

News, Notes and Queries

document to the officer in charge. Then letters were distributed to addressees. (Delamere, *op. cit.*, vol. 1, pp. 668–69).

9. *Ibid.*, vol. 1, pp. 675–78.
10. La Reynie had considerable authority over health and sanitation and enforced measures against plague in the capital. Since jurisdictional confusion and duplication were normal, it is scarcely surprising that the monarchy chose Châtelet officials for some special missions. If any Paris magistracy had the prestige necessary for dealing with recalcitrant local officials and merchants, it was La Reynie's.
11. AN, H 1821, 299–301, 322–23.
12. *Ibid.*, 323–24.
13. *Ibid.*, 329–30, 334.
14. *Ibid.*, 335–40.
15. Revel, *op. cit.*, p. 965.

ANDREW P. TROUT

HISTORICAL METHOD AND THE SOCIAL HISTORY OF MEDICINE

The Society for the Social History of Medicine set themselves an ambitious task in fostering a new field of study, the scope and purposes of which are difficult to define. In his Inaugural Lecture to the Society, Professor Thomas McKeown presented a personal definition of this field and gave some examples of subjects that could profitably be studied by attempting to write 'medical history with the public interest put in'.¹ This definition and its implications raise matters of great concern to the social historian. The purpose of this essay is to elaborate these concerns in the hope of stimulating further discussion of the problems involved.

According to Professor McKeown;

the social history of medicine is much more than a blend of social history and medical history, more than medical developments seen in the context of the period; it is essentially an *operational approach which takes its terms of reference from difficulties confronting medicine in the present day*. It is the lack of such insight, derived from contemporary experience, which makes a good deal of medical history so sterile for the uninitiated.²

It is regrettably true that until recently, much medical history was indeed sterile. To a historian, most of it was mere antiquarianism, relieved by hagiographies of outstanding physicians. Happily, this situation has changed considerably in recent years, and there are now several works which can profitably be used by the social historian who wishes to investigate the place of medicine in a given society. Surely the chief task of social historians of medicine is to provide more of the broad interpretive studies presently lacking.

Professor McKeown proposes a strikingly different task. According to him, the only social history worth pursuing—which will be neither sterile nor esoteric—is one which '... takes its terms of reference from difficulties confronting medicine in the present day'.³ Clearly his basic purpose is not to understand the past, but to provide necessary information for reforming present evils. This purpose is unhistorical. It has little to do with the study of history as understood by historians, whether they be interested primarily in diplomatic, constitutional, economic or social history. Most historians would admit to being some combination of artist, chronicler, detective and assessor: none should call himself a social planner.

Historians are not necessarily opposed to social planning, although their perspective may make them sceptical of its possibilities; but social planning is not their proper function in society. Any attempt to merge these two functions is doomed to futility, if not disaster. Under these conditions, the planning will become little more than corrective action, while the so-called history will be little more than reformers' tracts, as full of distortions as of good intentions.

It is not surprising to find Professor McKeown asserting that '... perhaps the most successful social historian would be *one who does not particularly care for history*, but turns to it because he considers it indispensable to an understanding of contemporary problems'.⁴ He assumes that the success of a historian is measured not by the extent to which he helps mankind to understand its past but by the prescriptions and advice he offers for its future. It is impossible to conceive of the past being illuminated by 'one who does not particularly care for history'. Historians, as a rule, do care for history and it is a concern which ought to be shared by social historians of medicine.

Professor McKeown has fallen into this unfortunate line of argument because he thinks, wrongly in my opinion, that medical history is somehow different from the rest of man's history. 'What history can teach is a much-discussed question and historians themselves are divided about the answer; what medical history can teach is a question not often asked and yet there can be little doubt about the answer'.⁵

It is misleading to suggest that historians quarrel among themselves over what history can teach as if the larger question of whether history can teach had already been settled in the affirmative. The significant disputes among historians arise not over which lesson from the past is the right one, but over the notion that lessons of any kind can be derived from the past. Even the most outspokenly utilitarian historians would not suggest that there is such a thing as an abstract, didactic history which dispenses advice to the interested enquirer. Opinions vary, however, about the extent to which a historian may assume that his apprehension of the past resembles the reality that once existed. The issues involved include the nature of historical perspective, the proper limits of generalization in history, and the objectivity or subjectivity of historical judgement.

To be more than a chronicler or antiquarian, the historian must be concerned with both the general and the particular in the past. He has to make generalizations which transcend unique events, but must be careful lest they lose their validity. He must be aware that his own present may incline him to regard certain generalizations as more valid than others. The present may also incline him to regard certain aspects of the past as more deserving of study than others.

A related problem is the historian's awareness of the limitations of his discipline. He works with haphazardly preserved and often fragmentary sources. He constantly faces the problem of assessing the veracity of evidence, not to mention subjective bias in his own mind. He is, therefore, wary of assuming that his tentative conclusions are truths upon which future action may be based.

There is no reason to assume that historians of medicine are in any way exempt from these general problems of the discipline. Medical history is also concerned with the particular and the general, and hence cannot escape the nagging problem of the limits of generalization. Its sources are no less haphazard or fragmentary, and its evidence no

more veracious than that which survives concerning other aspects of human endeavours. There is no reason why men who write about medicine should be exempted from those tests of reliability which the historian applies to men writing about politics or diplomacy, unless one is to assume that medicine makes its practitioners models of honesty and paragons of observation. Finally, the social historian of medicine cannot shed his own personality, and so his history is liable to those distortions attributable to bias, lack of imagination, and other human weaknesses.

It is understandable that those who study the social history of medicine face greater temptations to be didactic than their counterparts in some other fields of social history. Scientists have convinced men that the human race can be made healthier, and to this goal all endeavours, even medical history, must now apparently be subordinated. Faith in science is such that people will accept uncritically any dogma, any lesson, and any prophecy that claims to show how, in the area of medicine and health services, man can learn from his past. It is precisely because of this situation that social historians of medicine must expose, as vigorously as any of their colleagues in other branches of social history, the pitfalls which await those who assume that we can learn from the past the truth that will make us free. Far from encouraging such dubious propositions, they should be doing their utmost to make their readers aware of the formidable limitations which man faces in attempting to apprehend the past.

No historian can escape his own present, nor is it desirable that he should. However, he must not allow his attempts to understand the past to be guided exclusively by the transient concerns of the present. If, for example, the social historian of medicine assumes that medicine means modern scientific medicine, he cannot help but write a tale of the gradual but inevitable triumph of truth over error. Such an approach will distort the past, and probably the present as well, as surely as did those written about the Reformation by nineteenth-century Whig historians.

Professor McKeown's comments on the history of the public health service will serve as an excellent example of the kinds of distortion which are implicit in such an approach to the past. Referring to Public Health Act of 1848, he states that:

Chadwick, in spite of his heresy concerning the nature of infectious disease, outlined very precisely the programme subsequently endorsed by bacteriologists: 'That the primary and most important measures, and at the same time the most practical, and within the recognized province of public administration, are drainage, the removal of all refuse from habitations, streets and roads, and the improvement of the supplies of water.' In this way, after about a million years' experience, men came to recognize the step which is second in importance, or perhaps more accurately third, among measures which can be taken to improve human health.⁶

There are no less than three significant distortions in the passage just quoted. First of all, Chadwick was no heretic, because there was no established orthodoxy which he can be said to have transgressed. In the middle of the nineteenth century both contagionism and anticontagionism enjoyed popularity, albeit in different circles, as explanations of the nature of infectious disease, and it is anachronistic to suggest otherwise. Even after the victory of the bacteriologists, it is debatable whether historians should speak as if these new definitions of orthodoxy and heresy have some validity for previous ages. Secondly, Chadwick elaborated his programme of sanitary reforms not

despite, but because of his belief in the miasmatic theory of infectious disease. Its consistent good sense is only obscured by a reference to its subsequent endorsement by bacteriologists. Thirdly, and most important of all, Professor McKeown fails to ask why Chadwick became interested in the problems of public health, as if the nobility of such endeavours exempts them from the need for inquiry and explanation. It is surely relevant to point out that Chadwick came to the problem of the health of towns directly from his work with the Poor Law Commission. His purpose was to save the ratepayers of England—and hence England itself—from inevitable bankruptcy if the poor rates were not held in check. He saw the improvement of sanitary conditions in towns as a means of securing greater economy and social stability—goals worthy indeed of a disciple of Jeremy Bentham. Chadwick would be appalled to discover that latter-day historians have so misunderstood his work that they have neglected to ask whether his reforms were successful in achieving their aims.

As Edwin Chadwick was interested in lowering costs, so John Simon was interested in combatting what he regarded as the immoral behaviour of the lower classes. Here again, improved sanitation was but a means to an end. Hopefully, social historians of medicine will eventually produce a history of the movement for sanitary reform which bears some recognizable relationship to the social context in which the movement grew up. They are unlikely to do so, however, if their purpose is, like that of Professor McKeown, to understand the origins of the present with a view to improving the future. Nor are they likely to understand the extent to which public health in their own society may be serving as a means to larger ends, such as the preservation of a particular distribution of wealth, or the enforcement of a particular moral code. If a medical officer of health sends gypsies or hippies on their way, it is not merely, or even necessarily, the cause of human health which has been served.

Some further implications of Professor McKeown's approach deserve comment. His obsession with the needs of the future leads him to employ as absolutes, definitions of health and medicine which are merely products of nineteenth- and twentieth-century thought. When he calls for '... a critical evaluation of the influences on which human health depends', he is thinking of health as presently conceived. Yet surely the social historian of medicine should be concerned primarily with explaining changing ideas about health within society. His job is to explain why medieval man thought health depended in part upon the will of God and the movements of the planets, not to dismiss these ideas as worthless because they are not generally accepted today. Professor McKeown himself notes that public health legislation in the nineteenth century '... was a sequel to ideas, about the relationship between living conditions and health, which had been developing since the early eighteenth century.'⁷ But instead of suggesting a proper and rewarding historical enquiry—why did these ideas change in these ways at this time?—he goes on to appeal for a re-written history of the public health service that can be used to solve the contemporary problems of public competence and responsibility. One who does not care for the past invariably misses the exciting areas of historical enquiry.

Professor McKeown calls for more analysis of what doctors have been doing, under the headings of diagnosis, pathology, prevention, cure, prognosis and palliation of disease. These categories are at once too rigid and too narrow. For the social historian

of medicine to accept them would needlessly restrict his field of operations. Doctors have been doing many other things that deserve his attention, such as teaching, establishing a professional monopoly, acting as the friend and confidant of patients, testifying before courts and parliamentary commissions, and withstanding jibes about their fees as old as those directed at Chaucer's Doctor of Physick. In any case, the social historian cannot limit himself even to the curricular and extra-curricular activities of licensed professionals. The medieval monk in his Infirmarium, the itinerant quack in his wagon, and the apothecary in his herb garden, all occupy an incontestable place in the social history of medicine.

Even within these six categories of medical activity, there is room for a broader approach. Of pathology, for example it is said only that: 'In spite of earlier advances in related sciences such as anatomy and physiology, an accurate understanding of disease processes was delayed until the nineteenth century. It owed much to recognition of the bacterial origin of infections'.⁸ This passage seems to suggest that, apart from condemning the obscurantism that delayed the triumph of science, the social historian should be concerned with pathology only when it became scientifically accurate. But the historian is concerned with what people did and why they did it; he cannot ignore some actions or beliefs on the irrelevant grounds that they may later have been found to be inaccurate or ineffective. Medieval society must therefore be allowed to have its pathology called by its proper name, whatever the opinion held of it by modern medicine. The social historian will have said nothing important about it if he says only that it was scientifically unsound. His task is to explain the religious, astronomical, and astrological assumptions upon which medieval pathology rested. By the same argument, proponents of the miasmatic theory of disease cannot retroactively be called heretics once bacteriology has become orthodoxy. They deserve the respect and attention of the social historian; it is irrelevant to his purpose that later generations held infections to be of bacterial origin.

The social historian of medicine is the observer and interpreter of centuries of medical activity in various social contexts. If he restricts his vision with the blinkers of effective scientific medicine, he will be an untrustworthy observer and an incompetent interpreter of all but the most recent medical history. This is not what H. E. Sigerist had in mind when he called for serious study of the social history of medicine. In appealing for a greater understanding of such subjects as the conditions of health in rural France in the eighteenth century, Sigerist was setting worthwhile goals for the social history of medicine. In demanding 'medical history with the public interest put in', Professor McKeown has not only gone astray from Sigerist's original proposals; he has erected philosophical and methodological barriers which could separate social historians of medicine from those who should be their closest colleagues.

One may sympathize with Professor McKeown's appeal for more flexible attitudes towards change in the fields of medicine and public health. It is, however, a sympathy which has nothing to do with being a historian. As a citizen, I may care intensely whether medical services continue to drift, but as a social historian I must recognize that I am powerless to stop them, should they choose to do so. To do otherwise is to practise a particularly dangerous form of self-deception.

REFERENCES

1. McKEOWN, T., 'A sociological approach to the history of medicine', *Med. Hist.*, 1970, 14, 342. It is somewhat disturbing to find a passing reference to social history as 'history with the politics left out' in a paper written in 1970. The outstanding social historians of our time—men such as E. J. Hobsbawm, Christopher Hill, and George Rude—no longer work within the constricting framework of G. M. Trevelyan's definition. Professor McKeown's logic is thus based on a premise which would now find little support.
2. McKeown, *op. cit.*, p. 342. (Emphasis added.)
3. *Ibid.*, p. 342.
4. *Ibid.*, p. 342. (Emphasis added.)
5. *Ibid.*, p. 342.
6. *Ibid.*, pp. 348–49.
7. *Ibid.*, p. 348.
8. *Ibid.*, pp. 343–44.

J. F. HUTCHINSON

DR. THOMAS McKEOWN REPLIED TO DR. HUTCHINSON'S COMMENTS AS FOLLOWS:

I hoped that two things were clear from the outset of my paper 'A sociological approach to the history of medicine', but in view of Dr. Hutchinson's comments I think I should repeat them. In the first place, I was concerned only with the social history of medicine and did not attempt to generalize about historical studies of other kinds. I do not want to open this large subject here, except to say that I believe there are problems in the history of medicine which are distinguished, although perhaps not uniquely, by the difficulty of approaching them without a background of present-day experience. And secondly, I was speaking at the inauguration of a new society about a direction which I hoped it might give to medical historical research. I did not suggest that this was 'the only social history worth pursuing'* although I did consider it to be an important and neglected approach.

I should not wish to argue with Dr. Hutchinson about his choice of tasks awaiting the attention of the social historian in medicine; his agenda is advocated on grounds of interest rather than utility, and the historian is entitled to decide for himself what he finds interesting. 'Explaining changing ideas about health within society' is a legitimate subject of study, but so too is assessment of what our predecessors were doing against the background of present-day knowledge. For example, one may be interested to know both that some eighteenth-century physicians considered blood-letting an effective treatment of yellow fever, and that in adopting this measure they seriously overestimated the total quantity of blood. We do now know the blood volume.

However I think I can best identify the matters of substance about which we differ by stating two propositions with which it is clear that Dr. Hutchinson, and no doubt some other historians, would disagree. One is that historical research can provide valuable perspective on some present-day medical problems. The other is that there are important questions in the history of medicine which cannot be tackled satisfactorily without a background of present-day knowledge.

*The quotations throughout this note are from Dr. Hutchinson's paper.