3 *The Ministry of Offal*

Introduction

Francis Partridge, diarist and writer, attended a Christmas wedding in central London on 23 December 1962.[1] Recently widowed, her financial affairs were precarious. She would shortly take the difficult decision to sell her Wiltshire home, Ham Spray House, it being too expensive to maintain on a small widow's pension. Francis looked forward, even so, to her only son's yuletide marriage.[2] He had been a great comfort to her in the dark days of early bereavement. Bleak times seemed to be behind them both because there was now the promise of a future grandchild. Her son's fiancée was pregnant and would shortly give birth to a baby girl. Little did Francis know, however, that her hopes of enlarging her family circle would soon be dashed, and cruelly so. Her beloved son, an up-and-coming talented writer, was to die of a heart attack just nine months after his wedding and only three weeks after the birth of his new daughter.[3] On 7 September 1963, the day of her son's death, Francis's grief as recorded in her diary was raw: she wrote – 'I have utterly lost *my* heart: I want no more of this cruel life'.[4]

On her son Burgo's wedding day, Francis's heart had in fact been full of hope.[5] She invited a wide circle of friends to the celebration, many from amongst the famous Bloomsbury set of artists, painters and writers, her relatives by marriage. Her new daughter-in-law, 17-year-old Henrietta, was the offspring of David 'Bunny' Garnett.[6] He was a former bi-sexual lover of Duncan Grant the painter and the ex-husband of Francis's sister.[7] As Bunny lived in France, it was a gathering from across Europe and England that promised to closer entwine the bonds of friends and family. Francis wrote an affectionate and amusing account of those assembled in her diary:

> Notes on the wedding: the absolute charm of Duncan, arriving with a button-hole in a white paper bag, beaming at everyone. The geniality of Bunny who suddenly began talking about the necessity of leaving one's body to the doctors with a look of great jollity on his face (more suitable to the occasion, than the subject). His father's mistress, old Nellie someone-or-other, has just died and when Bunny went to arrange the funeral he found to his relief that the body-snatchers had been already, and all the trouble and

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expense were spared him: '*You just ring up the Ministry of Offal, Sackville Street*' is what I remember his saying, but I suppose he can't have.[8]

Having lost a husband and 28-year-old son to heart failure over a three-year period, Francis had every reason to revisit her diary entry on the *Ministry of Offal*. New medical research might have prevented the early deaths of those she loved. Yet, even this dispassionate, highly intelligent woman could not bear to donate her husband's or son's body to medical science. Here was someone so shockingly bereaved, in such emotional turmoil, that the physical pain she experienced was almost impossible to bear. The amusing quip at her son's wedding had foreshadowed a tragic end to her intimate family life, akin to a Grimms' fairy tale. As Burgo's publisher, Antony Blond, wrote years later:

> One afternoon whilst talking on the phone to Charlotte [Blond's wife], Burgo died. He was suffering from von Falkenhausen's disease [an aortic aneurysm discovered at the post-mortem] and part of his aorta had flaked off and choked him. I am told that when his mother was informed she telephoned Harrod's and asked them to collect her son's body, cremate him, and send her the bill.[9]

For a woman who did not believe in an afterlife, there was no solace gained from a sense of spirituality. Nor could she bear to contemplate the bodies of her loved ones displayed for public consumption in any respect. Indeed, in accordance with her rationalist and atheist beliefs, Francis refused to hold a formal funeral for Burgo – a decision that his publisher said he 'never forgave her' for taking.[10] The alternative consolation of the gift to humanity of her son's body was unconscionable as she sank into depression, unable to write her diary for the next two years. The gap came to symbolise the gulf that death left in her life.

Even so, Francis was a writer and what she could constructively do was to chronicle the human condition of trying to live with the pain of a double bereavement. As Anne Boston remarked of her diaries covering this sad period: 'The stages of grief stand out almost like a clinical case history. At first she feels eerily like an amputee, at the same time fearing her sense of loss still lies in wait.' Francis hence remarked in 1962 that grief is like a 'ghastly elephant trap. . . . I have buried and suffocated some part of it and one day I shall wake and find I've been falsely bearing the unbearable and either kill myself or go mad.'[11] It is precisely this sort of scenario that has often resulted in disputed bodies in modern biomedicine. For Francis could afford a cremation, she had legal control of the body and she never had to resort to voluntary donation out of poverty. A doctor did not compel her to think about when exactly the dead-end of life happens in a laboratory or dissection-room setting. Everyone respected her wish to cremate her son with dignity and in the way that she and her daughter-in-law envisaged. And without the proverbial *Ministry of Offal* this would also have been the ending story in all cases of untimely or tragic death. In practice, however, most 'ordinary' people did not know that at

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Coronial Inquests parts of their loved ones were used to establish a cause of death and for further medical study under one of the Human Tissue Acts outlined in Chapter 2. The *Ministry of Offal* had a fleeting presence in a doctor's interaction with patients or in written guidance and advice. This is not necessarily a criticism of medical science. Many researchers and other professionals acted within current guidance at the time, and the story above clearly shows the dilemmas involved in reconciling research ethics with painful personal sensibilities. In later life, Francis thus still recalled 'the sharpness of the death of her husband and son' even after forty years of bereavement.[12] Yet this was also the sort of person expected to be open to body donation. Francis never espoused religious beliefs that constructed medical research as something taboo: quite the opposite. Even so, like many of her contemporaries, it was the physical shock of grief that out-weighed the call of medical science. In this case, her wishes were respected. In others, the wishes of families were either ignored or never canvassed or undue pressure was applied for consent. The rest of this chapter unpicks some of the competing influences that shape how disputes about bodies (the focus of Part II of this book) might originate. Running from the early twentieth century to the present, it will concentrate on five core sets of life writing.

The first, letters by Mrs Pearl Craigie, explores how negative public sentiment about the use of bodies and the harvesting of organs could develop and the defensive attitudes in the medical establishment that could thus develop. The second, third and fourth sets of life writing – respectively, Richard Harrison, Jonathan Miller and Michael Crichton – illustrate the complex ethical, moral and personal standpoints of those who benefitted from or conducted anatomical research and its teaching activities. A final set of life writing – the author's own reflections on visits to modern anatomical spaces and dissections – focusses on the sentimental and experiential aspect of anatomical practices, in effect showing how the three types of body disputes that underpin the agenda for Part II of this book can sometimes (but not always) be generated by complex feelings when involved in medical research cultures rather than an intent to deceive. Here then, we encounter the human flow of medical research and the tides of public opinion in the serpentine river of life and death of a biomedical age.

Mrs Craigie's Complaint

At the turn of the twentieth century, female novelists who came to prominence in the press often did so with strong political convictions, and many went on to become journalists. One leading columnist was 'John Oliver Hobbes', the pseudonym of Mrs Pearl Mary Teresa Craigie. She used her writing talents and feeling for a good story, not just to entertain, but to tackle social inequalities

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in British society. Thus, the *London Review* observed how Mrs Craigie ‘with an unfailing finger pointed out the sores of modern life’ and did so in the belief that she should be ‘a woman who faithfully served her contemporaries to her utmost ability’ in popular print culture.[13] During the Edwardian era, she focussed public attention on hidden histories of the dead, to the embarrassment of those dissecting at leading London medical schools.

In the late spring of 1906, a series of letters appeared in the *Daily Mail*, which caused considerable consternation in medico-legal circles. They were penned by Craigie (see Illustration 3.1), a former president of the *Society for Women Journalists* in London.[14] One controversial letter asked ‘Mr Sydney Holland . . . Chairman of the London Hospital’ to reveal ‘how a post-mortem examination may be performed with the act of dissection’. Craigie queried the standard methods of cutting up a dead body according to the various definitions set out

Illustration 3.1 Photograph of ‘*Mrs Craigie*’ for an article by Margaret Maison, ‘The Brilliant Mrs Craigie’, *The Listener Magazine*, 28 August 1969, Issue 2109, p. 272. The photograph originally appeared in the flyleaf of John Morgan Richards, *The Life of John Oliver Hobbes told in her correspondence with numerous friends* (John Murray, Albermarle Street, 1911). As this publication is now out of the copyright clearance restrictions and this author owns a copy of that original book, the image is being reproduced here under creative commons Attribution Non-Commercial Share Alike 4.0 International (CC BY-NC-SA, 4.0), authorised here for open access, and non-profit making for academic purposes only.

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in a medical dictionary, pointing out that it was self-evident that there was a great deal of difference between:

Dissection: The operation of cutting-open a dead body.
Post-Mortem: An examination of the body after death: autopsy.
Autopsy: Dissection and inspection of a dead body.[15]

She wanted to know explicitly: 'Mr Holland speaks of the "small disfigurement" caused by a post-mortem examination. With all respect, I must ask him whether he has personally seen many bodies after the operation in question, or bodies not especially prepared for his inspection?' Mrs Craigie also queried whether relatives could dispute the use of their loved ones' remains for post-mortem and subsequent medical research, or whether medical science ignored their intimate feelings. She challenged the prevailing medico-legal viewpoint that post-mortem protected patients from future medical negligence and was always a positive experience that the bereaved had consented to. Surely, she queried, this was dependent on the number of material cuts to the body of a loved one:

> Again: is it always made clear to every patient (or to his or her relative), on entering other hospitals, that, in the event of his or her death, the body may be subjected to the 'small disfigurement' in question?[16]

She was sceptical that a relative would be told of deaths caused by the 'hospital's own negligence', or indeed from 'carelessness, or ignorance or bad nursing'. The common situation was surely that hospital doctors would instead close ranks to protect their reputations. Thus, she enquired, if the bereaved objected to a post-mortem and further medical research, 'in the event of a refusal' are the 'relatives reminded that they have received free treatment'? This question of financial obligation was to have remarkable longevity in Britain, and indeed often shapes media debates today about the need to open up patient data for research in the NHS (as we shall see throughout this book). Meantime, Mrs Craigie's questions about the ethical basis of medico-legal research and its actual working practices were to prove to be remarkably forward-thinking. In many respects, a lack of informed consent – her central complaint – was not resolved until the Human Tissue Act (Eliz. 2 c. 30: 2004), as we saw in Chapters 1 and 2. And so, in 1906 her letters caused an outcry at the start of a century of controversy. To appreciate her impact in the media and how defensive the medical science became at the time, we need to briefly reflect on her social origins and the reach of her social policy journalism in popular culture.

One of the reasons that *Mrs Craigie's Complaint* (as it was styled in the national press) received such widespread publicity was that not only was she a successful novelist but also a well-known playwright and contemporary of Oscar Wilde on the London stage.[17] Craigie was an American by birth, born in

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Massachusetts, but brought up in London by wealthy Anglo-American parents. As the *Listener* magazine explained:

> Her father, John Morgan Richards, was a successful businessman of Non-Conformist stock. At the time, there were only about a dozen American families living in London. Mr Richards became founder and chairman of the American Society in England. He introduced the sale of American cigarettes into this country and became a leading light in the brave new world of advertising. His interests were literary, as well as commercial, and at one time he was proprietor of the *Academy Magazine* and *Carter's Little Liver Pills*. His pioneering spirit made him a large fortune and he realised a cherished dream by buying a castle on the Isle of Wight.[18]

Richards thus had the financial wherewithal to fund his eldest child's expensive education. Pearl enrolled at Misses Godwin's boarding school at Newbury in Berkshire (1876–1877) before entering a number of private day schools in London. By 1885, she had grown into a confident young teenager and spent a year in Paris, where she became an accomplished pianist. Mrs Craigie was renowned, however, for having made an ill-fated marriage aged 19 to Reginald (known as Robert) Walpole Craigie, seven years her senior, and a banker.[19] On her honeymoon Pearl realised that she had made a serious mistake, as her husband proved to be an alcoholic and a philanderer. Her marital problems were, she told friends, akin to 'being strangled by a boa constrictor'. Nevertheless, she did her marital duty by giving birth to a son, John Churchill Craigie, in 1890. Soon, though, a legal separation and divorce followed in August 1895. In between, to avoid her husband's excessive drinking and womanising, Pearl enrolled as a student of classics and philosophy at University College London. She also started to do some serious creative writing and developed intimate friendships with gentlemen in her social circle. In part, these inspired Henry James's famous novel, *The Wings of a Dove* (1902). Consequently, according to commentators in the media, Pearl espoused the 'new woman' of the 1890s. For she was determined to speak her mind, earn an independent living and thus break free from the marital restraints of her bitterly unhappy home life. To become financially independent, and secure the sole custody of her only child in the divorce court, she published a novel, *Some Emotion and a Moral*, in 1891. The storyline concerned the trials of infidelity and a bad marriage.

It soon became an instant best-seller. Pearl was delighted when it sold '80,000 copies' in the first year. The publicity surrounding her publishing success and the notoriety of her divorce case reflected her wide social circle of not just political but bohemian friends too. Many were up-and-coming artists, poets and dramatists of the fin-de-siècle. They included the first contributors to the famous *Yellow Book*, a magazine devoted to the decadent arts, featuring Oscar Wilde, George Tyrell, Aubrey Beardsley and George Moore.

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She likewise was befriended by the elderly William Gladstone (former Prime Minister) and a young Winston Churchill. Yet, her closest friendships were from amongst a wave of wealthy young American women who migrated to England during the annual social season. Many went on to marry into the top ranks of the British aristocracy. Most bought their title but soon found the marriage bargain to be disillusioning. One such was Consuelo Vanderbilt, who resented, but had to comply with, an arranged marriage to the 9th Duke of Marlborough in exchange for her dowry of $2.5 million. Consuelo by 1906 (the date of Pearl Craigie's letter to the *Daily Mail*) had separated too and was to divorce in 1921. In many respects, then, Pearl espoused a new form of female liberation, and it was on this basis that medico-legal figures of the Gilded Age on both sides of the Atlantic derided *Mrs Craigie's Complaint.*[20]

In all the articles and letters written to counter *Mrs Craigie's Complaint* by those associated with the London Hospital and the medical research culture of the time in England, three things stand out. First, the responses all had an aggressive, affronted tone. To paraphrase their male sentiments, most said: Who is this woman with the effrontery to question what we as a medical profession do with the dead body? They next all sought to reassure the public that the dead were treated with the utmost respect. Again, a précis in the media often ran something like this: Why does this over-sensitive female writer, who is divorced and has converted to the Roman Catholic Church to assuage her guilt, think she has the right to interfere in our work of national importance? A third trend was that all responders to her letters stated categorically that only the poorest were dissected and a post-mortem for the rich and middle classes did not in any respect resemble what happened to the 'unclaimed' from amongst the lower classes who could not afford a pauper funeral. The line of argument stressed was 'that there was never a time when the hospitals of this country were so much endeared to all classes of the community'.[21] Yet, this trinity of stock responses was disingenuous and thus Mrs Craigie kept pressing for better public accountability.

Not one single medical correspondent was prepared to elaborate on the reasonable questions Mrs Craigie posed in print. Nobody defined what the material differences were between an autopsy, post-mortem and dissection. One angrily said: 'I think Mrs Craigie should have taken the trouble to understand the differences between dissection and post-mortem' before going into print.[22] Of course, this only made readers of the *Daily Mail* more suspicious as to why the medical profession was not prepared to do so in the first place. Even a family acquaintance, Edwin Howard MRCS, did not explain explicitly that dissection meant dismemberment in his letters to the editors of several national newspapers in which he defended his profession. Nor did he concede how little materially was left at the end to bury. For, as this author has shown elsewhere, at best it was only about one third of the body at the end of an

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average dissection done during the Edwardian era.[23] In other words, what Mrs Craigie had done was to ask some inconvenient questions.

The timing of Mrs Craigie's letter was particularly unwelcome for the London Hospital. Mr Sydney Holland, to whom her letters were addressed, was the 2nd Viscount Knutsford, a barrister and hereditary peer, who chaired the London Hospital House Committee from 1896 to 1931. He had just completed a major fund-raising drive, and would clearly have been embarrassed socially by the allegations of medical impropriety.[24] The press dubbed Holland *The Prince of Beggars* for the sheer number of financial activities he had personally undertaken to raise money to rebuild the rundown infrastructure of the London Hospital.[25] By 1906, he had generated enough capital donations to rebuild the premises in their entirety, and this gave the hospital doctors a new opportunity to increase their involvement in medical research. It was likely therefore that in the future they would want to acquire more, not fewer, bodies to dissect. In private, Holland conceded that the hospital focussed on '*B.I.D.*' patients – '*Brought-In-Dead*' – the initials doctors used in their medical case-notes to indicate that a body might be suitable for medical research after post-mortem.[26] The irony was not lost on those like Mrs Craigie that they would be 'bid for' in an expanding supply system that was becoming very competitive. In Part II we will be examining how these networks of actors acquired human material, their common activities, habits and procedures, building on and extending in new directions the conceptual approach of Bruno Latour, Michel Callon and John Law in actor-network theory, outlined in Chapter 1.[27] For whilst historians and sociologists have considered in general terms how actor networks were fashioned by the science and technology of the twentieth century, there is a much less refined sense of how and for what purpose anatomists, coroners and pathologists generated and regenerated complex chains of human material to sustain new research cultures. In this book, we will be describing this actor network by mapping it out. From 1945 to 2000, its acquired human material created notable research agendas, attracting external funding, building professional status and making careers. This had performative elements that were intended and unintended, orthodox and unorthodox, seen and unseen. In other words, we are going to take our research lead from Mrs Craigie and her searching enquiries about '*B.I.D.*' Her opponent Holland meantime was also a keen advocate of vivisection, believing that animal research was justified for the public good. So much so, that in 1908 he would become the president of the *Research Defence Society*, a position he held until 1931.[28] He was therefore a committed and vocal exponent of human and animal research: passions that set in context *Mrs Craigie's Complaint* and the press coverage it generated.

What Sydney Holland chiefly objected to was the accusation by Mrs Craigie in a letter to the *Daily Mail* of 28 April 1906 that said: 'it is known that the hospitals are not under any Government inspection'. This was despite the Anatomy Act (2 & 3 Will. 4 c. 75: 1832) setting up an Anatomy Inspectorate

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to oversee dissection and its supply lines from infirmaries, large teaching hospitals and workhouse premises.[29] As Pearl pointed out, 'Some are well managed; some are less well managed.' The fact that inspection was seriously underfunded meant it lacked rigour. She then used emotive language to describe bodies handed back after post-mortem: 'I leave your readers to imagine the feelings of parents and others on receiving the bodies of their dead brutally disfigured and coarsely sewn up as though they were carcasses from Smithfield' livestock market. There is no doubt that this was a controversial way to question contemporary medical ethics, and many thought that she should have used more measured language. Today, she would be criticised by some historians of science and medicine for her 'neo-liberal' values in a pre-liberal era (ironically), whereas she defended that what she espoused was a 'basic humanism'.[30] Pearl Craigie was a plain-speaking American who liked to take risks, and she thought that people of education in the public sphere of the arts should be radical. Thomas Hardy, the novelist, was praiseworthy of this character trait in her, often quoting the definition she espoused about the role of an artist in society. They should be a person, she said: 'who thinks more than there is to think, feels more than there is to feel, and sees more than there is to see'.[31] Even so, she had only a partial picture of reality, as subsequent letters to the press revealed.

Most dead patients underwent a post-mortem, but it was not their whole body that was taken for further research but rather their body parts, organs, tissues and cells that could and were often removed, supposedly to establish a cause of death, as we have already seen in earlier chapters. Coroners and the medical men they employed to do post-mortem work had a lot of discretion to remove human material as they saw fit. Mrs Craigie could not have known this in 1906, but she had potentially hinted at a trade shrouded in secrecy. There were in fact many unseen aspects to the business of anatomy and its supply lines.[32] For instance, an amputation of a leg or arm sold after operative surgery often entered the chain of anatomical supply in London. The poorest, used extensively for teaching and research purposes, were divided up before burial. Bodies were broken for sale because a body in parts was more profitable than whole. Generally, the anatomist on duty did their best to make sure the body contained enough human material sewn up inside the skin for burial. The dead body thus weighed enough to meet grieving relatives' expectations at the graveside (a theme we return to below). Meanwhile, the reference to Smithfield market in *Mrs Craigie's Complaint* was ironic, because across the road from the famous meat market stood St Bartholomew's Hospital, which always competed with the London Hospital to buy the dead and destitute of the East End for medical research and teaching purposes (see Chapter 4 for the modern period). In other words, the comments by Mrs Craigie were ill informed on the essential details, but they did hint that larger ethical problems

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existed. Predictably, perhaps, Sidney Holland picked on the inaccuracy of the finer details. He chose to ignore the bigger ethical dilemmas that the medical profession faced: there was a trade in the dead, it was active in 1906, and it would continue to be so at least up to the 1960s and often until very recently in most medical schools in Britain.

Sydney Holland admitted to the *Daily Mail* that the London Hospital undertook some '1,100 post-mortems every year'.[33] He did not, though, reveal how many actual full-scale dissections this involved. Instead, he stressed that in the case of post-mortems generated on the hospital wards, when he received a complaint from a relative about medico-legal impropriety, he always investigated them personally. Holland appreciated that 'the horror of post-mortem being made on anyone one loves is shared by the poor as well as the rich' but reiterated that only a 'small disfigurement' occurred, disguised by being covered over when relatives came to view the body. This was misleading: the poorest cut 'on the extremities and to the extremities' could not accurately be described as having a 'small disfigurement'.[34] Class played a central role in cutting a little, or a lot. Holland, by concentrating on what happened at a post-mortem *before* a body went for dissection, was being deliberately evasive. Instead, he defended that Mrs Craigie was not in a position to verify her statements, and that in his opinion 'she has permitted her tender feelings, stimulated perhaps by a complaint she has not tested, to tempt her to publish one more work of fiction, which, unlike her others, will give pain to many, and pleasure to none'. In a follow-up letter, he did reveal when pressed that there had been some 'one hundred and ten thousand' post-mortems in the 'last ten years' but stressed 'we have had only three complaints'.[35] He also emphasised that 'very special and loving care is shown to the dead in the London Hospital'. There was a mortuary chapel, built from the bequest of William Evans Gordon, a major benefactor. Yet, this still did not elaborate on the fate of those sent for a full-scale dissection and dismemberment. Instead, Mrs Craigie faced accusations of being an interfering female of a sensitive disposition, given to story-telling, who was not in command of the material facts. It was difficult to see how she could be so, when the dead-end of life seldom featured in public. Searching questions often created this sort of medical backlash, and it could be biting to protect the fact of many missed body disputes of the sort analysed in later chapters.

There was to be one final twist in this storyline about disputing the dead-end of those used for medical research. Pearl Craigie died within just three months of penning her robust exchanges with Sydney Holland in the *Daily Mail*. On 13 August 1906 she was staying at her father's house in London, excited about a touring holiday she was about to embark on to Scotland. Retiring to bed, she said she felt tired, but ill-health was not suspected. In the morning, a maid tried to rouse her in her bedroom, but to no avail. She had died of a heart attack in the

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night. Her shocked parents and her 16-year-old son were grieved to discover that, as her sudden death was unexplained, she would have to undergo an autopsy followed by a post-mortem. At a Coronial Inquest conducted in Paddington by Dr George Danford Thomas, the GP called to the death-bed scene (Dr Leslie Meredith) recalled that he 'found Mrs Craigie lying on her back in bed, dead'.[36] He thought that she had expired 'painlessly' and been dead 'three or four hours, probably more' sometime the previous evening. His post-mortem examination concluded with an informative summary: 'One division of the heart was dilated and the muscle was thin and degenerated. Death was due to cardiac failure, and entirely due to natural causes.' The jury heard the medical circumstances in full:

CORONER: Her death might have occurred anywhere suddenly?
DR LESLIE: Oh yes
CORONER: She must have fallen right back on her bed, dead?
DR. LESLIE: Yes.
CORONER: And that would be a painless death?
DR. LESLIE: Yes, quite . . .
CORONER: The case seemed a perfectly simple one. The deceased had probably been exerting herself. She was an active woman, and the heart not being able to stand the strain had given way, causing her death, which was quite painless. The deceased was a married lady. The marriage had been an unhappy one, and she took proceedings and obtained a divorce.[37]

Despite having been divorced for eleven years, this legal status, her gender and financial plight determined the courtroom's attitude to Pearl Craigie's unexpected death. The Inquest Jury was very concerned to make sure she had not committed suicide in despair at her failed marriage, or due to the exertion of having to work to earn a living. The fact that she would have strongly objected to a post-mortem of any description never featured in court. Yet until cause of death was confirmed, Craigie and her body did not belong in mainstream society. The need to establish why she died required that her family engage with a medico-legal process she had opposed determinedly and in recent memory. They understandably wanted to bury her but had to wait until the body was returned to them by the Coronial Court, and without her heart (a recurrent theme in such cases to which we return in Chapter 5). And when it was given back, at the reading of the will they discovered that Pearl wanted a cremation, which created yet more controversy. She had converted to Roman Catholicism in 1892 and the parish priest felt strongly that a burial would be more appropriate under the circumstances. Cremation was still a contentious and novel request in 1906. A requiem mass was thus held at Farm Street in Mayfair, and Pearl Mary Teresa Craigie was buried at St Mary's Cemetery, Kensal Green in London. Despite her best efforts to prevent it, her cut-open heart, major dissected organs and tissue samples did not join her cadaver sewed

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back up for internment in the ground, superseding in death all the things she objected to in life. The press did not disclose, moreover, tissue retention for long-term heart research goals. Yet, as we shall see, heart failure and research to prevent it was one of commonest entries in the dissection registers of leading medical schools like St Bartholomew's in London (see Chapter 4). It was incontrovertible that a 38-year-old woman in the prime of her life would have been a valuable research commodity and that, if not retained for further research, class had protected her from a fate the poorest could seldom hope to avoid. In many respects then *Mrs Craigie's Complaint* personified a dead-end that medical science denied and in which the *Ministry of Offal* did have a basis in reality. The material reality of what went on behind the closed door of this ministry – in effect the substance of the answer that Mrs Craigie was searching for when she penned her first letter to the press – can be garnered from another, later, representative set of life stories.

KEEP OUT – Private!

On the eve of WWII, Richard Harrison aged 17 was a grammar school boy living in London, where he was a diligent student.[38] Studying hard was essential if he was to realise his ambition of becoming a qualified doctor. He needed to obtain his Higher National Certificate in the sciences because entrance to a good medical school was very competitive. Like most young people of his wartime generation, Richard wanted to get ahead in his career plans. It was likely that he might have to enlist in the armed forces as war threatened across Europe. As a prospective medical student, he was eager to win a place at a prestigious London teaching hospital. He hoped to train somewhere with an excellent reputation. Before the National Health Service (hereafter NHS) in 1948, junior doctors needed a good reference from their medical school to be able to buy into a solvent general practice to start earning back the cost of their expensive, privately funded education.

Richard's father encouraged his son to engage with the recruitment brochures of medical schools that he sent for in the post. Together they made a decision to apply to St Bartholomew's Hospital, central London, and for three key reasons: first, it was where his mother had been treated successfully for laryngeal carcinoma; second, the medical staff had treated her with courtesy and professionalism which augured well; and third, the hospital was within travelling distance of the family home in Mill Hill, north-west London. Richard could commute daily, live at home to save costs, and do extra work in the holidays to earn his keep. As there was no tradition of a career in medicine in the Harrison family, Richard was nervous about his chances of securing a place at medical school. Yet, he impressed the interview committee by telling them that he never forgot his childhood inspiration, the medical novel *The Elephant*

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Man and Other Reminiscences written by Sir Frederick Treves, which he had read aged 13. It was, he believed, 'the best volume of surgical memoirs ever published'.[39] This was a curious coincidence because Mr Sydney Holland, 2nd Viscount Knutsford, had been responsible for the dissected body of the 'Elephant Man' in the collection of the London Hospital. Without knowing it, Richard Harrison had a strong connection to a hidden history of medical research that *Mrs Craigie's Complaint* had hinted at some thirty-three years before he became a new medical student. For now, Richard was convinced that by training at St Bartholomew's he would be at the centre of an exciting medical world.

Richard obtained a training place in the Indian summer of 1939. He remembered: '*the huge poster covering the wall of the building nearest to the Old Bailey which proclaimed Barts was the Mother Hospital of the Empire. It convinced me that I had made a sensible choice* [*sic*].'[40] Soon, however, the German Blitz on London would affect the training of all medical students. The *Daily Mail* announced on 29 September 1939 that some '6,000 medical students' were about to 'study amongst the sandbags'.[41] Central government then asked Oxford and Cambridge universities to prepare for a threefold increase in evacuated students from the capital. New medical students, like Richard Harrison, arrived at either Queens' College, Cambridge from St Bartholomew's Hospital or St Catharine's College, Cambridge from the London Hospital Medical School, sent there for the duration of the war. On his arrival, Richard found that 'Cambridge in wartime was a sombre, not very sociable, place. Barts was *at* the university, but not truly *of* it [*sic*]'. He needed to find a way to make his mark, and he did so in the dissection room. The sign on the door read *KEEP OUT – Private!* Even so, Richard gained permission to enter this exclusive and privileged medical space. In doing so, he provides us with insights into the material substance of *Mrs Craigie's Complaint* and the medical profession's appellation *The Ministry of Offal.*

Like most medical students, Richard reflected that he was nervous about dissecting his first corpse:

> We were required to dissect, and in considerable detail, the whole of the body. From time to time I had wondered, in desultory fashion, whether that might prove an emotional, even a fearful experience.[42]

He soon discovered that 'I need not have worried'. For 'our subjects were unclaimed corpses from the workhouse which had been steeped in preservation for so many weeks before reaching us that they would have been quite unrecognisable to anyone who might have known them in life'. Later he recalled what the bodies preserved with formaldehyde looked like: 'They were, indeed, so shrunk and wizened, with such tough and leathery skins, as not to be instantly identifiable as human at all.'[43] A relieved Richard explained

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that this inhuman appearance helped him to develop a clinical mentality of medical research in the dissection room: 'As we teased them apart we gave little thought to the existence each had led.' The priority was to compare each corpse according to *Cunningham's Manual on Practical Anatomy*, the set textbook. Yet, Richard was troubled too: 'I suppose we had become conditioned to the fact that we would have to dissect a human body.' It may have been mundane and routine after a while, but from time to time he was reminded that others might dispute his dispassionate demeanour. One incident he called to mind:

Visitors to the dissecting room were not encouraged, but one weekend, when it was deserted, I took my father. He was not a squeamish man, and had seen much service on the Western Front but I heard not long after that, for 24 hours, he felt unwell and could eat nothing.[44]

Richard was close to his father and it disturbed him that a man familiar with the horrors of trench warfare in WWI could still react in the way he did to death, and its dead-end.

The main reason that medical students like Richard developed a detached attitude was, of course, that the corpse they dissected was not a complete body shell for long. It soon became a fragmented human being in the dissection room. Seldom did medical students and those training them in anatomy discuss the material reality of dismemberment, and so Richard's recollections are strikingly honest:

Though we each dissected the whole body, it was not a single particular body. Six teams, each of three students, were assigned to every cadaver – one team to each limb, and two others to the torso and the head. This caused arguments at the start of each term, since those working on the arm began by approaching the shoulder from behind, whilst the 'leg' men commenced on the front of the hip. So a notice was hung from the subject's toes during the first fortnight, saying: '*Body will be turned at 2pm*'.[45]

Here we can trace the development of a medical discourse in anatomical action. The person on the dissection table without a name was a 'corpse' – then a 'cadaver' – the 'subject' – a 'body' to be 'turned over' – facedown. As Richard conceded, 'Gradual disintegration thereafter resolved the problem' of how to divide up the dead on a daily basis. There was also a further practicable problem to overcome – generally offensive to public sensibilities. Richard elaborated that

Each corpse was weighed when it came into the department. It had to weigh, when eventually buried in consecrated ground, about the same as it had done originally. So, at the end of each day, Arthur, the attendant, transferred the fragments, from each cadaver back to its specific coffin. At least he did in theory. In practice, he moved down the long, brightly lit, and spotlessly clean room, sweeping the pieces of tissue from each glass-topped table into one bucket. He divided its contents between all the coffins, tipping into

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each as much as he calculated would satisfy HM Inspectors [of Anatomy]. If that seems like an arbitrary or irreverent procedure I always understood Arthur had arranged when the time came, he too would be dissected.[46]

In many respects, this first-hand testimony is not only representative of what happened inside many medical schools in Britain; it also provides confirmation of *Mrs Craigie's Complaint*.

To use Richard Harrison's precise phrase, anatomists buried 'fragments' of corpses in pieces that were 'calculated' to be concealed. The macabre may have made medical history but it remained in the scientific shadowlands. There was no public engagement effort, and communication was clumsy. Seldom did a newspaper feature an article that led with: We did this with your dead-end to push past the deadline of life. Nor was that status quo debated or reformed as cultural tastes changed – effectively it did not exist in the public domain. Richard Harrison made clear that in his medical training he was taught 'punctilious history taking' at the bedside, but never at the dissection table for the obvious reason that his patient cohort was dead. Few thought to ask whether the dead should have a post-mortem passport, in which their material journey could be mapped and précised for relatives to connect them to the gift of donation and its medical legacy. The attitude was that it took too much time, effort and resources to design and maintain identity links, and without public pressure to do so, the practical option was to follow 'proprietorial' rather than 'custodial' medical ethics.[47] Ever since, this has essentially been the medical sciences' default position, enshrined in law, until, that is, HTA2004. Thus, the profession kept disputed bodies and bodies in dispute with modern medical research behind the *KEEP OUT – Private!* sign. A similar representative life story takes us forward in time to trace how this set of training attitudes endured after the 1950s into the 1970s.

'Say Ah!'

One key question that historians examining these sorts of personal accounts always need to ask themselves is how reliable and representative this recollection is of what happened. Did it reflect what occurred elsewhere? The answer is often straightforward – many medical students experienced dissection as a dehumanising encounter and they were relieved to do so. Jonathan Miller, writing for *Vogue* magazine in 1968, for instance, recounted his training as a doctor in the 1950s, which was in many ways similar to the sort of human anatomy sessions experienced by Richard Harrison in the 1940s:

That anatomy course stands out for another reason, too. As with most students, it was my first encounter with the dead. On the first day of term we were assembled in a lecture

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theatre and told what to expect. Afterwards we all trooped down to the tiled vestibule outside the dissection rooms and dared each other to be first inside. I cannot remember now just what macabre fantasies I had before going in the first time, but I remember quite clearly the vapid sense of anti-climax when we finally pushed through the frosted glass doors and stood facing our subjects.[48]

Once inside he was surprised how mundane the furniture, equipment and room looked. Again, the dead were called ‘subjects’, a professional language that Miller adopted easily. He recalled, ‘In our ignorance we had expected some ghastly parody of our living selves’ but instead ‘what we saw bore so little relationship to life that it didn’t seem to have anything to do with death either’. This was the grey zone of the dead-end of life, in which paradoxically the deceased would help the living push past a deadline. Soon he echoed Harrison’s impressions, but here the scale was greater. Miller trained at University College Hospital London (hereafter UCHL). The anatomy department had a policy of obtaining bodies of the homeless found dead in the streets around the back of Euston, King’s Cross and St Pancras stations. These were in plentiful supply during the cold winters of the early 1950s:

The bodies were laid out on fifty or sixty glass-topped tables, arranged in rows right down the length of an enormous shed lit from the windows in the roof. Most of them had been aged paupers. The pickle had turned them grey and stiff, and they lay in odd unfinished postures, like those pumice corpses fixed in headlong flight from the hot ash at Pompeii. Even their organs were dry and leathery, blood vessels filled with red lead, and hearts chocked with the ochre of brick dust. It was only much later, when we came to autopsies – dissection, that is, performed on the recent dead – that we finally experienced the ordeal of which we had been so mysteriously cheated.[49]

Miller then went on to describe what it was like to dissect a fresh cadaver. He soon came to appreciate the clinical importance of those aged paupers he encountered. Unbeknownst to him at that time, they were either destitute street deaths or passed on from old infirmaries and workhouse premises now run by the new NHS:

The body is opened from the chin to pubis and the organs are taken out and examined one by one and laid on a side table like a windfall of rotten exotic fruit. When it’s all been cleared, the carcass lies open to the sky with the ribs and spine showing like the hull of a wet canoe. It’s always a shock to see how much we hold inside us and the florid variety of it all. Heart, liver, spleen, bladder, lungs and guts, we know them all by name but we don’t feel them and know them directly as we do our limbs and torso. This bloody cargo of tripes [*sic*] is carried from day to day more or less without being felt.[50]

Unlike Harrison, Miller explains why this sort of clinical intimacy is essential for general practice. He elaborates on his belief that it may always be necessary for the dead with hidden histories to continue to inform the case histories of living patients, regardless of medicine’s technological prowess:

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The doctor is not just a critical spectator, he is a participant . . . licensed by law to go right up close to the actors [patients] and poke the suffering innards. He can feel the physical vibrato of the patient's pain and overhear the otherwise silent complaints of the injured heart. There is no job on earth that brings one into such close and such refined contact with the physical substance of human feeling.[51]

Every time a junior doctor asks a new patient to 'Say Ah' to be able to hear properly the heart and lungs functioning, it is ironically from holding the hearts of the dead that they owe their dexterity.

What is thought-provoking about this personal memoir is its candour and emotional engagement. At UCHL, remaining *unfeeling about* the autopsies of dead aged paupers was essential for a future doctor's ability to *feel for* his patients (literally). Indeed, Miller concludes that before he dissected 'it was almost as if one were deaf before going onto the wards'. For he says that taking his transferable skills from the dissection table to the bedside, meant that: 'The scales suddenly drop from one's sense and for the first time one can hear the complex eloquence of the tissues.' He observed often that: 'The muffled gibberish of the cells and organs suddenly makes sense, becomes grammatical, and makes itself heard in verses and paragraphs of distress.' Yet, he never knew the names of his aged paupers nor how they arrived at their autopsy. Even so, he was sensitive to his situation, more attuned perhaps than many others. For it is one of the greatest ironies of this type of medical education that students soon discover how the shapes of organs 'like the kidneys also provide a perfect illustration of the old-age anatomical truth: the body is designed to protect itself, *not* to be easy to dissect'.[52] Barriers have to be broken when going under the lancet, just as the doctor trained in human anatomy will later have to cut through the sensibilities of patients who might dispute her or his actions. Cutting-edge reach is paradoxically always about cutting into and up the deadline of life. That process can be strikingly personal, something that goes a little way to explaining why in the past and present some researchers suggest that too much knowledge about its unsavoury material side can be incompatible with the competing 'public good' of giving consent for the use of bodies in death. The final section of this chapter thus tries to show through personal experiences – notably by other medical students in the 1970s and this author's visits to current dissection spaces – just how complex the issues explored through the stories that underpin Part II of the book actually are.

'Cut!'

How candid would you want your dissector to be? Would you ask in advance to know everything, a bit or not that much? The usual riposte to this unsettling question is: Well why worry? After all, you will be dead! This is a material fact of life. All bodies are abandoned, you might reasonably reply. You cannot change decay. Yet, what about the question of dignity in death? Donors and

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their relatives need reassurance that loved ones are handled decently because there has been a long history of disrespect for those dying in destitution. And since that hidden history is inextricably bound up with ongoing questions of public trust in the medical sciences, it is not something that can be simply argued away by holding that it does not matter for the dead because it is the living who celebrate, commemorate, cremate and bury. So what was it like to experience dissection in the more recent past? Here is how Michael Crichton describes his first encounter with a dissected body at medical school by the 1970s:

> NOBODY moved. Everybody looked at one another. The instructor said that we would have to work quickly and steadily if we hoped to keep on schedule and finish the dissection in three months. Then, finally, we began to cut. The skin was cold, grey-yellow, slightly damp. I made my first cut with a scalpel. . . . I didn't cut deeply enough the first time. I barely nicked the skin. '*No, no*,' said my instructor. '*Cut!*'[53]

Crichton soon lost his appetite for this dead work. He was not supposed to find this difficult. It was a rite of passage – something all medical students did with dark humour. So why could he not simply grin and bear it like his fellow students? If laughter is the best medicine, he still found it difficult to see the funny side: 'The second-year students regarded us with amusement, but we weren't making many jokes in the early days.' In fact, he observed that most trainees 'were all struggling too hard to handle the feelings, to do it all'.[54] A lack of life experience created emotional hurdles not found with instructions in dissection manuals.

Then the atmosphere in the dissection room intensified as each body was broken up. Dissection soon gave way to dismemberment and the realisation that: 'There were certain jobs in the dissection [room] that nobody wanted to do.' Soon, he explains, the medical students 'portioned out these jobs, argued over them'. His recollection is that: 'I managed to avoid each of these jobs' until, that is, the demonstrator in anatomy said, '*OK, Crichton, but then you have to section the head* [sic].' He kept thinking, do not panic – 'The head was in the future. I'd worry about it when I got there. But the day finally came':

> They handed me the hacksaw. I realized I had made a terrible bargain. I was stuck with the most overt mutilation of all. . . . I had to go through with it, try to do it correctly. Somewhere inside me, there was a kind of click, a shutting off; a refusal to acknowledge, in ordinary human terms, what I was doing. After that click, I was all right. I cut well. Mine was the best section in the class. People came round to admire the job I had done.[55]

To test the integrity and reliability of memories like this, there are two options. Either analyse yet more autobiographies published in the past twenty years or so for comparable reasons, or leap forward in time to find out in person exactly what dissection has been like since the 1980s. Several logistical issues are the deciding factor.

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Medical students' memories are a mixture of feelings, general recollections and post hoc rationalisations – in other words, bias needs balancing out. Entering hence a selection of dissection spaces today to check credentials seems sensible, but it also does present its own contemporary challenges. There is the need for a strong stomach. Just because, for instance, this author has written extensively about the history of dissection does not mean that they would relish the thought of cutting up a body personally, any more than Richard Harrison, Jonathan Miller or Michael Crichton once did in the 1950s to 1980s. Then there is the question of how to judge what is happening inside the dissection space when your perception is going to be coloured by the vast amount of academic reading that you have done on this subject for fifteen years. Seeing the present with fresh historical eyes will take a great deal of reflection and self-control. Indeed, as E. H. Carr always reminded his undergraduate students at Cambridge, find out about your historian and you will then understand the sort of history they write.[56] Another thing to keep in mind is that medical schools have regulations about dignity standards and you generally need an invitation to enter the dissection room. This is an ethical requirement that is admirable, but it can also compromise the degree of physical freedom visitors can have once inside a dissection space. A uniform of a white laboratory coat is standard, talking loudly is discouraged and engaging with the reactions of students must be about participant observation. Nonetheless, on balance it is necessary to have a checking mechanism, because otherwise the unarticulated parts of this rite of passage – the feelings, sentiments and beliefs of those behind the closed doors of the *Ministry of Offal* – could be missed, or misconstrued. All good historians know that what is not said can be as important as what is – indeed, as Marianne Barouch, the dissection room poet, reminds us:

> *People say a lot of things.*
> *And think three times that many.*
> *Nothing like this place ever crossed my mind.*[57]

Three features of contemporary dissection spaces which this author visited as preparation for this book are an important addendum to the medical experiences we have already encountered in this chapter.[58]

The first is that they are seldom what you expect. Of course, they look clinical because they must be kept clean (refer to Illustration 3.2).[59] The furniture and basic equipment are much the same as they have been for a hundred years or more. And the layout of the tables in rows feels familiar from old photographs (compare to Illustration 3.3). But the air of anticipation, the sense that this room might be a bit smaller, lit slightly differently or run by individuals you have never met before, creates a first-time feeling on entering each new dissection venue. Indeed, the architectural variety and pragmatic use

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Illustration 3.2 Publicity photograph of 'Students Dissecting at the New Medical Centre' ©University of Leicester – see, https://www2.le.ac.uk/departments/medicine/resources-for-staff/clinical-teaching/images/students-in-dissecting-room/view, accessed 10 January 2017, authorised for open access, and non-profit making, reproduced here under (CC BY-NC-SA, 4.0), for academic purposes only. Authorised by the University of Leicester where the author works.

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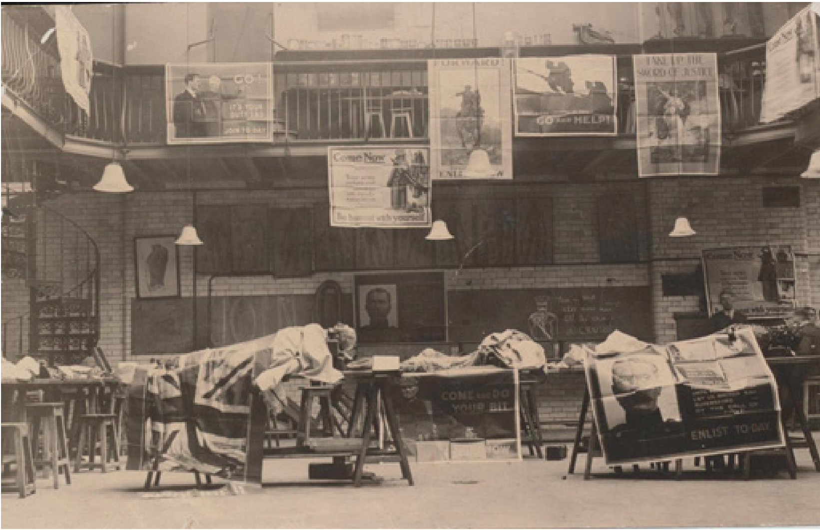

Illustration 3.4 ©St Bartholomew's Hospital Archives, Photographic Collection, 'Dissection Room, 1915', copyright cleared under creative commons Attribution Non-Commercial Share Alike 4.0, reproduced here under (CC BY-NC-SA, 4.0), authorised for open access, and non-profit making for academic purposes only.

in the past of these medico-legal spaces is surprising for the uninitiated. We can see this, by way of example, in archive images of St Bartholomew's Hospital dissection room in London. It was once hung with military recruitment posters from the WWI. These were also used to cover the cadavers being dissected each night (Illustration 3.4). Later teaching facilities were streamlined by building a separate new lecture theatre for the anatomy department to ensure clean sight lines: dissections were selected for special lectures and body parts placed on the lectern at the front of the room for students to observe (Illustration 3.5).[60]

Then once inside modern premises, a second experience starts to be stimulated naturally. The five senses recalibrate their normal running order. On entering the room, it is a place for smelling and listening, and then looking. Even a visual learner generally sniffs the air on entry, because the olfactory imprint of chemicals onto your skin, clothes and hair is what most people worry about. Being led by the nose into the room is commonplace. Quickly, though, the head turns to the side, because to most visitors' surprise there is the low hum of air-conditioning units. These reduce any lingering chemical smells and keep the atmosphere crisp and fresh on entry. The eyes soon start to adjust to the lights overhead too, before modifying their lenses from a portrait view (seeing

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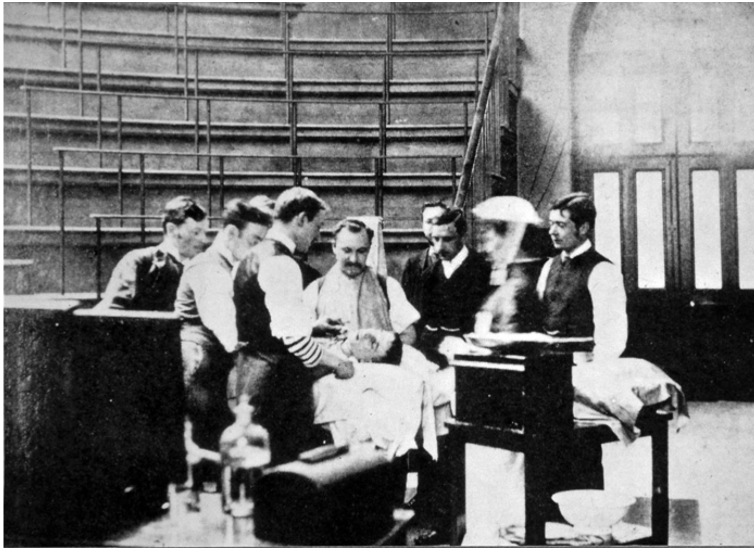

Illustration 3.5 ©Wellcome Images, s3_L0018000_L0018253, 'The New Operating Theatre at St Bartholomew's Hospital around 1910', looking recognisably modern with its stacked lecture theatre seats, Wellcome Trust Collection, digital download image reference, https://wellcomecollection.org/works/mtgyyb5w, reproduced under (CC BY-NC-SA, 4.0), authorised for open access, and non-profit making for academic purposes only.

the upright students and demonstrators in the foreground) to a landscape scan (glimpsing the actual corpses and dissection tables in the background). The brain is now processing information fast in the first few minutes to make the visitor feel safe and circumvent the hyper-arousal mechanism of fight or flight that deals with fear in the body. An unnerving feeling can be trigged on entry: the sense that someone is standing just behind you. Some nervous visitors shudder and then realise that there is no reason to be spooked. A member of staff assigned to stand behind the visitor's back makes sure they do not faint after a few seconds. The third feature of this experience is that most people generally want to look across the room, not down immediately to an actual corpse. It is the equivalent of having a fear of heights where you want to look out at a view but not down from a sharp precipice at what is below. This is so the mind has time to adjust to seeing a dead body with a human face. Generally, therefore, the new visitor is guided to an area of the room where the demonstrator in anatomy has pre-prepared a dissection of a limb called a prosthetic. First-time students are learning how to handle the human material with dignity,

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and touch the preserved tissues that will be the basis of their working life from now on. The ancient philosophy 'healer, know thyself' starts here. There is a human connectedness is this room even for those who have less interest in the anatomical sciences per se as a discipline-defining pursuit in their future careers.

One of the most common unforeseen experiences is the quality of human expressions still preserved in human body parts. Even an experienced visitor to these sorts of spaces can still be drawn to the touching beauty of the shape of a hand; the fingers that look female or male; the expressive quality of digits in an open greeting; all placed on the table for inspection. It is not difficult to spot a former farmer whose hands have toiled the soil for half a century – callouses, stodgy fingers, a big firm grasp; or the hairdresser who once chatted busily to her customers will have the telltale indentation of scissors marks on her forefinger. Again, all echoing what the poet Marianne Boruch recounts in her dissection-room visitor's book *Cadaver, Speak*:

> *The hand in cadaver lab – the first fully human thing*
> *we did. I thought. No hands alike, raging*
> *small vessels run through them – you'd never*
> *believe how many ribbons. The arm*
> *kept springing up, no*
> *not to volunteer. We tied it down with the ordinary rope*
> *you'd get at the hardware store, and even then –*[61]

Wrists too are surprisingly evocative. The thinner they are, the more elegant is the mental impression of the absent person. A ring mark on a third finger's paler skin likewise signifies a love token, taken perhaps in consolation by the bereaved before body donation. Slowly the fragmentary clues start to build a picture of the dead. Painted nails are redolent of a wartime generation for whom make-up was part of a person's glamour. Tattoos too 'are a reminder that this not just a body, but *some*body'.[62] It is striking how very few hands point the finger when preserved; all the moral judgements have evaporated. These are open hands that you can slip your hand into in a greeting and they can stimulate a student to respond in kind. Some stroke the hand and arm – *intuitively* (they often say later) – *impulsively* (most tend to claim) – *calmly* (say those whose interest in the science of dissection takes over quickly). There is a concentrated honesty in those present and it is a refreshing experience, because in the dead all pretence is stripped away.

Perhaps the most unanticipated aspect of visiting dissection rooms is the reaction of some of the staff on duty to the corpses and body parts. Those who work part-time to prepare the prosthetics generally tend to do shift work in local NHS general hospitals. Some are skilled in emergency medicine or intensive care nursing, and so this space can be challenging. For to them, it is a room full

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of failure. *Every-body* was a life that medical science could not save from death. The demonstrators in anatomy are dissecting their let-downs. Often, one of the most difficult emotional experiences involves unwrapping a cold storage body and recognising them as a patient who died in the care of the demonstrator; death can intrude uninvited into even the most impartial medic's memory. There is then a lot of subjectivity surrounding the research subjects; just as there is a lot of emotional anticipation in what will become an emotive scientific endeavour. One thing, though, from all the visits is obvious. Whether at Harvard Medical School (where Michael Crichton trained in the 1970s) or at a British medical school since then, most students find that they have 'that click' deep somewhere inside themselves. The switch can be flicked to shut off their emotions, or not. It really does depend on the person. Crichton discovered that he had a talent for dissection, but he still looked for his emotional exit strategy, eventually becoming a successful film-maker and novelist. Johnathan Miller also left medicine. He became a renowned literary polymath and playwright, with a deep respect for his former general practice. Richard Harrison meantime worked tirelessly for patients with cancer and gynaecological problems until his retirement. He had few plaudits in the press, but it was, he thought on reflection, a life lived well. All nevertheless depended on hidden histories from the corpses in dissection rooms, secretly dreaded and silently taken for granted in their youth.

Janus-Like Hidden Histories of the Dead

In Paul Thompson's seminal book about the value of oral history, *The Voice of the Past* (2000), he wrote that it is a combination of the written and spoken historical record that 'can give back to the people who made and experienced history, through their own words, a central place'.[63] Yet, in rediscovering threshold points, their research pathways and paperwork processes by actors who created hidden histories of the dead inside modern medical research cultures, it is evident that much more archival record linkage work is necessary to arrive at a revisionist perspective. Many closed conversations were never collected either on paper or recorded. In the official evidence base, there were gaps, silences, incomplete and shredded files. Private conversations were evasive in public. Even so, these were peopled with honesty, integrity and a sincerity too. Professional standards of behaviour continued to exude both medical altruism and clinical mentalities. Equally, medical staff and their students were trained not to speak openly outside their rank and file, or give only a partial account of their working lives about what really happened behind the dissection room door, pathology laboratory or hospital morgue because of wider cultural sensitivities about death, dying and the re-use of the dead in society. Part II thus sits at this complex cultural intersection where so much was

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consigned for filing but did not necessarily get forgotten. Often it was pared down, but could later be at least partially recalled, and thus, although considered lost forever, in fact endured in living memory to a remarkable degree. Chapters 4–6 nonetheless guard against the justifiable criticism of oral history that it could result in 'the collection of trivia' or 'become little more than the study of myths'. For as Julianne Nyhan and Andrew Flinn alert us:

> If oral history aimed to recover 'the past as it was', questions [from the 1970s] were asked as to whether the testimonies based upon retrospective memories of events (as opposed to documentary records produced contemporaneously and then authenticated and analysed through a professionally recognised method of 'objective' historical scholarship) could be relied on to be accurate. It was asked whether oral histories were not fatally compromised by the biases and uncertainties introduced by the interview process; and in the case of collective, community-focussed projects whether the selection of interviewees would introduce an unrepresentative or overly homogeneous data collection sample into the studies.[64]

Thus, the new case-material generated in this book essentially symbolises how the above historical debate moved on, and, recently so, with the advent of the digital humanities. Now historians of science and medicine test the validity of oral histories 'by subjecting them to rigorous cross-checking with other sources, arguing for the general accuracy of memory and its suitability as a source of historical evidence, importing methodologies from sociology and the other social sciences', particularly with regard to the representativeness of selected testimony.[65] Historians today concur that every piece of historical evidence – whether written and spoken – is partial, and through rigorous archival checking it is feasible to arrive at a new 'critical consciousness'.[66] To achieve this, finding and fusing new source material, according to Alessandro Portelli, will mean that we arrive at a new consensus in which: 'The peculiarities of oral history are not just about what people did, but what they wanted to do, what they believed they were doing, and what they now think they did.'[67] The *Oral History of British Science* (2009–2013) is one example, deposited at the British Library, of this fascinating and necessary research journey. Admittedly, the *ORHBS* has been criticised for being innovative yet inward-looking, seminal yet celebratory, significant yet not self-reflective enough, for some scholars. Concern has been expressed that some scientists are too quick to praise the past because of a club culture mentality. Even so, new digital oral history collections like this do mark a break with the more fragmented past on paper. Speaking up about the hidden past of the dead will always be about human paradoxes that sit today at the 'intersection and interaction with society, culture and ideology':[68] and this is where this book's novel contribution is located too.

Part II thus builds on Thompson's view that 'the richest possibilities for oral history lie within the development of a more socially conscious and

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democratic history'.[69] It does not seek to explore that historical record out of context, to apply 'neo-liberal' values to a time when the thinking was very different in the immediate aftermath of WWII. Instead, it is framed by a Janus-like approach, looking back to better understand a hidden past, and forward to engage with the long-term lessons of its lived experiences. As its focus is implicit, explicit and missed body disputes; at times there may be more of an emphasis on case-histories where things went wrong with medical ethics and inside research cultures in Chapters 4–6. This is balanced with a holistic sense that human beings can only learn from past mistakes when they get to know what those were in the first place to make future improvements. In other words, this is not a book about covering up, blame or pointing the finger – instead, its central focus is about joining in and renewing recent conversations about cultural change – from the proprietorial ethics of the past – to a custodial ethics of the future – from an ethics of conviction that framed the professionalisation of medical training – to an ethics of responsibility in a global community of precision medicine. For at the dead-end of life, as we shall see, there were many different sorts of hidden histories of the dead, and these created body disputes with stories that did not have to be buried or cremated without acknowledgement. Its bio-commons had medical dimensions and ethical implications not just in our keeping, but in our making too. In modern Britain from 1945 to 2000, we return to it, by looking forward to its past.

Notes

1. Anne Chisholm, *Frances Partridge: The Biography* (London: Weidenfeld & Nicolson, 2009).
2. 'Ralph Partridge died 30 November 1960 at Ham Spray House Wiltshire', *Times*, Death Notices, Friday, 2 December 1960, issue 54944, p. 1.
3. Burgo Partridge, *A History of Orgies* (London: Sevenoaks Publishers, 1958); this first book was published to acclaim.
4. Francis Partridge and Rebecca Wilson (eds.), *Francis Partridge, Diaries, 1939–1972* (London: Phoenix Press, paperback edition, 2001), p. 387, entry 7 September 1963. Ralph, her husband, died 30 November 1960 aged 66.
5. Named Lytton Burgo Partridge, he was known as Burgo in the Bloomsbury family circle.
6. Sarah Knights, *Bloomsbury's Outsider: A Life of David Garnett* (London: Bloomsbury Reader, 2015). His first wife (and Francis's sister) died of cancer and he then married Angelica Garnett.
7. Frances Catherine Partridge CBE (1900–2004) was a long-lived member of the Bloomsbury Group. She married Ralph Partridge (1894–1960) in March 1933. The couple had one son, (Lytton) Burgo Partridge (1935–1963). Ralph had previously been married to Dora Carrington, who committed suicide in 1932.

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8. *Francis Partridge, Diaries*, p. 367, entry 23 December 1962. See also, *Garnett Family Papers*, acquired by Northwestern University Library, USA in 2008, and deposited in the Charles Deering McCormick Library of Special Collections with an online catalogue at: http://findingaids.library.northwestern.edu/catalog/inu-ead-spec-archon-1489.
They reveal that a few weeks after Bunny's mother gave birth to him she suffered severe gynaecological complications (probably a prolapse of the uterus), which meant that she no longer enjoyed full sexual relations with her husband, as she had to wear a surgical support for the rest of her life. She took the decision to release him from the moral bonds of marriage and encouraged him to take a mistress – a painter named Ellen Maurice Heath aka 'Nellie Heath' (1873–1962). She was the daughter of Richard Heath, an engraver, and brought up in France. Her father was a devout Christian Socialist and multi-lingual. He wrote *The Captive City of God* about the alienation of the working classes from middle-class materialism. He returned to live in England in 1899, where he set up in Rugby a Christian community called *The Brotherhood of the Kingdom.* For a time, Ellen's brother, Carl Heath, was tutor to the Garrett family before he converted to Quakerism. Ellen was thus intimately involved in Bunny's upbringing through her brother and status as mistress in the family.
David Garnett in his youth won a place at the Royal College of Science to study botany, and this may account for the contacts he had in his wider social circle with the so-called *Ministry of Offal*. He was happy to take responsibility for the donation of Nellie's body to medical science since she had loved him as a child, and he wanted to fulfil the last wishes in her will. At http://www.npg.org.uk/collections/search/portraitLarge/mw185159/Ellen-Maurice-Nellie-Heath a contemporary portrait of 'Nellie' is available at the National Portrait Gallery in London, from a black and white photograph in the Bauhaus archives taken in 1937 and donated in 1995. 'Nellie Heath' worked predominately in Hampstead, London, where she had a studio. She was also the former lover and muse of two renowned men: first, her patron Walter Sickert, the artist, with whom she had studied painting in Paris, and then D. H. Lawrence, the novelist. She had an affair with the latter just before WWI. Lawrence first admired her paintings around 1913 according to his private letters, and the brief affair developed with the full knowledge of Lawrence's wife, see, Mark Kinkead-Weekes, *D. H. Lawrence: Triumph to Exile 1912–1922*, volume 2 of *The Cambridge Biography of D. H. Lawrence* (Cambridge: Cambridge University Press, 1996), p. 80.
9. A. Blond, *Jew Made in England* (London: Timewell Press, 2004), p. 128.
10. Burgo's literary agent, Antony Blond, was very critical of this decision but only voiced it after Francis's death in his autobiography, *Jew Made in England*, p. 128.
11. Anne Boston, review of Francis Partridge, *Hanging On: Diaries 1960–62* (London: Collins, 1990), *Guardian*, 1 November 1990, p. 22.
12. 'Bloomsbury groupie: she loved Ralph, who loved Lytton, who loved . . .', *Guardian*, 11 January 1999, p. B4.
13. Desmond Mountjoy Raleigh, 'Character sketches: Part II, in memoriam: Pearl Mary-Teresa Craigie', *The Reviews of Reviews London*, 34 (September 1906): 251–254, quote at p. 251.

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14. She was also a regular contributor to *The Women's Penny Paper* and *Woman's Herald*, 1888–1893.
15. 4 May 1906, '*Mrs Craigie's Complaint*', letter to the Editor of the *Daily Mail* by Pearl Mary-Teresa Craigie, 56 Lancaster Gate, Hyde Park London W 1. This address was her father's main residence in the capital where Pearl lived with her son after her divorce.
16. 4 May 1906, '*Mrs Craigie's Complaint*', letter to the Editor of the *Daily Mail*.
17. Hugh Chisholm (ed.), 'Craigie, Pearl Mary-Teresa', *Encyclopaedia Britannica*, 11th ed. (Cambridge: Cambridge University Press, 1911).
18. Margaret Maison, 'The brilliant Mrs Craigie', *The Listener*, 28 August 1969, issue 2109, p. 272.
19. See, John Oliver Hobbes and John Morgan Richards, *Life of John Oliver Hobbes Told in her Correspondence with Numerous Friends* (New York: Ulan Press, 1911).
20. Refer, Mildred Davis Harding, *Air-Bird in the Water: The Life and Works of Pearl Craigie (John Oliver Hobbes*) (Madison, N.J.: Fairleigh Dickinson University Press, 1996).
21. 30 April 1906, *Daily Mail*, reply by Richard Kershaw 'hospital official' [living at Wrexham Lodge West Hampstead] to *Mrs Craigie's Complaint*.
22. 1 May 1906, *Daily Mail*, reply by Edwin Howard MRCS, Shanklin, Isle of Wight to *Mrs Craigie's Complaint*. Craigie Lodge, St Lawrence, Isle of Wight was the family home of Pearl Craigie and her parents. Built as their holiday villa, it was where Pearl often wrote. Her father later retired from business and took up permanent residence until his death. There is a plaque to commemorate Pearl Craigie's life still at the villa today.
23. Refer, E. T. Hurren, *Dying for Victorian Medicine: English Anatomy and Its Trade in the Dead Poor, c. 1834–1929* (Basingstoke: Palgrave Macmillan, 2012).
24. Neville Langton [private secretary to Sydney Holland] *The Prince of Beggars: Being Some Account of the Beggings of Sydney Holland, 2nd Viscount Knutsford, During his 25 Years as Chairman of the London Hospital* (London: Hutchinson and Co, 1921).
25. See notably the caricature sketch by Spy [Leslie Ward] '*How Much*', depicting Holland with another begging letter in his hand published in *Vanity Fair*, August 1904 edition, p. 1.
26. See, Royal London Hospital Records, GB 0387 PP/KNU, Holland, Sydney, 2nd Viscount Knutsford (1855–1931), PP/KNU/1 – Speeches and notes, 1897 – 1931; PP/KNU/2 – Correspondence, 1898 – 1929; PP/KNU/3 – Publications, 1910 – 1925; PP/KNU/5 – Photographs, [c. 1904] – 1931; PP/KNU/6 – Miscellaneous Items, 1897 – [c. 1931]. Refer also, his comments on how to define *'B.I.D.'* patients to Lavinia L. Dock published in *The American Journal of Nursing*, 1906 edition.
27. Selectively, refer: Bruno Latour, *Science in Action: How to Follow Scientists and Engineers through Society* (Cambridge, Mass.: Harvard University Press, 1987) and *Reassembling the Social: An Introduction to Actor Network Theory* (New York: Oxford University Press, 2005); Michel Callon, John Law and Arn Rip, *Mapping the Dynamics of Science and Ethnology: Sociology of Science in the Real World* (Basingstoke: Macmillan, 1986); John Law and John Hassard (eds.), *Actor Network Theory and After* (Oxford: Blackwell Books, 1999); Bruno Latour and

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Michel Callon, 'Don't throw the baby out with the Bath School! A reply to Collins and Yearly', in Andrew Pickering (ed.), *Science as Practice and Culture* (Chicago: Chicago University Press, 1992), pp. 343–368 – conceptual themes that will be developed and discussed in subsequent chapters, notably Chapter 4, where their specifics are applicable.

28. See, the recent bequest of the *Research Defence Society papers,* Wellcome Library, London. I am grateful to the archivist for permitting me to access those from 1908–1931.
29. Mrs Craigie, Letter to the Editor of the *Daily Mail*, 28 April 1906.
30. See by way of example, Duncan Wilson, *Tissue Culture in Science and Society: The Public Life of Biological Technique in Twentieth Century Britain* (Basingstoke: Palgrave Macmillan, 2011); and Wilson, *The Making of British Bioethics* (Manchester: Manchester University Press, 2014). Michael Brown also made similar claims in 'Book review section', *History*, 98 (2013), 330: 302–304. There are regrettably many academics working today in the history of science who tend to excuse a lack of forward thinking in medical ethics, whilst exclusively praising medico-scientific achievements. This book argues that the medical sciences cannot on the one hand defend their obligation to be progressive for society, but then on the other hand ignore its fixed medical ethics. We will be returning to this important theme in Chapter 7.
31. Margaret Maison 'The brilliant Mrs Craigie', *The Listener*, 28 August 1969, issue 2109, p. 272.
32. See, Hurren, *Dying for Victorian Medicine*, chapter 4 and conclusion.
33. Sydney Holland, Letter to the Editor of the *Daily Mail*, 3 May 1906.
34. Hurren, *Dying for Victorian Medicine*, chapter 3, explains the material realities of an anatomical education.
35. Sydney Holland, Letter to Mrs Craigie and the Editor of the *Daily Mail*, 7 May 1906.
36. 'Mrs Craigie's death: the victim of a weak heart', *Daily Mail*, 16 August 1906.
37. Ibid.
38. Richard Harrison recounted his medical training in 2009 before his death in 'A student at Barts: seventy years ago – feature article', *Barts and the London Chronicle* (Autumn/Winter issue, 2009), pp. 1–6.
39. Ibid., p. 1.
40. Harrison, 'A student at Barts', pp. 1–2.
41. *Daily Mail*, Friday, 29 September 1939, issue 13551, p. 3.
42. Harrison, 'A student at Barts', pp. 1–6.
43. Formaldehyde preserves or fixes tissue or cells in a person or animal that is dead. Today it is used in DNA and RNA sequencing too. A solution of 4 per cent formaldehyde fixes pathology tissue specimens at about 1 mm per hour at room temperature. It is also used as a fixative for microscopy and histology. For embalming purposes, it will disinfect and temporarily preserve human and animal remains. It is the ability of formaldehyde to fix the tissue that produces the telltale firmness of flesh in an embalmed body.
44. Harrison, 'A student at Barts', p. 3.
45. Ibid.
46. Harrison, 'A student at Barts', p. 3.

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47. Again a point explored convincingly in, Prue Vines, 'The sacred and the profane: the role of property concepts in disputes about post-mortem examination', *Sydney Law Review*, 29 (2007): 235–261: a research theme introduced in the Introduction and more fully developed with new case material in Part II.
48. Jonathan Miller, 'Saying ah', *Vogue*, 1 January 1967, p. 40 and article continued on p. 46.
49. Ibid.
50. Jonathan Miller, 'Saying ah', p. 46.
51. Ibid.
52. Bill Hayes, *The Anatomist: A True Story of Gray's Anatomy* (New York: Bellevue Literary Press, 2009), p. 27.
53. 'Hack work' reprinted in the *Guardian*, 9 August 1995, column 11, taken from Michael Crichton, *Travels* (New York & London: Vintage Books, 2014 paperback edition), and also reprinted in 'Travelling with Michael Crichton', *Esquire*, Book Review section, 8 November 2008, p. 1.
54. Ibid.
55. Crichton, *Travels*, in which the early chapters cover his turgid time at medical school and desire to escape its confines.
56. E. H. Carr, *What Is History?* (Cambridge: Cambridge University Press, 1961).
57. Marrianne Boruch, *Cadaver, Speak* (Port Townsend, Wash.: Copper Canyon Press, 2014). She said this about the subtleties of her working experiences with medical students in dissection spaces during her tenure as a Visiting Fellow and poet in Scotland and the USA over the course of 2009.
58. I am grateful to those anatomists in London, Cambridge, Oxford and Leicester who talked to me about and facilitated my entry to dissection rooms and who are at all times concerned with the dignity of the gift to humanity.
59. This typical layout is taken from a publicity photograph of the new Medical Centre ©University of Leicester.
60. The same architectural design was used for the new lecture theatre for dissection after WWII – see ©Royal Institute of British Architects Archive, 'Photographic Image of St. Bartholomew's Medical School, lecture room of the anatomy department'. It has not been possible to reproduce the second image because of copyright costs.
61. Boruch, 'Hands', in *Cadaver, Speak*, p. 55.
62. Hayes, *The Anatomist*, p. 51.
63. Paul Thompson, *The Voice of the Past, Oral History*, 3rd ed. (Oxford: Oxford University Press, 2000), p. 3.
64. Julianne Nyhan and Andrew Flinn, introduction, 'Why oral history?', in *Computation and the Humanities: Towards an Oral History of the Digital Humanities* (Basingstoke: Palgrave, 2016), pp. 21–36, quote at p. 26.
65. Ibid., p. 27.
66. A conceptual approach first pioneered by Luisa Passerini, 'Work, ideology and consensus under Italian fascism', *History Workshop Journal*, 8 (1979): 82–108, quote at p. 104.
67. Alessandro Portelli, 'The peculiarities of oral history', *History Workshop Journal*, 12 (1981): 96–107, quote at pp. 99–100.
68. Nyhan and Flinn, *Computation and the Humanities*, p. 28.
69. Thompson, *Voice of the Past, Oral History*, p. iv.

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