (Howson 1993; Wilkie 1996; Edwards-Ingram 2001; Fisher et al. 2007), this topic remains understudied. When addressed, health and disease are often viewed through a biological lens that draws from analysis of skeletal remains. Only a few previous archaeological articles have analyzed medical material culture (Wilkie 2003; Hosken and Tiede 2018). Further, archaeologists have only recently begun to incorporate theoretical insights from medical anthropology. When considering topics related to health and medicine, archaeologists often analyze materials related to treating the physical body, neglecting the study of topics related to mental health. The articles in this thematic collection begin to address these understudied topics by incorporating medical anthropological concepts, such as structural violence (Cools, this issue) or slow violence (Lans, this issue), analysis of pharmaceutical bottles in broader social context (Linn, this issue; Lupu, this issue), examination of materials owned by medical practitioners (Saunders, this issue), laborers in a mining town (Cools, this issue), Black women living in New York (Lans, this issue), and residents of a mental institution (Ryan, this issue). Through these case studies, the authors provide new approaches to understanding the history of medical institutions, bodily care, and sociological categories of difference.

The authors in this collection address questions around healthcare and daily life through a range of approaches and case studies. Kyla Cools’s article incorporates the concept of “structural violence” to analyze health disparities across the Eckley Miners’ Village, a coal-mining company town in Pennsylvania. Using pharmaceutical bottles from two house lots alongside documentary records, Cools examines the unequal impacts of health hazards and medical care in this industrial case study. Aja Lans’s article centers on the stories of two Black women living in early 20th-century New York as told through their skeletal remains and for one’s physical body is an essential daily life activity, incorporating a range of tasks, ranging from daily hygiene habits, such as teeth brushing, to accessing and ingesting pharmaceuticals, to caring for ill or disabled family members. Bodily care can be accessed archaeologically through the material remains associated with these everyday activities.

Through an attention to individual and household contexts, archaeologists can explore the intersection of social prescription and daily life practice (Allison 1999). De Certeau’s (2011:xii–xiii) theoretical intervention into studying daily life centers on use, rather than social prescription, manifested not “through its own products, but rather through its ways of using the products imposed by a dominant economic order.” Mullins has applied this archaeologically, and he “argues for adopting consumption as a conceptual framework that ... embraces the agency of consumers and recognizes that goods assume meaning in a tension between structural and localized processes” (Mullins 2011:134). Studying medicine and healthcare in practice allows for a rigorous analysis of the ways that large-scale social changes, such as racialized segregation, patterns of immigration, gender and relationship norms, technological developments, and the professionalization of medicine, were enacted and experienced in daily life. Taking place in a broad range of contexts, the articles in this collection provide insights into daily care practices of an immigrant community (Linn, this issue), a midwife (Saunders, this issue), consumers of over-the-counter drugs (Lupu, this issue), laborers in a mining town (Cools, this issue), Black women living in New York (Lans, this issue), and residents of a mental institution (Ryan, this issue). Through these case studies, the authors provide new approaches to understanding the history of medical institutions, bodily care, and sociological categories of difference.
associated documents. Contextualizing her research through the recent case of Sandra Bland, Lans discusses Black women’s mental health in the context of “slow violence,” addressing how systemic anti-Black racism continues to influence Black women’s embodied experiences. Meredith Linn and Jennifer Lupu both begin from a call for archaeologists to consider pharmaceutical-bottle artifacts in broader sociohistorical context, but consider these artifacts in different ways. Meredith Linn’s article provides an in-depth analysis of prescription practices and social reception of patent medicines, focusing on their use in an Irish-immigrant community in the Five Points district of New York City. Her analysis examines medical worldviews of Irish immigrants, the profession of medicine in 19th-century America, and the material culture found in the Five Points site in order to examine pharmaceuticals in social context. Jennifer Lupu’s article brings the concept of “multimodality” from linguistic anthropology to examine branding and marketing of pharmaceutical products at the turn of the century. She discusses how the physical form of medicine bottles were semiotically meaningful, tied to a specific brand identity and set of associated imagery and texts. Madeline Ryan’s article explores the sensory dimensions of life in a 19th-century mental asylum, focusing on scent and discussing how “the smell of the insane” was pathologized. She centers her analysis on the Worchester State Hospital in Massachusetts, using documents, material culture, and spatial analysis to approach the olfactory, an element of experience rarely considered by archaeologists. Jennifer Saunders’s article analyzes the material culture associated with Olivia Taliaferro, a Black woman trained as a nurse and midwife, who lived in early 20th-century Washington, D.C. Drawing on Black-feminist scholarship, Saunders contextualizes the materials through discussions of Black-midwifery practices, documentary research into Olivia and her family members, chemical-remains analysis of liquids from the medicine bottles, and analysis of the medicines themselves. Each of the articles in the collection bring interdisciplinary approaches to considering healthcare and medicine in broader social context. Centering on the late 19th to early 20th centuries in northeastern American cities and towns, the articles are interrelated through context and share a focus on the historical manifestations of systemic inequalities in American healthcare and their embodied consequences in the experiences of individuals and communities.

Medical historians have pointed to the importance of the late 19th- to early 20th-century era in studying entrenched racial and gender disparities in American healthcare, emphasizing that many of the institutions and practices that today shape the U.S. healthcare system were created, developed, and enacted during that historical moment (Walkowitz 1982; Rothstein 1992; Bynum 1994; Savitt 2007). While historians have discussed these topics, the resulting research speaks to broadscale trends and medical practice. In contrast, archaeological analyses provide insights into individual practice and variation across a community. How were these changing understandings of race, gender, sexuality, mental illness, and socioeconomic class, and the resulting changes in medical care and access experienced by individuals and communities? Archaeology provides a uniquely valuable set of methodologies to explore how large-scale changes were experienced at the household and city scales. Medicine occupies a key site at the intersection of social constructions of difference, individual practices, and human biology because medical artifacts reflect both the types of ailments faced by household members as well as their access to medical care.

The articles in this collection seek to historicize the medical discipline by grounding its manifestations in their social contexts, examining the lived realities of institutionalization, marginalization, structural violence, and alternative-care practices in the 19th and 20th centuries. How were bodies understood, and how did this shape medical care practices? How did bodies interact with medical objects and institutions? How were structural barriers experienced in daily life? Shifting focus from triumphalist narratives of medical progress to everyday practices and specific settings, the articles in this collection expand, qualify, and challenge commonly accepted histories of medicine.

Declarations

Conflict of Interest Statement On behalf of all the authors, the corresponding author states that there is no conflict of interest.

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