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Second Opinions

History, Medical Humanities and Medical Education

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Summary. History of medicine has long been present in medical education, and over the previous century much discussion has turned on its relevance as the medical curriculum itself has evolved. The development of history of medicine graduate programmes and the 'social turn' of the 1970s stimulated further debate about the distance between history and medicine. At the same time, separate medical humanities programmes were finding advocates among physicians and medical educators. This article traces these curricular divergences and interactions, and highlights certain historical biases about the aims and audiences for historical instruction that impact the ways history might become more involved with medical humanities programmes.

Keywords: medical humanities; human values; applied history; medical education; interdisciplinary teaching

History of medicine has always had a place in medical education, and for over 100 years its relevance has been reviewed and discussed in medical education and history of medicine journals. In fact, nearly every decade of the twentieth century has seen the publication of a survey of what was on offer in medical schools in the USA, UK or parts of Europe. Written by authors who were predisposed to the cause, most lamented the minimalist presence of history while each echoed previous calls about the relevance and importance of it to the education of future doctors. Yet the way the history of medicine profession has matured over the last half century or so has made its relationship to medical education somewhat distant. In much the same way that history of medicine scholarship is no longer primarily written by or intended for a physician audience, but more often for other professional historians, its curricular presence has shifted away from medical schools to the liberal arts or social science areas of campus.

Many articles have debated the place of history in medical education, and many see the challenge to history's relevance for medical education corresponding to the professional turn toward 'social history' in the 1960s and 1970s. At the same time, more broadly conceived medical humanities programmes were gaining currency in American medical schools. Today, medical humanities programmes are receiving a fair amount of attention as a curricular component within medical schools in both America and the UK.[1] The first

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[1]Nearly half of US medical schools offer curricula that include the humanities and arts: Strickland *et al.* 2002.

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mention of a specific 'Department of Medical Humanities' that I have found was in 1948, in reference to anticipated medical school reforms at New York University.[2] In 1988, the Institute for the Medical Humanities at the University of Texas Medical Branch at Galveston was the first programme in the US to offer a PhD degree in the medical humanities.[3] With funding initiatives through bodies like the Wellcome Trust, new Centres and research collaborations are being supported in the UK.

When pressed to define 'medical humanities', it appears more inclusive than exclusive, thereby resisting conventional disciplinary identity. History of medicine, bioethics, narrative medicine, medicine in literature, creative writing, and various social sciences (for example, medical anthropology and sociology) are aspects of medical humanities programmes. However, it also embraces the creative arts, so that music, painting, reader's theatre, and dance are considered expressive of medical humanities. Anything that touches on 'the human condition', 'the humanising process' or 'the humanist philosophy' becomes relevant. It has been claimed that the *raison d'être* of the medical humanities is to remind us that modern medicine can and should look beyond its technological fixation and reductionism to reconnect with the conditions of disease and cultural contexts of illness, as well as the myriad ways people cope with it. It is an antidote to the alleged dehumanisation of modern medical education which is overly basic-science centred and fails to foster empathic patient care.

Medical Humanities programmes are often conceived as having two functions. First, they service a deficit in medical education by facilitating a wider perspective and reflection on healthcare, broadening the minds and qualitative research skills of students. Second, they promote better healthcare through therapeutic interventions and outreach to patients using literature, art, writing and other creative media for health recovery and promotion. As the oldest humanities subject involved with medical education, it is somewhat ironic that today history's contributions to these programmes rub against many historians' attitudes about history's methods, purpose and audience. However, the role of history of medicine instruction within medical humanities programmes opens up new possibilities of engagement with diverse audiences and confronts questions head-on about the practical utility of history in professional training.

This brief article examines the changing status of historical instruction in medical education over the last century, questioning what our experience has taught us about trying to bring historical instruction to bear on medical training. It begins with the views of early leaders in the field, such as Henry Sigerist and George Rosen, about the practical utility of history and its contributions to the emergence of social medicine programmes. We then see an expression of new social consciousness in the development of bodies like the Society for Health and Human Values, spearheaded by humanist physicians such as Edmund Pellegrino. We then conclude with reference to subsequent debates in the medical history community between physician-historians like Lloyd Stevenson and Sherwin Nuland, and a new generation of historians who were finding other ways for history to engage with medical knowledge. Throughout the overview, it suggests that an effective way of contributing to medical humanities programmes in the future is to

[2] Rosen 1948, though the department never materialised.
[3] Jones and Carson 2003.

shed certain biases regarding 'old doc history', social history, reductionism in medical education and the challenges of interdisciplinary teaching.

History in Medical Education

Historical instruction in American medical curricula enjoyed increased popularity throughout the first half of the twentieth century. Two medical schools, the Johns Hopkins and the University of California (at San Francisco, now UCSF), had by 1930 established departments of medical history. The results of a survey of US medical schools by Henry Sigerist published in 1939 showed that 46 of all 77 medical schools offered integrated medical history courses (two-thirds of those schools requiring the courses).[4] Yet by this point, medical history in medical schools seems to have reached its peak. In 1969, the historian Genevieve Miller published the results of a field survey from personal visits to all existing 85 medical schools reporting that 33 offered course instruction in medical history (11 of them requiring it).[5] However, the number of dedicated departments or 'divisions' of history of medicine among them had increased to 12, with six of these offering separate graduate degrees in the subject.[6]

Early twentieth-century writers argued for the practical utility of having students read historical medical books as part of their medical training. In 1904, the physician Eugene Cordell, president of both the Medical and Chirurgical Faculty of Maryland and the Johns Hopkins Hospital Historical Club, expressed concern about the 'inexcusable apathy on the part of our medical schools' for the teaching of medical history.[7] But Cordell implored his medical readership that history contained not only a store of valuable yet forgotten knowledge, but contained lessons about past failures and follies that could induce humility and perspective on the changing nature of medical knowledge. In 1919, Charles Singer, the well-known British medical officer, Oxford Regius Professor of Medicine and doyen of history of science and medicine, lamented the provision of medical history in British medical education. He too argued that history was important because it demonstrated how the 'presentation of truth' changed through time. Only dogmatists, he wrote, would maintain a vestige of eternal truth or tout the timeless stability of scientific knowledge.[8]

In 1948, Henry Sigerist opined that medical history books 'were read for their practical content, irrespective of the period at which they had been written. Doctors read them in order to learn how to treat their patients, and they thought that they could gain practical knowledge from Hippocrates or from Sydenham.'[9] But he also pointed out that the rise of the 'new pathology' changed the concept of the relevance of older clinical practices. 'The old literature reflected a different concept of disease', he wrote. It 'knew nothing of new

[4] Sigerist 1939.
[5] Miller 1969.
[6] Johns Hopkins*, UCSF*, Loma Linda University, University of Wisconsin*, Yale*, University of Kansas, University of Washington*, University of Oklahoma, UCLA*, University of Minnesota, Chicago Medical School, University of Texas Medical Branch at Galveston. Asterisk indicates those with graduate degree programmes.
[7] Cordell 1904, p. 273.
[8] Singer 1919.
[9] Sigerist 1948, p. 48.

diagnosis, was ignorant of many new treatments, surgical and others.'[10] Thus the recourse of using them in modern medical education was to demonstrate the value of documenting historical change and past errors of thought.

But with the emergence of new ways of conceptualising disease in the mid-twentieth century came new ways of offering historical insight to the conditions of disease prevalence and propagation. Once disease itself was re-conceptualised as 'social', historical scholarship found new claims of offering practical contributions to the literature of medicine, allied to transformations of medical practice itself. Both in Britain and in the USA, the mid-twentieth century saw the creation of social medicine programmes bolstered by funding bodies like the Russell Sage Foundation. Situated to enable medical institutions to interact with the world outside the laboratory walls, institutes were founded to facilitate interdisciplinary research into the social and economic problems of medical care. People on both sides of the Atlantic, including historically minded medical educators like Henry Sigerist and George Rosen, promoted the view that physicians must assume leadership in the struggle for the improvement of social conditions.[11]

While this affected innovations in medical education, social medicine was more closely tied to social science research than historical or humanities-based research. While Sigerist's own students were taught that 'the new physician [of the twentieth century] will be the social physician, protecting the people and guiding them to a happier and healthier life', the agenda for historical research was redefined.[12] Although Sigerist was a notable proponent of history of medicine, John Pickstone has observed that 'It was through his commitment to teaching the social relations of medicine that Sigerist found a wider mission—turning social history into social medicine.'[13] The birth of new disciplines such as medical sociology, anthropology, and other 'social and behavioural' sciences that drew inspiration from the 1970s' 'biopsychosocial' model of illness seemed to further destabilise the place of history of medicine and provide alternative models for analysing cultural dynamics in medicine.[14] As the physician and medical historian Chester Burns wrote in 1975, 'just as the social sciences had undermined the eminence of historical studies in collegiate education, they began to do the same for medical history in medical education after 1950.'[15]

History, Humanities and Human Values

So what happened to those earlier institutional initiatives that established medical history at places like Johns Hopkins and the University of California, where the 'humanist' physician was once conditioned by reading medical classics? Throughout the 'long 1970s', a few prominent symposia and conferences shifted attention from quantifying the presence of medical history in the medical curriculum to debating the purpose and impact it should have on such education.

[10] Sigerist 1948, p. 49.
[11] Porter in Solomon *et al.* (eds) 2008; Fee 1989.
[12] Sigerist 1948, p. 12.
[13] Pickstone 2005, p. 312.
[14] Kleinman *et al.* 1978.
[15] Burns 1975, p. 859.

In 1968, a volume of essays and roundtable discussions from a meeting sponsored by the Josiah Macy, Jr., Foundation and the National Library of Medicine focused in part, as one contributor put it, on the question of using history for 'somehow developing a soul in new medical students or providing therapy for what we consider amiss in contemporary medical education . . . '.[16] In an attempt to throw off the yoke of its former logic of practical utility culled from the pages of ancient medical texts, history's new lessons were embedded in tales of moral conduct, while other benefits pertained to a roaming 'historical perspective' on medical practices. In the mid-1970s, *Clio Medica*, originally the journal of the International Academy of the History of Medicine, published a series of short articles by a wide range of historians and physician-historians entitled 'Viewpoints in the Teaching of Medical History'. In this column, Edmund Pellegrino, the physician, philosopher and past chairman of the President's Council on Bioethics, advanced a broader agenda for 'humanities in medicine', writing:

> The engagement of medical history with medical education is itself a model of the way humanities in general might be more effective in the university and in society . . . consistent with the traditional aim of the liberal arts—to liberate the mind from subservience to the ideas of others. This is the educated man's defence against the tyranny of expertise. Medicine surely needs a large measure of this 'liberalizing' influence, since the education of the physician is so content-oriented and so anti-intellectually imparted. This is the aim of the growing number of programs which seek to integrate the humanities into medical education. History should not miss the opportunity for this important point of engagement with the education of physicians.[17]

Whether one focuses on disease, therapies or bedside manners from the past, the goal was to 'sensitise' the students to conditions that shape 'human values'.[18] As such, however, the language of relevance referred more often to the collective pursuits of 'humanistic studies', thus diluting the impact of history as a unique pedagogic aid.[19] Thus the opportunity was not 'missed', but where history once stood alone to offer humanistic perspectives on medicine, it now shared space within an increasingly crowded curriculum with a host of other disciplines.

In the 1960s and 1970s, medical humanities initiatives were stimulated amidst efforts to inform moral dilemmas facing medical practice. Whereas critical medical history in part embraced the politicisation of the humanities through allegiance to social rights movements such as feminism, indigenous studies, labour history and other academic developments, medical humanities found new expression in the birth of bioethics and new articulations of social responsibility in medicine. These latter discourses effectively embedded themselves within medical curricula, owing in part to institutional developments outside medical schools but spearheaded by physician-educators.

[16]Blake (ed.) 1968, p. 41.
[17]Pellegrino 1975, p. 301.
[18]Risse 1975.
[19]Leake 1973; Banks and Vastyan 1973.

In 1969, for instance, the Society for Health and Human Values was founded with the help of grants from the National Endowment for the Humanities and the Russell Sage Foundation. It emerged in the context of what Edmund Pellegrino, one of the Society's first presidents, called 'the troubled waters of the scientific and moral revolutions' of the twentieth century. Pellegrino, along with colleagues including David Thomasma, Eric Cassell and others who formed a sort of Christian coalition within medical schools, elaborated a history and theory of the philosophical basis to medical practice and helped define the place of medical humanities in medical curricula.[20] At one of the first meetings of humanists and medical educators that the Society sponsored, speakers emphasised that the true measure of humanism in medicine should reference one's *humane* treatment of those in need. 'For a medical school faculty member to teach students to operate most effectively in the community context, he must have a value system in which social issues have a high priority and he must base his behaviour on these values'.[21] And while service to humanity by practising medicine might have been guided by Christian values, the right to health was political; maintaining health gave one a shot at overcoming social vulnerabilities. As Pellegrino and Thomasma wrote, 'we perceive health as a means toward freedom and other primary values'.[22]

History's 'relevance' was now being defined according to its abilities to inculcate humanistic qualities among students (a point often resisted, citing George Rosen's well-known reminder in 1968 that 'medical history was being taught in practically every university in Germany before World War II and apparently had little effect on the medical students at the time').[23] But during this time historians' attention had turned to new forms of politically charged commentary, insightful critiques of paternalism in medicine and investigations of ethically dubious clinical practices and decision making. Social history of medicine contributed to this by illustrating the many contextual forces at work in the production of medical knowledge about the normal and the pathological, cultural beliefs about health, and the politics of the profession.

Social History without Medicine

Readers of *Social History of Medicine* are familiar with the social-historical trajectory of our scholarship, as well as with recent concerns about the direction in which the profession has drifted, some opining that the purpose of pursuing 'social history' has long been normalised and that we have ended up in 'politically and intellectually sterile' waters.[24] Others wonder what we can do to reconnect with a 'core constituency' of members we once had—the medical profession itself.[25] It is lodged in professional lore that it was in the context of the 'social turn' in the 1970s that editors of medical history journals like Lloyd Stevenson, Leonard Wilson and Sherwin Nuland complained that MD-historians were 'intimidated' and 'wounded' by 'professional' (for example,

[20] McElhinney and Pellegrino 2001.
[21] Falk *et al.* 1973, p. 153; Jonsen 1998, p. 25.
[22] Pellegrino and Thomasma 1981, p. 4.
[23] Rosen in Blake (ed.) 1968, p. 50.
[24] Porter 1995; Cooter 2007.
[25] Nuland 1988; Brieger 2004; Huisman and Warner (eds) 2004.

PhD-trained) historians' critiques of medicine.[26] Chester Burns, a physician and the first history of medicine PhD graduate from Johns Hopkins, expressed a common sentiment at another workshop on history's role in medical education in 1980 (again at Hopkins and funded by the Macy Foundation), lamenting the antagonism between MD and PhD historians:

> Historical studies were coldly analytical and absurdly comprehensive, not appropriate for the education of empathetically caring and realistically specialized doctors. Progressive history of medicine fuelled the paternalistic and self-righteous tendencies of a medical profession already being called upon to respond more adequately to the cries of anguished citizen-patients and the demands of fellow health care professionals who wanted equal status. While students were clamouring for involvement and breadth, professional historians were becoming more detached and narrow.[27]

One alleged implication of these developments besides losing touch with our core constituency is that this type of history—'medical history without medicine' (to use Leonard Wilson's pungent characterisation)—is irrelevant to the interests of medical students. While there are, to be sure, historians with varying degrees of knowledge and interest in clinical medicine or the minutiae of biomedical science, it seems misguided to assume that topics addressing wider social and political forces that impact such practices and knowledge are disregarded by students. While medical students do not attend medical school to become historians, historians do not work at medical schools to teach medicine. What medical students often do not know upon entering medical school, however, is that the very idea of practising 'medicine' is fluid and part of a 'system' about which historians have much to say. As Owsei Temkin insightfully remarked in 1968:

> What we mean by the history of medicine depends largely on what we mean by medicine, and here I discern basic differences. Whether the history of medicine is useful or not will depend on whether you visualize medicine as primarily the action of the practitioner at the bedside or as the complex of what we now unfortunately call the health sciences. That largely also defines what we mean as a basic content of the history of medicine. I would like to think that our scruples and our uncertainties about what the history of medicine may be are creative, and are a positive reflection of how we think about medicine.[28]

Indeed, changes from within medical education itself allow us to reconsider the place of history in medical education. Other than the integration of 'medical humanities' programmes, a number of curricula include elective courses or research opportunities dealing with global health interventions, working with non-government organisations (NGOs), physician advocacy, health policy, and similar activities outside the walls of the clinic or lab.

[26] Stevenson 1980; Wilson 1980; Nuland 1988; see the interesting account on this in Reverby and Rosner in Huisman and Warner (eds) 2004.
[27] Burns in Bylebyl (ed.) 1982, p. 37.
[28] Temkin in Blake (ed.) 1968, p. 47.

Since the days referred to above of promoting 'human values' to underwrite medical morality, students have greater awareness of the roles that physicians play in activism and community service—the modern manifestation of yesterday's social medicine agenda—which offers renewed opportunities for using history of medicine to inform strategies for engaging diverse patient populations. An underdeveloped role that history of medicine plays in medical education is to provide historical illustrations of how physicians have addressed political, professional and other regulatory bodies to affect change in medical practice. In this way, it complements recent calls to use history to inform health policy.[29] This is less about giving students historical skills than giving them historical insight to how their own profession engages with different patient populations, medical industries and governments.

With the help of the social sciences, 'social pestilences' have been made part of the vocabulary of healthcare. With origins in nineteenth-century concerns by social reformers to develop the political role of medicine in creating egalitarian societies, and the subsequent development of social medicine programmes, twentieth-century medical education adapted sociological methods to investigate disease causations. As Dorothy Porter has written, 'interwar sociomedical reformers on both sides of the Atlantic believed that the creation of a socio-political role for medicine could be achieved by turning it into a social science'.[30] Medical schools today would be judged grossly deficient if they neglected discussion of war, poverty, malnutrition, smoking, alcohol, drug abuse, occupational and environmental diseases that are 'social' in origin. Yet what physicians are supposed to do about these broader forces that affect their patients' lives remains unclear to medical students.[31]

Interestingly, since the 1990s medical educators have appeared more engaged with what they have termed the 'cultural' dimensions of healthcare than what was considered social concerns gestating in earlier decades. In response to the Association of American Medical Colleges mandate that medical education address the needs of a diverse society, medical schools widely implemented training in 'cultural competency'.[32] Such programmes in part adapted insights from ethnographic research conducted by medical anthropologists to raise awareness of varied cultural attitudes and practices that impact patients' relationships with the healthcare system.[33] This trend might be characterised as medical education's answer to the 'cultural turn' that also distinguished an apolitical cultural history of medicine from social history's more politicised critiques of oppressive social orders.[34] Yet more recent calls for 'social relevance' in medical education that aim to ensure social justice and address cultural disparities in access to healthcare are suggesting new ways that social science and humanities research can inform physician training.[35]

[29] Szreter 2009.
[30] Porter 2006.
[31] Eisenberg 1999.
[32] Crandall *et al.* 2003.
[33] Kleinman *et al.* 1978.
[34] Rosenberg and Golden (eds) 1992; Cooter 2007; Fissell in Huisman and Warner (eds) 2004.
[35] Kumagai and Lypson 2009.

While I am not trying to diminish the tensions between MD and PhD-trained historians that have existed since the 1970s, or suggest that there is less difference between 'old doc history' and social history than there is, it seems these tensions are less relevant today in discussions of medical education.[36] We should remember that it was not the development of 'social history of medicine' that displaced history of medicine from the medical curriculum. Rather, it was the growing sense of irrelevance of the 'medical classics' for contemporary medical training, and the politicised discourse of social responsibility and ethical conduct in medicine in new areas like bioethics and social science in medicine, that stimulated a turn toward social analysis. Collectively, these developments outpaced adaptations within the medical curriculum.[37] The disconnect between history and medicine can be explained just as much by the advanced level of analysis involved to understand history's relevance as much as by the alienating critiques for which much of the literature is condemned.[38]

Advancing Disciplinary Communication

The 'narrowing' of vision to which Chester Burns among others referred suggests an irony in the continued development of long-standing medical history programmes linked to medical schools which came to offer specialised instruction and advanced graduate degrees. The recognition of the complexity of the historian's craft and the lateral knowledge required to conduct 'social' history research (and not merely 'internalist' history) encouraged faculty to legitimise their programmes by launching separate degree programmes within medical schools. This shifted attention away from 'undergraduate' medical training to graduate education. In the course of medical history's own professionalisation, as Genevieve Miller observed, 'the majority of [medical] schools appear to have less need for medical history than in the past', despite their established presence.[39] History of medicine began to fulfil a prophesy of specialisation that in this context made it a victim of its own professional success. The challenge today is bridging the gap between grant-driven research agendas and finding support for providing medical student instruction. (The same duality of research and teaching commitments can be said to exist for the basic sciences, and it reflects a tension in medical schools as they transform into biomedical research corporations, at the expense of their educational missions.)

Presciently, at the inauguration of the Institute for the History of Medicine at Johns Hopkins in 1929, Harvey Cushing warned against the scholarly trend to turn institutional spaces into sanctuaries for withdrawn specialists. 'Will this foundation merely mean still another group of specialists having their own societies, organs of publication, separate places of meeting, separate congresses, national and international, and who will also hold aloof from the army of doctors made and in the making?'[40] Apparently so. Over

[36] Reverby and Rosner in Reverby and Rosner (eds) 1979; Duffin (ed.) 2005.

[37] Although fellowships in the medical humanities funded through the National Endowment for the Humanities offered more advanced engagement in these areas and explored issues of interdisciplinary teaching between humanities scholars and medical faculty: McNeur 1974.

[38] Yet, 'history's' relevance is weighted to the history of modern medicine. So what we mean by history of medicine, to paraphrase Temkin, depends on what we mean by history.

[39] Miller 1969, p. 586.

[40] Rosen 1948, p. 624.

the past 20 years, articles too numerous to cite have debated why it is necessary or desirable to have specialised historians (or other flavours of humanist scholar) in medical schools, when their insular professionalism defeats the ostensible purpose of counterbalancing similar problems in science. 'One would like to say', noted the coordinator of the Human Values Program at the University of North Carolina School of Medicine in 1975, 'were it not already so manifest, that it is precisely this narrowing of vision which makes humanities teaching in a medical school so necessary'.[41] Yet, today this very idea that medical schools are narrow in vision (to which broad vision humanities scholars provide an antidote) is disingenuous, as is repeating earlier concerns about their anti-intellectualism or reductionism.

Perhaps the most common concern that has been expressed with regard to the need for the humanities in medicine over the previous century is that it services a deficit left in the wake of basic science teaching. Yet, historians of medicine and the biomedical sciences should be the first to point out that this is an oversimplification of the work of science. For the past 30 years, our own scholarship has shown that 'basic science' research is itself intensely social and political. Medical students who receive lectures on genetic screening, stem cells, vaccination practices or 'rational' drug design already know that this is not 'reductionist' but is knowledge that is implicated in complicated strategies of global research, corporate interests and laboratory politics. History in this sense does not offer a 'macro' view to counterbalance a 'micro' molecular vision, but rather it explains how and why the micro became so socially and politically active itself. The very social and political nature of biomedical research is a topic of interest to medical students, and an area that history of medicine should help to address.

Historians and sociologists of medical education have thoroughly documented and analysed the ebbs and flows of ideology and 'resistance to change' in medical schools.[42] What is relevant here, I think, are related opinions about what different disciplines expect along performance lines from their students and how we measure the outcomes of our educational interventions. In terms of integrating history, the humanities, science and medicine into one educational mission, we are left with challenges regarding interdisciplinary teaching. As historians have continued to write about their experiences teaching within medical schools, including dozens of articles reporting case studies from universities that have recently supported medical humanities initiatives, we learn that there is not one model that translates across multiple curricula.[43]

Yet because these social/historical perspectives are integrated across the whole spectrum of medical indoctrination, and can pop up in discussions of cardiovascular disease as easily as in obstetrics, renal or mental health instruction, schools either need to have an incredible number of specialised historians of medicine or we accept that our skills are adaptable enough to be applied more 'liberally' across the curriculum. The reason why medical humanities programmes offer fertile ground for historians is that they allow us to contribute to a diversity of perspectives of the many contributing humanities and social sciences to move beyond disciplinary insularity and benefit from a mixed

[41] Churchill 1975, p. 1081.
[42] Bloom 1988; Ludmerer 1985.
[43] Macnaughton 2000; Lerner 2000; Jackson 2002; Sheard 2006.

methods approach to building case studies. This helps generate new dialogue for research collaboration, which is the bread and butter of employment in medical schools rather than teaching itself.

Collaborative teaching and research sets examples of how clinical, basic and social science scholars can collectively contribute to healthcare problems facing young physicians as well as nurses, social workers, pharmacists and others on the 'healthcare team'. This moves us beyond the position of critics outside the system, as well as moving the criticism itself beyond an accusation of weaknesses in other disciplines. As Huisman and Warner suggested, '*Pace* science wars, if there is such a thing as a crisis in medical history, then one may well argue that it is not the fault of crude realism or postmodern relativism, or of any other such pairings of bipolar opposites, but a result of pluralism without tolerant yet critical exchange'.[44]

As difficult as interdisciplinary collaboration has historically proved to be, helping to shape the medical humanities in the decades to come might be the most fruitful way to engage a diverse medical community—and realign our insights to the interests of a lost constituency. Our responsibility as educators is to demonstrate to students that historical scholarship is part of evidence-based medical practice, especially as it involves cross-cultural interventions and strategies for reforming the delivery of healthcare. In so doing, we could benefit from working with other scholars in promoting a comprehensive vision about how best to make 'social' research relevant to community, if not global, health politics. Instead of turning social history into social medicine, however, new curricular opportunities allow us to concentrate on making social history integral to the training of the next generation of social physicians. This involves not only understanding our own past challenges in this regard, but overcoming historical biases that have hindered constructive communication.

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[44]Huisman and Warner (eds) 2004, p. 18.

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