

Medical history can deepen our understanding of the present. However, if history is to function as a corrective to the current situation, it should not be regarded primarily as a tool for personal culture.

Do we need history?

As usual, this year's Christmas issue contains articles on medical history. In a time when column space is at a premium, it might be appropriate to justify why we give priority to this kind of manuscript year after year. What can medical history offer today's doctors?

It is relatively new that we question the usefulness of history. For a doctor in the early 1800s, medical texts from the past were a natural frame of reference, along with texts from the doctor's own time. Hippocrates, Galen and Vesalius could offer solutions to clinical dilemmas that were just as relevant as contemporary reference works, and were therefore also included in the medical curriculum (1). Frederik Holst's dissertation on *radesyke*, the first doctoral thesis defended at the newly established University of Christiania (later Oslo), draws on sources from antiquity and the renaissance in conjunction with medical writings of his own time (2). The career of R. T. H. Laënnec, subsequently credited with the invention of the stethoscope, began with a dissertation in which he extolled the relevance of the Hippocratic writings for practical medicine (1). At that time, a different slant was put on the well-known aphorism from the Hippocratic Corpus, «Art is long, life is short» from the way we understand it today. Whereas we understand «the art of medicine» as meaning those aspects of medical encounters which are not science proper, in those days the «craft» of medicine encompassed medical knowledge in its entirety. Geoffrey Chaucer's 14th century translation is «the lyf so short, the craft so long to lerne» (1).

The foundation for modern medicine was laid in the 1800s. From that time on, diseases were localised in the tissues of the individual sick body, hospitals became central medical institutions and pathological anatomy and, in due course, also experimental physiology came to constitute the foundation for the new medicine (3, 4). Along with the new theories came ever new diagnostic, preventive and therapeutic instruments, such as the microscope, the stethoscope, vaccination, anaesthesia, antiseptics and radiography. At the same time, a distinction developed between the art and the science of medicine. Science became the basis of knowledge; art came to be understood as the technological and humanistic aspects of the doctor patient relationship. The texts of the past had no relevance for the new science. They were at best delegated to a collection of classics, at worst curiosities that one could converse about at dinner parties.

In the late 1800s, however, a protest arose against this way of viewing medicine. Doctors like William Osler saw medical history as a corrective to the fragmentation and reductionism medicine was undergoing and wanted to teach students a holistic approach to medicine. (5). According to Osler, the formative tradition of humanism, and history in particular, was to give doctors an appreciation of the overall picture in clinical practice, at a time when scientific progress demanded ever more specialisation and compartmentalisation. Medicine needed its history, because medical practice was enhanced by art and the humanities.

A hundred years after William Osler, health and medicine are central cultural concerns in contemporary society. Magazines and newspapers are saturated with articles on health, discourse on risk takes place across the dinner table, and health tourism has become common. High-tech medicine has become a part of everyday life for ordinary people. Why, then, do we need medical history?

We can't escape history. Our individual history – our life history, our experiences – shape us as human beings. In the same way, our collective history affects how we relate to contemporary phenomena. History has shaped the organization of hospitals, the relations of disciplines to one another, the doctor-patient relationship. Medical history can delineate the connection between past and present events and identify factors which have shaped the present.

However, scholarly works of medical history have revealed the discontinuities and the contingencies of the historical process, rather than the continuity (4). Such histories enable us to think differently about our own time as well. If the present situation has *not* arisen as a result of ever advancing rationality, it is neither necessary nor inevitable. For example, it has been generally believed that the new drugs of the 1950s, such as antihypertensives and cholesterol suppressants, were developed as a *result* of new medical knowledge. However, medical historian Jeremy Greene has shown how diseases such as asymptomatic diabetes, high cholesterol level, hypertension and asthma were found to be a major public health problem *at the same time* as drugs came onto the market to treat them (6). By demonstrating that the connections between marketing, public health and medical practice were not an inevitable result of new knowledge, his research makes it possible to ask new questions about the economics of medical knowledge.

It has been claimed that our Christmas edition will protect us against ignorance of history (7). But the kind of history that is presented is by no means immaterial. The history we construct about our own past not only forms our view of that past. It also determines how we look to the future. For example, if we see medical history as a history of progress, we are more inclined to accept technological advances without question and as something we must of necessity employ. However, if we perceive medical history as a series of contingent events, we are more inclined to be critical about present day theory and practice. Therefore, if medical history is to function as a corrective to current practice, it should not be regarded primarily as a tool for personal culture.

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