*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.

In support of the first assertion let me give a few examples. Sometime before 1990 the decision will probably be taken to end the national programme of BCG vaccination against tuberculosis in Britain. This decision will be made largely on the basis of historical evidence, assessment of the contribution of BCG to the decline of mortality from the disease during recent decades and comparison of experience with that of a country such as Holland which has never introduced national vaccination. (To reject this type of enquiry as historical research because it is in the recent past when the evidence is reasonably clear, would be to suggest that history begins where the data become unreliable, and to press the role of 'the artist and detective' at the expense of 'the chronicler and assessor'.) On a longer time scale, going back to the registration of cause of death in 1838, the same approach can be used to evaluate the contribution of multiple influences—nutrition, overcrowding, immunization and therapy—to the reduction of mortality. On a still larger canvas the historian can interpret the contribution of all the major influences to the modern improvement of health and rise of population.

If the historian concedes that such investigations are possible, he may nevertheless ask for indications of their usefulness. The policy decision in the case of BCG vaccination has already been mentioned. Even more important is the relevance of this knowledge to issues confronting developing countries. Faced with enormous health problems and exiguous resources, they need the best evidence concerning the returns in health to be expected from influences such as improved nutrition, better hygiene and clinical services; and within clinical services they require to know the relative advantages of investment in preventive and therapeutic measures and in hospitals and other forms of care. This information is still very incomplete because the historical sources from which it is largely derived have been neglected. Indeed the extent of ignorance concerning these basic medical issues is quite remarkable. There are many clinicians and microbiologists who are still unaware that the contribution of immunization and therapy to the decline of mortality from infectious disease has been relatively recent and quite small.

Ironically the results of neglect of this type of research in medicine are the reverse of those implied by Dr. Hutchinson. He suggests that examination of the past against a background of present-day interests and experience 'will distort the past and probably the present as well'. On the contrary, it is the failure to look critically at the past from this viewpoint which has allowed modern medicine to be taken at its own evaluation, with profound consequences for medical education, medical research and medical services.[1]

Lest it be thought that the usefulness of historical enquiry is restricted to subjects for which the evidence is largely numerical, I will cite an example of a different kind. The modern teaching hospital is in many ways ill-suited for the purposes of medical education, since it can present neither a balanced picture of medical problems, nor an example of comprehensive services. Yet attempts to change substantially the role of the teaching hospital are blocked by two misconceptions which historical perspective could remove. One is the conviction that the contribution of acute hospitals, and particularly teaching hospitals is so important to health that it would be dangerous to modify the character of their work. The other is the belief that teaching hospitals were

designed to meet the needs of medical education. The history of voluntary hospitals in the eighteenth and nineteenth centuries leaves no doubt that when medical education became centred on hospitals it had to conform to traditions which had been established for more than a hundred years.

In support of the second assertion—that there are historical questions which cannot be tackled satisfactorily without a background of present-day knowledge—I will refer to one of the most important issues in economic history, namely the relation between population growth and industrial development. This subject requires assessment of reasons for the decline of mortality, which turns on interpretation of the behaviour of individual diseases. An economic historian can estimate the frequency of inoculation against smallpox in the eighteenth century, but he is on very treacherous ground in attempting to assess the results of this procedure without reference to recent virological and clinical experience of the disease. For example, it really is important to be aware that the protection afforded, even by vaccination, is very effective but relatively transitory, and that we owe the control of smallpox much more to vaccination of possible contacts with a confirmed case than to mass immunization programmes. Similarly the relation between nutrition and infectious diseases—among the most significant and complex issues in the history of medicine—cannot be unravelled without modern insight into the possible effects of natural selection on the relationship between micro-organisms and man.[2] It should be noted that such problems which require present-day knowledge do not arise only from consideration of the contemporary issues referred to above (for restricting 'vision with the blinkers of effective scientific medicine' as Dr. Hutchinson colourfully puts it); they are thrown up also by some of the traditional themes with which historians have been wrestling for quite a long time.

In my paper to the Society for the Social History of Medicine I suggested that the main purpose of the social historian in medicine should be the provision of perspective on problems in the present day. I did not suggest that this should be his sole purpose, and I recognize that the interests of many medical historians lie elsewhere. I can also understand that experience in other fields may make a historian dubious about the feasibility of contributing to an understanding of present-day problems in medicine, although I believe his doubts would be removed if he looked closely and 'without blinkers' at issues such as those to which I have referred. What I cannot understand is why he should regard this kind of activity as not merely useless but dangerous, and threaten to excommunicate those who engage in it.[3] If this is the approach of history it is not, or at least is no longer, that of science. Fortunately the investigator who believes he can learn from the past, and can tackle some problems more confidently in the light of modern knowledge, is unlikely to be deterred by a scholastic definition of historical interests, and he will lose no sleep if he is told that what he is doing is regarded as science rather than history. But before this distinction is imposed it will pay the historian to consider carefully the basis on which it is drawn. It can hardly be to the advantage of historical studies to define outside their scope investigations of the past whose results can be relied on and are demonstrably useful.

I have no wish to end by quoting authorities, but it may be of interest to add that unless I misunderstood Sigerist even more seriously than Dr. Hutchinson has misunderstood me, his viewpoint on these matters when we discussed them together was

very much in accord with the one I have given. I think it is true to say that although Sigerist did not himself pursue this line of enquiry he recognized its possibilities and was wholly sympathetic to it.

*REFERENCES*

1. This subject is discussed more fully in T. McKeown, 'A historical appraisal of the medical task', *Medical History and Medical Care,* (ed. G. McLachlan and T. McKeown), London, Oxford University Press, 1971, p. 27.
2. For a fuller discussion the reader is referred to T. McKeown, R. G. Brown and R. G. Record, 'An interpretation of the modern rise of population in Europe', *Population Studies,* 1972, **27,** No. 3, p. 345.
3. Dr. Hutchinson suggests that this approach will erect 'philosophical and methodological barriers which could separate social historians of medicine from those who should be their closest colleagues.'

*The Editor has received the following letter, commenting on 'The Struggle to Reform the Royal College of Physicians, 1767–1771: A Sociological Analysis' (Medical History,* 1973, **17,** 107–26).

In your April number, Ivan Waddington has discussed the edicts which prevented fellows of the Royal College of Physicians of London, from practising surgery and other manual disciplines. He has pointed out the important role played by Scottish graduates in the revolt against these rulings and has related this to the broader training received by Scottish, and especially Edinburgh, graduates. I agree entirely with all that he has written but I must point out that the situation was not peculiar to London. Certainly, Glasgow had the combined Faculty of Physicians and Surgeons, but in Edinburgh graduates faced the same circumstances as in London and at an earlier date. In 1707, the Royal College of Physicians of Edinburgh, passed a resolution forbidding fellows to practise surgery and in 1750 pharmacy was likewise banned for fellows.[1] The ban even included dispensing medicines for one's own patients. These restrictions were extended in 1763 to include licentiates as well as fellows, so in this respect the situation was worse than in London. Perhaps it was the existence of these restrictions at a time when they had not been introduced in London which encouraged some Edinburgh graduates to migrate south and thus promoted the struggle which ensued in London.

Midwifery was added to the banned list for Edinburgh physicians in 1765 but this aspect was repealed in 1788 after a bitter struggle. It was not until 1823 that surgery and dispensing for one's own patients were permitted. Similar restrictions existed in Dublin where, in 1756, Sir Fielding Ould, was refused a licence to practise medicine because he was already licensed to practise midwifery.[2]

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1. *Historical Sketch and Laws of the Royal College of Physicians of Edinburgh* (Edinburgh 1925).
2. WIDDESS, J. D. H. *A History of the Royal College of Physicians of Ireland,* Edinburgh, Livingstone, 1963.