The Social Construction of Medical Knowledge

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In the 1970s, social constructionist approaches were the subject of fierce debate, especially in English-speaking communities that were struggling to absorb "theory." Now, although debates continue, social constructionism is regarded with less suspicion; indeed, it has become institutionalized in much that goes under the name of sociology of science, and perhaps by that token it is less subversive. It is not my purpose here to analyze how that change came about or to summarize the philosophical issues social constructionism raises. I suggest that further debates among historians about whether such approaches are right or acceptable are unlikely to be productive. My position is simple: if social historians of medicine attempt more than anecdotal or descriptive history, they frequently adopt social constructionism in one form or another, even if they have been less explicit than historians of science about their conceptual maneuvers. However, it is vital to be clear about the historical perspectives that social constructionism opens up. In order to do so, we can assume that it is useful and then probe the nature of its fruitfulness for historical practice.

The chapter is divided into five parts. The first deals with the enabling potential of social constructionism, and with the intellectual currents that made it possible. The second deals with some common misapprehensions about it. The

next part sets out some interpretative issues to be addressed. In part four, I compare the historiographies of science and medicine. The final part attempts to draw the threads together.

It has not proved possible to formulate a neat definition of social history of medicine.[1] As the contributions to *Social History of Medicine* have shown, there are many social histories of medicine. Social constructionism has particular relevance for those interested both in medical thinking broadly conceived and in conceptualizing the relationships between such thinking and the settings in which it occurs. The phrase "medical knowledge" in my title reflects the centrality of knowledge claims in social constructionist approaches.[2] The term "knowledge" is hardly neutral, since it implies claims that have been validated in some way and foregrounds the cognitive dimensions of medical and scientific practice. It is a mistake to separate the knowledge claims of medicine from its practices, institutions, and so on. All are socially fashioned, and so it may ultimately be more helpful to think in terms of mentalities, modes of thought, and medical culture than in terms of "knowledge," which implies the exclusion of what is inadmissible, while the former are looser, more capacious categories.

The currency of the phrase "medical knowledge" reveals the debt of historians of medicine to writings on science. Social constructionists who study the natural sciences have been concerned to show how even the most dense theoretical claims of the so-called hard sciences are amenable to social explanation—that is, they have needed a rather strict interpretation of "knowledge." The agenda of those who work on medicine has been somewhat different, partly because commentators have become more scrupulous in distinguishing between medicine and science and partly because those who study science have been more preoccupied with the philosophical claims implicit in their work, not least because of the existence of history and philosophy of science as a field.[3] Some scholars have come to feel that "medicine" is a problematic term precisely because it has been unthinkingly treated as another form of science. They are concerned that "medicine" suggests orthodox knowledge systems thereby implicitly marginalizing not only healing practices but the whole range of behavior and representations associated with health. While this was a fair criticism of some earlier approaches to the field, we can now feel confident that social perspectives, in making the importance of medical practice their cornerstone, permit us to speak of medicine and to have far more than theory in mind.

I have used the word "knowledge" in the title to signal that thinking about ideas remains an important goal in the social history of medicine. In fact, together social constructionism and an attention to medical ideas constitute what might best be

called a cultural history of medicine. The recent growth of interest in cultural history has been stimulated by many of the currents of thought discussed below and a significant proportion of its exponents adopt a constructionist position.[4]

Enabling Potential for Historical Practice

It may be fruitful to think of social constructionism as delineating a space that the social history of medicine can occupy. By stressing the ways in which scientific and medical ideas and practices are shaped in a given context, it enjoins historians to conceptualize, explain, and interpret the processes through which this happens. The old Whiggish history permitted no such spaces to exist. In a progressivist narrative, the search for truth was told in terms of blind alleys and right answers; the model was a journey, and the main emphasis was on content. Since ideally there was a tight fit between explanans and explanandum, few questions were asked about the mediating processes between them or about how problems requiring explanation were defined. By stressing that knowledge is produced in and through social processes, social constructionism encouraged historians to conceptualize the constituent processes and to come up with imaginative ways of recreating them, including through the use of a wide range of primary sources. More than this, it became important to talk about these processes using the ideas and frameworks that other historians employed, such as state, class, imperialism, patronage, and so on. Put like this, it all sounds rather simple, but we are still novices and many of the potentials remain under- or unexplored.

Many intellectual strands have contributed to social constructionism over the last two decades or so. I would like to mention briefly eight styles of thinking, some of which overlap. Nonetheless, it is analytically useful to distinguish between them.

First, philosophy of science played a central role in providing tools for questioning the epistemological status of scientific and, by extension, medical theories and for reconstructing the intellectual maneuvers scientists employed. It was not that settled answers were arrived at but that permission was given to explore a number of different models of how natural knowledge was acquired. Attempts to uncouple "nature" and theories about it were particularly helpful: between the material world and our representations of it there now appeared to be a space, which it was the job of historians (and sociologists and philosophers) to examine. Social constructionist approaches conceptualize that space and thereby generate ideas about what is in it. Many figures played an important part in the process initiated by philosophers of science, especially after the first edition of Thomas

Kuhn's *The Structure of Scientific Revolutions* in 1962.[5] Some scholars interpreted Mary Hesse's writings as especially useful, although she did not herself adopt social constructionism.[6] In particular, her *Models and Analogies in Science* suggested some ways in which language acted as a mediator between nature and science.[7] Indeed, analyzing the languages—both verbal and visual—of science and medicine has been a major tool in the social constructionist project, which accordingly is similar to and has been influenced by new critical methods in art history and literature.[8] Into that space was also inserted a concern with the practices of scientists and medical practitioners, encouraged initially by an interest in how discoveries took place, and specifically in the distinction between logics of discovery and those of justification.

Second, and closely related to this, was the general revolt against Whiggish history, which had been especially prevalent in writings on science and medicine and indeed had been sustained by a realist philosophy of science. It was also sustained by the dominance of scientists and medical doctors over the history of their fields. The urge to applaud the "right" and castigate the "wrong" is still all too common as is clear in the continued use of the use/abuse model mentioned below. It follows from the critique of Whig history that historians should be critical of the use and perpetuation of canons and of the unthinking forms of heroization they imply. While it has long been fashionable to decry these forms of triumphalism, they remain entrenched. The task of sympathetically understanding actors' perspectives has proved more appealing than has the challenge to rethink the notions of "genius" and "great thinker" or the very concepts of "canon" and "hero"—all are equally central to an anti-Whig perspective. Interestingly enough, general historical writings on this issue have made less impact on the history of science and medicine than those emanating from more theoretical domains. Herbert Butterfield was better known for his book on the scientific revolution than for his *Whig Interpretation of History.*[9]

Third, the sociology of knowledge was especially important, and was a major impulse behind what became known as the Edinburgh school. There, sociologists, philosophers, and historians together examined the ways in which the sociology of knowledge could be applied to science and to medicine—Barry Barnes, David Bloor, Steven Shapin, and Donald MacKenzie are perhaps the best-known figures.[10] In the more general literature, Peter Berger and Thomas Luckman's *The Social Construction of Reality* is a convenient example of this perspective.[11] Other sociological approaches, such as studies of professionalization and power, have also been influential.[12] Bruno Latour has been unusually successful in bringing his orientation to wide audiences by developing sociological models others could put

to use and by demonstrating their value through his own detailed case studies. His stress on the practice of science, on the need to observe the details of *Science in Action,* has captured the interest of those sympathetic to social constructionism not only through forceful and vivid writing but by foregrounding the processes of knowledge-production.[13] Perhaps the best-known single sociological contribution for the history of medicine remains Nicholas Jewson's pair of articles, which have been followed up by many scholars, especially those who work on the eighteenth century.[14] My contention is that the sociology of knowledge inspired, especially among historians of science, scholarship that is so outstanding it enjoins us to explore ways in which those working on medicine can make better use of it.

Fourth, and in keeping with the trends already outlined, was the impact of social and cultural anthropology.[15] Robin Horton and Mary Douglas can stand as examples of this, although they were certainly not alone among anthropologists in claiming the relevance of what they were doing for the social nature of science and medicine. As a result of the influence of anthropology, statements about belief systems became commonplace, even if few took the trouble to spell out what the pay-off might be. In general, it seemed more plausible to treat magic and medicine not as successive stages in a progressivist trajectory but as somehow equivalent, if different *Modes of Thought.*[16] The interpretation of magic has become a major historiographical issue, not just for historians of science and medicine, but for all those who study what had been deemed the "irrational."[17] Indeed it was historians of witchcraft who drew the attention of the historical community as a whole to the value of anthropology.[18] The writings of Frances Yates along with the work of scholars such as Piyo Rattansi and Charles Webster, for whom magic, medicine, natural philosophy, and utopianism were intertwined, also suggested the direct relevance of taking magic seriously.[19] Mary Douglas's writings were especially influential in rekindling an interest in cosmology and in encouraging fresh reflections about the nature of fundamental social boundaries, as well as the symbolic density of all the realms that mediate nature and human nature.[20] Anthropology was inspirational because, as a reflexive discipline, it was pledged to understand sympathetically ways of being that were other. By that token, it offered far more than intellectual frameworks; it embodied relationships between knower and known that appeared exceptionally relevant to historians of science and medicine.

Fifth, a politicized reaction to scientific and medical power did much to nurture the sense that these were major arenas of conflict and struggle, in which concepts were contested precisely because they were forged and deployed as "social relations."[21] Particularly influential were feminist critiques of medicine,

which examined the complex relationships between practitioners and patients before there was a substantial feminist literature on the natural sciences.[22] It was precisely because there was a variety of social settings in which medical practitioners interacted with women as colleagues, subordinates, and competitors, and as "customers," that a social analysis of the resulting ideas about femininity and women's bodies was possible. Here was an instance where ideas and practices were analyzed together.[23] For just this reason, radical critiques of technology have also been important. They had an immediate relevance to contemporary political issues, such as nuclear power, pollution, imperialism, and scientific management. As a result, those who work on the twentieth century have developed forms of social constructionism for which political critiques of technology are central.[24]

Sixth, a number of these approaches encouraged scholars to look at how interests shaped the theory and practice of medicine. Clearly, this was not new, since in a sense it was precisely what Robert Merton had done for puritanism and science in the 1930s.[25] The question of how "interests" are studied remains a central issue for historians. What was laid down in the 1970s remains true today of the history of science and medicine. Interests were interpreted in terms of professional advancement; religious affiliation; political allegiance the quest for power, money, and authority; and patronage and networks. In practice, many historians of medicine try to consider a range of interests, but there is still a tendency to give weight to some interests and play down others, according to one's orientation. On the whole, an emphasis on professional advancement appeals to those most open to sociological theory, while those who see their work as closer to the historical mainstream prefer religious and political interests. The authors of political critiques lay particular stress on expertise—the interests that emerge with specialized, authoritative knowledge—but it has largely been left to those who study institutions to explore patronage and networks. The most obvious concept to invoke in this context is "class," yet how this is to be defined and to which periods it is best applied remain contentious. Thus, an anxiety about using notions such as class endures, and this is linked with a tension between understanding interests in individual and in collective terms. We still pay far too little attention to the complex manner in which interests are experienced, shaped, and expressed.

Seventh, critiques were developed, often in a self-consciously Marxian mode, of the use of nature and its cognates.[26] The argument went something like this: when scientists or the medical profession talked about nature they constructed that term, not just in their own interests, but in such a way as to veil its thoroughly social provenance. This enabled them to use their expertise in an authoritative way by insisting on their exclusive, privileged access to a domain that was

above and beyond society. "Nature" was thus a prescriptive category masquerading as a descriptive one and an instrument of class struggle.[27] This point was well exemplified in the power of orthodox medicine to designate a person fit or unfit, well or ill, and if unfit or ill to intervene as was thought appropriate. The formidable complexities of how this worked in practice can be seen in the now vast secondary literature on eugenics and in the resulting historiographical debates.[28] There are economic variants of this position for which medicine becomes a tool for controlling the size and composition of the work force.[29]

All of these strands opened up spaces for historians to explore; they encouraged an emphasis on the constituent processes of medicine and science; and they required the elaboration of infinitely more complex frameworks and models to help imagine the social placement of that amalgam we call "medicine."

Finally, we have a distinctive approach, which I shall call localism. It arose when historians worked on health and medicine who had neither been medically trained nor had their ideas shaped by history and philosophy of science. They, by contrast, had been trained to see particularities of all kinds, to detect the forces that shaped institutions and medical provision outside institutions. Never having believed in the tight fit between nature on the one hand and science or medicine on the other, they tended to take it for granted that social processes filled the gap. In a sense, they were social constructionists without knowing it. However, they often stopped short of analyzing how societies shape medical theories and beliefs, preferring to look at "popular" practices, charities, and so on, leaving theoretical or technical matters to one side.[30]

Social constructionist approaches can usefully be applied to all aspects of medicine. One reason why they have not is the continuing prevalence of the use/abuse model. It is vital that we consider this approach and at the same time dispose of some of the main misunderstandings concerning social constructionism. Inevitably, philosophical debates about social constructionism continue, and it is worth distinguishing between social constructionism as a heuristic device for practicing historians and its theoretical status. While attempts to clarify its status can have a bearing on historical practice, they do not necessarily do so, largely because discussion is pitched at such an abstract level. My interest is in its heuristic capacities.

Misapprehensions

Making a distinction between the use of scientific and medical ideas and their abuse serves both to affirm their value-neutrality and to effect a separation between the production of knowledge and its deployment. Social constructionists

want to show, through theoretical argument and empirical claims, that ideas necessarily carry or mediate values, that making and using knowledge cannot be so neatly separated, and that understanding the social meanings of natural knowledge is preferable to making moral judgments about the propriety of practitioners. A recent example of the use/abuse approach is Cynthia Russett's *Sexual Science* in which she pokes fun at the excesses of nineteenth-century science and medicine in relation to women and to the understanding of gender differences, using examples largely from the United States and Britain.[31] When "sexist" pronouncements were made or practices undertaken, practitioners were, for Russett, not employing very good science. Liberal feminism has become a reason for condemning scientific "abuse." The book simply assumes that earlier approaches to the biology of gender are at once risible and depressing. I read the use of this model as highly defensive. It leaves science and medicine intact epistemologically and politically. Two kinds of historical laziness result. First, the implicitly moral framework appears to make the work of understanding how people could think so differently unnecessary because it offers up simple answers—either they were not good scientists or their work was used by others for bad ends. Such moralizing is antithetical to the social constructionist project. Second, the use/abuse model does not challenge historians to unravel the mediating processes involved in the creation of knowledge, leaving the "best" science and medicine as unhistoricized, because true and acceptable, and capable of being used for worthy purposes.

This is the point to dispose of three misapprehensions related to social constructionism. The first concerns "medicalization." This refers to the process whereby domains of life that were not previously so came under the aegis of medical practitioners and/or medical theories. The implication is that since the eighteenth or nineteenth centuries, the periods most often taken to mark the onset of medicalization, medical power has slowly but inexorably grown. French historians especially have taken the number of trained practitioners for a given number of people as an index of medicalization.[32] This in turn implicitly privileges professionalization as a key historical process. Most English-speaking historians who use the term are less concerned with the number of practitioners than with the qualitative growth of medical power. In fact, there is no inherent link between "medicalization" and a social constructionist approach. Indeed, in some ways they are historiographically at odds in that the former has a teleology—that of modernization—built into it, while the latter opposes this and is generally quite hostile to present-centered approaches.[33] Exponents of a medicalization approach tend to see medical power as gained with relative ease or even simply appropriated. A social constructionist will more likely look for the points of tension, for negotia-

tions and conflicts through which particular kinds of authority may or may not be gained, and specify rather precisely the social groupings involved.

The second misapprehension concerns a charge that is still sometimes made and was mentioned frequently when social constructionist approaches were first debated, namely that they ignore the material dimensions of life. This is based on a misunderstanding of the philosophical claims that underlie social constructionism. It is often caricatured by critics, who impute to it the claim that diseases are not real and who associate it with a denial that science and medicine really work. The implication is that social constructionism deals with what is evanescent, epiphenomenal, precisely with what is not "real." There is no logical basis for these assertions. On the contrary, the material world is constantly shaped and interpreted through human actions and consciousness. Social constructionism takes this as one of its main tenets and without the dynamic relationship just described, it would have no meaning. It is not a form of idealism. But it does insist that there is room for a variety of interpretations and meanings, that behind consensus or "knowledge" lie social processes and that such processes involve negotiations and conflict, both overt and implicit. That is, to use the metaphor I employed earlier, it presents spaces that can be filled in diverse ways. It follows that forms of knowledge and the social processes whereby they are created are given intellectual priority. It does not follow that materiality and physical embodiment are denied.

The third misapprehension concerns the distinction between so-called internalist and externalist approaches.[34] Contained in this distinction is the assumption that what is "social" is what is also "external" to the heart of medicine and science, since their core is taken to be knowledge claims and these are assigned to the category non-social. Thus, as in the use/abuse model, something special is saved from the perceived taint of sociological analysis. While it is now evident that separating content and context in this way was profoundly unhelpful, integrating them is less easy than it looks, hence the importance of highly specific case studies.[35] Social constructionism is not allied with externalism, although this has sometimes been assumed; on the contrary, exponents of this approach have generally been skeptical about facile dualisms such as internal/external.

Before leaving the question of misapprehensions, I want to say something about Michel Foucault, who is, somewhat misleadingly, credited with a founding role in social constructionism. The trends that encouraged social constructionism were broader and more general than the influence of any one figure, and they were well-established among English-speaking historians long before Foucault

had a major impact. *Madness and Civilization* was one of a clutch of works tha sought to dismantle the pretensions and deceits of psychiatry in the 1960s.[36] Fa more important for the topic under discussion were *The Birth of the Clinic, Th Order of Things,* and *The Archaeology of Knowledge.*[37] It was the assertion containe in all three that ways of seeing/knowing (epistemes) contained their own logic and limitations and that radical shifts in epistemes occurred over a relatively shor period of time, which was both influential and contentious. A revulsion towar scientific and medical power was certainly present in these works, as it had bee in *Madness and Civilization* and in his less well known earlier work *Mental Illnes and Psychology,* but the claims about epistemes were and remain more intellec tually challenging.[38] Described in this way we can see why the impact of Foucaul and that of Kuhn via the notion of paradigm pointed in similar directions. Yet fo practicing historians there is a very important difference between them. Kuh tried to show through a series of case studies how one paradigm gave way t another, and he conceptualized the processes involved, if not as inherently social at least as having a significant social dimension. Foucault, by contrast, tended t create a very powerful but somewhat static sense of what each episteme consiste of, with the transformations from one to another appearing more like a gestal switch than complex processes of transformation. Indeed, he does not seem t have been interested in the processes that permitted the emergence of episteme or in precisely how shifts between them occurred.

Some would say that Foucault nurtured an interest in discourse, and especiall in medical discourse.[39] It is undoubtedly true that he drew the attention of, abov all, literary critics to these topics and that his work in effect brought the history o medicine to a wider audience, but those interested in the cultural history of medi cine had and have a wide range of intellectual models that may serve as inspira tion. In practice, history inspired by Foucault tends to be somewhat "flat," lackin in historical texture, and it could be argued that considerable effort has had to b expended on correcting the more common "truths" he put into the public do main, especially about the history of hospitals.[40] The best work inspired by Foucauldian orientation succeeds precisely because it does more than discours analysis, because it is not flat. The growing interest in scientific and medica discourse has been nurtured as much by scholars such as Raymond Williams as b Foucault.[41] The realization that texts are dense, and that they should be inter preted accordingly, has been productive. While just what counts as a text an what larger historical insights texts afford remains a subject for debate, a mor vivid appreciation of the ways in which languages carry, shape, and change idea

is extremely fruitful. The problems arise when discourse is detached from other historical processes, and when a small number of texts are taken out of their context and made to carry a heavy explanatory load.

Interpretive Issues

I have presented the potential of social constructionism in such a way as to suggest that it raises a number of issues that require further debate and elaboration. These discussions are particularly important if we wish to practice the social history of medicine as part of the general discipline of history and to explore its kinship with cultural history. The four issues that have been selected for brief discussion here reflect this agenda.

First, interests: these are often invoked to explain changes in beliefs and to account for situations where there appears to be a good fit between the content of beliefs and social attributes. An insistence on the shaping role of interests has been one way of breaking down the rather globalized approach of Foucault, for whom an episteme had a special meta-status; it somehow had the capacity to structure consciousness in general. Interests can do this too, but the concept suggests above all particularities and differences—to invoke the term is to imply conflict and competition between groups or ideologies with definable characteristics. Conventionally used, interests can also easily be construed as "external" to medicine, so that they become social forces outside medicine proper, which is equated with medical theories. Hence, there was a danger that interests were deemed, above all by those hostile to social constructionism, simply social trappings, irrelevant to the real business in hand. Even those sympathetic to social constructionist approaches tend to treat interests as independent variables or as simply economic at their base. For instance, Malcolm Nicolson's interesting argument about the social construction of pathological ideas in the eighteenth century, presents a particular theory—metastasis—as serving, in his words, "business interests."[42] Admittedly, he does widen the scope by referring to the metastatic theory as "a tool of professional interest and social control," but even here a sense of instrumentalism is conveyed.[43] All too easily the result of giving priority to interests is mechanistic explanations. This is not to deny the importance of interests, only to suggest that we develop more complex models of how they work, especially given that individuals and groups have innumerable actual or potential interests, some of which may be at odds with each other.

The growing concern with religion among historians of science and medicine has proved especially effective in opening up this issue.[44] We can identify a spate

of work—for example by Margaret Jacob, Jim Jacob, and Charles Webster—which insisted that religious-cum-political concerns (for these two could not be separated) shaped the content of medical and scientific beliefs and practices.[45] Thus the precise variety of Christianity adopted and the manner in which this was integrated with assumptions about political power and legitimacy was virtually the same as the form of natural philosophy that was favored. I say Christianity because the most compelling writings in this genre have concerned seventeenth- and eighteenth-century England. This approach is still evident in recent work.[46] For instance, in his article in *The Medical Enlightenment of the Eighteenth Century*, Robert Kilpatrick pays particular attention to the Quaker John Coakley Lettsom and his medical-cum-philanthropic activities. Speaking of dissenting physicians in late-eighteenth-century London, he states, "I will show that it is possible to account for their medicine—and the institutions and societies they founded to advance it—in terms of their religious and political beliefs."[47] He mounts a compelling argument, which shows the complex role interests, interpreted not just in professional terms but as religious-cum-political commitments, could play in medical practice and organization. Yet Kilpatrick also says, "Lettson was a Quaker first, a physician second and a philanthropist third."[48] What kind of claim is this? Biographical perhaps? About depth of commitment? And what kind of evidence sustains it (no footnote is given)? I feel uneasy about this disaggregating of variables. Does the reified concept of interests, as it is generally employed, serve well the social history of medicine?

Interests are generally used to link the content of beliefs with biographical attributes. One problem is that historians of medicine have relatively few detailed modern biographies to draw upon, in marked contrast to historians of science, who have become eager biographers especially over the last ten years or so.[49] A larger and more sophisticated biographical literature would enable scholars to provide more precise reconstructions of the relations between the constituent elements of the lives of medical practitioners.[50] Although a traditional form of scholarship, biography can help with other interpretative challenges thrown down by social constructionism. A specific example may help.

Take William Hunter (1718–1783). His ideas about the anatomy and physiology of the human body and about how these should be taught and represented were shaped by his institutional situations (teaching anatomy in his own school and in the Royal Academy) and by his collaborations with other medical men, students, artists, printers, and engravers. They were also molded by the multiple patronage relationships he experienced, both as client and as patron. It is by no means irrelevant to his medical work that he was an influential art collector, that

he sat for the court painter Allan Ramsay, or that his artistic connoisseurship enabled him both to work with highly skilled artists, engravers, and printers in producing his obstetric atlas, and to articulate the aesthetic vision that lay behind it. Thus, a full biography would provide significant insights into the relationship between medical practice and court life, the patronage networks of the period in medicine, politics, and the visual arts, medicine as a business, the relations between different professional groupings and their institutional bases, collaborations between artists, anatomists, and printers, and so on. Some of this is known, but the larger picture has never been drawn together in a systematic way.[51] It could be said that Hunter is atypical, but in fact he was by no means unique in the wide number of ways in which his medicine articulated with institutions, professions, and elites, indeed with many aspects of polite society. How can we judge him and his works until we have a range of studies of medical contemporaries to use as comparisons and to generate models of how knowledge was shaped? It would be possible to mount a similar argument for Sir Charles Bell (1774–1842).

The second issue that arises, then, is context. Context is not precisely the concept we need because it has dualistic connotations. In pairing context with content, the implication is that although related, they are distinct. As a result, affinities with the couple internal/external can be evoked, which is unfortunate and misleading. Nonetheless, context is the best available term. I have suggested that biographical studies, because of the sharpness of focus they can achieve, are capable of providing a more elaborate sense of context, of how things were seen at a given time and place—the equivalent of Michael Baxandall's "period eye."[52] Of course there are many other ways of generating context; the most successful studies of institutions can have the same effect, as can studies of specific conditions, illnesses and diseases, specialisms, and so on. By tracing as many of the threads as possible that lead from and to any given medical focus, by being conscious of doing so, and by conceptualizing the relationships discovered in this way, social constructionist approaches to medicine will be enhanced. There is a difficult balance to be achieved here between drawing in a context so specific that the findings do not readily bear on any other case study and using a schema that is not detailed or particular enough to have explanatory power.

The third issue is chronological specificity. Those who work on the twentieth century tend to think about context quite differently from those doing research on, say, the seventeenth century. A notion akin to the period eye can be particularly helpful because it is designed to elicit what is special about a given historical setting both as a whole and in nonteleological terms. Teleology still dominates the social history of medicine—even if we reject triumphalism, what is

about professionalization and state intervention, makes the assumption that medicine moves toward a modernist goal almost irresistible. One positive outcome of paying more attention to conceptualizing chronologies specifically in relation to medicine would be that, at last, we could have survey histories of medicine written in thoroughly social terms. Furthermore, the frameworks such writing would produce could constitute a first step toward generating a serious comparative literature in the field. It is fair to assume that the resulting histories would have a quite different shape from the more fragmentary accounts we have now. This will only be possible, however, if research on all historical periods is actively encouraged. The general drift of historical fields seems to be toward the study of the recent past; while this is understandable, it can lead to the loss of a bigger picture. Detailed historical work in the social constructionist mode has tended to take the form of case studies, which enhance our sense of period specificity, but there is no logical reason why it should not also deploy other frameworks that are more ambitious in their chronological, and geographical, scope.

The final interpretative issue is the use of models. Because of its closer links with philosophy of science, the history of science has had a range of models of scientific processes and scientific thinking to draw upon, and has on the whole been enthusiastic about "testing" such models in detailed historical research. This then predisposed the field to consider models from anthropology and sociology. The journal *Social Studies of Science* shows how especially those looking at contemporary natural science and technology have adopted this strategy. But it has appealed less to social historians of medicine, with good reason. The mismatch between model and case study can be a problem; often, convincing "translation" between the two is difficult. Hence, it seems attractive to use a more eclectic approach, to proceed more in terms of grounded theory than in terms of models, strictly speaking. Yet there is a case to be made for the use of models, not so much for the purposes of prediction, but more loosely as heuristic devices. Rather than turning to other disciplines for models, historians should be more active in generating their own. The "Me Tarzan, you Jane" approach that was once common, whereby historians provided data for a macho theoretical domain to crunch on, has long gone. Indeed, a few historians of medicine have written in such a way that their schema could be applied to other cases.

Historiographies of Science and Medicine

In turning to further examples, both of work done and of areas for future research, I want to come back to a topic that has run through this paper—a compari-

the differences between the history of science and the history of medicine were partly explainable in terms of differences between the two domains that have been identified with increasing clarity by some recent scholars, who would argue that they hold true across a long time span. The key to this lies in two related aspects of medicine. First, a very significant proportion of most populations have experienced medicine at first hand through social interactions with practitioners of one kind or another. Second, these interactions had an immediate significance for them, which was understood in the most intimate terms of bodily well-being, as well as through the languages and images that pervade societies.[54] Thus, in most societies, matters of health and sickness were far more dispersed, commonplace, and immediate than any aspect of science. In this respect, the history of medicine is more akin to the history of technology than to the history of science, hence the approaches found in the journal *Technology and Culture* and in radical writings on technology might be of particular value to social historians of medicine.[55]

One result of the dispersed, socially integrated nature of medicine is that certain kinds of historiographical approaches, especially those that are localist in character, are easier to develop. This partly derives from the nature of the primary sources—aside from official and semiofficial sources, they consist of numerous scattered and fragmentary references. Work is only just beginning on the almost infinite number of relevant materials in local archives. These generally relate to three aspects of medicine: the lives of practitioners, the experiences and behavior of patients, and the interaction of medicine with agencies that operated at a local level, such as the law, charities, the church, and relief of the poor. Other kinds of archives can be equally revealing. For example, the eighteenth-century State Papers Domestic in the London Public Record Office contain references to medicine when it impinges on government business—plague on mainland Europe or the serious illnesses of politicians, for example. The riches of the Public Record Office at Kew in relation to medicine are slowly coming to light. It is now becoming clear how valuable a source newspapers can be. One difficulty, however, is that unless a wide range of these materials is thoroughly analyzed, a small number of sources are given a paradigmatic status, as has happened to Ralph Josselin's diary.[56] The need to avoid anecdotalism is paramount. Superficially, there is no necessity for research on such sources to adopt a particular theoretical orientation or to work through the philosophical basis of its claims. In other words, unmodified "localism" might be thought to work perfectly well. But now local studies in the social history of medicine are emerging—Bristol has been particularly well served in this

respect—that reveal the value of a more analytical approach in addressing the issues outlined in the section on interpretive issues.[57]

Historians of science, by contrast, tend to proceed quite differently. Their sources are likely to be more systematic by their very nature; on the whole, they feel the need to spell out their logical maneuvers rather explicitly, and to explain the implications of these for "science." The result, I believe, is that in fact more rigorous work along social constructionist lines has been done in relation to science than to health and medicine; furthermore, the best work on the latter has come from those with an interest in history, philosophy, and sociology of science. Historians of science have been able to endow their writings with a special kind of conceptual coherence that others could emulate. So, despite the differences between science and medicine, it may be that the benefits of research with a strong conceptual focus, a clear sense of the theoretical issues at stake, and a systematic set of models to pursue can be adapted to the medical case.

Much classic work in the history of science has centered on fierce yet apparently clear-cut disputes, such as those between biometricians and Mendelians, Cuvierians and Lamarckians, natural theologians and materialists.[58] This has been effective because a definable set of claims, however complex these turned out to be, could be mapped against other variables: generation, politics, religion, and class. Although medicine is no stranger to controversy, its more fragmentary and dispersed quality makes it less amenable to study through polarized debates, or through processes of discovery, unless the thought processes of practitioners and researchers are to occupy center stage. While laboratory-based medical research can be examined using the scientific model, most medicine is not like this. It is therefore not surprising that social constructionism has worked particularly well in the history of medicine where specific conditions have been studied.[59] These are akin to debates, controversies, or theories in their capacity to act as a conceptual focus, but they are at the same time "dispersed" in medical practice, in cultures around illness, in literature, art, film, and in the social arrangements and reactions the condition elicits. This permits clarity of focus and historical richness to complement each other.

Orthodox Western medicine shares with the natural sciences the centrality of a self-consciously systematic and specialized group of theories. The organization of medical care and medical education embodies, if in highly complex ways, the ideas that lie at the heart of the medical endeavor. Some alternative systems also proceed in this way. This is to reiterate the point that the social history of medicine cannot avoid ideas, whether these are theories, common assumptions, part of a

"collective unconscious," or representations. The social history of ideas, medical or otherwise, remains an underdeveloped field, especially in Britain, and has perhaps been superseded by cultural history, which has never enjoyed more interest than it does now.[60] Yet distinctions between the two fields may be made. A social history of ideas would examine how ideas move about in societies and do justice to esoteric and highly technical ideas that enjoy a more restricted existence. Culture, however difficult it is to define, is more than ideas. The so-called new cultural history is not engaging with difficult ideas in the same philosophical depth as did scholars in the Lovejoy mould.[61] Nonetheless, if ideas are given due prominence, some form of cultural history will probably generate the most productive approaches to science and medicine, but it will need to be a form capable of analyzing ideas and social processes together. There is some evidence that this is beginning to happen, partly because cultural history is an umbrella under which literary critics with an interest in the social history of medicine feel comfortable.[62]

Processes

It has been implicit here that we need a historiography capable of explaining the imaginative reach of ideas of health, healing, and sickness. Medical ideas inform how people experience those states, react to them, act upon them, and construct their significance. These ideas have a primal quality in two senses: they underpin experiences and actions, and they are deeply embedded in our consciousness and hence only partly available for conscious manipulation. The challenge is to explain how such ideas change and to resist the temptation to attribute uniform beliefs to large groups of people. If we take this to be an area for cultural history, it may become easier to see how the processes through which disease construction takes place can be disentangled. Cultural history is a broad church that can encompass a wide range of methods and approaches, including attempts to do justice to the "collective unconscious" around health and disease. Models can accordingly be developed, their exact form depending on the period and the condition in question, whereby the interactions between a number of domains can be conceptualized. The range of interactions is likely to be formidable, and they will only make sense if the verbal and visual languages that mediate them are deconstructed. This is likely to work well where there are shared languages of health and sickness, and conditions that can be or have been fairly clearly defined.

There can be no doubt that social constructionism has represented a significant historiographical advance. In the absence of any coherent alternatives, we

have no choice but to test its potential to the full. Its great contribution, I suggest, has been to make historians think much harder about processes and interactions that were previously invisible, denied, or thought unproblematic. Three types of processes in particular have come to the fore. The first is often summed up in the phrase "the patient's perspective," but it is really more about understanding what goes on between patients and practitioners.[63] The supposition that patients were absolutely or even relatively passive has lost credibility, and it is precisely in contexts where patients had a certain economic bargaining power that it has been easiest to study these dynamics. Expanding the range of sources and interpretations used to explore these relationships must be a high priority.

The second concerns the ways in which divisions of labor are shaped and reshaped. I am using "division of labor" loosely here to include distinctions between mental and manual work; definitions of discrete skills; the divisions found in organizations, specialties, and disciplines; and the social and cultural forms they give rise to. Work on earlier periods has shown how very specialized many practitioners were.[64] Over a lifetime, even a person of quite modest means would be treated by many different hands, especially if we include those from whom they bought remedies, where, as Pelling has reminded us, the very idea of a remedy was extremely loose, often inseparable from cosmetics.[65] Overt competition between practitioners, in the eighteenth century for example, was fought out through definitions of quackery and over the issue of specialization. The situation reveals how central the division of labor was to negotiations about the nature and causes of illness and about therapy, as *Health for Sale* demonstrates.[66] The amount of time, money and effort expended on occupying the medical high ground indicates how fragile and labile everything to do with medicine was and how elaborate the processes were through which "proper," orthodox medicine was contested and constructed.[67]

There is indeed a kind of division of labor here, although very different from the one that is found in, say, late nineteenth-century Europe. Since the division of medical labor followed strikingly different patterns in North America, there is a significant opening here for comparative history. Indeed, social constructionism implies a comparative method, since a single instance or case study is a rather weak way, logically speaking, of demonstrating the claims upon which social constructionism rests. Knowledge and skills are molded by shifts in the division of labor—most obviously, the changing relationships between nurses and doctors have, since the late nineteenth century, demanded constant shifts in definitions of care, in the apportionment of skills, in the understanding of danger and risk, in "patient management," and in the social relations of medicine more generally.[68]

Along with paying greater attention to the division of medical labor would go more careful analyses of the full range of medical occupations and of the processes of specialization.[69]

The third type of process concerns the cognitive dimensions of medicine, especially the processes whereby health and disease are conceptualized. Many parts of a society contribute to such processes, which are often worked through in popular culture, advertising, art, and literature, as well as in the more obvious areas such as politics and policy-making around health issues. Social constructionists will want to look more at the cultural resources available for fashioning medicine. It is an approach that works especially well for the visual dimensions of clinical work. Medical practice is visual at its heart; hence, it would be to ignore a central historical issue not to study how looking shapes virtually all aspects of medicine.[70] The centrality of visual experience in medicine demands an interdisciplinary approach, learning from art history, film studies, and cultural studies. While social constructionism nurtures interdisciplinary history, it does not necessarily involve imposing frameworks from other disciplines on historical materials.

Of particular importance for the future will be the integration of the "top-down" approach that is so often implicit in social constructionist methods with "bottom-up," localist ones. I have suggested that focusing on specific conditions, although not necessarily or only on diseases as defined by official medicine, is one way of bringing these two rather different styles of analysis together. In effect, this achieves another important goal: a historical analysis that both explains even the most technical, arcane aspects of health and medicine and does justice to the pervasiveness of medical languages and ideas, by conveying how, when, and why they elicit reactions.

Social constructionism is a valuable perspective for historians of health, medicine, and healing. Far from neglecting material life, it is the only approach that integrates this with ideologies, images, ideas. It is effective partly because it eschews the rigid polarities that weaken other approaches: here, theories and archives are totally compatible; here, ideas are not separated from practices; here, an emphasis on process undercuts unproductive distinctions between internal and external factors, content and context, good and bad science. There is an important difference between a social history of these questions, which implies few theoretical claims, and social constructionism, which does. Because practices surrounding healing and sickness are so dispersed, there is a danger that untempered localism will lead to anecdotal history. Another possibility—subsuming such matters under a nonmedical rubric—religion, social policy, charity (the most favored alternatives)—may work in particular cases but perhaps loses us the chance of seeing how health and illness work across a whole society. This is surely important since medicine generates some of the most powerful vehicles for disapproval and approbation, for expressing moral values in naturalized forms. When images of disease and of health are potent (when are they not?) not just in relation to individuals and to collectivities, but to nations, even continents, a method for analyzing ideas is essential. Certainly, social constructionists emphasize ideas, not to deny the importance of everything else or to exaggerate the influence of elite groups, but because they have a vivid appreciation of their primal power. Ideas are primal by virtue of their capacity to act as mediators, to shape both conscious and unconscious experience, and to play a dynamic role in organizations and social life. Uncovering the fully social and cultural nature of medicine in all its facets requires a historical approach that takes ideas, be they about health, illness, or healing, very seriously indeed. So far, only social constructionism has applied for that job: the future will consist of seeing how well it performs in it.

Afterword

In rereading what I wrote in 1995 about the social construction of medical knowledge, I am struck by how many themes were later developed in *History in Practice*.[71] Although in the book I sought to speak of historical practice more generally, the ideas developed earlier, specifically in relation to science and medicine, became central. One conclusion I draw from this is that, for reasons mentioned in the chapter, we had no choice but to think through a wide range of conceptual issues in relation to the history of science and of medicine that turned out to have wider applicability.

My book is considerably more explicit than this essay could be about how we understand historical fields. In it, I suggest that we always need to be historians of our own practices, to understand their moments of origination, their life histories. I also discuss the professional investments in journals, the names of fields and subfields and institutional arrangements. Thus, we should see that notions such as "social history" and "cultural history" are more or less convenient labels and that we use them to effect other kinds of business, such as affirming professional identities. What they refer to is underdetermined. When I wrote this essay I held a position in cultural history, a field that was then receiving a lot of attention. While I do not think that its allure has gone away, to me the idea of cultural history has shifted in its significance. I still think of myself as a cultural historian, but that is no more than a convenient, sheltering umbrella. A huge shift in my professional practice occurred in 1996 when I took up a post in art history. Since

then, I have given careful consideration to the relationships between these various forms of history. That is a topic in its own right, but here I want to signal that this change of disciplinary location has made me acutely aware of how important what we call "social history" is.

Art, like science and medicine, has some chunky concepts at its heart, as well as a distinctive type of aura and its own elaborate gatekeeping mechanisms. All these phenomena are social—although that may not sound like a particularly strong claim. In fact, it is shorthand for the careful attention to practice and process that this chapter advocated. Since writing it, I have become a lot more interested in networks, including in medicine. The work I have done on portraits of medical men has demonstrated their value for me most vividly. Their specifically *cultural* density can only be fully released through carefully building up a *social* account. That is, in order to understand what and how they mean, it is necessary to know and to piece together intelligently a great deal of social information about patronage, commissioning, sitting, owning, and displaying. Medical institutions paid a great deal of attention to these activities, and they need to be charted painstakingly. Then it becomes possible to appreciate the cultural richness of the items of visual and material culture that they owned, their capacities to carry associations and lineages through which individual and collective medical identities are forged.

This example is designed to illustrate the point that social and cultural history are natural allies and that nothing is to be gained by drawing too strong a distinction between them. I can perhaps affirm the broader point by mentioning the status of economic history, which has been declining over the past twenty years. The fact is that this field, a bit like social history, is not seen as exciting as it used to be. I realize this is a generalization, but markers such as student demand bear me out. There are quarters where more "empirical" fields, as well as fields that are perceived to be old-fashioned and even abstruse (as is sometimes claimed about economic history), have become dowdy. It is commonly assumed too that interdisciplinarity and theory are somehow "good." I want to refuse those polarities. The social constructionist approach still has much to offer precisely because it does engage with the complexities of historical detail; because it can find, if you like, the cultural in the social; because it is flexible enough to see that, without warm engagement with human practices, theory is no good at all. All I might add is that for historians of medicine, material and visual culture are likely to be become increasingly important, not out of some abstract commitment to being interdisciplinary, but because (like medicine itself) they lie right at the heart of social-cum-cultural worlds.

NOTES

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Making Meaning from the Margins

The New Cultural History of Medicine

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Once I'd hit on the phrase "making meaning from the margins" as a way of encapsulating the project of cultural history, it annoyed me even though it captured my thoughts quite economically. My title irritates me because it points to a tendency in cultural history toward fetishizing the marginal that invites caricature as the history of the weird or bizarre. A friend and I were working in the British Library and met up for tea, and he told me he'd seen a book and immediately thought of me. The book was an early history of embalming. What could I say? Cultural history has attracted a fair amount of hostility, some of which comes from its predilection for the marginal or the transgressive (just as social historians were often attracted to the category of deviance), and I don't want to provide ammunition for further attack. In this chapter I want to explore how cultural history and the history of medicine have intersected, and I want to proselytize about the possibilities for new work that cultural history affords.[1] As will become clear, this is preaching from the converted. I began my historical career as a social historian committed to "history from below" and have, along with many others, become as interested in cultural processes as social ones. In part, this chapter gives me the chance to reflect on how we got here and what we may have lost as well as gained in the process.

What Is This Thing Called Cultural History?

By cultural history, I refer to the boom in historical scholarship influenced variously by anthropology, cultural materialism, the history of *mentalités*, and so forth that took off in the late 1970s and 1980s. That was the moment when what Donald Kelley has called the "old cultural history"—the history of high culture—became "old."[2] However, what makes "old" cultural history old is not just its attention to the production of canonical aesthetic or artistic works but also its methods. In what follows, I will highlight some of the methodological characteristics of new work in the cultural history of medicine, emphasizing the shift from social to cultural histories.

When I'm in an irreverent mood, I sometimes define cultural history as "the intellectual history of the semi-literate and their friends." Those who tease me about writing the history of the seventeenth-century equivalent of the sensationalist tabloid *Weekly World News* endorse this definition. In more serious moments, I argue that the core of cultural history is its attention to the making of meaning—to how people in the past made sense of their lives, of the natural world, of social relations, of their bodies. This definition suggests that meaning is not inherent, that it does not reside within a text or a practice, waiting to be called on. Meaning is not uniform or transhistorical or even apparent. It must be made, and "making" is not an easy or simple process; it admits of struggle, perhaps even of contest. Meanings that are made can be unmade and remade. On another level, "the making of meaning" can, in postmodern fashion, point to our own making of history itself. All of these aspects of "making meaning" imply that we must think about methods as well as topics.

My jokey definition about the intellectual history of the unintellectual, however, contains a grain of truth. Cultural history can be understood as an attempt to take some of the methods and questions of intellectual history (Why did he think that? Where did she learn this?) and apply them to members of social groups whose thoughts had not previously been considered of historical interest. Carlo Ginzburg's *The Cheese and the Worms* (first English edition, 1980) is paradigmatic of this attempt, as it is of so much else.[3] A heretical miller's thought is analyzed with great care—What books did he read? How did he frame his cosmology? With whom did he talk? Why did he think what he did?

This intellectual history of developments and prospects in our field is also a more personal story of generational change. I am at a kind of midpoint both in my career as a historian and in understanding where cultural history fits into the

larger field of history. I was trained in the heyday of the social history of medicine by one of its leading practitioners, Charles Rosenberg. My first book was a study of health care for the poor in eighteenth-century Bristol, a tale influenced by Rosenberg's compelling analyses of social dimensions of nineteenth-century hospitals, as well as by a "history from below" commitment derived from social history more generally.[4]

But now I'm working in a different mode and in a different time. My current project is a study of women's bodies in cheap print in early modern England, an exploration of how women's bodies became a cultural site for the articulation and discussion of historical changes such as the Protestant Reformation and the English Civil War. Some of the same concerns that motivated my first book drive this one: How does power work in minute and quotidian ways? How does the human body (or ideas about it) work within these microstructures of power? How does the inside of the body get imagined, diagnosed, and described when patients and practitioners have to rely on the outside of the body for information? But some concerns are new: What is being female and how do its meanings change? How do gender relations structure our imaginings of our own bodies? Are gender relations a pivot between political change and ideas about the body? In part, like many a midlife practitioner of any art, I'm experiencing the never-graceful transition from young Turk to establishment figure. Also, however, I am bothered that the commitments that exercised me and many of my contemporaries are quite alien to our students. I worry that my bright and talented students do not seem to have much of an idea about what the category "the social" might entail and explain.

Let me clarify what I mean by this generational change with a reminiscence. I recall quite clearly when I experienced an "a-ha" moment about the potential power of cultural analysis, but that insight was grounded in the minutiae of social history. In my first book, I had made extensive use of accounts generated by overseers of the poor under the Old Poor Law, England's pre-1834 welfare system. Each parish collected a tax or a "rate" and then disbursed those monies to the "deserving" poor. Social historians were acutely aware of the many ways in which the category "deserving" was constructed and reconstructed over time. My focus was on the health care aspects of this system and the ways in which the Old Poor Law made fairly generous provision for medical care for the poor. In the days before laptops, I reconstructed all of the payments made by one parish on a series of index cards, one card per recipient. I argued that medical care was an important component of social welfare and that welfare often provided for life-cycle exigencies. Welfare propped up families in trouble because they had too many young

children and a sick head-of-household or assisted an elderly widow whose children could not provide for her. My analysis was primarily social, grounded in the demographic facts I gleaned from parish registers of baptisms, marriages, and burials.

Sometime after finishing the book, however, I happened to read an essay by Leonore Davidoff in which she remarked in passing that the ideology of separate spheres was not just adumbrated in prescriptive literature but was also embodied in legal codes such as the New Poor Law of 1834.[5] All of a sudden, I saw the social facts in my account books as cultural constructions. On one level, the overseers were dealing with social problems, often created by demographic mishap: children suddenly orphaned, unwed mothers deserted by men who had promised marriage, and elderly people unable to work were supported by their neighbors through the redistribution of very local resources. At another level, however, the overseers were performing and enacting ideas about what "the family" was. By providing resources to those whose families were dead or gone, the overseers propped up the idea that the family, headed by a male breadwinner, was the basic economic unit of society. The overseers, in effect, created a temporary fictive family when they hired an older woman to cook for, clean, and nurse a sick man who lacked a spouse or paid the indenture for an orphan girl to be apprenticed to learn housewifery. They created more permanent families when they urged a man to marry the mother of his child or got the midwife to question an unwed mother in labor about the father of her baby. Their efforts thus underwrote intact, "real" families by creating substitutes for those that were lacking. At the same time, they reproduced a particular idea of "the family" through their disbursements of shillings and pence.

In what follows, I will emphasize this transition from social to cultural history as a means of clarifying what cultural history is, and as a reflection on the gains and losses attendant upon this shift. Of course, the division between social and cultural histories is not as clear-cut as my analysis will suggest. Carlo Ginzburg's germinal book was written as social history, explicitly oriented toward debates about the existence of a genuine popular culture that could be distinguished from an elite culture's attempts to squash it or reform it. Two essays by Margaret Pelling illustrate how cultural analyses have begun to occupy the space formerly inhabited by social histories of medicine.[6] In the first essay, which appeared in 1987, Pelling questioned the "rise of the profession" narrative that characterized early modern medicine as a few forward-thinking College of Physicians members lost in a kind of netherworld of ineffectual and superstitious practitioners. Practitioners, she showed, moved in and out of medical work, apothecaries for instance

doubling as grocers, spicers, and cosmetic salespersons. Hers is an exemplary social history that looks at ordinary practitioners and questions the sociological category of "profession."

In her subsequent (1996) essay, Pelling explored the rich set of meanings associated with medical work, and came to some unexpected insights. She argued that issues of status for medical practitioners were intimately related to questions about gender. In her discussion of the elite of practitioners, members of the College of Physicians, she illuminated many status and gender ambiguities, which may help us to understand some of the actions and behaviors of this group. The College of Physicians was resolutely all male, but its image was one of a certain gender ambiguity and effeminacy. The college distanced itself from the masculine world of guilds and political participation in the City of London, linking its fortune with the court through the membership of royal physicians. But court physicians occupied a curious niche; they were part of the royal household, and throughout the long reign of Elizabeth such body-servants tended to be female; on the accession of James I, court culture as a whole was characterized by gender ambiguities, as male favorites of the king vied for power. So, too, service was increasingly feminized. Pelling shows how cookery, long linked with physic, became associated with foreign cooks, luxurious and decadent food, and thence a certain effeminacy. Physicians' presumed familiarity with poisoning linked them with a method of killing seen as sneaky, underhanded, and quintessentially female. A medical practitioner, in other words, even one socially demarcated as a member of the College of Physicians, did not occupy a fixed social identity. Rather, he negotiated among an array of possible representations, from cook to spy, confounded by gender and status ambiguities that would only begin to be resolved over a century or more. Pelling's later essay is a good example of a cultural history that examines meaning as it was constructed by historical actors. Those meanings are not obvious—I for one had never thought about the womanly connotations of a physician's work, let alone the ominous court doctor/poison subtext.

With the clarity of hindsight, cultural history's ascendance seems overdetermined. Often, the publication of Clifford Geertz's *The Interpretation of Cultures* in 1973 is taken as a kind of germinal moment for the creation of cultural history, and it was certainly the anthropology book most likely to be seen on a historian's bookshelf when I entered graduate school in the early 1980s.[7] Historians took from Geertz the idea that an event could be read like a text, that a riot or a parade or a massacre of cats or other nonliterary production had symbolic meanings that a historian could recover and analyze. At the same time, however, English Marxist

historians were also coming to an interest in the symbolic aspects of social interactions. The noted collection *Albion's Fatal Tree* (1975) included a discussion of the ways in which the English ruling classes used the criminal courts as a kind of theater of power, reproducing social roles through symbolic means.[8] French Annalistes had been developing sophisticated analyses of mentalités, arguing about the nature of the category "popular culture" while doing much of the work that made it a category worth arguing about. Italian historians, such as Ginzburg, created the form of "microhistory," a close study of one particular person or event, often interpreted in relation to a large body of similar examples, such as Inquisition cases.[9]

These various strands converged in Anglo-American historiography, and along with a new commitment to thinking about the role of language as productive rather than reflective (the so-called linguistic turn), created the conditions for the inauguration of the "new" cultural history.[10] The 1984 publication of the collection of essays entitled *The New Cultural History* can serve as a marker of the subdiscipline's arrival.[11] When I told a friend that I was writing an essay on cultural history, he muttered something like "well, aren't we all?" In a sense, he is correct. The kinds of social history or intellectual history that dominated history-writing twenty years ago are rarely encountered in their pure forms anymore. It is as if aspects of social and intellectual histories have collapsed into each other.

However, when I say that I am proselytizing for cultural history, I mean something more specific than just this middle ground created by the intersection of social and intellectual histories. In what follows, I sketch out three aspects of a "new" cultural history that seem most pertinent to historians of medicine: the making of meaning, the shift from pattern to process, and an attention to forms of storytelling, including lapses, errors, and omissions.

Cultural History and Medical History

Before turning to these themes, however, we need to look more closely at the history of medicine's recent trajectory, which is somewhat peculiar in relation to cultural history. Cultural history has been especially significant to two areas of the history of medicine: the sociology of disease and the history of the body. In the 1970s, sociology was often the paradigm other discipline to which historians turned, be they students of urban riots or of behaviors in a scientific laboratory. The sociology of knowledge provided historians of science with a sword to cut their ties with internalist accounts of scientific developments. Their work was influential in histories of alternative medicine and ideas about disease.[12] I spent

the entire first year of graduate school completely under the spell of Steven Shapin's phrenology articles, in which he showed how the structure of the brain, as understood by phrenologists, was a correlate of their understanding of the social world they inhabited.[13] My first few graduate school papers tried to find other examples where I could make bodies and social structures so tidily parallel.

Not surprisingly, historians of medicine began to apply the kinds of deconstruction of scientific knowledge practiced by Shapin and others to disease categories. Some of this work was "soft" in the sense that it looked at "easy" diseases, such as masturbation and neurasthenia.[14] I do not mean "easy" or "soft" pejoratively; these essays were important to me and provided me with many happy hours of teaching. Instead, these adjectives point toward a kind of Comtean hierarchy, in which it is assumed (rightly or wrongly) that it is easier to show social forces shaping the knowledge of botany or phrenology than that of particle physics or radio astronomy. Essays in Wright and Treacher's 1982 collection, *The Problem of Medical Knowledge,* however, moved away from "easy" diseases to ones like miners' nystagmus, asthma, and genetic diseases.[15]

Charles Rosenberg's 1992 collection *Framing Disease* can be read as a reply to the social construction of disease that proposes a cultural model in its stead.[16] Rosenberg defanged the social construction of disease by claiming that it is a tautology, "a specialized restatement of the truism that men and women construct themselves culturally." He then did the same with the phrase "social history of medicine," saying that "every aspect of medicine's history is necessarily 'social.' "[17] He went on to fault the social construction of disease for focusing on a handful of culturally resonant diagnoses whose biological basis is unknown or contested (those "soft" diagnoses). Moreover, he dismissed a social-construction-of-disease model because he claimed it partakes of an outdated understanding of the ways in which knowledge circulates socially, casting purveyors of knowledge as agents of oppression.[18]

Instead of "constructing" diseases, Rosenberg chose what he considered to be a less-charged metaphor of "framing" diseases. He elegantly outlined the different ways in which disease entities are social players, for an individual sufferer, for a healer, and for social critics. In an interesting move, he talked about Owsei Temkin's germinal 1963 essay in which Temkin explained ontological vs. physiological models of disease and then put Temkin into dialogue with Arthur Kleinman, particularly on the topic of Kleinman's emphasis on the difference between disease (that entity understood by medicine) and illness (what the patient experienced).[19] Every year in the survey course, I write "ontological" and "physiological" on the chalkboard and, in a different lecture, "illness" and "disease," but until I reread Rosenberg, I had not thought of them together. Rosenberg is interested in the messy parts in between: the spaces between a practitioner and her patient, between the patient's family and a practitioner, between an institution and practitioners—those places where disease concepts "mediate and structure relationships." In many ways, what Rosenberg proposed is a fuller social understanding of disease that takes the practice of medicine seriously, rather than a "new cultural" history, but the richness of his model reminds us that "cultural" and "social" are heuristic structures, not exclusive commitments.[20]

The cultural analysis of disease has taken on a life of its own, distinct from the kinds of analysis pursued in *Framing Disease.*[21] In a 1996 essay, Colin Jones argued that we have lots of social histories of the plague but we lack an understanding of the meanings of plague. Interestingly, both Jones and Rosenberg point to a tension between historians' emphasis on bursts of infectious diseases compared with more quotidian miseries, such as chronic illness (Rosenberg) or infant mortality (Jones). Jones's mission was to "chart the metaphors and symbols" in the chief site where plague was discussed and debated, namely plague tracts. He worked with 264 of these books, many of which, as he acknowledged, are massively repetitive and even "arid." In other words, Jones explored the symbolic dimensions of the plague, rather than focusing on the patterns of transmission or the ways in which the disruptions of epidemic disease reveal social structures. Three languages characterize these texts: the medical, the religious, and the political. Jones argued that in the mid-seventeenth century, religious and medical discourse about the plague begins to converge toward a political script written in the language of high absolutism. However, Jones did not want to argue that this phenomenon was merely the triumph of the absolutist state *tout court.* Instead, traffic was "messy, complex, and two-way."[22] The state, for example, adopted the medical method of *cordon sanitaire* (quarantine enforcement to stop waves of desertion from the army). Both absolutism and the plague shaped each other.

The second aspect of the history of medicine that has a particular relationship with cultural history in its larger sense is the history of the body. Here, the relationship is largely one of absence. Most historians of medicine have shied away from considerations of the body as a cultural site, for reasons that I do not fully understand, while most of the history of the body has been written by literary scholars such as Jonathan Sawday or by historians who do not think of themselves as "medical," such as Caroline Bynum.[23] Thomas Laqueur provides a kind of crossover example. His first book was a social history of Sunday schools in nineteenth-century Britain. Even in his early days, the body beckoned; he wrote an essay on bodies, death, and pauper funerals published in the first number of

Representations (1987). When he wrote his blockbuster on the body, however, he situated himself within medicine—explaining how he attended the first two years of medical school—rather than in its history.[24] Ludmilla Jordanova's *Sexual Visions* or Katharine Park's essays on bodies, death, anatomy, and sexuality show us how the history of medicine and that of the body can each inform the other.[25] In each case, the author's deep knowledge of medicine makes a history of the body that helps us break down interpretive barriers between analyses of "medical" and "nonmedical" bodies. Barbara Duden's book is another of the rare ones that tries to integrate an account of "medical" bodies (those in a doctor's case book) with classic themes in the history of the body, such as the development of the closed, polite, bourgeois body.[26] Too often, sick or suffering bodies seem to be structured completely differently from healthy ones—sick bodies being the preserve of medical historians, while well ones are up for grabs by literary critics, art historians, and cultural studies professors.

Making Meaning: Microhistory and Ethnography

Harold Cook's award-winning book about Johannes Groenevelt tells the story of a practitioner who fell afoul of the College of Physicians.[27] It is a rare example of the explicit adoption of the methods of microhistory by a historian of medicine. Cook cited the classic example of this genre, Ginzburg's *The Cheese and the Worms,* and some readers may feel a tinge of disappointment that Groenevelt does not lend himself to some of the characteristics of the miller Mennocchio. As Cook acknowledged, we have no diaries or intimate letters, no subjective recording or construction of experience, that might illuminate Groenevelt's inner world. We lack the enticing, and sometimes distracting, exoticism of Ginzburg's miller, whose Inquisition testimony revealed a highly individual, not to say bizarre, syncretism.

However, Cook compensates for the lack of these customary microhistorical elements by writing a very personal book that invites the reader to speculate along with the author. It is personal in an old-fashioned way—no postmodern author peeking out of the text at every turn—that is highly satisfying. For example, we cannot know how Groenevelt understood or interpreted the fate that befell him, but Cook reminds us of some of the frameworks available to the Dutch physician. As the author thinks about how Groenevelt's Calvinist notions of the elect or his profoundly classical education might have given shape to his suffering, we too are drawn to wonder about the links between ideologies and individuals. As Cook tells us: "Time takes all things, and no modern magic allows us to conjure up the

real voices or shapes of people from the seventeenth century. All we have left are the words and objects, largely in the form of ink on paper: the tangible signs of vanished spirits. Yet with a bit of sympathy, and a collection of words, we can begin to sense something of the world in which Groenevelt and his acquaintances walked."[28] This interpretive modesty makes the book very appealing. While Cook's narrative talents may remind us of an older generation of scholars, his willingness to write a story with holes and gaps and questions into which we must enter is sophisticated and subtle.

Groenevelt, a learned man and member of the Royal Society, did not fall afoul of the college by accident. Cook shows how Groenevelt, along with Richard Browne and Christopher Crell, sought to reform both therapeutics and medical hierarchies. While experience and experiment were essential to the reformation of therapeutics, Groenevelt and his companions were careful to distinguish themselves from mere empirics when they opened a sliding-scale-fee, group-practice clinic in 1687. This group published *The Oracle for the Sick,* the first multiple-choice popular medical book in English. A prospective patient read questions usually asked by a physician and underlined which of the multiple answers most closely matched his or her affliction; patients with wounds or other external manifestations of disease drew them on the human figures provided in the book. Then the patient brought the book to the clinic, where the physician quickly read it and prescribed accordingly. Not only did Groenevelt openly dismiss the hierarchical divisions among physicians, surgeons, and apothecaries, he also streamlined the clinic's practice in a way that might implicitly criticize the customary detailed and highly individualized personal consultations that were the physician's habit. In lesser hands, this episode would have been read merely as a random moment when the College of Physicians cracked down on one John Greenfield (as Groenevelt was known in England), an unauthorized practitioner, but Cook shows how a web of personal connections, intellectual beliefs, and the political meanings ascribed to them produced this incident.

Although this story is billed as a microhistory, Cook borrows from a range of methods and positions, each of which derives from a different national context. In some ways, its careful explication of an individual life is more like Paul Seaver's reconstruction of the life and beliefs of London wood-turner Nehemiah Wallington than it is a microhistory in the Italian context.[29] Both Seaver and Cook employ a wealth of knowledge about their subjects' contexts, creating a rich miniature of religious or medical ideas and practices, and both are methodologically diverse, drawing on different strands of cultural history to make sense of their subjects. Guido Ruggiero's recent essay on the death of Margarita Marcellini

represents a more canonical medical microhistory in terms of method.[30] Ruggiero has read thousands of inquisition records and uses the breadth of his knowledge to contextualize this one woman's story. When Marcellini died in 1617, witchcraft was suspected. As Ruggiero shows, just when we think we understand what may have happened, there is another layer of meaning, another set of possible interpretations. Was it Margarita's sister Grazimana who had bewitched her, greedy for the return of her dowry to her natal family? Or did she die from the *mal francese,* what we might call syphilis, contracted from her husband? Ruggiero shows us how competing stories can be found in the inquisitorial records, forcing us, like the inquisitors themselves, to make sense of confusing and contradictory signs. We are all engaged in the making of meaning here.

In the American context, microhistory is often blended with or put alongside a home-grown tradition that derives from very different commitments, such as ethnography. Robert Darnton, who taught at Princeton with the anthropologist Clifford Geertz for a number of years, sought to translate some aspects of anthropological method into historical practice. Geertz advocated reading an event like a text, by which he meant pursuing a kind of formal symbolic analysis of something as seemingly evanescent as a cock-fight. Anthropologists, of course, have events to observe, while historians rarely participate in the events they study. The "text-analogy" is thus applied to events recorded in texts, such as Darnton's famous analysis of the cat massacre.[31]

Historians of medicine have not adopted this approach, although I do not know why it has not found more favor. A close reading of a surgical operation, or an anatomy riot, or the ritual of Grand Rounds might be undertaken on these lines. Given the ways in which the practice of ethnography has come under fire in anthropology itself, it may be that the moment for such a methodological borrowing has come and gone.[32] One of the few analyses of the rituals of medicine is Terri Kapsalis's study of the ways in which medical students are taught to perform gynecological examinations. This thought-provoking work is grounded in its author's training in performance theory, however, not anthropology.[33]

From Pattern to Process: Feminism, Poststructuralism, and Appropriation

Another theme in the cultural history of medicine has to do with how categories and concepts are made and remade constantly. This is a shift from pattern to process, from understanding social categories as fairly static entities to analyzing how cultural categories work as ongoing sets of negotiations. At least three quite

different strands of scholarship have promoted an interest in process. First, Judith Butler's work, among others, on gender roles as performance has made male and female into moving targets rather than fixed entities. What used to be fairly static—say, masculinity in early modern London—is now a role or category that is enacted, built, and rebuilt through the actions of thousands and thousands of historical actors.[34] Second, in part due to the so-called linguistic turn, class and race, those other crucial categories of social-historical analysis, have been reunderstood as categories that were constantly being produced and reproduced.[35] A third strand derives from Roger Chartier's germinal 1984 essay on appropriation, in which he argues that consuming a cultural artifact is a form of production, that different groups can and do read the same texts in radically different ways.[36] In this sense, the printing of a ballad is just one moment among many that need to be understood by the historian. The pinning-up of the ballad in an ale-house, the singing of it in the street, the borrowing of its title by a playwright for a "serious" piece of theater, the ballad composed in reply or in parody to the original—again, we have a sense of movement, even instability, compared to an earlier more static focus. These three inspirations for a shift from pattern to process each derive from a variety of historiographic traditions: feminism, deconstruction, poststructuralism, English cultural Marxism, and French studies of popular culture. I feel a certain sense of interpretive violence in wrenching them from their contexts, but the emergence of each has helped to push us toward a much more fluid sense of social process.

Carolyn Steedman's work provides an example of a poststructuralist attention to process and the remaking of identities and categories. In her book *Strange Dislocations,* Steedman explored the ways in which selfhood and interiority became connected to ideas about childhood in the nineteenth century by using the figure of Mignon, the strange child acrobat in Goethe's *Wilhelm Meister,* as a kind of shifting signifier.[37] Steedman showed how a mid-nineteenth century physiological fascination with the topic of growth and development and a subsequent evolutionary turn were the preconditions for Freud's version of interiority, in which childhood lives within us in repressed and forgotten ways. Thus far, we might mistake this for an intellectual history. But then Steedman shifts to an analysis of how these meanings of childhood were enacted on the stage and in the streets of London. For it was in the ceaseless social reporting about poor children and, in the 1870s, the campaign to "rescue" child acrobats that we can see these ideas about childhood being employed and recognized. The fascination with child acrobats, which produced tearjerkers such as *Pantomime Waif* (1884) or *The Little Acrobat and His Mother* (1872), was part of a deeper cultural inquiry into the

meanings of childhood and the connotations of loss ascribed to it. One of the accomplishments of Steedman's book is to focus on the places and processes through which these meanings of childhood were made and remade.

In a very different way, Nancy Tomes's article on the private side of public health shows us this making and remaking of categories that look the same and yet are different—or look different and yet are the same.[38] While both Steedman and Tomes cut their intellectual teeth as social historians, the intellectual roots of their cultural histories are quite different. Steedman's poststructuralist analysis grows from feminist inquiry and cultural Marxism, while Tomes builds on histories of consumption and political identity. Tomes shows how notions of cleanliness and dirt that derived from pre-germ-theory ideas about contagion were deployed by middle-class American homeowners and their wives to try to make their homes healthful. Manufacturers of all kinds of products, from soap to drains, capitalized on this preoccupation. The advent of germ theory did not, as one might expect, radically alter a perception of disease causation based largely on smell. Instead, germ theory was incorporated into older ideas about dirt and disease, and often manufacturers treated germicidal properties as add-ons or improvements to their cleansing products rather than incommensurables. As germ theory was appropriated and folded into an older set of ideas and practices, it was transformed in the process.

Tomes's essay also points toward an area of cultural history that has not yet been much explored by historians of medicine, namely, material culture. Before turning to my third theme of rhetoric and storytelling, I want to make a plea for more attention to the material world. In the past two decades, historians have come to think about the "world of goods" or the history of consumption. At the heart of many of these studies are questions about the ways in which people shape their identities through patterns of consumption. The 1990s, the decade that gave us the paradox of green consumerism, a decade of economic boom for many, saw historians remaking the eighteenth century into a moment of getting and spending, what Roy Porter called "pudding time."[39] Historians of the more recent past have explored the history of advertising and its complex cultural roles.[40]

There are not many histories of the material culture of medicine, but a few examples can suggest the potential for such work. In a fascinating book, Jacqueline Musacchio explores the material goods associated with childbirth that well-to-do Italians of the Renaissance consumed.[41] She gives us a kind of material culture of childbirth, from painted bowls and trays to paintings showing women wearing items of clothing with various significances for fertility.[42] Recently, John Styles has explored the ways in which the patent medicine Turlington's Balsam

was packaged and repackaged in the eighteenth century, how innovation novelty worked in an object as humble as a patent medicine.[43]

Many of these histories of consumption look toward the moment of prod tion rather than the moments of use. It is as if the end of the story is the purch of an item. Other histories of material objects tell us that the moment of acqu tion is only the midpoint. For example, in a fascinating essay, Diane Hug traced the shifting meanings of earrings in northern Italian cities in the la Middle Ages.[44] First, they connoted a kind of exoticism, but they then beca more tightly linked with Jewish women. In some cities, Jewish women beca legally bound to wear earrings, just as their husbands wore cloth circles or so other sign of difference. However, these associations eventually faded too, oft as Jews were segregated in ghettos or banished, in effect marked in other ways. women's fashions came to signify their husbands' wealth rather than their ov female folly, well-to-do women began to wear jewels in their ears. In this story, t production of earrings is largely irrelevant. What matters are the shifting mea ings ascribed to them.

An essay by Sara Pennell shows us how production and consumption might linked to provide a richer account of material objects.[45] She notes that the ov seers of the poor in an Oxfordshire parish redeemed a bastard-bearer's skillet fro pawn in 1727. In this moment, the overseers both sought to return Mary Bass to economic self-sufficiency and to underwrite the household as the unit of mor authority within the parish. A complex set of meanings could be ascribed to commonplace tool like a skillet. But values were also inscribed literally on cooki pots. Pennell gives us an illustration of a pot whose handle read "y wages of sin death" and notes another that said "pity the poor." It was cooking pots that we beaten and rattled in skimmingtons, community shaming rituals directed towa inadequate husbands who failed to rule hearth, home, and wife. Thus, a relative simple material object can be understood as the bearer of multiple meaning some built into the very substance of the item, others ascribed to it or performe with it. Such an analysis might be extended to any number of material objec employed in health and healing.

Earrings and skillets may seem very far removed from medicine, but for th early modern period they are not so distant. Ways of marking the body or th technologies of diet and regimen can point us toward thinking about materia things. Medicine was practiced not just through narrative but with tools. Fo example, I have long wanted to read a good analysis of the illustrations of instru ments in early modern surgical texts. There they are, these fierce-looking weapon that a surgeon must apply to the fragile human body. It is easy to understand tha

the images might serve as patterns for a local smith or metal-worker, but I suspect that they function in multiple ways. Lucia Dacome is beginning a study of wax anatomical models and their makers in eighteenth-century Bologna, building on Ludmilla Jordanova's pioneering study.[46] Much more could be explored in the material culture of medical education—the kymographs and other lab equipment of the early twentieth century, or skeletons so often hung in nineteenth-century American doctors' offices, mementoes of student days.

My plea for a medical history that pays attention to things is part of a larger desire to see what I call meaning and materiality addressed together. Too often, cultural history can seem to float free of any mooring in economic or social aspects of the past. A sophisticated and engaging reading of a text excites my imagination, but so too does an early modern wooden bed carved with elaborate figures (are they Adam and Eve? Who else would be depicted naked?). Living in our "world of goods," when forgetting to put out the recycling creates a mountain of tin cans and glass bottles, it is hard to imagine an early modern house in which almost all the material objects were deeply familiar, items of scarcity that might bear many meanings over their lifetimes of use.

Rhetorical Form: Listening to Stories after the Linguistic Turn

While things have been largely ignored in the history of medicine, words have not. One of the strongest themes in the cultural history of medicine is a new attention to rhetorical form, to the medium as well as the message. In part, an attention to narrative derives from historians such as Natalie Davis, who thought about the ways in which early modern French men and women framed their appeals in a court of law.[47] Attention to rhetoric is also a post-linguistic-turn habit of mind. Once we start thinking that language might be constitutive rather than reflective, we are drawn to consider how meanings are being conveyed through form as well as content. One of the most subtle practitioners of this art is Steven Stowe, who analyzed how ordinary doctors, the ones who were not the leaders of their profession, told stories about sickness and healing that enabled them to make their work, often bloody and unsuccessful, into something meaningful and even redemptive.[48] He showed how articles in medical journals related to other forms of autobiographical writing, such as letters and diaries. In the article on plague by Colin Jones that I discussed above, Jones noted how the style of writing about plague shifted as the threat of plague began to vanish. Writers became more

"literary." Following an argument of Thomas Laqueur, Jones suggested that when suffering bodies were no longer dying of the plague and being dragged off to mass graves, they began to be invoked in texts as a way of evoking feelings—both horror and sympathy—in the reader, who might then engage in some form of humanitarian action.

Like my other two themes—making meaning and process over pattern—the recent attention to rhetoric has been shaped by cultural history's roots in both social and intellectual history. The habits of close reading and attention to modes of persuasion derives in part from the history of ideas, while social history's commitment to history from below has drawn attention to a much larger set of stories and storytellers. These shifts can be seen especially clearly in oral history. Originally, oral history was a part of social history, a practice intended to give voice to the people history had left out. A recent essay by Kate Fisher demonstrates the value of this kind of social history.[49] Fisher interviewed elderly working-class women and men about their contraceptive practices in the interwar period. Surprisingly, the demographic transition seems to have owed much to male rather than female behavior. The women Fisher interviewed often stated that they left all that sort of thing to their husbands. Most strikingly, a woman who had deployed contraceptive knowledge during her first marriage played dumb in her second marriage, feeling that it was not seemly for her to be more knowing than her husband. Most historians and public policy makers have assumed that since women are the ones who get pregnant, they are the most important players in contraceptive use. This assumption, Fisher suggested, needs questioning.

At one point, Fisher acknowledged that she was being told tales shaped by her sources' assumptions about what they should say about this sensitive matter, narratives whose tropes tell us more than just the facts of who bought the condoms. Fisher draws on a school of Italian historians that has developed a rich account of the process of oral history that shows how memory and meaning are intertwined. Allessandro Portelli, Luisa Passerini, and others have inverted the usual quest of oral historians.[50] Rather than looking for the facts, they look for the slippages, the misrememberings, the displacements—what I am calling the marginal. Their claim is that these moments tell us the meanings people ascribed to the events they witnessed and experienced. Their emphasis on the comments that other historians would have discarded as wrong is reminiscent both of psychoanalytic inquiry and of Ginzburg's analysis of Menocchio, the Friulian miller. Menocchio's claim that the world came into being just as worms are bred from decaying cheese was thought just as bizarre in his own day as it is in our own. But

in this moment of misunderstanding, Ginzburg sees a creative process of appropriation and adaptation which tells us much about the possibilities of peasants' mental worlds.

An essay by Lynn Marie Pohl employs this new oral history to explore hospital desegregation in the American South. Pohl shows how her informants shaped their tales to save various phenomena.[51] For example, white doctors who cared for black patients emphasized their blindness to color in individual cases but did not acknowledge the profound inequities in the health care institutions in which they worked. Pohl has much to tell us, and often her analysis of the ways in which her sources' memories are constituted seems too brief. For example, many of her sources conflated two very different changes: hospital desegregation and the advent of what her informants called "high-tech" medicine. Pohl suggests that this trope of pretechnological "caring" medicine owes something to the myth of humane and caring plantation life often popular with white Southerners. I wish she had built an entire article around this insight and explored what it means to make segregation equal to "caring" and "humane" medicine. Pohl's work notwithstanding, the Italian-inspired mode of oral history has not been much adopted by historians of medicine despite some interest in the processes of memory.[52]

For some historians of Europe or North America, issues in oral history can feel somewhat peripheral unless one works on the recent past. Not so for Africanists. Historians of African cultures without written records have developed sophisticated methodologies for understanding and interpreting oral tradition, designed in part to grant oral testimony the gravitas usually assigned to written records. Recently, Luise White has turned these concepts upside down in her study of vampire stories in east Africa.[53] She takes material other historians would have discarded as clearly fictional and asks what it can tell us about a culture. Beliefs that forest rangers and firemen were actually vampires who fed on human blood suggest to White the ways in which some Africans experienced and transformed the traumas of colonial regimes.

Concluding Thoughts, or Wrestling with My Regrets

Throughout the above discussion of three aspects of cultural history—making meaning, from pattern to process, and attention to rhetorical form—I have pointed to a shift from social to cultural histories. Now I want to return to the anecdote I told at the beginning of this essay, my a-ha moment about the Old Poor Law, because it may shed light on the occasional hostility between social and cultural historians. All of a sudden, I had to think about process, about a kind of

struggle between an overseer and a person seeking help. In social history terms, that struggle would have taken the form of a person seeking to demonstrate that he or she was "deserving." The category "deserving" was fairly stable and fixed at any one historical moment. From a cultural history perspective, both parties are negotiating, bringing different categories to bear, invoking a variety of scripts in this encounter. One of the pluses of a cultural history perspective is that we can see how social categories are always being renegotiated as they are enacted: the overseer is maneuvering his ideas about families and dependency just as much as his supplicant is invoking his or her sense of an appropriately "deserving" narrative. Both parties are reproducing a model of the family even as they struggle to compensate for the moments when the model does not seem to be working very well.

Without care, however, the fundamental inequalities between overseer and supplicant, the profound economic injustices inherent in this encounter can be sidelined. My guess is that some of the tensions between social and cultural history come from this sense that something important is being forgotten. Understanding dependency and the category of "deserving" gives us the feeling that we can analyze social injustice and that the analysis might be a step toward challenging injustice. Cultural history does not offer that kind of promise. Its analyses are at once too big and too small. Large-scale cultural structures, like ideas about the family, about gender relations, about work, come into play in unexpected configurations in specific instances. In a sense, the political is deeply personal in relation to cultural history, rather being a more general call to action.

This shift is, of course, a much more general one. I don't know if we are really "bowling alone" in the apt phrase of Robert Putnam—that is, if our communities have become increasingly atomized and privatized as the possibilities of communal action have diminished.[54] But I think we all have experienced a kind of shrinking of horizons of possibility. At some points in the recent past, radical rearrangements of the social world seemed possible, maybe even immanent. Collective action engaged our imaginations and sometimes our feet. Not surprisingly, some of the history that was written then embodied those hopes and commitments. But I don't want to cede all moral authority away from the enterprise of cultural history, to portray it as "Commitment Lite." It does, however, imply a different kind of connection between our work and our lives.

For me, understanding how early modern English women's reproductive bodies came to be sites of political and social contest is a pursuit very closely connected to contemporary concerns. This, my current project, has deep personal significances that I can't quite see yet, although it doesn't take a deep analysis to posit a connec-

tion between my writing a book on constructions of the maternal body with my own reckonings with motherhood and eventual adoption of a son. But it is not solely the personal. The past two decades have seen a curious valorization of "the child" in our culture, accompanied by various policings of women. The balance of social interest in an unborn child versus a pregnant woman's rights has shifted toward the child. (And no, I don't think it's a good thing for pregnant women to do cocaine, but I object to the various American legal remedies that have been employed to jail them as dealers to their unborn children.) All reproductive politics have been confounded by complexities of the legacies of *Roe v. Wade* (the 1973 U.S. Supreme Court case that legalized abortion on demand). All of this may seem quite remote from my arguments about how the Reformation reshaped women's bodies or how the English Civil War problematized women's knowledge of their own bodies, but like most historians, the processes I study in the past are analogous to and suggestive of patterns today. What this kind of cultural history does not do, however, is point us toward collective action. Instead, I see a different way in which historians might matter, such as when a friend of mine gave his twelve-year-old daughter a copy of Joan Jacob Brumberg's excellent book about body image in nineteenth- and twentieth-century America, and she saw herself and her friends in a new way.[55]

What's missing, at least for me, is a kind of indignation or desire for justice. I'd like to conclude by thinking about two exemplary works, one social, the other cultural: Ruth Richardson's *Death, Dissection, and the Destitute* (1987), and Mike Sappol's *A Traffic in Bodies* (2002).[56] Both works address the complex relationships between anatomists, grave-robbers, and the people who feared that they would end up on the dissector's table. Both are grounded in a mastery of rich and detailed knowledge of the nineteenth century. Richardson's book is a social history of anatomy and the impact of the 1834 Anatomy Act in England. She shows, first, how profoundly the emergent culture of dissection violated ordinary people's ideas about appropriate attitudes toward the dead, especially the newly dead. She analyzes the politics of the act, showing how a punishment formerly reserved for the worst felons was now extended to all who had the misfortune to die a pauper in a state institution. She explores forms of resistance to the act and their connections to other political movements, such as Chartism. It is a tour-de-force, taking what had formerly been a triumphalist moment in the history of medicine, when rationality triumphed over superstition and sentiment, and showing that this was a struggle deeply embedded in English politics and class structures.

There are many historical specificities that may account for the difference in Sappol's and Richardson's accounts: perhaps class relations in the United States differed from those in Britain so that the meanings of state-mandated dissection of the poor varied; perhaps the role of popular anatomy in a new republic differed from that in Britain; perhaps the florid array and large numbers of medical schools in the United States compared to Britain made anatomical dissection a different kind of political hot potato. These speculations aside, what makes the two books different is their positioning in relation to the stories they tell.

Like Richardson, Sappol has an ear for a good tale, but he steps back and shows us a story's cultural purchase in a way that Richardson does not. At the very end of his book, Sappol notes briefly that, in 1886, an old woman was murdered in Baltimore and her body sold to the University of Maryland medical school for fifteen dollars. Although widely reported, this story never achieved the "folkloric notoriety" of Burke and Hare, the Edinburgh murderers.[57] By 1886, anatomists were able to turn tales such as these to their own advantage, lobbying state legislatures to pass anatomy acts that would grant medical schools the unclaimed bodies of those who died in state and local institutions. Sappol emphasizes the retellings of this story rather than the story itself.

When I read Richardson, I am drawn into the stories of body-snatching and violation she tells; I am made indignant, angry, distressed. Richardson leads the reader to identify with the poor who were at risk of dissection, both before and after the Anatomy Act. Before the act, it was the bodies of the poor that were likeliest to be "resurrected" from graveyards and it was the poorer class of criminal who was sentenced to dissection; after the act, any pauper dying in a state institution was liable to dissection. Richardson opens the book with a compelling chapter on popular beliefs about the body and death that makes us understand why a criminal might be resigned to execution but plead desperately to avoid dissection. She enlists our sympathies, and those sympathies position us to regard the Anatomy Act with horror.

Sappol's prose is cooler and more detached, and he looks at the effects of the kinds of stories that Richardson embeds her readers within. Sappol can therefore ask fascinating questions about the relationship between the construction of a bourgeois professional self and the role of an anatomical way of thinking. It is not that Sappol is blind to the unjust class politics that granted a poor person's body to a physician who did not risk dissection himself, just that he takes a step back from these stories and looks at how they worked in a variety of realms.

Each book ends on a very different note. Sappol, writing in the post-postmodern moment, leaves us with an open-ended conclusion. On the one hand, things had changed by the 1880s: anatomy's central role in medical self-definition was beginning to cede to physiology, microbiology, and other "laboratory" sciences, while

the newer social sciences borrowed anatomical metaphors and the authority with which they were imbued. On the other hand, as Sappol cheerfully acknowledges, the anatomical body is utterly dominant in Western culture: "The maps we carry of our innards are anatomical and will remain so for the foreseeable future."[58] Thus, newer techniques of self-making, such as the gland craze of the 1920s, often relied on an anatomical foundation.

Richardson's ending is far more poignant. She closes her book with two countervailing moments. She recalls interviewing an elderly man in 1978 who had contributed to a collection so that one of the regulars at his pub could avoid the ignominy of a pauper burial. She connects this deep working-class antipathy to pauper funerals to the violations sanctioned by the Anatomy Act that made what had been a dreadful sentence inflicted on executed felons into a routine deep indignity the state visited upon the poor. She goes on to suggest that three levels of silence have veiled the Anatomy Act from contemporary consciousness: that cultivated by the state bureaucracy in charge of the procurement of bodies for dissection, that of the larger society that does not want to know about the scapegoating of the poor, and last, a deep silence on the part of the working classes themselves. Richardson quotes George Steiner, "What is felt may occur at some level anterior to language, or outside it." She suggests that the profound repugnance for a pauper funeral derives from "the fact that the misfortune of poverty could qualify a person for dismemberment after death became too intensely painful for contemplation."[59] Turn the page, and Richardson implicitly invites her readers to atone for the sins of the past: "Bequests of bodies now ensure that the social injustice it [the Anatomy Act] represented before the Welfare State no longer operates. Should any reader wish to bequeath their body to anatomy . . ." and Richardson gives the address of the Inspectorate of Anatomy.[60]

In her attention to the ways in which the horrors of dissection were kept at bay both literally and figuratively by the desperate attempts of the poor to provide decent funerals for themselves, Richardson weaves together the social and the cultural for a moment. By inviting her readers to consider donating their own bodies for dissection, she urges them to imagine the weight of injustice that she has been describing. For me, the endings of both books suggest what we have gained and what we have lost. I miss both the emotional engagement produced by Richardson's account and the ways in which her account is profoundly a moral tale. We might think that history as an explicitly improving kind of writing had waned long ago, but rereading Richardson and other social historians reminds me that it was only yesterday. Sappol's story excites me intellectually, even as I am often frustrated by his unwillingness to tell his stories in depth, to engage my

emotions as well as my mind by means of narrative detail and structure. Perhaps I am especially liable to persuasion on this point, but he convinces me fully that anatomy and the body imagined anatomically were central to many nineteenth-century Americans' understandings of themselves. Nor do I want to say that we have sacrificed moral purpose for intellectual complexity. Instead, the trade-off is something deeper to do with the possibility of writing stories that do not question themselves by means of their openness. Nostalgia is cheap, and perhaps my wish for the kinds of moral engagement implied by social history not much better. After reading Richardson, am I going to leave my body "to science," as the delicately obscure and high-minded phrase has it? Hell, no.

NOTES

I am very grateful to Lucia Dacome, Mary Henninger-Voss, Harry Marks, and the editors of this volume for their thoughtful comments on earlier drafts of this chapter.

1. This chapter is intended as a think-piece rather than a literature review. Consequently, the works cited below are only a sampling of recent work in the cultural history of medicine, a sampling shaped by my own early modern interests and eclectic tastes.

2. Donald Kelley, "The Old Cultural History," *History of the Human Sciences* 9 (1996): 101–126.

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4. Mary E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol* (Cambridge: Cambridge University Press, 1991).

5. Leonore Davidoff, "The Separation of Home and Work? Landladies and Lodgers in Nineteenth- and Twentieth-Century England," in *Fit Work for Women,* Sandra Burman, ed., (London: Croom Helm, 1979), 64–97, 64.

6. Margaret Pelling, "Medical Practice in Early Modern England: Trade or Profession?" in *The Professions in Early Modern England,* Wilfred Prest, ed. (London: Croom Helm, 1987), 90–128, and "Compromised by Gender: the Role of the Male Medical Practitioner in Early Modern England," in *The Task of Healing. Medicine, Religion and Gender in England and the Netherlands 1450–1800,* Margaret Pelling and Hilary Marland, eds. (Rotterdam: Erasmus Publishing, 1996), 101–134.

7. Clifford Geertz, *The Interpretation of Cultures* (New York: Basic Books, 1973).

8. Douglas Hay et al., *Albion's Fatal Tree: Crime and Society in Eighteenth-century England* (New York: Pantheon Books, 1975).

9. See, for example, *Microhistory and the Lost Peoples of Europe,* Edward Muir and Guido Ruggiero, eds., Eren Branch, trans. (Baltimore: Johns Hopkins University Press, 1991), and *Jeux d'échelles: La micro-analyse à l'expérience,* Jacques Revel, ed. (Paris: Gallimard Seuil, 1996).

10. In formulating this overview of cultural history, I have drawn on the following:

Explorations in Cultural History, T. G. Ashplant and Gerry Smyth, eds. (London: Pluto Press, 2001); *The Postmodern History Reader,* Keith Jenkins, ed. (London: Routledge, 1997); and *Beyond the Cultural Turn: New Directions in the Study of Society and Culture,* Victoria E. Bonnell and Lynn Hunt, eds. (Berkeley: University of California Press, 1999).

11. *The New Cultural History,* Lynn Hunt, ed. (Berkeley: University of California Press, 1984).

12. *Natural Order: Historical Studies of Scientific Culture,* Barry Barnes and Steven Shapin, eds. (Beverly Hills, Calif.: Sage, 1979); Roger Cooter, *The Cultural Meaning of Popular Science: Phrenology and the Organization of Consent in Nineteenth-Century Britain* (Cambridge: Cambridge University Press, 1985); Adrian Desmond, "Artisan Resistance and Evolution in Britain, 1819–1848," *Osiris* 3 (1987): 77–110.

13. Steven Shapin, "Phrenological Knowledge and the Social Structure of Early 19th-Century Edinburgh," *Annals of Science* 32 (1975): 219–243; "Homo Phrenologicus: Anthropological Perspectives on an Historical Problem," in Barnes and Shapin, *Natural Order,* 41–71; and "The Politics of Observation: Cerebral Anatomy and Social Interests in the Edinburgh Phrenology Disputes," in *On the Margins of Science: The Social Construction of Rejected Knowledge,* Roy Wallis, ed., *Sociological Review* Monograph no. 27 (1979): 139–178.

14. Barbara Sicherman, "The Uses of a Diagnosis: Doctors, Patients, and Neurasthenia," *Journal of the History of Medicine and Allied Sciences* 32 (1977): 33–54; H. Tristram Engelhardt, "The Disease of Masturbation: Values and the Concept of Disease," *Bulletin of the History of Medicine* 48 (1974): 234–248.

15. *The Problem of Medical Knowledge: Examining the Social Construction of Medicine,* Peter Wright and Andrew Treacher, eds. (Edinburgh: Edinburgh University Press, 1982).

16. *Framing Disease: Studies in Cultural History,* Charles E. Rosenberg and Janet Golden, eds. (New Brunswick, N.J.: Rutgers University Press, 1992).

17. Ibid., xiv.

18. Ibid., xv.

19. Ibid., xxii–xxiii. The works to which Rosenberg refers are Owsei Temkin, "The Scientific Approach to Disease: Specific Entity and Individual Sickness," in *Scientific Change: Historical Studies in the Intellectual, Social, and Technical Conditions for Scientific Discovery and Technical Invention from Antiquity to the Present,* A. C. Crombie, ed. (New York: Basic Books, 1963), 629–647, and Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988).

20. This combination of social and cultural histories is characteristic of much of Rosenberg's work. His first book, for example, weaves together changes in ideas about cholera with the social particulars of nineteenth-century New York City: Charles E. Rosenberg, *The Cholera Years, the United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1962).

21. Colin Jones, "Plague and Its Metaphors in Early Modern France," *Representations* 53 (1996): 97–127. See also Giulia Calvi, *Histories of a Plague Year: The Social and the Imaginary in Baroque Florence* (Berkeley: University of California Press, 1989), which blends social analysis of the patterns of plague transmission with a cultural analysis of the meanings associated with a nun who was proposed for canonization during the 1633 plague.

22. Jones, "Plague," 116.

23. Jonathan Sawday, *The Body Emblazoned: Dissection and the Human Body in Renaissance Culture* (London: Routledge, 1995); Caroline Walker Bynum, *Holy Feast and Holy Fast* (Berkeley: University of California Press, 1985). The immensely influential collection by Michel Feher on the history of the body had much medical content but not many historians of medicine among its authors, *Fragments for a History of the Human Body,* Michel Feher, ed. (New York: Zone, 1989).

24. Thomas W. Laqueur, *Religion and Respectability: Sunday Schools and Working Class Culture, 1780–1850* (New Haven: Yale University Press, 1976); "Bodies, Death, and Pauper Funerals," *Representations* 1 (1983): 109–131; and *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, Mass.: Harvard University Press, 1990).

25. Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (Madison: University of Wisconsin Press, 1989). Katharine Park, "The Life of the Corpse: Division and Dissection in Late Medieval Europe," *Journal of the History of Medicine and Allied Sciences* 50 (1995): 111–132; "The Criminal and the Saintly Body: Autopsy and Dissection in Renaissance Italy," *Renaissance Quarterly* 47 (1994): 1–33; and "The Rediscovery of the Clitoris. French Medicine and the Tribade, 1570–1620," in *The Body in Parts: Fantasies of Corporeality in Early Modern Europe,* David Hillman and Carla Mazzio, eds. (London: Routledge, 1997), 171–194.

26. Barbara Duden, *The Woman beneath the Skin* (Cambridge, Mass.: Harvard University Press, 1991).

27. Harold J. Cook, *Trials of an Ordinary Doctor: Johannes Groenevelt in Seventeenth-Century London* (Baltimore: Johns Hopkins University Press, 1994).

28. Ibid, xvii.

29. Paul Seaver, *Wallington's World: A Puritan Artisan in Seventeenth-Century London* (Stanford: Stanford University Press, 1985).

30. Guido Ruggiero, "The Strange Death of Margarita Marcellini: *Male,* Signs, and the Everyday World of Pre-modern Medicine," *American Historical Review* 106 (2001): 1141–1158.

31. Robert Darnton, "Workers Revolt: The Great Cat Massacre of the Rue Saint-Séverin," in *The Great Cat Massacre and Other Episodes in French History* (New York: Vintage Books, 1985), 75–106.

32. *Writing Culture: the Poetics and Politics of Ethnography,* James Clifford and George E. Marcus, eds. (Berkeley: University of California Press, 1986).

33. Terri Kapsalis, *Public Privates: Performing Gynecology from Both Ends of the Spectrum* (Durham, N.C.: Duke University Press, 1997). Thanks to Christine Ruggere for this reference.

34. Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (London: Routledge, 1990); Laura Gowing, *Domestic Dangers: Women, Words, and Sex in Early Modern London* (Oxford: Oxford University Press, 1996).

35. See, for example, Gareth Stedman Jones, *Languages of Class: Studies in English Working-Class History, 1832–1982* (Cambridge: Cambridge University Press, 1983), and Patrick Joyce, *Visions of the People: Industrial England and the Question of Class, 1848–1914* (Cambridge: Cambridge University Press, 1991) and *Democratic Subjects: The Self and the Social in Nineteenth-Century England* (Cambridge: Cambridge University Press, 1994).

36. Roger Chartier, "Culture as Appropriation: Popular Cultural Uses in Early Modern France" in Steven L. Kaplan, ed., *Understanding Popular Culture: Europe from the Middle Ages to the Nineteenth Century* (Berlin: Mouton Publishers, 1984), 175–191.

37. Carolyn Steedman, *Strange Dislocations: Childhood and the Idea of Human Interiority, 1780–1930* (London: Virago, 1995).

38. Nancy Tomes, "The Private Side of Public Health," *Bulletin of the History of Medicine* 64

(1990): 509–539. Tomes incorporated this discussion in her subsequent book, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge, Mass.: Harvard University Press, 1998).

39. Lorna Weatherill, *Consumer Behaviour and Material Culture in Britain, 1660–1760* (London: Routledge, 1988); Carole Shammas, *The Pre-industrial Consumer in England and America* (Oxford: Oxford University Press, 1991); *Consumption and the World of Goods*, John Brewer and Roy Porter, eds. (London: Routledge, 1993).

40. T. J. Jackson Lears, *Fables of Abundance: A Cultural History of Advertising in America* (New York: Basic Books, 1994); Thomas Richards, *The Commodity Culture of Victorian England* (Stanford: Stanford University Press, 1990); Timothy Burke, *Lifebuoy Men, Lux Women: Commodification, Consumption, and Cleanliness in Modern Zimbabwe* (Durham, N.C.: Duke University Press, 1996).

41. Jacqueline Musacchio, *The Art and Ritual of Childbirth in Renaissance Italy* (New Haven: Yale University Press, 1999).

42. See also Jacqueline Musacchio, "Weasels and Pregnancy in Renaissance Italy," *Renaissance Studies* 15 (2001): 172–187.

43. John Styles, "Product Innovation in Early Modern London," *Past & Present* 168 (2000): 124–169.

44. Diane Owen Hughes, "Distinguishing Signs: Ear-rings, Jews, and Franciscan Rhetoric in the Italian Renaissance City," *Past & Present* 112 (1986): 3–59.

45. Sara Pennell, " 'Pots and Pan History': The Material Culture of the Kitchen in Early Modern England," *Journal of Design History* 11 (1998): 201–226.

46. Jordanova, *Sexual Visions*.

47. Natalie Zemon Davis, *Fiction in the Archives: Pardon Tales and Tellers in Sixteenth-Century France* (Stanford: Stanford University Press, 1988).

48. Steven Stowe, "Seeing Themselves at Work: Physicians and the Case Narrative in the Mid-Nineteenth-Century American South," *American Historical Review* 101 (1996): 41–79. See also his reflections on the process of reading letters in "Singleton's Tooth: Thoughts on the Form and Meaning of Antebellum Southern Family Correspondence," *Southern Review* 25 (1989): 323–333.

49. Kate Fisher, " 'She Was Quite Satisfied with the Arrangements I Made': Gender and Birth Control in Britain 1920–1950," *Past & Present* 169 (2000), 161–193.

50. See, for example, Alessandro Portelli, *The Death of Luigi Trastulli and Other Stories: Form and Meaning in Oral History* (Albany: State University of New York Press, 1991) and *The Battle of Valle Giulia: Oral History and the Art of Dialogue* (Madison: University of Wisconsin Press, 1997); Luisa Passerini, "A Memory for Women's History: Problems of Method and Interpretation," *Social Science History* 16 (1992): 669–692.

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