

Medical History for the Medical Student

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Summary

The modern medical student is necessarily heavily burdened with instruction in Medical Science. When the teaching of Medical History is added to the university course, it is first necessary to stimulate student interest in that discipline and show its clinical relevance.

Résumé

L'esprit de l'étudiant en médecine d'aujourd'hui se trouve lourdement surchargé par un volume considérable de connaissances médicales et scientifiques nouvelles qu'il lui faut acquérir. Si l'enseignement de l'histoire de la médecine est ajouté, en plus, au cursus universitaire de cet étudiant, il faut avant tout stimuler son intérêt pour cette discipline et lui en démontrer la pertinence clinique.

The number of specialist disciplines in medicine and surgery today grows with exponential increase. Patients may be sent from department to department in search of someone else believed to know more about their illnesses. It has been likened to care by a committee without a chairman. In order to appreciate current reality the student needs a balanced view of the history of medicine and surgery. Active treatment is not always desirable. Heroic surgery has been replaced by heroic chemotherapy. The student needs to learn that medical treatment is ephemeral: its dangers may be worse than the disease.

The nature of the patient's dependence on the doctor has changed. The growth of a technological medicine, extending beyond strictly clinical medicine, has led to a new sort of medical practitioner; a medical scientist often not holding a clinical medical degree. Such practitioners make an essential contribution to diagnosis and treatment, but without a personal social function in relation to the patient. In teaching medical history to the medical student, this needs to be evaluated. An ethical dilemma exists when the ability to diagnose or predict the possibility of serious disease precedes the ability to treat it.

To medical students, at the outset of their years of medical education, the status quo seems an enduring reality. Medical history reveals that this is not true. What we are looking at in the present is not something which was, and is, and shall be evermore. Our forefathers' time was their own present. Acceptance of its dogma was just as easy to them as belief in the natural order of things. The contemporary climate of opinion influences behaviour.

Confidence in the doctor brought and brings comfort to the patient. Empiricism does the same for the doctor. Before the cause of a specific disease was known its treatment remained empirical. Students learn from history the temporary nature of a panacea. Osier said "Give the medicine now, whilst it is still curing".

The strengths and weaknesses of empiricism in medical and surgical practice are reflected in the relief of

symptoms, which is synonymous in the minds of many patients with the cure of disease.

Reported "discoveries" of medical "cures" still provide popularised data of varying accuracy. The call for "evidence based medicine" seeks to displace the old empiricism. Patients are encouraged to question any disliked diagnoses and to threaten financial penalties for treatment failures. Increased caution has fostered the growth of "defensive medicine", with its own dangers; Medical History helps perspective.

Doctors had been wrongly regarded as comfortably omniscient by a generation of patients living at a time when there was less understanding of the nature of disease. The doctor's experience brought comfort in personal relationships. Competence was sought in the search for a recognisably "safe doctor" as a requirement before registration to practise; a commendable but unachievable aim.

The patient has always sought the quality of experience in his medical adviser. But the wisdom of the clinician is not in that of his own experience alone; such an isolated learning process can be expensively acquired from its punishing mistakes. The most important lesson of experience may be that of the recognition of probability. John Locke (himself physician to the first Earl of Shaftsbury) said that this lesson "supplies the defects of our knowledge and guides us when that fails and is conversant about things of which we have no certainty".

It is the quality that supports the comfort of "the tried remedy", but it may have a spurious claim to be evidence based. Yet, if the doctor does not prescribe his own remedy confidently, the patient will seek solace elsewhere.

What constitutes evidence? It was Eric Freeman, when Librarian and Director of the Wellcome Institute, who first alerted me to the apparently cynical, but realistic view that "History is not what happened, but is what is written about what happened".

Credibility is a necessary but difficult concept, requiring experience and understanding of probability. A

common difficulty of assessment, well known to the clinician, is the unpredictability of human behaviour. This needs teaching in the history of medicine. The instinctual reactions inherited from Neanderthal Man influence us more than that learned from the Greek civilisation.

How much historical writing need students do themselves? Writing medical clinical histories is not unlike writing medical historical essays. As an exercise it should improve student literacy, not always evident when a university career begins.

The clinical account begins with past and present signs and symptoms, the social background and anything of family relevance. Case records are thus made in historical terms. The primary source is the patient. "Listen to the patient. He is telling you what is wrong"!

Primary sources in the history of medicine are sought in personal or original documents in the history of medicine. Confirmation or refutation is tested by comparison with other relevant contemporary documents.

The clinician considers a differential diagnosis. The prudent doctor will refer to what has been written about the subject in the journals, testing theses and diagnoses against the views of colleagues. Scientific tests confirm or refute the diagnosis. Academic historians also seek evidence from laboratories and technical specialists. Medical students are already burdened with the task of learning the vast amount of clinical and technical information necessary to teach them the care of patients. The ability to interest students is of the greatest practical importance in a crowded curriculum. A medical history course should show the student its relevance for a medical or surgical career. It may restore neglected ideas of holism and *universitas*.

We should not be concerned in training the medical student as a specialist medical historian. The value of Medicine being concerned with humans and the ills that befall them, it is not surprising that for many of us the pleasurable introduction to history has been via biographies. The narrative form is the usual style, of which AL Rowse says "first rate biography will lead you straight into the atmosphere, the thoughts will give you the very pulse of the period."

Biography can be used imaginatively in the medical curriculum to illustrate, in an interesting and easily remembered manner, the health care of a period, the signs and symptoms of an illness of one of the characters, as well as the importance of a therapeutic discovery. Heroes remain memorably attractive despite the dread criticism of veneration by hagiography.

A study of the history of Scientific Medicine reveals

that what is now known as Alternative Medicine has close similarities with an earlier empirical stage in the development of Modern Medicine. Explanations of the nature of disease govern diagnostic methods.

Improvements in diagnosis anticipate improved treatment. Even so, herbal medicine played an important historical place in the development of pharmacy.

The patient is the common factor in all medical and surgical care and the tradition of listening and taking a clinical history extends from Hippocratic times. Kindly naturopaths and aroma-therapists were not the begetters of *caritas*. An intelligent interest in the history of medicine can alert the medical student to cultivate wisdom and remember to "comfort always". Scientific technology is guiltless of the charge of dehumanising a medical concept of the patient.

In practical terms the medical student should be taught the basic rules of writing a medical historical essay. My own teacher, the late Professor David Williams, Professor of Modern Welsh History at Aberystwyth, was a great communicator. His simple advice for historical writers was to start at the beginning, finish at the end, include no error and acknowledge your sources. To do the last, one must keep accurate notes of what one reads. The thoughts of others may rapidly become regarded as one's own. To state them as one's own was regarded by David Williams as the unforgivable historical sin.

The student needs to learn of the perils in the interpretation of historical writing. Eric Freeman's warning, which I have already given, bears repetition. "History is not what happened, but is what is written about what happened"; revised by Alan Bullock, in his Leslie Stephen lecture at the University of Cambridge in 1976, "History can only in truth be how people today interpret what people have written about what has happened in the past". This admonition needs also to be observed by the medical student in interpreting case notes written by others. Historical and clinical method requires the discovery of truth, which needs an understanding of experience, not limited to one's own.

Clinical medical historians have an ally in Bullock. He warns of the dangers of looking at the past "in ways similar to those in which social scientists look at contemporary society." And in social science he includes "anthropology, ethnology, sociology, economics, statistics, demography, social psychology, even psychoanalysis". The relevance of his criticism is understood by both the clinician and the clinical historian.

Bullock then continues that "most historians ...find no difficulty in discriminating between the solid

achievements of historical demography on the one hand, and the inflated claims of psychohistory on the other".

Contemporary medical historical writing and clinical practice provide examples. The historian Elie Kedourie feared that eventually "the efforts of the historian would be directed toward making history into a kind of event-free social science, the task of which is to discover the norms of human behaviour".

In relation to the introduction of statistics and numeracy into historical accounts, Bullock quotes Robert Fogel:

"by all means count when counting is possible and useful", but adds Arthur Schlesinger's caution "almost all important questions are important because they are not susceptible to quantitative answers".

In clinical practice it is difficult to quantify illness, or to predict the outcome of illnesses with anything more than probabilities.

Bullock appreciates the importance of "the irregularities as opposed to the regularities of history, the discontinuities as opposed to the continuities. The accidental and the unforeseen have to be taken into account". The clinician is well aware of similar pitfalls in anticipating human responses.

It is important, for those now teaching medical history, to tell students how doctors of the past cared for their patients: of their having to make decisions, of life-long consequence to the patient (sometimes resulting in immediate dramatic death) on very inadequate evidence.

In summary and in conclusion; medical students

should be given the opportunity to appreciate the continuing possibility that some new discovery may yet destroy the most cherished current teaching as it often has in the past. They may best learn this from those clinicians who themselves can appreciate the value of historical perspective.

Sources

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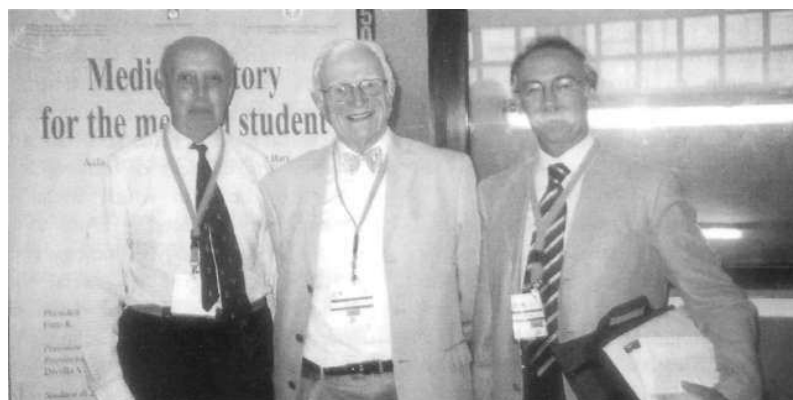
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The editors would be interested to hear comments, both from teachers and students, on the philosophy of teaching which this article raises.

Encouraging debate on this subject (and any other subject) is stimulating for us all and is something that we are keen to develop in *Vesaiius*.



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