

Locating Medical History

Stories and Their Meanings

Edited by Frank Huisman and
John Harley Warner

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Notes on Contributors

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YES

Martin Dinges is deputy director of the Institute for the History of Medicine of the Robert Bosch Foundation, Stuttgart, Germany, and adjunct professor of modern history at the University of Mannheim, Stuttgart, Germany. The volumes he has edited include *Neue Wege in der Seuchengeschichte* (1995, with Thomas Schlich), *Weltgeschichte der Homöopathie, Länder—Schulen—Heilkundige* (1996), *Homöopathie. Patienten, Heilkundige und Institutionen. Von den Anfängen bis heute* (1996), *Medizinkritische Bewegungen im Deutschen Reich (ca. 1870–ca. 1933)* (1996), and *Patients in the History of Homoeopathy* (2002). He has also written on the social history of medicine during the Enlightenment and on the reception of the work of Michel Foucault.

Alice Domurat Dreger is an associate professor of science and technology studies in the Lyman Briggs School at Michigan State University and associate faculty at the university's Center for Ethics and Humanities in the Life Sciences. She served for three years as the founding chair of the board of directors of the Intersex Society of North America, a non-profit policy and advocacy group. Her research and outreach focus on the biomedical treatment of people born with unusual anatomies and the relation between anatomy and identity. Her books include *Hermaphrodites and the Medical Invention of Sex* (1998) and *Intersex in the Age of Ethics* (1999).

Jacalyn Duffin is a hematologist and historian who teaches medicine, history, and philosophy from the Hannah Chair at Queen's University in Kingston, Ontario, Canada. She is author of *Langstaff: A Nineteenth-Century Medical Life* (1993), *To See with a Better Eye: A Life of R. T. H. Laennec* (1998), and *History of Medicine: A Scandalously Short Introduction* (1999). Her current research interests are in disease concepts, diagnostic semeiology, and medical saints.

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Danielle Gourevitch is directeur d'études at the École Pratique des Hautes Études, in Paris. She teaches history of medicine, especially Greek and Roman medicine and medical erudition in the nineteenth century. Her main works about this period are *La mission de Charles Daremberg en Italie (1849–1850)* (1994) and *Médecins érudits, de Coray à Sigerist* (1995). She has also published a collective manual, *Histoire de la médecine. Leçons méthodologiques* (1995). She is currently working on a book about Galenic *pathocenosis*.

Anja Hiddinga teaches science studies and sociology of medicine at the University of Amsterdam. Her research focuses on clinical medicine, especially obstetrics and maternal health. She is currently studying cultural differences and historical changes in the treatment and experience of pain during delivery. She is also interested in the cultural meanings of deafness and has recently produced a film on this subject.

Frank Huisman teaches in the Department of History of Universiteit Maastricht. He is the author of *Stadsbelangen Standsbesef: Gezondheidszorg en Medisch Beroep in Groningen, 1500–1730* (1992), and co-editor with Catrien Santing of *Medische Geschiedenis in Regionaal Perspectief: Groningen, 1500–1900* (1997), both local case studies of early modern Dutch health care. He has published on medical historiography, quackery, and the cultural authority of medicine. Currently, he is working on a book exploring the transformation of the Dutch health care system between 1880 and 1940.

Ludmilla Jordanova joined the University of East Anglia in 1996 having previously worked at the Universities of Essex and York. She is a trustee of the National Portrait Gallery, London, for whom she organized the exhibition of scientific and medical portraits, *Defining Features*, in 2000. Her recent publications include *Nature Displayed: Gender, Science, and Medicine, 1760–1820* (1999) and *History in Practice* (2000). Her current research is on self-portraiture and artistic practice in Britain from sixteenth century to now and art in fiction and poetry.

Alfons Labisch, historian, social scientist, and physician, is a professor of the history of medicine and head of the Institute for the History of Medicine at Heinrich Heine University, Düsseldorf, Germany. His main areas of research include social history of health and medicine (especially of preventive medical disciplines and institutions), social history of the hospital, and science and practice in medicine. His recent publications include *“Einen Jedem Kranken in einem Hospitale sein Eigenes Bett.” Zur Sozialgeschichte des Allgemeinen Krankenhauses in Deutschland im 19. Jahrhundert* (1996, co-edited with Reinhard Spree), *Adolf Gottstein: Erlebnisse und Erkenntnisse. Nachlass 1939/1940. Autobiographische und biographische Materialien* (1999, co-edited with Ulrich Koppitz), and *Krankenhaus-Report 19. Jahrhundert. Krankenhaussträger, Krankenhausfinanzierung, Krankenhauspatienten* (2001, co-edited with Reinhard Spree).

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Sherwin B. Nuland is Clinical Professor of Surgery and a Fellow of the Institution for Social and Policy Studies at Yale University. He is a member of the executive committee of Yale's Whitney Humanities Center and of the university's Interdisciplinary Bioethics Forum. His

1994 book, *How We Die*, won the National Book Award and was a finalist for the Pulitzer Prize and the Book Critics Circle Award. He has written on medicine, medical history, and ethics for the *New York Times*, *New York Review of Books*, *Wall Street Journal*, *New Republic*, *Time*, *Life*, *National Geographic*, *New Yorker*, *American Scholar*, and other periodicals. All eight of his books were written for the general reader, including *Doctors: The Biography of Medicine* and biographies of Leonardo da Vinci and Ignac Semmelweis.

Vivian Nutton is a professor of the history of medicine at University College London. He has edited several ancient medical texts, including Galen's *On Prognosis* (1979) and *On My Own Opinions* (1999), and has published many books and articles on classical medicine and its transmission down to the twentieth century. He is at present writing a large history of medicine in classical antiquity.

Roy Porter, before he retired, was a professor of the social history of medicine at University College London. Among his many publications are *Mind-Forg'd Manacles* (1987), *In Sickness and in Health: the British Experience, 1650-1850* (1988, co-authored with Dorothy Porter), *Health for Sale: Quackery in England, 1660-1850* (1989), *Reassessing Foucault: Power, Medicine, and the Body* (1994, co-edited with Colin Jones), *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (1997), and *Enlightenment: Britain and the Creation of the Modern World* (2000). He died in the spring of 2002.

Susan M. Reverby is a professor of women's studies at Wellesley College. Her work in the history of health care has focused on gender, class, and race issues. Her prize-winning book, *Ordered to Care: The Dilemma of American Nursing* (1987), is an overview on the history of American nursing. Her latest book is an edited collection, *Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study* (2000). She is currently completing a manuscript exploring the differing ways the stories of the Tuskegee study are told.

David Rosner is a professor of history and public health at Columbia University and director of the Center for the History of Public Health at Columbia's Mailman School of Public Health. He is author of *A Once Charitable Enterprise* (1982; 1987) and editor of *Hives of Sickness, Epidemics and Public Health in New York City* (1995) and *Health Care in America: Essays in Social History* (1979, with Susan Reverby). In addition, he has co-authored and edited with Gerald Markowitz numerous books and articles, including *Deadly Dust: Silicosis and the Politics of Occupational Disease in Twentieth Century America* (1991; 1994), *Children, Race, and Power: Kenneth and Mamie Clark's Northside Center* (1996), and *Deceit and Denial: The Deadly Politics of Industrial Pollution* (2002). Recently he has been awarded the Visellear Prize for Outstanding Work in the History of Public Health from the APHA.

Thomas Rütten, holder of a Wellcome Trust University Award in the History of Medicine at the University of Newcastle upon Tyne, holds a Ph.D. from the University of Münster and has over the last twelve years been teaching history of medicine at various universities, both in Germany (Münster; Witten/Herdecke) and in France (Paris VII). He is the author of *Demokrit-Lachender Philosoph und Sanguinischer Melancholiker* (1992), *Geschichten vom Hippokratischen Eid* (Habilitation, 1995), and numerous articles on classical, medieval, and early

modern history, ethics, and iconography of medicine, as well as on the history of his discipline.

Heinz-Peter Schmiedebach is a professor in the history of medicine and has been head of the Institut für Geschichte der Medizin, Universität Greifswald, Germany, since 1993. Among his publications are *Psychiatrie und Psychologie im Widerstreit* (1986), *Medizin und Krieg: vom Dilemma der Heilberufe 1865 bis 1985* (1987, co-edited with Johanna Bleker), and *Robert Remak (1815–1865): ein jüdischer Arzt im Spannungsfeld von Wissenschaft und Politik* (1995). His research interests include the history of psychiatry, development of public health, the history of deontology, and the history of medical theories and disciplines in the nineteenth and twentieth centuries.

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John Harley Warner is a professor and chair of the Section of History of Medicine at the Yale School of Medicine, and at Yale University is also a professor of history and of American studies and chair of the Program in the History of Medicine and Science. His books include *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820–1885* (1986; 1997), *Against the Spirit of System: The French Impulse in Nineteenth-Century American Medicine* (1998; 2003), and (co-edited with Janet Tighe) *Major Problems in the History of American Medicine and Public Health* (2001). He is now working on a book exploring clinical narrative and the grounding of modern medicine.

chapter eight

“Beyond the Great Doctors” Revisited

A Generation of the “New” Social History of Medicine

Susan M. Reverby and David Rosner

A Bildungsroman for scholars within the field of the history of American medicine over the last three decades might be expected to take the traditional form of all coming-of-age stories: young whippersnappers question the wisdom of their elders, get sent into the wilderness to test their skills, come home wiser, if slightly bloodied, and ready to join the clan. Yet, when differences of race, class, gender, or politics keep adhering to the young (and the increasingly not so young), not everyone gets welcomed back so easily, or decides to stay. Our experiences within the field of what we wanted to be called the history of health care is particular to our biographies. Our story, however, tells a great deal about our generation that came of age in the 1960s and 1970s and how the field, and we, have changed.

In the late 1970s, when we were still graduate students, we wanted to make a statement with an edited book about the cutting edge work being done in the “new” social history of medicine. Editor Michael Ames was attempting to revive Temple University Press lists and garnered support of two senior medical historians who vetted the book (Gerald Grob and Charles Rosenberg). With the go-ahead, we set about contacting our friends, other graduate students, even David’s adviser, most of whom were more than willing to send us a sample chapter. The result of this effort became *Health Care in America: Essays in Social History* (1979).

The book was our attempt to legitimize a type of history of medicine that, as we wrote, "both illuminates health policy concerns and explores the subtleties of medicine's past."¹ It contained thirteen essays with sections on medicine's boundaries, health care institutions, and professionals and workers.

To frame our efforts we struggled to write a short introduction we called, "Beyond the Great Doctors," an essay that has been likened to a "manifesto" by other historians. It appeared at a moment when the field itself was in turmoil, and our agenda for future work became a lightning rod for the ongoing debates in the new social history of medicine. We took the title from the physician-historian Henry Sigerist's line that "the history of medicine is infinitely more than the history of the great doctors and their books." We spent most of the essay seeking to establish continuity between our social historical interests and the work of some of our elders. Despite our attempt to situate this new agenda in ongoing traditions in the field, the book was received with a mix of reviews that saw it as the challenge we indeed meant it to be. Paul Starr's review in the *Journal of Social History* even likened it to the young impressionists' nineteenth-century "salon de refusés" that challenged the established traditions of classicism and romanticism in French art.²

Nearly a quarter of a century later, it seems appropriate for this volume to reexamine our efforts. Our aim is to reflect on the field's collective history and to discuss its problems and paradoxes. This is our renewed effort to stimulate a discussion to help all of us define more closely how all of our social and ethical views shape our scholarly work, define our lives, and shape our profession's collective ethical boundaries.

Why "Beyond the Great Doctors"

We realized it would be impossible in our edited book's introduction to trace out completely the intellectual history of the social history impulse within the history of medicine. It was our hope to validate a strand within the field we believed had been lost during the Cold War era. We argued that an engaged and useful history that was focused on the social relations of medicine and met rigid historical standards had existed and needed to be resurrected. We wanted written scholarship that would inspire doctors and also other health care professionals, workers, and consumers. Written before the push toward cultural and postmodernist history had taken hold, we sought to legitimize what we and others trained in social history were trying to do. Without consciously knowing this, we were indeed emulating Sigerist's sense of his own distance from what was seen as traditional history of medicine when he wrote in 1943: "They [Cushing, Welch, Klebs,

Fulton, et al.] all belong to the Osler school of *historia amabilis*. They 'had a good time' studying history. Their subjects were limited and never offensive. . . . My history is anything but *amabilis*, but is meant to be stirring, to drive people to action."³ We had no way of understanding then what a threat we seemed to be as we were also being "anything but *amabilis*" too.

To begin, we think it important to reflect back on our journeys that got us to that essay and how this shaped what would become our intellectual passions.

Susan: I was raised in a medical family: my father was a physician and my mother a medical technologist who became a community college teacher. Despite my parents' love of the sciences, my high breakage fee in a chemistry class in a small upstate New York high school and my gender seemed to condemn me to some other future than medicine. With all the clarity of a seventeen-year-old, I settled upon personnel administration. However, after being politicized by my brief experiences in the civil rights movement, a year at the London School of Economics, and a longer effort in the antiwar movement, it was clear that this career choice was a serious mistake. I survived getting a B.S. degree in industrial and labor relations from Cornell because of a real love for labor history and the mentoring of an idiosyncratic social historian named Gerd Korman, who actually believed women could be intellectuals. Graduate school just did not seem acceptable at the time, however. I, as with many of my class in the late 1960s, went off to make war against my own government and then to a community-organizing-related job in New York City instead. My brief foray into graduate school in American Studies two years later was shortened when the women's movement and the invasion of Cambodia in 1970 intervened to transform my life, and cast me into the land of the dropouts. Searching for a job, I managed to parlay my burgeoning interest in women's labor history and my brief experiences in New York City's legal abortion clinics into a position as a "health policy analyst" at the Health Policy Advisory Center, or Health PAC as it was known.

Health PAC was formed out of the Institute for Policy Studies, the left-liberal Washington think tank. At Health PAC, we struggled to transform the left critique of health care from a doctor/AMA focus to one that explored what we labeled the "medical industrial complex."⁴ For three years I learned to write and speak to and for an audience of health care providers, public health officials, and consumers, many of whom looked to Health PAC to provide an intellectual framework to understand the activism and varying crises in health care that swirled around.

My love of history, ambiguity, and my insistence on footnotes often put me at odds with the more journalistic bent of my colleagues. I left for a year in West

Virginia where I coedited a book on women's labor history.⁵ But by the mid 1970s I was ready to return to graduate school. Even then, I thought my work would be more in women's labor history (my first edited book was on this topic) than health care, although I was accepted to work with the late George Rosen at Yale in the history of medicine. Personal commitments drew me instead to Boston and to the graduate program at Boston University in American Studies. A dissertation that was, I thought, going to focus on nineteenth-century domestic service became focused on "health" instead because that was where my experience had been and where funds to support me were available.

Serendipity as in all tales plays a large role in the rest of this story. Diana Long, the historian of science and medicine, was in the history department and quickly became both a mentor and friend. Trained in Yale's program, Diana's approach to history required us to learn in bio-bibliographic form our intellectual predecessors. Diana marched our seminar through the great men: Sudhoff, Sigerist, Temkin, Acknerknecht, Rosen, and Rosenberg. Feminist rhetoric aside, I was hooked by their intellectualism, if not their focus. At the same time, I continued to see myself as an "activist" historian. With two other colleagues I formed the Massachusetts History Workshop and continued to work on history in the working-class communities in and around Boston, participated in a health study group filled with health policy activists and practitioners, and wrote history pamphlets for health care workers.⁶

As I was beginning work on my dissertation on a social history of American nursing that explored the tensions between gender and class, I reconnected with David Rosner, then finishing up his dissertation across the river at Harvard. We had met briefly in New York while I was at Health PAC and he was in the New York City State Department of Mental Hygiene. As I had already coedited a book that provided the documents to redefine labor history in gendered terms, putting together a set of historical articles by others like us did not seem so impossible.

David: My own background certainly shaped the ways that I would later see the field of medical history. I had grown up in New York City in a working-class/lower-middle-class family. My father, an immigrant who edited a Hungarian language paper until the mid-1960s, became a linotype operator at the *New York Post*, where he stayed until his technologically forced retirement following the phase out of "hot type" in the early 1970s. My mother was a nursery school teacher in a small private school where the pay was miserable. Both of them had been deeply involved in various labor struggles over the decades, and I was raised in a world in which the dinner table conversation revolved around social and economic problems of work-

ing people. My family was certainly not middle class. But neither was it poor or "underprivileged."

In fact, my mother taught nursery school at Walden, a small private school that I was therefore able to attend on a staff scholarship. From the time I was eight I had attended school with very privileged kids, many of whom had parents who were physicians. In 1964, just as I was graduating, Andy Goodman, one of the school's recent grads who had been in the same class as my sister and was the brother of a classmate, vanished in Mississippi while trying to register voters during "Freedom Summer." I spent a good portion of that summer at the Goodman's home, awaiting word as the search went on for Andy, whose body was discovered in an earthen dam along with those of Mickey Schwerner and James Cheney. This was certainly a signature event in my life.

I went on to graduate from CCNY, a college that catered to, in the words of my mother, "the best of New York's working people" and had, as most CCNY students did at the time, immediately entered the world of work in anticipation of ultimately going to graduate school.⁷ As a psychology major, the first job I took was with the New York State Department of Mental Hygiene. I joined a research unit involved in evaluating the impact of environmental damage on a group of overwhelmingly African American and Hispanic children. Deciding that most of the damage that we saw was a result of environmental exposures to lead, poor nutrition, and the like (rather than psychodynamics), I entered the University of Massachusetts in public health receiving my masters degree in public health two years later.

I returned to the New York State Department of Mental Health, nominally as the group leader for mental health services in lower Manhattan. This was a mammoth responsibility for a twenty-four-year-old, especially because of the "Willowbrook decree." This decision by the New York State courts, which mandated that developmentally disabled children in the state-run Willowbrook School on Staten Island were to be returned to their communities and that the facility itself be shut, sent the world of mental health and developmental services into a complete meltdown.⁸ In a series of newspaper reports and television exposés, the horrifying conditions under which these children had been "warehoused" had led to public outrage and the court decree that called for the children's "deinstitutionalization." It was the nightmare of feeling partially responsible for sending kids back to ill-prepared communities and to families with few financial resources that led me to "retreat" back to graduate school. It was about then that serendipity took over and I happened to meet Barbara Rosenkrantz, who first suggested that I come to Harvard and try to join my training in public health with the history of science.

From the first, I was encouraged to see history as a tool that could help me understand the evolution of policy, and particularly, my own frustrations with the inadequacy of the mental health and public health system. Finding Susan in Cambridge and getting to know other younger historians like Harry Marks, Elizabeth Lunbeck, Martha Verbrugge and Marty Pernick (all who had gathered either as students and visiting scholars under the wing of Barbara Rosenkrantz in the History of Science Department at Harvard) and developing lifelong friendships with fellow graduate students like Elizabeth Blackmar, Roy Rosenzweig, and Jean-Christophe Agnew was immensely important particularly because it happened shortly after my first "formal" encounter with the world of historians of medicine, one that had left me quite shaken.

In June 1973, just before the beginning of my first year in graduate school, I received a thick envelope from Lloyd Stevenson, then editor of the *Bulletin of the History of Medicine*. I had submitted an article on the dispensary abuse controversy of the 1890s to the *Bulletin* three months before and I assumed that the thick envelope was filled with reviews and, perhaps, an acceptance of what I believed was a meticulously researched paper and hoped was to be my second publication.

Instead, when I opened the envelope I found a three-page rejection letter, detailing a deep antipathy toward the paper and, seemingly, toward me for being arrogant enough to question the motivations of physicians who were involved in the story I told. Stevenson wrote that he had expected "that a paper coming from Harvard should be better informed."⁹ The letter was upsetting. The essay had not even been sent out for review, and a senior and powerful member of the field implied that I should not be in the field.¹⁰

What I did not understand was why Stevenson spent much of the letter discussing a paper I had published with Gerald Markowitz in *American Quarterly* the year before. That earlier paper, "Doctors in Crisis," had detailed the period before the Flexner report, during which major foundations had helped shape medical education. Stevenson claimed never to have read the article, but it was clear from it that his letter that he was deeply offended by its title. I felt that the article would have met a dismal fate had I had sent it to the *Bulletin* instead.

I showed the Stevenson's letter to my adviser, Barbara Rosenkrantz, terrified that she might tacitly or openly agree with what Stevenson said. Her reaction to the letter was immediate: "Don't pay a moment's attention to this," was a polite paraphrase of her comment as I recall. She reassured me that I should remain in the department. She sent a copy to Charles Rosenberg who reinforced Barbara's view. It was really my first inkling that I had stepped into a deep schism in the field.

Social History and the Medicine Minefields

When we entered the field, we did not yet realize we were coming into a minefield of historical traditions and challenges. In the history of medicine, as within history in general, the social history tradition of the pre- and early post-World War II years was focused on a variety of social aspects of how medicine was received by the public and affected by social attitudes and values. By the 1960s, the work of a small group of American medical historians such as Charles Rosenberg, David Rothman, Barbara Rosenkrantz, James Cassedy, Diana Long, John Blake, and Gerald Grob had expanded the openings to explore social history that Sigerist, Richard Shryock, and others had created earlier. Few in number, they were often not seen as a threat to those trained in older historiographic tradition that had placed clinical practice and the physician as the center of the field.

The field of medical history was fairly insular early in the 1970s. Medical and biological questions were much less integrated into the historical mainstream. Medical historians worked more in isolation, generally associated with medical schools or history of science programs. Often historians of medicine were trained as physicians first and historians second. Sometimes, the lone medical historian at a medical center took up the field after receiving his or her medical degree or, at times, after retiring from the practice of medicine. Historians without medical degrees did make lasting contributions to the field. By and large, however, the field retained a parochialism that reflected the dominance of its membership's professional affiliations. In nursing history, a parallel story played out.

That was to change by the late 1970s as the number of doctoral students increased dramatically in the aftermath of the expansion of the university system as a whole. Many of us who saw ourselves as the new social historians were students of the older generation or found nonmedical social historians willing to support our work. While we certainly disagreed about numerous issues, we had a common faith that the field was ripe for social histories that delved into issues relating to race, gender, class, and politics. Those in or around our cohort sought to approach the history of medicine more as a social enterprise than as purely scientific or celebratory one.

Both groups of historians, the older physicians and the somewhat younger "professionals" (as we were called by some of the physician-historians), lived in relative harmony, each with its own set of questions and groups of interested scholars.¹¹ But, as more and more of us entered the field in the late 1970s from the

periphery, the center of gravity shifted away from traditional centers of research such as Johns Hopkins, the home of the *Bulletin* and the Institute of the History of Medicine, and spread more widely throughout the historical landscape.

Following the antiwar, civil rights, and women's movements and other social upheavals, our own very naive view that we were creating a new field was undoubtedly seen by some of our elders as ignorant at best and arrogant at worst. In the late 1970s and early 1980s a rather strong and, at times, vituperative debate broke out. At the annual meetings of the American Association for the History of Medicine (AAHM) as well as in the pages of the two major American journals, some of the young "professionals" faced a fairly bitter set of attacks by the editors and physicians writing book reviews and commentaries.¹²

The growing number of younger historians writing on nonclinical issues was deeply disturbing to some. Leonard Wilson, editor of the *Journal of the History of Medicine*, titled a January 1980 editorial "Medical History without Medicine." Wilson declared: "The study of the history of medicine by medical men [sic] derived from a deep interest in medicine itself, an interest that made them want to learn how medicine had arrived at its modern state through the course of history."¹³ Medical historians, he argued, had previously seen themselves as "members of a long succession of physicians, scientists and teachers that extend back to antiquity in a continuous tradition of learning, teaching, and writing." He continued, "Medical historians had studied their historical predecessors" and "tended to look for those traits of medical character and quality of achievement which they respected and valued among their medical contemporaries." But the newer generations of younger non-M.D. historians were neglecting this tradition, he said. Despite the fact that he himself was not a physician, Wilson argued that younger historians were deficient in that they "focused on historical courses and seminars. They see little of the laboratory and less of the clinic," leaving them insensitive to traditional objects of historical inquiry, physicians and their activities.¹⁴

Part of Wilson's concern was certainly reasonable and at times prophetic. After all, by broadening out into a host of themes in gender, race, urban, political, institutional, demographic, and cultural history, there was a real danger that the history of medicine as a field would lose its master narrative. But larger forces were at work creating resentment.

Medicine's loss of control and status during the 1960s and 1970s (as well as the changes in the history profession) seemed to underline the sense of urgency that fueled the editorials linking attacks on critics of modern medicine, those promoting affirmative action for women and minorities within medical schools, and Ph.D.s who wrote medical history. The schism was never neatly doctors vs. social

historians. The scholarship clearly demonstrated that there were "Ph.D.s" who paid close attention to clinical issues and medical research while there were other "M.D.s" who were closely attuned to the questions of social history. Nevertheless, it must have appeared that a growing number of us could not be counted on to see either medicine or medical history uncritically. It may also have been due to simmering fears that the professors who were sponsoring us were displacing their colleagues as the movers and shakers of the next generation. Control over the future of the field seemed at the time to be very much at stake.

Several other controversies illustrate the tensions that surfaced. In January 1979, two books on birthing and midwives were reviewed dismissingly by obstetrician-historian Gordon Jones. Jones began his review of one book by saying that "the bias of this lay historian [*sic*] is obviously pro-midwife, pro-home delivery and against the obstetricians who, she believes, have for mercenary reasons obliterated midwifery in the United States." He dismissed the second book by stating it would be of interest only to "those who think socialized medicine is the ultimate and ideal solution to every imagined shortcoming of American medicine."¹⁵

In the *Bulletin of the History of Medicine*, the official organ of AAHM, the conflict escalated. Howard Berliner, a health policy/management Ph.D., was assigned by Lloyd Stevenson, the *Bulletin's* editor, to review our book, the first edition of *Sickness and Health*, another collection of social history of public health and medicine, edited by Judith Leavitt and Ronald Numbers, and a monograph critique by health educator/public health practitioner Richard E. Brown entitled *Rockefeller Medicine Men*. Berliner praised the new books, appreciating their differing attempts to stretch the traditional boundaries of medical history. The review so offended Stevenson that he took it upon himself to write an unprecedented five-and-a-half page response to Berliner's *review* as well as to the books themselves.¹⁶

In what Stevenson called his "second opinion," he accused the various writers of a number of professional crimes, some of which were perfectly valid, some of which were not. He found the writers not sufficiently respectful of physicians. According to Stevenson, the professionalization of the field by PhDs had intimidated "amateur" [i.e., M.D.] historians, and he worried that "physicians intimidated by 'professionals' [i.e., Ph.D.s] should consider taking action."¹⁷ Whether or not this meant purging the "professionals" or leaving the AAHM and starting another "amateur" association was never made entirely clear.

Underlying the controversy over the contours of medical history—who should do it, what it should address, what political or social content it should have—were more basic questions regarding the very definition of medicine itself. For "M.D."

historians, as Leonard Wilson explained, "in a strict sense the social history [of medicine] may not even be medical history. If such social history be considered medical history, it is medical history without basic medical science and clinical methods and concepts; that is, it is history of medicine without medicine."¹⁸ Yet the work of our cohort, as demonstrated by the mainstream presses that published the reviewed books, tapped into the historical zeitgeist of the time. We too began to wonder whether our critics were right: did we have a place in this field?

In May 1980, the AAHM met in Boston.¹⁹ At this point, the reviews had come out and tensions were relatively high. Half in jest in following Leonard Wilson's suggestions that we talk to physician-historian Gert Brieger, then the director of the Institute for the History of Medicine at Johns Hopkins, several of us did meet in a bar at the meeting hotel to consider bolting from the organization itself.²⁰ Brieger functioned as the go-between the generations and training, assuring us that there was a place for us within the AAHM. Somewhat mollified, we stayed.

By then, many of us had started university positions or were close to attaining tenure. Our professional identifications ranged as widely as the jobs we were able to get: in public health, medical and nursing schools, health policy programs, women's studies, and traditional history departments. Throughout the 1980s, the threat that our kind of history posed lessened as we aged, took on positions of authority, and watched as the older generation retired or died.

David: In 1980, my distinct sense that in a tight job market in traditional history of science and medicine departments and my continuing concerns about health care policy issues led me to take a position as an assistant professor in the Department of Health Care Administration at Baruch College in New York City.

Susan: Two years later, in 1982, I searched for jobs in the Boston area because I was then married to a tenured academic and had a five-year-old daughter. I landed at Wellesley College, as their first hire in their Women's Studies Program (not the history department) with a position that was half time, one year at the start.

Many of our cohorts continued to see the AAHM as their primary source of professional identification outside their institutional appointments. Others attended meetings more sporadically and found homes in other public health or historical associations. As Stevenson may have feared, multiple professional identities were becoming more the norm.

The tensions within the AAHM simmered much below the boiling point through the 1980s. In 1990, through the efforts of Elizabeth Fee and Ted Brown,

several historians (many in our cohort) created the Sigerist Circle, a separate section within the AAHM paralleling the Osler Society that met the day before the actual AAHM program began. The group's name reflected the identification with the activist and scholarly tradition that Sigerist himself represented. The circle would go on to present scholarly sessions each year, through the good works of Edward Morman to maintain a newsletter and bibliography, and to provide a home for those who needed an additional identity that made membership in the AAHM more than a scholastic endeavor.

The creation of this new section gave an institutional imprimatur to the more contemporary-oriented social historians while preserving their identity as medical historians. Thus, by the end of the twentieth century, social historians whose forays into medicine were more fleeting had left or never joined the AAHM. Others who continued to want to be seen as social historians of medicine and activist scholars found a home in the Sigerist Circle.

Reflecting the expanding acceptance of what counted as "medical history," the *Bulletin* began to publish a wider range of articles. In the early 1980s, about 50 percent of all articles published in the *Bulletin* focused on doctors. By the second half of the decade, this percentage dropped below 40 percent. By the end of the 1990s, it had declined below 30 percent. Significantly, articles focusing on gender, sexuality, race, and patients themselves increased from approximately 3 percent of the articles in the early 1980s to 10–15 percent by the end of the century.²¹

Given the growing emergence of gender, sexuality, race, and class as crucial categories in historical scholarship, it would have been nearly impossible for these arenas not to have grown within the history of medicine. It was becoming increasingly clear that what was once seen as peripheral to the core of medical history could be central. Further, newer work began to suggest that even considering that the very core of the history of medicine could exist without its relationship to the so-called periphery was exceedingly problematic.

Expanding the Social History Tradition

In 1979 we had argued that the social history impulse and the need to make our histories relevant were linked to the questions and concerns raised in the political movements of the 1960s and 1970s. In the next generation, historians influenced by social movements around women's health care, occupational health and safety, the AIDS epidemic, and racial disparities in health care delivery and health outcomes, and by the theoretical work that focused on the body, were being drawn into the field. Others, more influenced by the movements of postmodernism and

poststructuralism, moved toward more theoretical considerations of multiple identities and cultural discourses on the body and health. In tracing out briefly the differing directions that this scholarship has grown, we will focus on issues of gender, class, and race. We will reflect on some of the processes that shaped broad changes in the field, dividing the categories up in the ways the field began at first to divide. We want to make clear, however, we think these analytic categories are *not separate*, and we share the theoretical position that they are “intersectional.”²²

Gender

As the field of women’s history itself was expanding in the 1970s, explanations of the relationship between women and medicine played a central role. Any historical work that had to explain the social construction of womanhood came up against both the representations of the female body and the power of the institutions that defined womanhood. While some of the earliest books and articles took easy pot-shots at medicine with ludicrous quotes from nineteenth-century doctors, more thoughtful work attempted to put the beliefs about women’s bodies within the context of medical theory more generally.²³ Interestingly, most of the literature on women’s bodies was published in mainstream or women’s studies journals rather than history of medicine publications.

Those of us who were also really taken with the internal workings of the health care system and for whom medicine and science themselves were of interest worked to integrate experiences of women and the concepts of gender into the history of medicine field. This scholarship initially took three forms: explorations of the experiences of women as workers and professionals in health care; critiques of medicine’s ways of dealing with women’s diseases, reproduction, sexuality, and health care needs; and deconstructions of notions of scientific neutrality and scientific discourses. All of these efforts were buffeted by debates in the larger historical community, first on the limitations of a narrow focus on white middle-class women as stand-in variables for all women. The analysis then moved to critiques of essentialist positions that assumed women’s experiences could be knowable without a deconstruction of how the categories and representations were delineated.

Much of the earliest scholarship written in the 1970s was focused on the prescriptions and ideologies inherent in medical thinking. It assumed, however, a one-to-one correspondence between ideologies and women’s internalized beliefs and experiences. As the theoretical frameworks became more sophisticated, efforts to understand how medical assumptions were internalized, acted on, and critiqued became more crucial. In the process of this development, there was

much discussion between women's history specialists and medical historians with a focus on women's lives.

Underneath much of the scholarship was a desire to help the still growing women's health movement have a more reliable historical understanding of its own past and the institutions it was up against. As the AIDS and breast cancer epidemics spread and the attacks on hard won reproductive rights grew more violent, histories appeared to help make sense of these experiences. Historical accounts of how disease was defined, who became ill, and how their bodies were represented became essential.²⁴ New scholarship focused on the role of the state in monitoring women's bodies, defining the "normal" in sexuality, concerns with disease control in the past, the importance of gender to public health, and so forth. Others took their focus to be the wide range of reproductive experiences of women from abortion through birthing and menopause. In much of this work the focus moved from assuming the existence of all-powerful physicians to a search for various forms of women's agency as consumers, workers, and practitioners.

In the face of increasing contemporary demands for gender-based medicine, historians continued to provide more understanding of how gender and sex become biologized, under what conditions, and why. The link between the growing field of what became known as "science studies" and historians was forged. Historians of science provided complex historical narratives of the creation of understandings of the female body and the underlying gendered notions of science that supported such explanations. Those who worked on women as health care providers at first attempted to just chronicle the existence of such women (especially in medicine) and to understand the ways they (we) had coped with sexism and discrimination. Others took a more nuanced look at the disputes and differences among women physicians and created a less-conspiratorial and homogenous historical narrative. Nursing history's story paralleled medicine's, as scholarship in the 1980s explored themes of class, gender, and race. By the 1990s, other work focused on nursing-patient relationships, technology, and the importance of community to understanding nurses' and midwives' self-definitions and political organizations. Scholarship written by nurse historians and non-nurse historians together also expanded the audience for this work.²⁵

By the mid-1980s and into the early 1990s, there were many criticisms being written that chided those who wrote as if womanhood was only a category that fit white and middle-class women. Much of the early work on women and their relationship to medicine and the state began to be reexamined as its universality was questioned. Many of us, especially those who came out of labor history or African American history, had never separated gender from other categories of

analysis. In the face of wide-ranging political arguments over identity and who had the right to write about whom, however, concern over the very definition of womanhood spilled over into scholarly debates.

At the same time, the move within history from a focus on women to a focus on the concept of gender began to be felt in medical history. In her pathbreaking 1986 article in the *American Historical Review*, French historian Joan Wallach Scott made the argument for what she called "Gender: A Useful Category of Historical Analysis."²⁶ The concept that "women" were a stable historical subject came under attack as Scott and others influenced by poststructuralist arguments sought to undermine the assumptions that identity and the "authenticity of experience" had a one-to-one correspondence. As early American historian Kathleen Brown noted: "many of these approaches replace the search for stable, continuous and univocal meanings with analyses of contestation, discontinuity, and dissonance. . . . [this work] reflects a rejection of essentialism (the belief in a historical, transcendent core of experience and identity that is usually seen as derivative of the physical body), a project that many women's historians support in theory but find difficult to achieve in practice."²⁷

The difficulty of achieving this within history of medicine was especially acute. Trying to parse out the links among internalized subjectivity, structures of nation, class, race, and empire, and then women's agency became much more complicated. The separation of such gender analysis from medical history continued. Those who wrote more theoretical pieces, such as Regina Morantz Sanchez or Evelyn M. Hammonds, for example, tended to publish such work in history theory or feminist journals, rather than in the history of medicine journals.²⁸ In 1990, for example, Susan and Hammonds tried to lay out a research agenda that would link gender as a concept of power to class, race, ethnicity, and sexuality. In thinking back on this work, we did not attempt to give this paper at history of medicine meeting, but rather as part of a panel at the 8th Berkshire Conference on Women's History. We were arguing for a focus not just on actual bodies and what had happened to them, but the effects that the intersections among categories had as social formations in differing historical circumstances. We wanted, we wrote, "health care history in very particularistic ways to use race/class/gender/sexuality together as categories both when the 'bodies' are visible and when they are seemingly invisible, yet formative, in the creation of historical events."²⁹

Such efforts at discourse or cultural studies history, as it became known, however, often came under attack from both the right and the left. On the right, such history was often seen as gibberish, with the loss of narrative power seeming to move this work out of history. On the left, the analysis of the power of discourse

and representation often seemed to deprive individuals and groups of any agency or power to make change. In effect, this work seemed to erase politics as almost a possibility altogether. Influenced by postcolonial and subaltern cultural studies, however, more recent work in American medical history has begun to show new connections between central medical history concerns and class, race, and gender with the politics left in.³⁰ New analytic foci have also come from scholarship coming out of science studies and, in particular, understandings based on theories of embodiment that explore the ways gender, race, and class adhere to perceptions of the body.

Too often, however, the gender scholarship, and especially its emphasis on power, still has failed to influence the ways histories of hospitals, technology, or medicine are written. It was almost as if separate tracks existed.

Further, while the analytic depth of the historical scholarship grew, its clear relevance to health policy was often less obvious. If anything, various health policy analysts often selectively took from historical scholarship, turning "historical 'facts' into policy 'facts' that did not bear a close resemblance to one another."³¹ Narratives that fit contemporary needs often overcame historical narratives that sought to provide a more nuanced past. While the "linguistic turn" and its emphasis on representing the multiple ways of seeing experiences and the relationship of seemingly binary opposites has often created a more sophisticated history, it has not always provided the kind of guide practitioners and consumers want.³² The lessons of historians for contemporary policy remains much more problematic than any of us so innocently imagined several decade ago.

Class

"History from the bottom up" was the phrase that captured most directly the approach taken by social historians in the 1970s and 1980s. Attention to gender and race, and the intersection of both with issues of class, reframed the field and allowed for a flourishing of myriad local and national studies of the experiences of common people.

The creation of this new approach was profoundly influential in creating hybrid fields whose exact definitions were in high dispute as cultural, literary, postmodernist, and other approaches to the historical literature contended for control and space. For those interested in health, the growing attention to common laborers provided a new avenue for exploring the social production of disease and the impact of changing social environments on the health experience of Americans. During the mid-1980s and throughout the 1990s a plethora of new scholarship began to explore the ways in which crucial importance of health

issues was shaped by the experience of coal and hard rock miners, radium dial workers, workers in gasoline and chemical plants, and others in industrial work.

It is significant that much of the scholarship on labor and health appeared after some of the more basic investigations of the social history of the hospital and health care in general. Specifically, in the early and mid-1980s a series of books on hospitals began to call for greater and greater attention to the role of the patient as an object of medicine and as an agent of change in the organization of health care institutions. In some respects, the call for a history of "health care from the bottom up" was never accomplished, despite the efforts to focus attention on social class as a determinant in hospital organization.³³

One clearly class-related issue that was largely avoided was the implications of the source of patients and the reasons for their entry into a facility: accidents and injuries on the job were major reasons for the felt need for the growth in the number of hospitals in the period between 1880 and 1920. While all the authors acknowledged that social and economic factors contributed to the "birth" of the institution in the late nineteenth and early decades of the twentieth century, we generally ignored the implication of these factors for the eventual evolution of the institution as a means of ameliorating the growing number of accidents and deaths related to work among working people that accompanied industrialization and urbanization.

Beginning in the mid- to late 1980s, a new type of literature on workers' illnesses and accidents began to appear that looked more closely both at the worker's experience on the job and the corresponding changes in the dangerous American work environment. Occupational safety and health history seemed to be a perfect merging of political, medical, and cultural history at a time when the boundaries between labor history and community history were becoming less and less distinct. Alan Derickson's work on the hospital system for hard rock miners in the West, for example, was a groundbreaking effort to blur the lines between the new institutional and social histories of hospitals that had recently appeared and the new labor history.³⁴

The social creation of health and disease—central as they are to everyone's existence—were used as a kind of mirror on the social struggles and tensions in American society. They tied together a variety of historiographic traditions that were in danger of further fragmenting history as a field and isolating medical history as a sub-, sub-specialty.³⁵

In the process of rewriting the history of occupational health, one of the central themes that emerged in a series of books in the 1990s, was the ways that medical science itself had incorporated a series of social assumptions into profes-

sional ideas about causation. Particularly glaring for us was the distinction that separated occupational medicine from environmental medicine in textbooks, professional associations, and etiological constructs and how completely the medical community and the science that was developed reified the growing social divides that separated laboring people from the rest of the community. "Occupational" medicine as a specialty served to distinguish the laborer from those who never stepped into a factory and further fragmented the professional and public understanding of the link between the "environmental" diseases that affected people outside the plant and "occupational" issues of the laborers themselves. A number of books were themselves a socially negotiated product, and the separation of occupational from other forms of illness had deep social meanings and implications for workers and their families.³⁶

The history of working people has now really begun to transcend any narrow definition or parameter, linking varied groups inside and outside the factory gates.³⁷ What has been lost in terms of the clarity of subspecialization has been easily made up for in the ever-evolving richness of the questions that have developed and the breadth of issues pursued.

Race

In many ways the writing about race (usually translated into meaning the experiences of African Americans almost exclusively) in the history of American medicine parallels the developments in gender, except there has been much less scholarship. There are several explanations for the failure to take up race as fully, other than the effects of racism on academic scholarship. With several notable exceptions (Todd Savitt as the most prominent), in the 1970s and 1980s few white historians of medicine ventured into this topic area, and the number of African-American scholars could almost be counted on one hand. In turn, historians of the African American experience tended to focus on work, community studies, migration, sexuality, or gender, rather than medicine per se. The assumption that the history of scientific racism and eugenics had already been written left this topic somewhat understudied. The focus on the experience of particular people of color, rather than the concept of race itself as an indicator of power relationships and a underlying assumption inherent in medical thinking, limited understandings of why race was critical in the history of health care.³⁸

As with the work on gender, much of the initial scholarship filled in the gaps, told the story of racial minorities (again primarily African Americans) in the professions, in the building of medical and nursing schools and creating hospitals, and in differential treatment of disease. The focus continued to be on the struc-

tures and experiences of racism in the delivery and organizing of care which often seem underproblematized and treated as a transhistorical experience.³⁹ Nevertheless, building up histories that provide the narratives of the racialized experience has proven useful. The beginning of a scholarship that moves beyond the African American experience to explore health care within other communities of color is a much more recent and welcome addition.⁴⁰ The introduction of understandings of discourse around the African American body, most visible in the works of medical historians Evelyn M. Hammonds and Keith Wailoo, has helped to bring the sophistication from African American, gender, and cultural studies to history of medicine.

Still, historians of medicine have often failed to understand, as a nonmedical historian noted, "the subject of race is at root a question of power and is, therefore, whether we like it or not, profoundly political."⁴¹ Further, the continual saliency of the historically racialized experience in health care within communities of color makes it difficult for historians to historicize these experiences. Not only are there "facts" that are continually believed, there are standard narratives that are difficult to refute. This suggests that historians working on race need to consider, as historians working on memory and history have noted, the importance of understanding why certain truths and narratives continue to resonate and have power.⁴²

Historical scholarship on race and medicine has begun to engage with the fast-paced sophisticated analyses that are coming out of recent African American scholarship, subaltern and postcolonial studies, science studies, and work on other racial and ethnic groups. The kinds of emphases that move away from simple binaries of resistance and accommodation, and that account for regional and time variability (although historians of Southern medicine have often done this) in more subtle form enrich our understandings. Whether the new work on whiteness studies will have any impact on the history of medicine remains to be seen.⁴³

Of increasing importance in this area has been the work that begins to problematize the nature of the conceptions of race within medical and public health science, anthropology, and population genetics. Despite assumptions that the racial science and medicine of the nineteenth and early twentieth centuries had faded away, the search for a biological basis for race continues. In response to political demands made from within racial and ethnic communities and growing awareness of the health disparities between communities by public health practitioners, there is now a whole industry within medicine, nursing, and public health that starts with an assumption of differential outcomes based on race or

ethnicity.⁴⁴ Historical understandings of the choices as to why and specifically how race becomes a particular kind of biological category and how this is used has increasing political and contemporary relevance. Historians have much to contribute here to the understanding of when race becomes a stand-in variable for other factors (class, nutrition, living conditions, access to medical care) rather than a category assumed to exist in "nature."

Recent specialty conferences have highlighted how much can be learned by cross-disciplinary and cross-cultural perspectives that suggest both the multiple roots of the contemporary scholarship and how much it has to offer to our understandings of medical thinking, disease, and medical institutions. Whether this affects mainstream history of medicine remains to be seen.

Beyond "Beyond"

When we wrote "Beyond 'the Great Doctors,'" it was in the hope that we, and those who thought about the history of health care as we did, would have a future in the field. That question has clearly been settled. Many of us are tenured, published, and respected. In a prescient way, however, we worried in our introduction about whether those who wrote an engaged social history could be in danger of becoming what we called "sophisticated antiquarians" in our own right. We wanted histories that would have meaning to a broader public that we felt responsible to speak to, but never for. It is not as easy as we thought then to tell what was antiquarian and what will become useful to other historians, practitioners, or consumers. Nor do we think that all history has to be directly applicable to a contemporary issue. We have come to appreciate in a way that we did not in the late 1970s the critical importance of understanding how medical and scientific ideas and practices are created. We no longer think the old "internalist vs. externalist" division can be made. The newest work on the intersections of race, gender, sexuality, class, and empire make this abundantly clear.

Although we have discussed briefly the developments of writing scholarship on gender, class and race separately for heuristic purposes, we are well aware that their integration is central to richer historical understandings. If these categories are seen as regimes of power, not just as characteristics of bodies, then they have much to offer even historians of medicine who want to concentrate on the most traditional historiographic foci of our field.

Our own paths to how we do this have of course been different, again reflecting both opportunities and differences within the field.

David: Perhaps the most interesting way that I have found to merge my ongoing interest in the uses of history in policy analysis has been in the creation of the Columbia's Program in the History and Ethics of Public Health and Medicine that I've helped establish with David Rothman as codirector and Ronald Bayer as associate director for ethics at Columbia University. I was first approached by Columbia to help them think through the ways that a history curriculum could be integrated into their school of public health and later to help establish a program in the history of public health that would join together the faculty of the History Department with the medical and public health schools to train students in the use of history in public health education, policy, and practice. Offering both an M.P.H. and a Ph.D., the program is unique in the country in that it provides both academic and public health credentials, and it is deeply gratifying to produce students who feel comfortable discussing Foucault's *Birth of the Clinic* as well as evaluating cohort designs for epidemiological and statistical research.

Recently, I was named director of a new Center for the History and Ethics of Public Health at Columbia's Mailman School of Public Health which broadens the educational and research agendas significantly. We are now seeking to help define a new type of public health ethics that will use history as its intellectual core. The center brings together an amazing array of scholars from Columbia's faculty and Gerald Markowitz and Gerald Oppenheimer from the City University of New York and Christian Warren from the New York Academy of Medicine to ask broad questions about the ways social issues, attitudes, and historical experiences shape the ways we address population health. Using history as the base discipline, we are seeking to avoid the pitfalls of understanding ethical dilemmas as rooted solely or even primarily in the individual doctor-patient relationship or questions of personal morality. Rather, as Susan and I said in our essay of twenty-five years ago, the new center will "provide [students with] essential tool[s] for analyzing current health . . . problems by providing a sense both of their origins and the possibilities to affect change." It will also do so with a sense of morality, ethics, and social responsibility.

I see my own experience as a historian involved in public health policy as extraordinarily rewarding. My work with Gerald Markowitz has played a part in reshaping the experience of workers and communities. Of special pride is the role that *Deadly Dust* and now *Deceit and Denial* are playing in ending certain types of dangerous practices and addressing a series of injustices to groups of workers, children, and communities who have been ravaged first, by silicosis, and second, by lead poisoning and exposure to chemical pollutants. In the case of *Deadly Dust*, it was quite remarkable to us that what we had initially seen as a highly scholarly account

of the history of what we presumed to be a relatively obscure occupational disease came to play a role in court cases of workers currently suffering from the disease and in a national effort by three federal agencies—OSHA, MSHA and NIOSH—to eliminate the disease as a threat to workers. *Deceit and Denial* itself grew out of law cases we became involved in on the side of a variety of local and state governments and children who had been victimized by lead poisoning and communities polluted by petrochemicals. A Bill Moyers television special on the chemical industry, "Trade Secrets," an award-winning documentary called *Blue Vinyl*, and articles in *Newsweek* and other national publications have brought to public attention the importance of history in resolving questions of responsibility for past harms.⁴⁵

Susan: After more than twenty years of teaching in a women's studies department it would be no surprise that my work would be more influenced by the theoretical developments in this field as in women's and African American history than history of medicine. My book on the history of nursing, *Ordered to Care: The Dilemma of American Nursing* (1986), melded debates on work relations coming out of labor and class studies to women's history concerns with the history of caring. By the late 1980s and early 1990s, however, debates about representation and discourse theory never seemed to me as separate from politics as others on the left and right had argued.

My scholarship has done this in several ways. When the debates with philosophy and science studies focused on an assumption of a gendered difference in the doing of science, I tried to test some of this theoretical more philosophical work within the field of nursing.⁴⁶ I have also continued to think about the history of women's activism within the health consumer movement, using work on the body and memory as theoretical touchstones.

For the last decade, I have been engaged in a multipronged effort to reconsider the infamous Tuskegee syphilis study, the United States' longest (1932–1972) non-therapeutic research "study." It provided me with an opportunity to mesh my understandings of class politics, race accommodation, and gender possibilities within the context of science and experimentation. It has also been an incredible experience of engagement with the larger health care community, from survivors of the study itself and their heirs in Tuskegee to officers of the U.S. Public Health Service.

I have become concerned that the multiple ways of understanding the study were not reaching historians and the wider health care community. I edited a collection of both primary and secondary articles on the study to provide actual documents for teaching and learning purposes.⁴⁷ This project is perhaps as traditional as work could

get in history of medicine, except that I added poems, plays, and other forms of representation. Having supplied my "informants" book, as it were, I am now completing my own exploration of why the tales of the study are told in such differing ways. I am focused on what this teaches us and about power, views of science, and race, gender, sexuality, and class as integrated analytic concepts and lived experiences. In ways that I never expected, I have been caught up with both an internalist understanding of the medical views of syphilis and a more cultural political analysis of Tuskegee in the American imagination. It has also brought me back into intellectual conflict with differing views from medical practitioners and medical historians on how we understand the history of science and medicine in this story.

Teaching at an undergraduate college has left me without the pleasures (and difficulties) of having graduate students. Influence in a field can, I have learned, take other forms. My half time, one-year position in Women's Studies has turned into a four-person department that is growing. I am also building, along with other colleagues, a Health and Society major that will integrate on the undergraduate level the concern with ethics, history, and the social sciences that David is doing at the graduate level at Columbia.

The academy became more open to differences than we expected in the late 1970s. The methodological divides between historians are not as neat as we experienced then, as virtually all historians accept the "social history" approach as legitimate. On particular issues, however, we cannot predict who will take what side or another. The fault lines in the field do emerge again and again in the face of crises. When the AAHM went to meet in Charleston, South Carolina, in 2001, for example, tensions erupted within the association over whether the meeting should be moved to another state to honor an NAACP-called boycott of tourism over the continued flying of the confederate flag over the state house.⁴⁸ Perhaps because some of us have developed stature and place in the field, our roles in the AAHM as much as our politics led to differences on whether the meeting should be moved. In the end, the meeting stayed in Charleston, and a number of us made the decision not to attend.

Similarly, we have a profound sense of disappointment that our colleagues sometimes have few moral qualms about how they use their historical skills to cover up abuses by some of the industries that have caused Americans the most egregious harms. We stand by academic freedom, of course, for it can function to protect all of us. Yet thirty years after we first entered graduate school, we are troubled that leading medical historians have testified in lawsuits on behalf of the lead and tobacco industries, rather than consumers and communities harmed by their products.⁴⁹ It is heartening that others such as Robert Proctor at Pennsylv-

nia State University and Allan Brandt at Harvard have served as experts on the behalf of states and those injured by tobacco company activities.

There will always, we suppose, be differences over how history is interpreted and in whose interests we should be producing our stories and providing our expertise. More than we understood two decades ago, we believe linking history to ethical understandings is crucial. We still feel that people's lives are at stake in what we write and say. Whether we are concerned about children poisoned by lead, workers whose lives were shortened by silicosis, African American consumers who will not trust health care providers because of deceptions and inhuman treatment, or women who latch on to new technologies or drugs in hopes of cures, we believe we owe them the most truthful, nuanced, and carefully researched and argued history that we can write or testify to. We continue to believe that we and our students have much to offer in making the history we write more than an academic exercise, even as we meet the highest standards of the profession. We believe that there is much historians can do to be scholars as well as engaged and caring citizens, creating our own form of historical relevancy.

NOTES

We are grateful to John Harley Warner and Frank Huisman for their thorough comments. We also want to thank Elizabeth Robilotti of the Center for the History and Ethics of Public Health for her data on articles in the *Bulletin*. We also thank Nitanya Nedd for helping us with the very difficult technical aspects of getting Macs and Windows to speak to each other. This was our first joint writing effort since 1979. It reminded us of how enjoyable (and how much work) it was the first time around!

1. Susan Reverby and David Rosner, "Beyond 'the Great Doctors,'" in *Health Care in America: Essays in Social History*, Reverby and Rosner, eds. (Philadelphia: Temple University Press, 1979), 3-16, 3.

2. Elizabeth Fee and Theodore Brown, "Introduction: The Renaissance of a Reputation," in *Making Medical History: The Life and Times of Henry E. Sigerist*, Fee and Brown, eds. (Baltimore: Johns Hopkins University Press, 1997), 1-11, 5. See Paul Starr, Review of *Health Care in America: Essays in Social History*, *Journal of Social History* 14 (1980): 142-143.

3. Quoted in Theodore M. Brown and Elizabeth Fee, "'Anything but Amabilis': Henry Sigerist's Impact on the History of Medicine in America," in Fee and Brown, *Making Medical History*, 333-370, 333.

4. See the *Health PAC Bulletins* (New York: Health PAC, 1968-1992); Lily M. Hoffman, *The Politics of Knowledge: Activist Movements in Medicine and Planning* (New York: SUNY Press, 1989).

5. Rosalyn Baxandall, Linda Gordon, and Susan Reverby, *America's Working Women: A Documentary History* (New York: Random House, 1976).

6. See James R. Green, *Taking History to Heart* (Amherst: University of Massachusetts Press, 2002) for the details on the Massachusetts History Workshop and its connections to a similar historical effort in Great Britain and their still ongoing *History Workshop Journal*.

7. At CCNY, David had been active in a variety of civil rights and antiwar activities and had taken a psychology course with Kenneth Clark, whose work on racism and children had been critical in the 1954 Supreme Court decision *Brown v. Board of Education*. These activities led him to coauthor with Gerald Markowitz, *Children, Race, and Power: Kenneth and Mamie Clarks' Northside Center* (Charlottesville: University Press of Virginia, 1996; reprint, Routledge, 2001).

8. See David and Sheila Rothman, *The Willowbrook Wars* (New York: Harper & Row, 1974).

9. The letter is available online on David's syllabus website, www.columbia.edu/itc/hs/pubhealth/rosner/g8965.

10. The paper ultimately ended up as a chapter in David's book, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn, New York 1885-1915* (New York: Cambridge University Press, 1982; reprint, Princeton University Press, 1986).

11. At AAHM meetings in the 1970s, for example, it was not unusual to see an older doctor-historian taking the arm of a younger woman historian to escort her to the bar. As we often quipped, behavior that the women's movement taught us to object to with our contemporaries was sometimes tolerated as a quaint chivalrous practice not worth criticizing.

12. Some of this was briefly discussed in David Rosner, "Tempest in a Test Tube: Medical History and the Historian," *Radical History Review* 26 (1982): 166-171.

13. [Leonard Wilson], "Medical History without Medicine," *Journal of the History of Medicine* 35 (1980): 5.

14. [Leonard Wilson], "History vs. the Historian," *Journal of the History of Medicine* 33 (1978): 127-128. See also "Schizophrenia in Learned Societies: Professionalism vs. Scholarship," *Journal of the History of Medicine* 36 (1981): 5-8.

15. Gordon Jones, M.D., book review in *Journal of the History of Medicine* 34 (1979): 112-114.

16. Howard Berliner and Lloyd Stevenson, book reviews in *Bulletin of the History of Medicine* 54 (1980): 131-141.

17. Lloyd Stevenson, "Second Opinion," *Bulletin of the History of Medicine* 54 (1980): 135-136.

18. [Wilson], "Medical History without Medicine," 7.

19. Susan also chose to show the association's senior members that you could write about a physician's ideas in a social historical context. At the 1980 meeting, with Lloyd Stevenson in the audience, she presented a paper that would become "Stealing the Golden Eggs: Ernest Amory Codman and the Science and Management of Medicine," *Bulletin of the History of Medicine* 55 (1981): 156-171. By the time the paper was published, Caroline Hannaway had become the *Bulletin's* editor.

20. Our memory is that among those present with us were Harry Marks, Marty Pernick, Judy Leavitt, and Ron Numbers.

21. Elizabeth Robilotti, a graduate student in Columbia's Program in the History and Ethics of Public Health, did the research on topics in the *Bulletin* and compiled these statistics.

22. Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex," *The Univer-*

sity of Chicago Legal Forum (1989): 139–167. See also Valerie Smith, *Not Just Race, Not Just Gender* (New York: Routledge, 1998).

23. The influential 1978 book *For Her Own Good* by Deirdre English and Barbara Ehrenreich (New York: Anchor) was one of the earliest historical critiques (written by two non-historians) of medicine's paternalism toward women. Written in the tones of the anti-patriarchy argument of early second-wave feminism, the book did little to differentiate between ideology and practice or to put medical ideas on women within the context of medical theory in general. Nor did it allow for any sense of agency on the part of women. It came under almost immediate attack by most feminist historians. The book did have a powerful influence on nonhistorians looking for explanations of medical power.

24. Susan M. Reverby, "Thinking through the Body and the Body Politic: Feminism, History, and Health Care Policy in the United States," in *Women, Health and Nation: Canada and the United States since 1945*, Molly Ladd-Taylor, Georgina Feldberg, Molly Ladd-Taylor, Alison Li, and Kathryn M. Pherson, eds. (Toronto: McGill-Queen's University Press; Ithaca: Cornell University Press, 2003), 404–420.

25. The politics within history of nursing seemed to suffer a somewhat parallel fate in the beginning. In 1984, the first meeting of what was to be called the American Association for the History of Nursing, was held. Under the same scholarly umbrella were retired nursing practitioners, nurses trained in the education schools to do history, nurse historians trained by Ph.D. historians, and the social historians with no nursing experience. In nursing history, the difficulty was more a genteel tradition that tried to deny, rather than elucidate, the historical divisions (especially by race and class) within the profession. Over time, the Ph.D. non-nurse historians maintained an infrequent presence, and the associations' annual meetings became much more a home to the increasingly professionalized nurse historians. But it was clear that this organization, especially as led by the nurse historians with Ph.D.s in history, that high historical standards were to be established as a new journal, prizes, and lectureships were used to define the field's parameters. Although tensions existed among the groups for a short while, the field was too small to sustain large divisions. Turf battles also ended when it became clear that non-nurse historians could not be hired by nursing schools since they could not obviously teach public health or medical-surgical nursing and few schools could afford full time historians.

26. *American Historical Review* 91 (1986): 1053–1075. Two years later Scott published a collection of her essays that further expanded her position in *Gender and the Politics of History* (New York: Columbia University Press, 1988). For a critique of Scott, see Laura Lee Downs, "If Woman Is Just an Empty Category, Then Why Am I Afraid to Walk Alone at Night? Identity Politics Meets the Postmodern Subject," *Comparatives Studies in Society and History* 35 (1993): 414–437.

27. Kathleen M. Brown, "Brave New Worlds: Women's and Gender History," *William and Mary Quarterly* 50 (1993): 311–328, 312.

28. Morantz-Sanchez, for example, published her comparative paper on Elisabeth Blackwell and Mary Putnam Jacobi first in *American Quarterly* in 1982. Her rereading of Blackwell to take into consideration gender theory appeared in *History and Theory* ten years later. Hammonds, in turn, tended to publish her more theoretical papers on sexuality, AIDS, and black womanhood in such journals as *Radical America* and *differences*, and in collections on cultural studies and feminism.

29. Evelyn M. Hammonds and Susan M. Reverby, "Playing Clue: Do We Need the

Bodies to Name the Crime? Race, Gender and Class in American Health Care History," paper delivered to the 8th Berkshire Conference on the History of Women, New Brunswick, N.J., 9 June 1990, 4. Susan used this occasion to critique the analytic limits of her book *Ordered to Care* because it did not consider race but focused on gender and class.

30. See, for example, Laura Briggs, "The Race of Hysteria: 'Overcivilization' and the 'Savage' Woman in Late Nineteenth-Century Obstetrics and Gynecology," *American Quarterly* 52 (2000): 246–274.

31. S. Ryan Johansson, "Food for Thought: Rhetoric and Reality in Modern Mortality History," *Historical Methods* 27 (1994): 101–125, 101.

32. For an example of a struggle with how to present this viewpoint to a consumer audience and to think about how much "experience" could not be transparent, see Susan M. Reverby, "What Does It Mean to Be an Expert? A Health Activist at the FDA," *Advancing the Consumer Interest* 9 (1997): 34–36. Between 1993 and 1997, Susan served as the consumer representative on the U.S. Food and Drug Administration's OB-GYN Devices Expert Panel.

33. For the most part, these early attempts were aimed at examining the ways the institution incorporated social and class distinctions into its organizational structure and social relationships. See Morris Vogel, *The Invention of the Modern Hospital* (Chicago: University of Chicago Press, 1981); Charles Rosenberg, *The Care of Strangers* (New York: Basic Books, 1987) and Rosner, *A Once Charitable Enterprise*.

34. Alan Derickson, *Workers' Health, Workers' Democracy: The Western Miners' Struggle, 1891–1925* (Ithaca: Cornell University Press, 1988).

35. David Rosner and Gerald Markowitz, eds., *Dying for Work: Workers' Safety and Health in 20th-Century America* (Bloomington: Indiana University Press, 1987) and "Slaves of the Depression": *Workers' Letters about Life on the Job* (Ithaca: Cornell University Press, 1987). David Rosner and Gerald Markowitz, *Deadly Dust: Silicosis and the History of Occupational Disease in Twentieth-Century America* (Princeton: Princeton University Press, 1991) and *Deceit and Denial: The Deadly Politics of Industrial Pollution* (Berkeley: University of California Press/Milbank Memorial Fund, 2002).

36. Christopher Sellers, *Hazards of the Job: From Industrial Disease to Environmental Health Science* (Chapel Hill: University of North Carolina Press, 1997); Christian Warren, *Brush with Death: A History of Childhood Lead Poisoning* (Baltimore: Johns Hopkins University Press, 2000); and Claudia Clark, *Radium Girls: Women and Industrial Health Reform, 1910–1935* (Chapel Hill: University of North Carolina Press, 1997) are among the best recent works. David's most recent book with Gerald Markowitz, *Deceit and Denial*, builds on this theme and looks at the ways that industry has shaped our understanding of danger and risk.

37. Among the most challenging new efforts are Samuel Roberts, "Infectious Fear: Tuberculosis, Public Health, and the Logic of Race and Illness in Baltimore, Maryland, 1880–1930" (Ph.D. diss., Princeton University, 2002), and Amy Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: Johns Hopkins University Press, 2003).

38. For more on this, see Evelyn M. Hammonds, *The Logic of Difference* (Chapel Hill: University of North Carolina Press, forthcoming).

39. See W. Michael Byrd and Linda A. Clayton, *An American Dilemma: Race, Medicine and Health Care in the United States* 2 vols. (New York: Routledge, 2000, 2002). These authors are physicians and public health professionals. As they say clearly, "though history is uti-

lized as a major organizational and analytic tool, the book is not written as pure history or medical history."

40. For examples, see Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001), and Laura Briggs, *Reproducing Empire: Race, Sex, Science and U.S. Imperialism in Puerto Rico* (Berkeley: University of California Press, 2002).

41. Douglas A. Lorimer, "Race, Science and Culture: Historical Continuities and Discontinuities, 1850-1914," in *The Victorians and Race*, Shearer West, ed. (Aldershot: Scolar Press, 1996), 13-33, 12.

42. See, for examples, Stephen B. Thomas and Sandra Crouse Quinn, "The Tuskegee Syphilis Study, 1932-1972: Implications for HIV Education"; Vanessa Northington Gamble, "Under the Shadow of Tuskegee: African Americans and Health Care"; and Amy L. Fairchild and Ronald Bayer, "Uses and Abuses of Tuskegee," reprinted in *Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study*, Susan M. Reverby, ed. (Chapel Hill: University of North Carolina Press, 2000), 404-417, 431-442, 589-603; and Spencie Love, *One Blood: The Death and Resurrection of Charles R. Drew* (Chapel Hill: University of North Carolina Press, 1996).

43. Peter Kolchin, "Whiteness Studies: The New History of Race in America," *Journal of American History* 89 (2002): 154-173.

44. Waltraud Ernst, "Introduction: Historical and Contemporary Perspectives on Race, Science and Medicine," in *Race, Science, and Medicine, 1700-1960*, Waltraud Ernst and Bernard Harris, eds. (London: Routledge, 1999).

45. "Trade Secrets" aired on PBS stations in March 2002. *Blue Vinyl*, by Judith Helfand and Dan Gold, also used materials we uncovered. See also Geoffrey Cowley, "Getting the Lead Out," *Newsweek*, 17 February 2003, 54-56.

46. Susan M. Reverby, "A Legitimate Relationship: Nursing, Hospitals and Science in the 20th Century," in *The American General Hospital*, Janet Golden and Diana Long, eds. (Ithaca: Cornell University Press, 1989).

47. Reverby, *Tuskegee's Truths*.

48. The year before, the Organization of American Historians, at a cost of over \$100,000, boycotted the Adams-Mark Hotel in St. Louis over a racial legal dispute and moved its entire convention meetings to other places in that city. But questions of possible organizational bankruptcy hung over both decisions.

49. See Laura Maggi, "Bearing Witness for Tobacco," *American Prospect* 11 (27 March-10 April 2000) and available on the Web at www.prospect.org/print/V11/10/maggi-1.html. For the actual transcript of one historian's testimony for the tobacco industry, see www.tobacco.neu.edu/box/BOEKENBox/transcripts.html (accessed 28 August 2002). For a somewhat different view of the role of historians as experts, see David J. Rothman, "Serving Clio and Client: The Historian as Expert Witness," *Bulletin of the History of Medicine* 77 (2003): 25-44. It is a testament to the dynamism of the program at Columbia that divergent views exist among our faculty. A cautionary tale about the dangers of the effect of litigation based historical research is related in Ellen Silbergeld's review essay, "The Unbearable Heaviness of Lead," *Bulletin of the History of Medicine* 77 (2003): 164-171, a review of Peter English's book on lead poisoning, which outlines some of the historical distortions that can occur when a historian is hired by industry. The one substantive correction we would make is that she unfortunately included Christian Warren's fine book in her larger critique of English's work.