# Doctors and historians

## The Osler Oration 1990

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Osler was deeply interested in history and above all in the evidence of old books, and he had much to say and write about what may be called 'medical culture'. He was eager to stimulate and inspire medical students and doctors everywhere; medical students had always been prominent in his audiences. In a remarkable address of 1895 he had focused on his ideal for members of the medical profession:

> It is no idle challenge which we physicians throw out to the world when we claim that our mission is of the highest and noblest kind, not only in curing disease but in educating people in the laws of health . . . In late years our record as a body has been more energising in its practical results than those of the other learned professions. Not that we all live up to the highest ideals, far from it . . . But we have ideals, which means much, and they are realisable, which means more.

He invariably went on to emphasise the need not only for skills but for strength of character and for broadness of outlook:

> A physician may possess the science of Harvey and the art of Sydenham, and yet there may be lacking in him those finer qualities of heart and head which count for so much in life . . . Medicine is seen at its best in men . . . of the highest and most harmonious culture.

A historian must place Osler firmly within the context of his own time, although much that he had to say and to write was thought of by him as timeless. He was, indeed, interested in time as well as in history, and once, in 1891, described the period in which he was living as 'the childhood of the world'. He was then in his own 40s. A century later we now seem older if not wiser than we were then, yet we seem to me to be living in an age not of harmonious but of discordant culture. We have much to explain.

I want to pay tribute not only to Osler as an outstanding figure in medical history but to the work that historians of medicine, professional and amateur, have been carrying out, particularly to explain what happened between 1849 and 1919, Osler's lifetime, a period in which I have long been interested as a general historian. The conditions of our own time have much to do with the issues we select and the way we frame them as historians, but we may not be looking at the past from the best of vantage points, and what will be selected and framed in relation to his period in the future may not be what I shall select here. Perspectives change.

Doctors have long been interested in history, both of the profession and of the places where it has been practised. Likewise, historians have long been interested in doctors, not only as a major professional group but as individuals placed in a variety of different situations, some of which bring them directly into contact with people and problems little appreciated — or understood — by others from the same social background. It is only in recent years that there have been signs everywhere in the history of medicine of genuinely 'energising' initiatives — to borrow Osler's adjective — and I must begin with the historiography of just what has happened since 1945 as I see it myself from our present vantage point.

Undoubtedly, a key date was 1949, the year of the opening to scholars of Sir Henry Wellcome's superb library. Wellcome, a great collector, was born six years after Osler and lived seventeen years longer, and the scale of his activity was as extraordinary as Osler's own. Both collected books avidly. Osler dreamed of a 'College of the Book, where men could learn of everything relating to the Book from the preparation of the manuscript to the whole mystery of authorship'. Wellcome had the bold ambition of acquiring a copy of every significant printed text in the history of Western medical science.

Wellcome also collected manuscripts and incunabula. During his lifetime his library was a source of envy to scholars, and after 1949 it was turned into a centre of research. The materials made available to scholars include primary sources in pictures as well as in words. The collection contains Roentgen's first nine radiographs taken in 1895 and records of epidemics and plagues from all parts of the world, always a source of fascination to medical historians.

The Wellcome Institute, so named in 1968, was a direct product of a great individual legacy, and in 1976 it entered a new phase as an academic research centre closely linked with University College, London. Osler once said, before he left Canada for England, that the

ideal of his life would be to live within an hour of the British Museum and to have *The Times* on his breakfast table every morning. He would certainly have added the Wellcome Institute to this highly select list. He believed that the future of the world was bound up with the further development of science, and he was deeply interested in the relationship between science and medicine.

It would be impossible to chart the recent history of medicine without attention to the few key dates that I have mentioned, just as it would be impossible to study any aspect of the history of medicine without the institute's quarterly periodicals *Medical History* and *Current Work in the History of Medicine.*

As a social historian, however, I have to turn regularly too to the *Bulletin of the Society for the Social History of Medicine.* This society was formed in 1970, and for one year I had the honour to be its president. The fact that I was invited early in the history of the society was a sign of the intense concern of the founders to relate the history of medicine to the whole of social history. They were not interested in producing a new or an extended specialised branch of history, a new subdiscipline, of which there were more than ever before. In the editorial to the tenth anniversary number of the *Bulletin* they clearly identified both what they had in mind and what had been the first response to their efforts:

> In 1970 it was accepted that the membership of the Society for the Social History of Medicine would be interdisciplinary, and in this 'certain hybrid vigour' the Society has been particularly successful in its ability to hold the interest of a very diverse membership — archivists, librarians [I attach particular importance to these two groups, for without evidence we can do nothing], physicians, sociologists, anthropologists, professional historians and many others. This has probably exceeded early expectations. The non-medical element has far outweighed the medical, as was correctly anticipated; in fact, the Society has become an informal professional association for historians and others interested in the social history of medicine. The recent campaigns of the Society in the field of health and hospital records is a good example of the impact and recognition of the Society in matters of direct professional interest to its members. It would appear that the Society has become a bridge between the disciplines [and] a focal point for the exchange of ideas . . .

By 1980, when these words were uttered, the Society for the Social History of Medicine could correctly describe itself as 'a healthy child that has survived the trials of infancy' and shows promise of soon reaching 'maturity'. What 'maturity' means is an open question to which I will return.

The years between 1970 and 1980, like the years immediately preceding 1970, saw enormous changes not only in medicine but in the study of history as a discipline, and these influenced the course of scholarly development in the society. They were more important, I believe in this connection, than the even greater changes occurring in the life sciences.

I described some of the changes in the study of history in my inaugural address Nineteenth Century Medicine and the Role of the State. Much of the earlier history of medicine had been concerned with public health and epidemiology, topics to which I had turned as a young historian just after the Second World War, when I wrote two articles for *The Times* on the centenary of the Public Health Act of 1848 and lectured on Sir Edwin Chadwick as a pioneer of public health. There followed a paper for *Past and Present* on 19th century cholera outbreaks and the response, medical and social, to them. My favourite quotation — social not political — came from *The Economist* of 1849; it was printed again in 1949: 'The cholera seems a disease of society. It attacks towns rather than sporadic dwellers in the wilderness'.

Since I was already keenly interested in urban studies this quotation greatly stimulated me. I have always liked to see history connect. I spent much time in the 1940s studying the statistical reports on local health and disease which were usually compiled by doctors, who knew more of urban conditions at first hand than any other section of the population, including the clergy. These were my first encounters with primary sources. My attitude towards social history was that it was a synthesising history and not merely another 'subdiscipline'. When I thought of the role of doctors I thought of the role of others and came to believe that in approaching the history of any particular urban place a detailed examination of the ratio of doctors, clergy, teachers and policemen to each other is an essential preliminary.

By the late 1960s the development of the National Health Service — and a public sense of both its achievements and its problems — had already somewhat shifted the emphasis in research. The state now figured more prominently than the locality at the centre of the research scene. The emphasis was now on hospitals and on medical policies, including policies for medical education. There had been signs of such a shift earlier. The state could never be left out after the fierce debates of 1945–47, which had echoes of 1911, nor could doctors as a group, when party politicians placed private as well as public health on the national agenda, for no scheme could work without them.

I have the script of a fascinating Forces Education Broadcast by Dr Ashworth Underwood in 1946, designed for the widest possible audience, on Doctors and Hospitals. Such Forces broadcasting was my own introduction to both the pursuit and study of communication, and I know that Dr Underwood had his audience very much in mind. He compared the work of a family doctor in 1846, in 1911 and in 1946. What he said was informative and interesting, yet it now looks dated and incomplete, and even in this script, written at a time when the debate was beginning to be national, he still starts with the locality, not with the state, as would have been the case twenty years later. The first sentence runs 'Can you imagine what your own town would be like without its health service?' The word

'national' did not figure, but 'private health', as distinct from 'public health', already did. Children figured too. In retrospect, they were almost as important in generating 20th century medical reforms as they had been in 19th century factory reforms.

Since the 1960s there has been a further shift in historiography. Professor Charles Webster, in his presidential address to the Society for the Social History of Medicine in 1976, urged the need to examine medicine

> from the perspective of the beliefs, values, social organisation, and professional activities of every *stratum* within the ranks of medical practitioners; [and to regard patients] as more than passive objects of disease. It shall be an essential part of our belief to resurrect the patient, by contributing to the historical investigation of physical growth, medical development and social customs — of all the conditions surrounding birth, and the events connected with death — of the state of health, and perceptions of disease of all classes — within the population.

Since this statement was made, patients have been resurrected, while Professor Webster himself has produced a major work on the role of the state, the first volume in the history of the National Health Service which covers the period when Dr Underwood was broadcasting. Yet what he had to say in his inaugural lecture represented the historiographical ideal of the period when he delivered it, and by then there were other lively historians of medicine, like Roy Porter, who fully shared it.

Professor Webster's approach was not in itself entirely new. What approach ever is? In my own inaugural address I had stressed the need in studying policy making to look below the surface. It is never enough to be concerned exclusively with legislation and administration, the two being separated by lags and gaps that have become far more ominous since the early 1970s. One has to begin by examining the wants and needs of individuals and families as well as the role not only of politicians or administrators but of the medical professions. I argued that it was wrong to see policy making entirely in linear terms. We had to be very careful not to read back into past situations ... the attitudes, opinions or even language of the present and to assume that the processes of change were comparable.

I also pleaded for more analytical history. Around that time I was identifying six main changes in historical scholarship that were already apparent. The first was a new approach to local history, a far more sophisticated version than that well represented earlier, sometimes with an antiquarian bent. This was certainly bound to affect medical history as such, given the role of the doctor in the 'community' — a word burdened with historical and sociological baggage.

The second change was a new approach to comparative history, a natural sequel to the rediscovery of the variety of experience embedded in local, regional and national cultures. This kind of history has not developed as rapidly as I expected. The third change was the development of quantitative history — 'cliometrics' as it had already been christened. I reserved my judgement, as did most historians, concerning the implications of computerisation, but one point has not changed: everything depends on the reliability and comprehensiveness of the initial data that are fed in.

The fourth change was already well advanced — the rise of 'history from below', a self-consciously new kind of social history that directed attention to people whose names had never figured in the older history books, people who were deprived or neglected in their own lifetimes, whose participation in government was minimal or non-existent and whose attitudes towards 'authority' could be passive or hostile. Increased interest in this far from homogeneous group has been the most influential change in recent historiography, although there is the danger that, if 'history from below' is pressed too far and no attention is paid to people of power who figured in the older history books, it is impossible to explain what actually happened and why.

For this reason alone, a fifth change was already noticeable at the opposite end of the historian's spectrum — the advancement of a more searching kind of political and administrative history, concerned less with particular pieces of legislation than with cumulative processes. Historians of 19th century policy and administration were the first to move in this direction, yet too little attention was paid then to diverse modes of implementation or to what are now called 'options', to the changing scale of organisation and above all to costs and resources. There were too few links between administrative history and economic history.

The sixth change was recognition of the need for cultural history, something more than political, economic or social history. A broader cultural history would incorporate the history of the ideas of 'great thinkers' and encompass the transmission of ideas and their communication through what came to be thought of as different 'media'. As well as ideas there would be a place for customs and rituals, attitudes and languages. Anthropology would be as relevant as sociology.

This was a formidable list of changes, and each change had implications for medical history. Yet in his inaugural address Professor Webster went further, claiming that 'there are few questions in modern social history which are devoid of a medical dimension'. The opposite proposition had already been advanced that 'there are few questions in medical history which are devoid of a social dimension'. These were 'energising' propositions indeed.

The state of the social history of medicine in 1980 can be gleaned in more detail from a list of the topics covered in the *Bulletin* of the Society for June of that decennial year: 'From physician to scientist: changing styles of thought in late Victorian physiology'; 'Infanticide, illegitimacy and the medical profession in nineteenth-century England'; 'Social concepts in anatomy; theories of the cell state of Hertwig and Waldeyer'; 'Suicide in Victorian London, an urban view';

'Deviants in death? Plebeian secularists and spiritualists, 1860–1910'; 'The Dance of Death, an iconographic interpretation of the popular themes of death through five centuries' ('Death in history' had been the subject of the March conference of the society); 'A dissection of the Anatomy Act', a preview of Dr Ruth Richardson's fascinating *Death, Dissection and the Destitute* (1987), a book representative of the new social history at its best; 'The medical practice of the East India Company'; and an obituary of Dr Robert Heller, a founder member of the Society — a reminder of how much societies owe to particular individuals.

In April 1990 the pattern of articles had not much changed, although they were longer: 'Historians as demonologists' — sub-titled 'The myth of the midwife witch'; 'Age patterns of mortality in London during the Long Eighteenth Century', the product of research in an old field of study, first explored by insurance practitioners; and 'Dear Old Mother Levy's: The Jewish Maternity Home and Sick Room Helps Society, 1895 to 1939'. There was also a fascinating review article by Ludmilla Jordanova, 'Medicine and visual culture', in which she considered two American books *Images of Nurses: Perspectives from History, Art and Literature*, and *Photographing Medicine: Images and Power in Britain and America since 1840*. The former book particularly interested me because of my interest in nursing, which opened up entirely new horizons for me after I was appointed Chairman of the Committee on Nursing in 1969.

I found it almost as important to consider images of nursing — that is to say perceptions of the profession and of its roles within the profession itself (what are sometimes called self-images), in the press, in pictures, on the screen and in novels — as it was to deal with modes of entry, subsequent post-experience education and the actual conditions of work in the wards or in the community. Historians, visual or verbal, have to cope with clusters of perceptions, some of them contradictory, as well as with facts. That is why their own conclusions are controversial. History is debate. It is not a final record of account, although there is always necessary accounting to be attempted.

The nature of the evidence is crucial, as are the criteria for excluding it. Given that every kind of evidence, including ephemera, is grist to the historian's mill, the publication of pioneering new books depends on the accumulation and opening up of archives. Significantly the 1990 number of *Social History of Medicine*, now called a journal and not a bulletin, includes for the first time a section headed Archive Notes, an excellent readers' introduction to a subject that has always interested the society.

Reference to the two American books on 19th century medicine is a necessary reminder that it is not possible to chart recent tendencies in the history of medicine solely from journals and articles, some of them influenced by the style and format of medical journals, or from reviews of books. One has to turn to the books themselves, as Osler always did. Since 1970 there has been a remarkable proliferation of books concerned with medical history, particularly the social history of medicine. Long gone are the days, described by John Owen in the 16th century, when it could be written that

> God and the doctor we alike adore
> But only when in danger, not before;
> The danger o'er, both are alike requited,
> God is forgotten, and the Doctor slighted.

Doctors were neither slighted nor forgotten in the new literature. They were at the centre of it.

Two of the most important books that have appeared since 1980 are based on primary archival materials. Dr Irvine Loudon's superb study, *Medical Care and the General Practitioner, 1750–1850*, examines the development of the profession as a whole, what may be called 'rank-and-file practitioners', in the best spirit of 'history from below', setting out to explore their background and training, the range of their patients, their modes of practice, the fees they received and their social and economic status. From a study of two thousand entries in the London and Provincial Medical Directories of 1847 he has been able to reveal more fully than ever before just how wide was the variety of medical men calling themselves general practitioners — from the near illiterate to the highly educated — and just how blurred were the borders between general practitioners, physicians and surgeons. The situation was highly competitive, and Loudon gives vivid accounts of interprofessional rivalry and its causes. It is not surprising that attempts to found a College of General Practitioners in 1845 totally collapsed.

Loudon has challenged many previously held assumptions — for example, that the Apothecaries Act of 1815 was a watershed. He has also rightly stressed that the general practitioner of 1850 was not yet a scientific doctor. His work stopped short before the Medical Acts of 1858 and 1886 (which still stand out as landmarks) finally removed the longstanding divisions between physicians, surgeons and apothecaries. Yet even then the idea of a 'scientific doctor' needed substantial further development. The cultures of the medical profession require the attention of a new generation of cultural historians.

Osler knew much about these themes. In his striking address of 1895, from which I have already quoted, he also told his Canadian audience that those physicians who were without physiology and chemistry — and there still were some after the Medical Acts — were 'floundering along in an aimless fashion . . . practising a sort of pop-gun pharmacy, hitting now at the malady and now at the patient'.

Osler's horizons were international. Dr Loudon approached the subject from a very different vantage point in place and time. He had been in general practice at Wantage in Oxfordshire for nearly 30 years before being a Wellcome Research Fellow. He was doctor and historian in one.

Doctors who become historians are more plentiful

than historians who become doctors, and while I do not agree with Dr Thomas McKeown, in his inaugural lecture to the Society for the Social History of Medicine, that the social history of medicine is 'essentially an operational approach which takes its terms of reference from difficulties confronting medicine in the present day' — to accept this would be to become too closely tied to a contemporary set of pressing preoccupations — I do agree with him as a non-doctor that 'it is the lack of insight derived from contemporary exposure which makes a good deal of medical history so sterile for the uninitiated'.

Transatlantic perspectives remain at least as important in the history of medicine as they were in Osler's time; he seemed to straddle the Atlantic. Jeanne Peterson's *The Medical Profession in Mid-Victorian London*, published in California, set out to explain in the 1970s how medicine in 1858 was not truly a profession but within 50 years it had become one — at least to the extent that it had become autonomous.

The history of professions has become a favourite subject for historians, as Harold Perkin, himself straddling the Atlantic, has demonstrated in *The Rise of Professional Society* (1989). Yet Jeanne Peterson had many insights of her own. For example she was right to stress the family connection in Victorian medicine. 'A family connection in the community was a strong basis for honourable, reputable behaviour in the young practitioner. He had both his own reputation and that of his family to uphold'. Family history is even more popular today than the history of the professions, and doctors figure prominently in it not only as guardians or observers of other people's families but as family men in their own right.

There has been drama in the story too, a quality that the new social history sometimes leaves out. Certainly the efforts of experienced medical men to unite outside their own families to promote their own group interests and the efforts of individuals among them to secure increased power inside Victorian hospitals often carried with them a sense of drama that transcends the passage of time. It also carries the student of today well beyond the boundaries of the social sciences. Thus, a characteristic Victorian row at Guy's Hospital in 1879, following Miss Burt's efforts to reorganise the nursing staff into a trained sisterhood, still captures the imagination. The protest of the doctors, who feared that their medical authority would be undermined, made its way into *The Times*. This not uncommon outcome in medical rows doubtless explains in part why Osler wanted to have it every day. Perhaps *The Lancet*, which specialised in rows, made its regular way across the ocean to Canada.

Historians of medicine have made good use of *The Times* and *The Lancet* but relatively little use of literary sources. Dr McKeown suggested that Tolstoy's *War and Peace* included 'a characteristically profound appraisal of the medical task as well as a judgement on the ineffectiveness of treatment'.

I have written about George Eliot and, bringing in *The Times* yet again, of how she turned to old copies for colour and genuine information. Her novel *Middlemarch*, published in 1873, has much to say about the local position of the general practitioner earlier in the century — in what we may now call the Loudon period. It deals sympathetically but critically with the hopes of one particularly energising local general practitioner to raise the standards of his profession and in the process both to command the local hospital and to keep in touch with international research. Dr Lydgate brought to the provincial town where he worked 'grand schemes' of which he had learnt in a wider world. His ambition was to 'pierce the obscurity of those minute processes which produce human misery and joy, those invisible thoroughfares which are the first lurking places of anguish, mania and crime'. The words are George Eliot's, not Lydgate's, and the novel deals not only with his laudable medical ambitions but with their enmeshing in private and local links and obligations. Lydgate finally leaves Middlemarch for an excellent practice 'between London and a continental bathing place'. Instead of unravelling the mysteries of typhus and cholera, he writes a treatise on gout. To the outer world he has become a success. To himself he is a failure.

I wrote an article on Middlemarch and the Doctors in the *Cambridge Journal* in 1948, long before literary scholars had offered us keys to the way in which *Middlemarch* was written and just before George Eliot had returned to fashion. When I think of historians and doctors I still go back to George Eliot, believed by one of England's outstanding 19th century historians, Lord Acton, to have fathomed the secret of 'reading the diverse hearts of men' and of 'creeping into their skin, watching the world through their eyes, feeling their latent background of conviction, discerning theory and habit, influences of thought and knowledge of life and descent'. Such gifts are, as Acton noted, the gifts of a historian, and if George Eliot had not been a great novelist she might have been a great historian — or at least a great social historian of medicine.

I have always felt with the late Professor R. H. Tawney that 'the enjoyment of great literature is an end not a means' and 'only a barbarian would degrade its timeless truths to the status of materials for a humbler art.' Yet, like Tawney, I note that history is the province of a muse, Clio, and that however necessary it may be for historians to work in close interdisciplinary alliance with social scientists, literature as well as pictorial art is a necessary key to understanding.

Osler believed in such 'evidence'. Recently I re-read Trollope's novel *Dr Thorne*, which presents a very different portrait of a doctor from that of George Eliot's Lydgate. According to Harvey Cushing and other sources, Osler was an avid Trollope reader and he provoked a row when in 1905 he entitled his last lecture at Johns Hopkins University, Baltimore, after Trollope's now little-known novel *The Fixed Period* (1882). In it, on the point of his own departure from the United States, he asked whether as professors we do not stay too long in one place. Should not young men develop 'a peripatetic philosophy of life?'

It was his further questions, however, which got Osler into as difficult a row as Miss Burt had got into at Guy's. 'I have two fixed ideas well known to my friends', he stated, 'harmless obsessions with which I sometimes bore them':

> The first is the comparative uselessness of men above 40 years of age. This may seem shocking, and yet read aright the world's history bears out the statement. Take the sum of human achievement in action, in science, in art, in literature — subtract the work of the men above 40, and while we should miss great treasures, even priceless treasures, we would practically be where we are today. It is difficult to name a great and far-reaching conquest of the mind which has not been given to the world by a man on whose back the sun was still shining. The effective, moving, vitalising work of the world is done between the ages of 25 and 40 — these fifteen golden years of plenty, the anabolic or constructive period, in which there is always a balance in the mental bank and the credit is still good. In the science and art of medicine young or comparatively young men have made every advance of the first rank. Vesalius, Harvey, Hunter, Bichat, Laennec, Virchow, Lister, Koch — the green years were yet upon their heads when their epoch-making studies were made. To modify an old saying, a man is sane morally at 30, rich mentally at 40, wise spiritually at 50 — or never . . .
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> My second fixed idea is the uselessness of men above 60 years of age, and the incalculable benefit it would be in commercial, in political, and in professional life if, as a matter of course, men stopped work at this age.

If Osler had stopped at this point in his lecture he might have got away with it. Instead he added:

> In his *Biathanatos* Donne tells us that by the laws of certain wise states sexagenarii were precipitated from a bridge, and . . . in that charming novel, *The Fixed Period*, Anthony Trollope discusses the practical advantages in modern life of a return to this ancient usage. The plot hinges upon the admirable scheme of a college into which at 60 men retired for a year of contemplation before a peaceful departure by chloroform. That incalculable benefits might follow such a scheme is apparent to any one who, like myself, is nearing the limit, and who has made a careful study of the calamities which may befall men during the seventh and eighth decades.
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> Whether Anthony Trollope's suggestion of a college and chloroform should be carried out or not I have become a little dubious, as my own time is getting so short. ... I may say for the benefit of the public that with a woman I would advise an entirely different plan, since after 60 her influence on her sex may be most helpful, particularly if aided by those charming accessories, a cap and a fichu.

The archness of the last comment did not save Osler, who tried to explain, not entirely convincingly, that throughout his lecture — or was it an oration? — he had been joking. It did not please him either to learn later that a newly coined verb 'to oslerize' meant 'to put to death by chloroform', or that the verb had even made its way into the newspapers. Fond though he was of *The Times*, he had once written that 'if you see anything in the newspapers you know to be a fact, begin to doubt it at once.'

Whatever we may ourselves say about the 40s, the 50s and the 60s, Osler was right to direct attention to the age factor in history both in medicine and in life and to the significance of the interplay of different generations. I believe that there is some evidence, controversial though it may be, that historians get better the older they are. They reach 'maturity' then or at least have some better chance of reaching it. Their data bank will certainly be fuller than that of younger historians if they have been active historians earlier in their lives — provided that they still have access to it. Memory is of great importance to historians themselves, fallible though it may be, as it is of course in relation to the lives of the subjects whom they are describing.

In recent years the use of oral history has helped to transform the approach to social history. Indeed the tape recorder has been as useful a tool as the computer or the camera. If oral history had been developed in the 19th century, Loudon and Peterson would have been spared some of their labours. For the development of 20th century social history of medicine it is an essential tool. Something with which I have recently been associated and which seems to be of genuine national importance is the Real Lives project. Under the direction of Paul Thompson, a pioneer of oral history, individuals and groups are recording their own experiences. If doctors were not to be prominent among them this would be a great loss for history.

In examining the detail of 'real lives' — and detail should never be dismissed by the historian — attention is focused inevitably on the individual, and I believe this is as it should be. Historians, like doctors, are not concerned only with 'great lives'. All life is their province, and all kinds and conditions of people. A social history of medicine that concentrated only on groups — or, even worse, on concepts — would be completely inadequate. So, too, would such a version of institutional history, including the history of the National Health Service, for there is an individual dimension to this also. The experiences, expectations and aspirations of individuals — and their families — remain the very stuff of social history.