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THE HISTORIOGRAPHY OF MEDICINE IN THE U.K.

ROY PORTER
Wellcome Institute for the History of Medicine
London, UK

SUMMARY

The practice of the history of medicine in Britain is characterized by a healthy pluralism and diversity. Thirty years ago, history of medicine in Britain was generally considered a space of no particular relevance to history at large; today, public attitudes towards scientific medicine and the medical profession have grown critical, and the history of medicine has itself been problematized, commanding widespread scholarly attention. This article deals with some of the historiographical fields thanks to which the discipline has been energized over the last thirty years: the history of health, analyzing the healthiness of populations, the length of their lives and the causes of death; the history of the body, which has been considered as a biological and as a sociological entity; the history of sexuality and sexual behaviour; the demographic and epidemiological history, both connected with the environmental history; the history of death and corpses; the history of mental disorders; the historical role of the hospital in the reformation of popular health care.

We've all endured those *twenty countries in seven days* package holidays from which the wretched tourist emerges dazed and dizzy, remembering nothing at all about anywhere he's been. If I attempted to visit all the main trends in British history of medicine in this occasion it would induce a similar sort of academic travel sickness. In the interests of mental health yours and mine - I shall impose a strict regimen.

First, I propose to say nothing about movements common to Western scholarship at large[1]. Thus I shall not rehearse yet again the rejection of Whiggish triumphalism or revisit the impact of feminist history, of structuralism, of Foucauldian *savoir-pouvoir*, postmoderni-

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sm, Derridean textual analysis and the wider *linguistic turn*. These tendencies have been felt from San Diego to St Petersburg and even in Sheffield and Southampton[2].

Second, I shall keep silent about fields and periods beyond my competence, for example medieval studies, or the politics of modern health-care[3].

Third, I shall restrict myself to British-based historians writing about British medicine - while reminding you that many of the finest works produced by British scholars in recent years have been on foreign topics, for instance Lawrence Brockliss and Colin Jones's magisterial *The Medical World of Early Modern France*, which appeared last year[4].

Fourth, I hope to steer my historiographical ship between two reefs. On the one hand, I shall not speak abstractly of -isms and -ologies. To my mind, not only would that be tedious, it would also be misleading, because the practice of the history of medicine in Britain is not, in fact, ideologically polarized into doctrinaire sects but is characterized by a healthy pluralism and diversity: amongst historians English individualism still rules ok[5]. On the other hand, I shall refrain from bombarding you with fleeting and instantly forgettable references to hundreds of names, topics and titles. My plan, rather, is to address in some detail a mere handful of books which seem to me indicative of new trends and influential as rethinkings of the field. That way, I trust, we will at least avoid intellectual indigestion.

By way of prologue, I must say something about the institutional developments underpinning such scholarly tendencies. When I started out in the mid-1960s, history of medicine in Britain was generally thought an intellectually mediocre pursuit, holding no fascination for brash and bumptious apprentice historians of science like myself: it had no big issues, no clashes of the kind provoked by Popper, Lakatos, Kuhn or Feyerabend. It seemed to be the unproblematic chronicle of how dreadful diseases had been conquered by great doctors.

All this was to change. Over the last thirty years, new diseases like AIDS have challenged the progress saga, while public attitudes towards scientific medicine and the medical profession have grown critical. As an inevitable consequence, the history of medicine has itself been problematized[6].

British scholars have been well placed to take advantage of such new ferments thanks to two developments. The discipline has been

energized during the last quarter-century thanks to the founding and flourishing of the Society for the Social History of Medicine, a radical outfit which brought together younger historians, social scientists and left-leaning health professionals. Its thrice-yearly journal, *Social History of Medicine*, is now ten years old[7].

A comparable stimulus has come from the Wellcome Trust. By supporting the Wellcome Institute in London, Units in Oxford and Cambridge[8], Manchester and Glasgow, and lectureships in almost thirty universities, the Trust has set study of the history of medicine - once largely conducted by retired or Sunday doctors - onto a proper academic footing. Most Wellcome appointees are trained historians working in or alongside history departments. That has its *pros* and *cons* - arguably certain research topics really do require professional medical expertise and experience. But it has ensured that the history of medicine has been exposed to the trade winds of history and is now undertaken with due historiographical sophistication.

The most influential scholarship during the last generation has not been history of medicine in the traditional, narrow sense at all - that is, top-down accounts of doctors, by doctors, for doctors. It has been about health, in many cases the healthiness of populations at large. And in this regard, there can have been no more influential contribution to our understanding of how healthy people were, how long they lived, and what killed them, than that of the Cambridge Group for the History of Population and Social Structure. Hence I would first like to pay tribute to the work of these and other historical demographers, in establishing the population history of England - a topic especially relevant just now since this is the two hundredth anniversary of the publication of Malthus's *An Essay on the Principle of Population*, a work which emphasized the positive check of epidemic disease and which stirred considerable controversy amongst doctors[9].

Malthus's portrayal of Nature as ceaseless struggle long dominated scholarly approaches to the population history of preindustrial Europe. Malthusian orthodoxy taught that preindustrial societies sustained extremely high birth-rates. Hence they must also have suffered a correspondingly high death-rate. And did not the facts bear this out? After all, even relatively advanced France had undergone decimating famines well into the eighteenth century; from the Black Death onwards, Europe at large had been pestilence-ridden; while war too had been en-

demic. Nevertheless the Malthusian trap had evidently finally been sprung, since from around 1800 the major Western societies had supported the rising populations essential for industrialization.

So how had that great escape come about? Explanations traditionally looked to a relaxation in the regime of death. Exactly how or why people had stopped dying at such a shocking rate no one knew, but the cause was bound to lie there -in the death-rate - since the Malthusian model presumed that the birthrate was always near its ceiling.

For the last thirty years, however, this received population model has been under fire, and authoritative documentation of such revisionist thinking came in 1981 with Tony Wrigley and Roger Schofield's *The Population History of England*.[10]. Their achievement was twofold. Making national projections grounded on scrutiny of the registers of over four hundred parishes, they established for the first time reliable population aggregates of deaths, births and the total numbers of inhabitants alive at any time between 1541, when parish registers began, and the coming of Civil Registration at the dawn of the Victorian era.

Moreover, they proposed an interpretation of the dynamics of change which has since won acceptance. *Pace* the Malthusian model, early modern English society (and, to some degree, other Western European nations too) was marked by only a moderately high birth-rate - one far lower than the possible biological maximum or that now commonly found in the Third World. It also had a correspondingly moderate mortality rate. This equilibrium was maintained less through catastrophic Malthusian positive checks than through the other kind of check which he was to forefront in subsequent editions of his *Essay* - the preventive check which stopped too many surplus mouths being born in the first place.

Above all, Wrigley and Schofield held that the principal population regulator in pre-industrial England had been deferred marriage. By world standards, the English customarily married very late; in 1700, women commonly did not wed till they were around twenty-five, and men some years later still. This delay served as an effective fertility curb. Focusing on nuptiality, they demonstrated that the source of the dramatic population rise from around 1750 lay in changes in marital habits. Couples began marrying earlier, having children earlier, and having them over a longer overall span; in other words, the explanation for what Professor Thomas McKeown called the *modern rise in population* lay more in fertility than in mortality[11].

The Population History of England was a colossal and magisterial counting exercise. A follow-up work, *English Population History from Family Reconstitution 1580-1837*, published last year, supplements it by recourse to a further method, *family reconstitution*, pioneered by the French scholar Louis Henry[12]. Simply put, family reconstitution aims to exploit the fact that parish registers record baptisms, marriages and burials. Where registers have been conscientiously kept, and if a sufficient percentage of parishioners passed all their days in their native parish, it should be possible, Henry concluded, to plot precisely when in their lives identifiable individuals got married, when their offspring came along, and when they died in other words, one could proceed from mere aggregates to the reconstruction of the demographically significant acts and rhythms in the lives of actual individuals and groups. Disaggregating trends, one would be able to document whether particular cohorts of individuals were actually marrying earlier or later, were having their children more bunched up or more spaced out, were giving birth more frequently, and so forth.

So what does this follow-up volume demonstrate? It comes more as a relief than a disappointment that, with a few minor exceptions, its findings bear out the conclusions of the earlier volume. That can hardly be a surprise, given that both are products of the *Pop Group*, drawing on much the same raw data. Between them, these two volumes provide the indispensable factual foundations for all future study of mortality patterns and epidemiology.

In many ways a parallel work, drawing upon statistical and demographic expertise and developing methods of huge potential importance to medical history, is *Height, Health, and History. Nutritional Status in the United Kingdom, 1750-1980*, by Roderick Floud, Kenneth Wachter, and Annabel Gregory, a challenging essay in anthropometry[13].

The old question - did the Industrial Revolution make life better or worse? - sparked a long-running *standard of living debate*, in which the main kind of evidence traditionally used was wage rates. The shortcomings of such data are, however, all too familiar. The authors of *Height, Health and History*, by contrast, come up with fresh answers using data about physiques.

Biologists are confident that, *ceteris paribus*, variations in height reflect distinctions in well-being, tallness being a proxy for *nutritional status*. So is it possible to reconstruct how the physical stature of the

British changed? Floud *et al.* attempt this for army recruits, who have been assiduously measured since the late eighteenth century, and then seek to extrapolate on that basis.

What is revealed? The eighteenth-century base level for the labouring man was low, perhaps under 5' 4" (161 cm). There was then a slow rise till around the 1840s; these gains were then lost during the next generation; but, from the 1870s, heights began to rise in a continuous curve up to the present. Privates were once twelve or thirteen centimetres shorter than their officers: the upper (or, better perhaps, taller) classes really did look down upon the lower.

If we may make inferences from height to healthiness and so to quality of life, these are challenging findings. They contradict *pessimists* who have interpreted the advent of industrialization as eroding working-class living standards. They suggest a period in the mid-nineteenth century when, despite improving wages, survival prospects may have got worse - thanks, presumably, to the worsening sanitary condition of the early Victorian *shock town*. They undercut the scaremongering claims of *fin de siecle* eugenists about national deterioration and racial suicide. And they may give some indirect support to Thomas McKeown's belief that improvements in health were mainly due to better nutrition - though medical historians like Anne Hardy counter that public health and urban improvements played the chief role[14].

Thanks to works such as these, medical history has been forced to engage with the wider history of the body, considered simultaneously as a biological entity and as a social actor. Another link-up between the history of populations and the history of medicine is study of sexuality and sexual behaviour, an inquiry stimulated by feminism, by Foucault, and by the *bottom-up* history of everyday life[15]. Here I shall select for discussion a fine work which falls within the time-period covered by Wrigley and Schofield and by Floud and Co. It is Tim Hitchcock's *English Sexualities 1700-1800*[16]. How did sex change, and how did such changes mesh with medical history?

Dismissing as *Whiggish* the interpretation advanced by Edward Shorter - the view that *modernization* overcame traditional taboos and led to sexual emancipation, more and more pleasurable sex - [17]. Hitchcock contextualizes sex in terms of shifting male-female relations within local communities, and new readings of the sexual body. Avoiding Lawrence Stone's excessive emphasis upon the unrepresentative

upper crust[18], Hitchcock draws a distinction between the *public* sexual culture formerly predominant - sexuality as a kind of public play, legitimate so long as it was properly handled within the community - and the new private sexual milieu (associated with such phenomena as pornography and anti-masturbation literature) which he traces as emerging during the eighteenth century.

The earlier model squared with a broadly *humoral* view of the sexual body and with what Thomas Laqueur has called the *onesex* model[19]. It was a nest of beliefs which stressed the power of female sexuality, and it prescribed courting practices in which the successive granting of sexual favours led along the road to marriage. Casual premarital sexual activity was permitted, so long as it stopped short of penetrative intercourse.

This erotic world we have lost gradually gave way to a new system of sexual expectations and gender relations. Bio-medical teachings began to stress the essentially passive nature of female sexuality - female orgasm was no longer reckoned necessary for pregnancy. And the delineation of the active, phallocentric, male and the vulnerable virgin ushered the young into sexual role-models which accented what Hitchcock calls *compulsory heterosexuality* amongst *opposite sexes*, with penetrative intercourse becoming the norm. Hitchcock's model is not only highly suggestive in itself, it explicitly integrates the best recent medical and social histories of sexuality.

If our understanding of bodily health in its full biosocial richness is enhanced by the teaming up of demographic history with the history of sexuality, another fruitful alliance forged in recent studies has been that between demographic and epidemiological history on the one hand, and environmental history on the other. The outstanding work of this kind is Mary Dobson's *Contours of Death and Disease in Early Modern England*, which makes full use of the demographic researches of the Cambridge Population Group, while also drawing upon another significant tradition, the *Annales* school[20]. A generation ago, *Annaliste* history stimulated some fine regional studies of the health of populations, notably Jean-Pierre Goubert's 1974 account of Brittany[21]. The Cambridge and the Paris traditions have now been expertly combined in Dobson's pioneering essay in historical medical topography. Taking the counties of Sussex, Kent and Essex, Dobson - a geographer turned medical historian - exploits demographic data to explain dramatic geographical differentials in health.

Using burial/baptism discrepancies and other such indices, she reveals that certain environments in the South-East were far less salubrious than others. It was largely a matter of contours: high ground had the lowest morbidity, low ground the highest mortality. Particularly unhealthy were the salt marshes and creeks typical of Romney Marsh, the Thames and Medway estuaries and the Essex coast - a fact well-known to the pioneering eighteenth-century student of population, Dr. Thomas Short.

Today's historical demographers have principally dwelt upon the *urban graveyard* phenomenon; Dobson shows it would be a mistake to associate the countryside unequivocally with healthiness, for there were *rural graveyards* as well. She has also discovered what an excellent *health record* could be enjoyed in early modern times by certain upland areas, far off the main highways, with a dry soil, running streams and ample wood for fuel. The biological *ancien regime* was not everywhere inevitably unhealthy.

Making use of medical records as well as parochial data, Dobson analyses the fevers which decimated coastal fringes, paying attention above all to *marsh fever* or *ague*, which she confidently identifies as benign tertian malaria. She also shows that bitter winters produced severe mortality amongst the old, while humid summers bred the enteric fevers which worsened infant deaths.

While stressing how topography had a profound influence on mortality variations, Dobson avoids the trap of geographical determinism. She underscores *social* factors as well - migration patterns and the roles of wealth, class and occupation in the gradients of sickness. She also provides an illuminating account of the medical resources of the region, while not claiming that these weighed very heavily in the ultimate mortality scales, at least before the widespread adoption of quinine against malaria in the nineteenth century. Rather she submits that what was important in reducing mortality levels was that *civilization* was changing *nature*. Especially after 1750, the once-fatal marshy areas were growing less hazardous, thanks to agricultural improvement in its widest sense - marsh reclamation, fen drainage and new field systems.

These findings raise challenging questions respecting the interpretation of demographic change. Wrigley and Schofield have argued, as we have seen, that the population increase after 1740 owed more to a

rising birth-rate than to a declining death-rate, and they have attributed this change to earlier marriage. Emphasizing the topography of mortality, Dobson, by contrast, naturally focuses more on deaths than on births and nuptiality. The two approaches are not necessarily in conflict, for even Wrigley and Schofield, whilst primarily concerned with the national picture, do not rule out regional variations.

My discussion so far has suggested that crucial to the new medical history have been inquiries into the dialectics of disease and society. It will be no surprise that numerous works has appeared during the last decades examining the social development of specific health practices and medical provisions, against such a backdrop of epidemiological rhythms and demographic change. I shall single one out in particular, because of the exemplary manner in which it ranges all the way from social change, through medical provision, to the theory and practice of medicine itself: it is Mary Fissell's *Patients Power and the Poor in Eighteenth-Century Bristol*[22]. Concentrating on modernizing processes in an age of industrialization, Fissell pans, somewhat like Hitchcock, from the *traditional* medical milieu of the mid-seventeenth century through to the *modern* world of the New Poor Law of 1834, exploring transformations in the medical beliefs and practices of the people at large in context of tensions between high and low cultures.

The typical late-seventeenth century lower-class Bristolian was likely to be a participant in various overlapping health-care systems. These included magical, astrological and faith healing, often practised by *wise women*; home-brew herbal medicine and other forms of self-help kitchen physic; and, not least, regular medicine which, though beyond the pockets of the poor, could be available through charity. Patients picked the forms of therapy they preferred; everyone was, in a sense, his or her own physician.

The eighteenth century was to bring remarkable changes. In an emergent consumer society, medicine became commercialized[23]. There were swelling numbers of itinerants and regulars jostling in the medical market-place; and drug stores proliferated to meet the new preference for pills. This commodification of medicine impacted most upon the middle classes.

For the poor, by contrast, the turning-points were the foundation of the Bristol Workhouse in 1696, and of the Bristol Infirmary forty years later. Fissell maintains that the traditional reputation of Georgian ho-

spitals as *gateways to death* is undeserved: records suggest that the Bristol Infirmary played a positive, if minor, role in nurturing the health of ordinary people[24].

The true significance of the hospital, however, lay not in its cures, but in its role in the reformation of popular health care. The Infirmary's day-to-day running soon fell into the hands of the medical staff, above all the surgeons. Trained in Edinburgh's *medical factory*, such men brought an aggressive professionalism to their job. Out went the vestiges of magical and folk medicine; out went the old-style diagnosis dependent upon the sick person recounting his or her *complaint* to the doctor. All this was replaced by the practitioner inspecting the sick person for diagnostic signs, which could, in turn, be expressed in the technical, Latinate jargon of scientific medicine. Through the Infirmary and similar institutions, the people were deprived, in the name of progress, of the medical belief-systems which had given meaning to their sufferings. Popular medicine too was thus *reformed*. No longer was it every man his own physician; medicine, doctors now emphasized, was too complex, too serious, to be left to the sick. Patients, Fissell claims, were thus *deskilled*, and a patient-oriented system was replaced by a doctor-driven medical economy. Hence, to deploy Ivan Illich's rhetoric, the hospital *expropriated* the health of the poor by medicalizing them[25]. More dramatically, Fissell maintains that a significant function of the Bristol Infirmary lay in dissecting patients who had died in its beds. The corpses of the indigent become teaching fodder, and surgical operations themselves excited fear as perhaps heartless medical experimentation. In the popular mind, hospital and jail, medicine and punishment tended to be elided.

Mention of dissection is a further reminder of how the new history of medicine has been stimulated and strengthened by the development of body history, especially analysis of what might be called the people's two bodies, the physical and the cultural. Here a focal point has been the history of death and the corpse. Attention has particularly been directed to the rise of anatomy as the final meeting-point of doctors and the people, as brilliantly shown by Ruth Richardson's *Death. Dissection and the Destitute: A Political History of the Human Corpse*[26].

I wish instead to concentrate, however, on a similar work, *The Body Emblazoned. Dissection and the Human Body in Renaissance Culture*, by Jonathan Sawday, a literary historian[27], because his study affords

strong confirmation of the feasibility and desirability of ambitious interdisciplinarity in the history of medicine.

Addressed to the transformation of understanding of the body since the Renaissance, *The Body Emblazoned* seeks to establish intimate interactions between changing medical practices and intellectual and artistic images. The key new activity impacting upon the body was anatomy: from Vesalius through Harvey, the knife cut into corpses as never before. Anatomy became the cutting edge of medical investigation and of a doctor's training; moreover, with the erection of magnificent anatomy theatres, it also became a public display of the alliance between medical and civic power.

One consequence of the anatomical revolution was a discrediting of traditional thinking about the body, and its relations to mind, soul and self, which had dominated medieval Chistendom. Ancient taboos about bodily sanctity could no longer stand once dissecting was routinized. In certain ways the body became degraded - an object exposed to violation by the gaze, to be cut, dismembered and experimented upon. Yet in the eyes of others it could equally be ennobled, praised as a masterpiece of beauty or mechanical design, proof of Divine Wisdom. The polysemicity of the anatomized body is a point of emphasis with Sawday.

The newly exposed body did stout service as a metaphor and marker. Because the corpses surgeons cut were those of criminals, dissection assumed a penal character. But the cruel invasiveness of the knife could also suggest other modes of mastery, not least the bloody colonization of the New World, or the misogynistic conquest of women as envisaged by Restoration courtly poetry. *Anatomizing* also became a popular literary and philosophical genre, as in Robert Burton's *Anatomy of Melancholy* (1621).

The most daring aspect of *The Body Emblazoned* lies in its exploration of the symbiosis of the medical, the philosophical and the artistic. Especially in the Dutch Republic in the 1630s, painters were incorporating dissection scenes into their repertoire, audaciously alluding in their renderings of the corpse on the anatomist's slab to the *pieta* tradition of the crucified Christ. To paint the corpse was to dissect it with the artist's not the surgeon's knife, as in Rembrandt's *The Anatomy Lesson of Dr Nicolaes Tulp*. Can it be purely coincidental, Sawday asks, that Descartes too was living close to the butchers' quarter of Amster-

dam at roughly the same time, and was himself performing dissections?

The anatomical tradition culminated in William Harvey. His demonstration, in *De Motu Cordis* (1628), that the heart was but a pump undermined age-old correspondences and archetypes (the heart as monarch) and, for all Harvey's personal conservatism, corroborated the dualistic Cartesian separation of mind from body - now available at last to science, but treated as a thing apart. If anatomy was to be destiny, consciousness had to be incorporeal, or at most a ghost in the machine. Between them, Sawday argues, Harvey, Descartes and Rembrandt - or rather their shared *mentalite* - created the new mind/body dualism[28]. Through such suggestions, the salience of history of medicine for the history of philosophy and the history of the arts is established.

Finally and briefly, I wish to refer to a branch of the discipline flourishing in Britain in recent years: the history of mental disorder. For long, the history of psychiatry was undertaken mainly by psychiatrists, with the predictable admixture of strengths and weaknesses associated with in house approaches. Perhaps because Britain had no Pinel, Kraepelin or Freud, the history of psychiatry excited rather little attention.

Since the mid-1970s, the scene has changed remarkably. The history of psychiatry has become contested, partly because psychiatry itself has, thanks initially to the anti-psychiatry movement. The last fifteen years have seen extensive research, above all into the history of the asylum. We now possess, for the first time, full and critical studies of particular institutions. Patient records have been analyzed by computer to create in-depth profiles, decade by decade, of developments in diagnostics and treatment, admissions policies, length of stay, and so forth[29]. Charlotte Mackenzie and Trevor Turner have separately studied Ticehurst House, the plushest private asylum for the rich, looking respectively at the institution's management and its psychiatric categories[30]. Anne Digby has surveyed the chief charitable enterprise, the York Retreat[31]. Recent histories question stereotypes about conditions at Bethlem[32].

The outcome, not surprisingly, is a more complex picture than the benign vision of progress painted by older in house histories or that of callous exploitation and social control assumed by anti-psychiatry. If some institutions were scandals, others were well run; if asylums never fulfilled the great curative expectations of optimists, they did

not deteriorate into mere workhouses, jails, or dumps. Two volumes, entitled *150 Years of British Psychiatry. 1841-1991*, and edited by German Berrios and Hugh Freeman, form an extremely welcome foray into recent history and give the lie to the historians' sneer that insiders invariably write self-serving, Whiggish whitewashes of their profession[33].

The history of madness is another instance - like that of the history of the body - in which medical history and cultural history can interact, through discourse analysis and history from below. A fine example of this is Allan Ingram's *The Madhouse of Language. Writing and Reading Madness in the Eighteenth Century*, a study of mad people's writings[34]. It has become something of a historiographical orthodoxy that madness was *silenced* in the Classical Age. In coining that expression, Michel Foucault meant that the discourse of the insane ceased to be regarded as possessing any meaning and hence stopped being heeded by public authorities[35]. It is within this interpretative framework that Allan Ingram proceeds.

Like Sawday, Ingram brings to his study the linguistic skills of the literary historian. Scrutinising both the explicit messages and the latent meanings of a spectrum of texts psychiatric writings, fiction, autobiographies, and so forth he finds Foucault correct to a degree. Yet his investigation chiefly emphasizes the continuing vitality of traditions which privileged the words of the insane, whose punning, freewheeling, dislocated discourse attracted attention. Yet its signification underwent a transformation. In the Renaissance, mad language had been judged revelatory about the body politic or the cosmos, transmitting divine or diabolic messages. By contrast, Enlightenment auditors evaluated such talk as imparting messages about the individual psyche and personality. This psychologization of *inner voices*, Ingram maintains, owed much to Lockean notions of the association of ideas - chains of thought that were twisted and tangled in cases of delusion. The mad were not so much silenced as subjected to new modes of interpretation.

Looking back, I am appalled at all the important developments in British medical history upon which I have not touched at all[36]. But if I have emphasized certain developments over others, it is because these corroborate the chief theme of this lecture. Thirty years ago, the history of medicine seemed a back-alley, of no special relevance to hi-

story at large. Today the history of medicine is everywhere, it commands widespread scholarly attention; healing - the care and discipline of the body in the largest sense - is the thread which links together recent investigations into population, sexuality, gender, the disciplines of power, institutional history, the history of representations and so forth. From the wings the subject has moved stage-centre.

BIBLIOGRAPHY AND NOTES

1. For bibliographical surveys, see: BRIEGER H.G., *History of Medicine*. In: DURBIN P.T. (ed.), *A Guide to the Culture of Science Technology and Medicine*. New York, Free Press, 1980; IDEM, *The Historiography of Medicine*. In: BYNUM W. F. and PORTER R. (eds), *Companion Encyclopedia of the History of Medicine*. London, Routledge, 1993, pp. 24-44; JORDANOVA L.J., *The Social Sciences and History of Science and Medicine*. In: CORSI P. and WEINDLING P. (eds), *Information Sources in the History of Science and Medicine*. London, Butterworth Scientific, 1983, pp. 81-98; PELLING M., *Medicine since 1500. Ibid.*, pp. 379-407. BYNUM W. F. and PORTER R. (eds), *Companion Encyclopedia of the History of Medicine*. London, Routledge, 1993, contains many up-to-date surveys of recent scholarship.
2. For aspects of these see GEYER-KORDESCH J., *Women and Medicine*. In: BYNUM W.F. and PORTER R. (eds), *Companion Encyclopedia of the History of Medicine*. London, Routledge, 1993, pp. 884-910; JONES C. and PORTER R. (eds), *Reassessing Foucault: Power Medicine and the Body*. London, Routledge, 1994; for such elements in general historiography see: EVANS R., *In Defence of History*. London, Granta Books, 1997.
3. It will thus be obvious that many key dimensions of medical history are not mentioned in this paper. One is medicine and the state. Here a major achievement is WEBSTER Ch., *The Health Services Since the War: Volume 1: Problems of Health Care. The National Health Service Before 1957*. London, Her Majesty's Stationery Office, 1988) and Volume 2: *Government and Healthcare: the National Health Service, 1958-1979*. London, The Stationery Office, 1996. For conceptual discussion and a literature review, see: PORTER D. (ed.), *The History of Public Health and the Modern State*. Amsterdam, Rodopi, 1994. It will also be apparent that, in a broad-brush survey such as this, I have chosen to omit reference to the periodical literature and have concentrated on books.
4. BROCKLISS L. and JONES C., *The Medical World of Early Modern France*. Oxford, Clarendon Press, 1997; see also WEINDLING P., *Health, Race and German Politics Between National Unification and Nazism 1870-1945*. Cambridge and New York, Cambridge University Press, 1989. I shall similarly exclude works on the history of medicine in the British Empire, such as ARNOLD D., *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*. Berkeley, CA., University of California Press, 1993; and HARRISON M., *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*. Cambridge and New York, Cambridge University Press, 1994.
5. For some insight, see MACFARLANE A., *The Origins of English Individualism: The Family, Property and Social Transition*. Oxford, Basil Blackwell, 1978.
6. See ILLICH I., *Limits to Medicine: The Expropriation of Health*. Harmondsworth, Penguin, 1977.

7. PORTER D., *The Mission of Social History of Medicine: An Historical Overview. Social History of Medicine*, viii, 1995, pp. 345-60; JORDANOVA L., *The Social Construction of Medical Knowledge. Social History of Medicine*, viii, 1995, pp. 361-82.
8. As of 1998, the Cambridge Wellcome Unit will close as a result of a deplorable decision by the Wellcome Trust, but it will be replaced by a comparable Unit at the University of East Anglia.
9. For the influence of Malthus on historical demography see: SMITH R., *Demography and Medicine*. In: BYNUM W. F. and PORTER R. (eds), *Companion Encyclopedia of the History of Medicine*. London, Routledge, 1993, pp. 1653-82.
10. WRIGLEY E. A. and SCHOFIELD R. S., *The Population History of England 1541-1981: A Reconstruction*. London, Edward Arnold, 1981. Some of the thinking underpinning this may be found in: LASLETT P., *The World We Have Lost*. London, Methuen, 1965; 3rd edn London, Routledge, 1983.
11. McKEOWN T., *The Modern Rise of Population*. London, Edward Arnold; New York, Academic Press, 1975.
12. WRIGLEY E. A., DAVIES R. S., OEPPEN J. E. and SCHOFIELD R. S., *English Population History from Family Reconstitution 1580-1837*. Cambridge, Cambridge University Press, 1997.
13. FLOUD R., WACHTER K. and GREGORY A., *Height Health and History: Nutritional Status in the United Kingdom. 1750-1980*. Cambridge, Cambridge University Press, 1990. For a further study which stresses the interplay of medicine with demographic change, see: SZRETER S., *Fertility. Class and Gender in Britain 1860-1940*. Cambridge, Cambridge University Press, 1995; LANDERS J., *Death and the Metropolis: Studies in the Demographic History of London 1670-1830*. Cambridge, Cambridge University Press, 1993. For the role of food see: WALTER J. and SCHOFIELD R. (eds), *Famine Disease and the Social Order in Early Modern Society*. Cambridge, Cambridge University Press, 1989. For nutrition and medical history, see: KAMMINGA H. and CUNNINGHAM A. (eds), *The Science and Culture of Nutrition 1840-1940*. Amsterdam, Rodopi, 1995.
14. HARDY A., *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine. 1856-1900*. Oxford and New York, Oxford University Press, 1993. See also RILEY J.C., *Sickness Recovery and Death: A History and Forecast of Ill Health*. London, Macmillan, Houndmills, Basingstoke, Macmillan, 1989.
15. For some thoughts on this see: PORTER R., *History of the Body*. In: BURKE P., *New Perspectives on Historical Writing*. Cambridge, Polity Press, 1991, pp. 206-32.
16. See: HITCHCOCK T., *English Sexualities. 1700-1800*. Basingstoke, Macmillan, 1997.
17. SHORTER E., *The Making of the Modern Family*. New York, Basic Books, 1975.
18. STONE L., *The Family. Sex and Marriage in England 1500-1800*. London, Weidenfeld and Nicolson, 1977.
19. LAQUEUR T.W., *Making Sex. Gender and the Body from Aristotle to Freud*. Cambridge, Mass., Harvard University Press, 1990. In this area see also PORTER R. and HALL L.A., *The Facts of Life: The Creation of Sexual Knowledge in Britain 1650-1950*. New Haven, Yale University Press, 1995, which examines the roles of doctors and medical beliefs in regulating sexuality.
20. DOBSON M., *Contours of Death and Disease in Early Modern England*. Cambridge, Cambridge University Press, 1997.
21. GOUBERT J.P., *Malades et Medecins en Bretagne 1770-1790*. Rennes, Institut Armoricain de Recherches Historiques, 1974.
22. FISSELL M.E., *Patients Power and the Poor in Eighteenth-Century Bristol*. Cambridge, Cambridge University Press, 1991. See also her *The Sick and Drooping Poor in Eighteenth Century Bristol and its Region. Social History of Medicine*, ii, 1989, pp. 35-

58; and *The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine*. In: FRENCH R. and WEAR A. (eds), *British Medicine in an Age of Reform*. London and New York, Routledge, 1992, pp. 92-109. For other regional studies see PICKSTONE J., *Medicine and Industrial Society: A History of Hospital Development in Manchester and its Region 1752-1946*. Manchester, Manchester University Press, 1985. Issues underlying such works are astutely discussed in Lawrence C., *Medicine in the Making of Modern Britain 1700-1920*. London and New York, Routledge, 1994.

23. For studies which make use of the concept of the eighteenth century *medical market place*, see: PORTER R. and PORTER D., *In Sickness and in Health: The British Experience 1650-1850*. London, Fourth Estate, 1988; PORTER D. and PORTER R., *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England*. Cambridge, Polity Press, 1989; PORTER R., *Health for Sale: Quackery in England 1650-1850*. Manchester, Manchester University Press, 1989.
24. On hospitals, see GRANSHAW L. and PORTER R. (eds), *The Hospital in History*. London, Routledge, 1989; paperback edition, 1990.
25. ILLICH I., *Limits to Medicine: The Expropriation of Health*. Harmondsworth, Penguin, 1977.
26. RICHARDSON R., *Death. Dissection and the Destitute: A Political History of the Human Corpse*. London, Routledge & Kegan Paul, 1987. For the wider history of death, see: ARIES Ph., *The Hour of our Death*. Trans. H. Weaver London, Allen Lane, 1981; LLEWELLYN N., *The Art of Death: Visual Culture In The English Death Ritual c. 1500- c. 1800*. London, Victoria and Albert Museum, 1991.
27. SAWDAY J., *The Body Emblazoned. Dissection and the Human Body in Renaissance Culture*. London, Routledge, 1995.
28. For an earlier study from a literary viewpoint, see: BARKER F., *The Tremulous Private Body: Essays on Sublection*. London, Methuen, 1984. For a comparable work exploring the body, see: BOURKE J., *Dismembering the Male. Men's Bodies, Britain and the Great War*. London, Reaktion Books, 1996.
29. For conceptual discussion, see: DIGBY A., *Quantitative and Qualitative Perspectives on the Asylum*. In: PORTER R. and WEAR A. (eds), *Problems and Methods in the History of Medicine*. London, Croom Helm, 1987, pp. 153-74. For instances of asylum histories, see: ANDREWS J. and SMITH I. (eds), *Let There be Light Again: A History of Gartnavel Royal Hospital from its Beginnings to the Present Day*. Glasgow, Gartnavel Royal Hospital, 1993.
30. MacKENZIE C., *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792-1917*. London and New York, Routledge, 1993; TURNER T., *A Diagnostic Analysis of the Casebooks of Ticehurst Asylum 1845-1890*. Psychological Medicine, Monograph Supplement xxi, Cambridge, Cambridge University Press, 1992.
31. DIGBY A., *Madness Morality and Medicine*. Cambridge, Cambridge University Press, 1985.
32. ANDREWS J., BRIGGS A., PORTER R., TUCKER P. and WADDINGTON K., *The History of Bethlem*. London, Routledge, 1997; ALLDERIDGE P., *Bethlem 1247-1997: A Pictorial Record*. London, Phillimore, 1996.
33. BERRIOS G.E. and FREEMAN H. (eds), *150 Years of British Psychiatry, 1841-1991*. London, Gaskell, 1991; FREEMAN H. and BERRIOS G.E. (eds), *150 Years of British Psychiatry. Volume II: The Aftermath*. London and Atlantic Highlands, NJ, Athlone, 1996. Other major works dealing with psychiatry include SMITH R., *Trial by Medicine: Insanity and Responsibility in Victorian Trials*. Edinburgh, Edinburgh University Press, 1981. Much new research appeared in: BYNUM W. F., PORTER R. and SHEPHERD M. (eds), *The Anatomy of Madness*, vol. 1. London, Tavistock, 1985; *People and Ideas*; vol. 2. London, Tavistock, 1985; *Institutions and Society*, vol. 3. London, Routledge, 1988; *The Asylum and its Psychiatry*. For a fuller historiographical discussion, see: PORTER R., *History of Psychiatry in the U. K.*. History of Psychiatry, ii, 1991, pp. 271-80. Much recent scholarship has been published in this new journal, set up in 1990. A further recent development is study of mental deficiency. See WRIGHT D. and DIGBY A. (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities*. London, Routledge, 1996.
34. INGRAM A., *The Madhouse of Language: Writingand Reading Madness in the Eighteenth Century*. London/New York, Routledge, 1991. Compare Ingram's other study: *Boswell's Creative Gloom*. London, Macmillan, 1982.
35. FOUCAULT M., *La Folie et la Deraison: Histoire de la Folie a l'Age Classique*. Paris, Librairie Plon, 1961; trans. and abridged by HOWARD R. as *Madness and Civilization: A History of Insanity in the Age of Reason*. New York, Random House, 1965; London, Tavistock Publications, 1967. For evaluation see: STILL A. and VELODY I. (eds), *Rewriting the History of Madness: Studies in Foucault's Histoire de la Folie*. London/New York, Routledge, 1992.
36. Among the many fields about which all too little has been said in this survey are: history of paediatrics; clinical medicine; laboratory medicine; medical education; paediatrics; hospitals; medicine and empire; medicine and war; women's medicine; medical economics; history of surgery. The reason is not a lack of good work in these fields but a lack of space and competence on the author's part.

Correspondence should be addressed to:
Roy Porter, Wellcome Institute for the History of Medicine, 183 Euston Rd - London NW1 2BE, U.K.