

The New Social History of Medicine: Some Implications for Research

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It has become an historiographic cliché that medical history is traditionally written by doctors, about doctors, and for doctors.¹ A vast panorama of noted clinicians and startling biological discoveries are conventionally presented with a distinctly Whiggish enthusiasm for “the advance of scientific medicine”. In the last two decades, however, this approach, while certainly not superceded, has at least been augmented by what may be termed “the new social history of medicine”. Not content to assume progress as the underlying dynamic of history, these studies attempt to analyze health care and disease as they actually prevailed on a day to day basis. The providers of care, including irregular practitioners, are examined as struggling individuals rather than as a community typified by a few scientific giants. Disease is explored in its cultural and political context rather than in strictly epidemiological terms. The instruments by which health care is provided, whether hospitals and dispensaries or chemotherapy and home-remedies, are studied not just on the basis of their purveyors’ intentions, but also in the manner in which they in fact operated. Finally, the recipients of this care, the sick and disabled, provide an increasingly fruitful source for discerning the social meaning of illness and its consequences for individual lives.

The following observations are historiographic more in form than intent: by discussing recent trends and citing specific examples, it is hoped that implications for future research needs will become apparent. The initial section reviews the traditional approach to medical history and refers to existing Canadian works. The following section considers the nature of social history and dominant themes in the new social history of medicine. In the penultimate section, examples of recent research will be discussed under four headings: health care providers, mechanisms of health care, disease, and recipients of health care. Finally, the concluding paragraphs suggest what impact newer approaches may have on the future use of resource materials.

¹ See, for example, two recent surveys by younger historians: Susan Reverby and David Rosner, “Beyond ‘the Great Doctors’”, in their edited collection *Health in America: Essays in Social History* (Philadelphia, 1979), pp. 3-16; John Woodward and David Richards, “Towards a Social History of Medicine” in their edited volume, *Health Care and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine* (London, 1977), pp. 15-55.

I

Medical history has, in the past, been concerned chiefly with matters internal to medicine rather than considering health care in a wider social context. The profession itself has been portrayed in institutional or organizational terms as a homogeneous body evolving towards scientific competence. Much of this metamorphosis centres on discoveries of drugs, etiological agents or physiological mechanisms and, as a result, tends to focus on the work of individuals. Diseases are discussed largely in terms of their early incidence and prevalence and their eventual regression in the face of accurate theories of causation and subsequent therapeutic developments. Some disorders are subsumed under a consideration of public health, but it is a limited field which, if "it is not legislation, it is sewers and drains with a technical history about hydraulics and plumbing included".² Finally, institutions such as hospitals and medical schools are common subject matter but, as Charles Rosenberg has lamented, the resulting works are usually of "the 'centennial' sort, and are so thin and lacking in critical framework as to be of almost no use to succeeding scholars".³ Certainly, in the perceptive phrase used by an historian of science to describe his own discipline, the history of medicine has characteristics "internally determined . . . by the discipline which produces them" and their accurate appreciation requires description from within the profession.⁴ But equally, such studies, as Henry Sigerist observed almost forty years ago, have led to a regrettable neglect of the social implications of medical history.⁵

If the focus of medical history has been limited, so too has the methodology. Classically, the format is biographical, though the term may be broadened to include "biographies" of institutions or organizations. Such material is seldom presented in thematic fashion, but instead, is arranged in a simple chronology, making it necessary to leap from chapter to chapter in order to follow the development of an important idea or method.⁶ Predictably, the content is largely narrative rather than analytical, though the underlying faith that history represents indisputable progress is clearly evident. Indeed, as the authors are often physicians or scientists, such a philosophical assumption is doubtless a part of their professional creed.⁷ In part, too, the character of the works derives from their

2 Woodward and Richards, "Towards a Social History of Medicine", p. 19. An exception to this is Barbara Rosenkrantz, *Public Health and the State: Changing Views in Massachusetts, 1842-1936* (Cambridge, Mass., 1972).

3 Charles E. Rosenberg, "The Medical Profession, Medical Practice and the History of Medicine", in Edwin Clarke, ed., *Modern Methods in the History of Medicine* (London, 1971), p. 27.

4 Thomas S. Kuhn, "The Relations Between History and History of Science", *Daedalus* 100, no. 2, (Spring 1971), p. 292.

5 Henry E. Sigerist, "The Social History of Medicine", *Western Journal of Surgery, Obstetrics and Gynecology*, 48 (Oct. 1941): 714-722. Cited here from Felix Marti-Ibanez, ed., *Henry E. Sigerist on the History of Medicine* (New York, 1960), p. 25.

6 See, for example, Fielding H. Garrison, *An Introduction to the History of Medicine*, 4th ed. (Philadelphia and London, 1929). Particularly revealing are his appended "Questions and Exercises", containing, for example: "Make a List of the Papal Physicians."; "What Galenic texts did Linacre translate?"; or "What army surgeons have achieved distinction in other fields of activity?" He can perhaps be forgiven the latter question; though a prominent historian, Garrison himself was a Lieutenant-Colonel in the U.S. Army Corps. His work is still a standard reference.

7 J.F. Hutchinson, "Historical Method and the Social History of Medicine", *Medical History* 17, no. 4, (Oct. 1973), p. 425.

heuristic intent. Lengthy discussions of the history of disease in the nineteenth century were designed to teach incipient physicians about disease rather than about history. If this function has paled, a second goal persists. The edifying chronicle of medicine, some suggest, will create a patina of culture and professional pride for the otherwise culturally deficient medical student and practitioner.⁸

Canadian medical historiography has adhered to these themes and methods with depressing fidelity, producing a narrative of Carlylean proportions. The saga begins with a description of the “primitive” practices of the North American Indians to whom the simultaneous arrival of French medicine and diseases, if at first a mixed blessing, ultimately becomes a godly and scientific advantage. The contribution of religious orders and rudimentary hospitals leads, via numerous epidemics of smallpox and several of syphilis, to the conquest of 1760 and the introduction of English and Scottish medicine. The ensuing three-quarters of a century is an heroic amalgam of brutal military surgeons, ingenious fur-trader-physicians, and devastating cholera epidemics. The middle years of the nineteenth century are portrayed as a continuing feud between bleeding and purging orthodox physicians and quacks of various persuasions over issues such as licencing and medical education. Orthodoxy eventually triumphs, however, with the introduction of anaesthesia and antiseptics by 1870 and the victory is secured by subsequent discoveries such as radiography by 1900 or sulphonamide antibiotics during the 1930s. It is a stirring story when well told, but more often than not, leaves the significant questions unanswered and, indeed, unasked.

Though both subscribe to the general principles and format above, two schools or tendencies may be arbitrarily designated in Canadian medical historiography. The earliest tradition began with William Canniff's *The Medical Profession in Upper Canada, 1783-1850* (1894). Though he considered legislative and educational developments, the most striking feature and largest segment of the book is that devoted to 260 brief biographies of early physicians. Perhaps of interest to those concerned with quantification, the real significance of these portraits is that they established an enduring pattern in Canadian medical historiography. Edwin Seaborn, for example, writing half a century later, though including fragmentary material on a variety of subjects, ultimately rests his volume on a biographical format. With a few notable exceptions—Charles Duncombe, R.M. Bucke—most of his physicians are of interest only as members of a group yet no attempt is made to delineate group characteristics or activities. That this approach is still considered adequate is evident from W.B. Stewart's recent 400-page compendium of New Brunswick practitioners.⁹ Though biography has always been a strong point in Canadian historiography, historians of medicine have carried the approach to an unrewarding extreme.

A second and certainly more rewarding tendency traces its origins to the appearance, in 1928, of J.J. Heagerty's *Four Centuries of Medical History in Canada*. If the earlier school may be labelled biographical, the newer must be de-

8 Rosenberg, “The Medical Profession”, p. 34, endorses this view.

9 William Canniff, *The Medical Profession in Upper Canada, 1783-1850* (Toronto, 1894); Edwin Seaborn, *The March of Medicine in Western Ontario* (Toronto, 1944); W.B. Stewart, *Medicine in New Brunswick* (St. John, 1974). Others of this genre include: H.C. Jamieson, *Early Medicine in Alberta* (Edmonton, 1947); Ross Mitchell, *Medicine in Manitoba*, (Winnipeg, 1954).

scribed as encyclopedic. Heagerty, once director of the federal department of Health, employed primary documentation including the Jesuit Relations, early medical journals, newspapers and contemporary government reports to catalogue major episodes and minor details of professional and institutional development. Though a large part of one volume contains a tedious list of early physicians, the work remains the standard reference in the field. It was later complimented, but not superseded, by H.E. MacDermot's *One Hundred Years of Medicine in Canada, 1867-1967*, a volume which deals primarily with the development of the profession itself in terms of education, specialization, organization and publications. By focusing on the twentieth century it supplies information not available in Heagerty's earlier work.¹⁰

The bibliophiles and encyclopedists considered above and their disciplines are, of course, not the only practitioners of medical history in Canada, but their work certainly forms the essential super-structure of the discipline.¹¹ Their research, when documentation is presented at all, is primarily among the public records of hospitals, government reports, medical association proceedings, medical journals and various biographical materials. Despite their limited scope, however, the works prior to World War II were often no more deficient than those compiled by historians in other disciplines.¹² It must be remembered, as well, that for most of the authors considered, history was an enthusiasm pursued outside their regular medical duties, and done so with little stimulation from colleagues or recourse to research funds. Nevertheless, they identified and collected source materials and arranged events and characters in a coherent chronology.¹³ Their legacy was a diminutive but chronic interest in the field.

It is clear that E.H. Carr's dictum, "Study the historians before you begin to study the facts",¹⁴ in large measure explain the deficiencies of existing Canadian medical historiography. But an equally significant factor must be the reluctance of Canadian historians in general to examine the medical past. The reasons for this reticence are varied. Doubtless historians have assumed they lacked "the minimum technical knowledge which is an indispensable prerequisite for research"¹⁵ and have been, as in the history of science, unwilling to acquire such

10 J.J. Heagerty, *Four Centuries of Medical History in Canada* (Toronto, 1928); H.E. MacDermot, *One Hundred Years of Medicine in Canada, 1867-1967* (Toronto, 1967). Additional and often interesting members of this school include: Maude Abbott, *History of Medicine in the Province of Quebec* (Toronto, 1931); William Perkins Bull, *From Medicine Man to Medical Man* (Toronto, 1934); T.F. Rose, *From Shaman to Modern Medicine: A Century of the Healing Arts in British Columbia* (Vancouver, 1972); Robert E. McKechnie, *Strong Medicine: A History of Healing on the Northwest Coast* (Vancouver, 1972).

11 References to further monographs and articles will be found in the notes to section III. Additional references, though often of marginal interest are cited in Genevieve Miller, *Bibliography of the History of Medicine in Canada and the United States, 1939-1960* (Baltimore, 1964) and annually, 1960-1967, in the *Bulletin of the History of Medicine*.

12 Whatever his alleged theoretical merits, it would be difficult to argue that Harold Innis' *The Cod Fisheries: The History of An International Economy* (New Haven and Toronto, 1940) or *The Fur Trade in Canada: An Introduction to Canadian Economic History* (New Haven and London, 1930) are any less soporific than Heagerty at his worst.

13 Genevieve Miller, "In Praise of Amateurs: Medical History in America Before Garrison", *Bulletin of the History of Medicine* 47, no. 6, (Nov.-Dec. 1973), pp. 586, 615.

14 E.H. Carr, *What is History* (London, 1961), p. 17.

15 Gerald Grob, "The Social History of Medicine and Disease in America: Problems and Possibilities", *Journal of Social History* 10, no. 4 (June 1977), p. 392.

knowledge.¹⁶ Related to this unfamiliarity with the vocabulary of medicine is this impression, often correct, that research materials are obscure or, as in the instance of hospital case notes, for example, non-existent or inaccessible. North American scholars have failed to balance this view by acquainting themselves with the imaginative use of sources by their European counterparts.¹⁷ In many respects this reflects, as Gerald Grob suggests, "an excessive preoccupation with socioeconomic determinants" to the exclusion of a "comparable concern with the complex relationships between disease patterns, social structure, and environmental conditions".¹⁸ Finally, there seems to exist an unedifying but discernible antagonism between physician-historians and lay historians, with the former jealously guarding their previously exclusive preserve.¹⁹ As will become apparent in the following section, much of this is about to change.

II

Social history, at least in Britain and North America, is a discipline which has emerged over the last three decades²⁰ in several discrete phases.²¹ It began as an attempt to view "history from below",²² to dispense with kings and statesmen in preference for "the poor or lower classes".²³ It was a short step to reject political history in favour of virtually any other focus: social history had become, in Trevelyan's phrase, "the history of a people with the politics left out".²⁴ Finally, the nascent discipline borrowed analytical methods from kindred disciplines, particularly economics and sociology, leading one sociologist to remark that social history was simply sociology with "a long time scale and bad data".²⁵

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- 16 Kuhn, "The Relations Between History and History of Science", p. 276-77.
- 17 See, for example, Robert Forster and Orest Ranum, *Food and Drink in History: Selections from the Annales Economies, Societies, Civilization*, Vol. 5, trans. by Elborg Forster and Patricia Ranum, (Baltimore and London, 1979).
- 18 Grob, "The Social History of Medicine and Disease", p. 392.
- 19 See, for example, an acrimonious exchange in the *Journal of the History of Medicine and Allied Sciences*, 34, no. 4 (Oct. 1979), p. 458, in which a physician replied to a critique by three historians of his review of two books on the history of child birth by laymen. He referred to "the malaise or exasperation among certain M.D.'s about the obvious fact that the history of medicine seems to be coming under the control of Ph.D.'s". Thomas Kuhn goes further to suggest an inherent temperamental gap separates the historian from the scientist, the former being on the whole less intelligent and less accurate, while more verbal and of higher socioeconomic origins. He concludes "that a passion for history is seldom compatible with even a developed liking for mathematics or laboratory science, or vice versa". See his "The Relations between History and History of Science", pp. 295-96.
- 20 Harold Perkins, "Social History in Britain", *Journal of Social History* 10, no. 2 (Winter 1976), p. 130.
- 21 E.J. Hobsbawm, "From Social History to the History of Society" *Daedalus* 100, (Winter 1971): 20-45 and cited here from M.W. Flinn and T.C. Smout, eds., *Essays in Social History* (Oxford 1974), p. 2; Theodore Zeldin, "Social History and Total History", *Journal of Social History* 10, no. 2 (Winter 1976), pp. 238-39.
- 22 See E.P. Thompson, *The Making of the English Working Class* (London, 1963).
- 23 Hobsbawm, "From Social History to the History of Society", p. 2.
- 24 G.M. Trevelyan, *English Social History* (London, New York and Toronto, 1942), p. vii.
- 25 Bruce M. Stave, "A Conversation with Sam Bass Warner, Jr.", *Journal of Urban History* 1, no. 1 (Nov. 1974), p. 100. Such well-meaning assertions of academic comradere are not always as succinctly stated or, indeed, comprehensible. See W.J. Cahnman and Alvin Boskoff, "Sociology and History: Reunion and Rapprochement" in their edited collection *Sociology and History: Theory and Practice* (New York and London 1964), pp. 1-18. Note the views of a medical historian in George Rosen, "Health, History and the Social Sciences", *Social Science and Medicine* 7, no. 4 (April 1973): 233-48.

Agreement on these broad phases of development, it should be cautioned, does not imply that a mature and well-defined discipline yet exists. "At present," observed the editor of one of social history's journals, "there is a Mulligan stew quality to the field."²⁶ And if widely divergent suggestions for future development by prominent scholars²⁷ are an indication, this amorphous character is likely to persist. One is tempted simply to accept the rather circular assertion that social history is not a part of history but all of history looked at from a social point of view.²⁸

The purpose in discussing the current state of social history is twofold: first, to suggest that social history, as a function of its widely cast net, is rapidly becoming the dominant mode of historical inquiry and, secondly, to go further and suggest that the history of medicine broadly defined, is fundamental to the discipline of social history. The history of medicine, Sir William Osler is said to have observed, is the history of mankind. The acquisition and preservation of health is the primary human concern, willingly abrogated only in exceptional circumstances, and as such, provides the ultimate motivational basis for most social interaction. Seen in this light, virtually all human activity has some implication for the social history of medicine. An awareness of this perspective, in turn, may well explain the recent and growing interest in medical history.

There are, of course, additional factors spurring on those historians reluctant to accept completely the primacy of the social history of health and disease. For a steadily aging population beset by a virtual epidemic of degenerative diseases, as well as by issues of ecological survival, health becomes a timely concern. Similarly, the relatively distant and sacrosanct position once enjoyed by the medical profession has, over the last decade, been steadily eroded. Humanized, the doctors become legitimate targets of historical inquiry. That health care is an area of broad social implications has been emphasized, in North America, at least, by the recurrent political controversy surrounding the issue of state medicine. Finally, on a pragmatic level, younger scholars may well have found some conventional fields of inquiry at first over-crowded, and later, clearly pedestrian. Such is not to imply that agreement exists as to future research needs²⁹—quite the contrary—but a vague consensus on philosophical assumptions underlies many recent works. Appropriately enough, three such major premises mirror recent developments in the philosophy of clinical practice.

"Patients", observes Frances Smith, "loom small in medical history".³⁰ But historians, like contemporary physicians, are increasingly aware of the limitations of the doctor-oriented or iatrocetric model. It assumes a homogeneity within the profession on matters of treatment and etiological theory when such

26 P.N. Sterns, "Coming of Age", *Journal of Social History* 10, no. 2, (Winter 1976), p. 247.

27 For example, E.J. Hobsbawm, "From Social History to the History of Society", pp. 11-19; Asa Briggs, "The Study of the History of Education", *History of Education* 1 (1972): 5-22.

28 Richard T. Vann, "The Rhetoric of Social History", *Journal of Social History* 10, no. 2 (Winter 1976), p. 222.

29 See, for example, the contrasting suggestions in: Woodward and Richards, "Towards a Social History of Medicine", pp. 21-45; Rosenberg, "The Medical Profession, Medical Practice and the History of Medicine", pp. 24-32; Thomas McKeown, "A Sociological Approach to the History of Medicine", *Medical History* XIV, no. 4 (Oct. 1970), pp. 343-50.

30 Frances B. Smith, *The People's Health, 1830-1910* (London, 1979), p. 9.

was, and still is, often not the case.³¹ Even when such unity existed, as Erwin Ackerknecht suggests, there was often a marked hiatus between theoretical knowledge and actual grass-roots practice.³² It is equally facile to assume all or even a significant proportion of health care in the past derived from members of the medical profession. In fact, unorthodox healers and self-medication are an enduring source of medical aid.³³ Finally, as contemporary medical research reveals, even when patients have access to medical treatment, a large number elect not to comply with the prescribed treatment.³⁴ If this is the case with today's relatively benign therapy, how much more frequent must non-compliance have been during the heyday of "heroic treatment" in the nineteenth century. For reasons such as these, social historians of medicine are choosing to abandon the traditional iatrocetric approach.

As physicians fade in prominence, the sick and diseased gain in historical attention. Here, too, historians borrow from medicine in an attempt to view the patient as "a whole person". Rather than focusing on a particular symptom complex, attempts are made to consider the non-biological determinants of disease and illness-behaviour. Cultural and educational factors influence not only the type of disease—nutritional, for example—but also define what condition an individual identifies as abnormal and at what stage in its progression he chooses to seek medical attention. Such behaviour, in turn, dictates both the nature of treatment and the prognosis. Similarly, racial background may help to explain the prevalence of a particular disease among certain populations. The social circumstances of North American Indians, for instance, are intimately associated with a disproportionate incidence of tuberculosis.³⁵ Economic factors clearly influence accessibility to health care, the type of occupation-related disease encountered, and the ability to implement effectively concepts of preventative medicine. That class is important is clearly demonstrated by the epidemiology of "neurasthenia", an affliction which when first described was largely peculiar to the nineteenth century middle-class, or by working-class patterns of hospital utilization.³⁶ Illness, then, must be considered by both physicians and historians as a process which is as much social as biological.

Such assumptions are ultimately subsumed under a third concept borrowed from contemporary medicine: homeostasis. Modern physiology assumes the body's energy is devoted to maintaining a dynamic balance among its various biological functions. Similarly, the social historian of medicine considers an

31 For example, see Phyllis Allen, "Etiological Theory in America Prior to the Civil War", *Journal of the History of Medicine and Allied Sciences* 2, no. 4, (Autumn 1947): 489-52.

32 Erwin H. Ackerknecht, "A Plea for a 'Behaviourist' Approach in Writing the History of Medicine", *Journal of the History of Medicine and Allied Sciences* 22, no. 3, (July 1967): 211-14.

33 James H. Young, *American Self-Dosage Medicines: An Historical Perspective* (Lawrence, Kansas, 1974); G.B. Risse, R.L. Numbers, J.W. Leavitt, eds., *Medicine Without Doctors: Home Health Care in American History* (New York, 1977).

34 R.H. Leach and P.L. White, "Use and Wastage of Prescribed Medicines in the Home", *Journal of the Royal College of General Practitioners* 28, no. 186 (Jan. 1978): 32-36.

35 See Marion M. Torchia, "The Tuberculosis Movement and the Race Question, 1890-1950", *Bulletin of the History of Medicine* 49, no. 2, (Summer, 1975): 137-168.

36 Barbara Sicherman, "The Uses of a Diagnosis: Doctors, Patients and Neurasthenia", *Journal of the History of Medicine and Allied Sciences* 32, no. 1 (July 1977), pp. 43-46; Charles Rosenberg, "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary", *Journal of the History of Medicine and Allied Sciences* 29, no. 1 (Jan. 1974), pp. 34-5.

individual's primary goal the allocation of his material and social resources in order to sustain at least a critical balance of well-being. Such a model of biological man is, of course, open to many of the criticisms directed at the economists' economic man. In seeking a state of good health, whether defined as merely the absence of disease or, in broader terms, as a positive sense of well-being, individuals are no more "rational consumers" than they are in the market place. They are limited by their own ignorance of pathophysiology and, occasionally, by that of the medical profession as well. Access to health care facilities of adequate quality is not always readily available when required. Frequently, they are faced with the unpleasant necessity of balancing good health against other forms of consumption. Many forces beyond the individual's capacity to control, such as sanitation standards, plagues, and famine negate the effects of his decision making. And perhaps most frustrating is man's proclivity for self-destructive behaviour, often encouraged, as statistics on alcohol, tobacco and drug abuse suggest, by specific economic interest groups. Recognizing the validity of these caveats, however, the model of biological man remains a useful analytical tool. Given the choice between health and its converse, an individual will generally choose the former, and, indeed, place it at the top of his personal list of priorities. His subsequent socioeconomic behaviour will clearly reflect this concern which, after all, is all the model attempts to demonstrate.

The flow of the new social history of medicine, then, is influenced by three undercurrents, all analogues of concepts current in contemporary medicine: patient-oriented health care, a holistic view of the patient and the centrality of socio-biological homeostasis. The manner in which these themes have found expression in recent historiography is the focus of the following section. It will examine four representative areas: providers of health care, instruments used to convey medical attention, individual diseases, and recipients of health care.

III

A shift from the iatrocetric perspective is not meant to imply that physicians are to be neglected by medical historians; on the contrary, in recognition of their significant role, recent scholars have shown considerable interest in reinterpreting the evolution of the medical profession itself. Far from being a group which consciously determined the course of their own development, it is clear that the character of medical practice was largely dependant on external influences. The nineteenth century has been viewed as a period parenthesized by two vastly different levels of professional organization and competence. The early absence of valid medical therapy and curative surgery contrasts sharply with the proliferation in medical technology by 1900. Simultaneously, the profession itself evolved from an ill-defined collection of individuals of widely differing training and ability to a relatively homogeneous group with clearly delineated professional standards. These two developments—the so-called "rise of modern medicine"—are held to be causally related: as competence, based on scientific advance, increased, it was possible and necessary for the profession to define itself in more rigid and exclusive terms.³⁷ While such a relationship doubtless existed, social historians have presented a convincing alternative analysis: the

³⁷ See, for example, F.F. Cartwright, *A Social History of Medicine* (London and New York, 1977), chapter 8, "The Birth of Scientific Medicine".

process of professionalization ultimately rested on the pressures and expectations of a society increasingly concerned with matters of health. Canadian historians, it should be emphasized, have yet to examine the implications of this re-interpretation.³⁸

At the beginning of the nineteenth century, licencing laws appeared in many of the American states. During the 1830s, this attempt by the fledgling profession to secure definition floundered: “nearly every state had repealed its penalties on unlicensed practitioners”.³⁹ The “major force behind the repeal” was the popular Thomsonian sect of botanical healers. These self-trained dispensers of herbal remedies and their numerous local societies appealed to a rural and working-class population disillusioned with the expense and limited efficacy of orthodox physicians. In Ohio, for example, physicians readily admitted a third of the population followed Thomsonian remedies, while in Mississippi, the Governor estimated that proportion at fifty percent.⁴⁰ In this age of so-called Jacksonian Democracy, the Thomsonians represented “opposition to special privilege in the form of licensed monopoly”.⁴¹ A similar and temporally related challenge to orthodoxy and a greater economic threat since it appealed to urban middle and upper-class patients, was homeopathic medicine. Such practitioners were often regular physicians who abandoned “heroic” therapeutic measures such as bleeding or treatment with toxic doses of mercury in favour of extremely dilute prescriptions frequently of plant origin. It represented the first attack on the profession from within.⁴² Similarly, another significant source of pressure came from women whose increasing demands after 1850 for entry into the profession forced physicians to justify their exclusion in terms of professional definitions.⁴³ It was confrontations such as these which pre-occupied the medical profession during a period in which science was unravelling major biological mysteries. Indeed, the average practitioner had a “distrust of most scientific medicine”⁴⁴ and few doctors seemed to assume leadership in the nascent American scientific com-

38 Consider, for example, these institutional studies: John Ferguson, *History of the Ontario Medical Association, 1880-1930* (Toronto, 1930); D. Scatler Lewis, *The Royal College of Physicians and Surgeons of Canada, 1920-1960*. (Montreal, 1962); H.E. MacDermot, *History of the Canadian Medical Association, 1867-1956*, 2 vol., (Toronto, 1935 and 1958); Elizabeth McNab, *A Legal History of the Health Professions in Ontario: A Study for the Committee on the Healing Arts* (Toronto, 1970).

39 Joseph F. Kett, *The Formation of the American Medical Profession: The Role of Institutions, 1780-1860* (New Haven and London, 1968), p. 13.

40 William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore and London, 1972), pp. 125, 141.

41 Kett, *The Formation of the American Medical Profession*, p. 111.

42 Rothstein, *American Physicians in the Nineteenth Century*, pp. 160, 162, 168. See also Martin Kaufman, *Homeopathy in America: The Rise and Fall of a Medical Heresy* (Baltimore, London, 1971).

43 Mary Roth Walsh, *Doctors Wanted, No Women Need Apply: Sexual Barriers in the Medical Profession* (New Haven and London, 1977). Note also, Martha H. Verbrugge, “Women and Medicine in Nineteenth-Century America”, *Signs: Journal of Women in Culture and Society* 1, no. 4 (1976): 957-972. In Canada see: Carlotta Hacker, *The Indomitable Lady Doctors* (Toronto, 1974); Veronica Strong-Boag, “Canada’s Women Doctors: Feminism Constrained” in Linda Kealy, ed., *A Not Unreasonable Claim: Women and Reform in Canada, 1880’s-1920’s* (Toronto, 1979), pp. 109-129. An essential context is provided by Caroll Smith-Rosenberg and Charles Rosenberg, “The Female Animal: Medical and Biological Views of Women and Her Role in Nineteenth-Century America”, *Journal of American History* 60, no. 2 (Sept. 1973): 332-356.

44 Rothstein, *American Physicians in the Nineteenth Century*, p. 265.

munity.⁴⁵ Yet the period also saw the emergence of two of the major features fundamental to the character of modern medicine. First, medical education became relatively standardized, such that by 1870, physicians with degrees vastly outnumbered the non-degreed practitioners.⁴⁶ Secondly, these new professionals grouped together to improve their public image and financial status in both local and national organizations.⁴⁷ This process of professionalization, well-established by 1870, antedated significant interest in or contributions by medical science; rather it represented a series of responses to shifts in the popular perceptions of legitimate sources of health care. The structure of the American medical profession at the end of the nineteenth century, then, reflected demands made by the public with which the practitioners attempted to harmonize their own views of appropriate professional standards and behaviour.

Though such was the case in the United States, it seems not improbable that in an older community such as Great Britain, with an established professional structure and a relatively more visible scientific community, an intimate relationship would exist between professional development and scientific discoveries. This relationship, however, was tenuous at best. The ancient tripartite divisions in British medicine evident at the beginning of the nineteenth century—apothecary, surgeon and physician—gradually evolved into the modern duality of general practitioner and consultant. But it would be misleading to assume that the proliferation of scientific knowledge led either to the ascendancy of specialties or to the withering of the apothecary's art. In fact, the transformation began well before science exerted any appreciable effect and, indeed, before the Medical Act of 1858 institutionalized many of the changes. By mid-century, especially outside London, few medical men restricted themselves to practice in one discipline despite the rules of the various regulatory bodies. "In large part, the changes within the structure of the profession appear to have been brought about by the changing pattern of demand for health care, which in turn was associated with the changes in the class structure brought about by the Industrial Revolution." A growing middle-class, increasingly conscious of health, could not afford to engage a costly physician nor were such practitioners readily available. Into this void stepped the apothecary-surgeon, the prototype general-practitioner.⁴⁸ At the opposite end of the medical spectrum, and particularly in London, a small but dynamic group of consultants formed a professional elite. The source of their prestige derived not from scientific efficacy, but rather, "from the social evaluation placed on the work itself."⁴⁹ Indeed, in 1870 when this process was occur-

45 Sally G. Kohlstedt, *The Formation of the American Scientific Community: The American Association for the Advancement of Science 1848-60* (Urbana, Chicago, London, 1970), pp. 218-19.

46 Joseph F. Kett, "American and Canadian Medical Institutions, 1870", *Journal of the History of Medicine and Allied Sciences* 22, no. 4 (Oct. 1907): 343-356.

47 The formation of the American Medical Association was a direct response to homeopathy. Rothstein, *American Physicians in the Nineteenth Century*, p. 170.

48 Ivan Waddington, "General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of and Intra-Professional Conflict" in Woodward and Richards, *Health Care and Medicine in Nineteenth-Century England*, p. 169. See also S.W.F. Holloway, "Medical Education in England, 1830-1858: A Sociological Analysis", *History* 49, no. 3 (1964): 299-324. A traditional view is found in W.J. Bishop, "The Evolution of the General Practitioner in England", *The Practitioner* 168 (Feb. 1952): 171-79.

49 M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, Los Angeles, London, 1978), p. 4.

ring, British experimental medicine was both rudimentary and “in substantial isolation from the laboratories of Germany and France”.⁵⁰ Practitioners “combined an almost medieval respect for tradition with an excessive admiration for the manners and attainments of an eighteenth-century gentleman” and even the social elite among them “simply did not observe or think scientifically.”⁵¹ In the early years of the nineteenth century the public, hospital boards and the fellows of the surgical and medical colleges selected physicians on the basis of social deportment and family connections.⁵² As the century drew on and concern for matters of health increased, these criteria changed. The change was a reflection less of increased scientific competence on the part of the profession, than of the “rise of the expert in Victorian society”. The consultant elite, then, emerged on the basis of a presumed medical knowledge which was less “the power to do, but the power to know, and therefore to judge”.⁵³ As in the United States, the profession had evolved in response to social needs rather than as the result of either scientific advances or deliberate corporate decisions. This insight is a major contribution by the new social history of medicine.

Health care whether provided by physicians or laymen, reaches its recipients in many ways, of which the most visible, though perhaps not the most significant, has been the hospital. Historians have viewed these institutions in the eighteenth and nineteenth centuries as little more than charnel houses, peopled by brutish physicians and patients whose prognosis for longevity diminished markedly upon admission. “The chief indictment of hospital work”, wrote two historians, “is not that it did no good, but that it positively did harm.”⁵⁴ The chief villains are said to be the staggering surgical mortality before aseptic technique became general and the likelihood of contracting a fatal infection from the hospital and its contaminated accoutrements. Overcrowded, poorly equipped, inadequately heated and offering the dreariest of diets, hospitals were certainly unpleasant. But recent historiography suggests that the traditional “gateways to death” interpretation is both inaccurate and misleading. The Salisbury General Infirmary, for example, from its opening in 1767 to the year 1867 recorded a death rate of approximately three percent, a figure common to many provincial hospitals. If large urban hospitals had less salubrious statistics it was because they frequently admitted more serious cases, particularly those involving industrial trauma, and because they were less able to accommodate chronic but stable patients. Incurables were excluded from most hospitals as were, in theory, those suffering from infectious diseases, two groups which would have increased mortality figures. Similarly, until well into the nineteenth century, surgery was limited to minor procedures, lithotomies, and amputations, all operations which were attended by relatively low fatality.⁵⁵ In fact, it was not until after 1846, when anaesthesia

50 Richard D. French, *Antivivisection and Medical Science in Victorian Society* (Princeton, 1975), p. 36.

51 A.J. Youngson, *The Scientific Revolution in Victorian Medicine* (New York, 1979), pp. 15, 17.

52 Peterson, *The Medical Profession in Mid-Victorian London*, pp. 130, 141, 148, 154.

53 *Ibid.*, p. 286.

54 T. McKeown and R.G. Brown, “Medical Evidence Related to English Population Changes in the Eighteenth Century”, *Population Studies* 9, Part 2, (Nov. 1956): 119-141. See also K.F. Helleiner, “The Vital Revolution Reconsidered”, *Canadian Journal of Economics and Political Science*, 23, no. 1 (Feb. 1957): 1-9.

55 John Woodward, *To Do the Sick No Harm: A Study of the Voluntary Hospital System to 1875* (London, 1974), pp. 126, 129, 131, 134, 61, 77, 82.

made otherwise unbearable surgery a routine, that surgical mortality increased.⁵⁶ Hospitals, then, as their rapid proliferation in the nineteenth-century suggests, provided a necessary and not altogether ineffectual service to that segment of the population unable to engage the services of a private physician.⁵⁷

Beyond these practical considerations, however, resides the more ineffable problem of defining the character of such institutions. Historiographic controversy has been largely preoccupied with one particular type of hospital: asylums for the insane. It is generally conceded by historians that the institutionalized treatment of the mentally ill, particularly in the nineteenth century, was an unedifying and ineffectual exercise. One viewpoint suggests that this failure occurred in spite of initial humanitarian objectives largely through inappropriate or inadequate allocation of resources and accompanying weaknesses in psychiatric theory and practice. An alternative interpretation denies ameliorist intent and argues, instead, that since the primary goal of asylums was the social control of deviant behaviour, no therapeutic results were to be expected.⁵⁸ While general hospitals have not provoked such debate, it is clear here as well, in an age in which morbidity was all too often construed as a visitation upon the morally deficient, institutions relied less on medical than spiritual manipulation.

Hospitals emerged in nineteenth-century America as philanthropic structures, pietistic testimony to both their founders' generosity and the sharp class distinctions of the medical world.⁵⁹ The benefactors never believed that they or their families would have recourse to such institutions; rather, hospitals and the much more functional dispensaries were designed to serve the working but worthy poor.⁶⁰ Almshouses received the idle indigents but the deserving poor were allowed admission to hospitals when bearing a letter of sponsorship from a hospital benefactor. Lacking medical efficacy, much of hospital practice consisted instead "of environmental manipulation". Towering walls prevented the entry of not only undesirable visitors but also contraband alcohol and tobacco. Rude language and card playing were prohibited and appropriate deference was expected for physicians and lay governors.⁶¹ If enforcement was often lax, some institutions, such as the Philadelphia Hospital and its "punishment cell", were

56 E.M. Sigsworth, "Gateways to Death? Medicine, Hospitals and Mortality, 1700-1850", in Peter Mathias, ed., *Science and Society, 1600-1900* (Cambridge, 1972), p. 109.

57 Studies of Canadian hospitals include: G.H. Agnew, *Canadian Hospitals, 1920-1970: A Dramatic Half Century* (Toronto, 1974); Margaret Angus, *Kingston General Hospital: A Social and Institutional History* (Kingston, 1973); W.G. Cosbie, *The Toronto General Hospital, 1819-1965: A Chronicle* (Toronto, 1975); D.S. Lewis, *Royal Victoria Hospital 1887-1947* (Montreal, 1969); J.B. Scriber, *The Montreal Children's Hospital: Years of Growth* (Montreal, 1979).

58 The "good intentions with bad results" thesis is evident in Gerald Grob, *Mental Institutions in America: Social Policy to 1875* (New York, 1973), while a recent example of the social control approach is Andrew T. Scull, *Museums of Madness: The Social Organization of Insanity in 19th-Century England* (London, 1979). A useful summary of the debate is Gerald Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital", *Hastings Center Report* 7, no. 4 (Aug. 1977): 33-41. On Canadian asylums see Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces", *Acadiensis* 6, no. 2 (Spring 1977).

59 Morris J. Vogel, "The Transformation of the American Hospital, 1850-1920", in Reverby and Rosner, *Health Care in America*, p. 106.

60 Charles Rosenberg, "And Heal the Sick: The Hospital and the Patient in 19th Century America", *Journal of Social History* 10, no. 4, (June, 1977), p. 430; "Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary", p. 42.

61 Vogel, "The Transformation of the American Hospital", pp. 106, 108.

prepared to deal with transgressors. The prominence of this “muscular stewardship” was a clear reflection of the essentially lay character of the early hospitals.⁶² As the century drew to a close a growing urban middle-class, often divorced from traditional family supports, turned to the hospitals for medical attention. Simultaneously, the cost of operation outstripped the resources provided by charity and hospital boards were only too willing to accept a paying clientele.⁶³ As identification with the poor diminished, so too did the moralistic posture; in its place emerged diagnostic and therapeutic concern with physical pathology.⁶⁴ Whatever the eventual character of hospitals, for most of the century their orientation was primarily moral rather than medical. This insight, in turn, opens the door for a major reinterpretation of the role of such institutions in nineteenth-century society.

If a substantial proportion of traditional medical historiography has been iatrogenic, an equally significant literature exists which is disease oriented. In particular, diseases associated with high mortality figures over short periods of time have found favour, while chronic but, in the long run, more devastating afflictions such as tuberculosis remain relatively neglected.⁶⁵ Such accounts usually deal with the internal dynamics of the disease and the gradual steps by which scientists and physicians unravelled etiology as a prelude to effective therapy. When a popular but incorrect theory is considered at all, it acts largely as a foil for the researcher with superior scientific acumen. All too often such accounts terminate with vague assertions that the campaign to control a specific disease marked a significant and seemingly deliberate step in the development of contemporary public health. If this approach to disease has certain advantages, it also has marked limitations. In general, it fails to assess the social impact of disease and the manner in which its victims conceived of its onslaught. This deficiency is emphasized, for example, by the contrasting manner in which social historians have approached cholera. Since the mortality from the successive waves of the disease in the nineteenth century was less than that associated with epidemics of typhoid, scarlet fever, smallpox and measles, to a traditionalist the historical attention it has attracted might appear disproportionate.⁶⁶ But cholera was a shock disease. As a result, the social response it illicited was quite out of proportion to its practical consequences. It is this aspect which has attracted social historians: figments of the popular imagination became as important as the figures of the epidemiologist.

62 Rosenberg, “And Heal the Sick”, p. 433.

63 Vogel, “The Transformation of the American Hospital”, pp. 110-11, 114.

64 *Ibid.*, p. 112, Rosenberg, “And Heal the Sick”, p. 429.

65 The “white plague”, for example, has been largely neglected by Canadian historians. See George J. Wherrett, *The Miracle of the Empty Beds: A History of Tuberculosis in Canada* (Toronto, 1977); M.F. Campbell, *Holbrook of the San* (Toronto, 1953); and Catherine McCuaig’s comprehensive “The Campaign Against Tuberculosis in Canada, 1900-1950”, unpublished M.A. thesis, McGill University, 1979. A useful “internal” account of the disease is R.Y. Keers, *Pulmonary Tuberculosis: A Journey Down the Centuries* (London, 1978).

66 Margaret Pelling, *Cholera, Fever and English Medicine, 1825-1865* (Oxford, 1978), p. 4. See, for example: M. Barnet, “The 1832 Cholera Epidemic in York”, *Medical History* 16, no. 1 (Jan. 1972): 27-39; Asa Briggs, “Cholera and Society in the Nineteenth Century”, *Past and Present*, no. 19, (April 1961): 79-96; Norman Longmate, *King Cholera: The Biography of a Disease* (London, 1966); R.E. McGrew, “The First Cholera Epidemic and Social History”, *Bulletin of the History of Medicine* 34, no. 1 (Jan., 1960): 161-73.

Cholera presented a challenge to society in both Britain and America and provoked a remarkably similar pattern of response. Gruesome accounts of the epidemic's approach from India greeted newspaper readers and the sudden, crippling symptoms of its victims added to the terror. Most physicians had never encountered a case making diagnosis often difficult, while the pattern of outbreaks seem incompatible with the then current theories of contagion. Various treatments, heroic, but useless, discredited the profession and in the United States, contributed to the sudden popularity of both Thomsonian herbalists and homeopaths. The "respectable" middle class saw it as a disease of the poor, particularly vagrants, pedlars and the impoverished Irish. With the exception of Unitarians, most religious groups and, indeed, physicians, interpreted the epidemics as a Divine chastisement, directed specifically at the intemperate and more generally at a society obsessed with materialism and the false gods of science. As well, these pious individuals believed it their duty to provide subscriptions for poor relief. The stricken working-class, however, saw hospitals as harbingers of death and new rules of sanitation, quarantine and burial—with which rioting mobs refused to comply—as instruments of middle-class oppression. Once the epidemics of the 1830s and 1840s receded the *ad hoc* and largely lay boards of health left few permanent contributions to public health. If the social fabric of Britain and America remained intact, so too did the conditions which favoured cholera.⁶⁷ The transatlantic cholera epidemics, then, provide what Hobsbawm terms "moments of eruption" which "do not merely bring into the open so much that is normally latent, but also concentrate and magnify phenomena" for the benefit of the historian.⁶⁸

Not only do studies of the response to cholera illuminate significant aspects of a specific society, but they also emphasize significant differences between societies. To the historian who focuses primarily on, for example, the debate between competing contagion and anticontagion theories, these subtleties will be lost.⁶⁹ As R.J. Morris observes, "Because the choice between the two paradigms could not be made by scientific rules, the choice was directed by social pressures from outside the medical community."⁷⁰ Similarly, Rosenberg suggests, "with disease so flexible a concept, it was only natural that mental and moral factors should be presumed to play a role in its causation."⁷¹ Such social and moral influences as were operative in Britain and the United States, though broadly similar in derivation and expression as seen above, appear to have been quite different in operation. For Morris the epidemics illustrate "the relationships, the institutions, the means of social control" by which "cohesion and stability" was maintained in Britain. The governing and middle class "saw cholera as a massive threat to the social and economic well-being on which their prosperity depended". Hospitals and sanitation legislation "broke the 'rules' of stable class

67 Charles Rosenberg, *The Cholera Years: The United States in 1832, 1849 and 1866* (Chicago and London, 1962), pp. 3, 13, 76, 68, 72, 40, 59, 43, 131, 96, 125, 128, 89, 33, 119, 82, 233; R.J. Morris, *Cholera 1832: The Social Response to an Epidemic* (London, 1976), pp. 27, 16, 54, 177, 159, 91, 117, 133, 135, 139, 101, 103, 106, 108, 198, 112.

68 Hobsbawm, "From Social History to the History of Society", p. 17.

69 Indeed, as Pelling suggests in *Cholera, Fever and English Medicine*, the presumed debate between theories of contagion wrongly assumes two clearly delineated, anti-thetical positions and ignores variants such as the cholera-fungus controversy of 1849.

70 Morris, *Cholera 1832*, p. 180.

71 Rosenberg, *The Cholera Years*, p. 74.

relationships” and resulted in violent working-class protest. The “traditional respect for the recognized freedoms of the poor was quickly restored” even if this “freedom was only the freedom to die and be buried in peace”. The limited extent of riots and the reserved manner in which they were controlled, he concludes, “were indicators of the inherent stability of British society”.⁷² In contrast, according to Rosenberg, cholera illustrates American society in a state of flux. The “most striking of the changes in America” was revealed less by class tension, than by “the dissipation of piety”. In 1832, cholera was “a scourge not of mankind but of the sinner”, yet by 1849 the poorest “ignored religion”, while “the most able among the workers” became “free thinkers”. By 1866, most Americans accepted that “the gospels of Snow and Chadwick, not those of Mark and John, promised deliverance from cholera”. Accounting for the erosion of the “conservative convictions of an earlier generation”, he argues, were the turbulent “equalitarian and centrifugal tendencies of Jacksonian America”.⁷³ Whereas cholera in Britain revealed a hierarchical but stable society, in the United States it sheds dramatic light on a community in social turmoil.⁷⁴

If traditional medical historiography differs from the newer social history in its approach to physicians, hospitals and disease, no such contrast exists with respect to patients. Simply put, medical history has ignored the patients. In part, this may reflect the historian’s disinterest or lack of imagination; more probably, it is evidence of the anonymity of the patient. Since the ill were “generally inarticulate”, writes Charles Rosenberg, we are forced “to infer the nature of the patient’s experience from chance remarks and patterns of institutional practice.”⁷⁵ Recently, such inferences have been made concerning the experience of nineteenth-century English patients, among whom a particularly intriguing but mute subgroup were elderly paupers. After 1870, seventy percent of workhouse inmates were aged and infirm and in London, such institutions provided three times as many beds as the voluntary hospitals which refused admission to incurables. In the wake of the Poor Law, physicians attending paupers ceased to be private contractors tendering for the position and became salaried servants of the local authorities. At the same time, districts were increased in size and salaries reduced, such that in most cases only “unqualified and disreputable transients” were attracted to positions. Even the conscientious were grossly overworked and often employed unqualified assistants to attend minor and chronic cases, practices which may explain the hostility shown by patients to the Poor Law doctors. Few physicians appeared to have followed their prescribed duties in the workhouse infirmary, seldom seeing, let alone examining, patients. Direct care was usually entrusted to inmate “nurses” who represented “a harrowing compound of neglect and mindless cruelty”. Chronic ulcers, bronchitis, gout, arthritis, paralysis and senility accounted for most confinements and, after 1870, the practice of allowing the admission of the healthy partner of such patients became less

72 Morris, *Cholera 1832*, pp. 17, 125, 114.

73 Rosenberg, *The Cholera Years*, pp. 4, 40, 123, 213, 160.

74 Only in recent years has cholera in Canada been closely examined. See Geoffrey Bilson, “Canadian Doctors and the Cholera”, Canadian Historical Association, *Historical Papers*, 1977: 105-119; “Cholera in Upper Canada, 1832”, *Ontario History* 67, no. 1 (March, 1975): 15-30; “The First Epidemic of Asiatic Cholera in Lower Canada, 1832”, *Medical History* 21, 4 (Oct. 1977): 411-33. C.M. Godfrey, *The Cholera Epidemics in Upper Canada, 1832-1866* (Toronto, 1968).

75 Rosenberg, “And Heal the Sick”, p. 428.

common. Alone and ill, the routine which awaited was hardly therapeutic. A typical ward consisted of two dozen beds set seventeen inches apart in two rows. Windows were small and few, allowing little light or ventilation to freshen the drably painted interior. Sheets, when provided, were seldom changed and patients were permitted to bathe, in communal water, once each month. Supplied on contract and often adulterated, food was inedible and the elderly, frequently lacking dentation, could seldom masticate the dreary mutton and sour potatoes. Separated from families, attended by neglectful physicians or inept nurses, and confined in a hostile and unsanitary environment, it is clear that the experience of the aged pauper patient was a continuing agony. As a final indignity, medical historians have unfortunately considered them “necessary adjuncts as clinical material and sources of income to the heroes and heroines of the story . . . but otherwise irrelevant to the curative process and therefore unworthy of differentiation”.⁷⁶

For the inarticulate, inference from institutional practice is a necessary method of describing the impact of illness. But a smaller and more erudite group have left vivid accounts of their perceptions of health and its opponents. “No topic more occupied the Victorian mind than Health,” writes one historian. “Literary critics thought of Health when they read a new book of poems; social theorists thought of Health when they envisioned an ideal society. Victorians worshipped the goddess Hygia . . .” In part, this concern derived from the constant threat of illness or epidemic, and equally, it was influenced by well-publicized developments in the biological sciences. In their quest for well-being, “Victorians flocked to the seaside, tramped about in the Alps or Cotswolds, dieted, took pills, sweated themselves in Turkish baths, adopted this ‘system’ of medicine or that”. And joining this eager throng was a sizeable number of Victorian intellectuals—Carlyle, Darwin, Tennyson, Spencer, Meredith, Ruskin—from whose prolific literary output a consensus on the nature of “Health” emerged.⁷⁷

Victorian conceptions of well-being “show the influence of Carlyle’s healthy hero, Spencer’s biologically perfect man, Newman’s gentleman-Christian, and especially Kingsley’s muscular Christian”. Ultimately, they were subsumed in the phrase *mens sana in corpore sano*. It was assumed that the nature of mind depended on the physiological characteristics of the brain, an assumption which seemed “to provide an objective foundation for subjects like ethics and psychology that might otherwise remain subjective and speculative”. The body, seen in this light, became a key to epistemology: “the healthy body was not just an aid to mental cognition, but was itself a direct means of cognition”. Leslie Stephen, for example, recalled “the real majesty of an Alpine cliff” which was appreciated as much through the muscular exertion of its ascent, as through conscious thought. Health for such Victorians was “defined as that state in which reliable cognition

76 Smith, *The People’s Health*, pp. 383-85, 355-58, 384-86, 390-93, 9. Only with the rise of statistical competence did the nineteenth-century reformers become aware of the extent of disease in their society. See John M. Eyler, *Victorian Social Medicine: The Ideas and Methods of William Farr* (Baltimore and London, 1979). Note also W. B. Howie and S. A. B. Black, “Side-lights on Lister: A Patient’s Account of Lister’s Care”, *Journal of the History of Medicine and Allied Sciences* 32, no. 3 (July 1977): 239-51.

77 Bruce Haley, *The Healthy Body and Victorian Culture*, (London and Cambridge, Mass., 1977), pp. 3-5, 13.

and purposeful action continually reinforces each other". And while the sound mind-sound body philosophy influenced only very indirectly such practical matters as public health, it nevertheless, in popularized form, permeated various aspects of English social behaviour. In particular, it was the paradigm, albeit distorted, of "the British athlete—the player as gentleman-hero—" and sport became a display case for moral and physical hardiness. "Total health or wholeness" had, in effect, become "a dominant concept for the Victorians, as important in shaping thought about human growth and conduct as nature was to the Romantics".⁷⁸ A study of such thinking, in turn, reveals a great deal more about English history than do accounts of developments in medical specialties or descriptions of the work of individual physicians.

IV

The preceding pages have suggested that recent works in medical history, fundamental to wider social history, differ markedly from traditional medical historiography in their approach to doctors, patients, disease, and mechanisms of health care. These differences are reflected in the types of sources utilized by the social historians of medicine. We can learn more about the nature of hospitals from mortality statistics and popular patterns of utilization than we can from sterile reports by governors or physicians. Family papers and journals expose in fine detail perceptions and consequences of illness lacking in the scant case histories which characterized nineteenth-century medical practice. The impact and extent of disease, for which traditional epidemiological data are important, is given new depth when examined in sermon literature or popular novels. And the medical profession itself, revealed in its journals, books and proceedings, must be viewed through the eyes of its clientele and rivals as well. It is methodological assumptions such as these which explain Charles Rosenberg's assertion, in the introduction to *The Cholera Years*, that only a quarter of his material "was gleaned from medical sources".⁷⁹

Viewed from this vantage point, contemporary historians are unlikely to be as enthusiastic about the establishment of a distinct medical archives as were their more traditional predecessors. Such a concept seems best suited to an iatrogenic, disease and institution-oriented approach. Which is not to say that, in some form, such a collection should not exist. This repository might well house hospital records, fee bills, insurance manuals, industrial and union records, reports from government departments such as immigration, pharmacy records and medical journals and proceedings. But equally fruitful sources—manuscript diaries and travel accounts, transcripts of malpractice suits and coroners' inquests, medical advertisements in the lay press, sermon and devotional literature, census data, and parish records—will remain a part of other collections.

78 *Ibid.*, pp. 21, 18, 253-54, 261. That the "amateur" can also make important contributions to the social and intellectual history of medicine is evident from Philippe Ariès, *Western Attitudes Towards Death from the Middle Ages to the Present*, trans. by Patricia M. Ranum (Baltimore and London, 1974) and Susan Sontag, *Illness as Metaphor* (New York, 1979). A useful context for such studies is provided by F.K. Taylor's brief *The Concepts of Illness, Disease and Morbus* (Cambridge, 1979).

79 Rosenberg, *The Cholera Years*, p. 9.

There will always be a significant place for the internal history of medicine and disease to which a medical archives would be well suited. But increasingly, medical historians will be found with historians of other disciplines, firmly seated in the reading rooms of general archives. This is particularly true for Canadian historians who, relatively unburdened by an extensive but inadequate historiography, may initiate their research using insights and methods developed by recent social historians in other countries. Such are the implications of the new social history of medicine for future research.

Résumé

L'auteur analyse les approches traditionnelles à l'étude de l'histoire de la médecine et démontre à quel point elles ont été habituellement inadéquates. Il suggère qu'une histoire sociale plus vaste et plus significative de la médecine est en train de se manifester, qui s'écarte des biographies des grands hommes de la médecine ou des chronologies superficielles d'institutions. Shortt souligne aussi les implications que en découlent pour la recherche et l'archivistique.