*Broadening the Vision of the History of Medicine**

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The history of medicine as a branch of medicine

FROM THE TIME OF THE HIPPOCRATIC WRITERS UNTIL THE MIDDLE OF THE twentieth century, the history of medicine was a part of medicine itself; it was the business of physicians. But as medicine changed over this long period,[1] so too did the role of the history of medicine.

For the authors of the Hippocratic texts—for Celsus, Galen and other writers of antiquity—the history of medicine or, more precisely, the history of medical doctrines, was a matter to be considered and argued by an author as he worked out and justified his own position. This approach was similar to Aristotle's philosophical method of quoting from, criticising and correcting his predecessors. It was, for Aristotle as for the earliest historians of medical doctrine, a way of establishing the truest or most plausible view. The focus that Medieval and Renaissance medical scholars placed on authoritative texts, which now included authoritative texts from Arabic as well as Graeco–Roman sources, perpetuated the ancient role of the history of medicine within medicine itself throughout this period, although in a somewhat different form.

In the 250 years between the establishment of modern anatomical studies (most notably by Vesalius in the 1540s)[2] and the definitive linkage of clinical observation with pathological anatomy (most notably by French medical reformers of the Revolutionary and Napoleonic era),[3] the proliferation of new theoretical constructs and experimental techniques eroded the authority that canonical texts had previously enjoyed as models or paradigms of medicine as a system. The first group to lose this status were the Arabic texts, as they were replaced by more extensive and more accurate editions of Galen's works in the later Renaissance.[4] We should also not overlook the fact that works by Muslim authors became unfashionable at a time when the Reformation was heightening the Christian sensibilities of both Protestants and Catholics,[5] and when the Muslim armies of the Turkish Empire had conquered most of south-eastern Europe and were threatening Vienna.[6]

But Galen, too, soon lost his authority as the source of a comprehensive medical system as a steady stream of innovators produced new accounts of the human body and its functioning. Some of the more prominent among these innovators, and the approaches they inaugurated, were: Paracelsus and iatrochemistry; Vesalius and empirical anatomy; Descartes and iatromechanism; Harvey and experimental physiology; and Bordeu and medical vitalism.[7]

These innovators did not wipe the slate clean, however. Although there were few, if any, dogmatic Galenists in eighteenth-century European medicine, there were also few dogmatic adherents to any other medical system; or, rather, even if they were dogmatic in theory, they were most likely to be pragmatic or eclectic in practice. Classic therapies, such as bleeding, purging and manipulation of diet, were still the mainstay of medical practice in the late eighteenth century. But their use was now theorised in an eclectic terminology drawing upon Hippocratic–Galenic humouralism, mechanical and chemical theories, and the latest results of experimental physiology and natural philosophical speculation.

The poet Friedrich Schiller (1759–1805) was a member of the inaugural class of the Medical School at the Ducal Military Academy of Württemberg.[8] We can see in his medical dissertations of 1779 and 1780 the eclectic theoretical mix to which I just referred, as well as the mix of clinical case histories drawn from both classic and contemporary authors.[9] I will have more to say about Schiller's medical dissertations in the final part of this article, but here it is sufficient to point out the way in which material drawn from many different periods of the history of medicine was given equal status with case reports from the practice of Schiller's teachers and with Schiller's own clinical observations.

This same mixture was found in the curriculum of the Medical School, which included lectures on classic and modern medical texts as well as clinical study in a variety of Stuttgart hospitals. Nor was the Ducal Military Academy idiosyncratic or second-rate in this respect. Its medical curriculum was typical of the time and its medical teachers were, in general, better than those at the nearby University of Tübingen, whose authorities had done everything possible to prevent the academy from opening a rival medical school.[10]

So, for eighteenth-century medicine, the history of medicine still informed both theory and practice. Although ancient and early modern texts did not provide a paradigm for a medical system, they did provide a treasury from which the practising physician could draw resources that had equal standing with the latest experimental results and clinical observations. 'Life is short, the Art long', as the first Hippocratic aphorism put it,[11] and what made the art of medicine 'long' was its cumulative, still growing and still practically useful history.

At the beginning of the nineteenth century, R. T. H. Laennec (1781–1826), whose invention of the stethoscope in 1816 would represent the new turn in medicine toward a localised, tissue-based concept of disease, began his career with a thesis on the Hippocratic writings, affirming their relevance for practical medicine.[12] But the work of pathological anatomists early in the century, and, increasingly, of experimental physiologists from the middle of the century, and, finally, of bacteriologists in the last quarter of the century made it more and more unlikely that physicians would find practically useful information in pre-nineteenth-century medical texts.

Scientific medicine in the late nineteenth century was seen as having its foundations in the laboratory. Chemistry, physiology, microscopy and other fields that had previously been referred to by physicians as 'accessory' sciences would become known, around the 1890s, as the 'basic' sciences—that is, those studies on which practical medicine had to be based.[13] In this context, 'a school of thought grew up that regarded historical research in medicine as [a] waste of time'.[14] But a countervailing tendency, at least in English-speaking countries, was the view held by Sir William Osler (1849–1919) that historical background and the reading of original sources should be a small but integral part of clinical instruction.[15]

While it was still acknowledged at the end of the nineteenth century that 'Life is short, the Art long', the meaning of this aphorism was substantially reinterpreted. Medicine was now understood to consist of both art and science. The science was the knowledge base, while the art was the practical skill and the spirit of humanity required to apply this scientific knowledge to the treatment of individual patients. So 'Life is short' now referred to the fact that most of the medical curriculum would be devoted to science. The art was, therefore, too 'long' to fit in, other than by way of occasional extracts slipped into the interstices of this curriculum.

It was around this same time that the history of medicine became a specialised area in the organisational sense.[16] In preparation for the opening in 1893 of the Johns Hopkins Medical School in Baltimore, the first institution outside Germany to be devoted to the aggressive teaching of the new science-based medicine,[17] Osler and the other senior physicians planning the school also established the Historical Club of the Johns Hopkins Hospital in 1890.[18] It was set up as a voluntary organisation for physicians attached to the new Johns Hopkins Hospital, which had opened in 1889, as well as for students of the future Medical School. By the middle of the twentieth century this group, then known as the Johns Hopkins Medical History Club, came to be regarded as the oldest active medical history society in the world, since comparable bodies in France, Germany and Italy had not been established until after 1900.[19]

The Johns Hopkins Medical Society was another voluntary organisation established at about the same time as the Historical Club for the discussion of scientific and clinical matters. Evening meetings of the two groups were apparently well attended by both medical staff and students in the early days of the Medical School.[20] But the separate existence of the Medical Society, which met twice a month, and the Historical Club, which met once a month, was an indication that the history of medicine, while still of interest to medical practice and education, was no longer central to it.

The first research institute devoted to the history of medicine was founded in Leipzig, Germany in 1905 by Karl Sudhoff (1853–1938).[21] In 1929, the Johns Hopkins Medical School followed suit with the first such institute in the English-speaking world.[22] It was modelled on the Leipzig institute,[23] and Sudhoff himself attended its opening ceremony.[24] The founding of such specialised institutes for the history of medicine was intended to give a small number of physicians the opportunity to do full-time research in the field, to provide some teaching in medical history to medical students (usually on a non-compulsory basis) and (in Europe but not America) to allow the occasional medical student to complete an MD thesis in the history of medicine. The 'best contributions to medical history' from such institutes were expected to come 'not from professional historians but rather from scientists with a historical interest, who were able to handle the medical aspects with more authority'.[25]

While the field was still iatrocentric, or physician-centred, it was not necessarily focused on the search for pragmatic solutions to practical medical problems, as it once had been. Sudhoff, for example, approached his archival material in the way that any medievalist would have.[26] But it was assumed that both the producers and the consumers, or reading audience, of such studies were physicians who had been educated in the humanities as well as in medicine. It was still possible to take for granted that most physicians had studied Latin, and some of them ancient Greek, as part of their pre-medical education. Most had also been exposed to a modern foreign language and to the classics of Western literature, at least in translation where they were not originally in English, as well as ancient and modern history.[27] With this background, much (although not all) of the historical work done by physicians was of a high standard, and addressed topics and texts that would generally not have been covered by historians of other stripes.[28]

During the first half of the twentieth century this approach to the history of medicine was seen as an antidote to some of the negative features of the prominence of science in modern medicine.[29] It made use of—and, therefore, kept alive, as it were—the humanistic learning to which physicians had been introduced before they entered sci-

entific medicine, and this process was understood as a way of helping them to retain a balanced outlook. It also provided a sense of the wholeness and the traditions of medicine at a time when scientific advances were forcing greater specialisation and placing the focus on the latest knowledge rather than antecedent developments.

And finally, the history of medicine provided inspiring stories, sometimes exaggerated, of great figures who triumphed over adversity or achieved immortality as much through their moral qualities as through their technical work, even though that work was in many respects now superseded. Contemporary physicians, knowing that the pace of scientific development was such that their own work was likely to be superseded in the relatively near future, saw in this aspect of medical history the promise of a kind of immortality to which they could still aspire.

The history of medicine as a branch of history

In the decades after World War II, as medicine became 'the health industry', the gentlemanly attributes that the history of medicine was regarded as fostering among physicians lost their earlier value. At the same time, it became less likely that a physician would have had a premedical education in the classics or humanities. These changes within medicine were paralleled by external changes as general historians—like their colleagues in sociology, economics and many other social sciences—became interested in medicine as an integral part of human society, a trend that had started in the 1930s. These professionals came with their own agendas, and these agendas did not necessarily privilege the work of great physicians of the past.[30]

Historians whose careers are pursued within university academic departments are professionally trained in the standards of the discipline of history and reinforced in their adherence to these standards by university hiring and promotion practices. Their research is subject to peer review by other professional historians, so it must meet established standards while also reflecting new developments in the field in order to be accepted for publication by a professionally reputable journal or publishing house. The longer term reorientation of the history of medicine from a branch of medicine to a branch of history thus extended the history of medicine into virtually all the areas typically covered by the discipline of history.[31]

Changes in prevailing historical methodologies have opened the history of medicine to social history and historical sociology; feminist and post-colonialist approaches; 'history from below', or medicine as seen from the patient's perspective; history focused on groups marginalised

because of their sexual orientation, race, delinquency, religion or other factors; the social construction and deconstruction of expert knowledge and institutionalised authority structures; and many other approaches. These valuable trends have often appeared with revolutionary historiographical claims being made on their behalf, but the apparent discontinuities need to be seen against the backdrop of a more continuous development within the academic field of history toward greater scope and inclusiveness.

None of this is problematic in itself, but when applied to the history of medicine in particular, and combined with the relative lack of preparation that physicians now have for doing historical research, some alarm bells do sound. Firstly, to gain acceptance from their professional colleagues in history, university-based historians of medicine had to distance themselves as much as possible from the amateur medical history of physicians. Many of them would not join associations for the history of medicine, because these organisations typically welcomed physicians and other health practitioners as members and were, therefore, regarded as semi-amateur bodies.[32]

Secondly, physicians viewed some historians of medicine as 'anti-medicine' or 'physician-bashing' in their orientation. Critical organising concepts, such as 'medicalisation' or 'medical dominance', could be deployed in a variety of ways by historians: from neutral, descriptive categories to instruments for the deconstruction of all medical authority. To many physicians interested in the history of medicine, the emphasis seemed to be on the latter use. And for some historians this was intentionally the case.[33] By the middle of the twentieth century, medicine had developed what seemed to be an unchallenged position of authority; and it is not unusual for academics to challenge the heretofore unchallenged. But it is also necessary to ask, in retrospect, whether for historians the issue of 'medical dominance' within society was not, in part, a proxy for the issue of physician dominance within the history of medicine[34]—thus enabling historians to pursue, in an apparently disinterested context, their own professionally interested aim of displacing physicians from the centre of medical history.

Thirdly, by the last decades of the twentieth century, health care was being reorganised in developed countries in ways that would make the mid-century stereotypes of 'medical dominance' largely obsolete.[35] Government regulations, insurance requirements, hospital and health service administrators, the rise in status and improved formal training of other health professions, the health consumer movement, the redefinition of previously unorthodox and marginal health practitioners as providers of 'complementary' rather than 'alternative' services, and changes in medical education itself, have all greatly altered the role of physicians in the health industry and in society generally over the last generation.

University-based historians of medicine have been slow to incorporate these developments into their worldview. Perhaps as academics they have only recently been in a position to appreciate what such changes have meant to the autonomy and status of physicians, as they have begun to experience for themselves the effects of the greater professionalisation and profile of non-academic support staff in universities; the increasing constraints of government policy decisions and their funding implications; the exercise of non-collegial forms of executive authority by senior university managers; the prospect of mandatory continuing education and professional development in order to retain certification as a university teacher and research supervisor; the imposition of formal quality assurance procedures and cyclical audits by an outside agency; and many other changes that are analogous to those that have affected physicians over a longer period of time.

Contemporary agendas shape the questions that historians ask of the past and also cause certain features of what they find in the past to appear with greater or lesser salience. Because of this fact, the disjuncture between university historians interested in medical history and physicians interested in medical history has narrowed the vision of historians of medicine in a number of ways. Firstly, it has locked the view of some historians about the authority and status of physicians into a time warp, frozen in the 1970s. Secondly, it has reduced the opportunities for historians of medicine to explore questions about the past that relate to physicians' interests—questions about technical medical issues, clinical practices, or the experience of being a physician, for example. And thirdly, even in cases where the questions pursued do not relate directly to physicians' interests but arise from other agendas, the absence or marginalisation of the physician's perspective limits the salience that some aspects of the past will have in medical history research.

I have taken physicians as a reference point for my discussion so far because of their centrality to the origins of the history of medicine; but what I have said about the setting of questions and the salience of evidence relating to those questions can now be generalised to other health practitioners. Nurses, dentists, pharmacists, physiotherapists, indigenous and other traditional healers, complementary therapists, hospital and laboratory technicians, veterinarians, and many others all have something to contribute to the history of medicine—using the term 'medicine' now in its most generic sense, that is, not limited to the work or the profession of the physician.

It is acknowledged that relations between and among these various groups of health practitioners are not fixed for all time, and that each may wish to use claims about the past to advance its own position vis-à-vis any of the others. Eric Hobsbawm, in his contribution to a

UNESCO-sponsored collection of articles entitled *The Social Responsibility of the Historian*, noted that

> all human beings, collectivities, and institutions need a past, but it is only occasionally the past uncovered by historical research. The standard example of an identity culture which anchors itself to the past by means of myth dressed up as history is nationalism. … Inevitably the nationalist version of [a nation's] history consists of anachronism, omission, de-contextualization and, in extreme cases, lies. To a lesser extent this is true of all forms of identity history, old or new.[36]

How, then, to incorporate the practitioner's view into the history of medicine without falling into 'anachronism, omission, de-contextualization and…' I won't say 'lies' in this context, but rather, 'conclusions that are not supported by the evidence'?

The firm relationship of conclusions to evidence and the linking of events to their appropriate historical context are among the most fundamental standards of the discipline of history, and it is absolutely essential that these standards be upheld in relation to health practitioner viewpoints as well as any other viewpoints. Whether the historian's research concerns a dispossessed people or a professional group struggling for what it considers to be its appropriate place in society—and no matter how sympathetic the historian is to that group's cause—the relaxation of rigorous historical standards in order to score political points does the group a disservice, not least because the exposure and discrediting of unjustified claims also casts doubt on other, better supported claims.

The collaborative option: A personal view

Few health practitioners have received training in historical research methods and the caveats relating to the use of historical evidence. The intensive nature of the training that most of these practitioners receive makes it difficult to induct them into anything more than the rudiments of history while they are students; and the number who wish to undergo formal training in history after they have qualified in their profession is relatively small. This pathway is not to be discouraged: the small number who follow it are in a position to make exceptionally important historical contributions. But in quantitative terms, their impact is minor.

More promising, I believe, is the option of greater collaboration between historians and health practitioners in medical history research. A few years ago I would not have been in a position to make this sug-

gestion, having had no experience with a collaboration of this kind. But since I have now had the opportunity of working on a series of historical projects with a practising physician, I would like to use that experience to illustrate some of the points I wish to make.

My collaborator, Dr George M. Weisz of Sydney, is an orthopaedic surgeon who, late in his career, completed a BA majoring in History and then an MA in Renaissance Studies. We have jointly published two articles on Erasmus and medicine,[37] and a third article on Schiller's medical dissertations,[38] while a fourth project on medicine in Castiglione's *Book of the Courtier* is in the planning stages. My focus here is on the Schiller article.

Schiller studied medicine for five years and then practised as an army doctor for two years before abandoning the medical profession in 1782 for a literary career. His most extensive medical writings are the three dissertations that he submitted in 1779 and 1780 in order to complete his course of study and qualify as a practitioner. In addition, we have from him a necropsy report written in 1778, a series of reports on a fellow student suffering from melancholia in June and July of 1780, (all written by him in the same period), two short medical letters from 1788, and a prescription of uncertain date that probably emanated from his army medical practice. All these materials are published in English translations, together with a biography, commentaries, and an analysis of the influence of medicine on Schiller's literary work by Kenneth Dewhurst and Nigel Reeves in their 1978 book, *Friedrich Schiller: Medicine, Psychology and Literature*.[39]

At the time this book appeared, Dewhurst was a consultant psychiatrist and an eminent historian of medicine, having published extensively on the history of neurology and on a number of seventeenth-century medical figures, and Reeves was a professor of German. So in these two collaborators we had an apparently ideal combination for this project: a physician, who was also a historian of medicine, and a literary scholar.

I confess that when I first read the Dewhurst and Reeves book, I felt there was not much more that Weisz and I could add about Schiller's medical writings. Dewhurst and Reeves had analysed and contextualised these writings, to all appearances very carefully. And looking at the original texts from which they had made their translations, or at the comments of other Schiller scholars, or at Schiller's major literary work from his medical student days—the play entitled *The Robbers*—the points on which I thought we might disagree with or add to the comments of Dewhurst and Reeves, or other commentators, seemed too minor to warrant pursuing.

But here the issue of salience, to which I referred earlier, becomes important. Both Dewhurst and my colleague Weisz are medical prac-

titioners, but medicine is, of course, a complex field with many specialties and what is salient in the case of one specialty may not be so in the case of another. In the present instance, what is salient to a psychiatrist may not be so to a surgeon, and vice versa. What most attracted Dewhurst and Reeves were the psychological and psychosomatic aspects of Schiller's medical writings, a perception shared by literary scholars who have looked at these writings in connection with Schiller's poetry, plays and works on aesthetic theory.

From this psychological and aesthetic point of view the key medical texts by Schiller are his two dissertations on the connection of mind and body, and his reports on his fellow student's melancholia (all written in German). The remaining substantial medical text, a Latin dissertation on fevers, and the other brief materials in German, are generally treated more dismissively. I will limit my discussion here to the contrasting treatment of the psychosomatic dissertations and the fever dissertation.

The first psychosomatic dissertation was submitted in 1779 and was unsuccessful. Only chapter one (of five) remains, and it is in German although the thesis was apparently translated into Latin for submission. The second psychosomatic dissertation, submitted in German, and the Latin fever dissertation were presented to the examiners 'at virtually the same time in November 1780'.[40] This was an unusual step that 'has never been satisfactorily explained',[41] although Dewhurst and Reeves propose that Schiller was interested only in the psychosomatic dissertation—a substantially rewritten second attempt after the first dissertation of 1779 had been failed. The fever dissertation they consider a mere back-up or 'safeguard' in case the second psychosomatic dissertation was rejected as its predecessor had been.[42]

According to Dewhurst and Reeves, the fever dissertation addressed a 'more practical and pedestrian topic…, and as a further precaution [Schiller] presented it in the traditional language for medical theses of the day—Latin';[43] whereas the German dissertation on the connection of mind and body 'lucidly explored the exciting field of psycho-somatic medicine and philosophy'.[44] This contrast between the 'pedestrian' and 'traditional' fever thesis and the 'lucid' and 'exciting' psychosomatic thesis is reinforced by later comments that Dewhurst and Reeves make. The fever dissertation, they say, 'treats in a fairly orthodox manner a common subject for an eighteenth century graduation thesis';[45] 'both its topic and the language in which it was presented point to an attempt to satisfy solid convention'.[46] The psychosomatic dissertation, on the other hand, 'boldly tackled the controversial problem of body/soul relations…. Clearly this was where [Schiller's] heart lay'.[47] One also has to infer that this is where Dewhurst's and Reeves' hearts lay—or to put the matter differently, the 'problem of body/soul relations' was

clearly the aspect of Schiller's medical thought that appeared most salient to them, given their respective professional backgrounds.

In this judgment, Dewhurst and Reeves followed the opinions of earlier literary scholars. Herbert Meyer, for example, in his 1958 introduction to volume twenty-two of the German *Nationalausgabe* edition of Schiller's complete works, seems almost to resent that he has to include the fever dissertation for the sake of completeness. Schiller's text, he says,

> was written in haste, without serious consideration, and in reality it only rehashes the views of anthologies and of his teachers. It contains hardly any reference to critical analysis and in this regard cannot be considered as a significant medical history document. It is informative only in so far as it is a reflection of the medical education at the Academy and offers clear proof that Schiller obviously regarded medicine as just a 'compulsory subject'.... The young poet was generally interested in medicine only when he could pursue issues concerning the relationship between medicine and philosophy, and the relationship between the body and the spirit or soul.[48]

And yet, what evidence is there that the fever dissertation, which failed to interest Dewhurst and Reeves and other literary scholars, also failed to interest Schiller? This was essentially the question raised by my surgeon–collaborator Weisz in his response to Meyer's negative commentary, and it presented a challenge to us both to consider the fever dissertation more carefully.

Weisz examined the clinical descriptions reported in Schiller's text from the point of view of their clarity, empirical plausibility and relevance to the general conceptual scheme Schiller was using. Since there was no evidence of carelessness, superficiality or incoherence on that score, I then did the things that historians are trained to do: I mapped out chronologies of related and potentially related events; I compared different accounts of these events; I collated the available circumstantial information bearing on the two dissertations of 1780; and, in the light of this evidence, I developed in consultation with Weisz an alternative explanation to the one generally received. I will not elaborate the supporting argument here, since it can be read elsewhere,[49] but our conclusion is that the balance of evidence supports the view that Schiller, at the time in question, was as genuinely interested in the purely somatic aspects of medicine as he was in the psychosomatic aspects of medicine. His simultaneous presentation of two dissertations, far from being a puzzle, directly reflects this dual interest.

These are perhaps minor historical points, but apart from noting that a great deal of scholarship proceeds by such small accretions of knowl-

edge, I wanted to use this example to show how the involvement of a medical practitioner in a medical–historical research project had influenced the direction and outcome of that project for the better. And, in particular, I wanted to show how the specific clinical orientation of that medical practitioner raised research questions that had not previously been raised, or at least seriously pursued, and gave known evidence a different salience in the light of those research questions.

This example supports my contention that historians of medicine ought to seek out and welcome collaboration with health practitioners across the full range of contemporary health fields. If physicians with different specialist backgrounds—in this case, psychiatry and surgery—approach the same historical problem differently, it is evident that health practitioners from even more diverse backgrounds will contribute an even greater range of perspectives to historical research.

Within the context of university career advancement, professional historians are not typically rewarded for collaborating with people from outside the field of academic history, except in special cases where such people are themselves in some way the subjects of research. But in the history of medicine, collaboration with health practitioners can be highly fruitful both in generating research questions and in assessing the salience of evidence relating to these questions. These factors, in turn, can contribute to the successful completion of research projects—and this, of course, is something for which professional historians are typically rewarded.

The approach I am advocating is, in fact, a form of cross-cultural collaboration. The different professional cultures of university historians and health practitioners will undoubtedly lead to divergent views on some points, and to potential miscommunication between the collaborators. But I have found that with goodwill and trust these issues can be resolved. To some extent, also, the division of intellectual labour makes it easier to collaborate with someone outside one's own profession than someone within it. In any case, I have no doubt that given the right circumstances, a historian's collaboration with a relevant health practitioner (i.e., relevant to the historical topic under consideration) can produce far more benefits than difficulties. And for the history of medicine in particular, as distinct from many other sub-fields of history, this kind of collaboration is not so much a new venture as it is a reinvigoration of the original roots of the discipline.

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1. For an overview of the development of European medicine up to the beginning of the twentieth century, see Lawrence I. Conrad *et al.*, *The Western Medical Tradition, 800 BC*

to AD 1800, Cambridge University Press (CUP), Cambridge, 1995; and William F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, CUP, Cambridge, 1994.

2. C. D. O'Malley, *Andreas Vesalius of Brussels, 1514–1564,* University of California Press, Berkeley, 1964; and Roger French, *Dissection and Vivisection in the European Renaissance*, Ashgate, Aldershot, 1999.

3. Erwin H. Ackerknecht, *Medicine at the Paris Hospital, 1794–1848,* Johns Hopkins Press, Baltimore, 1967; and Michel Foucault, *The Birth of the Clinic* (1963), trans. A. M. Sheridan Smith, Vintage Books, New York, 1975. The accounts of Ackerknecht and Foucault are re-assessed in Caroline Hannaway & Ann Le Berge (eds), *Constructing Paris Medicine*, Editions Rodopi, Amsterdam, 1998.

4. Nancy G. Siraisi, *Medieval and Early Renaissance Medicine*, University of Chicago Press, Chicago, 1990, p. 190.

5. Galen, of course, was a pagan rather than a Christian writer, but his work, like that of Plato and Aristotle, had been assimilated into the worldview of educated Europeans and was thought to 'prefigure' some important Christian doctrines; see Owsei Temkin, *Galenism: Rise and Decline of a Medical Philosophy*, Cornell University Press, Ithaca, NY, 1973.

6. On European concerns about Turkish military expansion in the fifteenth and sixteenth centuries, and proposed responses to it, see Robert H. Schwoebel, 'Coexistence, Conversion, and the Crusade against the Turks', *Studies in the Renaissance*, vol. 12, 1965, pp. 164–87.

7. *cf*. Temkin, Galenism, and Conrad *et al., The Western Medical Tradition.*

8. Duke Karl Eugen founded the Academy in Stuttgart in 1776.

9. English translations of Schiller's three medical dissertations are published in Kenneth Dewhurst & Nigel Reeves, *Friedrich Schiller: Medicine, Psychology and Literature*, University of California Press, Berkeley, 1978, pp. 149–65, 203–38, 253–85.

10. ibid., p. 69.

11. 'Aphorisms', in *Hippocrates, vol. IV/Heracleitus*, trans. W. H. S. Jones, Heinemann, London, 1953, p. 99.

12. Owsei Temkin, 'An Essay on the Usefulness of Medical History for Medicine' (1946), in *The Double Face of Janus and Other Essays in the History of Medicine*, Johns Hopkins University Press, Baltimore, 1977, pp. 68–100, p. 79; and Jacalyn Duffin, *To See with a Better Eye: A Life of R. T. H. Laennec*, Princeton University Press, Princeton NJ, 1998, pp. 49–53.

13. See, for example, Ackerknecht, *Medicine at the Paris Hospital*, p. 12.

14. L. Cowlishaw, 'The Development of the Study of the History of Medicine', *Medical Journal of Australia*, vol. 1, 1938, p. 324.

15. ibid., p. 322; and G. L. Keynes, 'Introduction', in William Osler, *A Way of Life and Selected Writings*, Dover Publications, New York, 1958, p. xvi.

16. Most of the information relating to the period from the late nineteenth century to the middle of the twentieth century is derived from the following sources: Simon Flexner & James Thomas Flexner, *William Henry Welch and the Heroic Age of American Medicine*, Viking, New York, 1941, Chapter XIX ('History of Medicine'), pp. 416–43; Henry E. Sigerist, 'Medical History in the United States: Past—Present—Future: A valedictory address' (1947), in Felix Marti-Ibañez (ed.), *Henry E. Sigerist on the History of Medicine*, MD Publications, New York, 1960, pp. 233–50; Henry E. Sigerist, 'University Education' (1939), in ibid., pp. 251–68; Oswei Temkin, 'The Double Face of Janus', in *The Double Face of Janus…,* pp. 3–37; Temkin, 'An Essay on the Usefulness of Medical History'; John C. Burnham, *How the Idea of Profession Changed the Writing of Medical History* (*Medical History*, Supplement No. 18), Wellcome Institute for the History of Medicine, London, 1998; and Oswei Temkin, 'The Study of the History of Medicine' (1959), in *On Second Thought and Other Essays in the History of Medicine and Science*, Johns Hopkins University Press, Baltimore, 2002, pp. 231–40.

17. On the Johns Hopkins Medical School as 'the most radical departure from the old regime' of medical education in America, see Paul Starr, *The Social Transformation of American Medicine*, Basic Books, New York, 1982, pp. 115–16.

18. For the early activities of this body, see W. G. MacCallum, 'The Early Days of the Johns Hopkins Historical Club', *Bulletin of the History of Medicine*, vol. 10, 1941, pp. 513–9; and Victor A. McKusick, 'The Minutes of the Johns Hopkins Medical History Club, 1890 to 1894', *Bulletin of the History of Medicine*, vol. 27, 1953, pp. 177–81.

19. Flexner & Flexner, *William Henry Welch*, pp. 421–2; and Sigerist, 'Medical History in the United States', p. 233. During the 1970s the Johns Hopkins Medical History Club still held occasional meetings, but it faded from the scene in the following decade. Some of its functions were taken over by the Office of Cultural Affairs, which the Johns Hopkins Medical Institutions established around that time, but the club itself disappeared as a separate entity. (Personal communication from Professor Gert Brieger, former director of the Johns Hopkins Institute, 8 March 2005, via email from Ms Christine Ruggere, the current associate director).

20. Bertram M. Bernheim, *The Story of the Johns Hopkins: Four Great Doctors and the Medical School They Created*, World's Work, Kingswood, Surrey, 1949, pp. 84–6.

21. Sigerist, 'University Education', pp. 259–61.

22. Sigerist, 'Medical History in the United States', p. 241. The Wellcome Institute for the History of Medicine in London was not established until 1968. But the Wellcome Museum (which included an extensive library) had become a valuable resource for medical history research by the 1920s, as the founder and first director of the Johns Hopkins Institute, William H. Welch (1850–1934), acknowledged in 1929; see the quotation in Burnham, *How the Idea of Profession Changed the Writing of Medical History*, p. 41.

23. Welch visited the Leipzig Institute in 1927. Sudhoff, whom Welch described as 'a truly great man in his own field', had by then retired as director, but he retained an office in the building and was still active in research. From this visit, wrote Welch, 'I obtained some idea of what a real Institute for the History of Medicine should be'. Flexner & Flexner, *William Henry Welch*, pp. 425–6; *cf*. ibid., p. 437; and Bernheim, *The Story of the Johns Hopkins*, pp. 204–6.

24. Flexner & Flexner, *William Henry Welch*, p. 438; and Sigerist, 'University Education', p. 261. Sudhoff's student and successor as director of the Leipzig Institute, Henry Sigerist (1891–1957), became the second director of the Johns Hopkins Institute in 1932, and Sigerist's student Owsei Temkin (1902–2002), who had come with him from Leipzig, became its fourth director in 1958; see Sigerist, 'Medical History in the United States', pp. 241–2; and Temkin, 'The Double Face of Janus', p. 33.

25. Flexner & Flexner, *William Henry Welch*, pp. 437–8.

26. Temkin, 'The Study of the History of Medicine', p. 234.

27. For a discussion of arguments concerning the most appropriate form of pre-medical education for physicians, see Gert H. Brieger, 'Classics and Character: Medicine and Gentility', *Bulletin of the History of Medicine*, vol. 65, 1991, pp. 88–109.

28. Temkin, 'The Study of the History of Medicine', p. 233; and Temkin, 'The Double Face of Janus', p. 7.

29. See, e.g., the comments by Welch quoted in Flexner & Flexner, *William Henry Welch*, pp. 421, 437; and in Temkin, 'The Double Face of Janus', p. 24. For similar comments in the Australian context, see Cowlishaw, 'The Development of the Study of the History of Medicine', p. 325.

30. Burnham, *How the Idea of Profession Changed the Writing of Medical History*, pp. 61–8, 98–112; and Temkin, 'The Double Face of Janus', pp. 29–30. Both Burnham's study and the present article deal with the 'idea of profession' in relation to medical history. Burnham's work, however, is concerned with the use of this sociological concept by medical historians as an analytical tool for understanding the professionalisation of medicine, while this article is concerned with the professionalisation of medical history itself, as a consequence of it becoming a field of interest to professional historians.

31. See, for example, Charles E. Rosenberg, *Explaining Epidemics, and Other Essays in the History of Medicine*, CUP, Cambridge, 1992, pp. 4–5.

32. Membership of the Australian Society of the History of Medicine, for example, is open to anyone with an interest in the history of medicine, and the same is true of many medical history societies in other countries. On the relationship between physician and non-physician members of the American Association for the History of Medicine in the second half of the twentieth century, see Burnham, *How the Idea of Profession Changed the Writing of Medical History*, pp. 98–9; and James H. Cassedy, 'Diversity and Professionalism in American Medical History: The AAHM in the 1980s', *Bulletin of the History of Medicine*, vol. 59, 1985, pp. 390–4.

33. Burnham, *How the Idea of Profession Changed the Writing of Medical History*, pp. 113–6.

34. In the 1960s historians were still conscious of the need to ‘battle for the right and necessity of non-medically certified scholars to practice medical history’; see Rosenberg, *Explaining Epidemics…,* pp. 2–3.

35. On some of the limitations of the concept of ‘medical dominance’, see William Ray Arney & Bernard J. Bergen, *Medicine and the Management of Living: Taming the Last Great Beast,* University of Chicago Press, Chicago, 1984.

36. Eric J. Hobsbawm, ‘The Historian between the Quest for the Universal and the Quest for Identity’, *Diogenes*, vol. 42, no. 4, 1994, p. 55, reprinted in François Bédarida (ed.), *The Social Responsibility of the Historian*, Berghahn Books, Providence, RI, 1994, p. 55.

37. W. R. Albury & G. M. Weisz, ‘The Medical Ethics of Erasmus and the Physician–Patient Relationship’, *Journal of Medical Ethics: Medical Humanities*, vol. 27, 2001, pp. 35–41; and W. R. Albury & G. M. Weisz, ‘Erasmus of Rotterdam (1466–1536): Renaissance advocate of the public role of medicine’, *Journal of Medical Biography*, vol. 11, 2003, pp. 128–34.

38. W. R. Albury & G. M. Weisz, ‘“It is wisest here, as always, to maintain a balance”: The medical dissertations of Friedrich Schiller’, *Journal of Medical Biography*, vol. 12, 2004, pp. 231–38.

39. Dewhurst & Reeves, *Friedrich Schiller*.

40. ibid., p. 49.

41. ibid.

42. ibid.

43. ibid., pp. 49–50.

44. ibid., p. 50.

45. ibid., p. 203.

46. ibid., p. 253.

47. ibid.

48. Herbert Meyer, ‘Einführung’, in J. Petersen *et al., Schillers Werke*, *Nationalausgabe,* Band 22, Böhlau, Weimar, 1958, p. 333. I would like to thank Herman Lux, George Weisz and Kerry Dunne for their assistance with various aspects of this translation.

49. Albury & Weisz, ‘The Medical Dissertations of Friedrich Schiller’.