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Resuscitating the ‘Great Doctor’: The Career of Biography in Medical History
Beth Linker

The study of the history of medicine began as a practice of teaching and writing about individuals. In the first history of medicine courses taught in American universities during the late nineteenth century, instructors told stories of ‘great doctors’, mapping out a straight line of historical advancement. Early educators in the history of medicine (most of whom were physicians) validated their practice by claiming that historical study would have a humanising effect on their students. Progressives who believed that medicine held the key to human health and happiness worried that as medicine became more scientific, students would lose the moral and cultural foundations necessary to guide them. Early proponents of medical history hoped that by putting human faces on the increasingly abstract content of their fields, teachers could inculcate classical virtue. In such an educational atmosphere, the writing of biographies flourished.¹

Things are very different today. The change began in the 1970s with the arrival of the ‘new’ social history. At that time, a cohort of professionally trained non-physician historians of medicine rejected the authority of ‘great doctors’ and their ideas, reacting to the biographically oriented beginnings of the history of medicine with disdain. To this day, social historians of medicine throughout the English-speaking world continue to employ a rhetoric of patricide, distinguishing their ‘new’ (albeit now almost thirty-year-old) context-driven method of writing history from individual-centred ‘traditional’ medical history, a method manifested in biographies written for, about, and often by physicians.

Yet there is an important exception to the widespread hostility among American social historians of medicine to great figures in history. As part of their effort to purge the field of ‘elitist’ approaches of historical study that focus on individuals, social historians of medicine have come perilously close to producing a hagiographical portrait of one particular individual: Henry E. Sigerist, a Swiss physician and professionally trained historian who is today widely regarded as one of the most important figures in beginning the turn toward a more ‘sociological’ approach to medical history. What is most striking about the appropriation of Sigerist as a founding father to the ‘new’ history is not the apparent contradiction involved in looking up to one great physician-historian as the inspiration for a method that refuses to admire great doctors. Most striking is the fact that social historians have made

¹ For more on the history of medicine as a field of study, see Brown and Fce (1997), Brieger (1993), Burnham (1998), Miller (1973) and Huisman and Warner (2004).
Sigerist the leader of an ideological-methodological crusade in which he would have been, at best, a reluctant participant. A close examination of Sigerist’s work shows us that, compared to the ‘new’ social history, Sigerist’s ‘older’ approach to social history allowed for methodological pluralism that, despite what his inheritors have proclaimed, included medical biography.

Biography and the New Social History of Medicine

In 1979, two ambitious Boston-area graduate students, eager to move the study of medical history in a new direction, articulated a founding story of the field that would come to define the identity of professional historians of medicine for many years to come. Disenchanted with what they perceived to be medical history’s celebration of great white men, Susan Reverby and David Rosner wanted to make a clean break from what they called ‘traditional’ medical history by publishing a collection of works in the ‘new’ social history of medicine. But as two ‘young whippersnappers’ (Reverby and Rosner, 2004, p. 167). The authority they turned to was Henry E. Sigerist (1891–1957).

In the introduction to their edited book Health Care in America: Essays in Social History, Reverby and Rosner defined their ‘new’ social history of medicine as heir to Sigerist’s ‘old’ sociological approach to medical history. This argument of inheritance, a portrait of an intellectual family tree, rooted the ‘new’ social history in tradition, giving it a sense of permanence that most innovations lack. This sense of rootedness held great appeal. Once Reverby and Rosner’s proposed genealogy was in print and out of their hands, it went on to become a legend reiterated by many medical historians for decades to come, a founding story told and retold in classrooms, spun and re-spun at yearly history of medicine conferences.

As a Leipzig-trained historian who intended to bring the scholarly rigour of German medical history to the United States, Sigerist was, in many ways, the perfect candidate for Reverby and Rosner’s campaign. His self-proclaimed ‘sociological approach’ that situated medicine in economic and political history challenged those who thought that medical history was a kind of mentorship steeped in biographical accounts of great men. Indeed, Reverby and Rosner titled the introductory essay to their volume ‘Beyond “the Great Doctors”’, drawing on Sigerist’s line that the ‘history of medicine is infinitely more than the history of great doctors and their books’—an indication that their work, like his, would be an investigation specifically targeted at the social relations of health, rather than the activity and intellectual concerns of physicians alone (Reverby and Rosner, 1979, p. 3).

Treating Sigerist as a model, Reverby and Rosner pronounced the death of the old-school, biography-centred approach to the history of medicine. History of medicine, they argued, had too long been in a ‘political alliance’ with the practice of medicine itself. Writing about great doctors, they maintained, only perpetuated the physician’s professional hegemony over medical institutions and the very definitions of health and disease. With the new social history, they intended to question not only the authority of doctors, but also their supposed greatness. The new social history promised to unmask the ‘pervasive societal faith in the potential and efficacy of medical science’ and ultimately to break the control that physicians exercised over the stories that lay people tell themselves about health and sickness (Reverby and Rosner, 1979, p. 4). Taking the side of the laity over power-wielding experts, Reverby and Rosner implied that writing biographies about great men was an ‘unprofessional’ practice, an expression of false consciousness, a trade only for whiggish historians or physicians who merely dabbled in the past.

Reverby and Rosner’s book was only a small part of a much larger historiographical movement that transcended the small field of medical history. During the 1970s and 1980s, the new social history was an international movement, involving historians in Europe, Latin America, Japan, India and North America who applied theories of postcolonialism and cultural relativism to the study of everyday people and everyday life. At its extreme, this new history rejected the ‘traditional’ methods, assumptions, and aims of historical research—that is, political history, objective history, history from ‘above’, events-based history—in the pursuit of creating a ‘total history’, in which every human activity could be studied historically, and where no one event or one society would be privileged over another. But while the new social history enjoyed a universal reach, it affected the history of medicine in a distinct way.

When the new generation of social historians first made its attack against ‘traditionalists’ in medical history, veteran scholars fought back. Worried that the intellectual foundation of their field would collapse under the assault of social history criticism, key historians of medicine wrote in support of ‘traditional’ history, arguing that their field could not exist without the history of medical ideas. In January 1980, Leonard G. Wilson, editor-in-chief of the Journal of the History of Medicine and Allied Sciences, claimed that if social history succeeded in taking over the field, it would lead to the end of medical history, properly understood, for it would be ‘medical history without medicine’ (Wilson, 1980, p. 7). In the same year, Lloyd G. Stevenson, editor of the Bulletin of the History of Medicine, wrote a disparaging addendum to Howard S. Berliner’s (1980) positive review of Reverby and Rosner’s Health Care in America. In his ‘Second opinion’, Stevenson concluded that Reverby and Rosner’s social history had indeed fulfilled Wilson’s prediction; since their book was not ‘science-oriented or even practice-oriented’, it could not rightly be called history of medicine (Stevenson, 1980, p. 136).

The battles between new social historians and those of the medical history establishment polarised the field, creating a complex map of fault lines between old guard and new guard, clinician-historians and PhD-trained historians, ‘insiders’ and ‘outsiders’. While many old-guard historians of medicine complained that the new scholars in their field lacked medical knowledge, some of the new social historians made equally inflammatory claims, implying that ‘traditional’ medical history was medical history without history.²

2 For more on the ‘new’ history of the 1970s and 1980s, see Burke (1992a) and Burke (1992b). For the American context in particular, see Novick (1988).

3 Berliner implies this in (1980), pp. 131-4, esp. p. 131.
That the new social history had such a polarising affect on the history of medicine is, in many ways, unsurprising. The timeless power relationship between patient and doctor, sufferer and healer, provided a ready-made programme for studying ‘history from below’, a methodology deemed essential to the writing of social history.4 Already by the mid-1970s, British social historians were calling for the ‘resurrection’ of the patient. In 1976, historian Charles Webster, Director of the Oxford Wellcome Unit and the newly elected President of the British Society for the History of Medicine, made patient-centred history the primary initiative of the society.5 Ten years later, Roy Porter became one of the most articulate defenders of history from below, summoning his colleagues to combat ‘traditional history of medicine [which] simply ignored the patient’ by undertaking an exploration into the patient’s view of health and disease (Porter, 1985, p. 175).6

Once social historians of medicine accepted history from below, the step towards rejecting biography, especially of ‘great’ doctors, seemed a sensible one to take. This step, however, led to a mixing of historical methodologies and a blurring of the past with the present. Social historians not only wrote about patients, but also identified with the powerlessness that contemporary patients felt while under the authority of physicians.7 Although few of the younger historians of medicine were

4 To appreciate fully the degree to which history from below defined the social history of medicine, it is helpful to compare the fields of medical history and the history of science. Whereas the introduction of social history brought ‘history from below’ to medical history, historians of science followed the line of ‘social construction of knowledge’. There are some key differences that could explain this divergence between the fields. First, and perhaps most obviously, the practice of science did not (and does not) have a ready-made above-and-below distinction for its historical actors as medicine does. Moreover, whereas most social historians of medicine did not have backgrounds in practising medicine, most historians of science had spent some time at the laboratory bench, since, according to Nathan Reingold, ‘a majority’ in the field have scientific backgrounds (1981, p. 276). In other words, social historians of science, having some common ground with even ‘great’ scientists, might not have felt the same struggle against power as social historians of medicine did. Little has been written comparing social history in both fields. One exception is Jordanova (1995).


6 I would argue, however, that for historians of medicine, there was (and still is) an inherent difficulty in defining the ‘below’ in medicine as simply a category that constitutes ‘patients’, since illness is a shared phenomenon that cuts across all boundaries of class, gender and race. Labour historians of the 1970s were the first to employ history from below as a way to investigate the political activity of the working class. Since the division between working class and industrialists proved to be fairly consistent and concrete, labour historians could easily fit their historical actors into the appropriate hierarchical categories. The same is not true for the history of medicine. While in terms of power relations the division between physicians-as-‘above’, and patients-as-‘below’ works most of the time, the divide is nevertheless porous. Work has yet to be done on how health and disease as phenomenological experiences complicate the categories of ‘above’ and ‘below’, for even physicians, who medical historians tend to assume are ‘above’, are potential victims of disease. Almost every historical actor participates in the ‘below’ category at one point or another.

7 The best examples of how social historians began to identify with their patients as historical subjects can be found in the public health literature of the 1990s. Writing in the trained as physicians, they did have experience as patients, which they drew upon as they wrote history from below as well as when they entered into disputes with old-guard historians of medicine (many of whom had MDs).8 As a result, the rejection of medical biography became a measure of one’s commitment to history from the bottom up, and ultimately to the new social history. At the same time, old-guard historians who still wanted to preserve ‘traditional’ medical history rushed to rally behind biography in the hopes of restraining the rise of the new social history.

The issue of biography created an easily caricatured artificial duality in the field of medical history, with the non-PhD-trained physician-historian who wrote and read ‘cheery’ biographies on the one side and the sceptical PhD-trained historian who wanted to debunk physician-centred history on the other. In reality, the field of medical history was diverse and complex, home to scholars of many different stripes and backgrounds, yet divisive disputes about biography made the field look black and white.

But while certain ‘traditional’ medical historians might have promoted biography in theory, fewer and fewer biographies of physicians were being written. Whereas almost 40 per cent of the articles published in English-speaking medical history journals during the 1960s and 1970s were biographical in nature, by the year 2000 the number of articles devoted to medical biography dropped to nearly 10 per cent. As Olga Amsterdamksa and Anja Hiddinga have demonstrated (2004, pp. 245, 249), both PhD historians and physician-historians had become less likely to write medical biography and more likely to devote their attention to the history of medical practice and its institutions.

The decline in medical biographies throughout the 1980s led certain social historians to announce themselves as victors in the historiographic battles waged a decade earlier. In Britain, Andrew Wear boldly announced in 1992 that the social history of medicine had ‘come of age’, for it had replaced ‘the history of great doctors, great discoveries and great ideas’, and had proven to be the superior approach, showing how ‘medicine had affected society and how society had shaped medicine’ (Wear, 1992, p. 1). Wear had every reason to boast, since social history in Britain had earned a celebrated position in the medical history community, evinced most concretely by the establishment of its own scholarly periodical Social History of Medicine in 1988.9

In the United States, medical historians told similar triumphalist stories about the new social history, building on the founder story that Reverby and Rosner had established in 1979. In a 1990 American Historical Review essay surveying the wake of the AIDS epidemic, many social historians wrote about the public health movements of the early twentieth century as a means of curtailing what they saw as potentially invasive health policies in their own time. The public health literature is quite expansive, but some of the best examples from the 1990s include Kraut (1994), Leavitt (1996), Rothman (1994) and Toomes (1998).

8 For the decline in MDs writing medical history over the last forty years, see Statistics cited in Amsterdamksa and Hiddinga (2004), p. 258. While very useful, this study is also limited since it only considers articles published in the field, not books.

9 For more on the evolution of the social history of medicine in Britain, and the early years of the Social History of Medicine, see Porter (1995).
history of medicine, Judith Walzer Leavitt categorised the authors under review as direct descendents of Sigerist, for they had all moved the focus of historical investigation away from the 'great physicians and their texts' towards a context-driven approach. Not surprisingly, there were no biographies of physicians on Leavitt's list of reviewed books. Historiographic surveys of the field followed suit. In 1993, Gert Brieger discerned an emerging consensus in medical history. The Sigeristian program of study had become so prevalent, according to Brieger, that historians of medicine had come to take it 'almost for granted' (Brieger, 1993, p. 25). The question that needed to be asked was not whether the move to social history was worthwhile, but rather, why it took medical historians so long to 'heed the call to a social history voiced so eloquently by Sigerist' in the first place (Brieger, 1993, p. 26).

A common thread that ran throughout these triumphalist stories on both sides of the Atlantic was the denigration of the so-called 'Oslerian' approach of medical history. To the new social historians, William Osler (1849–1919) -- who held positions as a clinical physician in Canada, the United States, and Great Britain -- typified 'traditional' history of medicine. From his time as a founder of the Johns Hopkins Hospital Historical Club in 1890 continuing to his position as Regius Professor of Medicine at Oxford University during the early twentieth century, Osler was known for his historically oriented speeches, lectures and publications, where he would praise the accomplishments of dead white male physicians, for he believed that 'medical biography could inspire young members of the profession to envision bright possibilities for their lives.' This practical and highly optimistic view of medical history troubled many new social historians of medicine who wanted to bring about concrete changes to the way medicine was practised in the clinic, and to the way that doctors told stories about themselves. As a result, Osler came to represent everything that the new social historians had fought against: intellectual history, physician worship, an overenthusiastic 'love of history', and not least, the writing of medical biography.

The gap between the new social history and the 'traditional' Oslerian approach to history became even wider in 1999 when Elizabeth E. Fee and Thomas Brown led the effort to create the 'Sigerist Circle', a section within the American Association for the History of Medicine that paralleled the older and more well-established 'Osler Society'. According to Revery and Rosner, with the institution of the Sigerist Circle, social historians of medicine and activists scholars finally 'found a home' at the association's meetings (Revery and Rosner, 2004, p. 176). Sigerist Circle historians

11 For examples of this, see Porter (1995), Revery and Rosner (1979) and Fee and Brown (1997), pp. 336ff. Recently, however, Fee and Brown have contended that social historians constructed an exaggerated portrayal of Osler as an amateur medical historian who only 'mined the history of medicine for inspirational messages'. See Fee and Brown (2004), pp. 139-40.
12 William Osler, as quoted in Fee and Brown (2004), p. 144.
13 For more on how social history should be motivated by present-day medical concerns, see, for example, Fee and Brown (1997) and (2004), Porter (1995) and Revery and Rosner (1979, 2004), as well as Rothman (1994).

carved out an intellectual space where they and other like-minded scholars aimed to merge academic scholarship with political advocacy, an approach very different from the clinician-historian Osler Society and its unapologetic celebration of Osler's life and scholarship. And yet, as the Sigerist Circle gained numbers and recognition, two notable historians of medicine working in Canada -- Michael Bliss and Jacalyn Duffin -- appeared to buck the anti-biography trend. To be sure, 'corrective biographies' of women physicians, patients and unorthodox healers continued to be written (despite not being described or publicised in the field as biographies) since they were devoted to uncovering stories about groups of people marginalised by the medical profession. Yet Bliss and Duffin (each approaching the writing of history in a unique way) chose the 'traditional' path of writing about white male physicians and extraordinary scientific discoveries.

Aware of the pressing need for a dialogue about the status of biography in medical history, J.B.) Connor, editor of the Bulletin of Canadian Medical History, interviewed Bliss and Duffin, side by side, in 1996. At this time, Bliss had already published an award-winning biography of Frederick Banting (1984) and was well on his way to finishing William Osler: A Life in Medicine. During the interview, Bliss admitted that he had made a self-conscious effort to become a biographer, chiefly to challenge the new social history. 'It's clear', argued Bliss, 'that in our current academic culture, it's fashionable to be anti-biography, but in the real world ... people want biography' (1996, p. 134). In order to legitimise the practice of biography, Bliss equated doctors who had a hagiographic need for historical role models to 'feminists' and 'ethnic groups' who were in 'search for a usable past'. As Bliss put it, feminist-oriented historians who comb the past looking to support their own political agendas are 'the same thing as biographers' disguised all over again' (1996, p. 135).

Duffin, by contrast, arrived at medical biography by happenstance, largely unaware of the origins and agenda of the new social history. While she was still preparing a book manuscript on the scientific writings of René Laennec in 1985 (published in 1998), she began work on a little known nineteenth-century Ontario doctor, James Miles Langstaff. Sounding as much like a social historian as a biographer, Duffin claimed that she wrote her book Langstaff: A Nineteenth-century Medical Life in order to see 'what ordinary practice could tell us about the nineteenth century that hadn't already been said by very eminent people' (Duffin, 1996, p. 128). But despite having a research goal that was ostensibly in harmony with the new social history and demonstrating a rigorous method of analysing medical daybooks -- a method reminiscent of Fredric L. Holmes' use of laboratory notebooks to recreate the process of scientific creativity, as well as Laurel Thatcher Ulrich's utilisation of Martha Ballard's midwife diary -- Duffin was labelled an 'internalist' and had

14 For more on the Osler Society, see Fee and Brown (2004), esp. p. 140.
15 Ellen Singer More (1999) and Regina Morantz-Sanchez (1985, 1999) have written some of the most compelling histories of women physicians. Their accounts verge on biography, but do not entirely fit into the genre, since neither devotes a book to the entire life of an individual woman physician.
tremendous difficulty getting her books on Laennec and Langstaff published. 16 Tellingly, in the introduction to Langstaff, she resisted calling her book a biography. Instead, she wrote that it was "biography" of a practice not of a person, putting biography in scare quotes in order to distance herself from a word that had the power to taint her career (Duffin, 1993, p. 6).

Despite the many differences between Duffin and Bliss, certain social historians lumped them together, tagging them both as apologists for 'traditional' history of medicine. Responding to the interview, Janice Dickin of the University of Calgary wrote that biography was fundamentally 'at odds with the disciplined development of writing within the history of medicine'. Whereas true academic scholarship demanded 'a great deal of suspicion', biographers, she argued, engaged in uncritical use of sources and wrote from the heart instead of the head (Dickin, 1996, p. 174).

There was, it turns out, much truth in Dickin's portrayal of medical biography. Medical biographers themselves have admitted the role that emotion sometimes plays in their work. For example, Duffin has professed in person and print that she embarked on writing biographies of Laennec and Langstaff because it was "fun". 17 She has also argued that good history results from an unfailing 'passion' and 'personal desire' to answer a question that leads a scholar to delve into the past (Duffin, 2004, pp. 442-3). In a similar vein, Sherwin B. Nuland, a surgeon-turned-medical-historian who won popular acclaim for his Doctors: The Biography of Medicine, has staunchly defended what critics call his 'gee whiz!' style of writing and his enthusiasm for great doctors of the past (Nuland, 1988b, pp. xix–xx). 18 He even urges his medical historian colleagues to adopt a similar writing style on the grounds that doing so might lead to better and more readable medical history, books that one 'may curl up with on those pleasure-filled evenings' (Nuland, 2004, p. 453).

Salvaging Sigerist and 'Great Doctors'

There are many ways to explore the question of medical biography's potential worth to social history. One way would be to attend more fully to the career of biography in the history of science, a field that has long been known as the 'sister discipline' to medical history. While certain historians of science lament the steep decline in scientific biography since the 1970s, social history did not bring scientific biography to an end as it did in medical history. Although 'social constructionism' — a school of thought that believes that specific local practices and contexts produce scientific knowledge, not individual scientists — threatened scientific biography in theory, it failed to do so in practice.

For example, despite their radical claims to demonstrate that so-called experiential 'matters of fact' are entirely contingent and socially constructed, Steven Shapin and Simon Schaffer in Leviathan and the Air-Pump (1985) (arguably one of the most influential books to defend social constructionism) employed a rigorous historical methodology, firmly rooted in empirical evidence. Not only did they ground their argument in the authority of Boyle's New Experiments Physio-Mechanical Touching the Spring of the Air, but they also relied on Thomas Hobbes' Dialogus Physicus — a heretofore untranslated Latin text — to show other 'alternative' methods for knowledge-production. In the end, Shapin and Schaffer implied that without Boyle, the new empiricism of modern science would not have taken hold, and in so doing, they upheld the biography-centred notion that Boyle was a crucial figure to the history of science.

In a way, social constructivism helped biography to flourish in the history of science, for during the 1990s a kind of Hegelian synthesis occurred in the field, where the study of the individual and the social context merged to create a new form of biographical writing, known as 'social biography' (Söderqvist, 1996). 19 Historians such as Gerald Geison in The Private Science of Louis Pasteur (1995) and Mario Biagioli in Galileo, Courtier: The Practice of Science in the Culture of Absolutism (1993) began to redefine the very notion of scientific 'greatness', for they

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16 For Duffin's own compelling account of her experience as a 'biographer', and her repeated attempts at trying to get her books published, see her Chapter 11 in this volume and Duffin (2004). For more on her methodology as compared to other highly regarded contemporary historians, see Duffin (1993), Holmes (2004) and Ulrich (1990).

17 For more on Duffin's view of her own work, see Duffin (2004), esp. p. 442.

18 In the same year, Sherwin Nuland (1988a) wrote an editorial for The Journal of the History of Medicine and Allied Sciences advocating a kind of truce between non-PhD clinicians-historians and social historians, arguing that each had something to learn from the other.
saw that some of the greatest scientists in the past were motivated as much by career pressures and patronage as they were by the pursuit of knowledge. For these new biographers, greatness was not so much a function of the capacity to reach truth as it was a tribute to a scientist’s salesman ship.20

Thus, by looking to history of science, historians of medicine can see how it might be possible to incorporate the two approaches of biography and social history. Social historians of science and medicine have much in common; at base, both believe that scientific authority, medical or otherwise, is largely rooted in the practices of particular societies and cultures. But unlike most social historians of medicine, social historians in science have continued to acknowledge the importance of intellectual history and the centrality of scientific texts. As Ludmilla Jordanova and John Harley Warner have argued on separate occasions, there is much that social historians of medicine can learn from social constructionism in science, not least of which is how to salvage the history of ideas while still remaining true to social history.21

Another way to determine the potential value of medical biography to social history is to take a fresh look at the life and scholarship of Sigerist, a man who has come to represent the contemporary anti-biography stance in medical history. Fee and Brown, co-founders of the ‘Sigerist Circle’ and today’s leading experts on Sigerist’s life and scholarship, have called for a similar re-evaluation of Sigerist, realising that he has been ‘converted into [a] symbolic representation’ of himself, his differences with Osler ‘exaggerated’. For the purposes of judging the merit of medical biography, then, we must approach Sigerist’s life with a singular and penetrating focus, asking if he would have supported the anti-biography view ascribed to him.

By early twentieth-century standards, Sigerist was a renegade of sorts. As a Social Democrat who fled a disintegrating Weimar Germany in 1932 to become chair of the Johns Hopkins Institute of the History of Medicine, he pushed for socialized medicine in America at a time when the medical profession was overwhelmingly conservative, supporting the ideologies of big business and small government.22 Shortly after he arrived in the United States in 1933 – a time when American anti-communist sentiments ran high and ‘red baiting’ was common in national politics – Sigerist wrote in his private papers: ‘a social revolution [in American medicine] is needed’ Under the capitalist system, preventative medicine is not possible. Russia therefore signifies the beginning of a new epoch in medicine.23 For Sigerist, political ideologies were not simply a private matter. He held the firm belief that he could change the practice of medicine through his historical writings, and in 1937 published Socialized Medicine in the Soviet Union, advocating compulsory health insurance. While the book created controversy in the United States, it received a warmer reception in Canada, India and South Africa, where he was invited to lecture.24 In America, however, criticisms of his work mounted throughout the 1940s. Under strain from having to constantly defend himself against the American Medical Association and Hopkins medical alumni, Sigerist left the United States in 1947 to return to Switzerland.25

This was the political side of Sigerist’s life – the part that appears to harmonise with the uses to which he has been put by contemporary historians of medicine. But there was another side of Sigerist’s life – one that many American social historians of medicine from the 1970s onward have chosen to overlook: namely, that Sigerist often engaged in intellectual history and biographical writing in his own practice of social history. For instance, anticipating his 1931 lecture tour in America, Sigerist wrote that he would ‘speak of medicine and its growth, of the laws that control its development, of great doctors and great errors, and of cultural and intellectual patterns’ (quoted in Beeson, 1966, p. 69). Sigerist made this notation shortly after he published Grosse Ärzte: Eine Geschichte der Heilkunde in Lebensbildern (1931–1954), which appeared two years later in English translation as The Great Doctors: A Biographical History of Medicine (1933).

It would be inaccurate to call Sigerist’s biographical writing hero worship. Yet neither could it be described as sceptical towards the very notion of greatness, as is common among today’s social historians. Sigerist treated his subjects with reverence, but he also viewed them with a critical eye, motivated by the conviction that medicine should improve the general public’s health. Recognising the commonality shared by all physicians, ordinary and exceptional, Sigerist dedicated the Great Doctors to the ‘unknown doctor’, to all practitioners who do ‘heroic work’ on a day-to-day basis. For Sigerist, then, the physicians about whom he wrote served as inspiration for everyday doctors. As he put it: ‘The fact that [the great doctors of history] were privileged to reach supreme heights makes them our masters and exemplars, the thought of whom can encourage and invigorate us when the trivialities of the daily round are tending to dim our faith in the splendor of our calling’ (Sigerist, 1933, p. 18).

Sigerist’s concern for biography and ‘great doctors’ did not wane as he became more politically motivated. Even when he began to think of himself as a Marxist in the late 1930s, arguing that doctors should ‘lead struggles for the general improvement of working conditions’, he also upheld the writing of medical biographies.26 In a 1936 letter to George Sarton, Sigerist admitted frustration with ‘amateur historians’, who did not know that ‘historical research had exact methods’, just as scientific research did (Sigerist, 1936, pp. 3, 6). But he nevertheless concluded that such clinician-historians were ‘enthusiasts’ who should not be ‘discouraged’, even when they choose to write medical biographies. Indeed, Sigerist argued that physician-historian enthusiasts might be the best candidates for writing local histories – a kind

20 Geison (1995), esp. pp. 10 and 278. Geison came under a significant amount of criticism for his book, for its ‘debunking’ qualities and its ‘presentist’ criticisms of Pasteur’s research ethics. No matter the criticisms, though, Geison’s book was still a form of scientific biographical writing, a genre that had all but disappeared in the history of medicine. For a sampling from Geison’s critics, see Perutz (1995).


22 For more on Sigerist’s life history, see Fee and Brown (1997).

23 Beeson (1966), p. 83 (see Sigerist’s entry for 17 April 1933).

24 For Sigerist’s direct involvement in the development of Canada’s universal medical care system (1941–44), see Duffin and Falk (1996).

25 For the best and most concise account of Sigerist’s life, see Fee and Brown (1997).

26 For Sigerist’s relationship to Marxism, see Fee and Brown (2004), pp. 154–5.
of history he believed sorely lacking — for, as he put it, "who could do it better than the physician who lives on the spot?" (Sigerist, 1936, p. 2).

Sigerist's support of biography persisted throughout his career, informing his method of 'sociological medicine' until the end. Upon his return to Switzerland in 1948 and in the midst of writing an eight-volume history of medicine from Greek antiquity to the modern era, Sigerist advocated the need to understand medical theory, claiming that the medical historian must be familiar with 'the chief actors [in medicine], their training, their contributions, and the ideals that guided their actions'.

Five years later, Sigerist returned to The Great Doctors in order to revise the German edition, which had been out of print since the Second World War. In the preface to the 1954 edition of the Große Ärzte, Sigerist voiced his initial concern that the book may have been 'too old to revise'. 'But with surprise and elation,' wrote Sigerist, 'I found that [the book] had never lost its original appeal, and that it was still capable of awakening respect for the great accomplishment of medical science and enthusiasm for its work' (Sigerist, [1931] 1954, p. 11).

Sigerist's interest in medical biography should not be overstated, for his approach to the social history of medicine demanded that historians understand the economics and politics of medicine as well as its theory and 'great men'. While he used biography in The Great Doctors as a possible way to write a synthetic account of medical science, he was not, first and foremost, a medical biographer; he did not, that is, give biography priority over other methods of understanding medical history. Rather, he experimented and utilised very different methodological forms of historical writing throughout his career, ranging from high-culture explanations of medical discoveries to the employment of economic theory to explain poor public health. To Sigerist, biography had its uses (even if limited), and he said as much. 'Many doctors of old', wrote Sigerist in 1936, 'deserve to have their biographies written. Is there a more beautiful task than to resuscitate the life and achievements of a fellow-doctor even if he is not among the heroes of medicine?' (Sigerist, 1936, p. 3)

Here Sigerist points to several potential answers to the question 'Why biography?' As a man who wore many hats, Sigerist supported the writing of medical biography for varying, and equally compelling, reasons. At the time of his letter to Sarton, Sigerist admitted that it was not easy to keep the institute at Johns Hopkins afloat.

27 Sigerist, as quoted in Beeson (1966), p. 217. This quotation comes from Sigerist's discussion in 1948 of what his eight-volume history of medicine would aim to do.

28 As a contemporary of Sigerist, Owsei Temkin argued that Sigerist's Great Doctors was not 'biography'. Temkin contended that the book was 'not made to spring from a historical vacuum; nor [was] the history of development attributed to abstract forces of which the individual is a mere point of intersection' (1958, p. 492). Here we see how Temkin's rather narrow definition of biography stems from his background as a German-trained medical historian and his observations of lesser-trained physician-historians discussing medical ideas and theories without much concern for historical context. I would argue, however, that with a more robust definition of biography as a study of a physician's life, practice and ideas, Sigerist's Great Doctors does fall into the category of biography, and more precisely, collected biography. Although Temkin did not categorise Great Doctors as a biography, he did argue (1958, p. 493) that, as a book, it was one of Sigerist's three attempts to write a synthetic account of the history of medicine.

Acutely aware of his dependence on physician support, he concluded that biography might be the best method of maintaining financial backing from the medical school and its donors. In addition, like Osler, Sigerist saw biography as a means to recruit would-be medical students.

But biography was more than a means of financial gain or a tool for popularising medical history. To write biography was, in Sigerist's mind, as much a choice of utility as it was a matter of aesthetics. In his early career, Sigerist likened William Harvey's discovery of circulation to the Baroque, demonstrating that 'medical history itself could be beautiful, approached with the esthete's eye'. He brought much the same mindset to medical biography, well into his late career. When he spoke of biography, he talked about it in terms of 'beauty', a form of historical writing that could 'awaken respect' for physicians, a way to reveal the 'splendour' of doctoring, a 'calling' that included everything from the mundane tasks of caring for the chronically ill to extraordinary moments of medical discovery.

Finally, because he assumed that all medical historians would possess medical degrees, as he himself did, Sigerist thought that the life stories of 'fellow-doctors' would be of inherent interest to medical historians. Medical biography, in other words, would be history used as a process of self-discovery. As today's social historians readily point out, Sigerist insisted that the writing of history should be motivated by present-day concerns; for Sigerist, this also included the writing of medical biographies. 'Why', Sigerist asked, 'should a physician undertake the labour of consulting the past, of recreating it in history if it were not that he felt driven to such a task by medical considerations?' 'History', he concluded, 'is an instrument of life and medical history is an instrument of medical life' (Sigerist, 1936, p. 7). What mattered to Sigerist was not any particular historical methodology, but rather that a scholar's aim be true, with deeply felt 'historical dedication'.

Biography as a Means to Plurality

There is a limit, of course, to what historians of medicine can learn from Sigerist's own views and scholarship. He lived in an era when the history of medicine was remarkably homogeneous, when an overwhelming majority of its practitioners had medical degrees. Today, the field is heterogeneous, with historians of medicine coming from a multitude of educational, cultural and socio-economic backgrounds. But perhaps historians of medicine need not look outside of their own time period to approach the question of medical biography. There is, for example, Harold Cook's Trials of an Ordinary Doctor: Joannes Groenewelt in Seventeenth-century London.

29 For more on these points, see Sigerist (1926).

30 For Sigerist's use of art history to explain Harvey's discovery of circulation, see Sigerist (1929). On Sigerist's aesthetic sensibility, see Temkin (1958), esp. p. 490.

31 See Sigerist (1933) and (1954), as well as Sigerist (1936), p. 3.

32 For Sigerist's assumption that medical historians would also be medical doctors, see Temkin (1958), esp. p. 492.

33 Temkin (1958), p. 489, discusses Sigerist's belief in the importance of historical dedication.
The History and Poetics of Scientific Biography

Following traditional biographical writing, Cook begins his book with a full description of Groenevelt's Netherlands birthplace and education, and then proceeds to trace Joannes' medical career to England, where eventually, in 1694, the College of Physicians charged him with malpractice.

The fact that Cook chose to entitle his book Trials of an Ordinary Doctor tells us more about the profession of medical history than it does about the subject of his book. Cook takes great pains to avoid calling his study of Groenevelt a biography. Even though he employs much the same rhetoric that biographers use to introduce their subjects, Cook claims that the 'best justification for studying a person such as Groenevelt ... lies in the power of the genre "microhistory"' (Cook, 1994, p. xvii). While it is true that the scope of biography, like microhistory, is inherently limited — and that both tend to draw conclusions about the general from the particular — the two genres of writing are far from equivalent. Biographies might be a kind of microhistory, but not all microhistories take the form of biography. Indeed, surveying some of the original works of microhistory written in the 1970s and early 1980s — such as Carlo Ginzburg's The Cheese and the Worms (1980) and Natalie Zemon Davis's The Return of Martin Guerre (1983) — one finds that microhistories rarely focus on one person, and instead concentrate on a local group of people, usually in small, rural towns.

It seems that Cook's motivations for calling his book a microhistory are similar to those that led him to identify Groenevelt as an 'ordinary doctor'. Cook writes that Groenevelt was 'notorious' for his 1694 malpractice trial, becoming a cause célèbre in so far as his vindication in the English courts 'established an important legal precedent' (Cook, 1994, p. xv). Moreover, Cook points out that Groenevelt had published several works in medicine and was 'associated with an influential group of medical dissenters, innovators and translators, including Edward Tyson, John Pecbey and Thomas Sydenham' (1994, p. xiv). With such a description, one is left no other choice but to conclude that even Cook himself is not convinced of Groenevelt's 'ordinary' status. In a very real sense, Trials of an Ordinary Doctor is a biography of a great doctor in disguise.

With its biographical defensiveness, Trials of an Ordinary Doctor might give pause to the new social historians of medicine. Is the avoidance of biography and 'great' doctors detrimental to a field that aims toward scholarly sophistication?34 Jordanova, for one, has contended that such avoidance will inevitably keep the social history of medicine in a state of infancy. As she argued in 1993, the field of medical history will never mature until it is more 'fully confident in tackling areas of major historical debate' and it broadens its 'range of genres', including, and most importantly, 'scholarly biographies' (Jordanova, 1993, 438). In the United States, at least, it seems that the Sigerist founding story of liberation from physician-centred history has played a significant role in narrowing social history's scope, precluding full methodological and topical pluralism.

Conclusion

Since the 1970s, social historians of medicine have been trying to rewrite the history of their field from the bottom up. Many of them have been trying to recover the patient's view, the ordinary healer's view, the people's view — basically, any view that might challenge the elitist view, or, as it is commonly put, the view of the 'great doctors'. In the process, historians of medicine have banned biography as a valid form of historical scholarship, for they have convinced themselves that 'great doctor' history is synonymous with biography. Even scholars sympathetic to the new social history, such as Cook and Duffin, who find biography a fruitful means of exploring the past, are so affected by today's professional mores that they conceal their biographical leanings.

If the new social historians decide that biography should be reintroduced into the history of medicine, its reincorporation will not be an easy task, for their very identity is inextricably bound up with biography, or rather, with opposition to it. Social historians of medicine will thus only be able to accept biography once they reassess their own assumptions about their profession's past, whether it is a passing remark denouncing Oslerian history, or a tribute in praise of Sigerist. This, along with a re-evaluation of medical and science biographies written by some of today's leading historians, might be enough to generate a much-needed debate about biography — a form of historical writing that has, for better or worse, been crucial to the making of medical history throughout the twentieth century.

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34 Since I delivered the original version of this paper in May 2002, there have been two biographies written about 'great' doctors, namely Thomas Boser's Iconoclast (2002) and Alan M. Kraut's Goldberger's War (2003). At this point, it is too soon to determine whether these two books represent the beginning of a pro-biography trend. If they do and we are entering a new era of medical biography, we need to be fully self-conscious of the profession's troubled relationship with biography throughout the twentieth century. In other words, we need to ask ourselves 'Why biography?', and begin to establish some arguments for its use in the history of medicine.
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