History and Social Change in Health and Medicine (book chapter)
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In general, qualitative research – in health or otherwise – has not paid much attention to history. And why should it? While most qualitative scholars, particularly the more constructivist among us, would naturally acknowledge that the people and societies they study are different to those that preceded them, this mostly has little or no influence in practice on research design or conduct. History is interesting, yes, but in most cases must seem either too arcane, or too removed, to inform health research.

There are, however, occasions where history may seem to have some instrumental value for health research: to learn about the efficacy and impacts of interventions in the past; to avoid past mistakes or reinventing the wheel; to be more influential advocates. For example, health researchers may be interested in social histories of Prohibition-era USA in order to think about the feasibility of drug bans. Similarly, studies using oral history interviews with politicians and other stakeholders involved in tobacco control legislation were conducted to delineate the set of social conditions and processes that resulted in legislative change, in order to identify any generalisable features that might allow advocates to achieve further tobacco control more quickly and efficiently in the future, or at least to predict and produce conditions conducive to accomplishing further control (Bryan-Jones & Chapman, 2006; Claire Hooker & Chapman, 2006). These studies have empirically verified the utility of Kingdon's model of policy change (Claire Hooker & Chapman, 2006; Jacobson, Wasserman, & Anderson, 1997; Studlar, 2002) and underscored the key role of 'policy entrepreneurs' and 'windows of opportunity' in getting tobacco control onto the policy (and eventually, legislative) agenda.

These sorts of studies are certainly compelling and often useful. What they do *not* do, however, is capture the unique qualities of people's action and experience in a specific time and place, nor situate or understand these things in relation to wider social influences. There are different, good, reasons for qualitative researchers to be interested in history: for its capacity to enhance sensitivity to social context and its unique critical perspectives on health and medicine. The approaches and perspectives of history – the development of what I refer to as an 'historian's nose' – can lead scholars to ask important new analytic questions, challenging their assumptions and goals, and leading to much deeper or more novel analyses. For example, an analysis, from a cultural history perspective, of those same oral history interviews relating to tobacco control, looked totally different. It identified a broader discourse on 'drugs' that delineated social and moral concerns about consumer society, including its capacity for social alienation and political and commercial manipulation, that influenced (and was influenced by) talk and policy about tobacco (Claire Hooker & Chapman, 2007). This was not only interesting, but had instrumental advantages as well, since it means that an advocate may well be more successful if they are sensitive to the

broader discourses and concerns that frame social and political debate for a specific group of people at a specific time in history. (It also produced a critical theory approach to tobacco control itself, which was very important but also rather discomfiting for tobacco control advocates. I say more about this below).

History is a form of qualitative research, and historians and qualitative researchers do similar things - interviews, document analysis - and have similar sets of concerns - such as how to access and understand minority voices, or how to conceptualise someone's experience of illness. Nonetheless, in practice I have found that many historians have never even heard of qualitative research and that qualitative researchers rarely understand their topic in historical terms. Further, what each group means by 'methodology' is often quite divergent: the emphasis on procedure and process in qualitative research in particular is very foreign to imaginative and theoretical historical methods. Naturally, the results also diverge: which is why 'qualitative research' is likely to yield the instrumentalist model of policy change and 'history' the exploration of discourse on drugs I indicated above.

In this chapter I will review different approaches to the history of health and medicine and briefly comment on their implications for qualitative research in health. Historians and qualitative researchers confront many of the same puzzles about the relationship between theory, method and knowledge, and converge in their engagement with issues of power and representation, in their questions about what to count as evidence, and in their speculations about how to go about understanding it. I will therefore muse on the relationship between theory and method in history as we go.

Orientation: What is distinctive about history?

As we know, qualitative research has its roots in the social sciences, principally anthropology and sociology, and in the philosophical traditions within these (eg, pragmatism, phenomenology). History has developed as a separate, distinct discipline alongside the social sciences. The distinctions between them are a matter of degree, not of kind: there is, and has always been, considerable cross-fertilisation. Both are characterised by the same tensions – between aesthetics and formal reasoning, between humanistic descriptive exploration of people's experiences and identifying the processes and consequences of social systems, between attention to the general and theoretical and to the empirical and particular (Giddens, 2006) – that will be very familiar to qualitative health researchers.

So what is distinctive about history? In general – and throughout this discussion, the reader should bear in mind that overlap is considerable and counter-examples not uncommon – firstly, history is interested in tracking social *change*, and also *continuitie*s that have amazingly endured across social change. It is unsurprising that qualitative research has been largely uninterested in change over time, since it originated in forms of sociological inquiry, like symbolic interactionism, that were focused on the immediacies of social activity.

Secondly, historians have been somewhat more interested in the specific and particular, in delineating what is *unique* to each episode (Goldthorpe, 1991) (Thompson, 1994). Historians are not the only ones interested in social change: there is an entire field of sociological research, 'historical sociology', devoted precisely (though not solely!) to the question of how and why societies alter (Smith, 1992) (see also new trends in 'world history', eg (Ann Curthoys & Lake, 2006)). To a (small!) degree 'historical sociology' still remains different to 'history', because they are interested in different kinds of social change at different times and for different reasons (San Pedro Lopez, 2004). A primary focus for

historical sociologists from Weber to Parsons to Giddens has been identifying 'big picture' theories of what social processes have driven large-scale social and political changes, such as the rise of democracies or the occurrence of dictatorship or the creation of the working class. (Let us remember that Marx's was a deeply historical theory. In his view it was the dialectical relation between labour and capital that was the 'engine' of history and the motor for social change).

But the very aspect of a social theory that makes it compelling, namely its ability to identify common processes and the *generalisable* features of events and relationships, are precisely what hinders its ability to be very meaningful about a local context. Historians like to use these theories to understand the past, but they like even more to add detail and complexity to them. Many qualitative researchers will sympathise with the tension between developing 'theory', that is identifying causal relationships and social processes from a set of similar situations, and weaving together theory-based insights into a coherent explanation of the occurrence and character of a unique situation. This tension also exists *within* both qualitative research (think phenomenology and portraiture versus grounded theory) and history itself.

The most obvious difference between the practice of scholarly history and that of qualitative research is in their different approaches to the relationship between theory and method. Qualitative research has developed several formal methods to guide the processes of data collection, analysis and writing in each of the different traditions of qualitative research (Creswell, 2007). By contrast, it is virtually unheard of that any historian would have a formal plan for data collection or analysis. The practice of coding data is in itself already a far more self conscious process than anything I ever encountered in history, let alone strategies like member checking or constant comparison. By and large, you just follow your nose, and at some level I think most of us really value the emergent qualities of this loose approach.

Yet historians often mentally invent for themselves exactly the sorts of practices that qualitative researchers have named, discussed and formalised. We/they mentally make note of 'themes' and concepts; we/they identify discourses, explore social categories, and describe relationships. Like qualitative researchers, historians tend to iteratively (abductively) move between primary sources and 'secondary' or published theoretical material, using the latter to illuminate the subjects of the former, and then returning to the primary sources to reconsider and gather more material. And so, slowly, analysis develops, which may or may not include the explicit development of new theory.

Historians are very conscious that writing is a central act of analysis (Berger, Feldner, & Passmore, 2003; Burke, 2001; Ann Curthoys & Docker, 2006; Rusen, 2005). History is much more deeply entrenched in literary traditions than qualitative inquiry, which conforms more to the genre of scientific writing. While historians naturally privilege their own accounts and retain claims on truth telling and the accuracy and appropriateness of their interpretations (as we shall see below), they have also always been conscious, in a way most qualitative researchers are *not*, that their work is literary, that its persuasiveness inheres as much in its style and in the way the story is put together as in its empirical bases (Clendinnen, 1999; Ann Curthoys & Docker, 2006). The conventions of published history do not lie in the format of aims, methods, results and conclusions. Historical writing is often without organisational subheadings; its genre is the literary essay, in which the reader is led along a path of argued interpretation with the writer acting as narrator, tour guide, and fabricator.

As an increasing number of scholars begin to work in both history *and* qualitative research, historians may become more deliberate in their process-methods and qualitative researchers more sophisticated in their approach to context. Adele Clarke is an outstanding example of a scholar who works in both traditions, and whose practice can incorporate both the literary, imaginative and rhetorical *and* the formal, processual and empirical at relevant points in her work. It is perhaps not surprising that a scholar who was impelled to move from qualitative research to history (and then to continue with both) was working on health and medical issues (especially reproduction) from a feminist perspective, which, as I show below, often tends to beg historical questions (Clarke, 1998). Clarke's theory-method package – situational analysis –deliberately includes time, change and history as important components of analysis (Clarke, 2005).

But for now, the relationship between theory and method for the historian, then, is not predominantly located in the research process itself. It is a more subtle matter, involving conceptually locating historical practice in the ideological aims and approach of one's history writing.

Historiography and the Uses of History

To explore the theoretical foundations and methodologies of history, or any other discipline for that matter, we must first understand why it was written. The uses of history range from the heavily ideological and utilitarian (and this is often the *primary* way in which public health encounters history) to the domains of pleasure, entertainment and curiosity. But mostly they converge on what cultural ('postmodern') historian Hayden White described as 'some idea of what a good society might be'. 'Any science of society', according to White, 'should be' – I would say, always is – 'launched in the service of some conception of social justice, equity, freedom, and progress' (White, 1973). This was as true for historians in the past as the present, but their versions of what might make society 'better' were often very different from our own.

i. Empiricist / 'Whig' history

Should not history be the incontrovertible record of the past? Leopold von Ranke (1795-1886), a nineteenth century German founding father of the modern scholarly field of history (Krieger, 1977; Rusen, 1990), is traditionally regarded as the chief exponent of this view. For Ranke, history ought to be as objective and reliable as chemistry or botany (which were just coming into being at that time: science was new then, too, the word 'scientist' not even invented until the 1830s (Fisch, 1991)). History should be 'just the facts', an account drawn from close examination of 'all the documents' (by which he meant political records, diaries, letters, newspaper articles), with the historian as an external, neutral observer whose job was to neither 'judge the past' nor 'instruct one's contemporaries about the future', but merely to 'show how it actually was'. In other words, for historians today Ranke represents the *empiricist* approach to history (Gilbert, 1990; Huisman & Warner, 2004; Iggers & Powell, 1990).

This form of history exercises considerable attraction to scholars in public health. For many public health researchers history is often primarily considered simply as a *source of data* used simply to generate a *record* of the past, very much in the Rankean mould. This is the case for most histories of individual hospitals or medical schools, which aim simply to record

events and people. Similarly, many practitioner-authored works, in the traditions of antiquarian research (Griffiths, 1996), are largely chronological lists of the experiences and accomplishments of their counterparts in the past. Empiricist history is also of interest to health researchers whose historical research is conducted in order to *develop and test theories* about, for example, the habits of infectious diseases or the effectiveness of public health interventions. One of the most famous examples of this sort of history is the debate about whether decline in mortality in western nations over the past century and a half (or so) can be attributed to public health interventions such as immunisation, or if have arisen almost entirely as a result of increasing nutrition and fertility (Colgrove, 2002; Huisman & Warner, 2004; McKeown & Record, 1962; Szreter, 1988, 2002). Historical data of this kind is often of particular interest to researchers interested in the social determinants of health.

But of course there is no such thing as an objective just-the-facts record of the past. The historian must choose what documents and events to select and discard; s/he must then make the selections meaningful and interesting by weaving them together in a story. In health and medicine, an often dominating story was that of 'the conquest of epidemic disease' (Winslow, 1980 (1943)). Frequently written by physicians and health officers, these histories detailed the progress of medical science from primitive times to the present, from Hippocrates and Galen to Pasteur and Koch (R. Cunningham, 1996; Latour, 1988; H. J. Parish, 1968). Practitioner-authors who had worked for government departments of public health wrote a similar story about the development of public health itself, from the heroic quarantine measures applied to control plague in medieval Europe to the sanitary measures advocated, in the days before germ theory, by men like Edwin Chadwick (architect of a raft of sanitary reforms, like nightsoil disposal, building codes of housing, and the regulation of refuse and industry), John Snow (who identified a water pump as the source of an outbreak of cholera, and hence cholera as water-borne), August Semmelweis (who insisted on physicians washing their hands between patients as a means of preventing puerperal fever and lowering maternal mortality), and Joseph Lister (who generated *antiseptic* and *aseptic* conditions for surgery), (Newsholme, 1927; Rosen, 1993 (1958)) (Lewis, 2003) (D. Porter, 1999b).

Although purporting to simply record the series of events that led up to present day conditions, these sorts of histories in fact serve several functions – and the awareness of these multiple functions has led historians to a critique of empiricist history. What seems merely factual is in fact, as I have said, a powerful *story*, one told (like any good story) to produce a particular set of effects on its audience. The sort of story I have described above does several things. Firstly, it assumes a trajectory: it superimposes a beginning, middle and end onto the past, and in so doing generates a sense that history is moving towards a particular place, that it is *teleological*. This sense has strong imaginative power and has been common in narratives in the West since the Industrial Revolution (which was, and often still is, represented in terms of 'achievement', 'progress' and 'accomplishment'). Progress narratives were and are in everything from evolutionary biology - evolution as 'progress' from single celled critters to that pinnacle of alleged superiority, *homo sapiens* - to political nationalism (Beer, 1983; Jardine, 2003).

But they are not true. The history of health and medicine does not show a linear increase of enlightenment and progress. Scientists did not just accumulate increasingly accurate evidence and concepts, nor did health bureaucrats keep making better, more informed decisions (as public health advocates ought to know from bitter experience, if nothing else!). Nor did health officials always make decisions for the 'right' reasons: sanitation proceeded on the basis of miasmatic theory, which today we consider 'wrong', and could even have

been *hindered* by germ theory, which today we consider 'right' (A. Cunningham & Williams, 1992; Worboys, 2000). (Evolution doesn't 'progress' either, and I refer the lay reader to Stephen Jay Gould's books, especially *Wonderful Life,* for a stunning understanding of this and of how concepts of natural and human history get troublesomely intertwined (Gould, 1990). The most famous critique of progress narratives can be found in Thomas Kuhn's paradigmatic analysis of paradigm change (Kuhn, 1996).)

Secondly, this story serves mostly unstated social and ideological purposes: to celebrate and legitimate government-based, institutionalised, scientific health and medicine. The story is a story of *triumph*, a quality that validates the public health enterprise and shields it from critique. It is a good story, too, full of familiar and compelling plot devices: men of vision and courage (= hero), like Louis Pasteur, fight to overcome the forces of evil (= disease), struggling along the way to convince the prejudiced and the ignorant (= opponent), such as doctors who thought disease was caused by unpleasant odours associated with the socially devalued (the poor, the non-white). These plot devices lend the story moral weight. It serves to *commemorate*, and by corollary to reaffirm, the authority of the 'great men' who built and controlled the public health enterprise. It generates *originary moments* by commemorating what science values: the claim of discovery. So many histories of health and medicine are written to celebrate 'the first' clinical trial, the first discoverer of vaccination, and so forth (H. Parish, 1968). It also serves to establish a *tradition* in remembering and valuing the past, and, by anchoring us to that past, to construct our collective (Western) identity as rational, scientific, and forward-thinking (Huisman & Warner, 2004; D. Porter, 1999a).

This kind of teleological history is termed 'Whig history' (after a genre of late eighteenth and early nineteenth century histories that viewed history as the path towards the apex of human political development, British parliamentary, constitutional monarchy (Jardine, 2003)). It has long been subject to critique by those who recognise what the story leaves out. For example, this story about public health only includes particular actors – 'great men' who made significant discoveries or who, as doctors or as statesmen, had enormous influence on their social sphere, as is if it were individuals, rather than social changes or shifts in practice, that affect history (Reverby & Rosner, 1979). This makes the many other actors that took part in past events invisible, which is why women and non-white folk get left out of so many histories (Scott, 1996). In other words, empiricist / Whig history fails to acknowledge that theoretical perspectives inform the selection, interpretation and representation of 'facts'.

(The reader will have noticed that I've just done some Whig history myself by positioning Ranke as a 'founding father' of his field, as if it were 'fathers' who 'found' things and as if there was no real history written before him. Scholarly historians often reject histories written by earlier generations and those written by non-professional historians, like doctors. So by beginning my story, per tradition, with Ranke as history-to-be-rejected, I make the rejection of empiricist history normative, and validate my approach to history as correct (Huisman & Warner, 2004). Yet, like most historians and qualitative researchers, I too ground my research in primary sources; I try to put aside my own preconceived ideas in order to 'listen' to those sources; and therefore, while I acknowledge that history is always interpretive, I like to insist on the realness of my histories.)

The other problem with empiricist history is that its claims of objectivity are very often only a thin disguise for deeply ideological purposes. This explains my discomfort with my public health colleagues' use of history to support their advocacy for tobacco control. Theirs is a

largely triumphalist narrative of progress towards ever-increasing tobacco control, accomplished through heroic advocacy in the face of pitched battles with corporate interests (R. Cunningham, 1996; Glantz & Balbach, 2000). Their approach has been empiricist: mining millions of tobacco industry documents – letters, reports, marketing materials, notes of meetings - for any quotations that demonstrate how tobacco companies have deceived the public and manipulated and corrupted government practice for profit (Chapman, Byrne, & Carter, 2003; Glantz & Balbach, 2000). I was and am politically deeply committed to tobacco control, but I was and am simultaneously deeply uncomfortable with this kind of history: one claiming objectivity, but pursuing a preset intellectual and moral agenda; one that excludes material *not* related to the project of shaming the tobacco industry; one that sidelines discussions of the ideas, representations, language and values that frame its own politics or those of the actors of the past. Other histories of tobacco are both possible and, *pace* advocates, even desirable, as I shall show below.

ii. Social history

The strongest critical thrust against Whiggish history came from what was, in the 1970s, termed 'the 'new' social history' (in fact it had many antecedents). Emerging from the feminist, civil rights and other liberationist movements of the 1960s and 1970s, and with foundations in what was by then a half century of Marxist/left wing social critique and historical writing, these histories were driven by the ideological and political agendas of the day. Firstly, they intended to bring actors other than 'great men' into historical view, and secondly, they were written to validate the experiences and capacities of these social groups.

In the arena of health and medicine the manifesto for the new social history was laid out in the introduction to an edited collection produced by Susan Reverby and David Rosner while they were graduate students, generating a still-expanding universe of new insights and new research (Reverby & Rosner, 1979). The search for the history of various minority groups led to an enormous expansion of topics that could be studied: for instance by examining the history of nursing as well as of surgery, or exploring institutions, such as hospitals and asylums, founded by and for these groups. A major challenge for 'history from below' was that of accessing the voices and experiences of these groups, since the poor and excluded were often illiterate, leaving few records behind them (Fissell, 1991; Joyce, 1991). Reverby and Rosner were especially interested in acknowledging the agency of non-white populations, so that public health and medicine did not appear simply as things that happened *to* minority populations - a way 'to teach them how to live' (Sears, 1992) - but were altered and incorporated into their own practices, or rejected (Reverby & Rosner, 2004). A recent, elegant example of social history is Margaret Humphrey's history of malaria in the USA, which includes the reflections and views of the impoverished black communities that were mostly affected (Humphreys, 2001).

Researching the socially disadvantaged rapidly led historians to examine the power relations in which their subjects were enmeshed. For example, social historians examined how nineteenth century welfare (substantively including medical care) was distributed to the 'deserving' but withheld from the 'undeserving' poor, and how these categories were defined and redefined over time (Fissell, 1991). Similarly, feminist historians traced the exclusion of midwifery by the processes of professionalization in (mostly masculine) medicine, and the subsequent 'medicalisation' of women's reproductive bodies (English & Ehrenreich, 1978; Feldberg, Ladd-Taylor, Li, & McPherson, 2003) (Clarke, 1998) – though of course (as I discuss in the next section) it turns out that this was a very *middle class*

'feminist' view: getting *access* to 'medicalised' case such as caesareans was and remains much more important to women from low socio-economic locations.

Public health interventions were suddenly revealed, not as benign or even well intentioned, but as the exercise of often punitive social power. For example, historians revealed biomedicine's primary role in the construction of deviant sexuality and in the policing and literal incarceration (in so-called 'lock hospitals' or on islands) of women defined as immoral, diseased or disorderly (Bashford, 2004, 2006; Lewis, 1998; D. Porter, 1999a; Spongberg, 1997; Strange & Bashford, 2003). Perhaps the most tragic end of this spectrum is the history of 'social hygiene' (eugenics), which was a fundamental component of public health policy in all western nations in the period between the first and second world wars. Social historians explored the institutionalisation and/or forced sterilisation of people defined as 'unfit', including those medically classified as mentally retarded and large numbers of indigenous peoples, and of course, the coercive euthanasia policies of the national socialists (Kevles, 1985; D. Porter, 1999a; Proctor, 1988). Reverby herself produced several works on women's history (Reverby, 1987; Reverby & Helly, 1992) and then explored the vexed social and ethical issues that arose from the revelation that the USA Public Health Service had deliberately withheld diagnoses and treatment in order to study 'the natural progression of syphilis' over the course of 40 years in a town of poor black share-croppers without their knowledge or consent (Reverby, 2000) (for a different view see (Schweder, 2004).

While it was largely focused on reading wider social relations 'in' to the contexts of health and medicine, social historians did not forget to study the reverse – the influence of disease (and disease control measures, not to mention changes in agricultural practice, lifestyle and consumption,) on society itself. Present day 'ecological' histories are important in returning historical focus to macro and geographical social changes, such as patterns of human migration (Anderson, 2004; Crosby, 1986). Some of the most important have charted the devastating impacts of disease on former European colonies and the long-lasting implications for indigenous populations (Anderson, 2004) (Diamond, 1997). But, as eminent social historians Charles Rosenberg commented about the three devastating epidemics of cholera in early nineteenth century America (which provided the stimulus and context for initiating considerable public health reform), each epidemic occurs in unique social circumstances and hence may be understood differently and generate quite different social responses (Rosenberg, 1962).

Many diseases can, and have, been seen as primary shapers of society in similar ways – leprosy and the identification and exclusion of the stigmatised (Bashford & Hooker, 2001; Strange & Bashford, 2003); syphilis and the rearrangement of social and sexual mores (Quetel, 1990) (Brandt, 1985); smallpox and the development of vaccination (Bashford, 2004) (Farmer, 1993)– and so forth, up to and including SARS (shadowed by avian influenza) with its capacity to influence the reorganisation of global health governance and its re-identification of Asian peoples (but also travellers) as the reservoir of danger in the modern world (Bashford, 2006; Fidler, 2004). (The historical eye here also reveals the extent to which attention to the 'new and re-emerging' infectious diseases, far from altering practices, actually re-inscribe many of colonial-era ideologies of medicine and public health (King, 2002).)

My own micro study of tobacco control legislation in Australia was grounded in social history. Social historians have documented the vastly different forms and practices of smoking in the past, from the peace pipes of the 'New World' to the rise of the cigarette in the context of mass production and marketing and the reorganisation of the working day in

industrialised nations (Goodman, 1993). They tracked the social significances of smoking from the daring postures of the flappers to various poses of power, authority and reflection (Brandt, 2007). One historical sociologist identified smoking practices as extensions of the 'civilising' process in the history of manners (Hughes, 2003). Unsurprisingly, a prime focus of their attention has been to the ways in which smoking was practiced and controlled, particularly in across the increasingly adversarial political environment of the late twentieth century (Tyrrell, 1999; Walker, 1984). Histories of control practices and campaigns are of course forms of social history (Chapman, 1992; Jacobson et al., 1997; Studlar, 2002) (Troyer & Markle, 1983).

Social history has left historians with a twin legacy: it encouraged health advocacy and activism on the one hand, but generated critiques of public health endeavours on the other. Many qualitative health researchers would relate to this dilemma; think, for example, of indigenous health, where public health interventions are so urgently needed, and where so many public health interventions have had such destructive effects in the past.

History can help qualitative health researchers to think critically about their own projects, while remaining committed to the values and ideals that inspired them in the first place. History offers the perspective afforded by distance: once the immediate exigencies of politics and personalities are gone, it is often easier to be critical of how health issues in the past have been framed and the acted upon. It is easier, now, to see how otherwise admirable and certainly well intentioned public health workers framed indigenous women as poor mothers and removed their children, with disastrous consequences; easier to see prostitutes as vulnerable women in need of support, not as moral monsters in need of control; easier to identify and analyse the different kinds of bodily ideals that have framed public health endeavours, and so question, not merely our own physical ideals, but the entire project of self-discipline with the objective of achieving what public health and medicine deem to be an appropriate body. In time, perhaps, if and when tobacco companies become less threatening opponents, it might be more possible to see tobacco control as enmeshed in marketing and other processes of persuasion, not simply as scientific and moral righteousness. This critical stance is sharpened and honed by attention, not just to experience and outcomes, but to meanings.

iii. Cultural history

The 'add minority group and stir' (Noddings, 2001) approach of social history inevitably raises questions about knowledge and meaning. Start wondering about how women were active in Victorian era public health, when all the officials were men, and one soon realises the answer to this depends on how women were seen (which turns out to be often in terms of 'purity', as the agents of bodily, domestic and behavioural and moral 'hygiene', and 'pollution', as agents of physical and moral contamination (Bashford, 1998)). Ask further about how gendered binaries – mind/body, hard/soft, public/private (Reverby & Helly, 1992) – colour our worldview, and you start seeing categories like 'woman' and 'man' not as starting places for writing history (as in, 'where were all the women?'), but as *themselves* historical (Scott, 1986) ('what did they mean by 'woman'?'). As Mary Fissell put in, she suddenly saw all the 'social facts' she had so painstakingly garnered about early nineteenth century working 'families' from parish records as *cultural constructions*. What she was witnessing was the construction (and reconstruction) of the very idea of 'the family': families were not (just) facts, they were *artefacts* of systems of cultural attitudes and social power (Fissell, 2004).

The focus on meaning (which also comes under the umbrella term 'postmodernism') has been, and continues to be, an enormously and productive area of research in the history of health and medicine. For example, the HIV/AIDS epidemic has been treated as an 'epidemic of signification' that has had profound implications as to who was identified as 'at risk' or as 'sick' and how they were governed and 'treated' (both by medicine and by other people in their society) (Treichler, 1999), (Sontag, 1991). (For the purposes of comparison, a 'social history' approach might have stopped with identifying the experience of discriminatory treatment for homosexuals, prostitutes and IV drug users).

New theoretical approaches to the history of health and medicine have been derived from these insights. For example, Charles Rosenberg, the author of some of the most canonical works in the social history of medicine, proposed that we understand 'disease as 'frame': 'pictures' derived variously from social preoccupations, cultural beliefs, and biomedicine, whose creation and implications for various social actors can be historically traced (Huisman & Warner, 2004; Rosenberg & Golden, 1992). As qualitative researchers know well, a 'frame' offers us a particular view of a picture: it sharpens some aspects of an issue and obscures others (Goffman, 1974). Actor network theory, whose methodology effectively required scholars to trace the 'histories' of ideas and technologies (pasteurisation was an early, famous example (Latour, 1988)), was developed to overcome formerly assumed, and now increasingly untenable, distinctions, such as that between structure and agency and between 'nature' and 'society'.

This 'cultural turn' is of course familiar to qualitative health researchers under the guise of 'critical theory'. As is the case for qualitative health researchers, the work of Michel Foucault - itself deeply historical – has been much utilised in the cultural history of health and medicine (Dean, 1994; Huisman & Warner, 2004). His interest in 'discourse', in how systems of power/knowledge are generated and what sorts of effects they have in constructing identity and subjectivity, sharpened critiques of gender and race in medicine (Anderson, 2002; Bashford, 2004). His insistence that bodies were and are not simply biological entities, but that 'the body' itself also *has a history*, directed attention to the importance of health and medicine in constituting bodies marked with gender, race, class and sexuality (Gilman, 1985, 1998; Huisman & Warner, 2004; Jordanova, 1989). And his concepts of biopolitics and governmentality allowed historians to newly explore how public health operated as a means of government, from the level of self-government – the populace trained in all sorts of practices to micromanage their bodies, from handwashing and nose blowing to calorie-control – to the patrolling of national borders and the identification and exclusion of potentially dangerous 'Others'(Bashford, 2004, 2006; D. Porter, 1999a).

The 'cultural turn' has drawn from, and added to, research that questioned the nature and the limits to the validity of scientific evidence (for examples on the contraceptive pill see (Marks, 2001; Martin, 1987)), including that gold standard of public health, epidemiology (Lupton & Petersen, 1996) (Latour, 1988) (A. Cunningham & Williams, 1992). Historians of ideas traced how apparently factual, well established scientific concepts, like germ theory, had complicated histories that were shaped by social structures (such as the professionalization of medicine (R. Porter, 1999)) and cultural values (including concepts of purity and pollution as well as of objectivity, an attribute that has a reasonably recent history (Bashford, 1998)) as well as by metaphors (of 'seed' and 'soil' (Worboys, 2000)), narratives (of growth, fertility, invasion (Martin, 1994)) and technical practices (laboratories, microscopes, cultures (A. Cunningham & Williams, 1992)).

Questioning evidence about health may be discomfiting for some in public health, and make cultural history look at best tangential, and at worst, absurd. For example, historians trained to examine the 'social construction of science' are currently curious about how particular forms of epidemiology became constructed as a widely understood and acceptable evidence base for the early studies that linked cigarette smoking with lung cancer and heart disease (Veronica Berridge, 1998; Virginia Berridge, 2003b). This sort of history can seem nonsensical to tobacco control advocates because it seems to be self-evident ('of course we needed epidemiology to identify this problem!'), or it can be viewed as an anathema to those who have fought bitterly to establish that the negative health outcomes of tobacco smoking are *real* in the face of industry denial and malfeasance. But for the many qualitative health researchers who grapple with concepts of 'evidence' in their own research practice or in complicated health issues, cultural histories may provide useful insights into the many factors that influence what is regarded as true or authoritative, and what is not.

I was trained in history-since-the-cultural-turn, and that explains why, when reading debates about tobacco control, I wanted to go hunting for the many meanings loaded words like 'drug' and 'addict' were bearing. I certainly was not going to treat these terms as self-evidence biological entities. Instead, I wanted to trace the social circumstances that produced these meanings, among them, perhaps, a shift to a sort of high-corporatisation of politics, circumstances in which the politics of 'drugs' could fit neo-liberal discourses that posited autonomous individual choice as the key determinant of health, and on the other could be mobilised to critique the corruptions and predations of hyper-consumer society-capitalism (Virginia Berridge, 1990, 2003a; Boon, 2002; Courtwright, 2001; Davenport-Hines, 2002; Goodman, 1995; Claire Hooker & Chapman, 2007; Knipe, 1995; Porter & Teich, 1995). In a more sophisticated approach, Jordan Goodman saw the history of tobacco through the lens of 'cultures of dependence' (Goodman, 1993), which were at once conceptual, physical, economic and cultural, and which were located in the very real structures of colonialism and industrialisation (and see his subsequent interest in the cultural history of 'drugs' (Goodman, 1995)).

In the end, scholars in both history and qualitative research are often similarly concerned with the consequences of health and health practices for experience and identity. I therefore conclude this essay by thinking a little further about these issues.

Making things strange: investigating experience and identity

How to understand and represent those many 'Others' who lack of social power has been, and remains, a challenge for both historians and qualitative health researchers.
A primary response to this problem was and is to try and have those Others speak for themselves as much as possible. For historians this means looking for letters, diaries, speeches, photographs, interview notes, reports of conversations, drawings and material objects that might allow them to draw directly from these other peoples' experiences. Where it is possible to undertake this, oral history is a favoured approach by both historians and qualitative researchers alike. However, as qualitative researchers are only too aware, oral histories do not present reliable evidence. Interviewees are constantly *reconstructing* both their memories of their experiences and the significance of those memories throughout the interview process, in narratives that dynamically (re)create their sense of identity (Phillips, 2004). These days we even know something of the biological basis of the constant reprocessing and resourcing of memory.

But it is not just the partiality of memory that is worrisome. As feminist historian Joan Scott points out, and as I discussed above, uncritically accepting the evidence of experience avoids analysing how the social categories with which the 'experience' is associated are *themselves* historical. 'The evidence of experience then becomes evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world.'(Scott, 1991) That is, researching black experience only serves to emphasise difference. In a foundational paper, Richard Dyer argued instead that we should 'make whiteness strange' (Dyer, 1997) – to see instead how white culture has become so well established as a norm that it has become invisible, and hence how 'coloured' identities are defined through their differences to white. History can help us to make our own assumptions and approaches 'strange'.

Let us take for example the adolescent – a group whose health practices are often regarded as of enormous importance. Interventions with adolescents are often seen as crucial in terms of generating lifelong protective health habits, especially for diet, physical activity and drug use. We could, and many do, research adolescent experience, most usefully by asking adolescents themselves. But if we look historically, we can see that the category 'adolescent' is itself only a recent arrival, a product of the interlocking systems of medical knowledge and social power in the mid twentieth century (Prescott, 1998) (Johnson, 1993).

This kind of questioning can be disquieting because it questions concepts, categories and narratives that are attached to political goals that research in health supports. Scott's paper, for example, critiques a triumphalist narrative of empowerment – an autobiographical account of a gay man whose experience of entering a bathhouse for the first time, in the 1970s, tells of the ways homosexual desire was so irrepressible that it evaded social control and became visible. Scott's alternate reading of this account shows how identity, political power and consciousness were co-constituted, rather than their being some pre-discursive unmediated 'experience' of a gay identity (Scott, 1991). In plainer language, you do not just 'feel' something anymore than you just smoke (Hughes, 2003): 'experience' is always learned, mediated and interpreted in a social context (Becker, 1953, 1967).

In fact, a great deal of historical attention has been recently devoted to the extraordinary importance of public health in the fabrication of identity (personal and collective) and of many social categories themselves. At the most basic level of analysis, biomedicine works by defining the boundary between 'normal' and 'pathological', producing new sets of identities in consequence (Gilman, 1985). Historians influenced by Foucault's explorations of forms of discipline and regulation and their production of different categories of bodies have suggested that public health acts *spatially* to 'fabricate' forms of modern identity (Foucault, 1973, 1977, 1978). David Armstrong applied Mary Douglas' observations about the boundary rituals that separated the polluted from the pure to different hygiene regimes to argue that the spaces thus created became constitutive of modern forms of identity (Armstrong, 1983, 1993). Later scholars applied the varying forms of disciplinary and regulatory power Foucault identified in relation to crime to the government and care of personal and national bodies. Viewed from this angle, public health looks like a series of modes of surveillance and governance, from the most direct and impositional – Foucault's residual 'power of the sword', expressed in forcible quarantine, involuntary confinement, or the exclusion of unwanted Others by health checks at immigration – to those that are more subtle and pervasive, such as through clinics and screening programs (Bashford, 2004; Rosenberg, 1989). Identity may also be *produced* by epidemiology and discourses of risk, with new categories of identity being generated, experienced, accepted and sometimes

contested and resisted by categories that are derived from population-based data (Lupton & Petersen, 1996) (Claire Hooker & Bashford, 2002) (Bashford & Hooker, 2001).

The importance of tracing discourses of power/knowledge in biomedicine – while imperfectly but stubbornly respecting the separate integrity of local voices – may be most vivid in the case of the history of 'tropical' – now 'postcolonial' - health and medicine (Anderson, 2004). Mainstream histories of health and medicine largely have had, and continue to have, a focus limited to Europe and North America. The first histories of tropical medicine, for example, charted the geographical spread and impact of various 'new world' diseases (Ackerknecht, 1965) (Crosby, 1972), recorded white achievements in understanding, controlling and treating them, and celebrated heroic 'great doctor' (European) characters who fought extraordinary battles against little known diseases alone and unaided in jungle settings (Wilson, 1942), (Anderson, 1996). This has not only normalised Europe as the standard against which other histories can be compared (leading to questions such as 'how far behind is public health in Africa?' or to expectations that health and medicine in non-Western nations will 'develop' in the same pattern and stages), but has obscured the imperial/ colonial context in which health and medicine themselves developed and the degree to which public health and medicine are inherently imperial projects.

Critiques of colonialism led to historical interest in the experiences and lives of the colonised, and this gave the history of health and medicine prominence, since the study of disease and treatment gave them access to personal and social life in the colonies and revealed much of the functioning of the colonial state (Macleod & Lewis, 1988) (Manderson, 1996). Historians offered critical insights into how health and medicine were central in generating concepts and categories of race and citizenship, and how government practices of health were mechanisms by which white identities could be realised and validated while non-white bodies could be marked, segregated, disciplined, and retrained for citizenship in the colonial world (Anderson, 2006). In later works the extent to which western models of health and medicine actually became hegemonic in colonial settings have been questioned, and some of the ways that local identities and practices could remain resistant to the colonial state's attempts to reform them have been identified (Anderson, 1995; Arnold, 1993).

As is the case for qualitative research in health, these studies inevitably raise questions about the relationship between researchers, who are socially privileged in many ways, and their subjects (Chakrabarty, 1992) (Stoler, 2006). As Warwick Anderson pointed out, a truly postcolonial history might actually seek to treat the history of their subject in the developed and developing worlds in the same frame, looking at the links and movements of metaphors, people, money, techniques and practice between different sites (Anderson, 2004). But while in this instance historians might remain highly sensitive to the construction of whiteness as well as of other racial identities (Anderson, 2002) (not to mention the colonial relation of medicine to the body itself), it would take a radical alteration of the entire genre of scholastic history to actually engage the voices and experiences of the colonised Others.

Concluding comment: The long view and the local – keeping an eye on social change

If you are a poor immigrant being directed to hospital-based childbirth in a western nation – or an Italian grandmother with a heart attack overhearing doctors wonder if it is worth treating you because of your weight – or an Asian-looking person in a western city during an outbreak of avian influenza – or the mother of a First Nation child being examined in a clinic

staffed by white health care workers – you might well feel that history often matters to health and medicine.

There is something about holding the long view of history that lends itself to a mentally reflective pose. It is hard to commit full and unqualified belief in scientific knowledge when one has observed how equally deeply held supposed 'facts' have been superseded time and again – and this is true for those of us who simultaneously accept the uniquely powerful purchase science has on reality. It is even harder to place an unqualified and passionate faith in public health intervention, when the historical eye has revealed time and again that well-intentioned actions can also be methods for imposing hegemony, for generating social stigma, and for reconstructing highly negative forms of self-identity.

Even while historians can and do pay attention to the nitty gritty of everyday life, historical methods tend to understand and represent these anecdotes and details in relation to the wider social arrangements and cultural discourses that constitute them and are shaped by them in turn. Historical writing tracks – and a lot of qualitative research does not – at least the before, and not infrequently comments on the 'after', of their subject. Historians can keep an eye on both social change – new policies in health, new public concerns, changes in the framing of diseases – but also the continuities – ongoing power structures, methods of governance. Often health issues that seem novel today turn out to express longstanding cultural anxieties or attitudes, as in the relationship between genetics today and eugenics of yesteryear. Or changes in health policy, practice and especially promotion may actually appear superficial when the effects of the deep continuities of economics and social structure are considered.

History can be instrumentally useful. It can provide a critique of current practices and thinking, as when feminists referred to the history of non-interventionist, midwife supported forms of active labour when protesting against medicalised childbirth – or, as now, when histories of the regulated and unregulated body can remind us to keep our critical distance from the discourses and policies surrounding the 'obesity epidemic' (Gard & Wright, 2005). It can provide comparable and sample events from which to draw expectations about events of concern today (is the swine flu epidemic of 2009 like or unlike that of 1976? (Neustadt, 1983)), or demonstrate the limitations and consequences of particular ways of thinking. Much of the approach of critical theory and of recent sociology has emerged from considering social change.

Qualitative researchers should use this chapter to clarify for themselves *how* history may be useful to their research and to be explicit about that use in undertaking historical research. Is it simply to get data in support of their cause, or is it to understand some dimension of how that cause came to exist? Qualitative researchers should be equally self-conscious about the sorts of questions they ask of their primary sources. Accepting the particularities of each case, while simultaneously analysing the set of changing social and cultural circumstances in which the case is embedded, even while pursuing an instrumentalist project, may help identify significant new features or significant limitations to one's work. And possibly one may then also succumb to enchantments, to the power and wonder of human stories as they emerge from the past.

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