

Bibliotek for Læger

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Jesper Vaczy Kragh:

“The worst enemy we have to fight”. Malaria fever therapy and general paralysis of the insane
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In June 1917, the Austrian professor Julius Wagner-Jauregg first used malaria fever therapy for the treatment of general paralysis of the insane. Five years later, malaria fever therapy was also used in Denmark at the Sct. Hans Hospital in Roskilde. Soon after, other Danish mental hospitals began using the new treatment, and malaria treatment quickly became a highly regarded therapy in Denmark. Nevertheless, Danish psychiatrists disagreed about the effectiveness of malaria fever therapy. Some doctors suggested that malaria fever increased antibody formation, while others claimed that the high temperatures caused the patients' remissions. Despite these controversies, malaria fever therapy was considered a breakthrough in the treatment of a hopeless disease. There was, however, another side to the story of success. Danish psychiatrists were aware of the high risks of the malaria fever therapy, and mortality rates of 13% were reported. Because of the risks, the first regulation on informed consent in the history of Danish psychiatry was implemented by Directorate of the Mental State Hospitals in 1927. Malaria fever therapy was widely used until the 1940s, where other types of therapies became an alternative to malaria treatment. In 1942, the hyperthermal treatment of general paresis was introduced in Denmark, but it did not replace malaria treatment which continued to be used in Danish mental hospitals in the late 1940s. In the early 1950s, penicillin for the treatment of neurosyphilis became a topic in the Danish psychiatric literature. A few years later, penicillin became the treatment of choice, and malaria fever therapy and hyperthermal treatment was finally abandoned.

Kaj Bo Veiersted:

“Thus, no other exercise than the exaggerated is in itself harmful” – body and movement in the age of Struensee, with a particular focus on the background for his doctoral thesis (1757) on health benefits of physical activity
Bibl Læger 2008;200:179–210.

Johann Friedrich Struensee (1737–1772), the personal physician of the Danish King Christian VII and the lover of the queen consort, is best known for his political activities and dramatic downfall. Struensee was a firm believer in the ideas of the Enlightenment, and thanks to his role as de facto Head of State from December 1770 to January 1772 he was able to push through liberal reforms in Denmark, such as freedom of the press. Struensee was overthrown and eventually executed in 1772.

Struensee's medical activities are less familiar. He completed his studies of medicine in Halle, and in 1757 he defended his dissertation entitled “De Incongrui Corporis Motus Insalvabitate” (On Unhealthy Bodily Movements). The main message in the dissertation was to stress the benefits of exercise in general, but Struensee also warned of the dangers of excessive movement. The article presents newly-translated excerpts from the thesis, and puts the work into historical context.

Gerda Bonderup:

The Medical Police. Health issues and prophylactic policy in Denmark 1750–1860

Bibl Læger 2008;200:211–29.

From the middle of the 18th century, the Medical Police was the physicians' framework for the improvement of public health. Based on mercantile ideas, the Danish absolute government was interested in a large and healthy population. The doctors suggested four main initiatives: 1. 1750–1787 a maternity hospital was established, where unmarried women could give birth anonymously, and where midwives and young officers of public health could obtain their education in obstetrics. 2. A therapeutic hospital – Frederiks Hospital – was built in 1757 to remove patients from their small, dirty dwellings and cure them quickly. No patients with infectious or chronic diseases were admitted. 3. In 1782 a law on epidemics was launched, and vaccination against smallpox was recommended in 1810. 4. From the early 1770's, a number of public health officers were established outside Copenhagen, at first in the periphery of the country. In 1800, there were about 60, and in 1860 about 100. Initially, the quacks constituted the main group of therapists, but from 1794 only the good surgeons among them were allowed to practice.

This was the base of the new health care system, but it lacked a coherent legislation on the Medical Police. A committee was appointed in 1801 to create just that. The members' eagerness and carefulness resulted in a prolific correspondence with unique details on thoughts, lifestyle, and state of health of the population. But the committee gradually drowned in its own papers and gave up. Not until the disappearance of the cholera in 1853 the Medical Police was brought to completion with the law of 1858 concerning sanitary regulations.

The government and the physicians collaborated well during the entire process. The physicians normally were the initiators, but the government stepped on the brakes, when the doctors were too eager to introduce new measures by force. All over Europe a similar development was seen – each country inspired and got inspired. In some cases, the Danish public health system was in the frontline – in other cases it lacked behind.

Henrik K. Jørgensen & Ole J. Hartling:

Treatment tourism – ethical and legislative considerations

Bibl Læger 2008;200:230–45.

Nowadays so-called “treatment tourism” is increasing. It is often claimed that in a globalized time it will not be possible for any particular country to maintain regulations, laws, and limitations regarding various treatments. We argue that regulations are not only possible, but that they should in fact be encouraged. However, the issue is complicated and its handling depends on different and sometimes contradictory considerations.

Treatment tourism may legitimize that a value based legalisation can be preserved while citizens at the same time can make use of alternatives. A typical example is that many couples from Sweden seek anonymous donor semen in Denmark, because donor anonymity has been abolished in Sweden. Other examples, however, demonstrate that the issue is more complex. Thus, female circumcision, late abortions, buying of organs in poor countries, and euthanasia pose serious ethical dilemmas. In each and every case ethical and practical considerations must be made as to whether prohibition against treatment tourism should be upheld, and whether law breakers should or could be prosecuted and punished.

Philippe Provençal:

Arabic medicine. Its original contribution to medical science

Bibl Læger 2008;200:246–57.

As the Islamic caliphate came into being in the Middle East, North Africa and Spain after the advent of Islam, the Arabic-Islamic civilization adopted the scientific and medical knowledge of the conquered states, i.e. Byzantium and Persia, especially through the wave

of translations of primarily Greek philosophical and medical texts in the 8th and 9th centuries. The Arabic civilization thus continued the classical medical tradition and augmented and improved it through independent research and systematizations of the translated texts. In this way, improvements both in the anatomical and physiological understanding of the human body were conducted, and new views on diagnosis and treatments were established.

Jens Steensberg:

Drunk driving. Danish and Nordic policies during the 20th century
Bibl Læger 2008;200:258–71.

In general, the risk in the Nordic countries related to road traffic is highest in Finland and Denmark. The frequency of alcohol related injuries and deaths has – at least during the recent 30 years – been higher in Denmark than in Finland and especially Sweden. Also, the Norwegian situation traditionally seems to be better. Road side studies indicate that in the 1980's Danish drivers were under the influence of alcohol more often than in Finland, Norway and Sweden.

In 1936, Norway was the first country in the world to decide on a fixed limit value for the content of alcohol in blood, followed by Sweden in 1941 and Iceland in 1959. However, Denmark and Finland didn't follow until 1976. A lower limit of 50 mg% was used in Norway from 1936, in Sweden from 1957, in Iceland from 1959 and in Finland from 1976. In Denmark this wasn't the case before 1997. In 1989, the Swedish limit value was lowered to 20 mg% followed by Norway in 1999.

This paper summarizes and compares the Nordic policies during the 20th century. The main factor behind the larger traffic and alcohol problem in Denmark and the more hesitant legislative efforts is presumably the liberal Danish drinking culture and a relatively weak temperance movement. Particularly in Norway and Sweden, these movements were traditionally much stronger, and they acted as effective pressure groups and had an impact on drunk driving paragraphs in road traffic acts.