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Second Opinions

Mixing with Medics

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Summary. Historians are increasingly required to produce research that makes an impact. This is particularly the case for medical historians, partly because of our funders' expectations, but also because there is a sense that medical history can inform today's thorny debates about health. Unfortunately, many historians struggle to make an impact. I suggest that participating in medical conferences (broadly defined), not only provides opportunities to make an impact on the medical community, but also offers chances to observe and participate in medical history as it happens.

Keywords: Impact; medical history; conferences

Why Study the History of Health and Medicine?

Well, where to start? We might have a genuine interest or, even, passion for the subject. We might have a connection to our particular field based on personal or professional experiences. Perhaps we find the history of medicine and health a helpful lens through which to view historical change and to attempt to understand what life (and death) in previous periods was like. We might enjoy teaching it, particularly if our students are headed for a career in health services. Some of us might have fallen into medical history by chance, on the suggestion of a sensible supervisor who heard that there was funding to be had if one studied the history of health and healing. I would suspect that many of these reasons might ring true for many readers of *Social History of Medicine*. And there is nothing wrong with any of them. But in 2010, in the midst of government cutbacks, changes to how medical history is funded, not only in Britain and Ireland, but elsewhere, and growing calls for interdisciplinary academic research, these reasons are not quite enough.

It could be that many of us have not asked such existential questions, but it is certainly time we did. Governments, funding bodies and universities are asking them, and not only of medical historians. Publications remain the most influential arbiter of whether a return on funding has been realised, but they are no longer the only factor involved. Having some kind of broader impact (a word dreaded by historians perhaps more than any other type of researcher) is quickly becoming another prerequisite to success with many funders, particularly those solicited by medical historians.

On one level, apprehension about impact is understandable. Historians are not trained to have impact; good history, as defined by some, necessarily lacks broader appeal or

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application. It is intended for other historians and postgraduates who study something similar, and if one is a decent writer and reasonably catholic in one's approach, possibly undergraduates. Academic historians who are interviewed on BBC's *Today* programme are seen as vaguely suspicious. Popular historians are often considered by academic historians to be the veritable quacks of the historical community, sometimes justifiably.[1]

But shouldn't we all be somewhat concerned about whether we have an impact outside of the dozen or so people who read our work with a semblance of the care and attention that we've given to it? Don't we all want to make some kind of difference?[2] Maybe some of us don't care, but it is clear that our funders do. Sooner or later, we will be asked hard questions about why our research is worth the money that is poured into it and we should be prepared to answer them. Fortunately, as medical historians, we are possibly more equipped to make an impact than other historians, given that our field has an inherent, if not always recognised or utilised, interdisciplinarity about it; the question becomes how are we to do so. As Simon Szreter has argued recently, one excellent way is to publish our policy-relevant findings in places like Historyandpolicy.org, a website devoted to applying historical research to public policy.[3] Other medical historians, such as Virginia Berridge and Abigail Woods, have gone further, becoming directly involved in debates about health policy.[4] Then again, there remain plenty of excellent medical historians who are also medics: Jacalyn Duffin, Howard Markel and David Healy, to name but three, whose medical qualifications have made their historical research more transferable to the medical world. While it might be unrealistic to ask all medical historians to have as much impact as Berridge and Woods, or study for an MD on the side, there are other ways in which we can begin to make a difference. In what follows, I suggest that one such way is by participating in conferences for health practitioners. Conferences are an opportunity not only to convey our ideas to the people who might be best-placed to implement or, at least, reflect upon them, but also gives us a chance to learn a great deal about how notions about health emerge, which we can then apply to our research and teaching.

The Social Determinants of Mental Health

In the autumn of 2009, I opened up an email from H-Net.[5] I am on the history of science, technology and medicine list-serve and receive daily emails about relevant events, publications and projects. Although weeks may pass by without anything being particularly eye-catching, on this day one post captured my attention. The blurb invited 'innovative speakers from diverse interdisciplinary and professional backgrounds to address the Social Determinants of Mental Health' in Chicago. It was billed as the first conference of its kind in the United States.

[1]One example of a Canadian popular historian who divided opinion with respect to the quality of his historical writing was the prolific Pierre Berton (1920–2004). While some academic historians criticised his work as 'lacking in critical analysis and new insights into past events', and never read his books, others admired the accessibility of his work. Austen 2004.

[2]Of course, the individuals on whom we make the greatest impact are our students. It is rather disconcerting how discussion of that sort of impact is often missing from debates about public engagement and knowledge transfer.

[3]Szreter 2009; http://www.historyandpolicy.org, accessed 28 October 2010.

[4]For instance, Berridge 2007; Woods 2004.

[5]Humanities and Social Sciences Online http://www.H-Net.org, accessed 28 October 2010.

At first, it felt like a blast from the past. I had written a little about the history of social psychiatry, the notion that mental illness is largely determined by social factors, such as poverty, overcrowding and exposure to violence, but had argued most such theories had faded away during the 1970s, in the wake of the newly dominant neurological explanations for and pharmaceutical treatments of mental illness.[6] I had been contemplating writing an article about the topic for a couple of months with my University of Exeter colleague, historian Edmund Ramsden, but with the much duller intent of filling a historiographical gap, as if we were civil engineers endlessly constructing a bridge to the past, rather than engaging with a thriving, contemporary debate. Here social psychiatry seemed to have risen from the dead, and not like a zombie, but more like a phoenix, if the list of invited speakers, which included former Surgeon General of the United States, David Satcher, was any indication. I was intrigued by the opportunity, but wondered whether they'd be interested in a historian crashing the party.

I re-read the blurb again, and the phrase about the conference being the first such convened in the United States. Hold on, I thought, that's not right. Maybe it was the first such conference convened in years, decades even, but it was certainly not the first in any historical sense. Social psychiatry had been a major force in inter- and post-war American psychiatry, threatening to supersede both psychoanalysis and biological psychiatry if President Kennedy's 1963 'Message to Congress on Mental Illness and Mental Retardation' was to be believed.[7] More obviously, the movement arguably got its start in Chicago, with the publication of Faris and Dunham's *Mental Health in Urban Areas* in 1939, which mapped the city according to regional rates of mental illness.[8] Many other influential, though apparently forgotten, monographs had been written about social psychiatry, and most of the presidents of the American Psychiatric Association during the 1960s supported its revolutionary and prophylactic ideas in their Presidential Addresses.[9] Perhaps no psychiatrist had uttered the phrase 'social psychiatry' in 30 years, but that didn't mean that its history should be forgotten, particularly now, given its apparent resurgence. Sensing an opportunity to make an impact, or at least ruffle some feathers, I decided to send in an abstract.

Ed Ramsden wasn't able to attend the conference, but was eager to collaborate in writing the abstract and the paper, if we got that far. We figured that there were two ways of proceeding, as there tends to be in medical history. We could give a rather didactic account of the history of social psychiatry, full of names, dates and places, and hope that the old-timers in attendance might turn up for old time's sake. This ran the risk of being rather dull, but wouldn't offend anyone too much. The other option was to write a more critical account of social psychiatry, outlining not only what it achieved, but also what it failed to achieve and why, hinting that the reasons for such failures might, yet again, hinder the implementation of the social determinants of health agenda. In other words, history might not repeat itself, but the barriers facing mental health professionals who want to improve the mental health outcomes of society's

[6] Smith 2008.
[7] Kennedy 1963/64.
[8] Faris and Dunham 1939.
[9] Some of the key social psychiatry texts include Hollingshead and Redlich 1958; Leighton 1959; Srole *et al.* 1963. See also Ewalt 1959/60; Branch 1963/64; Blain 1965/66; Brosin 1968/69; Waggoner 1970/71.

disadvantaged—lack of funding, disciplinary in-fighting, political pressure, discrimination and apathy—have remained fairly constant.

In the end, we opted for a combination approach. Given that the history of social psychiatry had seemingly been forgotten, we had to provide a good deal of background for our audience to understand what we were on about. But Ed and I also felt compelled to include some critical analysis as well. We were both broadly sympathetic towards social psychiatry as a general principle—if you improve people's lives socially, culturally and economically, you improve their chances of having good mental health—but we also knew from our research that social psychiatrists faced enormous challenges during the 1960s, both from within and without the movement. It was foolhardy for those who wanted to re-kindle interest in social psychiatry to ignore what had happened to such attempts in the past, to believe that they were going where no one had gone before. Perhaps the history of how social psychiatry fared in the past could help its advocates be more successful today.

Of course, they first had to accept our paper. I laboured over the abstract, agonising over how to describe our paper in a way that was not overly negative, yet still plainly stating the gist of our argument. After a good deal of dithering, I filled up the 300 words, making an effort to link our paper to the stated objectives of the conference, and sent it in the day of the deadline, feeling the same way I have felt submitting a job application to Oxbridge: this might have been a big waste of time. And then, again like an Oxbridge application, I promptly forgot about it. Only this time, six weeks later, I received an email of acceptance.

Big Ideas in a Windy City

The months prior to the conference went by in a blur. I had to finish a book manuscript, go to the United States for a research trip, present at a number of conferences and seminars, teach, supervise and digest the fact that my partner was expecting our first child. Before I knew it, I was on an airplane to Chicago, wondering what would be in store for me and my paper. I had never been to the Windy City and it immediately made a positive impression. It was a historian's sort of town, at the crossroads of not just the United States, but North America, full of compelling stories and, with the recent election of a local hero to the White House, ready to write some more. History, it seemed, mattered here.

But would it matter at the conference? My presentation was on the second of the two days, giving me time to see the lay of the land, and it didn't take long to realise that the organisers wanted their conference to make an impact. The welcoming address, delivered by a Director of the host institute, the Adler School of Professional Psychology, emphasised that the 'conference was the first of its kind', and intended 'to facilitate action on the social determinants of mental health'. The keynote, by former Surgeon General David Satcher, was more sanguine. Satcher advocated for a 'global movement' aimed at improving mental health through social action. Mental illness, Satcher argued, involved both social and personal factors, but too much time and effort was focused on individuals, rather than communities, leaving some American neighbourhoods, particularly African-American neighbourhoods, in a state of chronic 'community depression'. The

key to improving mental health, therefore, was 'eliminating health disparities for underserved groups, such as minorities and the poor'.

The panel discussion that followed was similarly political. The participants also stressed the historical significance of the occasion, describing the conference as 'groundbreaking' and that they 'had never seen one like it yet'. As they hailed the gathering as the ideal opportunity to launch the social determinants agenda, two things occurred to me. The first was that, if this movement was actually successful, I, a historian, had the opportunity not only to witness history being made firsthand, but also to participate in it. Having read about the Tea Party movement in the Chicago Tribune over my morning coffee (served by a member of the Drake Hotel's seemingly exclusively Latino catering staff), and knowing how social psychiatry fared during the 1970s, I wasn't particularly optimistic about how conservative Americans would view the social determinants agenda, but the possibility remained that historians decades hence would make reference to this conference as when it all kicked off.

I then asked myself the most important question a historian ever asks: why? If a social determinants model of mental health was to become the next big thing in mental health, well, why now? Why here? During the Q and A session, no one seemed to be asking this, so I figured it was up to me. I carefully weaved through dozens of round tables and queued up at a microphone behind an imposing gentleman dressed in a dark suit. I wished I had worn a tie. After posing my query, the panellists looked at one another, eyebrows either furrowed or raised. An awkward silence presided until one of them, the Chief Medical Officer of the Cook County Health System, shrugged and speculated about the impact of the new president and reiterated that, strange questions from historians notwithstanding, the time for action was now.

I tip-toed back to my chair as inconspicuously as I could, avoiding eye contact and trying not to draw more attention to myself by tripping on the plush ballroom carpet. The answer, or lack thereof, was bemusing. I could think of plenty of possible reasons for the resurgence of social psychiatric ideas—dissatisfaction with biomedical explanations and pharmaceutical treatments; a desire to find preventive approaches in the midst of a recession and rising health costs; increased interest in launching social equity initiatives, including a public health system, following the election of an African-American president—but none had been forthcoming. During the coffee break that followed, a couple of people mentioned that it had been a good question. 'It really made me think about the whole issue differently', a nursing professor said, 'Puts it all into context, I suppose.'

If I had managed that, then the trip might have been worth it. As I attended subsequent panels, listening to what was being said by both the panellists and the audience, it became clear that the perspective I brought as a historian was valuable. The questions asked by most audience members, for example, could be broken into a few different categories. First, a good number of people asked for more details about the specific project being described or related the research that they were doing. Others challenged the findings based on shortcomings in the study design or because it clashed with what they had found. Then there were the devil's advocates—typically those with a clinical background, who would state that, while the findings were interesting, they would be difficult to implement. Finally, there were those who took the opportunity for speaking as an opportunity to rattle on endlessly about their own personal bugbear. One psychologist must

have mentioned his belief that a vegan diet was central to preventing mental illness at least four times. I made a mental note not to eat lunch at his table.

It wasn't so different from a history conference, where you get the same sort of questions, but falling within the broad historical remit. What I brought to the table, I hoped, was an additional perspective, one that could not only contextualise matters, but also cut through the tacit assumptions that enveloped the discourse at the conference. As my courage to ask the odd, almost apologetic, question grew, I began to feel that I did have something to contribute, that historical analysis did have a role at a mental health conference that was very much aimed at the future. It was almost as if I was making an impact.

These positive feelings had pretty much evaporated by the time of my presentation. It was one thing to sit back and ask a clever question or two; it was quite another to stand in front of a large number of mental health professionals and spend 20 minutes telling them how the history of previous attempts to launch a social determinants agenda did not bode well for the ambitions discussed so warmly at the other panels. As it turned out, Ed and I had packed in about five minutes more than we should have and, with the draconian chair keeping a close eye on her watch, the talk came out rather more hurriedly and rather less intelligently than I would have liked. I had a great deal of trouble pronouncing 'psychoanalysis', which was particularly annoying. Nevertheless, I hoped that my argument, that the social determinants agenda was as much a political movement as a mental health strategy, and had to be seen as such, was clear. It was time for questions.

The first couple were fairly innocuous and, indeed, had little to do with what I said. I re-emphasised a couple of my points and relaxed a bit. Then a well-dressed gentleman, the same fellow I had queued behind to ask a question, stood up, introduced himself as a high-ranking psychiatrist with an American government agency, and proceeded to tear me apart. According to him, psychiatrists were always portrayed as the bad guys and that the criticisms levelled at them weren't fair. I hadn't presented the entire story and there was no reason to doubt the social determinants approach to mental health, which was being carried out successfully in the UK and Canada. Just as I was about to launch into a fiery response, the chair announced that time was up and we had to move on. Annoyed that I wouldn't be able to defend myself in front of the entire audience, I tracked the psychiatrist down and attempted to address the issues he'd raised. By the end of our exchange, we shook hands, agreeing to disagree to a certain extent, and exchanged cards (I did send a follow-up email which wasn't returned). After he left, I spoke to a number of other people, particularly students, who were much more appreciative, and I left the room feeling more energised than shell-shocked.

As I strolled around Chicago the next day, after the proceedings had concluded, I thought a good deal about the conference, what I had learned and if I had contributed. Putting the question of impact to one side, I had easily gained enough out of the conference for it to have been worth the trip. Most of the papers themselves weren't all that exciting—mainly simply spoken scientific papers, and some fairly bad—but the opening and closing remarks, plenary speeches, Q and A sessions, casual conversations, networking and the overall atmosphere were of enormous value to me as a historian. When you read an article in a psychiatry journal, for example, you are reading a carefully-worded,

edited and un-annotated take on a particular issue. There might be a discussant, and the article might generate a letter to the editor, but generally you get a one-sided and, increasingly during the last 50 years, dispassionate description of events. This isn't quite the case at a conference. Questions are asked and answered, disagreements are raised out in the open and opinions and attitudes are often laid bare. Even at the Social Determinants of Mental Health conference, which was billed as a call to action, and where it was all but taken for granted that everyone believed the premise underlying the occasion, cracks and fissures appeared.

For instance, after the panellists of the final round table session had their say, a psychiatric social worker from South Chicago walked up to the microphone. She applauded the speakers for their energy and conviction, but then proceeded to describe how she doubted policy makers and politicians would be willing or able to put the social determinants agenda into action. She wondered if this was because many of the academics doing the speaking had not really seen what life was like in the communities they wanted to save. Unlike them, she lived in those communities. She knew it would be much more complicated than they made it out to be. She was warmly applauded when she finished, but I also sensed an underlying tension. Was this the way to launch a global movement? Amidst doubts and concerns about its very viability? And should such a movement be launched in the Drake Hotel in the middle of sparkling downtown Chicago? Shouldn't we have been in the gymnasium of some crumbling high school in south Chicago? The social worker's words may not have reassured many conference participants, but it reinforced, for me, that medical knowledge is always a matter for debate, and that it is at conferences such as this one that the intricacies of such debates come to the surface. Moreover, if I weren't now chronicling the conference following my participation in it, would anyone else have remembered what she had said?

Making an Impact

But what about me? Had I made any kind of impact? In a way, that will be up to me. As far as the questions I asked and the paper I presented, it would be nice to think that my historical take on the social determinants agenda provided a perspective that the conference participants would find valuable. If I convinced even a few people to consider how such initiatives materialised in the past before launching similar strategies, I would have made a small impact. But one appearance at a conference does not an impact make. If I really want history to play a role in the debates about the social determinants of mental health, I have to stay involved, to keep in contact with the people I met at the conference and to continue to participate in future events. It might be difficult to measure or evaluate but, if I keep at it, and attend more such conferences, I like to think I'll be making a difference, however modest.

By this point, some of you might be thinking that it is all well and good for someone doing twentieth-century medical history to go on about the benefits of attending medical conferences. What about those doing early modern, medieval or ancient history? So much the better, I would answer. As sociologist Harry Collins has said, reflecting on the work of Ludwik Fleck, 'distance lends enchantment'; it is quite possible that the more distant the historical period, the more intrigued non-historians will be in the insights

provided.[10] At the University of Exeter, for example, classicists such as John Wilkins, Chris Gill and Julius Rocca have effectively emphasised the applicability of Galenic thinking, particularly the concept of balance, to members of the Peninsular Medical College. Others, such as Brian Dolan, writing in *Social History of Medicine*, have argued that historical analysis can have a role in evidence-based medical practice and, more specifically, in medical education.[11] Whatever the means, it is ultimately up to us to explain why the history of health and medicine can have relevance to modern practitioners and researchers, but if my experience presenting to non-historical audiences is any indication, the efforts to do so can be worthwhile.

In a different world, historians might not have to worry about impact. Policy makers would come to us, not seeking direction, but insight and context. The general public would be genuinely interested in learning about the past, not just to find out whether their ancestors were navvies or nobles, but because it gives meaning and shape to their lives. Perhaps even funding bodies, such as the Wellcome Trust, would think it wise to have historians on their medical funding panels, just as they have medics on the medical history funding panels. But that isn't the world we live in, not yet anyway. We need to be proactive in order to assert the viability and importance of our profession; reaching out to health professionals by participating in the odd medical conference is just one way we can do this. Engaging in the many debates about health is not easy. It means taking risks, both in terms of communicating with audiences that may not like to hear what we have to say and sometimes extending our conclusions further than we would normally prefer. But it might also help to keep us relevant in troubling times.

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[10] Collins 1992, p. 145.

[11] Dolan 2010.

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