

Historical Geographies of Diabetes and Emotion

gENTRY hANKS

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1 How Is This Geographical?

Turning to David Livingstone (1993) and embracing his approach to “The Geographical Tradition,” I employ his questions “What role, for example, did geography play in past society? Was it used for political, or religious or economic purposes by particular groups? Who benefited from the latest theory, and who lost out?” (p. 2). With these questions in mind, Firstly I bring to the fore an overview of different perspectives on diabetes from different places and pieces of history, then provide an examination of medical literature, historical writings and archival material to geographically situate the social, political and economic contexts of historical scientific thought on diabetes in relation to emotion, which will include historical examples of what role emotion plays and how it has been understood throughout a history of diabetes. Livingstone (1993) warns, “reconstructing intellectual history is never a once-and-for-all activity” (p. 3), but allows one to “work with a more realistic picture of geographical knowledge as a cultural product and a political resource, without assuming that scientific knowledge is somehow immune to such forces” (p. 3). There are limitations to this historical approach beginning with the fact that “the past...is only contemplated in terms of the present” (Livingstone, 1993, p. 3). There is also the business of selection, because “inevitably historians are involved in selecting from the available sources the material they deem significant in light of the problems under scrutiny” (p. 4), I will be unable to tell a whole or complete story where facts are somehow able to represent themselves, but instead, “the historian stage-manages their performance on the contemporary scene” (Livingstone, 1993, p. 5).

I put forth that, over time and place, different geographical locations within the body have come to be understood as the “seat” of the illness. For this analysis I will rely on literature review and Archival methods. Archival mate-

rials are a staple of historical geography and they like geography have a sorted history with colonialism and power. The collections I drew from, The Sir Frederick Banting Papers and the Hughes (Elizabeth) Papers, are housed at the University of Toronto’s Fisher Rare Book Library in Toronto, Ontario.

2 Background

Mainstream historical accounts of diabetes are well documented (Engelhardt, 1989; Tattersall, 2009), but are often too quick to fast forward to the discovery of insulin. There have descriptions of the symptoms of diabetes at least as old as the 11th century BCE when Susruta, an Indian physician, documented the condition, which didn’t receive this name until Greek physician, Aretaeus in 100 BCE. He used the Greek word, *dia-bainein* meaning “to siphon” (Sattley, 1996).

Up until the Renaissance, the medical writings of prolific Greek scholar and physician Claudius Galen (130–201 BCE) were seen as doctrine not only in European medicine, but were also regarded in the medical practices of Persia and Arabia (Henschen, 1969). Galen wrote about the seat of the illness (diabetes), that is, where the disease was geographically located as indicated by organ names. He described diabetes as a type of dropsy and gave rise to a long held misbelief that the kidneys were responsible for the symptoms of diabetes (Henschen, 1969).

Using divisions from medical historians as provided by Sanders (2001) will prove useful in organizing some background information on diabetes. Sanders warns the reader at the beginning of his book that there is no way to provide a complete or whole history and “the omission of any event or individual’s role in the history of diabetes in no way lessens the importance of that con-

tribution” (p. xiii). Sanders (2001) names the 4 divisions of the history of diabetes, “The Descriptive Period: describing and naming the disease, The Diagnostic Period: learning how to diagnose the disease, The Experimental Period: learning what causes the disease and the Therapeutic Era: learning how to treat the disease.” (p. 1), which are well accepted by medical historians (Papaspoulos, 1964). Sanders has also offered a fifth period, “The Era of Complications, in which we learn how diabetes causes additional health problems” (p. 1). These periods are not discrete as there are temporal and geographical overlaps. For example, 2000 years before Hippocrates, physicians in Egypt had already described diabetes and were already seeking ways to diagnose and treat the condition (Sanders, 2001).

2.1 Describing Diabetes

Egyptian physicians produced 7 papyri from 2000 BCE to 1200 BCE, one of particular interest— The Ebers (Bryan and Smith, 1974). The Ebers Papyrus was written circa 1550 BCE and describes polyuria (frequent urination that causes dehydration and extreme weight loss) and remedies for polyuria (Bryan and Smith, 1974). While Hippocrates (460– 377 BCE), perhaps the most widely recognized Greek Physician, didn’t write about diabetes specifically, he too described conditions of extreme urination and body wasting (Avicenna and Gruner, 1930).

Another Greek physician, Aretaeus (130–200 CE), who was mentored by Hippocrates and a coeval of Galen, hailed from Cappadocia, which is in modern day Turkey (Henschen, 1969). As mentioned earlier, Aretaeus is credited with using the term diabetes to describe the body as a siphon through which liquids entered and then were quickly dispelled. Aretaeus, like Galen, believed that the source of diabetes was located in the kidneys. He also believed it to be a

disease of the bladder. According to Aretaeus (1856), “for the thirst there is need for a powerful remedy, for in kind it is the greatest of all sufferings; and when fluid is drunk, it stimulates the discharge of urine; and sometimes as it flows off it melts and carries away with it the particles of the body” (p. 487). This liquification of the flesh into urine is used to describe diabetes in quite a few historical medical accounts. Although he isn’t the first to describe the pancreas, Rufus of Ephesus ¹ is credited with coining the term *pancreas* (c. 100 CE): *pan* meaning all and *kreas* meaning flesh due to the organ’s perceived amorphous shape (Papaspnyros, 1964).

Although Hindu medical writings described urine from a person with diabetes as honeyed well before Europeans (Frank, 1957), Western historians place emphasis on the Latin term *mellitus*, which then allows the West to claim linguistic authority over medical knowledge. The Vedic Scriptures in Sanskrit provided the basis of Hindu medical knowledge, which came to be a set of three medical textbooks known as *samhitas* and were named for 3 renowned hindu physicians— Chakara, Susruta and Vagbhata (Frank, 1957). These texts are believed to have been written between 100 BCE and 700 CE. Many European physicians of the ancient world mistakenly identified the residue left from evaporated urine of PWD as salt instead of sugar. Hindu medicine primarily focused on prevention of diabetes and very little on the treatment of the symptoms (Frank, 1957). The treatments they did implement were unfortunately diets high in carbohydrates and emetics along with the helpful suggestion of weight reduction and plenty of exercise (Sanders, 2001). The medical writings of Chakara and Vagbhata offer 20 varieties of diseased urine or urination known as *prameha*, one of which Chakara describes the patient as losing strength, then flesh and finally the loss of a healthy complexion (Frank,

¹The exact origin of the term is not known and contested (Sanders, 2001).

1957). While Chakara and Susruta briefly mention that insects are attracted to the urine of PWD, the writings of Vagbhata provide more detail about how diabetes is acquired, which is of importance in a medical system that focuses on prevention. *Prameha* was described by Hindu physicians as having the potential to be inherited or acquired and displaying characteristics (Frank, 1957) such as extreme thirst, obesity, chronic fatigue, obesity, recurring infections, impotence and excessive urination in both frequency and quantity (Frank, 1957).

In 3rd century BCE China, a dialogue between the Yellow Emperor and his personal minister was written and came to be widely known as the *Nei Ching* and was revised in the 8th century CE (Veith, 1950). The *Nei Ching*, believed to be written by Huang Ti (The Yellow Emperor), is the foundation of Chinese and Japanese traditional medicine and like Hindu medicine was also prevention focused. Symptoms like insatiable thirst and abnormally frequent and copious urination make an appearance in the *Nei Ching* (Veith, 1950).

After the demise of the Roman Empire, during the middle ages of Europe, medical concepts were based in the writings of Hippocrates and relied on understanding the four humors— blood, phlegm, yellow bile and black bile (Lloyd et al., 1983). The middle ages, for the most part, aren't known for their advances in physiology and anatomy. This vacuum of knowledge led to a robust desire to understand the composition of the human body in the centuries to come (Sanders, 2001).

During the 11th and 12th centuries two prolific physicians, Avicenna from Persia and Maimonides of Arabia, proffered new knowledge about diabetes. Avicenna (Ibn Sina) was a philosopher and physician who attempted to compile as much medical knowledge of his time into a medical textbook— the *Qanun*, which was originally written in Persian and translated into Latin in the

12th century (Avicenna and Gruner, 1930). Avicenna was held in such high regard that he was often referred to as Galen's equal (Sanders, 2001). In the *Qanun* (The *Canon of Medicine*) Avicenna gave detailed accounts of tasting sweet urine, unyielding wounds, diabetic gangrene, and withering bodies, as well as an understanding that diabetes could either be primary or secondary (Avicenna and Gruner, 1930).

Islamic beliefs were incongruent with the practice of cadaver dissection, causing Avicenna to be somewhat lacking in his knowledge of human anatomy and giving way to his heavily philosophical understandings of medicine. Human cadaver dissection was a rare practice in Greek antiquity (?). According to Von Staden (1992), "the first half of the third century B.C, two Greeks, Herophilus of Chalcedon and his younger contemporary Erasistratus of Ceos, became the first and last ancient scientists to perform systematic dissections of human cadavers" (p. 223). The practice of dissecting pigs was part of human anatomy education and dissecting human cadavers didn't make a reappearance in Europe until the 14th century (Von Staden, 1992).

In mid to late 12th century Arabia, a rabbi, astronomer and philosopher, Moses Maimonides (Rambam) familiarized himself with the writings of Galen, which inspired his own magnum opus, *The Medical Aphorisms of Moses* (Maimonides et al., 1989). Maimonides wrote nearly 1500 aphorisms, which began with the phrase "Moses says" (Maimonides et al., 1989), as these bite sized medical principles were a tradition of medical writing that harkens back to Hippocrates (Sanders, 2001). When the term diabetes came to the scene, Maimonides pointed out that up-to-date physicians called the illness diabetes, while many others still merely described the symptoms, polydipsia (excessive thirst) and polyuria (excessive urination)' Like Galen, Maimonides located the illness within the kidneys, adding to that, the bladder. Unlike Galen's rare

experience with PWD, Maimonides claimed to have encountered 20 or more people displaying symptoms of diabetes over a 10 year period (Maimonides et al., 1989). This difference led Maimonides to arrive at the conclusion that the disease was place based; he posited that diabetes was more prevalent in warmer climates (Maimonides et al., 1989).

2.2 Diagnosing Diabetes

Although the Renaissance began roughly in 14th century Europe, it wasn't until the 16th century that medicine saw a rebirth and revision of scientific concepts. Traditional medical concepts from Galen and Avicenna were no longer taken for granted, but challenged and questioned. Osler (1921), a medical historian, noted that the diagnostic period ushered in 3 essential new ways of thinking in medicine: "1) it shattered authority, 2) it laid the foundation of an accurate knowledge of human anatomy, and 3) it demonstrated how the body's functions should be studied intelligently" (p.

2.3 Diabetic Therapy

In the 17th century the term *Mellitus*, the Latin for "honeyed," was tacked on to *Diabetes*, giving us the contemporarily used term *Diabetes Mellitus*, by a physician from London, Thomas Wills (Sattley, 1996). Wills arrived at this term through sampling his patients' urine, which, if it tasted sweet like honey, meant a diagnosis of Diabetes Mellitus. The tasting of urine² remained the standard for monitoring glucose levels into the 1900s (Sattley, 1996).

Physicians were all but left to watch their patients fade away. Many prescribed low-calorie diets, but little else prolonged the lives of people with

²Urine and blood are key bodily fluids for surveillance in the management of diabetes. PWD are required to take a snapshot as evidence of blood glucose level at a particular time with a blood glucose meter.

diabetes until the discovery of human-consumable insulin (Ebstein, 1989). Of course this discovery didn't come without the help of companion animals (Balfe and Babinec, 2008)³ and agricultural livestock. In 1921, Canadian surgeon, Banting, along with Best, treated a canine with diabetes by injecting extracts from a non-diabetic dog's pancreas (Zimmermann, 1989). From there they joined Drs. Collip and Macleod ⁴ in injecting a purer form of animal insulin into an adolescent, Leonard Thompson, whose high blood sugar lowered over the next 24 hours (Sattley, 1996).

In 1935, Hinsworth delineated something that had been understood as one illness into two types (Sattley, 1996). There are people with insulin sensitivity, but without the capability to produce insulin (Type I) and others with insensitivity, but with the capability to produce insulin (Type II). With this breakthrough research in diabetes proliferated bringing with it medical and technological innovation. Towards the end of the 1930s various kinds of beef and pork insulin were developed to try and match the speed and variance of human insulin. While the livestock based insulin was a tremendous help, insulin therapy was nowhere near as effective as a human pancreas (Sattley, 1996). During the discovery of insulin in Canada, Joslin was the first doctor in the US to do comparative and complementary research on insulin therapy.

Over the next several decades there was a proliferation of synthetic insulins, oral medications, syringes, urine test strips, glucose meters, insulin pumps, and other new technologies (Phillip and Battelino, 2012) for the treatment and management of diabetes. The drive in innovation has generally been to make these apparatuses smaller and more portable to enhance mobility, which

³See Wilkie (2013) for research on health and multi-species encounters.

⁴The Best and Banting Collections in the Fisher Rare Book Library at the University of Toronto reveals a contested claim and ownership over the patent right of insulin between Best and Banting and Macleod and Collip.

consequently increased one-time-use (disposable) supplies⁵. With the arrival of the insulin pump and an artificial pancreas we continue on a post-human trajectory⁶.

Most surviving records of people with diabetes are largely descriptive of physiological conditions rather than emotional states. There is a lack or absence of literature and records detailing the emotional lives of PWD. The voices of patients who have been described as having the symptoms of diabetes have largely been represented by physicians and not the patients themselves. The arrival of insulin allows those with access to have a voice. These voices from the archives don't necessarily fill the void of undocumented emotional lives of the past, but their letters of extreme gratitude, expressions of hope and happiness bring to light a heretofore quiet misery.

3 The Eradication of Emotion

Boehm and Hoffmann (1878) experimented on cats whereby they observed glucose levels in the urine after exposure to several conditions. It was later found that physical pain, bondage and temperature weren't necessary ingredients for raising levels of sugar in the urine, but although Boehm and Hoffman didn't acknowledge it in their publication, emotional excitement was certainly involved. Bond (1896) published an article based on his presentation to the annual general meeting of the British Medical Association in 1896 regarding the potential relationship between diabetes, glycosuria and insanity. During Bond's study he was the Assistant Medical Officer at the London County Asylum in Banstead, from whence his research cases hailed. Of 180 recent cases

⁵My initial analysis of the data reveals a sense of guilt associated with the amount of biomedical waste and its disposal for some PWD.

⁶See Wilson (2011) for a reflection on mobility, digital frontiers and more-than-human contact.

(mostly male) admitted to the asylum he observed 32 cases which showed sugar in the urine, glycosuria, some of which were from true cases of diabetes and others of unknown etiology. In the cases of glycosuria, Bond found, “in other cases of glycosuria, where no anti-diabetic treatment was adopted, and where recovery still occurred, [he] was also able to point to a considerable degree of parallelism between the presence and amount of glycosuria, on the one hand, and the presence and acuteness of the mental symptoms on the other” (p. 295). Bond subdivided the cases of true diabetes into two subcategories, those whose diabetes presented after manifestations of mental illness and those whose diabetes presented before manifestations of mental illness. In the latter, Bond believed, “the mental phenomena were actually caused by the diabetes” (p.297). Conversely, Bond found it unlikely that glycosuria was the cause of mental symptoms in most cases (p. 299). Other medical doctors participating in the discussion portion of Bond’s article mentioned the following observations. Dr. Savage thought it “common to find alternation between diabetes and insanity both in families and individuals” (p. 311) and “ [has] seen a good number of patients suffering from true diabetes who, when they have become insane, have lost all the symptoms of diabetes, and when they have recovered from the insanity they have again developed diabetes” (.p 311). Savage also noted that in the cases where he had observed both diabetes and insanity in the same individual, he saw a tendency toward particular mental illnesses, those of melancholia or dementia (Bond, 1896). Dr. Goodall (Bond, 1896) discussed the possibility that while insanity and diabetes may not be directly causative in either direction of flow, “persons suffering from diabetes undoubtedly show various morbid physical manifestation” and “are neurotic in many ways; members of neurotic families no doubt; they show hypochondriasis, irritability, sometimes excitement, mania, and so on ” (p. 311). Goodall

went on to posit that people with diabetes “have hysterical manifestations and mental instability, but perhaps the very fact of the family being neurotic keeps them from becoming insane, as appears to obtain in the case of so many people who have insane relatives” (p. 311). Dr. Bower (Bond, 1896) mentioned a case of a female patient who had suffered from diabetes for many years, but “no sugar was found in the urine as long as she remained maniacal...in two or three months she passed out of the maniacal state and became demented, then the sugar reappeared” (p. 312). Cannon et al. (1911) reported “in cases of mental disease, also, states of depression have been described accompanied by sugar in the urine” (p. 280). When Boehm and Hoffman’s experiment was repeated to address the emotional factors, which they had not addressed in their results other than to intimate that the designation of “Fesselungsdiabetes” was not justifiable as “emotional glycosuria” (Cannon, 1916, p.281). Their results found that pain was the contributing factor in elevated sugar levels in the cats. The discovery that “during fright (or rage?) the adrenal secretion is increased, and the fact that injection of epinephrin gives rise to glycosuria, suggested taht glycosuria might be called forth by emotional excitement” (p. 282). When the experiment was repeated without the element of pain, an increase in sugar in the urine occurred. The work and writings of Naunyn described instances of crisis, long term anxiety and profound grief as possible causes of cases of diabetes in some individuals as well as raised sugar levels in the urine of those already known to have the disease who have experienced grave anger or fear (p. 72).

A study by Folin, Dennis and Smillie where the urine of 34 medical students (all male) was checked for the presence of sugar both before and after a major medical exam found that of those students only one had sugar in the urine both before and after the exam, whereas a total of 7 students were found to present

with sugar in the urine after taking the exam. After running this experiment, they decided to run another one, based on an assumption that women were more emotional and would thusly present with more instances and/or higher levels of sugar in the urine, they tested 36 sophmores at a women's college and found that only six students presented with sugar in the urine after an examination (Bowman and Kasanin, 1929, p. 343).

Whitehorn (1934) conducted research at McLean Hospital in Waverly, Massachusetts of a 12 year period beginning in 1921 with 958 mental patients. He studied the emotional reactions of patients in relationship to blood sugar (not sugar in urine). Due to difficulty in establishing a consensus among staff in reading affect of patients for minor emotional reactions, the experiment only included major episodic emotional reactions of which there was no doubt about emotional distress (p. 988). Of the 958 mental patients, only 13 were known diabetics. According to Whitehorn (1934):

All of these cases, when psychiatrically improved or recovered, showed some improvement in the diabetic tendency, as a decrease either in their insulin requirement, or in their necessary food restriction;... The association of mental improvement and somatic improvement raises the question as to which is the cause and which is the effect. I had expected that the administration of insulin or of a better balanced diet might improve the mental condition more especially because the patients were able to maintain or increase body weight, but experience did not justify this expectation. The depression appeared to run its course, unaffected by these aids; yet when the depression cleared the organism required less assistance from without in handling carbohydrate metabolism. So far as this evidence goes, it indicates that the depressed mood itself may decrease the capacity to metabolize carbohydrates (p. 998).

Whitehorn's understanding speaks to the role of mood or emotion in diabetes as certainly correlationally and questionably causative. Cannon's work (Cannon et al., 1911) on elevated sugar levels in the urine during emotional

distress is refuted by the work of Whitehorn and many contradictory research discussions are pointed out by Bowman and Kasanin (1929) (Stragnell, 1921; Miles and Root, 1922; Masson, 1923; NEILSON, 1927). Menninger (1935) conducted a thorough review of pre 1934 literature dealing with emotion and raised sugar levels in the urine and blood. He concluded “the evidence supporting the theory of emotional causation of glycosuria in mental disease is somewhat contradictory” (p. 2). There is a great confusion, which states “arises in the interpretation of these various findings, not because of their very excellent chemical studies, but because of the vagueness of the specification of the emotional factors involved” (p. 2). Menninger describes a major quandry in this type of research that not only rings true in research of the early twentieth century, but remains true:

The “emotional glycosuria” theory seems correct in the physiology of its somatic functioning but it is inadequate in the delineation of the psychic factor, namely the “emotion.” That glycosuria and all the train of thalamic functioning, vegetative nervous stimulation to the adrenals, with glucose mobilization may result from psychic stimulation, is established. But it is still very much of an unsolved problem as to what the “emotion” may be. The origin of this emotion and the associations with it, which differentiate its external manifestations as “fear of death,” or “anger,” is entirely unsolved. Such vague general descriptive terms as “emotion” and “fear” and “anger” are as non-specific in psychiatric medicine as “cholic” and “dyspepsia” are in internal medicine. It is an unfortunate fact that in the description of an emotion as to its specificity of origin or motive, the psychiatrist is accused of talking a foreign language, and the average medical man abruptly drops the investigation at this point (p. 2–3).

Daniels (1948), a doctor in the field of psychosomatic medicine in the 1930s and 1940s explained that the lack of attention to the role of emotion in diabetes sprang from a lack of evidence supporting a relationship between war stress and an appreciable increase in diabetes cases in post-WWI soldiers:

At this time, Joslin. . . entirely reversed an earlier tentative position that emotion might have a part in the onset and course of diabetes and issued an authoritative statement to the contrary. Chief emphasis was laid on obesity and heredity, with a complete denial that emotional factors may even significantly influence the sugar level during the course of the disease (p. 288).

This particular change of focus has greatly influenced the geneticization and biomedicalization of diabetes. Daniels’s call for an attention to the role of emotion in the onset and course of diabetes was in effect silenced by Joslin, one of the most well known names in the diabetes medical community ⁷. Daniels wasn’t convinced:

A counter-current to the receding tide of medical interest in emotional factors in diabetes appeared in the reexamination of the literature and direct observation of clinical cases by psychoanalytically-oriented psychiatrists in 1935—36. Both the reevaluation of literature and the case material demonstrated unequivocally the role of emotion in the course of the disease by influencing the blood-sugar level in established diabetes. This has been further amply confirmed. Observations point in certain cases to a correlation between depression or conversion symptoms and increased sugar, and also between exhilaration and anxiety symptoms and a temporary clearing of or decrease in sugar (p. 288).

While, perhaps, at the time it was not known if emotion was or was not involved in the precipitation of diabetes, “it [had] been definitely established that emotions play a role in the fluctuation of sugar level in cases of diabetes” (? , p. 290). The role of emotion has been seen as more prevalent and important, particularly in the first half of the twentieth century. The bulk of research and writing arrived through psychosomatic medicine. In the late 1800s and early 1900s, there was a distinction made based on the etiology of one’s diabetes.

⁷Joslin is still a well known name in diabetes medical research because his research legacy remains visible in clinics dedicated to diabetes research and patient treatment at the main clinic in Boston and branches throughout the US.

The initial presentation of diabetes after prolonged times of sorrow, anxiety and crisis was classified as emotional glycosuria. Emotional glycosuria also referred to increased sugar levels in the urine of those who already have diabetes following cases of mental illness and depression. Although medical doctors in the past and present acknowledge that emotion plays a role in the course of the illness, exactly how and to what degree has been and still is not well understood. Astutely, Burch et al. (1962) noted, “that as new understanding of the disturbed physiology of the disease has developed, or as new advances have been made in therapy, interest in the role of emotional factors has receded” (p, 131/93). While the main current focus of medical communities centers on heredity and obesity, a focus on emotion has largely fallen by the wayside, particularly in medical fields that have achieved legitimacy through their willingness to neglect the role of emotion in human health. This has created a rift in the treatment of diabetes— maintaining a split between mind and body— and has been positioned as a metabolic disorder. This mind/body split in current medical practice relies on the assumption that emotion is not bodily and vice versa. This split is furthered through a carving up of geographical delineations of the body, almost completely obscuring the concept that the mind/body dualism is a false one. The carving up of bodies, as it were, parallels that of medical disciplines and academic fields in general.

The current focus on heredity and obesity in the discourse surrounding diabetes hasn’t always had the lime light. Emotion was once very much considered as part of the etiology of diabetes. As Daniels (1948) proposed, “In seriously considering emotional conflict in the etiology, it is not necessary to discard facts relating either to heredity or obesity, as both appear of great clinical importance and must be included in any calculation” (p. 289). While we acknowledge that food is a major factor in diabetes, we neglect the emotional

and cultural connections to food as agents of belonging and identity. Historically the prime way of treating diabetes involved a restricted diet, which in conjunction with polyuria, lead to dangerously low body weights. Throughout the history of diabetes research body size has certainly taken up its fair share of ink, paper and computer screens, but is in most instances deployed to reify the notion that obesity is the main culprit of Type 2 diabetes and that people with Type 1 diabetes should be or are typically thin (add archival letter from Dr. Banting about his female T1D patient struggling with weight gain). The many cases of people with Type 2 being thin and cases of people with T1D as larger are severely overlooked.

Contemporarily, it is rare that a physician takes into account the emotional factors in the course of diabetes (among other illnesses). There has been a turn in North America to ‘fix’ this with band-aids called diabetic educators. The current model of treatment relies on the individual requisitioning a team of doctors and professionals, thereby splitting one’s own person into compartments based solely on the bodily geographic location of symptoms or secondary problems. This team often consists of a family doctor, an endocrinologist, an ophthalmologist, a nutritionist or dietician, a podiatrist, and a gynecologist (for women). Oddly, although men’s sexual and reproductive health is also affected by diabetes, it is almost unheard of that they are approached about these topics outside of written information plastered on walls and laid out on waiting room tables, let alone are men encouraged to broach this subject with medical professionals.

While there seemed to be a trend toward understanding causal and correlational relationships between emotion and diabetes, this trend faded with the rise of a focus on obesity, medicalization and genetics. Only now in and after the affective turn do we again see a rise in interest between the two.

Interestingly in the last hundred years we have seen people desperate for insulin therapy (as seen in the letters to Drs. Banting and Best) and have come full circle to a phenomenon called diabulima, whereby one restricts insulin intake in order to lose weight or to maintain a lower weight. Much like Anorexia Nervosa or Bulimia, receiving compliments on one's weight or appearance after practicing diabulima only serves as a positive reinforcement to continue underuse of insulin. Likewise the ability to eat almost anything and not gain weight, as well as not having to pay for insulin and use needles to inject it makes diabulimia all the more appealing. This highly emotional practice serves to play into a vicious cycle of hormonal undulations, which in turn leads to self-loathing and shame, while simultaneously garnering societal approval.

4 Annotations and Quotes

Medical and academic literature regarding diabetes produced from the 1930s through the 1970s is saturated with snippets of biological and environmental determinism, which ultimately allowed the baby to be thrown out with the bath water.

1. “The prevailing features in this class of case seem to be melancholia —an exaggeration of that frequently associated with non-insane diabetics —accompanied by delusions, these either of persecution, or visceral ones, the latter being possibly mistinterpretations of real bodily discomfort attendant on the presence of diabetes” (Bond, 1896, p. 297)
2. (Major, 1933) One of Hippocrates disciples, Aretaeus, is attributed with the first use of the word *diabetes* in connection with a description of

symptoms associated with diabetes. This is generally accepted, but not without criticism.

3. (Fishbein, 1959) In medical resources and literature geared towards women in the 1950s and 60s mention diabetes in several contexts: According to McKusick (1959), "Babies born of mothers with diabetes are much more likely to suffer from respiratory distress after birth than if the mother did not have the disease" (p. 4), which almost reads as a warning to not reproduce if you have diabetes.

5 Archival Data

Elizabeth Hughes was a patient of Dr. Allen of New York and came to be treated by Banting via Dr. Joslin. She was the daughter of a wealthy, political family, which afforded her access to insulin very early on. Her father Charles Evans Hughes served as the Governor of New York from 1907-1910, an Associate Justice of the Supreme Court and later became the Secretary of State from 1921-1925. Elizabeth, like many people of means with chronic illness in the late 19th and early 20th centuries, headed for warmer, tropical climates in hopes of improving their health. Elizabeth spent time in Bermuda beginning in 1922.

MS Collection 00334 Box 1 Folder 13 January 8, 1922 Letter from Elizabeth Hughes to Mrs. Charles Evans Hughes, mailed from Bermuda to Washington, D. C. "I am getting along beautifully now on the new diet and am not feeling the change any in strength at all. In fact I really feel better than when I was on a high caloric diet and 'showing traces all the time. I fear the excitement of Nov. did it, but I wouldn't have missed it for anything, but I don't want another excitement like it to upset me again. Mrs. B is planning to raise my

carbohydrate again, slowly but surely, if everything goes ‘bien’ till then after my next fast day and , as far as my tests go now I’ll be able to stand it alright, she feels sure.”

MS Collection 00334 Box 1 Folder 15 January 15, 1922 Letter from Elizabeth Hughes to Mrs. Charles Evans Hughes, mailed from Bermuda to USA Elizabeth requests her mother to bring “a couple of tins of beef sterile cubes” and a “pound boz of agar” when she comes to Bermuda to visit her.

MS Collection 00334 Box 1 Folder 16 January 22, 1922 Letter from Elizabeth Hughes to Mrs. Charles Evans Hughes, mailed from Honeymoon Cottage in Bermuda to USA “I’m doing just what I expected to do down here, as you can see

James Havens was a patient of Dr. Williams of Rochester, NY. He is known as the first American from the United States to receive insulin treatment. Williams came to know of insulin therapy from a friend whose golf partner was acquainted with men in the School of Medicine at the University of Toronto. It seems in the world of insulin, the same things remain important as in the rest of life— who you know and where you are.

JAMES D. HAVENS
Postage Stamps for Collectors

1370 EAST AVENUE
ROCHESTER, N. Y.

Dec. 11th 1922

Dear Dr. Banting:-

A little while ago we celebrated a Feast Day here in the U.S.A. called Thanksgiving. Without the "e" it would have been a Fast Day but on the contrary it was quite the opposite for me. I've celebrated a lot of Fast Days in the last few years but it's been some time since I've celebrated a Thanksgiving Day in the real old New England manner. A week ago last Thursday, however, marked an historical event as I then tasted my first Egg on Toast; Egg on Toast is my idea of the only food necessary in heaven. Moreover if they don't pass out at least that much rations up there I guess I prefer the other place.

Dad and Dr. Williams grouped themselves around me in a half circle and watched the slaughter of the would-be hen on toast with great enthusiasm.

I hiked up to my Studio and made the enclosed contributions to the Art and Beauty of the Age. I know you haven't any false dignity; maybe this type of fool stuff would upset any type of dignity. Anyhow you see to what depths my own august esthetic mind has fallen; but I can't help feeling that way lately and if it keeps on I'll puff up and burst with good spirits. Spirits are forbidden over here but Insulin is "within the law" and yet has all the old kick of the stuff Dad has hidden somewhere prohibition doesn't know about.

If these are worthy caricatures of myself it must be of my former self --- they are too thin. Dr. Williams says you wouldn't know me. Dad greets me with "golly you're fat." When I went to the grocery for the

Figure 1: Letter from James Havens to Dr. Banting (December 11, 1922)

The following primary source material is from the Bating Collection (MS Coll 76) in Fisher Rare Book Library at the University of Toronto as well

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JAMES D. HAVENS
Postage Stamps for Collectors
1370 EAST AVENUE
ROCHESTER, N. Y.

first time in quite a spell the grocer looked at me sort of surprised like and said "why you're better aintcha?" He thought I'd been to Florida or the Fountain of Youth or somewhere and been cured. I do hope something will come up to make you come over here and make the acquaintance of my new self soon; lots of any brand of cigaretts on hand if you prefer the Lowly Camel I'll soon be able to "walk a mile" and then come to get you some.

Well, Thanksgiving has recently become a great institution over here; you ought to celebrate it there. It makes a fellow think a lot of great sentimental stuff about his good fortune and how lucky he is; he discounts all the little whims he's been cussing out the past 364 days and really convinces himself the world is a fine old house of optimism after all. You can bet your last farthing a lot of people are thinking the same things, and laying it to Insulin; but I'm going one step further back and laying it to Dr. Banting.

work at university
Merry Christmas is coming around all of a sudden and I'm going to have a merry one all right; so are the above mentioned Lot of Other People. ~~I sure hope you do; you deserve it. If you don't come over here I feel as if I might just rise up and sail over there without wings or an aeroplane.~~

Respectfully (?) -- anyway

In deep appreciation,

Jim D. Havens

Figure 2: Letter from James Havens to Dr. Banting P. 2 (December 11, 1922)

as the University of Toronto Archives. On December 15, 1922, one of Dr. Joslin's patients, Richard Witner, sent a letter to Banting from Rock Hill, South Carolina, which expresses gratitude for the impact insulin has had on his life: "As long as I live I'll think of you with the greatest gratitude. You have saved the lives of so many and given happiness to diabetics all of the world." Here, Witner does not merely acknowledge the saving of lives in a medical or physical sense, but also recognizes the impact on the emotional lives of PWD the world over.

Helen Zualey, another of Joslin's patients, wrote to Banting from her Portland, Maine home on December 14, 1922. She wrote, "Thru your wonderful discovery of insulin [I] am able to enjoy one of the best things I have been deprived of, namely a good diet. I feel like a different girl." Here Helen brings up one of the emotional relationships regarding diabetes, that is, the human relationship to food.

Richard Lester of Savannah, Georgia wrote to Dr. Banting on January 26, 1923 to describe his daughter's state before using insulin: "In the meantime, the child who is of a very happy nature, and extraordinarily bright, became dazed, and took no interest in anything." Richard goes on to describe his daughter after being treated with insulin: "the patient was sitting up in bed singing and playing with her toys. In 48 hours she was up. While still emaciated, she is apparently herself."

Elise Downing Spinar write to Banting about her husband on June 25, 1924. She described his state: "Until about 2 months ago he has carried on fairly well despite a very active life. Then he had a complete breakdown, lost weight rapidly and found he was suffering from acetone poisoning." Elise's husband went to Duff House in Scotland for treatment and "now he finds that with injecting insulin twice a day that he is able to absolutely control the acetone

and sugar, and from a nervous wreck he seems to be strong, vigorous and altogether a different man.” This letter illustrates how one becomes a “nervous wreck” when living with diabetes.

Greta Rudberg of Sweden sent a letter written on September 15, 1925 to Banting describes her son’s state after using insulin: “Not only is his life thereby saved but he is as well, happy and full of life as any sound child.” She makes a point to go beyond gratitude for saving his life and speaks to the quality of his emotional life.

Ruth Henry of New York (January 6, 1928) wrote to Banting, “I would venture to tell you of one rich and joyous life that had returned from the Valley of the Shadow as a result of your work. Now here I am, a normal happy and I even hope useful individual in the strenuous life a rural parsonage, glad to be alive and grateful to you.”

In the late 1920s, after the wider spread and availability of insulin, there were some who began to notice various concerns. John Comyn of Kent, England wrote, “I do not wish to seem ungrateful for I am most grateful for what you have already done in the research line; but injections at the rate of 3 per day every day of one’s life become wearying and depressing at times” (December 1, 1929).

Alice Faulkner of Selma, Alabama wrote to Banting on January 2, 1929 about her daughter with diabetes, “The doctors here are more afraid of the harm that the insulin will do than they are aware of the good it does.” This shows a glimpse into the emotional risk taken on by Physicians administering insulin for the first time, perhaps fearful of causing hypoglycemia. Alice described her daughter after the use of insulin, “In fact, she has more life and ‘pep’ than anyone I know of.”

DEAR DR. BANTING
I AM FEELING SO
GOOD AND GETTING
SO MUCH TO EAT -
I GET OATMEAL AND
POTATO
I WAS IN THE
HALLOWE'EN PARADE
AND GOT A PRIZE.
HERE ARE SOME
PICTURES, DON'T I LOOK
FAT? WITH LOVE
JANET

Figure 3: Letter to Dr. Banting from Janet

The introduction of insulin into medicine was by a group of men at the University of Toronto, who then sent the recipes to a group of men at Eli Lilly Corp for improvement, production and distribution.

In the following letter, Dr. Woodyatt writes to Dr. MacLeod to update him on the improvement of his patients with diabetes. One patient stands out to him among the rest:

We have one man appeared to be incapable of burning more than 46 g. of glucose, whose power to burn has increased by 33 g. for each cc. of this same preparation. I think that this striking improvement is due in part to the tremendous relief of mental depression that it was for this man to find that his condition was not hopeless and that he could again take a comfortable diet... Diabetics are extremely sensitive to psychic influences, and I have seen in the past many cases whose actual severity varied tremendously in response to such things⁸

⁸Letter to Dr. MacLeod, October 4 1922. University of Toronto Archives, A1982-0001, Box 15, Folder 4

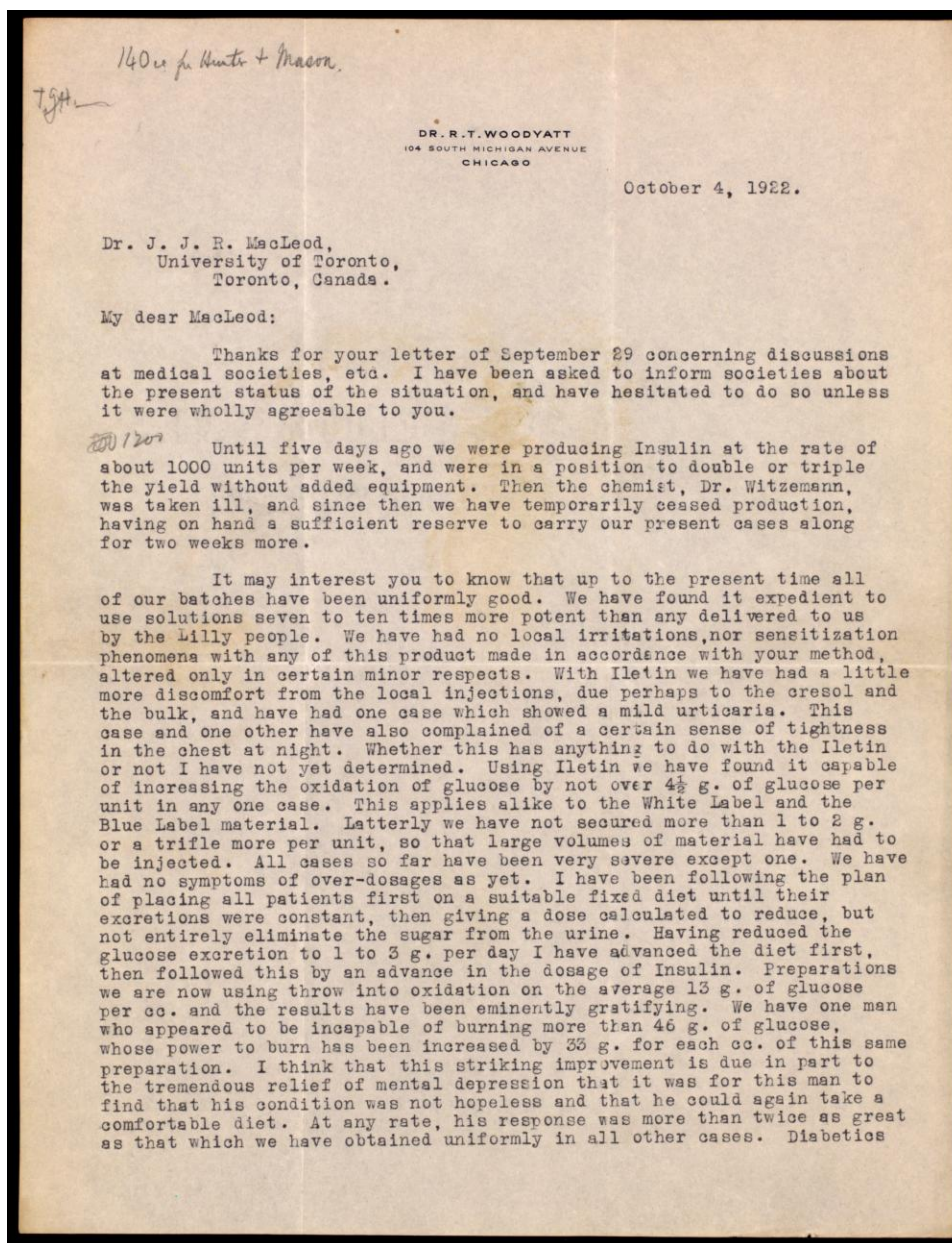


Figure 4: Letter from Dr. R.T Woodyatt to Dr. MacLeod (October 4, 1922)

DR. R.T. WOODYATT
104 SOUTH MICHIGAN AVENUE
CHICAGO

are extremely sensitive to psychic influences, and I have seen in the past many cases whose actual severity varied tremendously in response to such things.

We have used Insulin to desugarize borderline cases by temporary dosages followed by omission of the Insulin. Once a case is desugarized in this way he may remain sugar free on the same diet for a considerable length of time afterwards, in much the same way that this occurs following a desugarization by diet adjustment alone. I have not attributed this apparently lasting effect of Insulin to anything more than the improvement which follows desugarizations in general, but am watching it with interest.

I hope very much that Dr. Clowes will not fail to stop in Chicago on his way back from Toronto, as there are many questions which I would like to discuss with him. As the knowledge of Insulin has been spread abroad, there are many more applicants for Insulin treatment than can possibly be accommodated as you are well aware. I wonder what your plans are concerning the holding of a meeting or conference of some sort before very long to decide what you wish done about the data which is accumulating. Would you like to have me send you the detailed case reports up to date?

I wish to say that this Insulin effect is as striking and the results as brilliant as anything I have ever seen in medicine or surgery. It constitutes one of the great advances. Also I deem it a great privilege to be in a position to make and apply it. I am very grateful to you and the other gentlemen up there, and if you come down here I can show you some appreciative patients.

Yours very truly,

R.T. Woodyatt

Figure 5: Letter from Dr. R.T Woodyatt to Dr. MacLeod P. 2 (October 4, 1922)

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