THE HISTORIOGRAPHY OF MEDICINE IN THE U.K.

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SUMMARY

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

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

First, I propose to say nothing about movements common to Western scholarship at large. Thus I shall not rehearse yet again the rejection of Whiggish triumphalism or revisit the impact of feminist history, of structuralism, of Foucauldian savoir-pouvoir, postmoderni-
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energized during the last quarter-century thanks to the founding and flourishing of the Society for the Social History of Medicine, a radical outfit which brought together younger historians, social scientists and left-leaning health professionals. Its thre-earlier journal, Social History of Medicine, is now ten years old.

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

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

Malthus's portrayal of Nature as ceaseless struggle long dominated scholarly approaches to the population history of preindustrial Europe. Malthusian orthodoxy taught that preindustrial societies sustained extremely high birth-rates. Hence they most also have suffered a correspondingly high death-rate. And did not the facts bear this out? After all, even relatively advanced France had undergone decimating famines well into the eighteenth century; from the Black Death onwards, Europe at large had been pestilence-ridden; while war too had been en-
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The Population History of England was a colossal and magisterial counting exercise. A follow-up volume, English Population History from Family Reconstitution 1580-1837, published last year, supplements it by recourse to a further method, family reconstitution, pioneered by the French scholar Louis Henry. Simply put, family reconstitution aims to exploit the fact that parish registers record baptisms, marriages and burials. Where registers have been conscientiously kept, and if a sufficient percentage of parishioners passed all their days in their native parish, it should be possible, Henry concluded, to plot precisely when in their lives identifiable individuals got married, when their offspring came along, and when they died in other words, one could proceed from mere aggregates to the reconstruction of the demographically significant acts and rhythms in the lives of actual individuals and groups. Disaggregating trends, one would be able to document whether particular cohorts of individuals were actually marrying earlier or later; were having their children more bunched up or more spaced out, were giving birth more frequently, and so forth.

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

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

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

Biologists are confident that, ceteris paribus, variations in height reflect distinctions in well-being, tallness being a proxy for nutritional status. So is it possible to reconstruct how the physical stature of the
British changed? Floud et al. attempt this for army recruits, who have been assiduously measured since the late eighteenth century, and then seek to extrapolate on that basis.

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

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

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

Dismissing as Wriggle the interpretation advanced by Edward Shorter - the view that modernization overcame traditional taboos led to sexual emancipation, more and more pleasurable sex - Hitchcock contextualizes sex in terms of shifting male-female relations within local communities, and new readings of the sexual body. Avoiding Lawrence Stone's excessive emphasis on the unrepresentative upper crust, Hitchcock draws a distinction between the public sexual culture formerly predominant - sexuality as a kind of public play, legitimate so long as it was properly handheld within the community - and the new private sexual milieu (associated with such phenomena as pornography and anti-masturbation literature) which he traces as emerging during the eighteenth century.

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

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

If our understanding of bodily health in its full biosocial richness is enhanced by the teaming up of demographic history with the history of sexuality, another fruitful alliance forged in recent studies has been that between demographic and epidemiological history on the one hand, and environmental history on the other. The outstanding work of this kind is Mary Dobson's Contours of Death and Disease in Early Modern England, which makes full use of the demographic researches of the Cambridge Population Group, while also drawing upon another significant tradition, the Annuale school. A generation ago, Annuale historian studied some fine regional studies of the health of populations, notably Jean-Pierre Goubert's 1974 account of Brittany. The Cambridge and the Paris traditions have now been expertly combined in Dobson's pioneering essay in historical medical topography. Taking the counties of Sussex, Kent and Essex, Dobson - a geographer turned medical historian - exploits demographic data to explain dramatic geographical differentials in health.
Using burial/baptism discrepancies and other such indices, she reveals that certain environments in the South-East were far less salubrious than others. It was largely a matter of contours: high ground harboured the lowest morbidity; low ground the highest mortality. Particularly, the Thanes and Medway estuaries and the Essex coast - a fact well-known to the pioneering eighteenth-century student of population, Dr. Thomas Short.

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

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

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

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

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

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

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

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

For the poor, by contrast, the turning-points were the foundation of the Bristol Workhouse in 1696, and of the Bristol Infirmary forty years later. Fissell maintains that the traditional reputation of Georgian ho-
sptals as gateways to death is undeserved: records suggest that the Bristol Infirmary played a positive role, not in curing the sick, but in its role in the reformation of popular health care. The Infirmary’s day-to-day running soon fell into the hands of the medical staff, above all the surgeons. Trained in Edinburgh’s medical factory, such men brought an aggressive professionalism to their job. Out went the vestiges of magical and folk medicine; out went the old-style diagnosis dependent upon the sick person recounting his or her complaint to the doctor. All this was replaced by the practitioner inspecting the sick person for diagnostic signs, which could, in turn, be expressed in the technical, Latinized jargon of scientific medicine. Through the Infirmary and similar institutions, the people were deprived of, in the name of progress, of the medical belief-systems which had given meaning to their sufferings. Popular medicine too was thus reformed. No longer was it every man his own physician; medicine, doctors now emphasized, was too complex, too serious, to be left to the sick. Patients, Fissell claims, were thus deskilled, and a patient-oriented system was replaced by a doctor-driven medical economy. Hence, to deploy Ivan Illich’s rhetoric, the hospital expropriated the health of the poor by medicalizing them.

More dramatically, Fissell maintains that a significant function of the Bristol Infirmary lay in dissecting patients who had died in its beds. The corpses of the indigent became teaching fodder, and surgical operation. In the popular mind, hospital and jail, medicine and punishment tended to be elided.

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

I wish instead to concentrate, however, on a similar work, The Body Embalzoned. Dissection and the Human Body in Renaissance Culture, by Jonathan Sawday, a literary historian, because his study affords strong confirmation of the feasibility and desirability of ambitious interdisciplinarity in the history of medicine.

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

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

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

The most daring aspect of The Body Embalzoned lies in its exploration of the symbiosis of the medical, the philosophical and the artistic. Especially in the Dutch Republic in the 1630s, painters were incorporating dissection scenes into their repertoire, audaciously alluding in their renderings of the corpse on the anatomist’s slab to the pietà tradition of the crucified Christ. To paint the corpse was to dissect it with the artist’s not the surgeon’s knife, as in Rembrandt’s The Anatomy Lesson of Dr Nicolaes Tulp. Can it be purely coincidental, Sawday asks, that Descartes too was living close to the butchers’ quarter of Amster-
not deteriorate into mere workhouses, jails, or dumps. Two volumes, entitled 150 Years of British Psychiatry, 1841-1991, and edited by German Berrios and Hugh Freeman, form an extremely welcome foray into recent history and give the lie to the historians' sneer that insiders invariably write self-serving, Whigish whitewashes of their profession.18

The history of madness is another instance - like that of the history of the body - in which medical history and cultural history can interact, through discourse analysis and history from below. A fine example of this is Allan Ingram's The Madhouse of Language: Writing and Reading Madness in the Eighteenth Century, a study of mad people's writings.19 It has become something of a historiographical orthodoxy that madness was silenced in the Classical Age. In coining that expression, Michel Foucault meant that the discourse of the insane ceased to be regarded as possessing any meaning and hence stopped being heeded by public authorities. It is within this interpretative framework that Allan Ingram proceeds.

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

Looking back, I am appalled at all the important developments in British medical history upon which I have not touched at all. But if I have emphasized certain developments over others, it is because these corroborate the chief theme of this lecture. Thirty years ago, the history of medicine seemed a back-alley, of no special relevance to hi-
story at large. Today the history of medicine is everywhere, it com-
mmands widespread scholarly attention; healing - the care and discipline - is the thread which links together recent investigations into population, sexuality, gender; the discipline of power; institutional history, the history of representations and so forth. From the wings the subject has moved stage-centre.

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(1984) and Volume 2: Government and Health Care: A History of the National Health
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5. For some insight, see MACFARLANE A., The Origins of English Individualism: The

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8. As of the 1990s, the Cambridge Wellcome Unit will move as a result of a deplorable decision by the Wellcome Trust, but it will be replaced by a comparable Unit at the University of East Anglia.


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36. Among the many fields about which too little has been said in this survey are: history of medical care; clinical medicine; laboratory medicine; medical education; paediatrics; hospitals; medicine and empire; medicine and war; women's medicine; medical economics; history of surgery. The reason is not a lack of good work in these fields but a lack of space and competence on the author's part.

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