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

Do we need history?

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

It is relatively new that we question the usefulness of history. For a doctor in the early 1800s, medical texts from the past were a natural frame of reference, along with texts from the doctor’s own time. Hippocrates, Galen and Vesalius could offer solutions to clinical dilemmas that were just as relevant as contemporary reference works, and were therefore also included in the medical curriculum (1). Frederik Holst’s dissertation on radesyke, the first doctoral thesis defended at the newly established University of Christiania (later Oslo), draws on sources from antiquity and the renaissance in conjunction with medical writings of his own time (2). The career of R. T. H. Laënnec, subsequently credited with the invention of the stethoscope, began with a dissertation in which he extolled the relevance of the Hippocratic writings for practical medicine (1). At that time, a different slant was put on the well-known aphorism from the Hippocratic Corpus, «Art is long, life is short» from the way we understand it today. Whereas we understand «the art of medicine» as meaning those aspects of medical encounters which are not understood as drugs came onto the market to treat diseases such as asymptomatic diabetes, high cholesterol level, hypertension and asthma were found to be a major public health problem at the same time as drugs came onto the market to treat them (6). By demonstrating that the connections between marketing, public health and medical practice were not an inevitable result of new knowledge, his research makes it possible to ask new questions about the economics of medical knowledge.

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

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

Anne Kveim Lie
a.h.k.lie@medisin.uio.no

References