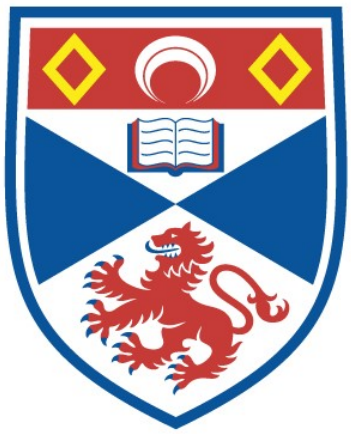
DISSECTING MUSEUMS: UNDERSTANDING MEDICAL HUMAN REMAINS AS INSTITUTIONAL BETRAYAL

Emma Black

A Thesis Submitted for the Degree of MPhil
at the
University of St Andrews



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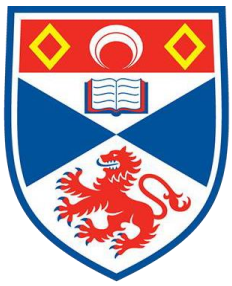

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Contents

Abstract

Historical medical human remains were created for research through dissection, mainly without gaining consent from the deceased or the deceased's family. Hard tissue (bone and teeth) and soft tissue (internal organs and the tissue that surrounds, supports and connects to them) were procured through acknowledged acts of punitive justice, illegal acts of grave robbing, murder and medical entitlement. This abuse is not hidden. Beyond the 'heroic discovery – or heroic squabbling' of developing medicine, the social history of medicine demonstrates how medical human remains are 'rooted, unambiguously, in human cruelty and misery'.[1] Yet, discussions on this topic in medical museums are often reframed as arguments suggesting that the harm caused was mitigated by advancement of medical research.[2] Similarly, arguments that discount the active discrimination behind these acts by suggesting ignorance or differing moral values of the time as reasonable justification are prevalent in this area.[3] By drawing from the field of trauma psychology and my own reflexive practice, this study aims to step away from these often circular arguments and focus directly on the human cost of medical human remains and the modern implications for museum professionals and visitors. Through the chapters of this study, I aim to provide information and knowledge gained from my own experience in working with medical human remains in the hope that it will protect both the living and dead. Ultimately, this study issues a call to courage, to remove medical human remains from display, and for the wider museum community to draw upon this study to recognise and address the impact of all forms of discriminations.

[1] S. Sawday, *The Body Emblazoned: Dissection and the human body in Renaissance culture* (London and New York, Routledge, 1995), 3.
[2] See the case study of Charles Byrne, pp.26–27.
[3] See discussion on Surgeons' Hall Museum visitor statement, p.48

General acknowledgements

“We have only a little time to please the living. But all eternity to love the dead.”
— Sophocles, Antigone

This study is dedicated to Sarah Baartman, Charles Byrne, David Myles, Mary Patterson and all those who were taken for medical research without consent, with hope all can, one day, rest in peace.

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I was admitted as a research student at the University of St Andrews in September 2014.

I, Emma Black, received assistance in the writing of this thesis in respect of N, which was provided by Dr Colin Harper.

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Introduction

Historical medical human remains were created for research through dissection, mainly without gaining consent from the deceased or the deceased's family. Hard tissue (bone and teeth) and soft tissue (internal organs and the tissue that surrounds, supports and connects to them) were procured through acknowledged acts of punitive justice, illegal acts of grave robbing, murder and medical entitlement. This abuse is not hidden. Beyond the 'heroic discovery – or heroic squabbling' of developing medicine, the social history of medicine demonstrates how medical human remains are 'rooted, unambiguously, in human cruelty and misery'.[1] Yet, discussions on this topic in medical museums are often reframed as arguments suggesting that the harm caused was mitigated by advancement of medical research.[2] Similarly, arguments that dismiss the active discrimination behind acts of creating medical human remains by suggesting ignorance or differing moral values of the time as reasonable justification are prevalent in this area.[3] By drawing from the field of trauma psychology and my own reflexive practice, this study aims to step away from these often circular arguments and focus directly on the human cost of medical human remains and the modern implications for museum professionals and visitors.

Nevertheless, defining the abuse behind medical collections as a cohesive set of actions is a challenging task. This form of abuse happened across continents, mainly identified in Europe and the United States of America. It began as a systematic method of medical research in sixteenth-century Europe, spanned over hundreds of years, spread to other continents including America and affected many thousands of people. Therefore, attempting to define this area in relation to specific geographies, differing laws, changing standards of medical ethics or a historical timeline would be a lengthy study, which could distract from the focus of this dissertation. Therefore, to set the parameters for this study, it was necessary to find common characteristics that explain the creation of medical human remains as 'abusive and hierarchical acts of ownership against those perceived as a lower social status'.[4] Consequently, this study focuses on the common characteristics of the two groups within this hierarchal structure. Those who took bodies for research enjoyed an elite status within the medical profession, which mainly favoured white, financially privileged males. Those who were most at risk of being

[1] S. Sawday, *The Body Emblazoned: Dissection and the human body in Renaissance culture* (London and New York, Routledge, 1995), 3.
[2] See the case study of Charles Byrne, pp.26–27.
[3] See discussion on Surgeons' Hall Museum visitor statement, p.48
[4] S. Sawday, *The Body Emblazoned*, 2

taken for research were those seen as 'other' to the medical elite. These people had common connections of disempowerment through poverty, enabled by discrimination including sexism, racism and ableism. Under the current Equality Act 2010, unfair treatment because of these characteristics would be classed as 'domestic discrimination'; under the Human Tissue Act 2004 and 2006 (Scotland), these acts would be illegal. Hence, medical museums are left with a painful and complex legacy.

To examine this area, my methodology draws upon reflective knowledge and insight gained through both my work and study in this area for over ten years. Due to the location of my work, the majority of this study is based in Scotland, with examples of international collections also referenced. Finding the right lens through which to examine this area has been challenging; it needed to both capture a sense of atonement for past abuse, which is often still visible within the original offending institutions. Additionally, the terminology had to acknowledge the anxiety, fear and discomfort both practitioners and the public can feel when confronted with the graphic and unchallenged products of violent discrimination. Consequently, turning to the field of trauma psychology provided the term 'institutional betrayal', which can be used to define medical human remains as both historical abuse and a modern responsibility. Institutional betrayal can occur in mainly two ways: through acts of *commission*, which are direct acts of harm, or through acts of *omission*, which occur when harm is caused by a failure to provide a duty of care.[5] The concept relates to social harm and injustice,[6] and is defined as:

> wrongdoings perpetrated by an institution upon individuals dependent on that institution, including failure to prevent or respond supportively to wrongdoings by individuals (e.g. sexual assault) committed within the context of the institution. The term 'Institutional Betrayal' as connected with betrayal trauma theory was introduced in presentations by Freyd in early 2008…[7]

Institutional betrayal was first applied to the breach of trust within medical environments in 2015 by Smith in her doctoral thesis.[8] More recently, it has been applied to healthcare

[5] C.P. Smith and J.J. Freyd, "Institutional betrayal," *American Psychologist* 69 no. 6 (2014), 579. https://doi.org/10.1037/a0037564
[6] C.P. Smith and J.J. Freyd, J.J., "Institutional betrayal," 576.
[7] J.J. Freyd, "Institutional Betrayal and Institutional Courage," 2020, https://dynamic.uoregon.edu/jjf/institutionalbetrayal/
[8] C.P. Smith, 2015, "First do no harm: Institutional betrayal in healthcare" (PhD thesis, University of Oregon, USA, 2015): https://dynamic.uoregon.edu/jjf/theses/smith15.htm

negligence during the COVID-19 pandemic in 2020.[9] However, this is the first time the term has been applied to medical human remains.

Institutional betrayal is pertinent to this study for many reasons, but in particular, in relation to the three 'barriers to change' identified by Smith and Freyd.[10] As trauma psychology is outside my area of expertise, I shall contain my focus to this small but powerful area of institutional betrayal. These three barriers present as interrelated problems brought by: a lack of language to define abuse; a lack of cohesive knowledge about the abuse; and the ultimate fear of controversy when tackling abuse for those working in institutions with abusive pasts. The first two chapters of this study are dedicated to challenging the first and second barriers. The third chapter aims to provide institutions and individuals with the knowledge and courage to tackle the third barrier, the fear of controversy, in the ways they see fit.

This fundamental issue of language is well defined by Smith and Freyd, who draw from a range of sources, including Power's study on genocide and holocaust survival, to demonstrate how correct terminology can help to define 'a crime without a name' and allow 'people to link together and underscore the gravity of a series of otherwise unrelated crimes'.[11] This naming helps validate the severity of what has happened to victims of abuse, helps people to organise against the repetition of abuse and also helps to safeguard against normalising the abuse. Ultimately, naming abuse is important, as denying or erasing language of oppression can lead to a process of silencing. Within the context of medical human remains, the conceptualisation of silencing is important as it 'highlights social power structures that privilege some voices while excluding others. As metaphors for privilege and oppression, to speak and be heard is to have power over one's life. To be silenced is to have that power denied.'[12]

[9] See: B. Klest, C.P. Smith, C. May, J. McCall-Hosenfeld and A. Tamaian," *Psychological Trauma: Theory, Research, Practice, and Policy* 12 no. S1, 2020: S159–S161. http://dx.doi.org/10.1037/tra0000855
[10] C.P. Smith and J.J. Freyd, "Institutional betrayal," 581
[11] S. Power, *A Problem from Hell: America and the age of genocide* (New York: HarperCollins, 2007) referenced in C.P. Smith and J.J. Freyd, "Institutional betrayal," 581
[12] S. Power, *A Problem from Hell: America and the age of genocide* (New York: HarperCollins, 2007), referenced in C.P. Smith and J.J. Freyd, "Institutional betrayal," 581

When considering the second barrier, the lack of knowledge of the abuse within collections, it is easy to see how silence can lead to a lack of cohesive understanding of the situation. The study of medical museums is often based on polarised studies, the reality of abuse through the social history of medicine, and the heroic narrative of the pioneers of medicine within the medical museum. In many ways, the choice of the medical museum to concentrate on the positive advances of medicine is, understandably, a way to protect the public from the display of trauma. Hence, why we are met with courageous narratives surrounding the pioneers of medicine and shadowy references to 'body snatchers', rather than the acknowledgement of a graphic systemic problem. However, in my experience, these narratives are often passed on to both staff and visitors. This can result in a lack of critical information, with some never questioning the culpability of all those involved in creating medical human remains. Here, practitioners can be almost guided into a dialogue of deflection that excuses an unnamed discriminatory problem within the medical museum. Therefore, the more challenging or critical narratives are often to be found outside the museum, mostly in the social history of medicine (see Chapter 1).

A powerful explanation for the lack of direct action comes from a third barrier, which presents a deep, and almost ironic, fear that members of institutions can experience when confronting institutional betrayal. Smith and Freyd define this as a fear of ''cultural trauma' (e.g., punitive policies, sudden loss, accusation of wrongdoing)',[13] which can see people excluded from their own professions. Similarly, 'discouraging reporting and doubting those who do report in this way could serve as a protective factor to maintain 'not knowing' about the true extent of the problem and to allow the system to continue to function'.[14] Therefore, although the term institutional betrayal does initially seem a controversial point to introduce to this area of study, it could serve as a powerful way to put distance between past abuse and modern, ethical medical practice.

To examine this area, my methodology draws upon reflective knowledge and insight gained through both my work and study in this area for ten years. The time period covered, 2005 – 2015, was a pivotal period for medical human remains due to progressions including the Human Tissue Acts of 2004 and 2006 (Scotland) and large redevelopment funds for medical museum. Due to the location of my work, the majority of this study is based in Scotland, with

[13] C.P. Smith and J.J. Freyd, "Institutional betrayal," 582.
[14] C.P. Smith and J.J. Freyd, "Institutional betrayal," 582.

examples of national and international collections also referenced. Writing this study has been complex and often uncomfortable, as my knowledge on the origins of medical human remains increased. My growing insight brought anxiety, discomfort and an absolute change in opinion from supporting full access to believing in greater restrictions. In this respect, to protect the dignity of the dead and the emotional safety of the viewer, this study will not reproduce images which are related to abusive practice but will provide links to additional information for anyone wishing to access further information. Thus, this study is motivated by a desire to protect not only the dead within medical collections, but, as we move into a time of more awareness of human rights in museums, to protect the professionals and viewers who may be unaware of the depth of abuse within medical collections. Through a working exploration of the social history of medicine, modern legislation and museum practice, this study aims to provide a guide to both professionals and non-professionals concerned about the safeguarding of medical human remains. Ultimately, this study intends to provide the concise information that I, now retrospectively, know was needed when beginning my work and associated duty of care in medical collections.

Due to the location of this study, it is important to begin with an understanding of how Scottish medicine and Scottish medical collections developed. As discussed by Dingwall, when understanding the history of European medicine, it is important to understand the European 'nature' of Scotland, which was developed and strengthened through strong trading links, and by many Scots travelling to European universities to study medicine from as early as the twelfth century.[15] These universities developed within the Christian areas of Europe within the landscape of what is now considered the evolution of modern medicine during the Renaissance.[16] The origins of this area of medical study were formed through Greco-Roman and Arabic knowledge, but, during this period, came under the edict of the Christian church.[17] The study evolved through universities, many of which were 'founded by religious orders'.[18] From 1505, Scotland participated in legal dissection for medical research, and by the Enlightenment, it was a centre for European medicine. However, Scotland's first permission to dissect was granted in 1505 not by the church, but by the Town Council of Edinburgh.[19] This freedom from religious edict meant that Scotland began to attract medical students from abroad, and, by the Enlightenment, Scotland became a centre of European medicine. Consequently, the narrative of Scottish medicine often concentrates on prominent figures and their achievements, such as Sir Joseph Lister and the advancement of antisepsis, and Sir James Young Simpson and the development of anaesthesia.Yet, this medical legacy was built on research that centred

around knowledge gained through abuse and trauma, which must be named.

The study comprises of three chapters as follows:

Chapter 1: Protecting the dead: Understanding medical human remains as institutional betrayal. This initial chapter begins by providing a history of the abusive acts committed to gain medical human remains. Through case studies of four people who were dissected without consent – David Myles, Mary Patterson, Sara Baartman and Charles Byrne – this chapter expands to show why medical human remains should be understood as betrayal. In doing so, it provides a human point of reference for those who are concerned by historical discrimination including classism, sexism, racism and ableism, and its display in modern museums. To encourage empathy, those dissected will be referred to as 'people' rather than bodies or cadavers; first names are also used to bring a sense of personal connection to those who are mentioned in this study.

Chapter 2: Informing the practitioner: Understanding modern acts of omission and Commission. The second chapter begins by exploring residual issues relating to medical human remains and consent in the period building up to the Human Tissue Act 2004 and Human Tissue (Scotland) Act 2006. This chapter explores how modern protections for medical human remains were formed in reaction to controversies including Alder Hey, and the work of Gunther Von Hagens. Yet, it also examines how the confidence gained by new legislation brought vulnerabilities in the display and use of medical human remains. To demonstrate how seemingly positive change brought new acts of omission, this chapter will include a short case study on *Anatomy Acts*, the first ever UK tour of human remains. In contrast, and to conclude, the projects Cabinets of Curiosity and Exceptional and Extraordinary will be used to demonstrate how disability activists and Research Centre for Museums and Galleries used progressive practice to challenge acts of historic and modern discrimination in medical museums.

[15] Helen M. Dingwall, *A History of Scottish Medicine: Themes and Influences* (Edinburgh: EdinburghUniversity Press, 2003), 52.
[16] M. Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge: Cambridge University Press, 2010), 90.
[17] Helen M. Dingwall, *A History of Scottish Medicine*, 41.
[18] Helen M. Dingwall, *A History of Scottish* Medicine, 44.
[19]See: https://archiveandlibrary.rcsed.ac.uk/special-collections/incorporation-of-surgeons-and-barbers-of-edinburgh

Chapter 3: A duty of care to the living: Understanding why medical elitism causes socio-economic discrimination. The concluding chapter addresses the fundamental and continuing medical elitism central to the reoccurring failures in duty of care towards the living. This concluding chapter begins by exploring medical elitism as a widespread, institutional problem which causes socio-economic discrimination in medical museums. After clarifying this issue, a case study of my own work at Surgeons' Hall Museum provides a reflexive analysis evidencing how developing a social role for medical museums can initiate new learning methods, behavioural competencies, and community-focused outcomes. The study will end with an assessment of the use of medical human remains in a co-designed community project with one of Scotland's highest areas of deprivation.

This study concludes with a re-assessment of historic and modern acts of institutional betrayal against living people and medical human remains, and issues a call for institutional courage. My call for courage is hopeful, that with encouragement, we can acknowledge and end acts of betrayal in medical museums, and that the wider museum community can draw upon this study to recognise and address the impact of all forms of discriminations.

Chapter 1: Protecting the dead: Understanding medical human remains as institutional betrayal

1.1 The betrayals

Through exploring the social history of medicine, this chapter will focus on the acts of commission involved in procuring medical human remains, and also the acts of omission towards the human remains of people taken for research and display in medical museums. Within this study, the institutional betrayals discussed relate to non-consensual acts of *dissection* and *anatomisation*. Here, dissection refers to the process understood as cutting up the human body for scientific research. 'Anatomisation' is defined in *Anathomia*, Mondino de Luzzi's anatomical text of 1538, as including 'the extra processes of analysing or experimenting on the body', which could be carried out in private or public dissecting theatres.[1] Dissection and anatomisation became legal in Europe throughout the early sixteenth century. The laws to dissect and anatomise originally gave rights to universities for medical experimentation on the bodies of a few executed criminals a year, as part of punitive justice. As these medico-legal collaborations were formed, medicine in Christianised areas of Europe became legally part of a judicially violent process that discriminated, largely against poor males.[2] Furthermore, the striving to advance medicine through knowledge of anatomy, and the associated professional and financial gains, meant that anatomists became keen to find bodies different to the male population – a population that was more at risk from execution. This meant further societal risks for women, children, the disabled and people of colour, who were taken for medical dissection via methods including murder, grave robbing, colonialism, trafficking and procurement via medical institutions. These inequitable and illegal processes involved stages of abuse and brutality for those dissected. Beginning with legal dissection, it is important

[1] A. Mavrodi and G. Paraskevas, "Mondino de Luzzi: A luminous figure in the darkness of the Middle Ages," *Croatian Medical Journal*, 55 no. 1 (2014), 50–53. http://doi.org/10.3325/cmj.2014.55.50, p51

[2] Bennett's study shows the data and context of this point: between the passing of the Murder Act in 1752 and the Anatomy Act in 1832, a total of 110 murderers were sentenced to the post-mortem punishment of dissection in Scotland between 1752 and 1832: 85 men and 25 women. R.E. Bennett, "A Fate Worse than Death? Dissection and the Criminal Corpse," in *Capital Punishment and the Criminal Corpse in Scotland, 1740–1834. Palgrave Historical Studies in the Criminal Corpse and its Afterlife* (Cham: Palgrave Macmillan, 2017), 170.

to view how each act of dissection and anatomisation was sanctioned by the church, law and medicine as a violent, punitive action that caused feelings of terror for those at risk.

1.2 Dissection and punitive justice

In the Christian areas of medieval Europe, human dissection for medical research was initially practised on a small scale, as it was a cultural taboo.[3] During this period, the church had moral and legal control over the bodies of the deceased. Medicine was taught by an instructor reciting the texts of Galen to students and took place inside religious institutions such as monasteries.[4] In 1231, advances were made when the Holy Roman Emperor Frederick II 'decreed that medical schools were allowed to dissect at least one human body each five years'.[5] Further to this, in 1241, Frederick II issued a decree that 'required knowledge of anatomy on the part of all those seeking a license to practice medicine in the Kingdom of Naples'.[6] Important changes occurred in the fourteenth century throughout Italy with the 'gradual change in attitude of religious authorities towards human dissection from being the primary dissuader to playing the role of mediator'.[7] Institutional progress came to Bologna in 1292 when Pope Nicholas II issued a papal bull 'which permitted all doctors having graduated from Bologna to teach in any University in the world'.[8] This influx in students and rights to dissect brought financial gain to the university and demonstrated how to capitalise through progressive anatomical teaching.

The university advanced further with the 'first officially sanctioned systemic human dissection since Herophilus and Erasistratus,[9] being performed in full public display by Mondino de Liuzzi (1275–1326) in 1315 in Bologna'.[10] By the time of this dissection, medical faculties had been established in universities in France, England and Italy, and dissection was practised in these private, academic environments. Yet, even under religious license, dissection was still not entirely acceptable to the public: 'while few Italians seem to have viewed the opening of

[3] http://broughttolife.sciencemuseum.org.uk/broughttolife/techniques/dissection: accessed November 26, 2017.
[4] R.E. Elizondo-Omaña, S. Guzmán-López and M. de Los Angeles García-Rodríguez (2005), "Dissection as a teaching tool: Past, present, and future," *Anatomical Record*, 285B no.1 (2005), 11–15. doi:10.1002/ar.b.20070, p11
[5] A. Mavrodi and G. Paraskevas, "Mondino de Luzzi," 50.
[6] T.F. Glick, L. Livesey and F. Wallis, *Medieval Science, Technology, and Medicine: An Encyclopedia* (London: Routledge, 2014), 33.
[7] S.K. Ghosh, "Human cadaveric dissection: a historical account from ancient Greece to the modern era," *Anatomy and Cell Biology*, *48*(3) (2015), 153.
[8] A. Mavrodi and G. Paraskevas, "Mondino de Luzzi," 50.
[9] Herophilus and Erasistratus are recorded in the work of Galen as practicing vivisection on criminals in fourth-century BC Alexandria, see: M. Lock and V. Nguyen, *An Anthropology of Biomedicine* (Hoboken: John Wiley and Sons, 2011), 206-7.
[10] S.K. Ghosh, "Human cadaveric dissection," 155.

the body as sacrilegious, it shamed and dishonoured the dead person and his or her family when performed in public.'[11] The decisions on who could be subjected to this dishonour in death should, in my view, be recognised as the start of a divisive and classist process, which grew more contentious with time. Initially, due to the balance in criminal convictions, poor, working-class men were more likely to be executed within the British legal system.[12] In comparative studies in America, poor, working-class African and African American men were most in danger from execution and dissection.[13]

Medical dissection as part of punitive justice was not without challenge from the public and medical profession. In the eighteenth century, several Acts to increase the number of bodies for dissection through the penal system failed due to fears of public reaction. 'The events of 1786 and 1796 showed, medical science itself could not effect change for its own benefit. Rather, as anatomists in the later eighteenth and nineteenth centuries became all too aware, the development of anatomy would fundamentally rely upon its ability to align itself with broader social, cultural, and political change'.[14] A prominent bill that did not pass through Parliament was William Wilberforce's 1786 Dissection of Convicts Bill, which Ward argues went against the 'prevailing mood in the press and in the government'. Wilberforce

> *began to explore alternative solutions to the crime problem. These included an emphasis on prevention; reform of the police; renegotiating poor relief and new approaches to vagrancy; transformations in the punishments meted out to convicted offenders; confining convicts to the hulks; and a desperate search for a replacement location for transportation, culminating in the first fleet to Botany Bay, Australia, in May 1787.*[15]

In Edinburgh, where this study is based, a timeline of punitive procurement clarifies who was at risk of dissection and anatomisation:

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[11] T.F. Glick, L. Livesey and F. Wallis, *Medieval Science,* 33.
[12] S. Sawday, *The Body Emblazoned*, 54.
[13] D.C. Humphrey, "Dissection and discrimination: the social origins of cadavers in America, 1760–1915," *Bull N Y Acad Med.*, 49 no. 9 (1973), 819–27.
[14] R.M. Ward, "The Criminal Corpse, Anatomists and the Criminal Law: Parliamentary Attempts to Extend the Dissection of Offenders in Late Eighteenth-Century England," *J Br Stud*., 54 no. 1 (2015), 63–87. doi:10.1017/jbr.2014.167, 20.
[15] R.M. Ward, "The Criminal Corpse,", 5.

1505: The first dissection act in Scotland was the 1505 Seal of Cause grantedto The Barber Surgeons of Edinburgh*, later known as The Royal College of Surgeons of Edinburgh. In Edinburgh from 1505, the body of 'ane condampnit man efter he be deid'. In England, from 1540, four bodies a year were granted to the Company of Barber-Surgeons, later known as the Royal College of Surgeons of England (Patrizio and Kemp 2006).*

> ***1752: The Murder Act 1752 was implemented as a deterrent to prevent the act of murder through fear of dissection.*** *The law at this time disproportionately affected those seen as 'lower class' who had limited access to legal defence and were at more risk of offending due to impoverished circumstances and living in areas of higher risk behaviours (Bryant and Peck 2009). The criminal justice system was the main legal source of bodies for dissection until the Anatomy Act of 1832.*
>
> ***1832: The Anatomy Act of 1832 aimed to put a stop to grave robbing and the illegal trade of human bodies by increasing access to cadavers****. By the time this was passed, 'dissection' and 'anatomisation', as the legal process of and disarticulating the human body for teaching and research, was already associated with a social stigma and was often an exploitative process (Searle 1998). Importantly, the 1832 Anatomy Act shifted the source of bodies from the criminal justice system to the poorhouse (Richardson 1987).*[16]

However, arguments for dissection, which became linked to religious ideologies, were also present. A demand for repentance through judicial violence had become popular during the late eighteenth century,[17] and this theme could be used to obscure progressive arguments for rehabilitation. Yet, in terms of the relationship between the medical profession and the public, the graphic and unjust nature of anatomisation and dissection caused fear and divides. Additionally, it seems that some may have seen this division as beneficial.

[16] E. Black and O. Varsou, "Dissecting art: Developing object-based teaching using historical collections," in *Biomedical Visualisation, Volume 5*, ed. P.M. Rea (Cham: Springer, 2020), 79–92.
[17] C.D. Bryant, *Handbook of Death and Dying* (Thousand Oaks: SAGE, 2003), 358.

In his study on the social and economic context of hangings in London during the eighteenth century, Linebaughconcluded that 'the Tyburn Hangings were the central event in the urban contention betweenthe classes, and indeed were meant to be so'.[19] Tyburn was a notoriously brutal execution pointin London, where hanging took place until 1783. Tyburn demonstrates the dichotomy in public reaction to judicial violence, between those present who believed the executed deserved deathand disrespect, and those who attended to express their sorrow and comprehension of the socialinjustice. In Tyburn:

> *Prisoners were transported to the gallows along a three-mile route by cart, often followed by a huge, jeering crowd numbering several thousand people. Prisoners were executed in front of these noisy, riotous audiences and many hangings resembled more of a fair than a solemn legal ceremony. Other hangings, by contrast, were sombre affairs, accompanied by deep mourning and widespread commiseration for the condemned. White doves were sometimes released by the spectators as a symbol of their sorrow, and executions were accompanied by a hushed silence as the frightening moment of death arrived.*[20]

The execution and dissection of David Myles, a young man from Edinburgh, demonstrates the promoted theme of repentance through execution by the press, the brutal reality and fear for the victim, and the graphic nature of his anatomisation. Additionally, the modern destination and interpretation of David Myles' story is not without controversy.

1.3 The betrayal of David Myles

David Myles was the first recorded public dissection in Scotland. David came to the dissecting room legally after being convicted of, and executed for, incest on 27 November 1702, a week later than his sister Margaret.[21] In Scottish law, incest was seen as a 'violation of not only biblical[22] but also natural Law'.[23]

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[18] P. Linebaugh, *The London Hanged: Crime and Civil Society in the Eighteenth Century* (London: Verso, 2003).

[20] See Mathew White's article on Crime and Punishment in Georgian Britain for primary source press cuttings and court documents on the Tyburn hangings: https://www.bl.uk/georgian-britain/articles/crime-and-punishment-in-georgian-britain

[21] See: "THE LAST Words and Confession of DAVID MYLES": https://digital.nls.uk/broadsides/view/?id=16311andtranscript=1

[22] Biblical law as incest was condemned in Leviticus; from 1709, Scots law began to abandon scripture as a relevant legal source 18:6-18, see: B. Levack, "The Prosecution of Sexual Crimes in Early Eighteenth-Century Scotland," *The Scottish Historical Review*, 89 no. 228 (2010), 190.

[23] B. Levack, "The Prosecution of Sexual Crimes," 176.

The crime was prosecuted as a sexual offence, which were graded in order of severity from fornication, adultery, incest, sodomy, bestiality and rape, all of which could be punishable by death, except for fornication, which was sex between unmarried males and females.[24] David is thought to have been around the age of 19 when executed.[25]

The broadside account of this execution is seen as unusually repentant for the press at this time, which would not often miss an 'opportunity to entertain the audience with sordid and squalid details of an incestuous relationship'.[26] The tone of the article takes a 'higher moral ground' for David Myles, and emphasises the lack of parental guidance available to him. This is stated in the words attributed to him just prior to his execution:

> *I got a very ill Example from my Parents; Therefore I desire all you that are Parents to give a good Copy to your Children and desire that you would all pray to GOD for me; Where-upon the Auditors cryed out, Lord have Mercy upon his Soul; And Mr. Heart Prayed to this purpose, viz. That God would give him a sight of his Sins, and open a Door of Mercy to him and that the infinit Goodness might speedily pre-vent him.*[27]

Yet the repentance was not allowed for David's sister, Margaret, who 'dyed very obduredly and Obstinately, and gave little or no satisfaction to the Spectators'.[28] The execution of David Myles is used to show the growing theme of repentance through execution, and how through sin, a life could be seen as no longer viable in 'godly society'.[29] Despite his repentant words, in the eyes of the biblical and natural law of the time, David had interpreted that only by dying a Christian death, assured by a representative of the church, Mr Heart, would he be absolved of sin.[30] David Myles went to his execution weeping and asking for forgiveness for his sins, 'and tho' his Body suffered upon the Gibbet, yet he hoped his soul would go to Glory, &c. Then he went up the Ladder, and weeping sore, entreated the Spectators to take warning by him, and avoid Sin, left they fall in the same snare.'[31]

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[24] B. Levack, "The Prosecution of Sexual Crimes," 174.
[25] See Surgeons' Hall Museum collection record: GC.15308 at https://museum.rcsed.ac.uk/the-collection/search-the-museum-collections-adlib
[26] See: "THE LAST Words and Confession of DAVID MYLES": https://digital.nls.uk/broadsides/view/?id=16311andtranscript=1
[27] B. Levack, "The Prosecution of Sexual Crimes," 174.
[28] See: "THE LAST Words and Confession of DAVID MYLES": 1
[29] B. Levack, "The Prosecution of Sexual Crimes," 174.
[30] Mr James Heart received the confession of David Myles at the gibbet and recommended him to God after death, see: "THE LAST Words and Confession of DAVID MYLES"
[31] See: "THE LAST Words and Confession of DAVID MYLES":

Yet, the account of the Incorporation of Surgeon Apothecaries, unwittingly, shows less dignity behind the execution of David – with tickets for sale, guards for the body, and weights to quicken death by stopping strangulation.[32] At David's execution, there were:

> *men for carrying David Mylles corps … sealing wax for tickets … two sentinels [sentry for criminal trials] for 6 days attendance … weights for weighing the body … carrying the body from the Gibbet [gallows] to [th]e church*[33]

Thus, when viewing the theme of repentance through execution, it should be remembered that profit was made, and pain, terror and loss was still felt. These accounts show that finance was raised from the execution, and that protection was needed for the body of David Myles. Furthermore, it shows that the 'hanging drop', in which the length of rope and weight of body were increased, was to be used.[34] Bryant argues that the hanging drop was not developed to ease the suffering of those executed, but rather to minimise the time involved in controlling an often drunk and rowdy audience, which could spend 'upward of half an hour' watching the executed strangle to death on the gibbet. Bryant also argues that middle-class sensibilities were becoming more humanistic towards criminal justice, and that attendance at public executions was no longer socially acceptable.[35] Therefore, the penitent account of the execution of David Myles should be viewed as a contrivance, possibly motivated towards new sensibilities of readers or in support of the judicial violence that helped maximise sales.[36] However, in death, a more precise account of what happened to David Myles exists, and this shows how the medical profession benefitted from this execution.

In Edinburgh, the anatomy theatre of the Incorporation of Surgeon Apothecaries, which became the Royal College of Surgeons of Edinburgh, was built for public dissections and completed in 1697.[37] The new teaching programme of the Surgeon-Apothecaries shared duties 'amongst themselves in a strikingly collaborative fashion',[38] which sometimes meant 30 or more medics in active participation. In 1702, in the new hall, an eight-day dissection[39] was carried out on the body of David Myles. The dissection of David shows how lengthy the process

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[32] C.D. Bryant, *Handbook of Death and Dying* (Thousand Oaks: SAGE, 2003), 358.
[33] https://rcsedlibraryandarchive.wordpress.com/2016/08/31/rcsed-archive-catalogue/
[34] C.D. Bryant, *Handbook of Death and Dying*, 358.
[35] C.D. Bryant, *Handbook of Death and Dying*, 358.
[36] See: "THE LAST Words and Confession of DAVID MYLES": 1
[37] D. Kemp and S. Barnes, *Surgeons' Hall Museum: A museum anthology* (Edinburgh: The Royal College of Surgeons of Edinburgh, 2009), 29.
[38] A. Cunningham, *The Anatomist Anatomis'd: An Experimental Discipline in Enlightenment Europe* (Farnham: Ashgate Publishing, 2010), 121.
[39] A. Cunningham, *The Anatomist Anatomis'd*, 121–2.

could be, especially during winter months, where the natural cold would slow down deterioration. In summer months, dissections could take place over shorter numbers of days.[40] David Myles' dissection is documented in the College minutes and involved dissection of the body and demonstration of its anatomy. Whether performed in public or private, the bodies of those taken for dissection would undergo a similar procedure.[41] The body would be opened, and dissection would begin with the organs at greatest risk of deterioration. The account of the dissection of David Myles shows the theme of dissection and surgeon for each day:

> *Day 1: Anatomy in general, dissection and demonstration of the common teguments and muscles of the abdomen (James Hamilton – current deacon)*
>
> *Day 2: The peritoneum, omentum, stomach, intestines, mesentry and pancreas (John Ballie)*
>
> *Day 3: Liver, spleen Kidneys, ureters, bladder and parts of generation (Alexander Monteith)*
>
> *Day 4: Brain and its membranes with discourse of the animal spirits (David Fyfe)*
>
> *Day 5: Muscles of the extremities (Hugh Paterson)*
>
> *Day 6: Skeleton in general, with the head (Robert Clerk)*
>
> *Day 7: The articulation of the skeleton (James Auchinleck)*
>
> *Day 8: Epilogue (Archibald Pitcairne)*[42]

[40] W. Brockbank, "Old anatomical theatres and what took place therein," *Medical History*, 12 no.4 (1968), 376.
[41] But faster and even more destructive processes could be used to avoid discovery of illegal activity in relation to dissection. This is shown by the flaying of the body of a female who had been illegally taken from her grave by the students of Vesalius. See: H. Marchitello, *Narrative and Meaning in Early Modern England: Browne's Skull and Other Histories* (Cambridge: Cambridge University Press, 1997), 31. Also, the decision of anatomist Robert Knox to perform the dissection of James Wilson, known as 'Daft Jamie', with the cadaver face down as an attempt to distract from those in the dissection room who claimed to recognise him from the local streets of Edinburgh, and as a way of destroying evidence that could identify Jamie as the victim of anatomy murderers Burke and Hare; see L. Rosner, 190.
[42] D. Kemp and S. Barnes, *Surgeons' Hall Museum: A museum anthology* (Edinburgh: The Royal College of Surgeons of Edinburgh, 2009), 29.

Initially, the process of public dissection had to be educative and was viewed as a 'rigid academic ceremony',[43] with a self-selecting audience whose members attended to learn. However, towards the end of the fifteenth century, the dissecting theatre had become 'an extravagant spectacle attracting a broad audience'.[44] During the period discussed, both public and private dissections took place, meaning some were purely for medical audiences, while others took place as public events, including carnivals.[45] Artists could be positioned in several locations to create illustrations. Some had reserved seats in dissecting theatres, where they observed and sketched.[46] Drawing would often take place in the dissecting room in direct collaboration with anatomists, with bodies kept open by use of hooks and ropes. Bodies could also be taken to 'artist studios'[47] that sometimes existed within surgical colleges. Here, bodies were often pulled apart during further studies, pinned to reveal sections for illustrations or positioned using pulleys and ropes to gain better vantage points to record dissections.

Hence, what started as a closed, academic study grew to be an interdisciplinary and, sometimes, public spectacle. In terms of dignity, this offered little respect for the deceased and was possibly also an attempt to normalise a brutal, punitive practice. After the dissection of David, a vote was held to ascertain satisfaction with the standards of dissection, for this Bennett draws on the contemporary term 'cut to the extremities'.[48] Hurren explains this term more fully:

> *A dissected body of a criminal corpse or person whose body has been resurrected and/ or stolen from a graveyard in the 18th Century for the purposes of medical education and /or research. Little will be left for burial, less than one third of the original corpse. Remaining flesh and bones sewn together with a large surgical needle then wrapped in a woollen shroud used as a winding-sheet and buried in a common grave, normally no less than six deep. Lime thrown on each bodies to accelerate decomposition. No visible sign of burial above ground-level; social death.*[49]

[43] A. Carlino, *Books of the Body: Anatomical Ritual and Renaissance Learning* (Chicago: University of Chicago Press, 1999), 3.
[44] M. Stapelberg, *Through the Darkness: Glimpses into the History of Western Medicine* (Crux Publishing, 2016), 144.
[45] M. Stapelberg, *Through the* Darkness, 147.
[46] W. Brockbank, "Old anatomical theatres".
[47] S. Sawday, *The Body Emblazoned*, 54.
[48] R.E. Bennett, *Capital Punishment and the Criminal Corpse in Scotland, 1740–1834* (London: Springer, 2017).
[49] E.T. Hurren, *Dissecting the Criminal Corpse: Staging Post-Execution Punishment in Early Modern England* (Basingstoke: Palgrave Macmillan, 2016), 151.

After this process, the skeleton of David Myles was not buried, but documented as taken into the collections of Surgeons' Hall Museum, the Royal College of Surgeons of Edinburgh. The modern narrative around the life and death of David Myles demonstrates the complications of 'owning' a body and claiming the narrative of a person abused. For Surgeons' Hall Museum, this history has placed the institution in a situation where it is responsible for the remains of a person who was historically betrayed by it.

For modern medical museums, this highlights how several areas need to be negotiated if housing and displaying human remains. Primarily, there is a duty of care for the storage, preservation and dignity of medical human remains. This has proved a difficult point for Surgeons' Hall, as in their own records, the identification of the remains of David Myles are inconclusive.[51] Furthermore, through the modern use of the story of David Myles, Surgeons' Hall Museum has unintentionally positioned itself as determining the public memory of a young boy, from what would appear to be an abusive household, who died in shame, horror and pain.

Yet, the dramatic, digital interpretation of the dissection of David Myles is currently the first event visitors view as they enter Surgeons' Hall Museum, and is designed to be so.[52] However, when viewing the story of David Myles as an institutional betrayal, Surgeons' Hall Museums has placed itself in a position of vulnerability by displaying and celebrating acts of commission that are now illegal, and abhorrent to the institution's own modern practice. Furthermore, the lack of protection offered to the body of David Myles, and the paucity of dignity offered through the modern museum narrative, could be seen as acts of omission, which leave the institution open to criticism and reputational damage. By continuing an unchallenged narrative

[50] D. Kemp and S. Barnes, *Surgeons' Hall Museum*, 30–31.

[51] Record C.15308: 'BONE, skeleton, young subject in wooden display case. Originally thought to be the cadaver of David Myles who was executed for incest. The body was dissected after execution by Archibald Pitcairn who was Deacon of the College. It is thought to be the first dissection that took place in Old Surgeons' Hall. The cadaver is certainly that of a young person but the physiology of the subject and the size of the bones suggest the body of a person much younger than Myles was ae time of his execution (possibly nineteen). It may be that this is a dissected body of child dissected by Pitcairn but not that of Myles.' This record can be accessed by searching GC.15308 here: https://museum.rcsed.ac.uk/the-collection/search-the-museum-collections-adlib

[52] The beginning of the introduction to this display can be heard here: https://www.bbc.co.uk/sounds/play/p0576kj7

of dissecting and retaining human remains without consent, the Museum is daily showing acts of entitlement that have caused pain and created a loss of trust for many through history, but also in recent times (see Chapter 2). Hence, through the digital dissection of David Myles, once again, tickets for the public to witness his dissection, terror and shame are now back on sale.[53]

1.4 Anatomisation

Anatomisation, the process beyond dissection, brought its own terror. This process is not often mentioned in medical museum narratives, as it can involve graphic procedures that inflicted further 'post-mortem harm'[54] on the human body. Hurren clarifies an important point on penal dissection and challenges assumptions that those sentenced to execution were dead by the time they reached the dissecting room. One example is 'half-hanged MacDonald' or Ewan MacDonald, who was sentenced to death on 28 September 1754, reportedly still alive after execution and killed in the dissecting room.[55] Whether true or not, MacDonald's case gained wide media attention, and Hurren draws on his story to show how the Murder Act 1752 raised questions regarding the 'will of God in death, the efficiency of hanging as execution and the surgeon's role in judicial authority'.[56] More specific evidence shows the conditions of those who were taken from the gallows: 'in medico-legal circles there was a confusing vocabulary in vogue: the *'half-hanged, 'dead-alive', in the name of death, truly dead or pained, 'death, the uncertain, certainty'* and so on'.[57]

Anatomisation experiments on the body were further disturbing processes that could be carried out in private or public. William Clift, Conservator of the Hunterian Museum, the Royal College of Surgeons of England, from 1830–32, would perform tests to show proof of the executed criminal's death.[58] As part of these experiments, MacDonald shows that a private test was carried out on the body of Martin Hogan, involving an attempt to stimulate the iris with a needle. This experiment, recorded in the College minutes of 1814, shows that Clift was tasked 'to thrust a needle into each eye' of the cadaver 'to see if that produced an effect'.[59] This part of the anatomisation went beyond the technical investigation of the dissecting room and was

[53] Tickets are currently priced at £8/£4.50 concession, see: https://museum.rcsed.ac.uk/plan-your-visit/opening-hours-and-admission, accessed August 13, 2020.
[54] E.T. Hurren, *Dissecting the Criminal* Corpse, 151.
[55] E.T. Hurren, *Dissecting the Criminal Corpse*, 4.
[56] E.T. Hurren, *Dissecting the Criminal Corpse*, 5.
[57] E.T. Hurren, *Dissecting the Criminal Corpse*, 7.
[58] H.P. MacDonald, *Human Remains: Dissection and Its Histories* (New Haven: Yale University Press, 2016), 14.
[59] H.P. MacDonald, *Human Remains*, 14–15.

'so violently crude that William Clift clearly found the work distressing'.[60] The fascination with reanimation or stimulation of movement after death produced some of the most flamboyant disregards for human dignity. Records on Professor Giovanni Aldini's experiments, based on *galvanism*, or the use of electricity to convulse the muscles by use of galvanic battery,[61] show a recognised and distressing technique of experiment.[62] MacDonald links these experiments, seen as part investigation and part showmanship, as displaying attitudes that contributed to the perception that anatomists were 'playing at being god' by making 'the dead perform tricks'.[63] Yet, returning to private dissecting rooms, behaviour could be disrespectful in further ways, as numerous reports through diaries and letters detail brawling with body parts, the abuse and mistreatment of female bodies, drinking and indecent language.[64] The abuse that was inflicted on Mary Patterson highlights the dangers for women and the predatory behaviour that could be present in the anatomy room.

1.5 The betrayal of Mary Patterson

Mary Patterson was a young woman from Edinburgh and was one of the, at least, 16 victims of the anatomy murderers William Burke and William Hare, in what became known as the 'West Port murders' of 1828. In April 1828, Mary Patterson was murdered and then taken to the dissecting room of Anatomist Robert Knox, Fellow of the Royal College of Surgeons, at Surgeons' Square, Edinburgh. Her body was received by the assistants of Robert Knox. Here, members of the Edinburgh medical establishment committed and colluded in a series of betrayals against the body and character of Mary Patterson. Due to the purpose of killing to sell bodies to medical research, this form of abuse became known as *anatomy murder*; it happened across Europe and America and included the similarly high-profile case of the 'Italian Boy' murder in London 1831.[65] Anatomists created this market for anatomy murder, through paying high prices[66] for illegal bodies.[67] After this anatomy murder, the members of

[60] H.P. MacDonald, *Human Remains*, 14.
[61] R.E. Bennett, "A Fate Worse than Death?" 175.
[62] Perhaps the most famous comment on, and against, galvanisms comes from Mary Shelley's *Frankenstein*. A wider discussion of Shelley and galvanism is provided by Anne K. Mellor, *Mary Shelley: Her Life, Her Fiction, Her Monsters* (London: Routledge, 2012), 99–100.
[63] H.P. MacDonald, *Human Remains*, 12.
[64] H.P. MacDonald, *Human Remains*, 33.
[65] S. Wise, *The Italian Boy: Murder and Grave-robbery in 1830s London* (London: Pimlico, 2005), 144–5.
[66] Burke and Hare recorded that they were paid between £7, 10 shillings and £10 for 14 bodies; see 'The "Merchandise" of Burke and Hare' in R.M. Gordon, (2009), *The Infamous Burke and Hare: Serial Killers and Resurrectionists of Nineteenth Century Edinburgh* (Jefferson: McFarland & Co., 2009), 16.
[67] Owen Dudley Edwards estimates the navvy's wages earned by Burke and Hare would have been around half acrown (two shillings and sixpence): O.D. Edwards, *Burke and Hare* (Edinburgh: Birlinn, 2014), 28.

the medical profession exploited Mary Patterson. Rosner's research on her life and death demonstrates how Mary, as a woman in poverty, was targeted for medical research, and practices than went far beyond these purposes.

In the few years before Mary Patterson's death, Rosner traces her to Edinburgh's Magdalene Asylum, a cross between refuge and reform school where she was resident from c.16–18 years old, after losing her job with the engraver Mr Deuchar, possibly Mr Alexander Deuchar of 57 North Bridge.[68] Mary's release date from the Magdalene Asylum, was 7 April 1828, which was 'one day to one week' before her murder.[69] On the morning of her death, William Burke had met Mary and her friend Janet Brown in a local spirit dealers, where he could have been coincidentally, or actively stalking potential victims.[70] The two women were invited back to the home of Constantine Burke, brother of William, where they had more alcohol. Janet left for 15 minutes, and while William Burke and his wife quarrelled over the presence of the two women in the house, Mary had gone to sleep or passed out.[71] When Janet tried to find her way back to Mary, she struggled with direction.[72] In the time that passed, Mary was murdered through choking and suffocation 'by covering her mouth and nose, and compressing her throat.'[73] Not more than four hours later, she was delivered to Robert Knox for dissection.[74] The assistants of Knox raised concerns about the freshness and provenance of the body. Mary was recognisable as a local attractive young woman with deep red hair; Knox's reaction was to give Burke scissors to cut off Mary's hair. [75]

The betrayal of Mary did not end here; what happened next was a process of further sexualisation, and objectification. Dissection did not take place at this point. Instead, Robert Knox invited artists to draw Mary Patterson, to 'look at her, she was so handsome a figure, and well shaped in body and limbs'; other students attended, sketched and kept their drawings.[76] The biographer of Knox, Henry Lonsdale, wrote of the occasion:

[68] R. Rosner, *The Anatomy Murders: Being the True and Spectacular History of Edinburgh's Notorious Burke and Hare* (Philadelphia: University of Pennsylvania Press, 2011), 116.
[69] R. Rosner, *The Anatomy Murders*,120.
[70] R. Rosner, *The Anatomy Murders*, 102.
[71] R. Rosner, *The Anatomy Murders*, 101.
[72] R. Rosner, *The Anatomy Murders*, 103.
[73] See https: Broadside Account of the Trial and Sentence of William Burke: https://digital.nls.uk/broadsides/view/?id=15219andtranscript=1
[74] R. Richardson, *Death, Dissection and the Destitute* (London: Penguin, 1987), 135.
[75] R. Rosner, *The Anatomy Murders*, 105.
[76] R. Rosner, *The Anatomy Murders*, 122.

> *The body of the girl Paterson could not fail to attract attention by its voluptuous form and beauty, students crowded around the table on which she lay, and artists came to study a model worthy of Phidias and the best Greek art.*[77]

Knox treated the body of Mary as a 'prized possession' and kept her body preserved in whisky for three months.[78] Furthermore, through the press, unsubstantiated speculation circulated that Mary had been involved in prostitution at the time of her death. This narrative originated from a fictionalised story that she had been recognised on the dissecting table by a student who had solicited her for sex. However, Rosner argues that Mary was more likely to have been recognised from the teaching ward of the Royal Infirmary, where the same students worked and where she was a patient.[79] Through these actions and narratives, Mary Patterson's life was ended, and she was not allowed to rest in peace. Although her friends informed the police and refused to stop looking for her, no action was taken. The remains of Mary's body have never been found.

Instead of being the case that brought down Burke, Hare and the anatomists involved, the story of Mary became a cautionary tale to women, a salacious press story.[80] The police did not pursue justice for Mary Patterson, and Robert Knox and his assistants did not stop receiving bodies or raise their concerns. This meant that others were murdered for anatomy and that Burke and Hare remained at large for about six months more. The murder of Mary Patterson occurred around April 1828, and Burke and Hare are thought to have committed their final anatomy murder on 31 October 1828.[81] On 25 December 1828, William Burke was convicted of murder, executed and 'given for Dis-section on 28th January 1929'.[82] Robert Knox was not put on trial for illegally receiving murder victims for dissection. However, an investigation by his peers at the Royal College of Surgeons of Edinburgh found him not guilty.[83] Many residents of

[77] H. Lonsdale, *A Sketch of the Life and Writings of Robert Knox, the Anatomist* (London: Macmillan and Company, 1870).
[78] R. Rosner, *The Anatomy Murders*, 123.
[79] R. Rosner, *The Anatomy Murders*, 105.
[80] C. McCracken-Flesher, *The Doctor Dissected: A Cultural Autopsy of the Burke and Hare Murders* (Oxford: Oxford University Press, 2012), 83.
[81] A. Knight, *Burke and Hare* (London: The National Archives, 2007), 37–39.
[82] See https: Broadside Account of the Trial and Sentence of William Burke: https://digital.nls.uk/broadsides/view/?id=15219andtranscript=1
[83] For the committee report see: H. Lonsdale, *A Sketch of the Life and Writings of Robert Knox, the Anatomist* (London: Macmillan and Company, 1870), 85–88.

Edinburgh did not agree with the decision, and rioted outside his house in Newington, Edinburgh.[84] Robert Knox resigned from the Royal College of Surgeons in 1831.[85]

The culpability of Robert Knox in the West Port murders was something that still divided opinions when I first began to work for Surgeons' Hall Museum in 2009, and this will possibly always be the case. Within the museum, the narratives of Mary Patterson and Robert Knox remain connected, and in my first few years, the false narrative on Mary Patterson was still mentioned in tours of the building. However, this was something we could change. During the initiation of the public engagement programme, and with the help of museum volunteers who assisted in the programme, many of whom were also Fellows of the Royal College of Surgeons, we agreed to remove the false narrative on Mary Patterson from the tour. Furthermore, on 19 April 2015, we held an event, *The Inquest*, as part of the Edinburgh International Science Festival programme,[86] where attendees could hear the full story of Robert Knox, view associated medical texts and medical models, speak to experts in surgery, medical history and forensics and vote on whether they agreed with the acquittal. Ninety-eight per cent of 134 visitors disagreed with the acquittal and believed Knox was guilty.

Yet, the narrative of Mary Patterson still persisted through Edinburgh 'ghost walks', webpages, including Wikipedia, and rose again in popular culture with the 2010 film *Burke & Hare*.[87] Later, in 2015, the story of Mary Patterson was to become a strong theme in an outreach programme with the NHS project Willow, which is for women leaving the criminal justice system, and some who had also been coerced and forced into the sex industry.[88] Here, we needed great care to work with this subject, as the women in the group had often suffered severe forms of violence and sexual violence both domestically and as a consequence of the sex industry. The women wanted to discuss and challenge this narrative, as it reminded them of not only how they had been treated but also of how the female victims of the 2006 Ipswich murders had been treated. Here, we recalled the sentiment expressed by Canon Graham Hedger, who accused the police of not taking the serial murder of five women seriously because they had been in the sex industry.[89] As part of our creative activities, we paid tribute to Mary Patterson.[90]

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[84] H. Lonsdale, *A Sketch of the Life and Writings of Robert* Knox, 79–80.
[85] S.J.M.N. Alberti, *Morbid Curiosities: Medical Museums in Nineteenth-Century Britain* (Oxford: Oxford University Press, 2011), 83.
[86] For events listing of *The Inquest*, see: https://museum.rcsed.ac.uk/news-and-events/events?year=2015andmonth=4
[87] See: https://www.imdb.com/title/tt1320239/
[88] For the project details see: https://services.nhslothian.scot/willow/Pages/default.aspx
[89] H. Kinnell, *Violence and Sex Work in Britain* (London: Routledge, 2013), 242.
[90] See Project Venus: https://goddessgallery.co.uk/our_projects/willow/

However, we also targeted the Wikipedia entry on Mary Patterson, whose authors had applied the term 'prostitute' to her name. As part of our reclaiming of Mary Patterson's story, each day, one of us would go into the page, and write in capital letters 'THERE IS NO EVIDENCETHAT MARY PATTERSON WAS A PROSTITUTE, SEE LISA ROSNER, THE ANATOMY MURDERS, P116–17'. For six months, every day, the authors of the Wikipedia page would delete our text, until, one day, they took this false story of Mary Patterson away, and used our reference to highlight the false story in contemporary accounts.[91] This activity brought empowerment to the group, but it also demonstrated that Surgeons' Hall Museum was not going to repeat or continue the betrayal of Mary Patterson. This activity helped to create a division between historical abuse and modern practice, which meant that we gained the groups' trust. Furthermore, Willow contributed feedback that was used in the £4.2 million redevelopment *Lister Project* (see Chapter 3) and, therefore, gave their support to the museum.

1.6 Anthropological concerns

A further concern of dissection and anatomisation was the denial of anthropological rites such as funerary practices and burial. Carlino argues 'it was not impossible to consider the cutting open of a cadaver as an anthropologically innocuous deed or to think of a delayed burial as religiously irrelevant'.[92] The legal requirements of the dissection and anatomisation process included provision of Christian burial. However, as shown, bodies were often decimated during dissection, buried piecemeal in unmarked graves or displayed in museums. Anthropological concerns can relate to the indignity of public dissection, but also to the lack of proper burial.[93] MacLaren argues that the Seal of Cause 1505[94] was granted in Scotland despite 'very strong religious, cultural and social prejudices against dissection of the human body'.[95] Yet, the sources for this assertion are not clear. In current scholarship, religious fears relating to dissection are often linked directly to a literal interpretation of Christian scripture, which

[91] See the Wikipedia entry for Burke and Hare murders here: https://en.wikipedia.org/wiki/Burke_and_Hare_murders#cite_note-FOOTNOTERosner2010116%E2%80%9317-54
[92] A. Carlino, *Books of the Body*, 7.
[93] D.L. Peck and D. Clifton, *Encyclopedia of Death and Human Experience* (Thousand Oaks: SAGE, 2009), 876.
[94] The Seal of Cause was a 'charter of privileges' that gave exclusive rights to perform surgery to the institution that is now known as the Royal College of Surgeons of Edinburgh. See here for timeline: https://www.rcsed.ac.uk/the-college/about-us/history-and-vision
[95] I. MacLaren, "A Brief History of the Royal College of Surgeons of Edinburgh," *Res Medica*, 268 no. 2 (2005), 55.

'anticipated the resurrection of the soul within an intact body'.[96] The Catholic church had allowed dissection for the study and teaching of anatomy from the twelfth century, and had 'played a critical role in appeasing the people's social and religious consciences' in relation to this use of the cadaver.[97]

The practice of graverobbing, often referred to as resurrection, differed slightly from other forms of procuring bodies for dissection, and targeted the class of people who had the financial resources to afford burial. This process involved removing the dead from their graves, illicitly, often at night. In Edinburgh, graverobbing was an organised procedure that involved anatomists and surgeons; those involved in this practice were known as 'resurrectionists':

> *The resurrectionists in Edinburgh were split into two groups lead by Doctors Monroe and Barclay, the two prominent anatomists at the time. Each team was careful to only rob graves that were deemed a part of their respective 'territories'. However, Liston failed to abide by these unspoken rules, creating conflict between the two parties [9]. As a result, obtaining bodies depended largely on the resurrectionists' ability to strategize and not to just brute force.*[98]

This practice assisted in forcing the Anatomy Act 1832,[99] which increased the amount of bodies available for dissection.[100] However, this act also 'shifted the main source of bodies for anatomical dissection from executed convicts to the unclaimed poor',[101] with workhouses providing most of the supplies.[102] As dissection and anatomisation had become associated with punitive justice, Searle argues that this law was viewed by many as a 'deplorable piece of class regulation', which criminalised the poor to protect those of higher social status.[103]

Taking the dead for medical research seemed to be common practice and often not well hidden. In addition to graverobbing, others could be taken before they reached a resting place. Possibly, one of the best known or visually striking examples of how this was recorded is by Dutch

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[96] J. Duffin, (1999*) History of Medicine: A Scandalously Short Introduction* (Toronto: University of Toronto Press, 1999), 18.
[97] S.K. Ghosh, "Human cadaveric dissection," 158.
[98] A. Mian, M.M. Shoja, K. Watanabe et al., "Robert Liston (1794–1847): Surgical anatomist and resurrectionist with an interest in hydrocephalus," *Childs Nerv Syst*, 29 nos.1–4 (2013). https://doi.org/10.1007/s00381-012-1994-3
[99] See Anatomy and dissection laws, Chapter One
[100] P.D. Mitchell, C. Boston, A.T. Chamberlain, S. Chaplin, V. Chauhan, J. Evans, L. Fowler, N. Powers, D. Walker, H. Webb and A. Witkin, "The study of anatomy in England from 1700 to the early 20th century," *Journal of Anatomy*, 219 (2011), 92. doi: 10.1111/j.1469-7580.2011.01381.x
[101] D. Kemp, ane condampnit man efter he be deid, 44.
[102] R. Richardson, *Death, Dissection, and the Destitute* (London: Routledge and Kegan Paul, 1987), 271.
[103] G.R. Searle, *Morality and the Market in Victorian Britain* (Oxford: Oxford University Press, 1998) 73.

anatomist Fredrik Ruysch. Ruysch used his position as Instructor to the City's Midwives and Forensic Advisor to the Amsterdam Courts to procure female bodies, foetal remains and the bodies of young children.[104] How Ruysch preserved and displayed foetal human remains can be seen in perhaps his best-known work, *Opera omnia anatomico-medico-chirurgica*. The works of Ruysch show how he used and posed foetal skeletons to create tableaux.[105] Those taken by Ruysch remain anonymous. However, Scottish surgeon Willian Hunter recorded some of the names he took for dissection via his private practice, including maternity wards for his research and publications including *The Gravid Uterus*, an influential study on pregnancy.[106] Yet, most of his sources remain unnamed.[107] Perhaps one of the best-known cases of theft of a body for dissection, which currently still causes controversy, was committed by John Hunter, anatomist and brother of William. In 1783, John Hunter stalked and bribed his way to obtaining the body of Charles Byrne, known as 'the Irish Giant'. Byrne was targeted due to pathological difference caused by a rare medical condition.

1.7 The betrayal of Charles Byrne

Charles Byrne, born in County Londonderry in 1761,[108] was known as 'the Irish Giant' due to his height of 7'7" (2.31m).[109] The skeleton of Charles shows evidence that he lived with the condition of *pituitary giantism*, which 'is caused by over-production of growth hormone from the pituitary gland in the base of the skull'.[110] The modern medical definition of this condition shows:

> *In addition to the accelerated linear growth, patients with pituitary gigantism may slowly develop many of those features seen in adults with acromegaly – for*

[104] F.F.A. Ijpma, A. Radziun and T.M. van Gulik, "The anatomy lesson of Dr. Frederik Ruysch' of 1683, a milestone in knowledge about obstetrics," *European Journal of Obstetrics and Gynecology and Reproductive Biology*, 170 no. 1 (2013), 50–55. https://doi.org/10.1016/j.ejogrb.2013.05.028.
[105] For image foetal tableaux from Frederik Ruysch (1638–1731), see: F. Ruysch, *Opera omnia anatomico-medico-chirurgica, hucusque edita* / [Frederick Ruysch]. Amsterdam: Jansson-Waesberge, 1737[-1744]. Tab. 1 of *Thesaurus anatomicus octavus* 1727, can be seen here: https://wellcomecollection.org/works/qxyhczyw
[106] https://wellcomecollection.org/works/pg6qnqwa
[107] M. Campbell, E. Hancock and N. Pearce, *William Hunter's World: The Art and Science of Eighteenth-Century Collecting* (Farnham: Ashgate Publishing, 2015), 46–47.
[108] L. Doyal and T. Muinzer, "Should the skeleton of "the Irish giant" be buried at sea?" *BMJ* 343 (2011), d7597.
[109] See the Royal College of Surgeons' catalogue entry and photographs of the remains of Charles Byrne: RCSHC/Osteo. 223 – Skeleton, gigantism, Acromegaly, Pituitary Neoplasms, General Osteology of Man: http://surgicat.rcseng.ac.uk/Details/collect/4123
[110] See the Royal College of Surgeons' catalogue entry and photographs of the remains of Charles Byrne: RCSHC/Osteo. 223 – Skeleton, gigantism, Acromegaly, Pituitary Neoplasms, General Osteology of Man: http://surgicat.rcseng.ac.uk/Details/collect/4123

> *example, soft tissue over growth, progressive dental malocclusion (underbite), a low pitched voice, headaches, malodorous hyperhidrosis, oily skin, proximal muscle weakness, diabetes mellitus, hypertension, obstructive sleep apnea, and cardiac dysfunction.*[111]

Due to his height and gentle nature, Charles became a local then national celebrity as he toured to Scotland and through England as a natural curiosity to the crowds that would come to see him. Evidence of the life of Charles exists through various sources, including the work of art and biographical sketches of caricaturist John Kay,[112] and, more infamously, the public display of his skeleton at the Hunterian Museum, the Royal College of Surgeons of England.[113] The celebratory aspects of the life of Charles should not overshadow the difficulties of his life or the exploitation that was present in self-exhibiting. Through accounts of the time, there is evidence of Charles being unwell and finding life difficult. By the time he was in London he was drinking heavily,[114] possibly to self-manage his undiagnosed condition, which may have included tuberculosis.[115] In addition, de Herder argues Charles' drinking may have increased as a coping mechanism to deal with the theft of his £700 savings, the sum total of his wealth.[116] When Charles came to London in 1780 he was 21.[117] Due to his height and pathology, Charles attracted the attention of anatomists, including John Hunter, and 'lived in terror' of dissection and anatomisation after death.[118] Due to this fear, Charles expressed a wish to be buried at sea;[119] having been a performer in life, he expressed a wish for peace and privacy in death.[120] However, Hunter did not accept these personal wishes and legal rights, and initiated agents to

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[111] F.W. Young, *Netter Collection of Medical Illustrations: Endocrine System E-book: Volume 2* (Berlin: Elsevier Health Sciences, 2011), 21.
[112] Seven sketches of Charles Byrne by John Kay are held by the British Museum. Byrne is the central figure in each sketch and can be identified as the tallest person in each sketch: https://www.britishmuseum.org/collection/term/BIOG131540 Also, Kay's biographical portrait of Charles can be seen here: J. Kay, *A Series of Original Portraits and Caricature Etchings: With Biographical Sketches and Illustrative Anecdotes, Volume 1* (London: A. and C. Black, 1877), 10–11.
[113] See the Royal College of Surgeons' catalogue entry and photographs of the remains of Charles Byrne: RCSHC/Osteo. 223 – Skeleton, gigantism, Acromegaly, Pituitary Neoplasms, General Osteology of Man: http://surgicat.rcseng.ac.uk/Details/collect/4123
[114] J. Kay, *A Series of Original Portraits and Caricature Etchings: With Biographical Sketches and Illustrative Anecdotes, Volume 1* (London: A. and C. Black, 1877), 10–11.
[115] W.W. de Herder, "Acromegalic gigantism, physicians and body snatching. Past or present?" *Pituitary*, 15 (2012), 313. https://doi.org/10.1007/s11102-012-0389-5
[116] W.W. de Herder, "Acromegalic gigantism, physicians and body snatching. Past or present?", 313.
[117] L. Doyal and T. Muinzer, "Should the skeleton of "the Irish giant" be buried at sea?"
[118] A. Gasperini, *Nineteenth Century Popular Fiction, Medicine and Anatomy: The Victorian Penny Blood and the 1832 Anatomy Act* (Cham: Palgrave Macmillan, 2019), 50.
[119] A. Gasperini, *Nineteenth Century Popular Fiction, Medicine and Anatomy*, 50.
[120] D. Challis, *The Archaeology of Race: The Eugenic Ideas of Francis Galton and Flinders Petrie* (London: Bloomsbury Academic, 2013).

stalk him in the hope of stealing his body when he died.[121] Due to Hunter's agents, Charles began to 'fear for his soul in the afterlife'.[122] His fears were realised when, on his death, aged 22,[123] a member of the funeral party was bribed for £500[124] to give the body over to Hunter. Unknown to the friends of Charles, a coffin weighted with stones was buried at sea. A contemporary report from *The Dublin University Magazine*, shows how the final wishes of Charles Byrne were subverted by John Hunter:

> *Yesterday morning, June 6, the body of Byrne, the famous Irish giant (who died a few days ago), was carried to Margate, in order to be thrown into the sea, agreeable to his own request, he having been apprehensive that the surgeons would anatomize him.*
>
> *It is to be presumed that this fancy as to the disposal of his body was in some way obviated, as his skeleton is said to be now in the Hunterian Museum, Royal College of Surgeons, London.*[125]

The disrespect shown for the last wishes of Charles Byrne, and the intimidation and fear produced by John Hunter's stalking of him, are disturbing. Furthermore, the medical profession's objectification of a person living with disability and chronic health formed an ableist 'worth' being ascribed to Charles Byrne, as shown by the closing comments from *The Dublin University Magazine*:

> *From all these statements we may collect that giants are not of much practical use in the working world, except to be exhibited as objects of curiosity or scientific inquiry. They are neither long-lived, numerous, prolific, nor savage; and the social system is not likely to be disturbed or unhinged by their occasional appearance.*[126]

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[121] S.S. Hall, *Size Matters: How Height Affects the Health, Happiness, and Success of Boys – and the Men They Become* (Boston: Houghton Mifflin Harcourt, 2006).
[122] See Warwick University and Wellcome Trust Project The Irish Giant: https://warwick.ac.uk/fac/arts/history/chm/outreach/irish_giant/thestory/
[123] W.W. de Herder, "Acromegalic gigantism, physicians and body snatching. Past or present, 313.
[124] Which would have equalled £50,00 in 2011; see Warwick University and Wellcome Trust Project The Irish Giant: https://warwick.ac.uk/fac/arts/history/chm/outreach/irish_giant/thestory/
[125] J. Kay, *A Series of Original Portraits and Caricature Etchings: With Biographical Sketches and Illustrative Anecdotes, Volume 1* (London: A. and C. Black, 1877), 10.
[126] *The Dublin University Magazine*, 66, William Curry, Jun., and Company, 1865, 205.

Hunter prepared the body of Charles quickly 'possibly out of fear of revenge, and immediately boiled Byrne's body down to the skeleton'. However, this act is later referenced positively in Jackson's portrait of Hunter, in which the legs of Charles Byrne are used in the background to celebrate medical achievement.[127] Hunter hid the skeleton of Charles for four years before it became a key feature of his museum, generating badly needed funds.[128] The skeleton of Charles Byrne remained on display at the Hunterian Museum, London, until its closure for redevelopment in 2017. The digital record of Charles Byrne remains online as 'object number' RCSHC/Osteo. 223,[129] and the retention of his remains continues to cause controversy.

Here, through the historical actions of its anatomists, the Hunterian Museum finds itself in a similar position to Surgeons' Hall Museum and their inherited institutional betrayal of David Myles. However, here, a victim of resurrection is displayed and named as a prized exhibit. This leaves the Royal College of Surgeons of England vulnerable to criticism and forces a defence of a practice that is now legally and ethically prohibited by the Human Tissue Act 2004 (see Chapter 2).

The story of Charles began to resurface in 2011 when Doyal and Muinzer opened a discussion on 'Should the skeleton of 'the Irish giant' be buried at sea?', which was published as a feature in the *British Medical Journal*.[130] From the perspective of medical ethics and law, Doyal and Muinzer argue unequivocally that Charles Byrne should be buried at sea, as per his last wishes. In 2017, when the story gained press attention, Muinzer was interviewed in print and for podcast.[131] Here, Muinzer argued 'the fundamental point is – with our burial instructions, what we rely on is people to respect them morally. The instructions have moral force.' The press, when covering this story, contacted the Hunterian Museum for its views. This press attention forced a statement of defence of Hunter's actions, and their subsequent decisions regarding this display, from the Royal College of Surgeons of London:

[127] John Jackson's portrait of John Hunter shows the dissected legs of Charles Byrne in the background, see: F. Haslam, *From Hogarth to Rowlandson: Medicine in Art in Eighteenth-century Britain* (Liverpool: Liverpool University Press, 1996) 285. For image, see: https://www.npg.org.uk/collections/search/portrait/mw03322/John-Hunter

[128] L. Doyal and T. Muinzer, "Should the skeleton of "the Irish giant" be buried at sea?", 343.

[129] For the collection record and photos of Charles Byrne held by the Royal College of Surgeons of England, see: http://surgicat.rcseng.ac.uk/Details/collect/4123

[130] L. Doyal and T. Muinzer, "Should the skeleton of "the Irish giant" be buried at sea?", 343.

[131] The podcast of the interview can be heard here: https://www.npr.org/sections/health-shots/2017/03/13/514117230/the-saga-of-the-irish-giants-bones-dismays-medical-ethicists?t=1597828061724

> *The Royal College of Surgeons believes that the value of Charles Byrne's remains, to living and future communities, currently outweighs the benefits of carrying out Byrne's apparent request to dispose of his remains at sea. No will or testament survives – there is no direct evidence of his burial wishes.*[132]

The statement led to criticism as it ignored the many historical references to Charles' fear of dissection and request to be buried at sea. In 2017, the statement was updated with a reference to the historical sources: 'The Royal College of Surgeons believes that the value of Charles Byrne's remains, to living and future communities, currently outweighs the benefits of carrying out Byrne's apparent request to dispose of his remains at sea.'[133]

As mentioned above, it is not the aim of this study to analyse the merits of these polarised arguments. However, the somewhat circular defence of the benefits of medicine verses the ethical treatment of medical museums is a point that limits progression and indeed a call to courage. Primarily, this form of argument forces those in the discussion to take sides, which could cause inflexibility when deciding whose opinions matter, or could lead to a danger of aligning an individual or institution with disrespectful commentary. An example of this is shown by the journal article 'Should We Display the Dead?'[134] In 2009, this discussion was opened to 'provoke further informed and respectful debate on this important issue in principal and practice',[135] and to move medical museum literature on from being 'dominated by questions of repatriation and reburial'.[136] The intentions were to 'provoke further informed and respectful debate on this important issue', and it was stressed that 'to segregate the interested public from the bona fide scholar is to promote an aura of elitism'.[137] Yet, the public was not included in this discussion. Additionally, the authors included derogatory comments from Professor Thomas Hibbs, whose attack on *Body Worlds* labelled the public as 'ignorant and indifferent citizenry'.[138]

As shown above, this form of argument forces medical institutions to show allegiance to, excuse and arguably celebrate past institutional betrayals. Through public programmes, tours

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[132] The published press statement can be seen here: https://www.thejournal.ie/irish-giant-charles-byrne-museum-3267289-Mar2017/

[133] Again, this statement was published digitally, with no link to the Royal College of Surgeons of London: http://isciencemag.co.uk/features/skeleton-in-the-closet/

[134] S.J.M.M. Alberti et al., "Should we display the dead?" *Museum and Society*, [S.l.], 7 no. 3 (2015), 133–149.

[135] S.J.M.M. Alberti et al., "Should we display the dead?" 144.

[136] S.J.M.M. Alberti et al., "Should we display the dead?" 133.

[137] S.J.M.M. Alberti et al., "Should we display the dead?" 136.

[138] T.W. Hibbs, (2007) "Dead Body Porn: The Grotesqueries of the "Body Worlds" Exhibit," *The New Atlantis*, 15 (Winter) (2015), 128–31.

and the retention and display of the skeleton of William Burke,[139] the University of Edinburgh purposely promotes its links with the West Port murders (see the betrayal of Mary Patterson). The hosting of Burke and Hare themed events is certainly not unique to the University of Edinburgh. Edinburgh tourism regularly capitalises on the story through museum exhibits, ghost tours and themed events. However, this meant, when hoping to engage the public with modern, ethical practice, for some, the boundaries between historical and modern dissection were blurred.

In 2015, the University of Edinburgh designed a project to 'put dissection back in the public spotlight'.[140] The anatomists, who had carefully planned this course, believed that 'by making the 'fabric of nature' available to members of the public for educational purposes, in an environment where dignity and respect for the donors remains paramount, we hope to bring an appreciation and understanding of the human body to a new audience'.[141] Yet, several press and public comments revealed resentment at the perceived disrespect of those who had willingly donated their bodies to medical science.[142] The anatomists expressed their disappointment at the concentration on the 'more macabre aspects of anatomy education' and the 'harking back to the days of Burke and Hare'.[143]

Finally, and perhaps most profoundly, the defence of historical practice forces institutions to declare their ownership of people who were taken without consent. As shown above, due to the retention and display of medical human remains, institutions have been compared to *Body Worlds* and the work of Dr Gunther van Hagens. These links are high risk to the reputation of modern, ethical medical practice. The work of van Hagens purposely links to historical dissection and through his use and display of medical human remains. In 1995, van Hagens produced *Body Worlds*, a touring exhibition of dissected, plastinated cadavers of the recently deceased for the 'dual purpose' of 'education and entertainment'.[144] *Body Worlds* provoked negative comments from the public and museum professionals who expressed concern over the

[139] The image of Professor Gillingwater with skeleton of serial anatomy murderer William Burke demonstrates how the medical institutions were struggling to find a modern identity to attract a public audience to their events: Mike Wade, "Autopsies are public theatre again," *The Times* March 18, 2015.
[140] T.H. Gillingwater and G.S. Findlater, "Anatomy: back in the public spotlight," *The Lancet*, 385 no. 9980 (2015), 1825.
[141] Mike Wade, "Autopsies are public theatre again," *The Times*, March 18, 2015.
[142] See public discussion: Carla Valentine, *The Guardian*, March 31, 2015: http://www.theguardian.com/commentisfree/2015/mar/31/public-dissection-of-cadavers-about-time-embrace-death
[143] T.H. Gillingwater and G.S. Findlater, "Anatomy: back in the public spotlight," 1825.
[144] C.M. Moore and C.M. Brown, "Gunther von Hagens and *Body Worlds* part 1: The anatomist as prosektor and proplastiker," *Anatomical Record*, 276 no. 1 (2004), 12. doi: 10.1002/ar.b.20003

lack of dignity afforded to cadavers. Van Hagens had already caused controversy through his use of human remains and reintroduction of the 'public autopsy'. Although warned of contraventions to the Anatomy Act 1982, in London, van Hagen dissected a preserved body before an audience of 500 who paid £19 each to attend. Many complained; however, no charges were brought against van Hagens. Van Hagens continued his work in dissection and plastinisation. When *Body Worlds* toured to the USA, the exhibition became subject to an ethical committee by the Californian Science Center in 2004/5. It was deemed suitable for the public.[145] However, the links to historical practice went further than the display of medical dissection; lack of consent and punitive, judicial violence caused further controversy. During the 2000s, von Hagens and his exhibition manager Dr Sui Hongjin were forced to return seven bodies, destined for *Body Worlds*, to China after wounds, specifically two bullet holes in the back of the head, which are consistent with execution, were found. Furthermore, Sui Hongjin's breakaway touring display *Bodies: The Exhibition* openly accepts cadavers from the Chinese penal system. This 'disclaimer' is issued on the webpage[146] and reportedly at each of its exhibition venues:

> *This exhibit displays full body cadavers as well as human body parts, organs, fetuses and embryos that come from cadavers of Chinese citizens or residents. With respect to the human parts, organs, fetuses and embryos you are viewing, Premier relies solely on the representations of its Chinese partners and cannot independently verify that they do not belong to persons executed while incarcerated in Chinese prisons.*

Body Worlds brings into focus the links between historical practice, and ethically questionably modern practice. Both involve the taking of bodies without consent and through judicial violence. Until medical museums distance themselves from displaying and utilising the products of institutional betrayal through acts of omission, the public will, rightly so, continue to make connections and question those who display human remains without full, informed consent.

[145] See: *Body Worlds Ethics Report*: http://www.bodyworlds.com/Downloads/englisch/Exhibition/Original/EthicReport_CSC_E_190110.pdf

[146] See: http://www.premierexhibitions.com/exhibitions/4/4/bodies-exhibition/bodies-exhibition-disclaimer

1.8 Display

Once bodies had been used for dissection and anatomisation, human remains were conserved for medical collections, in the categories *soft tissue* (including flesh, muscles, nerves and organs) and *hard tissue* (bone and teeth). In simplified terms, these remains become either *dry* or *wet* specimens, where conservation was achieved through either removing natural liquid, through a process of cleaning and drying, or by adding liquid to form wet preserved suspensions. For hard tissue, this was a process of 'maceration, defatting, cleaning'.[147] This began with softening the flesh that had not been dissected. Bones could be boiled for these purposes,[148] especially in the case of skulls, where skin can be more difficult to remove. Then came defatting to remove the 'blood, fat, bone marrow and fibrous tissue'.[149] Cleaning would follow with anatomists using and experimenting with their own recipes. In the sixteenth century, Dutch physician Peter Forestus documented his use of aqua vita, which was largely made of 'strong vinegar' and aromatic spices, before the wider use of alcohol became more prevalent through the middle ages.[150] Hard tissue would be mainly stored and preserved as dry tissue, although bone could be preserved in fluid, especially in the case of pathology specimens, where tumours were to be preserved.

Conserving soft tissue was a lengthier and less stable process, involving a procedure of embalming. The aim of these specimens is described by Professor Albert Gellért, former curator and founder of the University of Szeged Anatomy Museum, as being to 'demonstrate the anatomy and topography of muscles, nerves and blood vessels of the body part or organ'.[151] John Hunter, whose collections formed the Hunterian Museum, the Royal College of Surgeons of England, took the preservation of human remains to an industrial level.[152] On his death, Hunter's collection included 1,300[153] specimens.[154] When reflecting back on Bennett's figures

[147] A.A. Gregory, J.C. Andrews and D.S. Maxwell, "Preparation of the Human Skull for Skull Base Anatomic Study," *Skull Base*, 3 no. 1 (1993), 1. DOI: 10.1055/s-2008-1060557
[148] J. Evanoff, "Sterilizing and preserving human bone," *AORN Journal*, 37 (1983), 972. doi:10.1016/S0001-2092(07)70034-0
[149] J. Evanoff, "Sterilizing and preserving human bone," 37.
[150] E. Brenner, "Human body preservation – old and new techniques," *Journal of Anatomy*, 224 no. 3 (2014), 318. https://doi.org/10.1111/joa.12160
[151] A. Mihály, R. Weiczner, Z. Süle and A. Czigner, "The Anatomy Specimen Collection of Albert Gellért: A Unique Paraffin Wax Method of Body Preservation," *Austin J Anat.*, 1 no. 3 (2014), 1013.
[152] S. Chaplin, "Nature dissected, or dissection naturalized? The case of John Hunter's museum," *Museum and Society* [online], 6 no. 2 (2008), 139.
[153] Hunter's entire collection contain 4000 artefacts, see: J.L. Turk, "The medical museum and its relevance to modern medicine," *Journal of the Royal Society of Medicine*, 87 no. 1 (1994), 40–42.
[154] G. Shklar, "John Hunter as an oral pathologist," *Journal of the History of Dentistry*, 56 no. 1 (2008), 31–34.

of 110 executions and dissections in Scotland between 1752–1832, this shows the scale of activity in illegal body trade (see footnote 16).

The methods developed to preserve tissue are too numerous to explore in this study. However, the work of Hunter gives a good overview of what could happen to human remains in the form of soft tissue. To prepare soft tissue as dry specimens, Hunter trialled various methods. As argued by Moore in her biography of Hunter, 'dry specimens were relatively easy to make' and, along with dry bone specimens, 'muscles or organs were dried in the air, often by hanging from the rafters of dissecting rooms, then varnished to preserve them from decay'.[155] The preservation of wet specimens revolved around the development of embalming fluid, which was another competitive area for anatomists, who made their own secret formulae. The development of an alcohol-based solution for preserving specimens is credited to seventeenth-century scientist Robert Boyle, with the eventual development of formalin in 1893.[156]

Fixing specimens for display was the final clinical process for medical human remains. These wet and dry specimens showcased the anatomists' research and were often and still can be displayed as works of art in medical museums. This brought a further opportunity for anatomists to use methods that went beyond the process of preservation, and in actuality objectified the human whose remains were now 'owned' by medical museums. In the case of Sara Baartman, scientific racism led to what became a landmark case in the repatriation of human remains.

1.9 The betrayal of Sara Baartman

The practice of displaying those who were anthropologically classified as non-European[157] ethnicities,[158] by those in the medical profession who supported and elaborated on Darwin's theory of racial superiority in their own scientific work, was part of scientific racism.[159] The European men who concocted this false 'science of race' placed 'European men at the apex

[155] W. Moore, *The Knife Man: Blood, Body Snatching, and the Birth of Modern Surgery* (New York: Broadway Books, 2006), 120.
[156] W. Moore, *The Knife Man*, 121.
[157] In anthropological terms, 'European' would now be placed within the four recognised ancestry groups as European or Caucasoid; see: E. Ferguson, N. Kerr, C. Ryan, "Race and Ancestry," in *Forensic Anthropology: 2000 to 2010*, ed. S. Black and E. Ferguson (London: Routledge, 2011), 126–7.
[158] For a discussion on the birth of the scientific concept of race and skeletal structure see: R. Bhopal, "The beautiful skull and Blumenbach's errors: The birth of the scientific concept of race," *BMJ*, 335 no. 7633 (2007), 1308–1309. doi:10.1136/bmj.39413.463958.80
[159] D.M. Rutledge, "Social Darwinism, Scientific Racism, and the Metaphysics of Race," *Journal of Negro Education*, 64 no. 3 (1995), 243–252.

and black women at the nadir', manipulating fictitious images of racial inferiority and deviancy.[160] This pseudoscience used characters of race to reinforce 'Europeans' overblown opinions of their cultural and biological superiority and provided justification of European medicines prejudicial treatment of other races'.[161] Medicine used the practice of scientific racism to reduce the status of non-European ethnicities to animals and curiosities, leading to many abuses similar to those committed against African woman Sara Baartman, who was trafficked and displayed as a 'supposedly paradoxical freak of race and sexuality' in life and death.[162] This was scientific racism. However, Sara Baartman's biological sex added to her discrimination and resulted in her display as the 'sexualised, racialised identity of the Hottentot Venus'.[163]

Sara Baartman was born in c.1789, 50 miles north of Gamtoos River valley, known by its people as Camdeboo, now known as the Eastern Cape of Africa.[164] As a young woman, she moved to Cape Town, living 'on the edge of freedom and slavery'.[165] At this time, Cape Town was an outpost of the Dutch East Indian Company, where the Dutch 'understood status and identity as forged primarily as through the categories of Christian verses non-Christian and, more importantly, through a person's relationship to slavery'.[166] During her life here, Sara Baartman may have been exhibited or self-exhibited at the local hospital, from where the idea for her subsequent trafficking may have originated.[167]

In 1810, Sara Baartman was trafficked to Britain by Hendrick Cezar and 'Alexander Dunlop, (ship's doctor and procurer of museum specimens)'.[168] When they got to Piccadilly Circus, she was exhibited for two shillings a ticket.[169] This display has been described as 'juxtapositions of difference around gender, race, the body and culture in a way that created something new –

[160] G. Baderoon, "Baartman and the Private: How Can we Look at a Figure that Has Been Looked at Too Much?" in *Representation and Black Womanhood: The Legacy of Sara Baartman*, ed. N. Gordon-Chipembere (Cham: Springer, 2011), 65.
[161] R.S. Levy, *Antisemitism: A Historical Encyclopedia of Prejudice and Persecution, Volume 1* (ABC-CLIO, 2005), 586.
[162] C. Crais and P. Scully, *Sara Baartman and the Hottentot Venus: A Ghost Story and a Biography* (Princeton: Princeton University Press, 2009).
[163] P. Scully and C. Crais, "Race and Erasure: Sara Baartman and Hendrik Cesars in Cape Town and London,", 304.
[164] P. Scully and C. Crais, "Race and Erasure," 306–7.
[165] P. Scully and C. Crais, "Race and Erasure," 309.
[166] P. Scully and C. Crais, "Race and Erasure," 310.
[167] P. Scully and C. Crais, "Race and Erasure," 309.
[168] H.B. Young, "Rude Performances: Theorizing Agency," in N. Gordon-Chipembere, *Representation and Black Womanhood: The Legacy of Sara Baartman* (Cham: Springer, 2011), 48.
[169] N. Gordon-Chipembere, *Representation and Black Womanhood: The Legacy of Sara Baartman* (Cham: Springer, 2011), 4.

the ethnopornographic freak show'.[170] During the autumn of that year, abolitionists instigated an investigation into the well-being of Sara Baartman. However, the courts accepted Sara Baartman's own testimony that she performed under her own will, and the case was dropped.[171] Yet, the negative publicity had destabilised an already controversial area of display, and the exhibition closed down.[172] When Dunlop died, in 1812, Sara disappeared from public view for two years, reappearing in Paris, summer 1814, and exhibited by the animal trainer and showman, Reaux.[173] By this time Sara's health was failing due to recurring flu and bronchitis, possibly self-managed with alcohol.[174]

Shortly before her death c.1815, Sara Baartman was pressed, by the Surgeon General to Napoleon, George Cuvier, to pose nude for the first time. Sara had never allowed this before and her failing health and vulnerability may have led to this agreement. These drawings were done to capture her figure, but mainly her buttocks, which had been part of the ethnographic obsession of her exhibition.[175] However, after her death, the scientific focus turned to her genitalia, Curvier dissected Sara's body in an attempt 'uncover the source of what was both popularly and scientifically thought to be the deviant sexual lasciviousness of African women'.[176] Curvier placed the drawing and dissection study of Sara in his illustrated report, inside his racist, sexist and sexualised ideology, and within medical research.[177] Cuvier compared Sara to a monkey and an ape, concluding, after the dissection 'that the 'secrets' that the Hottentot hid between her legs had now been definitely uncovered and analyzed'.[178]

As Gilman argues:

> *The figure of Sara Baartman was reduced to her sexual parts. The audience which had paid to see her buttocks and fantasized about the uniqueness of her*

[170] C. Crais and P. Scully, *Sara Baartman and the Hottentot Venus: A Ghost Story and a Biography* (Princeton: Princeton University Press, 2009), 73.
[171] H. Davies, *Neo-Victorian Freakery: The Cultural Afterlife of the Victorian Freak Show* (Cham: Springer, 2016).
[172] S.O. Pinder, *American Multicultural Studies: Diversity of Race, Ethnicity, Gender and Sexuality* (Thousand Oaks: SAGE, 2013), 150.
[173] G. Kirk McDonald, *Black Women and International Law* (Cambridge: Cambridge University Press, 2015), 301–2.
[174] G. Kirk McDonald, *Black Women and International Law*, 301–2.
[175] R. Mitchell, "Another means of Understanding the Gaze: Sara Bartmann in the Development of Nineteenth-Century French National Identity," in *Black Venus 2010: They Called Her "Hottentot"*, ed. D. Willis, (Philadelphia: Temple University Press, 2010), 41.
[176] R. Mitchell, "Another means of Understanding the Gaze," 41.
[177] R. Mitchell, "Another means of Understanding the Gaze," 41.
[178] R. Mitchell, "Another means of Understanding the Gaze," 41.

> *genitalia when she was alive could, after her death and dissection, examine both.*[179]

Following the actions of George Cuvier, Musée l'Homme continued to enable scientific racism through the display of Sara Baartman's skeleton, brain, genitals[180]and body cast until as recently as 1979.[181] Hence, the body of Sara Baartman was used to propagate stereotypes of scientific racism and her display the acceptance of violent colonialism until little over 40 years ago. However, at the end of the twentieth century, the retention of Sara Baartman's remains became a subject of international debate, 'turning Sara into an icon, which stands for all the horrors of colonialism, scientific racism and misogyny'.[182] Sara's story resurfaced in 1985 when palaeontologist Stephen Jay Gould found reference to 'the 'dissected genitalia of three Third-World women', one of which was in reference to Sara.[183]

> *Gould's accidental discovery coincided not only with the rise of postcolonial theory, especially the concept of 'the Other,' but with crisis for white South Africa, with the State of Emergency of the following year signalling (as we now know it retrospect) the beginning of the end of apartheid.*[184]

In 1995, following the victory of the African National Congress and the formal end of apartheid, Nelson Mandela was approached by the Griqua National Conference on the issue of repatriation for Sara.[185] This became a political matter that highted both historical and current abuse of indigenous people.[186] The dialogue 'between states' involved 'a personal request from President Mandela to successive French presidents: first François Mitterrand, and subsequently Jacques Chirac.[187] Musée l'Homme did not have the power to repatriate Sara's remains, as

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[179] E. Alexander, "Prologue: The Venus Hottentot (1825)", 5.
[180] G. Baderoon, "Baartman and the Private: How Can we Look at a Figure that Has Been Looked at Too Much?" in *Representation and Black Womanhood: The Legacy of Sara Baartman*, ed. N. Gordon-Chipembere (Cham: Springer, 2011), 65.
[181] T. Obradović, "Distorted Images of The Other and The Self in Christopher Hampton's savages, Suzan-Lori Park's Venus and Erik Ehn's Maria Kizito," in *The Face of the Other in Anglo-American Literature*, ed. M. Knežević (Newcastle: Cambridge Scholars Publishing, 2011), 64.
[182] T. Obradović, "Distorted Images of The Other," 64.
[183] C. Youé, "Sara Baartman: Inspection / Dissection / Resurrection," *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines*, 41 no. 3 (2007), 560, accessed August 18, 2020, url: www.jstor.org/stable/40380104
[184] C. Youé, "Sara Baartman." 560.
[185] S.O. Opondo, "Embodied envoys, 'objects' and the spectres of estrangement in Africa," in *International Politics and Performance: Critical Aesthetics and Creative Practice*, ed. J. Edkins and A. Kear (London: Routledge, 2013), 138.
[186] S.O. Opondo, "Embodied envoys," 138.
[187] S.O. Opondo, "Embodied envoys," 138.

French Law stated that all artefacts in French museums belonged to the French state.[188] However, 'case-specific provisions for the de-accession were to be enacted', with reference to bio-ethics law.[189] In addition to political and legal arguments, a key influence in the passing of the Bill that allowed the repatriation of Sara Baartman's remains was Diana Ferrus' poetic tribute to Sara 'I have come to take to you home'. The poem was presented by Senator Nicolas About, who introduced the Bill in 2001, and used the poem to show 'how Sara's people were emotionally and psychologically affected by her remains still being in France'. On 29 April 2002, Sara Baartman's remains were handed over to the South African Government, as Diana Ferrus[190] recited this poem.[191] On 9 August 2002, National Women's Day in South Africa,[192] Sara Baartman was finally buried in the valley where she came from.[193]

The betrayals of David, Mary, Sarah, Charles and the reactions by institutions, governments, political groups, media, and through my own work with vulnerable women's groups demonstrates the devasting consequences and feelings of anger, fear and despair that acts of commission and omission against medical human remains can provoke. During the twentieth century, legislation to protect human tissue in medical environments progressed. Yet, this progression advanced due to the discovery of series of modern betrayals. Furthermore, the progression of legislation brought new vulnerabilities to both institutions and museums medias as the display of medical human remains again became acceptable.

[188] D. Ferrus, *I've Come To Take You Home* (Bloomington: Xlibris Corporation, 2011), 103.
[189] S.O. Opondo, "Embodied envoys," 138.
[190] D. Ferrus, *I've Come To Take You Home*.
[191] Diana Ferrus performing "I have come to take you home" can be seen here: https://www.youtube.com/watch?v=ymXW5iA-PkQ
[192] A. Haber and N. Shepherd, *After Ethics: Ancestral Voices and Post-Disciplinary Worlds in Archaeology* (Cham: Springer, 2014), 21.
[193] D. Ferrus, *I've Come To Take You Home*, 103–4.

Chapter 2: Informing the practitioner: Understanding modern acts of omission and commission

2.1 Introduction

This chapter begins by outlining recent acts of commission and omission committed against foetal remains in the UK during the Alder Hey Controversy. This modern betrayal of medical human remains shows how residual issues towards ownership of the deceased manifested in the late 1990s, leading to a change in legislation through the Human Tissue Act 2004 and Human Tissue Act 2006 (Scotland). This new legislation had positive impacts on museum policy relating to medical human remains, and improved guidance and clarity for those institutions who displayed these collections. However, the clarity in law encouraged a new level of visibility for and access to human remains which had been taken through acts of institutional betrayal. This new visibility brought greater equality of access yet also, vulnerability, and also the opportunity for activism.

2.2 Law, policy and practice

2.2.1 Towards modern ethics for medical human remains

In 1961,[1] the Human Tissue Act criminalised procurement of human remains without consent.[2] Yet, in terms of retaining organs for research, the laws were unclear and open to abuses. Section 1, subsection 2, which dealt with permission and organ retention states that 'the person lawfully in possession of a body of a deceased person may authorise the removal of any part from the body for use of the said purposes [therapeutic, education or research as stated in subsection 1]'.[3] The desire for medical progression led to the circumstances in which Dr John Hay initiated the collection of paediatric hearts in 1948. These hearts were held at the Institute of Child Health at Alder Hey Hospital, Liverpool.[4] Hay began his research collection to address infant mortality at a time when there 'was little that could be done for babies born with malformed

[1] Also, see B.W. Rycroft, "The Corneal Grafting Act, 1952," *Brit J. Ophthal*., 37 (1953), 349.
[2] M.D.D. Bell, "The UK Human Tissue Act and consent: surrendering a fundamental principle to transplantation needs?" *Journal of Medical Ethics*, 32 no. 5 (2006), 283–286. doi:10.1136/jme.2005.012666, 283
[3] See The Human Tissue Act 1961: https://www.legislation.gov.uk/ukpga/Eliz2/9-10/54/section/1/enacted?view=plain
[4] M.D.D. Bell, "The UK Human Tissue Act and consent".

hearts' and 'was determined after the war to find better ways of investigating and treating such unfortunate babies, who often died very quickly'.[5] Whatever the intentions, Hay took these samples without parental knowledge or consent. This disregard for the law, which Bell sees as systemic, eventually led to the Alder Hey controversy. Despite being named after Liverpool's Alder Hey Children's Hospital, this controversy began in 1999 at the Bristol Infirmary, when parents discovered that children's organs had been harvested and retained for research purposes.[6] This process 'was not a secret, but neither was it always made explicit to parents, and the revelation caused a storm of outrage directed at pathologists'.[7] Much of the controversy centred around Professor Dick van Velzen, the Head of the Foetal and Infant Pathology Unit at the University of Liverpool, and honorary paediatric pathologist at Alder Hey from 1988 to 1995.[8] van Velzen initiated a policy to retain all human organs in 'all cases' which were used for his own developing research:[9]

> *Van Velzen's professional misconduct was extensive and is thoroughly documented in Redfern (2001a, 2001b).*[10]
>
> *What follows is an illustrative and non-exhaustive list of what Redfern found van Velzen guilty of:*
>
> - *lying to patients generally and lying to them about his post-mortem findings more specifically;*
> - *deceiving both Alder Hey and the university;*
> - *unethical and illegal retention of organs;*
> - *falsifying research applications, post-mortem reports and encouraging staff to falsify records and statistics;*
> - *ignoring consent that stated a preference for limited post-mortems;*

[5] M.D.D. Bell, "The UK Human Tissue Act and consent".
[6] For the full report of The Royal Liverpool Children's Inquiry Report 2001 see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250934/0012_ii.pdf
[7] "Conversations with Pathologists," The Pathological Society: http://www.pathsoc.org/conversations/index.php?option=com_contentandview=categoryandlayout=blogandid=34andItemid=81
[8] F. Tomasini, *Remembering and Disremembering the Dead: Posthumous Punishment, Harm and Redemption over Time* (London: Palgrave Macmillan, 2017), 76.
[9] F. Tomasini, *Remembering and Disremembering the Dead*, 76.
[10] The Royal Liverpool Children's Inquiry Report 2001 is also known as The Redfern Report or 'Redfern', as the inquiry was led by Mr Michael Redfern QC.

- *failing to keep proper records of stored organs, and failing to maintain proper accounting procedures (Redfern 2001a, pp. 9–10).*[11]

From a historical perspective, Dr Ruth Richardson deemed the public outcry as an incident 'waiting to happen for at least a generation' and 'a product of cultural baggage which predates the establishment of the NHS'.[12] From a medical perspective, Professor David Hall, then President of Royal College of Paediatrics and Child Health, questioned if the 'cataclysmic' events at Alder Hey were borne from the medical profession's arrogance or residual 'medical paternalism'.[13] When considering the evidence of institutional betrayal, as presented in Chapter 1, the perspectives of both Richardson and Hall are compelling.

The Alder Hey controversy brought a new, forced dialogue on medical human remains with the public. This meant that medical professionals were challenged, often angrily, about their use of human tissue. Reactions to Alder Hey were mixed, and relationships between the public and the medical profession were forced into the open, as shown by the Pathological Society's *Conversations with Pathologists*.[14] Consultant Paediatric and Perinatal Pathologist Irene Scheimberg and Paediatric Neuropathologist Waney Squier chose to alter their practice and began to meet and talk to bereaved families: 'I often tell the paediatricians or the coroner's officers they don't need to worry about talking to families, I'll speak to them.'[15] Others, however, experienced intimidation and abuse. Sebastian Lucas, Professor of Clinical Histopathology at Guy's, King's and St Thomas' Hospital reported that 'some (pathologists) received threatening phone calls at home; others found their children being bullied at school because of their parent's profession'.[16] These tense interactions affected how some medical museums functioned. Some became cautious and closed collections, while others continued to operate as usual. These polarised reactions are shown by Professor Lucas of the Gordon

[11] F. Tomasini, *Remembering and Disremembering the Dead*, 76.
[12] D. Hall, "Reflecting on Redfern: What can we learn from the Alder Hey story?" *Arch Dis Child*, 84 (2001), 455.
[13] D. Hall, "Reflecting on Redfern", 455.
[14] 'Conversations with Pathologists grew out of a book project for which Sue Armstrong interviewed pathologists from varied backgrounds and working in a wide range of specialised fields in the USA, UK, Italy, South America and South Africa.'
[15] "Conversations with Pathologists," Waney Squier: http://www.pathsoc.org/conversations/index.php?option=com_contentandview=categoryandlayout=blogandid=34andItemid=81
[16] "Conversations with Pathologists," Sebastian Lucas: http://www.pathsoc.org/conversations/index.php?option=com_contentandview=categoryandlayout=blogandid=34andItemid=81

Museum at Guy's Hospital. Professor Lucas stressed 'not for a moment did we shut a door, remove an exhibit, close anything at all – unlike Dublin, which closed its museum... Unlike the London, which cemented it in – I joke not!' [17]

By 2001, the Chief Medical Officer's summit (a major public inquiry) had judged the ownership of human tissue for study and research as 'complex, uncertain and obscure'.[18] Consequently, the Human Tissue Act 2004 was introduced in England, Wales and Northern Ireland to 'regulate activities concerning the removal, storage, use and disposal of human tissue'.[19] In 2006, further regulations were introduced, meaning 'two pieces of human tissue legislation apply in Scotland; both with the fundamental principle of obtaining consent [UK] or authorisation [Scotland]'. The Human Tissue (Scotland) Act 2006 'sets out provisions for the removal, retention and use of 'organs, tissue and tissue samples' from the deceased'. The 'Human Tissue Act 2004 – applies in its entirety in England, Wales and Northern Ireland and uses the term consent. Only one section of the Human Tissue Act applies in Scotland (section 45, which regulates DNA analysis).'[20] In regard to this study, this law is important as it brings equal protection to all humans against non-consensual collection of human tissue for research. Furthermore, the legal requirements helped set a deeply reverential tone regarding body donation. This is shown by the statement on body donation from Edinburgh Medicine: Biomedical Sciences, University of Edinburgh:

> *Bequeathing your body to Edinburgh University after death for anatomical examination is a very generous decision which we appreciate will not have been taken lightly.*
>
> *You may be assured that, were it not for such acts of selflessness, it would be impossible to maintain Scotland's high educational reputation in the medical professions and for this we are extremely grateful.*
>
> *The Anatomy Act (1984) and the Human Tissue (Scotland) Act (HTSA 2006) regulate the use of bodies donated for anatomical examination, education or*

[17] "Conversations with Pathologists," Sebastian Lucas: http://www.pathsoc.org/conversations/index.php?option=com_contentandview=categoryandlayout=blogandid=34andItemid=81
[18] D. Hall, "Reflecting on Redfern", 456.
[19] The Human Tissue Authority: https://www.hta.gov.uk/policies/human-tissue-act-2004 (paragraph 1): accessed May 10, 2018.
[20] Medical Research Council, Summary of Legal Requirements for research with human tissues in Scotland: https://mrc.ukri.org/documents/pdf/scotland-summary/: accessed May 3, 2018.

training and medical research. It sets out the legal framework for the removal, retention and lawful use after death, of human bodies and body parts.

However, the medical institutions that held collections of historical human remains needed clarity on how to adjust to the new laws. For medical museums, the Human Tissue Acts led to progression within museum policy and practice.

2.2.2 Museum policy and practice

In line with the Human Tissue Act 2004, in 2005, new guidelines were set by the Department for Culture, Media and Sport for the treatment of human remains in museums. England and Wales clarified several controversial and confusing issues including: repatriation of indigenous and religious human remains; how to deaccession and dispose of human remains; and new guidelines on the display of human remains under 100 years old.[21] In Scotland, as long as a specimen is held legally under the Anatomy Act 1984, and a public license is held, specimens can be displayed. Under the Human Tissue Act 2006:

> *Section 6A(3) applies to a part of a body in two circumstances: The first requires that where a person has requested that their body be used after their death for anatomical examination that the request also includes permission for public display. The second applies to imported bodies where anatomical examination is authorised under section 4A of the Anatomy Act 1984 and that authorisation includes authority for public display.*[22]

These changes meant the use of human tissue was now under new legal restrictions, which are non-negotiable:

> *Although advice and guidance on the care and display of human remains has been available from the Department for Culture, Media and Sport (DCMS) since 2005, the activity of public display was not covered by statute before the HT Act. Prior to this, there was no restriction on the display of human bodies or material of human origin (referred to in the HT Act as relevant material).*[23]

[21] Museums Association, Campaigns: Human remains in museums: https://www.museumsassociation.org/campaigns/8125: accessed May 3, 2019.
[22] https://www.museumsgalleriesscotland.org.uk/media/1089/guidelines-for-the-care-of-human-remains-in-scottish-museum-collections.pdf, 36.

Importantly, there was a change in attitude within both UK and Scottish museums. In Scotland, the 2004 and 2006 Human Tissue Acts were used by the National Museums of Scotland to provide a framework for collections care in Scottish museums. Some of the most visible corrections of past abuses came from a new openness on repatriating human remains that had been acquired by colonial abuse, and the removal of items under 100 years old from identifiable display. The Museums Association highlighted a vital shift in perspective: 'in general UK museums accord human remains of all kinds special treatment, whereas in the past they tended to be treated as 'objects', like any other part of the museum's collection.'[24] Similarly, the National Museums of Scotland's new strategy acknowledged human remains having a 'unique status within museum collections' with 'special responsibilities placed on those who acquire and display them'.[25] However, in relation to human remains taken during colonialism, legislation was already more advanced.

2.2.3 Repatriation and 'ethnographical' law and policy

The ICOM Code of Ethics for Museums, developed by the International Council of Museums (ICOM) has been in existence from 1986. ICOM plays a key role in museums' practiceas 'a membership association and a non-governmental organisation which establishes professional and ethical standards for museum activities'.[26] ICOM includes 32,000 professionals as members, represents over 20000 museums in over 117 countries and has 119 national committees and 31 specialist committees'.[27]

The ICOM Code of Ethics for Museums was created to set:

> *minimum standards of professional practice and performance for museums and their staff. In joining the organisation, ICOM members undertake to abide by*

[23] The Human Tissue Authority, Public Display: https://www.hta.gov.uk/sites/default/files/Code%20D.pdf, 6: accessed May 3, 2018.
[24] See: https://www.britishmuseum.org/sites/default/files/2019-11/DCMS-Guidance-for-the-care-of-human-remains-in-museum.pdf
[25] http://culturalpropertyadvice.gov.uk/public_collections/human_remains this page has now been removed and has been replaced by updated policy: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/529489/2016Updateof2010to2015governmentpolicymuseumsandgalleries-GOV.UK20160425.pdf.pdf
[26] See ICOM objectives: https://icom.museum/en/about-us/missions-and-objectives/
[27] See ICOM homepage: https://uk.icom.museum/about-us/icom-international/

> *this Code. The ICOM Code of Professional Ethics was adopted unanimously by the 15th General Assembly of ICOM in Buenos Aires (Argentina) on 4 November, 1986. It was amended by the 20th General Assembly in Barcelona (Spain) on 6 July 2001, retitled ICOM Code of Ethics for Museums, and revised by the 21st General Assembly in Seoul (Republic of Korea) on 8 October, 2004.*[28]

The objective of the ICOM Code of Ethics is to establish and maintain a 'minimum standard of practice, which can be built on by individual institutions'.[29]. In relation to human remains and materials of sacred significance, the original ICOM Code of Ethics has specific section on care and display of human remains (2.5[30]; 3.7[31]; 4.3[32]). Under section 3.7, principles and guidelines are set out for Human Remains and Materials of Sacred Significance to protect 'the interests and beliefs of members of the community, ethnic or religious groups from whom the objects originated'.[33] In addition to the Code of Ethics for Museums, the ICOM Code of Ethics for Natural History Museums 'was developed between December 2006 and November 2012 to address specific issues relevant to the life and earth sciences' and 'adopted unanimously by the 23rd General Assembly of ICOM in Rio de Janeiro (Brazil) on 16 August 2013'.[34]

This document took the opportunity to explore the ethical issues surrounding ethnicity and human remains in greater depth than the ICOM Code of Ethics.[35]

Section 1 details the code of practice for human remains. From a seven-point document, four points relate to the need for consultation with cultural groups on origin, display, repatriation, dignity and disposal:

> *B. The origin of the material and the wishes of any descendants or other stakeholder groups must be considered in all circumstances.*
>
> *D. Human remains should only be displayed or used scientifically in circumstances where the highest professional standards can be implemented. Where extant representatives of the cultural groups exist, any display,*

[28] ICOM Code of Ethics for Museums: https://icom.museum/wp-content/uploads/2018/07/ICOM-code-En-web.pdf, 1.
[29] ICOM Code of Ethics for Museums, 3
[30] ICOM Code of Ethics for Museums, 10
[31] ICOM Code of Ethics for Museums, 20
[32] ICOM Code of Ethics for Museums, 25
[33] ICOM Code of Ethics for Museums, 20
[34] ICOM Code of Ethics for Natural History Museums: https://icom.museum/wp-content/uploads/2018/07/nathcode_ethics_en.pdf, iv
[35] ICOM Code of Ethics for Natural History Museums,1

representation, research and/or deaccession must be done in full consultation with the groups involved.

E. Artefacts made from or including human remains should be afforded the same dignity as human remains. In cultures where hand-made artefacts have the same cultural and/or spiritual significance as human remains, this material should be treated similarly, with full consultation.

G. Repatriation is appropriate where objects still confer a spiritual and/or cultural significance, or where they can be irrefutably demonstrated as being stolen. All material being considered for repatriation, even unprovenanced material, must be properly documented with respect to the repatriation process. Any repatriation that does take place must be undertaken with the full knowledge and agreement of all interested parties and comply with the legislative and institutional requirements of all parties involved.[36]

Within medical and natural history museums, repatriation of human remains from Indigenous groups taken under colonialism was being openly discussed and addressed. However, as discussed by Alberti[37] (see Chapter 1), conversations on the display, dignity and disposal of human remains taken in other abusive situations was lacking in medical museum dialogues. In actuality, the new laws had given medical museums a new confidence to increase access to human remains. This increase in access was viewed as progression as it challenged the residual exclusionary attitudes towards the place of the public in medical museums. At this time, I agreed with this perspective.

2.2.4 Increasing access

Historically, access to medical museums has risen and fallen in line with individual institutional priorities and changing legislation. The display of the collections of German anatomist Bernhard Siegfried Albinus (1653–1721) challenge the assumption that medical museums were always hidden or closed from public view. The collections of Albinus were displayed in Faliedebagin Kerk, Leiden, alongside the town's anatomy theatre and medical collections.[38]

[36] ICOM Code of Ethics for Natural History Museums
[37] S.J.M.M. Alberti et al., "Should we display the dead?"
[38] M. Hendriksen, R. Knoeff and H. Huistra, "Recycling Anatomical Preparations," in *Medical Museums*, ed. S. Alberti and E Hallam (London: Royal College of Surgeons of England), 78.

Yet, the more detailed accounts of Dutch anatomist Frederik Ruysch's collections demonstrate that public and private access was never meant to be on equal terms or for shared learning. By 1689, Ruysch had opened his collections as a museum in Bloemgracht, to ordinary visitors, seen to look at collections 'superficially', and physicians 'who actually wanted to increase their knowledge'.[39] Printed information given on entry to the museums was in Latin for scholars, which introduced the museum as Museum Anatomicum Ruyschianum, and information was in Dutch for locals, where the environment was termed 'Anatomisch cabinet', or cabinet of curiosities.[40]

Access to medical museums in Europe progressed through the eighteenth and nineteenth centuries, but still with a hierarchical view of the public, which can still exist. Maeker argues that the Florentine medical museum, La Specola, was an 'experiment in public enlightenment' to teach 'the purpose natural order has destined upon him'.[41] Importantly, Maeker does not challenge the inequality behind this 'experiment', which ensured that public access was carefully measured to ensure 'unsuitable persons' were not allowed to enter and 'only a few peasants, but not too many gained access'.[42] This paternalistic attitude regarding public access was not exclusive to medical museums. During a meeting at Westminster Abbey in 1837 to discuss free access to 'Westminster Abbey, St Paul's Cathedral, and all depositories of works of art, natural history, and objects of historical and literary interest in public edifices',[43] the chair, Joseph Hume, began his address by setting out an objective to ban the 'exclusive system' that had denied the working classes access to cultural buildings and art collections. An attendee, Mr Wilbraham, noted 'a favourable change in the conduct and behaviour of the working classes', arguing that 'English people are not the barbarians, are not the vandals which some patrons have reported them to be'. Even though access for the working classes was presented as beneficial to society, the patriarchal intentions of those at the meeting is obvious when considering Ewart's analogy of denying free public access to 'a parent who consigned to the hands of his children a book … on the very moderate condition that they should never open it'.

[39] L. Kooijmans, *Death Defied: The Anatomy Lessons of Frederik Ruysch*, trans. D. Webb (Amsterdam: Brill, 2010). 176
[40] L. Kooijmans, *Death Defied*, 176
[41] A. Maerker, "Anatomy and public enlightenment: the Florentine Museum 'La Specola'," in *Medical Museums: Past Present, Future*, ed. S.J.M.M. Alberti and E. Hallam (London: The Royal College of Surgeons of England, 2013), 91.
[42] A. Maerker, "Anatomy and public enlightenment", 97.
[43] Copy of correspondence (printed by the House of Commons). 6 February 1838. Regarding the free admittance to public national buildings, museums etc. from, Administration File: Opening the museum to professionals and the general public (and other miscellaneous correspondence). Reference RCS-MUS/11/1/10; Date;1800-1856, Hunterian Museum Royal College of Surgeons of England.

At the same meeting, it was recorded that Kew Gardens welcomed 'intelligent strangers', and free access to the Hunterian Museum at the Royal College of Surgeons of England was included in the society's remit. The Hunterian Museum, the only medical museum discussed at the meeting, remained more exclusive, and did not specify opening times, stating it will 'open four days a week'. This shows that extra knowledge or the confidence to communicate with those familiar with organisation would be needed to gain access. In additional material, the support for free access included letters from MacGillivray and George Ballingal of the Royal College of Surgeons. These letters, pertaining to Surgeons' Hall Museum, show that public access had been possible since July 1832. However, access was dependent on 'persons having an order from a fellow of the college, or applying to the conservator'. Consequently, literacy (or access to) was needed to progress an application for admission, and confidence was necessary when seeking to be approved entry to medical museums.

The opportunity for the public to interact with medical museums began to decline in nineteenth-century Britain. Public dissections had ended with the Anatomy Act 1832. Public anatomy museums that existed outside academic institutions had been fully accessible until the mid-1850s, but had been closed down via the medical profession use of the Obscene Publications Act 1857. Although done under the guise of 'anti-quackery',[44] these actions created a monopoly over the use of medical collections by the medical profession. The very public nature of the so-called 'freak shows', the displays where both Charles Byrne and Sara Baartman had been exhibited, had diminished during the early twentieth century. The timing of the UK decline is poignant. Durbach shows how ''The Disabled' … emerged as a category in Britain only around the turn of the century, in the years after the outbreak of the Boer War', and after World War One, 'British society was compelled to rethink the social meanings attached to bodily disfigurement'.[45] In many ways, post-war Britain created a new environment formedical art collections; the level of trauma that society had suffered brought new personal experiences of death and injury. The medical professionals that tended and taught in medical museums had been lost to warfare, injured or had new post-war priorities to deal with. Furthermore, some medical art collections did not survive. On 11 May 1941, a German bombing raid destroyed almost three quarters of the Hunterian Museum's collections.[46]

[44] A. Bates, ""Indecent and demoralising representations": Public anatomy museums in mid-Victorian Museums in England," *Medical History*, 52 no.1, 1–2.
[45] N. Durbach, *Spectacle of Deformity: Freak Shows and Modern British Culture* (Berkeley: University of California Press, 2009), 16.
[46] *A Guide to the Hunterian Museum: John Hunter, 1728–1793* (London: Royal College of Surgeons of England, 1993), 3.

In post-war Britain, the professional use of medical collections in teaching waned as medical advances gave rise to new technologies and techniques. This decline in teaching with medical collections impacted on their value in terms of finance and prestige. Hallam shows how the art collections of Marischal College, the University of Aberdeen, followed a common trajectory for medical museums during this period.[47] The Aberdeen collections were reduced from a 'powerhouse for producing and communicating knowledge'[48] to being 'considered irrelevant … categorised historical', with the collections largely being pushed into storage.[49] This lost value meant a loss of direction for medical museums, some of which closed completely. Outside the UK, a similar pattern can be seen at the museums of the Karolinska Institute, Stockholm, which was continually affected by changes in scientific developments, space requirements and funding. The majority of these collections, currently, 'remain inaccessible in a remote storage facility',[50] with a 'small exhibit' viewed by appointment only.[51]

In 1951, the British section of the International Association of Medical Museums published a survey of medical museums in Great Britain, and data from 81 existing medical museums were analysed.[52] The majority of museums had been planned for postgraduate study, and over half were only accessible to students with written permission from the Dean. These restrictions were seen as protective measure to ensure that students would not be distracted by 'the rush of outsiders, who might otherwise monopolize the material', and the report stresses that staff and students should be able to 'at a glance identify and warn off any 'stranger'' or 'unwanted visitor'.[53] Hence, when medical museums gained clear legal guidelines on the display of human remains, opportunities were taken to open up collections, some of which had been restricted. Under this stance, the Scotland and Medicine partnership-initiated *Anatomy Acts*, the first touring exhibition of human remains held in Scottish medical museums.

[47] E. Hallam, "Disappearing museums? Medical collections at the University of Aberdeen," in *Medical Museums: Past Present, Future*, ed. S.J.M.M. Alberti and E. Hallam, (London: The Royal College of Surgeons of England, 2013), 56.
[48] E. Hallam, "Disappearing museums?", 46.
[49] E. Hallam, "Disappearing museums?", 56.
[50] E. Åhren, "Making space for specimens: The museums of the Karolina Institute, Stockholm," in *Medical Museums: Past Present, Future*, ed. S.J.M.M. Alberti and E. Hallam (London: The Royal College of Surgeons of England, 2013), 114
[51] E. Åhren, "Making space for specimens", 113–4.
[52] C.J. Hackett, "A list of medical museums of Great Britain (1949–50)," *British Medical Journal*, 1 no. 4719 (1951), 1380–3.
[53] C.J. Hackett, "A list of medical museums of Great Britain (1949-50)," 1380–3.

2.3 Case study: *Anatomy Acts*

2.3.1 Increasing access: The first tour of UK human remains

In 2006, the Scotland and Medicine partnership was formed through a collaboration led by the Royal College of Surgeons. The collaboration brought together 27 founding members including 'university, local authority and independent museums as well as National Libraries of Scotland and National Galleries of Scotland'.[54] This partnership between museums, together with growing confidence brought by clear law and museum policy on human remains, opened up new funding streams for medical collections. Financially, *Anatomy Acts* was made possible by funding from the Scottish Museums Council. The aim of this fund was to 'build capacity and improve the sustainability of Scotland's non-national museum sector by stimulating and supporting the development of new strategic and creative partnerships across local authority boundaries, between local authority and independent museums and with national museums'.[55] In 2006, the *Anatomy Acts* project was accepted as 'one of ten projects funded by the Scottish Executive's Regional Development Challenge Fund'.[56] As a project, *Anatomy Acts* aimed to 'promote the medical collections in Scottish Museums, Libraries, Archives and Galleries to local, national and international audiences'.[57] *Anatomy Acts* was developed from the perspective of the history of medicine and aimed to work with transparency to present the origins of the historical medical human remains; hence, a recognisable perspective of the benefits of dissection verses the abuses suffered formed part of the narrative. Yet, the objective clearly stated that the partnership wanted to invite discussion on the subject:

> *Our rationale has been to explore new models for public engagement with anatomy through both a book and an exhibition. We have sought to innovate in terms of exhibition presentation not just for its own sake, but to develop and deepen audience engagement beyond cynical spectacle and controversy.*[58]

The lead curator of the *Anatomy Acts* project was Andrew Patrizio, Edinburgh College of Art, with co-curator Dawn Kemp, Director of Heritage, Surgeons' Hall Museum, the Royal College

[54] A. Patrizio and D. Kemp (eds.), *Anatomy Acts: How we come to know ourselves* (Bloomington: Birlinn, 2006), xii.
[55] A. Patrizio and D. Kemp (eds.), *Anatomy Acts*, ix.
[56] A. Patrizio and D. Kemp (eds.), *Anatomy Acts*, ix.
[57] S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide* (Scotland Medicine: Collections & Connections, 2006), 7.
[58] A. Patrizio and D. Kemp (eds.), *Anatomy Acts*, viii.

of Surgeons of Edinburgh. The project consisted of a touring exhibition, *Anatomy Acts*; the publication, *Anatomy Acts: How we come to know ourselves*;[59] a published object guide, *Anatomy Acts Object Guide*;[60] a poetry anthology, *The Hand that Sees: Poems for the Quincentenary of the Royal College of Surgeons*;[61] two commissioned visual artworks, *Black, White and Shades of Grey* by Christine Borland and *Heir it be Sene* by Claude Heath; and *A series of six poems specially commissioned by Anatomy Acts* by Kathleen Jamie.

The *Anatomy Acts* exhibition contained 175 'objects',[62] which can be broadly defined by the following categories: loose leaf illustrations (46), anatomical models (25), human remains (12), manuscripts (2), sculpture (2), illustrated medical text books (47), instruments (7), oil paintings (7), comparative anatomy (2), medical imaging and photography (17), commissioned art works (5), and miscellaneous items including a botanical specimen, MRI equipment and design drawings (4).[63] In 2006, medical collections had not been toured across Scotland.

With this new initiative and the extensive number of partners involved, *Anatomy Acts* promoted itself rightly 'as the largest touring exhibition of its kind ever undertaken in Scotland'.[64] The exhibition toured to venues in Scotland from 13 May 2006 – June 2007 and was hosted by: City Art Centre Edinburgh (13 May – 9 July 2006); Lamb Gallery, University of Dundee joint with the Gateway Gallery, University of St Andrews (November 2006 – January 2007); Inverness, Kingussie, Thurso and Wick (January – April 2007);[65] and Collins Gallery, University of Strathclyde (April – June 2007).[66] The exhibition opened up often inaccessible medical collections to the public for the first time. The medical museums that loaned collections to *Anatomy Acts* included publicly accessible galleries of Surgeons' Hall Museum, the Royal College of Surgeons of Edinburgh and the Hunterian Museum, University of Glasgow. Additionally, collections that were only accessible to medical professionals were included from the University of Aberdeen and the University of St Andrews. Furthermore, there was archive material, accessible by appointment only, from the Royal College of Surgeons of Edinburgh, the Royal College of Physicians of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow. In terms of challenging residual discriminatory and

[59] A. Patrizio and D. Kemp (eds.), *Anatomy Acts.*
[60] S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide*.
[61] Conn. S. (Ed) (2005) The Hand That Sees: Poems for the Quincentenary of the Royal College of Surgeons of Edinburgh, Royal College of Surgeons of Edinburgh
[62] See: S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide.*
[63] S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide*, 10–67.
[64] S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide*, 9.
[65] Dates as listed in *Object Guide*, 5.
[66] S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide*, 24.

closed attitudes to public access, *Anatomy Acts* was innovative. However, the enthusiasm to open collections also exposed vulnerabilities for acts of omission to appear.

2.3.2 Acts of omission

Anatomy Acts operated with a level of transparency regarding the origin of medical human remains. The opening essay from the exhibition publication *The Paradoxes of Interiority: Anatomy and Anatomical Rituals in Early Modern Culture*[67] explores the graphic history of abuse in medical human remains (see Chapter 1). Additionally, displayed in the exhibition was the 'Noxiana: The Lecturer all alarmed', c.1829, produced by Lithographer R.H. Nimmo, with anonymous artist, showing Knox 'being pursued by ghosts (perhaps the restless souls of those he dissected)'.[68] However, unless visitors to the exhibition could access the accompanying publication or knew the context behind the actions of Robert Knox, it would be difficult for them to comprehend the gravity of the abuses contained within the exhibition. There are many reasonable explanations for this, including protecting the public audience, which included families and school groups, from overly graphic information. Yet, this opaque, rather than transparent, attitude to the presentation of medical human remains is recognisable as a deeper attitude within medical museums. This is shown by the visitor statement, issued at the exhibition, and, until 2015, at Surgeons' Hall Museum.

> *The Pathology Museum of the Royal College of Surgeons of Edinburgh, Visitor Notice (The following notice is positioned to be viewed before visitors enter the display areas.) Note to Visitors. The Pathology Museum of the Royal College of Surgeons of Edinburgh has been used to teach and inform medical students and the general public since 1832. The collection of the Royal College of Surgeons of Edinburgh represents the changing nature of medical and scientific teaching and research since the late 18th century. Specimens were collected at times that held different ethical and moral values from our own. They are displayed acknowledging the debt to those whose suffering has advanced our knowledge*

[67] S. Sawday, *The Body Emblazoned.*
[68] S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide*, 34, object 81 (loan from Scottish National Portrait Gallery, P/I1/1 SP VI 166.2), see: https://www.nationalgalleries.org/art-and-artists/33461/dr-robert-knox-1791-1862-anatomist-wretchs-illustrations-shakespeare-knox-frightened-ghosts-no-6

of disease. Some people can find viewing human anatomical and pathological remains unsettling. Please ask for advice if you are unsure what to expect.[69]

Part of this statement brings discomfort: 'specimens were collected at times that held different ethical and moral values from our own. They are displayed acknowledging the debt to those whose suffering has advanced our knowledge of disease.' The statement bypasses apology, responsibility or accountability by imposing a somewhat inaccurate statement that suggests *'moral value'* as a concept belong to time, rather than to conscience or empathy. Additionally, through the use of 'debt' the statement demonstrates a false relationship of reciprocity, where something has been given freely and can be repaid. This can be more appropriately seen as an abusive power dynamic, not a relationship. To suggest otherwise is to normalise abuse, which, in relation to institutional betrayal can be viewed as an act of omission. Considering the Surgeons' Hall Museum statement in the context of institutional betrayal, it could be viewed as 'Supporting Cover-Ups and Misinformation'.[70] As discussed by Smith and Freyd, this involves an 'invalidating bystander silence' which can occur due to fear of becoming a target or by 'protective unawareness'.[71] As mentioned above, prioritising the emotional safety of staff and visitors is a major concern for medical museums, and this could be viewed as a unintentionally enabling a form of protective unawareness. Yet this has consequences, in situations where abuse has occurred this can be viewed as having a 'direct silencing effect'.[72] In museums, this silencing reinforces the historical power imbalance by obscuring the narratives of those who have been abused and heroicising abusive actions. This presentation of the positive outcomes of historical medical dissection, means classism and domestic discrimination including sexism, ableism and racism in displays and interpretation remain unchallenged. Hence, when viewing the Surgeons' Hall Museum visitor statement in this context, the gaps in progression, outside the Human Tissues Acts, are visible. Therefore, Anatomy Acts happened both at a time of progression and great vulnerability for medical museums. The implications for the first tour of human remains were vast, and meant that some areas of concern were overlooked. In particular, three displays, demonstrate why all appropriate legislation needed equal consideration to avoid acts of omission.

[69] Page 18 https://www.museumsgalleriesscotland.org.uk/media/1089/guidelines-for-the-care-of-human-remains-in-scottish-museum-collections.pdf
[70] C.P. Smith and J.J. Freyd, "Institutional betrayal".
[71] C.P. Smith and J.J. Freyd, "Institutional betrayal".
[72] C.P. Smith and J.J. Freyd, "Institutional betrayal".

Omission: Femoral trumpets and calvarial drums

Presented in the exhibition and object guide[73] as 'object 106', *Anatomy Acts* displayed:

> *Femoral Trumpets and Calvarial drums, Tibet, date unknown.*
>
> *Human bone.*
>
> *The Tibetan femoral trumpets and calvarial drums are made from human thigh bones and skull caps and would have been used by Lama priests to summon the faithful to worship. Human skulls have also been used in Tibet as drinking vessels and by the Lamas for Libations – drink offerings to the gods. They were presented to the University of Edinburgh in 1895.* [74]

Through this display, the ICOM Code of Ethics for Natural History Museums, Section One, was not fully adhered to. The Tibetan femoral trumpets and calvarial drums were not accompanied by any information surrounding the circumstances of their presentation or provenance. Furthermore, there was no evidence of consultation with the cultural group of origin concerning the display of these human remains. Thus, through an act of omission, unchallenged acts of colonialism could be on public display. In the following years, examples of good practice were developed. An exemplar of where collections similar to these were displayed with sensitivity and in consultation, is shown by the Victoria and Albert Museum, London (V&A). The V&A loaned their Tibetan skull drum to the Wellcome Trust for its exhibition *Tibet's Secret Temple*, which ran from 19 November 2015 – 28 February 2016. To gain approval from descendants[75] for display and interpretation, this Tibetan skull drum received a blessing from the Dalai Lama before the exhibition.[76]

French officer's skin from the battle of Breda, 1793

An issue not touched upon so far, but as important when identifying abuse in medical human remains, is the acquisition of human remains during war crimes. The reason for not fully covering this topic within this study is the vastness and specific forms of abuse which deserve a study of their own. Human remains from war can be displayed in medical museums to demonstrate military medicine and surgery. As with civilian human remains, bodies of military

[73] See: S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide*, 25
[74] See: https://wellcomecollection.org/exhibitions/W3Ls-SkAACgAEWMx
[75] See, ICOM Code of Ethics for Natural History Museums, Section 1b)
[76] See: https://www.vam.ac.uk/blog/caring-for-our-collections/the-curious-case-of-the-tibetan-skull-drum

personnel were often taken without consent, to collate information on injury caused by weaponry and wounding.[77] However, the origin of these human remains can come from violations of human rights including genocide[78], vivisection and execution[79] and trophy taking. The human remains presented as 'Object 52'[80] comprise human tissue collected during an act of war crime and possible trophy taking:

> *French officer's skin from the battle of Breda, 1793.*
>
> *Human Skin, specimen.*
>
> *An uncomfortable thought today but items made from the skin of executed criminals, or, as in this case, wartime enemies were sometimes presented by anatomists as gifts to friends. The presentation to the Royal College of Surgeons of Edinburgh suggests this specimen was possibly thought to be of some use in instructing students of medicine and was not merely a gruesome trophy.*

The permanent record card for these human remains at Surgeons' Hall Museum shows more detail:

> *French officer's leg skin*
> *@LGN*
> *Dry specimen. French officer's skin from the Battle of Breda, 1793. Breda, in Holland, was captured during the French Revolutionary Wars in which France had declared war of Great Britain and the Netherlands. This skin was tanned by a local man, possibly as a trophy in defiance of the invasion of his town. It was presented to the College by a Fellow in 1834 perhaps due to its unusual nature rather than as a teaching specimen.*
> *LEG, skin*
> *Height: Frame 930 cm*[81]

[77] Samuel J. M. M. Alberti, "The 'Regiment of Skeletons': A First World War Medical Collection," *Social History of Medicine*, 28 no. 1 (2015), 108–133, https://doi.org/10.1093/shm/hku038
[78] For an example of rediscovered skulls and death masks of Jewish Polish freedom fighter of World War Two in the Vienna Museum, see: From Clinic to Concentration Camp: Reassessing Nazi Medical and Racial Research, 1933-1945. United Kingdom: Taylor & Francis, 2017. 130
[79] See: RCP on British Advisory Committee for Medical War Crimes https://history.rcplondon.ac.uk/blog/these-grim-documents-physicians-responses-nazi-medical-war-crimes
[80] 'Object 52' Courtesy of the Royal College of Surgeons of Edinburgh, LGN.
[81] To see record card, search @LGN here: https://museum.rcsed.ac.uk/the-collection/search-the-museum-collections-adlib

Under the Human Tissue Acts 2004 and 2006 (Scotland), these human remains were displayed legally. However, The Department for Culture, Media and Sport's G*uidance for the Care of Human Remains in Museums* section 2.7 Public Display states:

> *Human remains should be displayed only if the museum believes that it makes a material contribution to a particular interpretation; and that contribution could not be made equally effectively in another way. Displays should always be accompanied by sufficient explanatory material.*[82]

Hence, when viewing the interpretation for these human remains, it is difficult to comprehend the objectives for display. It is admittedly 'uncomfortable' and 'gruesome', and the labelling makes little case for inclusion on the exhibition.

2.3.3 The Equality Act 2006

Outside the museum profession, legislation on domestic discrimination was also progressing. These new laws would, eventually, influence museum practice. For medical museums, it would provide vital guidelines for how to represent equality and protect the emotional safety of the living. During the development and delivery of Anatomy Acts, the Equality Act 2006 came into law and made provision for:

> *the establishment of the Commission for Equality and Human Rights; to dissolve the Equal Opportunities Commission, the Commission for Racial Equality and the Disability Rights Commission; to make provision about discrimination on grounds of religion or belief; to enable provision to be made about discrimination on grounds of sexual orientation; to impose duties relating to sex discrimination on persons performing public functions; to amend the Disability Discrimination Act 1995; and for connected purposes.*
>
> *[16th February 2006]* [83]

[82] See: https://www.britishmuseum.org/sites/default/files/2019-11/DCMS-Guidance-for-the-care-of-human-remains-in-museum.pdf, 20
[83] Equality Act 2006, Chapter 3, Introduction: https://www.legislation.gov.uk/ukpga/2006/3

The Equality Act 2006 protected many of the characteristics of those who had been abused by the collection of human tissue from domestic discrimination. This Act specified protected groups under the 2006 Equality Act as:

> *In this Part 'group' means a group or class of persons who share a common attribute in respect of any of the following matters— (a) age, (b) disability, (c) gender, (d) proposed, commenced or completed reassignment of gender (within the meaning given by section 82(1) of the Sex Discrimination Act 1975 (c. 65)), (e) race, (f) religion or belief, and (g) sexual orientation.*

In Scotland's wider museum community, it took almost ten years for the Equality Act to be represented in policy. The first being the National Museums of Scotland (NMS), a partner of *Anatomy Acts*. In 2015, NMS defined its duties under the amended Equality Act 2010 as policy maker, employer and service provider, in its policy document *Mainstreaming the Equality Act: Progress report on the delivery of the aims of the general duty of the Equality Act 2010*.

The characteristics are protected under the Equality Act 2010:[84]

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.

As part of a five-step plan for service provision and equality, National Museums Scotland began a review of their Project Management Framework 'to prompt the planning of better engagement with a broader range of audiences, including those who share one or more protected characteristics, by Summer 2015'.[85] National Museums Scotland was the first partner of *Anatomy Acts* to implement new practice in line with the Equality Acts. The lack of consideration for equality legislation leads to a more complex issue, which can help to further safeguard medical museum displays from acts of omission. Stepping, briefly, away from

[84] See the Equality Act 2010, Part 2 Equality: key concepts, Chapter 1: https://www.legislation.gov.uk/ukpga/2010/15/contents

[85] *Mainstreaming the Equality Act Progress report on the delivery of the aims of the general duty of the Equality Act 2010* http://www.nms.ac.uk/media/738593/2015-mainstreaming-report.pdf, 9

human remains to consider the representation of the work of Ambroise Parè within the exhibition demonstrates the implications of displaying historic ableism and sexism in modern displays.

On display within the *Anatomy Acts* exhibition was the text *Opera Chirurgica* by French surgeon-anatomist Ambroise Parè (1510–1590). The text was labelled in the accompanying object guide and exhibition as:

> *Object 19*
>
> *Opera Chirurgica, Frankfurt am Main, Latin edition, 1594*
>
> *Ambroise Parè (1510 – 1590), Book*
>
> *Frenchman Ambroise Parè is considered to be one of the pioneers of modern surgery. He specialised in military surgery and introduced key innovations in surgical techniques such as the use of safe cauterising and ligatures to treat amputations. He was surgeon to four French kings, including François II, husband of Mary Queen of Scots. He acknowledged using illustrations from major atlases including those by Vesalius. Parè was interested in reports of anatomical abnormalities (pathologies) in humans and other animals. Here are illustrations and texts concerning conjoined twins. This is a Latin translation of Parè's Oeuvres, first published in French 1575.*
>
> *Special collections, University of St Andrews, Typ GF.B94FP*[86]

The presentation of Parè and his text demonstrates the heroic narrative used to obscure the dangerous and discriminatory side of his work. There are many positive and fascinating facts about Parè's life and work that can be used to capture the visitors' attention. Parè held positions within the royal court of France, serving the monarchs Henry II, Francis II, Charles IX and Henry III, and was an innovative and progressive military surgeon, especially in dealing with wounding. Amongst Parè's many notable achievements are the development of eye and limb prosthetics, the protective and progressive nature of his work included rejecting the common practice of use of boiling oil to cauterise gunshot wounds[87] and stopping the practice of

[86] S. Barnes and D. Kemp (eds.), *Anatomy Acts Object Guide*, 16.
[87] P. Hernigou, "Ambroise Paré II: Paré's contributions to amputation and ligature," *International Orthopaedics*, 37 no. 4 (2013), 770. http://doi.org/10.1007/s00264-013-1857-x

castration in hernia operations.[88] Parè was deeply concerned by the psychology of military action and the connection between suicide and the loss of limbs in battle. He showed great compassion when working to mimic biological functionality in prosthetic limbs for wounded soldiers, including a pully system that 'mimicked arm muscles'.[89]

Yet, the section of *Opera Chirurgica* on display was not a progression of medicine and contains pseudoscience, sexism and ableism. *On Monsters and Marvels* is Parè's illustrated text on 'monstrous bodies' and consists of a collection or compendium of ancient attitudes, mythology and his own views on congenital difference, or what would become the study of *teratology*. Parè's work differs from collections discussed so far, they are illustrations of conjoined twins which are drawn from mythology not medical research. Parè uses these drawings in conjunction with his own anatomical studies, some of which pertains to those who 'were dissected and preserved at his house'.[90] Hence here we have a dangerous mixture of science and mythology which is used to propagate pseudoscience. In this work, Parè broadly defined two categories of 'monsters' including foetal difference such as conjoined twins, intersex births, disability or deformity. The second category were 'marvels', which read as superstitions relating to women giving birth to animals and supernatural beasts. Parè's work shows 'the ableist implications of the rhetorical warrant 'normal is natural''.[91] Parè articulates these differences as:

> *Monsters are things that appear outside the course of Nature (and are usually signs of forthcoming misfortune). Marvels, too, are 'against nature,' and may—along with monstrosity—reveal the 'judgment of God, who permits fathers and mothers to produce such abominations from the disorder that they make in copulation, like brutish beasts, in which their appetite guides them'.*

Parè's status in society and the medical profession gave scientific credence to a resurgence of dangerous ideas relating to maternity, intersexuality, disability and deformity. The 'sixteenth-century humanist revival of classical literature had excavated theories of monsters and prodigies which, when influenced by medieval religious and popular folk-belief systems,

[88] V.K. Nigam and S. Nigam, *Essentials of Abdominal Wall Hernias* (Delhi: I.K. International, 2009).
[89] P. Hernigou, "Ambroise Paré II," 770.
[90] A.W. Bates, *Emblematic Monsters: Unnatural Conceptions and Deformed Births in Early Modern* (Amsterdam: Rodopi, 2005).
[91] J.L. Cherney, "The Rhetoric of Ableism," *Disability Studies Quarterly*, 31 no. 2 (2011).

effected a powerful hold on the Renaissance imagination'.[92] *On Monsters and Marvels* details birth defects as a 'sinister sign ('mauvais augure') that expresses guilt or sin of the parents', and, in terms of who was to blame for foetal deformities, 'sexual excess, especially in the women is always a factor'.[93] Therefore, *Opera Chirurgica* and the accompanying interpretation left discriminatory and pseudoscientific ideas towards women and those born with congenital difference unchallenged. This act of 'invalidating bystander silence' not only misrepresents vulnerable historical patients, it also has the potential to impact on the emotional safety of modern viewers, especially those with lived experience of these forms of discrimination.

The unintentional acts of omission in Anatomy Acts most probably came from error due its early and fast progression which was concurrent with new legislation. The partnership involved museum professionals who produced a ground-breaking exhibition on a challenging subject area at a pivotal point in the history of medical human remains. A further explanation on why these points were missed, can, perhaps be explained by the need to reconcile the heroic and painful narratives of the history of medicine. However, during the period of Anatomy Acts, approaches which challenged this narrative were difficult to find. It was not until 2012, five years after Anatomy Acts, that the hierarchical concept of medical museums would be challenged by artistic activism through the Wellcome Trust funded project *Stories of a Different Kind* (2012 – 2014). [94] This project was led by the Research Centre for Museums and Galleries (RCMG) at the University of Leicester in partnership with the Hunterian Museum atthe Royal College of Surgeons, the Science Museum, the Royal College of Physicians, SHAPE,and the Smithsonian Institution.[95] In the context of Institutional Betrayal, this project directly challenged the 'invalidating bystander silence' by openly discussing and challenging the acts of omission and commission in medical museums.

[92] J. Hubert, *Madness, Disability and Social Exclusion: The Archaeology and Anthropology of 'Difference'* (London: Routledge, 2013).
[93] J. Price and M. Shildrick, *Feminist Theory and the Body: A Reader* (Abingdon on Thames: Taylor and Francis, 1999), 291.
[94] For introduction to *Cabinet of Curiosities* with Matt Fraser see: https://youtu.be/L9z378LBmBU;
[95] See *Stories of a Different Kind* website: https://le.ac.uk/rcmg/research-archive/stories-of-a-different-kind

2.4 Disability activism: Research Centre for Museums and Galleries

The RCMG was founded in 1999 by Professor Eilean Hooper-Greenhill.[96] *Stories of a Different Kind* was initiated and led by Professor Richard Sandell and Professor Joycelyn Dodds of the RCMG. For this project, critically acclaimed actor and performance artist Matt Fraser was commissioned to create 'a new artistic work, shaped out of a collaborative engagement with museum collections, research and expertise in medical history, museums and disability'.[97] The result was a live performance entitled *Cabinet of Curiosities: How disability was kept in a box*.[98] Whereas *Anatomy Acts* had been groundbreaking in terms of increasing public access, *Cabinet of Curiosities* forged the way for ableism within medical museums and society to be challenged in a vibrant and open environment. In an interview with *Disability Arts*, Sandall explained how the process of 'trying to use museums to tell different stories around disability and challenge audiences'[99] began with the commission of '*Cabinet of Curiosities* where disabled artist Matt Fraser was invited to respond to the exhibits and archives of the Royal College of Physicians [of London]'. Sandell describes how this shift in perspective impacted on practice:

> *Working with artist Matt Fraser was new to us. What we saw were stories of a different kind with Cabinet of Curiosities. We saw the amazing potential that bringing in those different voices into the museum context held for the kinds of work we were trying to do. We could see that live art was really powerful. It brought a personal experience of lived experience of disability into the museum. It also had a very visceral emotional capacity to provoke that very emotional, visceral response in audiences which is something museums haven't always embraced and been so good at.*[100]

Cabinet of Curiosities was performed at the Thackray Medical Museum, Silk Mill Museum, and Manchester Museum. *Stories of a Different Kind* won the *Observer* Ethical Awards for

[96] See RCMG website: https://le.ac.uk/rcmg/about
[97] See RCMG: *Cabinet of Curiosity* webpage: https://le.ac.uk/rcmg/research-archive/cabinet-of-curiosities
[98] The full performance can be seen here: https://youtu.be/49gXhrmmj9M youtu.be/49gXhrmmj9M
[99] Kate Lovell, *Disability Arts Online*: "Museums on the move: Richard Sandell on 'Exceptional and Extraordinary'," 13 June 2016: https://disabilityarts.online/magazine/opinion/museums-move-richard-sandell-exceptional-extraordinary/
[100] Lovell, "Museums on the move".

Arts and Culture 2014. It also provided a sound and equitable knowledge-base from to extend the theme of disability activism with more artists and more museums. In relation to this study, and returning to Sandell's interview for *Disability Arts Online*, a pertinent point relating to barriers of change in institutional betrayal was well articulated:

> *Individual museum staff that we've worked with have been incredibly open and up for it. Museums generally have a reputation for being quite conservative, quite risk averse, and there is a broader debate in museums about taking a more political and moral stand point on issues and being bolder and braver, so all the individuals we're working with closely are really up for that. But they have to negotiate their own institutional contexts and it's where the research centre is quite helpful because we've initiated and led on the projects, so the partners are all in it together. We're supporting them, and they're able to perhaps take a bigger risk than if they were doing it on their own, and I think that has been really crucial.*[101]

The ethos of the RCMG to support artists and practitioners in difficult conversations is an important point, and this stance was, again, highly visible in its next project. In 2015, following on from *Stories of a Different Kind*, the RCMG initiated *Exceptional and Extraordinary*. The project was again led by Professor Richard Sandell and Dr Joycelyn Dodds of Museum Studies, University of Leicester, with artists Francesca Martinez, Julie McNamara, David Hevey and Deaf Men Dancing. The project represented 'a collaboration between four artists and experts in medical history, disability and museums, exploring behind the scenes of eight of the UK's most renowned medical museums'.[102] This project used medical collections rather than medical human remains, a point I shall return to in the summary of this project, below. The participating museums were:

- Hunterian Museum, Royal College of Surgeons, London
- Royal College of Physicians Museum, London
- Science Museum, London
- Royal London Hospital Museum and Archive, London
- Langdon Down Museum of Learning Disability, Normansfield, Middlesex
- Bethlem Museum of the Mind, Beckenham, Kent
- Thackray Medical Museum, Leeds
- Surgeons' Hall Museum, Royal College of Surgeons, Edinburgh

[101] Lovell, "Museums on the move".
[102] See University of Leicester press release: https://www2.le.ac.uk/offices/press/press-releases/2016/march/unruly-bodies-and-minds-in-the-medical-museum

This project reversed the established hierarchal perspective of medical museums that places medical professionals and knowledge above lived experience. The project statement explains not only its importance to museums, medicine and activism, but its importance to this study and the situation of medical human remains within institutional ideologies:

> *Medical museums contain a wealth of collections that are relevant to the lives of disabled people; however many of these collections are under-researched or are understood through biomedical perspectives that do not represent the lives and experiences of disabled people through their own voices and stories, but rather through the voices of surgeons, doctors and other medical practitioners. In recent decades, disabled people, activists and researchers have fought and struggled to challenge these medical perspectives as part of a global disability rights movement, to challenge the view that physical and mental impairments are 'deficiencies' that need correction or cure to conform to ideas about what is 'normal' for the body and mind. Rather than disability being a result of impairment (body or mind), it is a product of barriers created by society (physical, sensory, attitudes) that prevent disabled people from playing a full and active contribution. It is society that disables people, not their impairment. This social model of disability is very different to the medical model, which sees the individual's impairment as the 'problem' that needs intervention, fix or cure.*[103]

Exceptional and Extraordinary produced four performances:

- *The Fight for Life*, David Hevey[104]
- *Hold the Hearse!*, Julie McNamara[105]
- *The Wobbly Manifesto*, Francesca Martinez[106]
- *Let Me Tell You a Story*, Deaf Men Dancing (Mark Smith)[107]

[103] See: https://www.unrulybodies.le.ac.uk/the-project/why-medical-museums/
[104] *The Fight for Life*: http://www.unrulybodies.le.ac.uk/4-extraordinary-artists/david-hevey-and-the-fight-for-life/
[105] *Hold the Hearse!:* http://www.unrulybodies.le.ac.uk/4-extraordinary-artists/1st-artist/
[106] *The Wobbly Manifesto*: http://www.unrulybodies.le.ac.uk/4-extraordinary-artists/francesca-martinez-and-the-wobbly-manifesto/
[107] *Let Me Tell You a Story*: http://www.unrulybodies.le.ac.uk/4-extraordinary-artists/2nd-artist/

One of the many progressive points of *Exceptional and Extraordinary* was the forethought for accessible legacy, which was achieved by detailing and interrogating processes as the project progressed. This was captured and is detailed on the project webpage, and in the *Exceptional & Extraordinary Audience Engagement and Response Report*, published in June 2017.[108] Accessibility for practitioners is not often considered as a priority in evaluation or reporting. However, I have been involved in many discussions with arts practitioners who often feel that the intensity of their work and the hours required mean that their own development and reading has to come second to delivering activities or performing multiple roles. Yet, the concentration on artist dignity and identity was a profound point, which showed demonstrable progression for engagement in medical museums.

From the beginning, the presentation of *Exceptional and Extraordinary* used the artists' words and images of their engagement with collections to demonstrate how they led their own artistic processes. It also gave a sense of getting to know the artists outside their performance piece, and a heightened sense of ownership of work, rather than it being the museums' activity. The short video clips demonstrate how progressive debate was brought by an open, respectful discussion forum where a sense of distance from the past could start to be achieved. 'Behind the Scenes' shows how the artists articulated a sense of privilege in being able to explore the collections, and also the enjoyment felt in the learning and development of their own activism. David Hevey described how he felt 'massively privileged' to go behind the scenes at the Science Museum, Hunterian Museum and other collections the explore the 'specimen culture'.[109] Julie McNamara stated: 'I just loved the process – everything in the set has come through something I've witnessed inside those collections.'[110] Mark Smith's account gives more information on why he felt the processes of *Exceptional and Extraordinary* presented vital opportunities for disability activism:

> *Well, basically, I've been given a very amazing and lucky opportunity to receive a commission to visit museums and to look at equipment and objects, you know, that a hundred years ago … deaf people wore, like ear horns and even boxes, which were amazing. And I felt a very personal connection with it, and I spoke*

[108] *Exceptional & Extraordinary Audience Engagement and Response Report*, RCMG, University of Leicester June 2017: https://www.unrulybodies.le.ac.uk/wp-content/uploads/2016/11/EE-Evaluation-June-2017.pdf
[109] Q&A with David Hevey – "Behind the Scenes": https://youtu.be/zdzgs2g0Myk 0.04–0.12
[110] Q&A with Julie McNamara – "The Process": https://youtu.be/DtZr9dK6Xc8 0.00–0.08.

> *to people, you know, professors and people who know a lot about the deaf history of the deaf culture. And, for me, I felt I've learned so much about myself as a deaf person, you know, and I felt it was my responsibility to retell the story – retell the history to the next generation, you know, who may not know anything about the Milan Conference,*[111] *for example.*[112]

These video clips were an inspiring part of the project, and gave autonomy to the artist activists. Yet, a point made by Hevey made me question how the use of medical collections, without the context of medical human remains, can perhaps obscure the gravity of abuse present in medical museums. In 'Behind the Scenes', Hevey explains the lack of representation or voice of disability in medical collections as being due to the collections beingbuilt solely as 'apparatus of understanding from science points'.[113] Yet, the performances didnot obscure the reality of residual ideologies towards disability. Francesca Martinez's performance *The Wobbly Manifesto* explored how historical attitudes of discrimination can affect the living in medical museums, which is particularly relevant to the second part of thisstudy. Martinez explored medical ideologies reacting to disability by 'bringing back to life' Sir William Ostler and challenging the ideologies and the legacy of medical discrimination heleft for her and everyone else who lives with cerebral palsy.[114] Martinez's statements on disability in this performance offer deep insight, and her delivery style takes us with her through her challenge to Ostler. Yet, she does something more, in this five-minute clip: she manages to encapsulate the layers of ableism, classism and sexism that still permeate the grandbuildings and halls that are still used by medical institutions to display medical collections and medical human remains.

Both *Cabinets of Curiosities* and *Exceptional and Extraordinary* brought a new artist- and activism-led perspective to medical museums. These projects demonstrated why a duty of care for medical museums should include actively challenging discriminatory ideologies as part of protecting the dignity and emotional safety of both the living and dead. The RCMG projects

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[111] The Milan Conference was the second International Congress on Education of the Deaf; a resolution banning the use of sign language in school was passed here. It came into effect in European and American schools. See: Margret A. Winzer, *The History of Special Education: From Isolation to Integration* (Washington, DC: Gallaudet University Press, 1993).
[112] Q&A with Mark Smith – "The Process": https://youtu.be/4cQ70q6tFrY 0.35–1.29.
[113] Q&A with David Hevey – "Behind the Scenes": https://youtu.be/zdzgs2g0Myk 0.38–0.39.
[114] See Martinez's challenge to Ostler and his naming of cerebral palsy: "Francesca Martinez meets her Nemesis – Wobbly Manifesto": https://www.youtube.com/watch?v=64hhDLw6hWs&feature=youtu.be

proved an important point: medical museums are public spaces that represent the medical profession. Thus, their attitudes towards patient health must show a demonstrable stance against discrimination. Following on from the progression in law and policy, and innovative projects, the concluding section of this study examines how the medical museum can adapt to becoming equitable spaces that welcome community groups and challenge residual discriminatory attitudes. Yet, before this is possible, the specific forms of classism and elitism within medical museums should be further understood.

Chapter 3: A duty of care to the living: Understanding why medical elitism causes socio-economic discrimination

As discussed in Chapter One, acts of *omission* occur when harm is caused by a failure to provide a duty of care.[5] For the medical museum, failures in duty of care can occur through the treatment of the dead and of the living. This chapter concentrates on the duty of care to the living, specifically those who could experience socio-economic discrimination in medical museums due to medical elitism. Here, the terms medical elitism and socio-economic discrimination are used to define a direct and explicit form of residual institutional classism which occurs within medical museums. These two terms have been selected because, together, they help to define the intersectional point of disempowerment which enables all betrayals discussed in this study - medical elitism relates to a value system which believes decision making belongs to those of a high socio-economic status; socio-economic discrimination is the impact of these decisions.

Whereas the previous chapters have focused on physical acts of harm and procedural matters, this chapter questions the attitudes which allow failures in duty of care to occur in medical museums. Here, it is important for medical museums to consider how their own 'moral values'[6] are communicated through elitist behaviour. Within contemporary elite medical institutions, the display of those whose socio-economic status left them vulnerable to execution, anatomy murder and the withdrawal of anthropological rights, should be an obvious point of tension. Yet, the lack of transparency on why this behaviour remains unchallenged is often not discussed. Although medical human remains were taken historically, the decisions to retain and display collections have been made recently, in some cases after the Human Tissue Acts of 2004 and 2006. As discussed in Chapter One, The Hunterian Museum has decided to keep the remains of Charles Byrne on display, even after public protest. Similarly, in 2015, Surgeons' Hall Museum reopened their exhibition of medical human remains. The exhibition opens with the story of David Myles, who died during an act of judicial murder, and whose human remains are listed as 'may be that this is a dissected body of child dissected by Pitcairn but not that of Myles'.[7] By doing so, both institutions have publicly reiterated the elitist stance that their ownership of these human remains is more important than individual anthropological rights[8].

[5] See introduction, p7
[6] See discussion on Surgeons' Hall Museum visitor statement, p.48
[7] See https://museum.rcsed.ac.uk/the-collection/search-the-museum-collections-adlib -search object ref: GC.15308
[8] See section 1.3 for David Myles; Section 1.7 for Charles Byrne

Consequently, to question the place of medical human remains in museum spaces can be seen as a challenge to both historical and modern decisions of prominent individuals and institutions. Therefore, although medical human remains are the most graphic representation of inequality in medical museums, it is important to examine why decisions to ignore the impacts of medical elitism still occur, and to reflect on how this demonstrates a failure in the duty of care to the living.

For contemporary museum practitioners, open discussions on equality practice are vital. However, for this area of study, challenging medical elitism is a vast and complex area. Furthermore, initiating change can bring a 'fear of controversy', Freyd and Smith's third barrier to change.[9] Yet, overcoming these challenges is important not only for the sake of good equality practice, but because the medical museum is a space representative of the medical profession. As discussed by Smith and Freyd, 'wrongdoings perpetrated by an institution upon individuals dependent on that institution' can cause social harm.[10] Hence, it is vital for medical museums to consider how their behaviour and choices affect the duty of care they have to those who are dependent on public healthcare, i.e., the majority of the public, and not least those whose health is affected by socio-economic discrimination.

Consequently, the aim of this concluding chapter is to demonstrate how medical elitism and socio-economic discrimination can be deconstructed through developing contemporary medical museum practice. This chapter begins with a brief exploration of the origins of socio-economic divides in medical museums, demonstrating that the residual nature of medical elitism is a widespread, institutional issue. This is important to understand as the following, main section of this chapter concentrates on a case study of my own work within one institution, Surgeons' Hall Museums. The case study details a reflexive analysis of my work with Surgeons' Hall Museum and explores the process of developing a social role for the museum. The case study begins by exploring how appropriate attitudes for social roles can be developed though understanding and negotiating the tensions between medical behaviourism and participatory methods. After this exploration of attitudinal issues, the purpose of a social role is considered through developing practice in health and wellbeing community engagement. Finally, this study provides a practitioner-based account of developing the first community engagement programme for Surgeons' Hall Museum. This case study demonstrates the level of safeguarding and consideration needed when working with elite organisations and sensitive

[9] See Introduction, p8
[10] See introduction, p7

collections. In doing so, it shows how to build the foundations needed for social roles. In the closing section, to reconsider the main themes of this study, the use of human remains in a community engagement project will be reassessed. References to domestic discrimination as racism will be more fully addressed in the final section of this study. Ultimately, this chapter reinforces the evidence presented in Chapters One and Two and argues for a radical change in practice. This argument aims to provide guidance for contemporary practitioners within medical museums and the wider museum community.

3.1 Understanding the socio-economic divide in medical museums

Returning to Chapter One and the origins of the medical museum, the displays of Rusch and Albinus demonstrate the original, intentional two-tier system for academic visitors, who were there to learn, and an interested public, who were there to satisfy curiosity. These museums were intended to be exclusive, prestigious and elitist places to study and work. Here, it is important to acknowledge the primary purpose of medical museums in the development of medical institutions and medical education. This significance is articulated well by Reinarz:

> *Birmingham medical school's museum was central to instruction at the institution from its foundation in 1828. This is signalled by the speed of its establishment. It is also clearly expressed in the school's first minute book, dating from 1831. Besides the everyday administration of the school, the ledger lists each donation and change to this educational facility. In fact, its first entry is a request that lecturers 'solicit donations in order to develop a museum adequate to the purposes of the medical school'.*[11]

Therefore, medical museums were not originally designed to be public spaces, they were integral parts of educational institutions. Yet, these museums were 'one of the few spheres of medical schools that were occasionally unveiled to the public during special events, such as university conversaziones, or open days'.[12] Historically, and from my own experience, access was seen as an invitation, not a right, as these were places of work and study. Therefore, throughout the rise and fall of medical museums, use for medical research was always prioritised over public access. Practically, withdrawing public access to concentrate on

[11] Jonathan Reinarz, The Age of Museum Medicine: The Rise and Fall of the Medical Museum at Birmingham's School of Medicine, Social History of Medicine, Volume 18, Issue 3, December 2005, Pages 419–437, https://doi.org/10.1093/shm/hki050, 423

[12] Jonathan Reinarz, The Age of Museum Medicine: The Rise and Fall of the Medical Museum at Birmingham's School of Medicine, Social History of Medicine, Volume 18, Issue 3, December 2005, Pages 419–437, https://doi.org/10.1093/shm/hki050, 420

research is perfectly rational if public access was only intended to satisfy 'curiosity'. These decisions could be explained as 'legitimate position power, based on a social norm requiring obedience to people who are in a superior position in a formal or informal social structure' [13].

Here, it is important to demonstrate the function and position of the medical museum within its institutional context, and thus demonstrate their primary function. The first category, 'Medical museums that house medical human remains' is central to this study. However, a brief explanation of other environments is included in 'Museums that house medical human remains.'

Medical museums that house human remains

Medical and Surgical Colleges whose primary function is the advancement and development of practice for qualified medical professionals, i.e., post university development, and include institutions such as Surgeons Hall Museum (The Royal College of Surgeons of Edinburgh), and The Hunterian Museum (The Royal College of Surgeons of England) and The Mütter Museum (The College of Physicians of Philadelphia).

Research Institutions within universities whose primary function is higher education and research, institutions who house these museums include University of Edinburgh, University of St Andrews and University of Glasgow[14]

Teaching hospitals whose primary focus is treatment, research and education, these museums include UCL Pathology Collections situated within the Royal Free Hospital Campus of the UCL Medical School, Barts Pathology Museum, situated in St Bartholomew's Hospital and Museum Vrolik within Academic Medical Center (University of Amsterdam).

Museums that house medical human remains

National museums operated and owned by the state or government, which care and provide access to collections of national and international importance, and where human remains, and medicine are not the primary focus. These Museums include National Museums of Scotland, Musée l'Homme, Paris and British Museum. These human remains are often related to social anthropology rather than medicine, however, there is often crossover between categorisations.[15]

[13] Pierro, A., Cicero, L. and Raven, B.H. (2008), Motivated Compliance With Bases of Social Power. Journal of Applied Social Psychology, 38: 1921-1944. https://doi.org/10.1111/j.1559-1816.2008.00374.x
[14] See: 2.3.1 Increasing access: The first tour of UK human remains
[15] See 1.9 The Betrayal of Sarah Baartman

Other notable exceptions are Wellcome Collection, which is an independent global charitable foundation, founded by pharmaceutical entrepreneur, Sir Henry Wellcome. Controversially, and as discussed in Chapter One, [16] private exhibiters such as Gunter von Hagen's Body Worlds, also display anatomised human remains, which are now processed through von Hagen's own private laboratory Gubener Plastinate GmbH.[17]

Therefore, although collections of human remains have played a significant part in developing education within medical institutions, they were created for those viewed as higher social status at the expense of those with a lower social status. Unfortunately, socio-economic discrimination is still dominant within the UK. Elitist Britain 2019, produced by the Sutton Trust with the Social Mobility Commission, shows the 'latest indications are that social mobility across the UK is low and not improving. This deprives large parts of the population, both socio-economically and geographically, of opportunity.'[18] Within the medical profession, this problem is prevalent:

> *Entry to the professions traditionally regarded as 'elite', positions with significant prestige, and usually high financial remuneration, is known to be particularly heavily stratified by socio-economic background. (….) Across these roles, individuals from professional or managerial backgrounds are consistently over-represented, including 74% of those working in medicine, 64% of journalists and the same percentage of those working in law coming from higher socio-economic backgrounds cannot be fully addressed in this study.*[19]

This study cannot address the socio-economic balance within the medical education system and profession. However, it can highlight the negative impact of socio-economic discrimination in medical museums. Within medical institutions, an over representation of those from a high socio-economic background decide how the remains of those who were

[16] See: 1.7 The betrayal of Charles Byrne
[17] See: Gubener Plastinate GmbH, https://anatomicexcellence.com/gubener-plastinate/
[18] Elitist Britain 2019: The educational backgrounds of Britain's leading people, the Sutton Trust and the Social Mobility Commission, Sutton Trust & Crown: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/811045/Elitist_Britain_2019.pdf, accessed 23/02/2022
[19] Elitist Britain 2019: The educational backgrounds of Britain's leading people, the Sutton Trust and the Social Mobility Commission, Sutton Trust & Crown: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/811045/Elitist_Britain_2019.pdf, 11, accessed 23/02/2022

discriminated against were, and still are treated. Those who pay fees by becoming students and members, or bring funding and innovation become of value through their initial status, contribution and continued social mobility. Those who are underrepresented and who cannot contribute professionally or financially are not valued to a business model unless an object of profit. The socio-economic priorities within the medical profession, can be related to arguments on the destructive force of Neoliberalism creating open markets in health and education.[20] In relation to medical environments, the open market allowed private medical institutions to profit from private practice, and encouraged placing financial values on health service users and education. Hence, Neoliberalism continues to reinforce the socio-economic divide between medical professionals and those who cannot access further education or private healthcare. One of the results of this socio-economic inequality in medical institutions, is that museum engagement with communities experiencing poverty is often not viewed as a vital purpose. However, at the beginning of the 21st century, the emerging field of museums, health and wellbeing began to develop through increased research and funding. This area of research and practice worked conversely to the Neoliberal standpoint and aimed to explore how museums could bring social impact to community health. For Surgeons' Hall Museum, this provided an opportunity to begin to refocus their priorities.

[20] D. Harvey, "Neo-liberalism as creative destruction," Geografiska Annaler: Series B, Human Geography, 88 no. 2 (2006), 145–58.

3.2 Case Study: Developing a Social Role for Surgeons' Hall Museum

This case study demonstrates how the process of developing a social role for medical museums can be used to deconstruct and challenge medical elitism and the resulting socio-economic discrimination. It is a candid, reflexive study of my own work conducted from 2013-2015, showing developments, challenges, and modern acts of omission.

In December 2014, Surgeons' Hall Museum, The Royal College of Surgeons of Edinburgh began the £4.2 million Lister Project[21], funded by Heritage Lottery Fund (£2.7 million), and a college-led fundraising initiative (£1.5 million). This project had been in development from 2009 and aimed to transform, renovate and conserve the internal and external museum and library spaces. One of the funding conditions was that it would be an accessible learning space for all. As part of the process, I had undertaken an audience development plan. A major area of deficit in local visitor demographics was from communities in areas of high socio-economic deprivation. As a community focussed funder, engaging with excluded communities was a priority for Heritage Lottery Fund, and therefore had to be an area of development for Surgeons' Hall Museum. For Surgeons' Hall Museum this presented an opportunity to develop ways to bring social impact to the surrounding areas, who were often at high risk of poor health due to socio-economic deprivation. Yet, the painful history of Surgeons' Hall Museum meant developing methods for social impact would be a complex process.

Finding ways to develop social impact is not exclusively a problem for medical museums. In 2018, Graham Black, reflecting on his career in museums, commented 'we have a difficult record to overcome in terms of social impact. 19th century museums had a specific remit to promote a stable social order, supporting the values of the middle and upper classes and a social hierarchy, and hence a stable society'.[22] This is true, however, medical elitism in medical museums can manifest in particularly cruel and inhumane ways, through the use and display of human remains, which is accepted practice. Hence, before medical museums can bring social impact, attitudes and behaviours need to develop to become appropriate for social roles. The context of social role here can be articulated by Sandell's comment on the wider museum community. If medical 'museums are to become effective agents for social inclusion, a paradigmatic shift in the purpose and role of museums in society, and concomitant changes in

[21] https://www.heritagefund.org.uk/cy/node/82244
[22] The Social Role of Museums – by Graham Black (interview): https://www.nightshift010.nl/the-social-role-of-museums-by-graham-black/ ('track record') 25 October 2018

working practices, will be required.[23] Yet, as shown throughout this study, implementing change in this area involves addressing a complicated set of historic and modern social structures, which are too vast to explore here. Therefore, this case study focuses on the pathway to social impact and demonstrates how individual practitioners can navigate the behavioural challenges of developing community-focused activities for medical museums, or for other museums with sensitive collections.

3.2.1 Developing methods: Formal Education Vs Community Engagement

In 2009, Surgeons' Hall Museum developed a schools' programme for secondary students studying biology and history, all activities were linked to curriculum learning. In 2010, a public engagement programme was developed through a series of events for Edinburgh Science Festival, Doors Open Day, Black History Month and a series of public lectures. Yet, community engagement was still not a part of the museum's' activities. A social role for the museum outside education and events had not been considered. In 2013, a development in this area was motivated by an external approach from Margaret Aitken, Director of Daisychain Associates, who invited us to join a ten-week programme *Our Natural Capital: Young people and social equality.*[24] This project was for young people not in formal education and ran from September 2013 to January 2014. For this project, Daisychain Associates were working with lead partners A&DS (Architecture and Design Scotland) and Circle Scotland, and delivery partners Historic Scotland: Edinburgh Castle, Historic Scotland: Holyrood Park, Wasteland Collective, Scottish Natural Heritage, Cockburn Association, Storyteller, Claire Druett, and graphic facilitator Clare Mills. The aim of *Our Natural Capital* was to invite:

> *young people from estates across the city to participate in a programme exploring aspects of built and natural heritage within Edinburgh's remarkable cityscape. Edinburgh is a city of landscapes, and stories. The lives of people and the landscape are closely linked. These links shape the heritage of the city, and the values we use to make decisions about why the city, and its spaces, are the way they are.*[25]

What this meant practically was working with a group of 14 young people aged between 15–

[23] Sandell, Richard. (2003). Social Inclusion, the Museum and the Dynamics of Sectoral Change. Museum and Society. 1. 52
[24] For full *Our Natural Capital* story map, see: http://ournaturalcapital.blogspot.com/2014/01/story-map.html
[25] See: https://www.ads.org.uk/our-natural-capital-programme/

17 years old who lived in Pilton[26] and who had been excluded or were self-excluding from school. The project aim was for them to co-produce an engagement programme relating their own experiences of Edinburgh city centre. The goal was for them to participate in the cultural landscape of Edinburgh. Surgeons' Hall Museum was invited to be part of the project, our role was to facilitate sessions on unseen and inaccessible heritage areas and to contribute content on health and wellbeing.

As part of this project, visits to Surgeons' Hall Museum took place in September and October 2013. Prior to Our Natural Capital, visits to the museum by young people were mainly repeat visits from local private schools, including Loretto and George Heriot's. Therefore, in retrospect, we were not ready to deliver equitable community education activities. Due to our limited knowledge on engagement outside school settings, the first session with Our Natural Capital at Surgeons'Hall Museum took the same format as a school visit, which proved unsuitable. This curriculum-based method of engagement uncovered barriers to museums and triggered anxiety in some of the group who had suffered traumatic experiences while in formal education. Other members of the group openly expressed feelings of boredom.

This highlighted that a different approach was needed, rather than celebrating social status, behaviour suitable for social roles for community groups had to be developed. For this group, exploring participatory methods was essential in helping us replan the activity. As argued by Fielding and Rudduck, 'if theoretical perspectives and teaching methods cannot develop, learners can start to feel patronised, bored and ignored'.[27] In reassessing where we had failed in our original activity, Grek's study of learning in four Dundee Museums was useful to understand the value of taking participatory approaches. [28] In her interviews, a major benefit of museum education is touched on by an Education Officer, who explains we do not have to 'push people' through exams.[29] This comment reinforces Hooper-Greenhill's point, that introducing the strict pedagogical structures from formal learning institutions could be counterproductive when working with those excluded from education. Both Grek and Hooper-Greenhill highlight that developing creative pedagogies could progress intellectual access to collections for those

[26] Pilton remains the highest area of deprivation in Scotland, see: http://www.healthscotland.scot/media/2644/community-led-placemaking_muirhouse-and-west-pilton_hina-hirani.pdf

[27] M. Fielding and J. Rudduck, "The transformative potential of student voice: confronting the power issues," paper presented at the Annual Conference of the British Educational Research Association, Exeter, 12–14 September 2002 [online], http://www.leeds.ac.uk/ educol/ documents/ 00002544.htm

[28] S. Grek, "'In and against the museum': the contested spaces of museum education for adults," Studies in the Cultural Politics of Education, 30 no. 2 (2009).

[29] S. Grek, "'In and against the museum'," 199.

intimidated by formal learning styles and environments. Hence, in terms of transforming practice, the potentially less formal environment of community and not 'school' presented opportunities for Surgeons' Hall Museum to develop new methods for community engagement.

Therefore, the continuing sessions had to become more about participation rather than formal education. Furthermore, to make the follow-on sessions work, there had to be a good level of consultation with the group. As discussed by Nind, the approach to participation is about 'listening, accessing perspectives, understanding experience, consulting, involving participants in decision making, or working together to make something happen'.[30] In reassessing this session, it became clear that we had not been doing any of this. Sessions were predesigned to meet curriculum targets, or to present the history of medicine from an institutional perspective. To make the sessions participatory, we needed to listen to the groups' perspectives and experiences, not only in relation to our activity but to their wider experience, and what they wanted from us. Here, it was helpful to draw on the practical guidance of Nina Simon's *The Participatory Museum.*[31] We arranged a focus group, which used 'hosting' where 'the institution turns over a gallery or a program to community partners'.[32] This meant the group took the lead and co-designed the next visit. The group wanted to see behind the scenes. Here, we reversed the social hierarchy and the group became VIP visitors to the museum, accessing 'staff only' and private areas. They wanted to concentrate on social history, to explore and find collections that were relevant to their experiences and anxieties, not see the collections through our perspectives. Hosting this visit as an open forum, meant the group consulted with us on what was important to their health and wellbeing. Instead of us talking about the museum's history, we discussed topics relating to pregnancy, eating disorders and anxiety. Through, participatory methods we reassessed the use of the collections for community engagement for young people, with the members of the group acting as co-researchers rather than subjects.[33]This session was professionally supported by Daisychain Associates and Circle, Scotland, and we would not have chosen these methods, for this age group, without youth worker support.

From an uncertain start, and through listening and adapting, Surgeons' Hall Museum helped to support young people outside formal education to produce their first engagement project. The outputs included 'Places for Young People' – a suggested code of practice that formed part of

[30] M. Nind, "Participatory data analysis: a step too far?" Qualitative Research, 11 no. 4. (2011): 349–363, 351.
[31] Simon, N. (2010) The Participatory Museum, Museum 2.0: http://www.participatorymuseum.org/
[32] Simon, N. (2010) The Participatory Museum, Museum 2.0: Hosting Participants: http://www.participatorymuseum.org/chapter9/
[33] M. Nind, "Participatory data analysis: a step too far?" Qualitative Research, 11 no. 4. (2011): 349–363, 351

the *OurNatural Capital* learning resource pack.[34] As an institution we did gain from this project, but not in the usual sense, through using participatory methods and with the patience and the support of the group and partner organisations involved, we learned the difference between education and community engagement. However, to lead our own activities, there would need to be a deeper understanding how our original methods had caused tensions.

In reviewing Our Natural Capital, a main point of learning was that traditional methodologies were unsuitable for community education and the development of social roles. Here, it is important to reiterate medical museums are a specific group of educational institutions, and to not see the rigid methodologies discussed as an issue relating singularly to Surgeons' Hall Museum. Traditionally, in medical institutions, learning activities are often based around established education activities, including talks, demonstrations, and tours, frequently delivered by medical professionals who are presented as 'the sage on the stage'[35]. These events often involve an expert opinion with an emphasis on the social and professional status of the speaker. This is not a comment on quality of activity or delivery, but an important point when trying to understand how educational theory in medicine impacts on museum spaces. Pugsley's definition of behaviourism in medical education as 'a very controlling approach to education with the teacher determining what is learned and how and when the learning occurs'[36] is valuable when trying to understand how educational methods cause psychological barriers. If behaviourism is considered to be the 'proper' teaching method in medical environments, tensions can arise when developing new styles are suggested.

Concerns regarding the disempowerment of prominent medical professionals may not be an obvious or instantly pertinent point when developing community engagement. However, empathically understanding these tensions and working to develop social skills and social roles can benefit the practitioner and the community. The development of emotional intelligence and emotional regulation can increase medical competency, which benefits all.[37] Skills which utilise emotional intelligence and communication have more obvious advantages in situations such as delivering unwelcome or shocking news.[38]Emotional regulation such as 'detached concern' is

[34] Our Natural Capital learning pack resource: https://www.ads.org.uk/wp-content/uploads/9973_our-natural-capital-learning-resource.pdf
[35] Zwaagstra, M. (2020) A Sage on the Stage: Common Sense Reflections on Teaching and Learning John Catt Educational, Limited
[36] L. Pugsley, (2011) 'How to … Begin to get to grips with educational theory," Education for Primary Care, 22 no. 4 (2011), 266–8.
[37] B.D. Hodges and L. Lingard, *The Question of Competence: Reconsidering medical education in the twenty-first century* (Ithaca: Cornell University Press, 2012), 88.
[38] B.D. Hodges and L. Lingard, *The Question of Competence: Reconsidering medical education in the twenty-first century*, 88.

rightly seen as a sign of competency in situations of trauma.[39] Furthermore, developing physician empathy has been shown to bring positive impacts including 'improved patient satisfaction, greater adherence to therapy, better clinical outcomes, and lower malpractice liability'.[40] For particular interest to medical museums, there is evidence that more collaborative and contemplative environments have been experienced in undergraduate programmes where 'art-based interventions have enhanced medical students' self-reflection, communication and collaboration with colleagues, and understanding of physician-society relationships'.[41] Therefore, developing educational methods which concentrate on emotional intelligence, can help to deconstruct educational and social hierarchies.[42] However, to develop a social role, a community focussed purpose needed to be found for Surgeons' Hall Museum.

3.2.2 Recognising the importance of health and wellbeing in museums

A social role for Surgeons' Hall needed to combine the museum's original objective of health education with the community's need for empowering health and wellbeing activities.[43] Fortunately, the Lister project came at an innovative time, as strategies to support wellbeing and build 'more engaged communities'[44] were being developed by museum practitioners outside the medical museum community. The main strands of this engagement work were being developed by academic institutions with targeted funding to address specific areas of community health. The *Museums, Health and Wellbeing* project in the East Midlands demonstrated how collaboration between museum practitioners and health and social care practitioners could develop new levels of community engagement practice.[45] *Museums, Health*

[39] B.D. Hodges and L. Lingard, *The Question of Competence: Reconsidering medical education in the twenty-first century*, 87.
[40] S. Batt-Rawden, M. Chisolm, B. Anton and T.E. Flickinger (2013), "Teaching Empathy to Medical Students: An Updated Systematic Review," *Acad Med.*, 88 no. 8 (2013), 1171.
[41] M. Muszkat, A.B. Yehudam S. Moses and Y. Naparstek, "Teaching empathy through poetry: A clinically based model," Med Educ., 44 no. 503 (2010), 2.
[42] P. McLaren, "Critical pedagogy," in Transforming Practice: Critical Issues in Equity, Diversity and Education, ed. J. Soler, C.S. Walsh, A. Craft, J. Rix and K. Simmons (Stoke-on-Trent/Milton Keynes: Trentham Books/The Open University, 2012), 7.
[43] For a summary of the benefits of this type of engagement, see: M. O'Neil, "Cultural attendance and public mental health – from research to practice," *Journal of Public Mental Health*, 9 no. 4 (2010). Examples of similar projects in recent years include: C. Neal, "Can creative engagement in museums improve the mental health and wellbeing of people experiencing mental distress? A mixed methods pilot study," Final Report: April 2012: http://welshmuseumsfederation.org/uploads/online%20resources/Arteffact%20Final%20Report.pdf 8
[44] L. Milbourne, "Valuing difference or securing compliance? Working to involve young people in community settings," Children & Society, 23 no. 5 (2009), 346–63.
[45] J. Dodds and C. Jones, "Mind, body, spirit: How museums impact health and wellbeing," Arts CouncilEngland

and Wellbeing was 'a year-long action research project funded by Arts Council England (ACE) and initiated by the Research Centre for Museums and Galleries (RCMG), based in the School of Museum Studies at the University of Leicester'.[46] The 2014 project report began by acknowledging that 'health is increasingly recognized as a societal issue, linked to multiple and complex factors, persistent inequalities such as social and economic deprivation, and lifestyle'.[47] Furthermore, and importantly, *Museums, Health and Wellbeing* aimed to progress community engagement beyond often undocumented individual institutional activities and bring together five museums 'to expand the conversation, to advocate for museums and galleries making health and wellbeing part of their core activity.'[48]One of the conclusions, of particular interest to this work, was the suggestion that 'museums could work more closely with public health agencies to develop more sophisticated and longer-term measures of health and wellbeing assessment alongside tried and tested methods'.[49] Here, museums were developing social roles through health and wellbeing, outside of healthcare settings.

Within healthcare settings, Chatterjee's early work on 'object therapy' was exploring how museum collections could be used to culturally engage patients receiving hospital treatment.[50] In 2014, this work progressed to the £439,316 AHRC-funded project *Museums on Prescription: Exploring the role and value of cultural heritage in social prescribing*, which ran from August 2014 to December 2017. The project research demonstrated progressive outcomes in relation to health and well-being, which has definite relevance for developing community engagement in medical museums:

> *engaging in museums provides: positive social experiences, leading to reduced social isolation; opportunities for learning and acquiring new skills; calming experiences, leading to decreased anxiety; increased positive emotions, such as optimism, hope and enjoyment; increased self-esteem and sense of identity; increased inspiration and opportunities for meaning making; positive distraction from clinical environments, including hospitals and care homes; and increased communication between families, carers and health professionals*.[51]

and Museum of Leicester, June 2014: http://www2.le.ac.uk/departments/museumstudies/rcmg/publications/mind-body-spirit-report

[46] J. Dodds and C. Jones, "Mind, body, spirit", 3.
[47] J. Dodds and C. Jones, "Mind, body, spirit", 3.
[48] J. Dodds and C. Jones, "Mind, body, spirit", 3
[49] J. Dodds and C. Jones, "Mind, body, spirit", 43.
[50] H.J. Chatterjee and G. Noble, Museums, Health and Well-being (Farnham: Ashgate, 2013).
[51] "Museums on Prescription: Exploring the role and value of cultural heritage in social prescribing": https://gtr.ukri.org/projects?ref=AH%2FL012987%2F1 accessed February 21, 2019.

Outside the UK, excellent practice in medical museum community engagement and preventative health care was being developed by the Mütter Museum, the College of Physicians of Philadelphia. The Mütter Museum provided outreach sessions on public health topics including sexually transmitted infection and body modification and took medical collections into the community.[52] This was a progressive development for medical museums, and all these projects provided inspiration for how Surgeons' Hall Museums could find a social role through contributing to community health and wellbeing. However, for the first community project led by Surgeons' Hall Museum, there were considerations. The project had to be containable as there were limited staff resources, and for our funders, engaging with an area of geographical relevance who had priority health and wellbeing concerns was important. Furthermore, the additional funding requirements were to find a community partner in an area of local area deprivation close to Surgeons' Hall.

To begin to this area of development, I undertook a short scoping study to ascertain which areas local to Surgeons' Hall Museum were most adversely affected by poverty. The initial influences on this study were Scottish Index of Multiple Deprivation (SIMD),[53] and *The Scottish Government: Health of Scotland's Population*[54] and Hanson's study on child deprivation in Edinburgh.[55] These statistics and reports helped me to argue that Craigmillar Community Arts (CCA)[56], in Edinburgh North East, should be approached as our potential community partner. At the time of this work, Craigmillar was ranked amongst the highest 1% in the Scottish Index for Multiple Deprivation 2012. Consequently, the residents were at a high level of risk from ill health. Research carried out by CCA[57] showed that '12% of the community are on prescribed drugs for anxiety, depression or psychosis, mothers are 4 times more likely to smoke, hospital admissions for substance abuse related issues are 5 times more than the national average'. The Audit Scotland Report of December 2012 also showed 'men in deprived areas died 11 years earlier than those in the most affluent, with the age gap 7.5 for women'.

[52] These outreach activities now take place at the Mütter Museum, http://muttermuseum.org/education/museum-education/m%C3%BCtter-lessons/, or, for outreach, cost '$150 for the first lesson and $65 for any additional lessons at the same site. These classes are available within a 25-mile radius of Philadelphia': http://muttermuseum.org/education/museum-education/
[53] Scottish Index of Multiple Deprivation: https://simd.scot/
[54] The Scottish Government: Health of Scotland's Population [online] http://www.scotland.gov.uk/Topics/Statistics/Browse/Health (accessed February 1, 2015).
[55] L. Hanson, *Child Deprivation and Compulsory Measures: Exploring the links in Edinburgh* (Sterling: Scottish Children's Reporter, 2006).
[56] CCA is now under new management as Craigmillar Now: https://craigmillarnow.com/
[57] Craigmillar Community Arts: http://craigmillarcommunityarts.org.uk/ accessed October 13, 2018 (document now removed)

Additionally, the geography of Craigmillar had a historical resonance with Surgeons' Hall. The council areas of Craigmillar had been set up on the peripheries of Edinburgh in the 1930s to rehouse the residents of the St Leonards slum clearances, which were directly behind Surgeons' Hall Museum.

This combination of ill health imposed by social inequality and historical links to Surgeons' Hall seemed like a good place to begin building community links. Yet, this project would involve bringing together an elitist organisation with a community who suffered from socio-economic discrimination.

Returning to Our Natural Capital, it was important not to start community engagement with CCA as a structured health and wellbeing 'intervention'. I needed to begin through participatory methods, and how consider how barriers to participation may occur. To begin this process, I spoke in consultation with a representative from CCA. During our conversation, which took place as we walked around the museum, she was able to disclose how much enthusiasm there was for a visit, but how this was inseparable from intimidation and fear of not being welcome inside the museum. A great deal of her concern was that the group would be rejected, unwelcome or judged because of stigma relating to Craigmillar as an area of deprivation. The group representative's comments demonstrated this community's awareness of the attitudinal issues relating to socio-economic discrimination in Surgeons' Hall. The Scottish Government 2018 *Annual Report on Welfare Reform Benefit* showed what the CCA community were already discussing at the time of this project, that, since the Conservative-led government of 2010, poverty and deprivation had increased in Scotland.[58] Additionally, the *New Welfare Reform* report of 2017 concluded that systemic failures in the benefit system meant that 'claimants in Scotland have lost large sums already, and are set to lose further large sums'.[59] The UK government-led push to intensify poverty for some communities led to a further divide in wealth, and health and well-being. The realities of socio-economic discrimination on health are shown by Edinburgh City Council's *Edinburgh Health Information Report (Key public health issues for Edinburgh May*

[58] 'Since 2010, the UK Government has enacted a range of welfare reforms that have significantly reduced the generosity of the UK welfare system. We estimate that the welfare reform policies of successive UK governments since 2010 mean that welfare spending in Scotland in 2020/21 will be £3.7 billion lower than had they not been introduced. Within its limited powers, the Scottish Government has taken action to reduce the impact of welfare reforms, however the substantial welfare cuts will continue to have an effect and make Scotland's child poverty targets more challenging.' For full 2018 Annual Report on Welfare Reform, see: https://www.gov.scot/publications/2018-annual-report-welfare-reform-9781787812628/ accessed February 28, 2019.

[59] THE IMPACT ON SCOTLAND OF THE NEW WELFARE REFORMS, Christina Beatty and Steve Fothergill Centre for Regional Economic and Social Research Sheffield Hallam University, October 2016, DOI:10.7190/cresr.2017.8449573656, 20
A report to the Social Security Committee of the Scottish Parliament

2015):

> *Life expectancy, like most measures of health, is directly correlated to socioeconomic status. More affluent people tend to live longer lives and are more healthy during their lives. These health inequalities are 'systematic, unfair differences in the health of the population that occur across social classes or population groups'. Mortality increases with greater inequality and there is evidence of pronounced variation in mortality rates in Edinburgh. People living in the least deprived communities in Edinburgh can expect to live 21 years longer than people living in the most deprived communities: boys born in Greendykes and Niddrie Mains between 2005 and 2009 had a life expectancy more than 25 years less than girls born in Barnton and Cammo.*[60]

Additionally, this report also shows 'the psychosocial consequences of differences in social status. There is now strong evidence that 'status anxiety' leads to psychological and physiological changes that affect health.'[61] 'Status anxiety' defined what the CCA representative had articulated. In this wider societal context, community engagement with CCA began when social divides caused by defence of austerity were at a heightened level. Just over a year had passed since the 2012 austerity budget, and the Chancellor of the Exchequer's unsubstantiated speech on welfare recipients 'sleeping off a life on benefits'.[62] Here, Slater's argument on the construction of the myth of 'Broken Britain' showed the judgements that the community had to fear:

> *'Broken Britain' would thus appear to be an archetypal and especially cunning terministic screen: it is a selection and deflection of reality (bolstered by the strategic deployment of ignorance), which encourages all who encounter the screen to view society through its behavioural filters of family breakdown, out-of-wedlock childbirth, worklessness, dependency, anti-social behaviour, personal responsibility, addiction, and teenage pregnancies.*[63]

Understandably, anger and fear of the increasing hostility towards areas of deprivation were

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[60] Edinburgh Health Information, May 2015, Key public health issues for Edinburgh: http://www.edinburgh.gov.uk/transformedinburgh/download/downloads/id/87/topic_paper_6_edinburgh_health_information_key_issues.docx, 2, accessed May 12, 2019.

[61] Edinburgh Health Information, May 2015, Key public health issues for Edinburgh: http://www.edinburgh.gov.uk/transformedinburgh/download/downloads/id/87/topic_paper_6_edinburgh_health_information_key_issues.docx, 3, accessed May 12, 2019.

[62] Bagehot, "George Osborne's sad triumph," *The Economist*, July 9, 2015, accessed 29th Jan 2021 https://www.economist.com/britain/2015/07/09/george-osbornes-sad-triumph

[63] T. Slater, "The Myth of Broken Britain," *Antipode*, 46 no. 4 (2012), 948–969, https://www.geos.ed.ac.uk/~tslater/assets/mythofbrokenbritain_slater.pdf

noticeable within Craigmillar, and the damaging impacts of benefit cuts and sanctions were being openly discussed during the outreach sessions discussed below. In contrast to the negative views towards their community, a member of CCA described Craigmillar as a 'proud working-class area which had broken due to the dumping of all social issues in one area'. Nevertheless, to CCA, institutions associated with wealth and private medicine had become synonymous with the political perspective that blamed communities for their own deprivation. This shows the effects of modern 'othering' or negatively labelling people[64] because of their socio-economic class. Therefore, the initial purpose was to explore what the community would find beneficial to their wellbeing, and as discovered, traditional health-based activities were not their initial focus. Before planning a structured partnership project with CCA, we needed to use participatory methods to build a trusted relationship, establish a safe environment, and explore what CCA wanted and needed. To proceed with community engagement, at CCA's request, I visited them for monthly community consultations and took selected items from the collection for the to assess. We discovered that certain objects including instruments, or anything associated with pain could be distressing for group members. However, objects such as nurses' diaries, letters, photos and personal affects provided excellent and sustained cross-generational discussion. Through these methods, it became clear that social history was important to this group, especially the stories relating to the patients, nurses and soldiers who appeared in the photographs and narratives of the collections. The members also expressed an interest in looking at anatomy, if 'it wasn't too gory'. Through these sessions, we established a trusted relationship, and built a co-curated outreach collection. The next step was to test how we could explore social history and anatomy without causing any distress. An opportunity to do this arose in June 2014. This partnership activity brought many positives, but also provided lessons on the use of collections which originate from human remains.

3.2.3 Removing acts of omission

The first structured activity between CCA and Surgeons' Hall Museum, with a designed output was The *Word of Mouth* project. *Word of Mouth* began as an ASA 2014 (Association of Social Anthropologists) conference activity by the 'bones collective' and was inspired by the last remaining skull in Edinburgh College of Art's teaching collection. This event was held as an external booking at The Royal College of Surgeons of Edinburgh, CCA and Surgeons' Hall Museum were not involved in this original activity. During the conference break-out activities, attendees were asked to build displays around the skull. The original aim was to provide a fringe

[64] C.S. Walsh, "Docile citizens? Using counternarratives to disrupt normative discourses," in Transforming Practice: Critical Issues in Equity, Diversity and Education, ed. J. Soler, C.S. Walsh, A. Craft, J. Rix and K. Simmons (Stoke-on-Trent/Milton Keynes: Trentham Books/The Open University, 2012), 125

activity for the ASA 2014 conference.[86]

> *The bones beneath the face: an interactive installation and osteological study*
>
> *This interactive installation is co-curated by the 'bones collective', the Edinburgh College of Art and Archaeology at the University of Edinburgh (John Harries, Joan Smith, Elena Kranioti, Linda Fibiger, John Nowak and Joost Fontein, from an original idea of Jane Cheeseman). It will take place from 9am to 4pm in the Alistair Duff Room, Symposium Hall, Surgeons' Hall.*[87]

Originally, Surgeons' Hall Museum had discussed the possibility of working with the Bones Collective to create a legacy exhibition or blog with the images collected from this activity. The conference organisers led on this activity and a number of stills were produced on 21 and 22 June 2014.

However, as the organisers were not used to working with human remains, several acts of omission occurred, and human remains were used insensitively. Some items supplied to create the displays meant a number of images appeared violent and disrespectful.[89] 10 images were removed from the Surgeons' Hall collaboration. A summary of my assessment and the reasons follow below. However, in retrospect, I fully understand the limitations of this assessment, and this issue is addressed in the next session.

[86] The ASA 2014 (Association of Social Anthropologists) conference: https://www.theasa.org/conferences/asa14/index.shtml
[87] The ASA 2014 (Association of Social Anthropologists) conference programme: https://www.theasa.org/conferences/asa14/fringe.html, June 21, 2014.
[88] The conference activity took place without representation from Surgeons' Hall Museum but was carried outon the property of the Royal College of Surgeons through an external event booking. [89] All images from the conference can be viewed here: http://jharries.wixsite.com/skulls-and-faces/page2

The 10 images were removed for the following reasons:

1. Links to scientific racism
2. Unsterilised materials placed on or inside human remains
3. Inappropriately placed materials or 'dressing up of skull'
4. Images relating to violent death, which could be perceived as sensationalising death
5. Consent was not asked for and names were not attributed to any of the narratives, so these were all removed

Still life with skull 3, Aklo signs (winter)

This image shows links to scientific racism, as the skull placed next to comparative anatomy (issue 1), and collections care issues through inappropriate and unsterilised piece of holly placed in the skull (issues 2 and 3, respectively)

Still life with skull 5, Dilemma

This image shows a hatchet next to skull and suggestion of violence (issue 4)

Still life with skull 8

This is about my aunt (father's elder sister) now 101 – wooden frame: she was a wood-worker
+ tool – scarf + wooden measure: also made and repaired clothes – model of brain: she has dementia – artificial flowers: these now decorate her room – photo of young woman: looks rather like she did – map of Ireland: as a girl and young women went [there] for her holidays –brass fire iron: similar object in her house – keys.

This image shows an example of how a powerful narrative was constructed but lost as consent was not sought and a name was not attached to the comments card. Therefore, consent to include in exhibition could not be requested (issue 5).

Still life with skull 19, Untitled

This image shows unsterilised and inappropriately placed material over skull (issues 2 and 3,respectively), and skull placed next to comparative anatomy (issue 1).

Still life with skull 21, Inside-out, outside-in

This image shows unsterilised holly placed insensitively in skull (issues 2 and 3, respectively).

Still life with skull 26, The one that got away!!!

This image shows a hatchet next to skull and suggestion of violent death (issue 4)

Still life with skull 28, Enlightenment conversation for the hard of hearing

This image shows skull placed next to comparative anatomy (issue 1), and unsterilised and

inappropriately items placed next to skull (issues 2 and 3, respectively).

For the above reasons, the proposed images and narratives could not be accepted by Surgeons' Hall Museum as part of this project. However disappointing this was for the conference organisers, the situation presented scope for a new community collaboration with CCA. We were left with six acceptable images and a 3D cast of the ECA skull.[65] When I approached CCA about their involvement in *Word of Mouth*, the response was very positive, and the activity became part of the Craigmillar Arts Festival during July 2014.

3.2.4 Challenging the Heroic Narrative

The aim of the session was for CCA perspectives to form a new narrative for the ECA images, and to reverse the 'heroic narrative' of medicine. As discussed throughout this study, in the medical museum, there is a tendency to celebrate the achievements of the medical profession, often at the expense of telling a humanising patient story. In relation to education and engagement, this means behaviourism and medical history can combine to build a narrative of the 'great men' of medicine[66] as told by those who are their professional descendants. This encourages the 'hagiography which has dominated the history of medicine and medical museums'[79]and leaves little room for critical perspectives. For this activity to centre a social role, community perspectives had to be prioritised.

Here, it was important to consider what CCA would enjoy, and what they wanted from this activity. The community had strong interests in social history and had expressed a further interest in viewing anatomy in safe and supported environments. CCA had enjoyed drop-in sessions 'hosted' by Surgeons' Hall Museum, where they could have time to consider different collections and leave their comments. Therefore, this session was based on the familiar style we had co-developed. The activity would be an open, drop-in afternoon, where members of the community could come and discuss their views on the 3D print and images, and use cards to leave written interpretation, or verbally leave their comments with me. The methods used link into current participatory theories, where 'the power of the visual' is understood to encourage more 'accessible' and 'compelling' engagement.[67] For this session, we used traditional paper and pen methods, as working digitally would have meant further

[65] For a video clip of the 3D printing process of the skull see: https://www.youtube.com/watch?v=DKyxiRVT7ocandfeature=youtu.be.
[66] S. Chaplin, (2008) "Nature dissected, or dissection naturalized?", 136.
[67] "The Dittrick: From doctor's museum to medical history centre," 161

safeguarding in terms of anonymity of the participants.

To ensure the process was participatory, I considered the level of interpretation to provide for the images and 3D print involved in the activity. Here, it was important to consider object-based theory and if the process would become more creative 'by interaction with objects on a pre-cognitive, sensory or material level before information is provided'.[68] However, it was also important not to make the activity confusing or disempowering. After consideration, I decided we should all begin at the same point of knowledge for the activity. This was simple, at the start of the project, nothing was known about the identity of the person whose skull this was. Therefore, to centre the activity on CCA's interests in social history, it became a joint exploration of identity and anatomy. This took two forms: a scientific analysis and facial reconstruction by forensic artist Gillian Taylor, who would report back to us on her findings[69] and an exploration of narrative with CCA. The facial reconstruction would provide us with facts and aim to restore the dignity and identity of the 3D cast of human remains, and the outreach activity would help us form community-led interpretation beyond the heroic narrative. The facial reconstruction became part of the project at my request, as I felt this would humanise the process by centring the deceased as a person, and that it would bring a tangible outcome for CCA.

By concentrating on social history, it was possible to co-produce a narrative considering 'the larger social reality'[70] of the images and 3D print. Community members were interested in anthropological questions if 'all skulls are the same regardless of race and gender?'. Colonialism in collections was discussed as many participants assumed this skull would belong to a white person, originally from the UK, who had 'been taken locally centuries ago'. Some participants linked poverty and social history to the appearance of the skull 'the teeth are in bad condition so, likely to have been poor or from a time when teeth were generally bad'. By using an approach centred on one person's life and death, humanising narratives which considered the importance and value of an individual were discussed. The importance of individual life is a vital issue to consider when aiming to work with subjects relating to human remains. Richardson's interviews with families whose loved ones were victims of

[68] S.H. Dudley, Museum Objects: Experiencing the Properties of Things (London: Routledge, 2012), 2.
[69] For a video clip of Gillian Taylor discussing this facial reconstruction see: https://www.youtube.com/watch?v=V4gg0qm5bYIandfeature=youtu.be.
[70] P. McLaren, "Critical pedagogy," in Transforming Practice: Critical Issues in Equity, Diversity and Education, ed. J. Soler, C.S. Walsh, A. Craft, J. Rix and K. Simmons (Stoke-on-Trent/Milton Keynes: Trentham Books/The Open University, 2012), 3.

illegal organ removal remind us that, an 'ordinary death' presented to us through medical human remains, is still mourned as 'extraordinary' and 'special' person.[71] When Gillian Taylor revealed her reconstruction of the ECA skull, he was a young, African male aged between 20–25 years old.[72] It was an emotional experience for many of the participants, as he had become a special person to us. Members of the group expressed sorrow at the brevity of this man's life and questioned how his remains had come to be in an Edinburgh teaching collection. Some were angry that there may have been connections with slavery.

Considering the emotional impact of connecting individuals to any areas related to medical human remains is essential. In this activity emotional and empathic responses provided good discussion in a safe and familiar environment. However, when working to re-sensitise medical human remains, there also needs to be a deeper consideration of those still dealing with the loss associated with modern acts of illegal organ retention. In 2004, Richardson reported 'more recently, as the scale of the scandal emerged to include families in every part of the country, and, as members of the public realised that the problem was not confined to infants, more and more people have found themselves involved.[73] Modern acts of commission in this area were personally relevant to one member of the group. Originally, they had not wanted to take part in the activity, due to their own experiences with illegal organ retention of a family member. Yet, because I was familiar, they explained why, and, in their own time, this member decided to participate and made an outstanding contribution. This demonstrated the importance of building trusted relationships before undertaking this activity. Furthermore, it shows, that stepping away from formal education methods and using participatory methods can bring more dignity to the narratives - we connected to this person, not as an 'object' or 'other' in a medical collection.

The Word of Mouth exhibition, with CCA narratives is available virtually.[74] The panels were displayed at the front of the Royal College of Surgeons of Edinburgh from August 2014 –

[71] R. Richardson, "Narratives of Compound Loss: Parents' Stories from the organ retention scandal," in Narrative Research in Health and Illness, ed. B. Hurwitz, T. Greenhalgh and V. Skultans (Malden, Mass: BMJ Books, 2004), 246

[72] See here for Gillian Taylor's assessment of the forensic reconstruction: https://surgeonshallmuseums.wordpress.com/2014/09/02/forensic-reconstruction-of-the-eca-skull/

[73] R. Richardson, "Narratives of Compound Loss: Parents' Stories from the organ retention scandal," in *Narrative Research in Health and Illness*, ed. B. Hurwitz, T. Greenhalgh and V. Skultans (Malden, Mass: BMJBooks, 2004), 246.

[74] For exhibition images and narrative, see *Word of Mouth* blog: https://surgeonshallmuseum.wordpress.com/2014/08/14/word-of-mouth-talking-about-how-we-interpret-skulls

February 2015.[75] This work was used to maintain the presence of Surgeons' Hall Museums during closure for redevelopment, and held a visible and prestigious position at the front of the building.[76] Most importantly, the insights of CCA provided a relevant and sensitive narrative that had not been possible to gain at the academic conference. However, as discussed below, in retrospect, I would not repeat this activity.

3.2.5 Recognising our own acts of omission

In retrospect, *Word of Mouth* was always going to involve acts of omission as it had originated with the use of historic human remains, of unknown provenance, at the AMA Conference. Although policy and protections were adhered to during the CCA activity, the fundamental issue of consent to dissect can never be gained retrospectively. As a team, we worked to ensure dignity of the human remains by scientifically restoring the skull, so we could talk and react appropriately around areas including sex, ethnicity and age. Images relating to scientific racism were removed, and therefore we adhered to the ICOM Code of Ethics. A 3D cast of the skull was used, so human remains were not taken out or handled by the participants of CCA; this protected the human remains and adhered to the Human Tissue Acts 2004 and 2006. We ensured that the participants were not subjected to images of domestic discrimination, and therefore we adhered to the guidelines of the Equality Act 2010. However, the original activity was an act of omission. The conference breakout session had allowed the skull to be handled and repositioned without considering implications of origin. This skull was reconstructed to show a man of African descent. Therefore, the remains of a person at risk from discrimination, who had probably been dissected without consent was placed, unintentionally, in compromising positions by conference attendees. The skull was not part of an accessioned collection, and Surgeons' Hall was not responsible for these human remains. However, for museum practice, this activity did not adhere to the ICOM Code of Ethics, as consultation from invested groups was not sought.[77] Therefore, the original conference activity brought with it acts of betrayal that could not be removed. In retrospect, it was not necessary to involve the skull in any activity – all of which could have been completed with the 3D print. However, was taking this 3D print of this skull also an act of omission? Through this work, for me, it became clear

[75] The Word of Mouth exhibition was display outside the front entrance of the Royal College of Surgeons of Edinburgh during the building's use as a venue for the Edinburgh Festival Fringe 2014, recognised as part of the largest cultural event in the world.
[76] See Royal College of Surgeons of Edinburgh news story: https://museum.rcsed.ac.uk/news-and-events/news/2014/august/word-of-mouth-talking-about-how-we-interpret-skulls
[77] ICOM Code of Ethics for Museums, 20

that the ‘paradigmatic shift in the purpose’ and ‘concomitant changes in working practices’ needed for the medical museum are inextricably linked to acts of institutional betrayal. Therefore, this study ends with a call for institutional courage, with encouragement that progress can begin.

Conclusion: A call for Institutional Courage

My conclusion is brief. Through the chapters of this study, I have provided information and knowledge gained from my own experience of researching and working with medical human remains, in the hope that it will protect both the living and dead. This evidence shows an established pattern of systematic socio-economic discrimination against those vulnerable due to inequalities including sexism, racism, and ableism. Even when part of a sanctioned medico-legal process, dissection without consent was a purposefully judicially violent act which targeted those without protection. Those taken were not those who ‘would not be missed’, they were those who an elitist society had objectified to the point that their lives and remains did not matter to the legal or medical profession. Their voices and the voices of their bereaved were intentionally silenced. Additionally, these brutal betrayals were carried out as part of social control, and for institutional and personal gain. Although advancing medicine may be given as the reason for this behaviour, the subtext of social murder cannot be ignored, and should no longer be hidden. We can no longer use the excuse of these acts being from ‘different times’ of different ‘moral values’, these acts must be named as Institutional Betrayal, and the modern responsibility for the remains of the abused needs to be accepted.

The betrayals of David Myles, Mary Patterson, Charles Byrne and Sarah Bartmaan show the graphic terror, pain and humiliation inflicted by medical institutions and propagated by their museums. If a personal sense of responsibility has not been motivated through these case studies, modern acts of omission are detailed to show the reputational risk that institutions will have to navigate if they continue to display and justify the use of medical human remains. As shown by the progressive movements to decolonialise museums, there will come a time when this practice of displaying medical human remains is held to account. The Alder Hey controversy and the growing realisation of the number of people affected by illegal organ harvesting demonstrates that this change has already begun. Bringing change is not straightforward, and through a case study of my own work, I have shown the level of safeguarding, consideration and navigation needed to begin change within medical museums. However, lone practitioners and outside groups cannot bring the sustained changes needed, our work and projects are temporary, and acts of omission continue despite our efforts.

Despite the influence of *Cabinets of Curiosity* and *Exceptional and Extraordinary*, Charles Byrne will be redisplayed by one of the museums involved in this project, when the Hunterian Museum reopens. The remains of thousands of others betrayed by medical institutions remain on display or in stores around Europe and the United States of America.

Throughout this study, I have addressed Smith and Freyd's barriers to change brought by a lack of language to define abuse; a lack of cohesive knowledge about the abuse; and the ultimate fear of controversy when tackling abuse.[78] By doing so, I have provided the language needed to recognise that the taking of people for medical human remains is a specific act of abuse. Once this language was found, it became easier to articulate this abuse as a cohesive issue involving both acts of commission and omission, which need to be challenged. This study, in many ways, is my own apology for my work with medical human remains, but, hopefully a proactive one, which can directly challenge 'the fear of controversy' in discussing this subject within medical museums. Without language, without discussion, there cannot be progress. Hence, I end this study with a final call to Institutional Courage. In the words of Freyd, this:

'is an institution's commitment to seek the truth and engage in moral action, despite unpleasantness, risk, and short-term cost. It is a pledge to protect and care for those who depend on the institution. It is a compass oriented to the common good of individuals, institutions, and the world. It is a force that transforms institutions into more accountable, equitable, healthy places for everyone.'[79]

The Institutional Courage this study calls for is two-part – firstly, moral action - for medical museums to remove historic medical human remains from display. Secondly, for truth – for the impact of medical elitism to be understood and taken seriously as part of medical museum equality practice. This form of discrimination can no longer be acceptable, especially by the medical institutions we depend on. Yet, this call for truth is for all, we cannot choose to be selective in matters of equality, the impact of socio-economic discrimination is still taking and shortening lives. Hence, discussions in all museums must broaden to acknowledge and address equally the impact of all forms of discrimination.

[78] C.P. Smith and J.J. Freyd, "Institutional betrayal," 581.
[79] Centre for Institutional Courage, Our Founder: https://www.institutionalcourage.org/our-founder

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