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# Why Do We Do What We Do? The Values of the Social History of Medicine



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# Why Do We Do What We Do?

## The Values of the Social History of Medicine

**Richard A. McKay**

**Summary.** At the Society for the Social History of Medicine's biennial conference in Liverpool in July 2018, members gathered to discuss a short working paper developed by the Society's executive committee to articulate the values underpinning the SSHM's mission. The occasion marked the first public discussion of this document, in development since 2015, which was intended to encourage disciplinary self-awareness and engagement, to give a sense of the breadth and importance of work carried out in our field, and to spark broader discussion. To further these aims as the Society celebrates its fiftieth anniversary, the working paper appears here, accompanied by a foreward from the Society's Policy Development Officer and the lightly revised invited responses shared that day by five members at different career stages.

During a lunchtime session at the 2018 biennial conference in Liverpool, members of the Society for the Social History of Medicine (SSHM) gathered to discuss a short working paper developed by the Society's executive committee to articulate the values underpinning the SSHM's mission. The occasion marked the first public discussion of this document, in development since 2015, which was intended to encourage disciplinary self-awareness and engagement, to give a sense of the breadth and importance of work carried out in our field, and to spark broader discussion.

As the Society's Policy Development Officer and the committee member responsible for steering this exercise, I chaired the panel session, offering opening

remarks for context, introducing the five invited speakers who delivered their responses to the document, and facilitating the ensuing group discussion.

How did this process begin? In part, the working paper grew from a series of precipitating events that contributed, for me, to a growing sense of frustration and disciplinary vulnerability as a historian of medicine. These misgivings resonated both in my academic work as an early career researcher and in my position on the Society's executive committee.

In 2012, the same year that I was first elected to the committee, I began collaborating as the sole historian on an interdisciplinary research study led by evolutionary biologists.[1] At times during that collaboration, I found it challenging to articulate the value of my historical contribution, beyond a deep knowledge and careful curation of content and context. In 2014, against a broader backdrop of doom-mongering about the future of the humanities, many colleagues and I were dismayed by a dismissive account of our field from the editor-in-chief of *The Lancet*, in which he branded 'most medical historians' as 'invisible, inaudible, and … inconsequential'.[2] This description did not at all resemble what we knew to be true about our field and our work: that what we practice is tremendously valuable, but that this value might not always be evident to others—nor, possibly, to ourselves.



[1] Michael Worobey, Thomas D. Watts, Richard A. McKay, Marc A. Suchard, Timothy Granade, Dirk E. Teuwen, Beryl A. Koblin, Walid Heneine, Philippe Lemey, and Harold W. Jaffe, '1970s and "Patient 0" HIV-1 genomes illuminate early HIV/AIDS history in North America', letter, *Nature,* 3 November 2016, 539, 98-101.

[2] Richard Horton, 'Offline: The Moribund Body of Medical History', *The Lancet*, 2014, 384, 292. See also Carsten Timmermann's response, 'Not moribund at all! An historian of medicine's response to Richard Horton', *The Guardian*, 4 August 2014, https://www.theguardian.com/science/the-h-word/2014/aug/04/not-moribund-historian-medicine-response-richard-horton.

At one point I looked to our Society's constitution in an attempt to draw guidance and inspiration from our mission statement. I found little help there: since 1979—in a bid, it seems, to comply with charity legislation in the UK—this document has succinctly explained that our objects are: 'to advance the education of the public in the social history of medicine and as ancillary thereto and in furtherance of the said object to promote research and disseminate the results'. One might take this to read that 'you will know the social history of medicine when you see it'. Or could it be that it remains to each generation to define the specifics of what the social history of medicine means in practice?

For me, the final stressor occurred in early 2015 when the Advisory Committee to the Director of the National Institutes of Health (NIH) initiated a review of the National Library of Medicine (NLM)'s mission. Amid concerns that this information-gathering exercise might be the first step towards cutting funding for the NLM's history of medicine programmes, historians and societies like SSHM were encouraged to write responses supporting these important activities.[3] Regrettably, the call for responses came at a challenging time—midway through the academic term—exposing a key vulnerability of an executive committee composed predominantly of university-employed scholars. Though I managed to submit a personal response outlining how the NLM's historical offerings were important for my own research, I was unable to coordinate a response on behalf of the Society before the deadline. At the time this felt like a core failure, and one which contributed to my deepening sense of frustration.

[3] National Institutes of Health Request for Information Notice NOT-OD-15-067, released on 13 February 2015, which sought submissions to the Advisory Committee to the NIH Director National Library of Medicine Working Group. The Committee's final report, released in June 2015, cited 650 responses from individuals and organisations: https://acd.od.nih.gov/documents/reports/Report-NLM-06112015-ACD.pdf.

Yet it was from this low ebb that the idea formed for the development of the current working paper. Having expended considerable effort to justify the importance of medical history in my own letter to the NIH, it seemed reasonable to assume that other respondents might have done the same. We hypothesized, then, that other letters, like mine, would offer compelling justifications for the history of medicine, and that gaining access to this collection of responses might provide a valuable starting point for developing a statement that outlined the importance and value of our field. Securing these submissions through a Freedom of Information Act request to the NIH also seemed satisfyingly self-referential to the archival work that forms the heart of much historical data-gathering practice.[4]

Once the NIH transferred to me in anonymised form the responses they had received, I reviewed these for specific references to the history of medicine, and began grouping the results according to several emergent themes. When I reported periodically on my progress to the executive committee, we observed how refreshing it was to step out of 'business-as-usual' mode and reflect explicitly on why our work as historians of medicine—and specifically *social* historians of medicine—really mattered to us. One of the responses to the NIH review had cited the article by Jones et al., and our further committee discussions prompted us to draw on several additional reviews of the field and of the Society's history.[5] In 2017, we formed a

[4] Freedom of Information Act Case No. 43846; request submitted on 15 June 2015, with 1,168 pages of records received from the NIH on 31 July 2015.

[5] David S. Jones, Jeremy A. Greene, Jacalyn Duffin, and John Harley Warner, 'Making the Case for History in Medical Education', *Journal of the History of Medicine and Allied Sciences*, 2014, 70, 623-52; Mark Jackson, 'Introduction', in Mark Jackson, ed., *The Oxford Handbook of the History of Medicine* (Oxford: Oxford University Press, 2011), 1-17; Ilana Löwy, 'The Social History of Medicine: Beyond the Local', *Social History of Medicine*, 2007, 20, 465–81; Dorothy Porter, 'The Mission of Social History of Medicine: An Historical View', *Social History of Medicine*, 1995, 8, 345-59.

subcommittee to refine the statement and to navigate a tension inherent in our work and among our membership: pursuing the study of the past for its own sake versus using history to illuminate the present. Finally, we invited five members of the Society at different career stages to respond to the working document in Liverpool.

What is the product? Compared with the 1979 description of our mission, the working paper is descriptive and elaborative, yet still concise and clearly worded. Not surprisingly, given the process by which the statement took shape, it is polyphonic and multi-perspectival. The document is richly expressive of our field's diversity and many values: what *we* value, or cherish, as social historians of medicine, and the value that we offer others through our work and activities. The five speakers' comments extend the statement's reach in complementary ways: by focussing on the Society's history, by emphasising the questions that social historians of medicine ask of their topics, by pointing to the strengths and limitations of the working paper, and by inviting us all to be even more self-reflexive in our historical practice.

The open discussion that followed the speakers' comments was deeply engaged, often frank, and not solely focussed on the statement itself. Significant political and institutional upheavals and precarious employment opportunities for members—particularly those in their early careers—exposed some tensions. Many of those present saw utility in our efforts to expand upon the Society's existing, and very briefly worded, mission statement. That is not to say, however, that the working paper was unanimously supported in its current guise. One attendee, for example, pointed to a phrase which made her question whether the document—and thus, by extension, the Society—embraced her approach to history. Would it make others feel unwelcome? Another believed that the statement was insufficiently bold in its ambitions; instead, she would prefer a full-throated manifesto. The contemporary political context in the UK—with the government requiring that immigrants learn

arcane facts to demonstrate their commitment to British values in a written citizenship examination—also shaped a somewhat jaded reaction by some against any use of the word 'value'. Others spoke more generally about the importance of consciously reflecting on our Society's aims and activities, and on increasing the diversity of our membership. This last point connected to one of the main strengths left *out* of the statement, a recognition which came up repeatedly in the discussion: that our Society successfully promotes an inclusive, non-hierarchical, and welcoming community of scholarship and that this value in particular should be noted and celebrated even more.

In many ways, the discussion highlighted a perhaps irresolvable issue present in such an exercise. A mission statement of few words provides little in terms of inspiration, leaving much—possibly too much—to the imagination. Expanding a statement can provide a greater sense of the diversity and range of work in a field, but it may also leave some readers searching, sometimes in vain, for a specific articulation of their passions. Another reservation might be the view that it is a losing game to attempt to demonstrate your worth to others—by doing so, you will inevitably privilege *their* values. And certainly, as a society of historians, we may be more keenly aware than others about the speed with which mission statements can become dated.

What next? Ultimately, the SSHM's executive committee is much less wed to a finalised document capturing a disciplinary quintessence than it is to the value of fostering self-reflexive discussions such as these as the organisation celebrates its fiftieth anniversary in 2020. In the spirit of continuing the discussion, we are publishing the working paper here, along with the five speakers' lightly revised comments. We hope that this collection of papers will continue to generate a lively

conversation among members about the importance, richness, diversity, and value of the Society's work, and of the field of the social history of medicine more generally.

I would like to extend thanks to the five panel speakers for taking the time to prepare their thoughtful comments; to colleagues at the NLM for sharing news about the NIH review initiative as part of their public service to inform interested stakeholders; to members of the SSHM executive for taking part in the committee discussions and suggesting respondents and a title for the panel discussion; to members of the subcommittee—Erica Charters, Rosemary Cresswell, Claire Jones, Trish Skinner, and Carsten Timmermann—for their efforts in fine-tuning earlier drafts of the statement; to Sally Sheard and the co-organisers of the Liverpool conference; to those who attended the session on 12 July 2018 and enriched the conversation; and to our members for all of the work that they do out in the world to render what the Society does so valuable.

# Values of the Society for the Social History of Medicine

*Revised 8 December 2017*

Inaugurated in 1970, our Society exists to educate the public in the social history of medicine. To do so, we organise and support conferences, promote teaching and research, and disseminate work through our periodicals and book series. While our audience is broad and our work interdisciplinary, most of our members are historians interested in interpreting 'social' and 'medicine' as broadly as possible in the histories that we write and teach, and valuing the study of the past for its own sake.

Our founders were predominantly medical and social workers interested in using history to better understand the relationship between the social sciences and medicine, as a basis for policy formation in the present. As the Society developed, members came to emphasise the importance of studying past medical cultures on their own terms. As social historians of medicine, our work oscillates between studying the past for its own sake and revealing the current social and political implications of histories of health and illness.

## The contextual

Through our work, social historians of medicine and health highlight the ever-changing and provisional nature of the present while also emphasising continuities of behaviours, concerns, and inequalities. We raise questions about historically produced assumptions that influence present-day attitudes and policies. We show how medicine and healthcare are deeply embedded social enterprises and how many aspects of human health are shaped by a wide range of non-medical factors. We use medicine and healing as lenses for exploring different experiences of health and disease, which are affected by class, race, ethnicity, gender, and sexuality. We reveal the historical contingency of disease categories, disease burdens, and medical knowledge, and anchor the production and circulation of this knowledge to social, political, and economic contexts.

**The inspirational and foundational**

In our work, which draws upon many disciplinary approaches, we share stories that inspire, move, entertain, and intrigue. Some view the histories we produce as an important resource to suggest paths for future scientific and medical breakthroughs. Others stress the importance of understanding past worlds on their own terms, using the history of medicine to develop historical tools, methodology, and knowledge in order to deepen our understanding of the past. Our work is crucial for the development of healthcare providers' professional identities and competencies. It provides a foundation of knowledge for health professionals to understand and critique notions of therapeutic efficacy and progress, and to interpret changing causes of disease. It permits them to understand the constantly changing nature of healthcare systems, the diverse range of individuals' bodily and illness experiences, and to draw out and record perceptive and sensitive patient histories. But our work is also fundamentally historical. We build on the research and approaches of fellow historians to illuminate histories of health and illness, whether or not the persons described therein engaged with medical practitioners. And we teach our students historical skills and methods alongside an appreciation for the past on its own terms.

**The ethical**

Observing, honouring, and interpreting history is a fundamental civic responsibility. To fully understand ourselves in the present we must be able to identify the ways our thoughts, actions, and institutions echo those of our predecessors and the ways in which they differ. Historians of medicine and health, together with our colleagues in archives and museums, work to uncover, authenticate, interpret, and preserve the material riches of the past. We draw wisdom from past successes. We shine light upon dangerous and unethical historical missteps. At the same time, we show how the values and categories used to evaluate these incidents themselves change over time. The social history of medicine also enhances current scientific and medical research. An in-depth knowledge of the past can prevent the

inefficient, expensive, and harmful duplication of past efforts, correct past misunderstandings, and showcase what is truly novel in current investigations. We can also explore past ethical conflicts to better understand and safely navigate present-day dilemmas.

**The educational, civic, and political**

The history that we produce is vital, not only for helping to teach health professionals how to be skilled diagnosticians, but also for educating taxpayers, journalists, and elected officials, among others, on important health policy issues. We teach critical thinking using historical examples, and encourage empathy, tolerance, and breadth of analysis in making sense of the unfamiliar in the past, and in studying past practices and the social value attributed to them on their own terms. Our work helps citizens understand the historical circumstances shaping current healthcare systems and to use this understanding as a basis for both fostering institutional stability and driving political change.

## Roundtable Comment

**Margaret Pelling**

It is notoriously difficult to produce meaningful 'mission statements' and I applaud the seriousness with which the Society is attempting to do this. I am hoping in the course of discussion to hear more about why it was thought necessary to revise the existing statement. As an 'old lag' I am particularly interested to hear from younger colleagues as to what value they place on the word 'social'. In the wider historical world, it seems that few practitioners self-identify as social historians or as doing social history. Is this simply a matter of fashion, in which we see 'social' being replaced by 'cultural', or is there something embarrassingly passé and 1960s/70s about the word 'social', redolent of battles long ago either won or lost? Do we all do social history now, without having to think about it?

My own comments will inevitably have an historical dimension, which I hope will not sound either passé or embarrassing. When I entered the field, history of medicine (HoM) in this country barely existed as an independent historical discipline. Instead it was a kind of adjunct, a hobby for those we rudely called 'old docs', or a facetious preliminary to grab the attention of medical students at the beginning of a lecture, or a form of professional validation of the medical vocation. That history of medicine was a joke, a licence to laugh at the past, was something we felt we needed to combat very strenuously. That is, to do justice to the past, and to be taken seriously, we needed to do serious history. Overall though, it was the profession's view of itself which dominated. Even Henry Sigerist, one of the pioneers of the social history of medicine in the US, wrote a book (first published 1933) entitled *The Great Doctors*. This approach inevitably meant the exclusion not only of the supposedly

unenlightened but also of those apparently irrelevant to the march of medical progress, including women and even patients. Moreover, as enlightenment really only began in the nineteenth century if not later, earlier periods were also irrelevant.

The predominant grant-giving body, the Wellcome Trust, reflected these views. HoM was always an adjunct to its main purpose of supporting medical science. Its HoM programme was always administered by scientists rather than historians, using scientific models, and arguably still is, in spite of the co-option of professional historians onto committees. For a long time, for example, the Trust felt that the history of nursing was a subject which lay beyond the pale. The contrary view of social history of medicine (SHM) was that health and disease, logically and actually, came before medicine, and that the academically qualified physician was a very small tip of a very large health-care pyramid, all of which had to be taken into account in any historically valid analysis. This was also by way of recognising the relevance of individual and community choices in determining the nature and structure of medical occupations. Further, it involved moving away from the usual sources, which were the publications, many of them far more polemical than was realised, produced by those who have tended to monopolise the pen and the press, namely male physicians. There was a commitment also to recovering the voices of historical actors which had been submerged or which were only indirectly on the record. Finally, it was about producing a form of history which connected with the concerns of other historians. Here we have to use the word contextualisation, although it is very inadequate, because what we really mean is a form of integration and a wider range of comprehension. We should be comprehensible to those I will loosely call generalists, and they should be comprehensible to us.

For me, it follows that what we do is the same as for other historians. We try to make sense of the past, correcting misconceptions where necessary, and breaking new ground when we can. We are not adjuncts, and our commitment to academic freedom is the same as it is for other historians. Although we may hope to enlighten policymakers, we do not exist to assist them, just as we do not exist to prop up a profession's view of itself. As an early modernist by inclination if not by training, I concede that many of these issues seem clearer when one works on earlier periods. However, by the same token, early modernists have to fight in ditches to maintain access to funds, to posts, and to space in journals, and early modern history of medicine is far more likely to be casually dismissed as irrelevant, self-indulgent, or even ludicrous. I also concede that the pressures involved in preparing grant applications push us all in the direction of proving relevance and easy accessibility to the modern reader. But it does not follow from this that we should modify, let alone abandon, our core mission.

# The Social History of Medicine—Some Thoughts (and Questions)

**Margaret Humphreys**

'Why do we do what we do?' has multiple answers that will differ by respondent. Because it is 'really cool stuff'—fascinating, engaging, fun to excavate. Some will point to direct social good—informing health policy or educating health providers.

But I'd like rather to focus on 'what do we do?' What distinguishes the 'social' history of medicine from any other sort? This was much clearer in the 1960s and 1970s when the social history of medicine emerged in contrast to 'internalist, doctor-centred, great man/great discoveries' history of medicine. I revisited this distinction in the summer of 2017 when I taught a seminar in the social history of medicine in China. My hosts asked for a historiography lecture, but I think they were mightily puzzled by my talk. Because I focused not on method *per se*, but on questions.

I began with describing an experiment designed by Professor Michael J. Crowe that I participated in as an undergraduate at the University of Notre Dame. He presented teams of us with a white metal can that had a knotted rope coming out a hole in the side. There was a penny inside. We were told to discover five important things about the can.[1] 'Correct' answers included these 'important facts': the penny was attached to a rubber band; the penny was a 1943 steel penny and could be caught with a magnet; there was a menthol-scented substance on the rope; there was a balloon in the can that would pop if heated; there was red dye in the can, revealed by immersion. Various tools, such as a magnet and lighter, were available

[1] Michael J. Crowe, 'Investigating the Ways of Nature: An In-Class Experiment', 1998, http://depts.washington.edu/hssexec/committee/hss_nature.html.

but only on request. Most of us measured the can, calculated volume, etc. But that information was discarded as unimportant.

I ask my students to do a similar exercise. Take out a sheet of paper and write down five important facts about this room. Their lists are often humorous. Still, I tell them they got it all wrong because I'm the person that needs to lay new tile, or replace the bulbs, or fix the projector—and they haven't told me what I need to know. Or I'm an officer from immigration and I need to see their papers. This helps to emphasize how variable the concept of 'important' is. And that is exactly my point.

As historians we ask questions of historical 'rooms', but those questions are entirely determined by what we think is important. Earlier historians tended to focus on war or kings or great discoveries. History served national or professional glory. Social historians have changed the questions. In the United States there is an anti-racism initiative entitled #blacklivesmatter. Social historians think black lives, female lives, LGBTQ lives, disabled lives, non-dominant ethnic lives, immigrant lives, refugee lives, impoverished lives all matter. And ask penetrating questions about experiences, rights, and oppression. Our history naturally flows into policy, as needs and discrimination are revealed.

In my current research I am uncovering the life of an African-American male physician first found in an 1865 manuscript source. Dr J. D. Harris had hitherto been unknown to the historical record, but via multiple sources I have sketched his eventful life from birth to a free black family in Fayetteville, N.C. in 1833 to death in a Washington, D.C. insane asylum in 1884. His life course was remarkable. Why is this story worth telling? It is a story of success against long odds, albeit with a tragic ending. It gives life and depth to a little studied part of the population, the free black artisans who travelled to northern cities, and through haphazard access to education

moved into ‘white collar’ jobs and acquired fragile respectability. He is inspirational for medical students of colour, who like to know that such heroes existed, even at the time of slavery.

With such research we are back to ‘great man’ history of a sort, but with the overall message that such men (and women of course) are important too, and deserve the historian’s excavation and rejuvenation.

## Roundtable Comment

**Frank Huisman**

The Executive Committee of the Society for the Social History of Medicine is to be applauded for rethinking and articulating the mission of our field. Its members have produced a thoughtful and well-crafted document with which it is difficult to disagree. The document highlights four thematic clusters: the contextual; the inspirational and foundational; the ethical; and the educational, civic and political. It stipulates that social historians of medicine study the relationship between change and continuity of medicine and health care in order to intrigue, inspire or teach fellow citizens, policymakers or students. They do so because they are taking their civic responsibility in helping others to understand historical circumstances shaping contemporary health care systems. Reading the document, one feels proud to be a social historian of medicine, and one cannot wait to realise the potential of the field and contribute to the health and wealth of society.

At the same time, one realises that this is a normative document, speaking about values that all of us should cherish and seek to realise. Reality may be somewhat different: not all social historians of medicine are convinced that they have a civic duty to fulfil. As the values document observes, some of us stress the importance of understanding past worlds on their own terms; they value the study of the past for its own sake. As far as I am concerned this is perfectly fine, if only in the bigger picture of the division of labour within the field. But there is the potential danger of causing a legitimacy crisis in the outside world. In a well-known editorial, Richard Horton reproached medical history for not doing what it could and should be doing. Building on the physician and historian Oswei Temkin's much earlier view that

'"medical history should provide a humanistic counterweight to the claims of allegedly irresistible developments"', he argued that historians should be concerned with 'teasing out aims, attitudes, motives, moral and religious convictions'.[1] Horton thought that there was both a need and a potential for our field, but he did not see it happening.

In thinking about these issues, we need to be aware of at least two things in relation to legitimacy: audience and institutional context. Like medicine, medical history is no homogeneous, unified discipline. Its funding rationale differs from country to country, with important repercussions for its mission and organisation. Even within a given country there may be huge differences between universities and faculties. The UK is blessed with the Wellcome Trust's funding, which over the years has created a sophisticated body of literature and a strong discipline. Still, this mainly concerns professional medical history research at humanities faculties. The discipline is less well represented in the field of teaching at medical faculties. Wherever Medical Humanities was introduced in the medical curriculum medical history tends to be 'diluted' by ethics and narrative medicine. In Germany the opposite seems to apply. Under the *Approbationsordnung für Aerzte* there is a legal obligation for medical faculties to have an *Ethik, Theorie, und Geschichte* (ethics, philosophy, and history, or ETG) department. As a consequence, every single medical faculty in Germany has an ETG professor. He or she tends to have a medical background and is free to teach either of the three disciplines, depending on

[1] Richard Horton, 'Offline: The Moribund Body of Medical History', *The Lancet*, 2014, 384, 292. Horton quotes from Oswei Temkin, 'On Second Thought', in *'On Second Thought' and Other Essays in the History of Medicine and Science* (Baltimore: Johns Hopkins University Press, 2002), 1-18, 14.

personal taste or inclination. More often than not, this leads to courses in medical ethics taught by a medical doctor. In the Netherlands, there is no real system or rationale to the appointment of professors in medical history—either at a humanities or a medical faculty—other than local idiosyncrasies.

If and when we are keen to create an audience for the social history of medicine—not just in the UK but across Europe and the wider world—it is essential to create and maintain a strong infrastructure which allows for diversity and cross-fertilization: between history and medicine, between research and teaching, between professionals and amateurs, between policymakers and citizens, between and transcending nations. To conclude on a normative note, we should:

- cherish and develop the SSHM and the European Association for the History of Medicine and Health, because they supply valuable platforms for knowledge production and exchange across Europe;
- not only be there for professional medical historians but invest in other constituencies as well (physicians, policymakers, the general public, students);
- not only be devoted to research but to teaching and outreach as well;
- seek to link up with less well-developed parts of the world.

## Roundtable Comment

**Abigail Woods**

This is a very personal response that reflects my career stage and my career trajectory—as a health practitioner who shifted into the social history of medicine (SHM), initially in dedicated history of science, technology, and medicine (HSTM) units, and then in a large, diverse history department, which I now lead.

There is little to disagree with in the statement's characterisation of the work we do as social historians of medicine. However, there are three areas in which it could go further: education, inter-disciplinarity, and community.

1. Education

Most of what is described in the statement as 'our work' relates to the type of knowledge we produce, and which the SSHM supports by promoting conferences and publishing journals and academic book series. This focus on research reflects our identity as scholars who see the production of knowledge as our core business, and the education of the various publics identified in the statement as a spin-off. However, it does not align with the Society's original objectives, which were 'to advance the education of the public', and it neglects to consider the very important work that we do to educate students. As lecturers, we educate many more undergraduates than journalists and policymakers, and much of our employment depends on it. The delivery of research-led teaching makes students a very significant audience for our research. They can also potentially shape it through teaching-led research. Yet they barely feature in the statement except as recipients of generic training in historical skills and methods. Every student survey shows that

what students value about their university education is inspirational teaching and teachers. In the current climate, with a metrics- and market-obsessed government that is highly sceptical of the value of a humanities education, it is vital that social historians of medicine celebrate the difference they make in developing student skills, worldviews, and prospects as the policymakers, healthcare professionals and journalists of tomorrow.

## 2. Inter-disciplinarity

The institutional and intellectual scope of SHM has changed considerably over the last decade. However, these changes are barely reflected in this rather unambitious statement. In following the Society's founders to focus upon the links between 'history' and 'medicine' it has excluded the wide-ranging inter-disciplinary networks in which SHM is now situated today. Medical Humanities is notably absent, yet to capture university positions and Wellcome Trust funding in the UK today, it is often necessary to position ourselves as Medical Humanities scholars who happen to specialise in SHM, and to forge links with other such scholars from different disciplinary backgrounds.

The push for inter-disciplinarity is continuing to develop within universities—which are refashioning their curricula—and in new funding streams offered by UK Research and Innovation (the British national funding agency for science and research). If SHM is to survive and thrive in this changing world, it needs to go beyond the activities listed in the statement: to not simply draw on various disciplinary approaches, but to seek out and forge alliances with practitioners of science, social science, health and humanities, and work with them to build new inter-disciplinary methods, knowledges and educational experiences.

This is already happening. Our openness to working across disciplines is something that sets SHM apart from mainstream history. It gives us the skills to act as leaders within our institutions in the promotion of inter-disciplinary learning, and it allows us to make important contributions to addressing those wicked real-world problems that cannot be tackled effectively from any single disciplinary perspective (while at the same time advancing our own disciplinary perspectives). We sell ourselves short by not including these skills, qualities, and contributions in our statement of values.

3. Community

In focussing on the work we do as scholars and educators, the statement seems to say more about the individual members of the SSHM than the Society itself, but the Society is more than the sum of its parts. It advances SHM not simply by supporting our individual scholarship but also by forging us into a community—a very special community that is increasingly rare in the marketised, cut-throat, individualistic world of higher education today. It is welcoming, inclusive, collegiate, collaborative, and affirming. It assists scholars in finding peers, sponsors, and mentors, the crucially important people who will not only inspire great work but also build confidence, provide moral support, and general good company. It embeds scholars in networks that stretch beyond institutions and nations, and which promote intellectual exchange, personal and professional development. Its work in this respect has exerted a tremendous influence over my career, and has shown me what the sort of community I want to build in my institution, as a head of department. At a time when precarious employment and workloads are increasing and mental health deteriorating, the Society's achievements for the SHM community cannot be

underestimated. This statement needs to celebrate that, and say more about how the values of the Society are expressed in the culture and community it has built over the years and will continue to build in future.

# Is it time for social historians of medicine to embed positionality as part of the process of writing about 'the other'?

**Yewande Okuleye**

The Society's work on a values statement presents a welcome opportunity to question and reflect upon how social historians of medicine problematise the historiography of 'the other'. This is especially pertinent for medical historians researching, writing, and disseminating work located at the intersections of race, colonisation, and global histories, where the voices of 'the other' are barely present and frequently marginalised within the academy. For example, the Royal Historical Society's 2018 report on race, ethnicity and equality in UK history, emphasised that university history departments were predominantly white. In effect, histories and the discourse about the 6.3% black and minority ethnic (BME) 'other' are being reproduced by 93.7% white historians. This disparity is further exacerbated if we consider that 0.5% of university history academics are black.[1]

One contextual premise in the values statement maintains that 'We use medicine and healing as lenses for exploring different experiences of health and disease, which are affected by class, race, ethnicity, gender, and sexuality'. However, this statement does not sufficiently problematise how race inequalities among researchers might influence the production of historical knowledge and insights. Could sharper lenses, calibrated to reveal these complexities, be mobilised to write more nuanced and well-rounded histories? I ask this question from the

[1] Royal Historical Society, 'Race, Ethnicity & Equality in UK History: A Report and Resource for Change', 2018, 22, https://5hm1h4aktue2uejbs1hsqt31-wpengine.netdna-ssl.com/wp-content/uploads/2018/10/RHS_race_report_EMBARGO_0001_18Oct.pdf.

position of a historian who is racialised as Black, who has lived in the UK and Nigeria, and who draws on Black feminist literature to examine gaps and incongruences in the ways that representation and knowledge construction reproduce a Eurocentric hegemony.

Reflecting on the Society's draft statement of values creates a moment for social historians of medicine, who are predominantly white, to examine how their positionality, and especially their white privilege, might influence the production and dissemination of historical knowledge.[2] The examination of positionality and privilege might be counter-intuitive to our practice; nevertheless, I am persuaded by Nigerian author Chimamanda Ngozi Adichie's insights about the power of cultivating reflexivity. In her TED talk, 'The danger of the single story', Adichie frames positionality as an important analytical skill, and she illustrates how entanglements of difficult histories and the situatedness of the researcher are inextricably linked. Adichie's reflexive piece is pertinent, since it demonstrates how her experience of being 'othered' in the United States gave her a heightened awareness about situatedness and power. Adichie notes that:

> It is impossible to talk about the single story without talking about power. There is a word, an Igbo word, that I think about whenever I

[2] Peggy McIntosh, 'White Privilege and Male Privilege: A Personal Account of Coming to See Correspondences Through Work in Women's Studies', Working Paper 189, Wellesley Centers for Women, 1988, https://nationalseedproject.org/Key-SEED-Texts/white-privilege-and-male-privilege. McIntosh observed that men might acknowledge that women were disadvantaged; however, they did not acknowledge or denied their privilege. This prompted McIntosh to examine aspects of her lived experience, which conferred certain advantages in comparison to her black colleagues. McIntosh concluded that, like male privilege, white privilege was unconscious, and its potency was invisible to white people.

> think about the power structures of the world, and it is 'nkali'. It's a noun that loosely translates 'to be greater than another'. Like our economic and political worlds, stories too are defined by the principle of nkali: How they are told, who tells them, when they're told, how many stories are told, are really dependent on power.[3]

In the context of Adichie's narrative, she was 'greater than' Fide, the family servant. Adichie was initially unaware of how her class privilege within Nigerian social hierarchies empowered her to internalise and reproduce an uncontested narrative about Fide's family. Eventually, Adichie's insights from her lived experience—as someone subsequently othered within American society—highlighted how power and language are mobilised to construct the single story. Her experience of being the object of the single story helped Adichie appreciate and eloquently articulate how cultivating researcher reflexivity enhances our ability to continuously clean our lenses—instruments which become smudged by our subjectivities and unacknowledged privileges. Adichie cautions us that: 'The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story'.[4] Single stories mask complexities and nuances, flattening the richness, diversity, and complications of the human experience. Adichie's realisation that Fide's family was hardworking

[3] Chimamanda Ngozi Adichie, 'The Danger of a Single Story | TED Talk,' TED, 2009, https://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story/transcript?language=en. Adichie's books include *Purple Hibiscus,* which won the Commonwealth Writers' Prize, *Half of a Yellow Sun*, which won the Orange Prize and *Americanah*, which won the National Book Critics Circle Award and was named a Top Ten Best Books of 2013 by the *New York Times*. Adichie is of Igbo ethnicity, and Igbo is the language spoken by people from South West Nigeria.

[4] Ibid.

and creative, despite their economic status, destabilised the power of the single story.

I found Adichie's insights inspiring and instructive in formulating my ideas about the potential impact of embedding reflections on positionality and racial privilege within the Society's statement of values. What would this look like, and how would we negotiate this journey? Could medical historians borrow from the social sciences the practice of writing positionality statements, an approach that acknowledges the multi-layered aspects of research and writing? Undertaking this critical self-reflective exercise might be a challenging or uncomfortable journey, but one worth the reward of more complete stories.

Why Do We Do What We Do? Panel Discussion, Liverpool Conference, 18 July 2018 (Photograph by Trish Skinner)