

# Introduction

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In 1837, the Antwerp physician Jean-Corneille Broeckx published his *Essay on the History of Belgian Medicine Before the 19th Century*. Broeckx left no doubt as to his motives. He wanted to prove that ‘in medicine, as in the other sciences, Belgium is capable of bringing forth its share of famous men.’<sup>1</sup> Published only seven years after the Belgian Revolution of 1830 – during which the southern parts of the United Kingdom of the Netherlands broke away to form a new nation state – Broeckx’s *Essay* is the earliest example of ‘Belgian’ medical history. It is a work pervaded by patriotism and professional pride, one of the products of an expanding historical culture comprising also paintings, statues, parades, public lectures, plays and history books, which was to affirm the new country’s *raison d’être* alongside its European neighbours. The history of medicine was ‘nationalised’ in the writings of Broeckx and his colleagues. From the mediaeval surgeon Jan Yperman to the sixteenth-century anatomist Andreas Vesalius and the seventeenth-century physician and chemist Jan Baptist van Helmont, these writings have presented us with a series of ‘Belgian’ medical heroes, representatives of the Belgian nation in the (internationally competitive) field of the medical sciences.<sup>2</sup>

This book does not intend to offer – like Broeckx’s work – a glorifying and legitimising narrative of ‘Belgian medicine’. Yet, it does take the national level as its starting point and point of synthesis by offering a set of medical histories that treat the Belgian medical field in the nineteenth and twentieth centuries. The book presents a broad view of medical history both *of* Belgium and *in* Belgium, and does not reduce the country to a matter of socio-political context for medical developments or to state infrastructure in public health. Its aim is rather to assemble narratives that go beyond such traditional ‘national’ overviews, which tend to focus

on state–profession interactions, and explore the relation between medicine and sociopolitical views and realities, treating a variety of themes such as gender, religion, disability, media and colonialism. It goes without saying that a ‘national’ medical history of this kind bears a resemblance to Broeckx’s *Essay* in name only. The narratives in this book are intended as critical and accessible historical overviews of medicine and health in modern Belgium.

A focus on national frameworks does not exclude contributing to a wider historiography. On the contrary, by developing the Belgian case study more deeply and broadly, we seek to offer insight into a European historiography of medicine for the twenty-first century. We do this, first, by engaging thoroughly with the second half of the twentieth century. Medical history often remains stuck within the perspective of the long nineteenth century, from the 1830s until the 1940s. The second half of the twentieth century too often only appears as an appendix. Yet, the post-1945 period was marked by a crucial rethinking of medicine and of the social role of medical institutions and their boundaries. What was the meaning of ‘cure’, ‘care’ and ‘therapy’? Who determined what was to be considered medical knowledge?<sup>3</sup> This brings us to a second, related point on which this book innovates: the attention to a multiplicity of actors, places and media. This heterogeneity seems evident for the last thirty years but constitutes an equally valuable perspective to apply to the past two centuries: which role does the carpenter play in psychiatry by constructing a bed, the accountant in the hospital when introducing new management methods, the designer in public hygiene when developing a television programme on human immunodeficiency virus (HIV)? One could multiply the examples of professions that until now have rarely been taken into account when historians write about medicine.

Finally, this book aims to enrich and ‘decentre’ the European historiography of medicine by adding the perspective of a particular region, of a particular country, to the mix. The narratives of medical historiography as found in most syntheses are organised around the European triad of Great Britain, France and Germany, to which comparisons with the case of the United States are added. This book does not want to replace Germany by Belgium in a new history full of ‘facts and firsts’. Rather, it makes a plea to include other localities – be it Belgium, Finland, Albania or Portugal – to

introduce new chronologies, heterodox practices, unknown places. The benefit of such a regional perspective to the history of medicine, this book shows, is precisely that it allows us to study how different (foreign) medical traditions have intersected, for example in medical and hygiene education. It also enables scrutiny of how issues such as the gender balance in the medical field or the organisation of medical services developed in ways specific to that region's socio-cultural and political traditions.

### Physicians and the state

In Belgium, as in other European countries, a historiography of medicine developed in the 1980s that challenged older notions of medical progress. Medical sociologists and social historians denounced the 'triumphalist' discourses that underpinned the growing social power of the medical profession (see also the Epilogue). This social history of medicine, written by professional historians, developed against a backdrop of an uneasy relationship to medical power (in particular with regard to psychiatric institutions). Since the 1960s, a growing criticism on the latter institutions, and the organisation of healthcare more generally, had been linked to calls for more extensive patient rights and to worries about the sustainability of the welfare state. Karel Velle, among others, developed a critical historiography of medicine, scrutinising the processes of 'professionalisation' of medicine and the 'medicalisation' of Belgian society.<sup>4</sup>

These social histories of medicine produced a new, strong metanarrative about Western medicine in which the national level was very present. In these histories, the central evolution of the nineteenth and twentieth centuries was the joint development of the medical profession and the state. In other words, the rising social status of physicians developed in parallel with the expansion of government intervention in healthcare. Their relationship was one of mutual legitimising. Medical expertise underpinned state expansion into new social realms. State legislation, in turn, strengthened physicians' position in the medical marketplace. Belgium appeared as a case study that confirmed broader, Western, narratives already well proven for Great Britain, Germany or France. This main

narrative of the social history of medicine has resulted in a series of representations that have also found their way into more general (political) histories of Belgium. Given the attention historians paid to the government regulation of public health, the image of the physician as a social expert, as embodied by public health specialists, became the dominant representation of the medical profession as a whole.<sup>5</sup> As a by-product of the theory of the medicalisation of society, which was said to reinforce an ongoing process of secularisation, the physician has also been represented as a substitute for the priest, suggesting a competitive relationship between the medical and religious fields. A third and related imagery concerns the progressive ‘medicalisation’ of the hospital. This narrative stressed a rather one-sided evolution of the hospital from a space of religious and social ‘care’ (by women religious) to one of ‘cure’ (by doctors and lay nurses).

Research into the social history of Belgian medicine has resulted in a thorough understanding of the creation of medical legislation, public healthcare institutions and professional organisations of physicians. Medical reforms introduced in the mid nineteenth century have received particular attention, such as the foundation of the Royal Academy of Medicine of Belgium in 1841 and the Belgian Medical Federation in 1863, the introduction of the unified academic degree of Doctor of Medicine, Surgery and Obstetrics in 1849 (see Chapter 5) and the Medical Treatment Act in 1850 (see Chapter 8).<sup>6</sup> More recently, a second series of legislative reforms that reshaped the medical field almost a century later have been scrutinised. In 1936, the Belgian Ministry of Public Health was founded; in 1938, the Order of Physicians was established; in 1944, mandatory health insurance was introduced for all employees, effectively creating a form of Belgian social security; in 1957, after long debates dating back to the interwar years, medical specialists were legally recognised; and in 1963, the Leburton Law (named after secretary Edmond Leburton) further expanded health insurance, leading to a nationwide physicians’ strike (see Chapter 6).<sup>7</sup>

Over the last two to three decades, historians’ interests have expanded beyond legal shifts, state developments and professional struggles in the Belgian medical field. This work clearly built on the groundwork of the social history of medicine, but also challenged its established categories and narratives. Without going into too

much historiographical detail, for which we refer to the discussion of the literature in the chapters, we will here point to some main trends. A first observation is that medicalisation has continued to act as an important analytical framework, but now with much more attention to the social role of medical discourse and the construction of medical knowledge. By studying the intellectual origins of medical metaphors and their different uses in society, Belgian historians of medicine have addressed new topics such as science, art and gender in relation to an expanding medical field.<sup>8</sup> More recently, a rich historiography of the body has emerged at the crossroads of gender history, the history of sexuality, the history of religion and the history of science.<sup>9</sup> In these studies, historians not only look at intellectual medical discourse, but also pay attention to medical practice and caregivers' performance as professionals. While the term 'performance' may refer to different types of medical conduct in this book – such as the performance of a professional identity or of scientific expertise, and the performance of healing – it is clear that in moving beyond the history of a profession, the history of medicine does not return to a narrow view of medical knowledge, but has embraced a more complex understanding of the interplay between medicine as science and practice in different settings. This includes looking at how knowledge about the body circulates between different academic and public contexts, for example in medical subfields such as anatomy (see Chapter 9).<sup>10</sup>

A second general observation about medical historiography in recent years concerns the actors that historians have put on the stage. A growing diversity of themes has gone hand in hand with a greater variety of players; hydropaths and naturalists operating at the medical fringe, novelists and artists engaging with the body within the performing arts, social scientists, legal experts and academics from different backgrounds, missionaries and politicians from diverse ideological strands have entered medical history. More recently, this diversity has expanded even further together with new methodological approaches to the history of medical institutions. Roy Porter's call to make the patients' voices heard has been integrated into histories of Belgian medicine. By paying attention to the materiality of medical practice and to the agency of the different actors involved in clinical encounters, patients'

perspectives and their asymmetrical power relation to caregivers in the past have been brought to light. To this end, the rich archives of the public welfare institutions in Brussels offered many opportunities. In writing a new type of institutional history, historians also moved beyond the classic duo of the sick person and the physician, and brought new actors to the fore such as women religious and lay nurses, medical students and hospital attendants, architects, accountants and psychologists.<sup>11</sup> The result of this attention to a greater variety of actors has been that historians have 'decentred' medical history, placing the pivotal position of doctors, their professional organisations and the state into perspective.

This book builds on these efforts. In presenting a series of medical histories, it adopts a much broader view of the medical field than previous accounts. From the missionaries who travelled to the Belgian Congo and combined the provision of medical care with efforts for conversion, to the popular anatomists who simultaneously entertained and educated the public with their fairground shows, each account shows the (sometimes surprising) ways in which issues of health and illness were tied up with sociopolitical shifts and cultural developments in Belgium. It goes without saying that physicians continue to appear in these histories. They remain central players, but their roles and identities become more complex once we consider them as more than only experts in public health or advocates of the medical profession.<sup>12</sup> In this book, they take on roles as educators, scientists, designers, ethicists, caregivers and politicians, and interact with people far beyond the strictly professional medical milieu.

The broadening of actors and themes, however, has inevitably also led to more fragmentation. This is illustrated by the fact that, compared to the social historiography of the 1980s and 1990s, the national level has become far less central to medical historians. Recent hospital histories, histories of medical faculties and histories of medical subfields such as gynaecology and anatomy tend to focus on the local (often the urban) level for the exploration of medical practices and interactions, using these sites as illustrations of international trends.<sup>13</sup> When writing a history of a psychiatric institution from below, for example, one tries to capture a clinical reality that seems quite distant from political debates on health on the national level.<sup>14</sup> In such histories, the level of the nation

state has tended to be rather absent. To a lesser extent, the same is true for the transnational histories that have emerged on topics such as colonial medicine or social reform. Historians highlighted the development of expert communities across national boundaries (e.g. at international conferences). Here again, the local and the international are interconnected in more direct ways.<sup>15</sup>

The absence of attention to the national level is not a problem in itself. For some topics, the impact of government policies was simply limited or offered no added value because Belgian trends followed international trends closely, without national particularities. But the fact that the broadening of our understanding of the medical field has not yet resulted in a new overview, which takes the national level as its point of reference, does have its disadvantages. It hampers a strong profiling of Belgian medical historical research – a small field – both within the general historiography of Belgium and within the international historiography of medicine. Even more important is the danger that when historians present Belgian medicine to an international audience (e.g. in scholarly articles), the older narratives of state–profession interactions and their related representations of physicians, medical institutions, reforms and laws, reappear as the (sole) contextual ‘frames’. This means that the sociopolitical particularities of Belgian medicine are reduced to questions of legislation, state intervention and professional union – a representation that is contrary to the gains in historians’ understanding of medicine’s diverse roles in Belgian society. In other words, while Belgian historians have succeeded in opening up the medical world in their case studies, they have yet to summarise their findings and reassess the stories they tell about the Belgian medical field as a whole.

This volume aims to fill this void and establish new narratives about the Belgian medical field in the nineteenth and twentieth centuries. As Belgian medical historiography matures as a scholarly subfield, we need more effective and nuanced ways of situating our case studies and discussing general trends without reducing them to matters of legislation or state expansion. Here the national level, situated in between local dynamics and international shifts, offers new opportunities as a shared point of reference for Belgian scholars and as a means of mid-level analysis.<sup>16</sup> The challenge this book takes up is therefore also an exercise in connecting

medical developments to the sociopolitical realities that shaped Belgium's history as a modern nation, an exercise in broadening our understanding of the political embeddedness of Belgian medicine beyond the well-known story of physicians and the state. In the next two sections, we discuss some of the ways in which the authors took up this challenge: first, by including a broad perspective on the 'politics' of Belgian medicine and by paying particular attention to the care provided by different actors; second, by looking more closely at the scales and levels on which health and healing took place in – and indeed beyond – Belgium.

### The politics of (health)care

The weakness of the Belgian nation state is a recurring theme in Belgian history, which emerged well before the many government reforms that transformed the country into a federal state from the 1960s onwards.<sup>17</sup> Two reasons may be identified for this weakness: first, private initiative – whether in the form of Catholic initiatives or by different players in the economic realm – played a powerful role in the country. Second, the Belgian state often functioned at a lower level than the level of the national government; many responsibilities were left to local authorities.<sup>18</sup> The social history of medicine that emerged in the 1980s can be said to have challenged this image. It was characterised by a firm national perspective and depicted the nation state as a powerful player. Medical history therefore casts critical doubt on the notion of a weak Belgian state. The new medical histories in this book again paint a more nuanced picture. They emphasise, above all, the diversity of players involved – especially the strong Catholic influence – and the interplay between different levels, with a particular focus on local players and transnational currents.

When the Belgian state was created in 1830, the political elites devised a twofold system for medicine and health, spearheaded by the two dominant ideological trends of the time: liberalism and Catholicism. Private initiative was not stifled; on the contrary, it was encouraged. Mental asylums in nineteenth-century Belgium, for example, were not state-run institutions like in France; they were generally run by religious congregations. In 1876,



these congregations managed three-quarters of all the country's psychiatric patients.<sup>19</sup> The psychiatric infrastructure shows that in Belgium, more than elsewhere in Europe, Catholicism had a massive impact on the provision of healthcare (see Chapter 8). Historians of nineteenth-century Belgian Catholicism Vincent Viaene and Peter Heyrman have shown how a shared resistance to state intervention among liberals and Catholics – a key feature of the Belgian nation state – allowed the Catholic Church to develop extensive charitable initiatives (including hospitals, schools, homes for elderly people, etc.), many of which were subsidised by the state. They rightly speak of a Catholic 'empire by invitation'.<sup>20</sup> Catholic influence was at least as decisive in the colonies, via the missions set up in the Congo. Since the colonial governance structures were not well developed, these missions served several purposes, including the provision of healthcare.<sup>21</sup> In the first half of the twentieth century, when secularisation began to take hold in Belgium, there was a significant rise in religious vocations for the colonial missions: the number of Belgian missionaries increased from 2,686 in 1922 to 10,070 in 1961 (see Chapter 3).<sup>22</sup> Parallel yet in contrast with these rising colonial vocations, the impact of secularisation became visible in Belgium itself. First, the number of people entering religious life, in both congregations and healthcare institutions, began to drop. Second, a movement led by urban, liberal middle classes called for the secularisation of hospital staff. In Brussels, from 1887 onwards, classes were offered to nurses with the specific aim of breaking the monopoly of religious congregations.

Given the importance of Catholicism, one of the challenges this book takes up is to bring the history of care into the narratives about the Belgian medical field.<sup>23</sup> Several chapters illustrate how attention to care allows historians to complicate the narrative of the medicalisation of society, as a linear evolution 'from care to cure', and pay more attention to the religious motives that underpinned medical practice. Taking care of someone's body was closely linked to spiritual care. The figure of the nun-nurse, who has been somewhat marginalised in a medical history focusing on doctors – a neglected position that Barbra Mann Wall counters in her work in on American religious congregations and their involvement in (colonial) healthcare – represents this connection most clearly (see Chapter 2).<sup>24</sup> In a colonial setting, moreover,

medical care went hand in hand with conversion. But traditions of care were not solely inspired by religion. The link between care and femininity was made in a variety of debates over women's access to the medical profession, and more generally to different areas of social life (see Chapter 1). Furthermore, reassessing the relationship between 'care' and 'cure' from a religious or gender perspective guides our attention to lesser-known aspects of Belgian medical history with considerable research potential, such as the history of home care, medical ethics and the history of pain.<sup>25</sup> The perspective of care also has the potential of writing intertwined histories of psychiatry and disability by transcending a too narrow view of medicalisation and by pointing to the shared trajectories of the institutionalisation and deinstitutionalisation of care, and to the role of a variety of caregivers (see Chapter 8).

The Belgian government gave considerable autonomy to the local authorities, some of which played a major role in the organisation of the medical field. Charitable organisations, especially the committees of civil hospitals, were important local players. In Belgium's major cities, these committees managed huge hospital complexes, the most significant example being Brussels, where the General Council of Hospices and Assistance was responsible for a vast hospital empire. Although local authorities took the lead in the development of public hospital infrastructure, they did so in close collaboration with (wealthy) private players, who acted as philanthropists (see Chapter 6). This also held true for medical education and research. The medical sciences initially developed within an engaged urban civil society, through the activities of 'private' learned societies that cooperated with state-subsidised institutions such as the Royal Academy of Medicine of Belgium (set up in 1841), a space where Catholic and liberal doctors could meet. The model of the research university was only introduced in the late nineteenth century in Belgium, and in the case of the ideologically opposed Catholic University of Leuven and Free University Brussels, its infrastructural development largely depended on private capital. As an intellectual field, Belgian medicine had its particular dynamics of compromise and competition, infused by competing ideologies and the room given to private initiative (see Chapter 5).

Turning to the twentieth century, the century of the welfare state, the Belgian national government did more actively intervene

in the field of healthcare. The development of health insurance companies involved a considerable degree of state intervention, through the establishment of a regulatory legal framework and the allocation of state subsidies. Yet the organisation of these companies remained firmly in the hands of Catholic, socialist and, to a lesser extent, liberal communities – the so-called ideological pillars of Belgian society (see Chapter 6). With regard to hospital infrastructure, religious congregations managed to reinvent themselves and maintain a grip on the sector. Unlike in Quebec, another region where these congregations played a key role in the nineteenth and early twentieth century, Belgian congregations retained their hold over healthcare institutions despite the upheavals of 1968 and the rapidly falling numbers entering religious orders.<sup>26</sup> This nineteenth-century Belgian model – involving both public and private players, with a key role played by local authorities – therefore went on to characterise the medical field until the end of the twentieth century. Of course, the development of the welfare state gave greater influence to the national government. But a strong centralised system was never set up in Belgium. While the 1944 Mandatory Health Insurance Act was undoubtedly a key moment in the creation of a social security system in Belgium, this system never exerted the same degree of control as in the United Kingdom or France. Considerable responsibility was left to private players, in particular the socialist and Catholic mutual health insurance funds. Since the late 1960s, the national set-up has also begun to splinter as a result of successive government reforms that have created federal entities. The latter have been given increasing responsibilities in the fields of medicine (university education) and health (mental health and elderly people).<sup>27</sup>

So, while this book challenges the tendency of Belgian medical historiography to focus on the state, it also emphasises that over the past two centuries, healthcare has been one of the areas in which different forms of citizenship and access to medical service have been under constant discussion. Do women and colonised people have the right to be integrated into the nation state? To what extent does the state have the right to intervene on and in the bodies of individuals to guarantee the health of the nation? The moments of exclusion and inclusion that define the nation state in the nineteenth and twentieth centuries can often be seen in terms of Belgian

biopolitics. These specific Belgian characteristics run through most chapters of the book as subtext, while developments in the field of medicine are also considered as part of a broader European history.

### From the local to the international level

It is clear, therefore, that while those writing the history of medicine in Belgium cannot ignore the role of the nation state, other perspectives must also be considered. Indeed, the specific national characteristics of Belgium can be attributed precisely – in part – to the absence of a strong state and the delegation of responsibilities to local players such as municipal authorities or to transnational players such as religious congregations. The interplay between different levels – which for at least thirty years has been posited as one of the best ways for historical narratives to incorporate the experiences of key players and for historians to take account of influences beyond the national framework – is particularly pertinent in the case of Belgium.<sup>28</sup>

The levels that came into play varied hugely in the nineteenth and twentieth centuries, and their relationship was often complex. In scientific publishing, for example, the first ‘national’ medical journal, the *Bulletin médical belge* (1834), appeared as an annex to a Brussels-based journal with international ambitions, the *Encyclographie des sciences médicales* (1833). It was designed to compensate for the lack of publishing space for Belgian scholars as the *Encyclographie* reprinted articles from across the Western medical world by making use of the absence of international copyright. The journals of ‘local’ Belgian medical societies, while mostly comprised of regional authorship, attracted a readership that was surprisingly national and even international (see Chapter 5).<sup>29</sup> After a century marked by a certain degree of nationalisation, scientific exchange in the period after the First World War was equally complex. On the one hand, international political tensions hampered relations within the medical field. On the other hand, internationalisation and specialisation increased, in particular in terms of research. Within this changing context, no Belgian medical journal gained scientific recognition in the competitive world of international academic publishing, yet many continued to exist

(such as the *Bulletin of the Belgian Academy of Medicine*) as a means of debate among local academic and professional audiences.

When incorporating these different levels in medical historiography, the challenge is to move past a narrative of a gradual increase in scale. The development of the medical field, in fact, continued to be characterised by a significant degree of localism. In the nineteenth century, several professional associations, whether for pharmacists or physicians, initially emerged at the local level before meeting at the national level. New national professional associations for medical specialisations – such as the Society for Mental Illness (1869) or the Belgian Society of Gynaecology and Obstetrics (1889) – initially served as spaces of sociability for fledgling communities, which were spread geographically unevenly across the country and at the same set up international contacts (see Chapters 1 and 8).<sup>30</sup> Until the mid twentieth century, some of the country's more influential professional medical journals were developed in a highly local setting, such as the Liège-based *Le Scalpel* (1848). And in the second half of the twentieth century, the reform of the psychiatric field was essentially centred on Brussels, where favourable local circumstances (the existence of a university, social players open to experiences in psychiatry and political majorities interested in developments in public health) can explain the establishment of non-hospital-based structures, which remained extremely rare in the rest of the country.<sup>31</sup>

Beyond the local and national levels, the transnational level has proven to be particularly stimulating in recent years for Belgian historiography. Belgium has often been seen as a 'mini Europe' that is transnational by definition, and there is no doubt that the Belgian medical community has at times been particularly open to its neighbouring countries.<sup>32</sup> In the nineteenth century, as the medical sector was in the throes of nationalisation, several first editions of international medical and hygiene conferences were held in Brussels.<sup>33</sup> In addition to highlighting Belgium's role as 'a key site for international conferences, world's fairs and the headquarters of international associations', as social and political historians have argued, the attention to transnational movements has also put the nation state into perspective regarding its colonial project in the Congo (and for two decades in Ruanda-Urundi) (see Chapter 4).<sup>34</sup> The history of medicine in the colonies is a field in which the

transnational approach has proved to be particularly effective for telling the story of Belgium. In the colonies, local Belgian initiatives coincided with projects spearheaded by the British and French, but that were also conducted within the imperial space (see Chapter 3).<sup>35</sup>

While at times Belgium has been at the crossroads of new developments, at other times it has found itself on the sidelines. The topos of the ‘Belgian latecomer’ is a recurrent narrative pattern in medical and political debates: whether with the 1850 Mental Treatment Act or the development of public health films in the early twentieth century, Belgium has regularly been presented as a country that is lagging behind. While the use of such imagery was often politically inspired, the impact of foreign influences is an important aspect of medical historians’ work, especially when a strong ‘national’ production is lacking as in the case of health exhibits or medical cinematography (see Chapter 9). As a country that belongs to two linguistic areas and is surrounded by larger neighbours such as France, the United Kingdom and Germany, Belgium can be seen in medical history as a ‘seismograph’ that enables historians to identify, examine and reconstruct transnational developments as well as local adaptations.

Finally, moving beyond the realm of medical history, paying attention to the different levels at which healing and healthcare took place may be of great value for investigating the history of Belgium in general, and especially the Belgian state. When Belgian historiography first emerged in the nineteenth century, the strength of local entities was immediately emphasised.<sup>36</sup> While this book to some extent reflects that view, an examination of medicine and health also enables us to emphasise moments when the nation state assumed a stronger role, especially after the two world wars and also during the rise of the welfare state: at these points, the state appears as a strong player rather than a weak entity (see Chapter 6).

### Medical histories of Belgium

This book reflects a renewed interest in Belgian medical history over the past twenty years. At different levels, ranging from master’s and PhD theses to published articles and monographs, historians have engaged with questions of health and healing, science and the body.

For this book, we brought together twenty-one authors from both the French-speaking and Dutch-speaking academic communities of Belgium, and asked them to compare their approaches and sketch the state of the art for various topics. Our intention was not to create a single standard account of Belgian medical history, but to bring more synthesis to the existing scholarship in the form of accessible *histories* of the medical field. Each chapter, moreover, ends with a selected bibliography of key works, providing easy access to further reading.

As expected, clear gaps in the historiography emerged during the process of making this book. At the very start, as we conceptualised its structure, it became clear that while for some topics considerable research existed, other topics had only scarcely been looked at. It is a telling fact of itself that we could find no authors to write an overview chapter on the history of pharmacy and illegal drugs in Belgium – topics that we would have liked to see combined in a single chapter. For other possible subjects as well, such as rural medicine or medicine and age, we hit upon a similar lack of research.<sup>37</sup> Moreover, as we organised two workshops to discuss texts, we were surprised to find that the history of disease has in fact been relatively little developed within Belgian historiography. In line with historians' attention to state interference, some diseases that have been framed as public health threats such as acquired immune deficiency syndrome (AIDS), tuberculosis or sleeping sickness in the Belgian Congo have been well studied. In addition, there exists an established tradition of demographic historical research into health, disease and mortality in Belgium.<sup>38</sup> Yet, few studies have appeared on the experience of and changing medical views on diseases such as cancer, polio, diabetes or migraine, in a way comparable to the rich Anglo-Saxon historiography of disease.<sup>39</sup> Similarly, the history of everyday medical practice and 'alternative medicine' is relatively little explored.<sup>40</sup> Finally, traditional subjects that are recurrent in Belgian historiography, such as the linguistic conflict between the Francophone and Dutch-speaking (Flemish) communities make only a brief appearance in Belgian medical history.<sup>41</sup>

Taking these gaps into account, each chapter attempts to fulfil three criteria: to review the current state of the historiography, to offer an overview that includes recent research findings and to highlight any persistent blind spots. This threefold approach provides

readers with a critical snapshot of current research and indicates areas that could benefit from further investigation. Other than that, the authors made their own choices in line with their topics, for example in the way they composed the narrative of their chapter and structured the period treated. To bring more unity to the volume as a whole, and as an additional tool to navigate the history of the Belgian medical field, we also drew up a timeline together with the authors. This timeline includes not only the major events, typical of the social history of medicine (e.g. acts of legislation, foundations of professional bodies), but also events specific to the topics of the chapters (e.g. the graduation of the first female Belgian physician). In addition, cross-references between the chapters indicate that many evolutions were closely related and that the authors treated the same wide themes (e.g. the relation between medicine and sexuality) from different angles.

The book is organised in three thematic parts. This thematic approach focuses on the three traditional players in medical historiography – namely the nation state, the hospital and the physician – but viewed from a decentralised perspective, with the aim of proposing innovative narratives. The titles of the three parts – ‘Beyond the Nation State’, ‘Institutions and Beyond’, and ‘Beyond Physicians’ – serve as idealistic exhortations to produce new histories. But in all three sections, the difficulties in moving beyond these ‘pillars’ of medical history, which continue to dominate the narrative, became clear. The fact that not all parts of the book have an equal number of chapters is in itself symptomatic of the current state of the field. It reflects the fact that Belgian historians have been more successful in employing wide frameworks to write medical history (instead of looking only at state–profession interactions) than in broadening the range of players beyond institutionalised settings or adopting an approach that looks at the field ‘from below’ (e.g. through patients’ eyes). While historians’ analyses increasingly reveal the cultural anxieties, religious beliefs and gendered stereotypes that have underpinned much medical discourse, they are still strongly centred on physicians. Here lies an agenda for further research.

Part I, ‘Beyond the Nation State’, highlights those dynamics in the medical field that transcended Belgian borders, yet impacted Belgium in a particular way. The four chapters show how medical



knowledge was intimately connected to colonial conquest, notions of gender, religious views and expanding state power in public health. Specialisms such as tropical medicine, gynaecology and ‘hygienism’ may be considered as products of these social views and transformations, but at the same time played an important role in legitimising them. While histories revealing this complex entanglement between medicine and modern society may be written for many countries, Belgian particularities also appear. These include the clear impact of Catholicism on the ways in which views about the healthy body were constructed, resulting in sexual codes that were framed in moral and religious terms, and the dominance of religious congregations in healthcare both in Belgium and the Belgian colonies of Congo and Ruanda-Urundi. Focusing on gender, reproductive medicine and sexuality, in Chapter 1 Jolien Gijbels and Kaat Wils present a history in which medicine becomes both a tool of power and inequality (e.g. of men constructing the female body and medical insights underpinning labour divisions), but also a means of gaining more control for women and men over their bodies (e.g. the attention paid by the feminist movement to abortion). In Chapter 2, Joris Vandendriessche and Tine Van Osselaer write a history of Catholicism in Belgian healthcare in more than only political terms. By looking at the evolution of Catholic institutions, at the medical meanings that were ascribed to religious practices and rituals, and at Catholic medical ethics and professional identity, they present a varied overview of the many interactions between medicine and religion.

In addition, the chapters in Part I of the book engage with the notion of the relatively weak Belgian state. In Chapter 3 on medicine and colonialism, Sokhieng Au and Anne Cornet make clear how a lack of political will to invest in healthcare in the colonial territories, which was tied to a relative ‘indifference’ towards the colony, left all the room to private players such as religious missions, industrial companies and universities to develop health programmes and infrastructure. One of the implications of this indifference was that for a long time Belgian state citizenship remained inaccessible for colonial subjects – who Au and Cornet suggest were rather treated as ‘objects’. As for the weak state in Belgium itself, in Chapter 4 Thomas D’haeninck, Jan Vandersmissen, Gita Deneckere and Christophe Verbruggen move beyond a narrative

of slow or speedy developments in public health, or of strong or hesitant state interventions. Instead, they structure their chapter according to changing networks and modes of exchanging knowledge of ‘reformers’, many of which (but certainly not all) were physicians. In this way, the history of public health shifts between local medical societies, international conferences and transnational health programmes – in which the nation state forms only one level or actor.

In Part II, ‘Institutions and Beyond’, the authors highlight most clearly those aspects of the Belgian landscape of medicine and healthcare that make it unique. In seeking ways to turn the history of respectively medical faculties, mutual societies and hospitals into a broad analysis with different actors and covering two centuries, they come to a defining characteristic of Belgian medicine: the strong influence of ideology. In Chapter 5, on medical education in Belgium, Renaud Bardez and Pieter Dhondt argue that the ideologies of liberalism and Catholicism, and the struggle between them, are key to understand the changes and particularities in the medical curriculum of the state universities and of the private and ideologically opposed Free University of Brussels and the Catholic University of Leuven. Catholic viewpoints, for example, underpinned the latter university’s hesitance in the nineteenth century towards far-reaching scientific training at the expense of broad and practical clinical courses designed to educate ‘conscious’ practitioners. In Chapter 6, Dirk Luyten and David Guillardian equally refer to competing ideologies and their translation into particular systems of financing healthcare, to explain historically how mutual societies have come to occupy such a strong position in Belgian healthcare. In a long-term perspective, they show how the Belgian state supported private initiatives (mostly Catholic and socialist) through a system of ‘subsidised liberty’ since the late nineteenth century and extended this system in 1944 when Belgian social security was introduced. While 1944 is often seen as a foundational moment of the Belgian welfare state, in terms of the political and financial logic there was no clear ‘break’ with the past. In Chapter 7, Valérie Leclercq and Veronique Deblon show expressions of ideology in healthcare in unexpected places, as they write the history of Belgian hospitals – institutions that have socially and medically completely been transformed over the past two

centuries – by focusing on their material outlook. Strikingly, the influence of Catholicism becomes clear even in the public hospitals of the liberal stronghold of Brussels in the form of religious symbols (e.g. crosses) and practices (e.g. communion) that were introduced on request of patients. Somewhat contradictory, the modernist hospital architecture of these same institutions propagated an image of (anti-religious) progress.

While the chapters in Part II politically ground Belgian medicine within competing ideologies, they also pay attention to medicine as a profession. By also including this more traditional perspective, they show that Belgian physicians were above all trained to be practising professionals – an ambition that had to be balanced with their scientific schooling. Physicians furthermore organised themselves as actors in an economic market, where they sometimes clashed with other players (mutual societies, political parties) on the modalities of democratising the access to healthcare. New perspectives, such as attention to the financing of healthcare and the material culture of healthcare institutions, allow historians to renew this history of professional struggles. This innovative potential becomes most clear in the image of the hospital presented in these chapters. As more diverse patients' groups found their way to the hospital to receive specialised care, the involvement of physicians increased as well, along with the development of different functions of these institutions as spaces of instruction, healing and science.

The chapters in Part III, 'Beyond Physicians', put into practice most clearly the ambition to give agency to non-professional actors, patients in particular, in the history of medicine.<sup>42</sup> In Chapter 8, Benoît Majerus and Pieter Verstraete boldly bring together the histories of disability and mental illness, and in doing so include the voices of disabled people and people with mental illnesses. They pay attention to the very different experiences of these people (e.g. in their relation to their own bodies and to social prejudice and governmental structures in Belgium), but also to their shared historical trajectories of segregation and classification as 'subgroups', and the growing unease in the course of the twentieth century with such institutionalised segregation. In Chapter 9, Tinne Claes and Katrin Pilz draw attention to curators, to patients in their role as consumers of information about health and the body and to journalists

and film-makers. They call for a history of the ‘popularisation’ of medical knowledge in Belgium that avoids a top-down relationship between professionals and laypersons, and between science and the public. Their analysis of health exhibitions (such as the Spitzner Museum in Brussels) and medical films (such as the first Belgian public health film *Un ennemi public* from 1937) reveals how different audiences were not passive consumers, but instead chose and adapted the available views on health, responding to them in unexpected ways.

Given the focus in both chapters in this final part on experiences ‘from below’, they also question – more clearly than elsewhere in the book – the narrative of medicalisation and point to its limitations. To understand the experiences of disabled people, for example, a medical gaze excludes too many social aspects related to being categorised as ‘disabled’ in Belgian society. A narrative of boundaries and people’s agency in coping with these structures and reacting against them offers an alternative. To understand the function of medical knowledge within Belgian society, a gaze through the eyes of experts and scientists is similarly insufficient. Instead, narratives of travelling knowledge, and of the adaptation and consumption of medical information by users, seem more suited to bring to light that medicine and health had a ‘demand side’ as well – besides the better-studied ‘supply side’ as offered by physicians.

To place Belgian medical historiography in a wider European perspective and wrap up this book, we asked the Dutch historian of medicine Frank Huisman to write an epilogue. Huisman does so eloquently by identifying how the chapters reflect the different ‘turns’ that medical historiography has taken since the social history of the 1970s and 1980s. Huisman comments how new understandings of the body as an object of biomedical knowledge, as a gendered construct, as something fragile and prone to care, have impacted medical historiography and resulted in much more varied and dynamic histories. He concludes by discussing the book’s ambition to look beyond the profession and the state and refers to Roy Porter’s work, stating that such an effort also means – in Porter’s words – reflecting and redefining the goals and limits of medicine. By presenting a new set of narratives about ‘Belgian medicine’, this book hopes to contribute to such reflection.

## Notes

- 1 J.-C. Broeckx, *Essai sur l'histoire de la médecine belge avant le XIXe siècle* (Ghent: Hebbelynck, 1837), iii.
- 2 J. Vandendriessche, *Medical Societies and Scientific Culture in Nineteenth-Century Belgium* (Manchester: Manchester University Press, 2018), 206–17.
- 3 Overviews of twentieth-century medicine include R. Cooter and J. Pickstone (eds), *Companion to Medicine in the Twentieth Century* (London: Routledge, 2003); and L. Monnais, *Médecine(s) et santé: Une petite histoire globale – 19e et 20e siècles* (Montréal: Les Presses de l'Université de Montréal, 2016). On the particularities of the twentieth-century history of medicine in the Low Countries, see F. Huisman, J. Vandendriessche and K. Wils, 'Blurring boundaries: towards a medical history of the twentieth century', *BMGN-LCHR (Bijdragen En Mededelingen van de Geschiedenis Der Nederlanden: Low Countries Historical Review)*, 132:1 (2017), 3–15. Specifically on the field of psychiatry in the twentieth century, see V. Hess and B. Majerus, 'Writing the history of psychiatry in the 20th century', *History of Psychiatry*, 22:2 (2011), 139–45.
- 4 K. Velle, *De nieuwe biechtvaders: de sociale geschiedenis van de arts in België* (Leuven: Kritak, 1991); C. Havelange, *Les figures de la guérison (XVIIIe–XIXe siècles): une histoire sociale et culturelle des professions médicales au pays de Liège* (Paris: Lettres Liège, 1990); R. Schepers, *De opkomst van het medisch beroep in België. De evolutie van de wetgeving en de beroepsorganisaties in de 19de eeuw* (Amsterdam: Rodopi, 1989).
- 5 See, for example, J. Craeybeckx, A. Meynen and E. Witte, *Political History of Belgium from 1830 Onwards* (Brussels: ASP, 2009).
- 6 R. Schepers, 'Towards unity and autonomy: the Belgian medical profession in the nineteenth century', *Medical History*, 38 (1994), 237–54; J. Demolder and B. Pattyn, 'Het ontstaan van de psychiatrie in België', in *Psychiatrie, godsdienst en gezag*, ed. P. Vandermeersch (Leuven: Acco, 1984), 153–69. Another Belgian medical institution founded in the mid nineteenth century was the Superior Health Council (1849), see E. Bruyneel and L. Dhaene, *Le Conseil Supérieur de la Santé (1849–2009): trait d'union entre la science et la santé publique* (Leuven: Peeters, 2009).
- 7 I. Meul and R. Schepers, 'De opkomst en consolidering van medische specialisten in België (1857–1957)', *Belgisch Tijdschrift Voor Nieuwste Geschiedenis*, 43:2 (2013), 10–45; G. Marchildon and K. Schrijvers, 'Physician resistance and the forging of public healthcare: a comparative

- analysis of the doctors' strikes in Canada and Belgium in the 1960s', *Medical History*, 55 (2011), 203–22.
- 8 L. Nys, H. de Smaele, J. Tollebeek and K. Wils (eds), *De zieke natie: over de medicalisering van de samenleving 1860–1914* (Groningen: Historische Uitgeverij, 2002); J. Tollebeek, G. Vanpaemel and K. Wils (eds), *Degeneratie in België 1860–1940: een geschiedenis van ideeën en praktijken* (Leuven: Leuven University Press, 2003).
  - 9 K. Wils (ed.), *Het lichaam (m/v)* (Leuven: Leuven University Press, 2001); E. Peeters, *De beloften van het lichaam: een geschiedenis van de natuurlijke levenswijze in België 1890–1940* (Amsterdam: Bert Bakker, 2008); E. Peeters, L. van Molle and K. Wils (eds), *Beyond Pleasure: Cultures of Modern Asceticism* (New York: Berghahn, 2011); De Ganck, *Le sexe, une invention moderne? Histoire des réactions face aux anomalies sexuelles et à l'hermaphrodisme en Belgique contemporaine (1830–1914)* (Brussels: Université des femmes, 2012).
  - 10 T. Claes, *Corpses in Belgian Anatomy, 1860–1914: Nobody's Dead* (Basingstoke: Palgrave Macmillan, 2019); K. Wils, R. De Bont and S. Au, *Bodies Beyond Borders: Moving Anatomies, 1750–1950* (Leuven: University Press, 2017).
  - 11 See, for example, S. Richelle, *Hospices. Une histoire sensible de la vieillesse: Bruxelles, 1830–1914* (Rennes: Presses Universitaires de Rennes, 2019); and J. Vandendriessche, *Zorg en wetenschap. Een geschiedenis van de Leuvense academische ziekenhuizen in de twintigste eeuw* (Leuven: Leuven University Press, 2019).
  - 12 J. Vandendriessche and K. Wils, 'Een traject van onderhandeling. Hygiënisme als wetenschap, Antwerpen 1880–1900', *BMGN: Low Countries Historical Review*, 128:3 (2013), 3–28.
  - 13 Some recent studies include: J. De Ganck, 'Cultiver la différence. Histoire du développement de la gynécologie à Bruxelles (1870–1935)' (PhD diss., Université libre de Bruxelles, 2016); L. Nys, *Van mensen en muizen: Vijftig jaar Nederlandstalige Faculteit Geneeskunde aan de Leuvense universiteit* (Leuven: UPL, 2016); and R. Bardez, 'La Faculté de Médecine de l'Université Libre de Bruxelles: Entre Création, Circulation et Enseignement ses Savoirs (1795–1914)' (PhD diss., Université libre de Bruxelles, 2015). We refer to Chapter 5 in this volume for a discussion of the literature on the history of medical education, to Chapters 6 and 7 for an overview of Belgian hospital history and to Chapter 1 for a discussion of historical studies on gynaecology in Belgium.
  - 14 B. Majerus, *Parmi les fous. Une histoire sociale de la psychiatrie au 20e siècle* (Rennes: PUR, 2013).

- 15 On public health reformers and their networks, see, for example, N. Randerad, 'Triggers of mobility: international congresses (1840–1914) and their visitors', *Jahrbuch für Europäische Geschichte/European History Yearbook*, 16 (2015), 63–82. On international networks of colonial doctors and missionaries, see, for example, S. Au, 'Medical orders: Catholic and Protestant missionary medicine in the Belgian Congo', *BMGN: Low Countries Historical Review*, 132:1 (2017), 62–82.
- 16 When it comes to synthesising historical knowledge and moving beyond the level of the case study, Robert Kohler and Kathryn Olesko make a plea for such mid-level analysis instead of composing a new 'big picture'. See R. E. Kohler and K. M. Olesko, 'Introduction: Clio meets science', *Osiris*, 27:1 (1 January 2012), 1–16.
- 17 M. Beyen and B. Majerus, 'Weak and strong nations in the Low Countries: national historiography and its "others" in Belgium, Luxembourg, and the Netherlands in the nineteenth and twentieth centuries', in *The Contested Nation: Ethnicity, Class, Religion and Gender in National Histories*, ed. S. Berger and C. Lorenz (Basingstoke: Palgrave Macmillan, 2008), 283–310.
- 18 For a nuanced discussion of municipalism in Belgium, see M. van Ginderachter, 'An urban civilization: the case of municipal autonomy in Belgian history 1830–1914', in *Nationalism and the Reshaping of Urban Communities in Europe, 1848–1914*, ed. W. Whyte and O. Zimmer (London: Palgrave, 2011), 110–30.
- 19 *Onzième rapport sur la situation des asiles d'aliénés du Royaume (1874–1876)* (Brussels: Fr. Gobbaerts, 1878), 8.
- 20 P. Heyrman, 'Catholic private poor relief and the state in 19th-century Belgium: reconquest, competition and complementarity' (forthcoming); V. Viaene, *Belgium and the Holy See from Gregory XVI to Pius IX (1831–1859): Catholic Revival, Society and Politics in 19th-Century Europe* (Leuven: Leuven University Press, 2001), 177.
- 21 Au, 'Medical orders'.
- 22 G. Vanthemsche, *Belgium and the Congo, 1885–1980* (New York: Cambridge University Press, 2012), 67.
- 23 For a recent historiographical overview, see A. Jusseaume, P. Marquis and M. Rossigneux-Meheust, 'Le soin comme relation sociale: bilan historiographique et nouvelles perspectives', *Histoire, médecine et santé*, 7 (15 November 2015), 9–15; and R. L. Numbers and D. W. Amundsen, *Caring and Curing: Health and Medicine in the Western Religious Traditions* (Baltimore, MD: Johns Hopkins University Press, 1998).
- 24 B. M. Wall, *Into Africa: A Transnational History of Catholic Medical Missions and Social Change* (New Brunswick, NJ: Rutgers University

- Press, 2015); B. Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865–1925* (Columbus: Ohio State University Press, 2005), 5.
- 25 In the international historiography, much more attention has been paid to such subjects. See, for example, M. Stolberg, *A History of Palliative Care, 1500–1970: Concepts, Practices, and Ethical Challenges* (Cham: Springer International, 2017).
- 26 On religious congregations in Québec, see A. Charles and F. Guérard, ‘Les religieuses hospitalières du Québec au XXe siècle: une main d’œuvre active à l’échelle internationale’, in *L’incontournable caste des femmes: Histoire des services de santé au Québec et au Canada*, ed. M.-C. Thifault (Ottawa: Presses de l’Université d’Ottawa, 2012), 79–102.
- 27 M. Mormont, ‘Régionalisation, bonne pour la santé’, *Alter Échos*, 377 (2014), 29–32.
- 28 Historians have, for example, written the political history of Belgium ‘from below’. See M. van Ginderachter, *The Everyday Nationalism of Workers: A Social History of Modern Belgium* (Palo Alto, CA: Stanford University Press, 2019); M. van Ginderachter and M. Beyen, *Nationhood from Below: Europe in the Long Nineteenth Century* (Basingstoke: Palgrave Macmillan, 2012).
- 29 J. Vandendriessche, ‘Turning journals into encyclopaedias: medical editorship and reprinting in the Low Countries (1815–1860)’, *Centaurus*, 62:1 (2020), 82–97; J. Vandendriessche, ‘Setting scientific standards: publishing in medical societies in nineteenth-century Belgium’, *Bulletin of the History of Medicine*, 88:4 (2014), 626–53.
- 30 E. Andersen, ‘De Société de Médecine Mentale de Belgique in transnationaal perspectief (1869–1900)’, *BTNG-RBHC: Journal of Belgian History*, 47:4 (2017), 50–84; Vandendriessche, *Medical Societies and Scientific Culture*, 250–78.
- 31 B. Majerus, ‘La désinstitutionnalisation psychiatrique: un phénomène introuvable en Belgique dans les années 1960 et 1970?’, in *La fin de l’asile? Histoire de la déshospitalisation psychiatrique dans le monde francophone*, ed. A. Klein, H. Guillemain and M.-C. Thifault (Rennes: Presses Universitaires de Rennes, 2017), 143–55.
- 32 P.-Y. Saunier, ‘The next big thing ... historians, let us all be Belgians! A few comments about Belgium’s heuristic power’, *Journal of Belgian History*, 4 (2014), 150–4.
- 33 For example Brussels (1899), the first International Congress on Radiology and Ionization, Liège (1905), the first International



- Congress of Pedology, Brussels (1911), the first International Congress of Catholic Physicians, Brussels (1935), etc.
- 34 C. Verbruggen, D. Laqua and G. Deneckere, 'Belgium on the move: transnational history and the belle époque', *Revue Belge de Philologie et d'Histoire*, 90 (2012), 1219; D. Laqua, *The Age of Internationalism and Belgium, 1880–1930: Peace, Progress and Prestige* (Manchester: Manchester University Press, 2013); N. Randerad, *States and Statistics in the Nineteenth Century: Europe by Numbers* (Manchester: Manchester University Press, 2010).
  - 35 M. Mertens and G. Lachenal, 'The history of "Belgian" tropical medicine from a cross-border perspective', *Revue Belge de Philologie et d'Histoire*, 90:4 (2012), 1249–71.
  - 36 Beyen and Majerus, 'Weak and strong nations'.
  - 37 Sophie Richelle's work on care for elderly people in public institutions in Brussels forms an exception, see Richelle, *Hospices*. A historiography as reflected in the chapters 'Childhood and Adolescence' and 'Medicine and Old Age' in the *Oxford Handbook of the History of Medicine*, ed. M. Jackson (Oxford: Oxford University Press, 2011) is lacking for Belgium.
  - 38 See, for example, I. Devos and A. Janssens (eds), 'Reconsidering the Burden of Disease in the Low Countries in Past Centuries', special issue of *Low Countries Journal of Social and Economic History* 14:4 (2017); and I. Devos, *Allemaal beestjes: mortaliteit en morbiditeit in Vlaanderen, 18de-20ste Eeuw* (Ghent: Academia Press, 2006).
  - 39 We refer here, for example, to the historiography of cancer developed by Ilana Löwy, Carsten Timmermann, David Cantor and Elizabeth Toon, among others. Belgian scholars, however, have not engaged in writing disease histories or 'biographies' of disease as have been published in the series of Johns Hopkins University Press or Oxford University Press over the past decades.
  - 40 Scarce examples of such research are the work by Anne-Hilde van Baal on homeopathy and Evert Peeters on Catholics' openness to more holistic approaches to medicine such as hydrotherapy. See A.-H. van Baal, *In Search of a Cure: The Patients of the Ghent Homoeopathic Physician Gustave A. van den Berghe (1837–1902)* (Rotterdam: Erasmus, 2008); and E. Peeters, *De beloften van het lichaam: een geschiedenis van de natuurlijke levenswijze in België, 1890–1940* (Amsterdam: Bakker, 2008). For a more elaborate discussion of the relation between orthodox medicine, alternative healers and the public, see Chapter 9 in this volume.

- 41 A counterexample to this observation is the role played by physicians in the splitting up of the University of Leuven in the 1960s, an event with nationwide political consequences. See J. Vandendriessche and L. Nys, 'Expansion through separation: the linguistic conflicts at the University of Leuven in the 1960s from a medical history perspective', *BMGN: Low Countries Historical Review*, 132:1 (2017), 38–61.
- 42 A. Bacopoulos-Viau and A. Fauvel, 'The patient's turn: Roy Porter and psychiatry's tales, thirty years on', *Medical History*, 60:1 (January 2016), 1–18.