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Problems of Progress: Modernity and Writing the Social History of Medicine

SUMMARY: Reflecting on the discipline over the last sixty years, this historiographical essay considers how social historians of medicine might deal with the problem that ‘modernity’ and its associated phenomena -- progress, tradition, and backwardness -- have become normalized. It argues that such terms require conscious interrogation and should be situated within a critique of sources, actors’ categories, and competing historical interpretations. The essay suggests three routes out of the problem of modernity. First, by shifting the focus to re-interrogate those areas commonly framed as backward; second, by using the metaphor of ‘blended modernities’ to examine commonalities across time and space, and finally by employing the everyday as an analytical category to approach those ambiguities and ambivalences that helped structure the nineteenth- and twentieth-century social history of medicine.

KEYWORDS: backwardness, historiography, modernity, progress, social history of medicine, tradition

Any examination of Anglophone scholarship on medical history over the last sixty years would reveal a shift to more complex social and cultural histories of medicine; how historians have slowed down chronologies of progress, highlighting contingencies, continuities, and the contested nature of change, and rethought the active sites of knowledge production. The resulting scholarship emphasises how the path to modern medicine was anything but straightforward. However, when historians talk about the medicine’s pasts over the last five hundred years, it remains hard for them to escape what Carol Gluck refers to as a common

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‘grammar of modernity’.¹ As the authors of the introduction to the *American Historical Review*’s roundtable discussion on modernity made clear in 2011, this common grammar presents problems across a range of historical subfields. The authors suggest that for all our sophistication as historians there appears to be a ‘disconnect’ between how scholars ‘think about “modernity” and its kindred concepts -- modernism and modernisation -- and how they teach, discuss, and even write history.’² Despite rejecting essentialism, connections between modernity and progress, tradition and backwardness, are (often implicitly) embedded in our examination of the social histories of medicine they act as short-hands to refer to an interrelated series of economic, social, and political transformations associated with western societies. In part, this is because, as Barbara Weinstein explains, a metanarrative of modernity is so entrenched in our cultural frameworks that it is presented as the historian’s ‘common sense’, even if historians harbour strong reservations about the legitimacy of using the term modernity.³

If ‘modern’ is a temporally unstable concept, how do we describe historical change in different times and places? How do we recognise that modernity, tradition, and backwardness are all historically contingent? As ideas and ways of describing processes of change, they all draw on a universalising narrative associated with European Enlightenment thinking and a vision of order and progress intrinsically bound up a variety of cultural, social, and political

¹ Carol Gluck, ‘The End of Elsewhere: Writing Modernity Now’, *American Historical Review*, 2011, 116, 676-87, 676.

² AHR Roundtable: Historians and the Question of ‘Modernity’, ‘Introduction’, *American Historical Review*, 2011, 116, 631-67, 631.

³ Barbara Weinstein, ‘History without a Cause? Grand Narratives, World History, and the Postcolonial Dilemma’, *International Review of Social History*, 2005, 50, 71-93.

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projects connected to nineteenth- and twentieth-century liberal industrialised states in Western Europe and North America. While the dismissal of modernisation theory in the 1990s saw references to modernisation largely disappear from historical writing, it continues to inform scholarship in a semi-casual way. As the early modern historian Garthine Walker writes, “‘Obviously’ the world has modernised’, but how to deal with modernity and corollary notions of progress, tradition, and backwardness continue to present problems for how we approach medicines’ past.⁴ Rather than suggesting new chronologies or periodisations, the central question this essay explores is: can historians working on European and North American medicine still use notions of modernity, tradition, and backwardness as useful tools to understand the social history of medicine? This leads to two further questions: what does progress mean? Moreover, whose progress or modernity is being measured?

In exploring these questions, this historiographical essay seeks to encourage social historians of medicine working on Europe and North America to position themselves actively within wider historical debates about chronologies, methodologies, and narratives. It opens with a review of how social historians of medicine working on Britain, Europe and North America have struggled to dispense with the normative image of modernisation embedded in the larger intellectual apparatus of social history. Yet, as discussed in the following section, it is not just a question of modernity: it is also necessary to reflect on the problems in using tradition and backwardness as normative terms. The essay goes on to explore how shifting the focus to areas commonly framed as backwards -- in this case the countryside -- reveals both the entanglement of the normative discourse on modernity with urban models and the possibility of different perspectives. The essay then turns to examining different models of

⁴ Garthine Walker, ‘Modernisation’, in Garthine Walker, ed., *Writing Early Modern History* (London: Hodder Arnold, 2005), 25-48, 25.

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modernity by placing studies on Britain and Europe in dialogue with scholarship on the history of medicine and science in the Global South. As scholars working on science and medicine in Asia and Africa have established since the 1990s, there is a complex negotiation between cultural producers and consumers in the production of a hybrid, modern world. The essay applies this scholarship of medicine and science outside Europe, particularly Gluck's metaphor of 'blended modernities', to a European context to highlight other ways of thinking about commonalities across time and space. Finally, the essay considers how the concept of the everyday offers another way of approaching those ambiguities and ambivalences that helped structure nineteenth- and twentieth-century medicine. In making these suggestions, the essay acknowledges that these are only three ways of thinking – it is likely that there are other answers to these problems that arise from different historical subfields and perspectives.

MODERNITY AND THE SOCIAL HISTORY OF MEDICINE

From the outset, it is important to recognise that the social history of medicine has come to mean many different things. As a term, an approach, and as a category it has been the subject of contention and challenge. Any survey of such a rich field runs the risk of flattening the nuances and complexity of scholarship. What is offered in this first section therefore is an overview of the expansion (and fragmentation) of scholarship on the social history of medicine and its engagement with questions of modernity and progress.

If there is no one social history of medicine, now familiar studies of the Anglo-American history of medicine as a field of inquiry have drawn attention to how before the 1960s historians seemed particularly prone to using modernisation theory; how they used this approach to describe the inevitable progression from the medicine of the Ancient world to

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biomedicine and its universal global adoption in the twentieth century.⁵ For early scholars working in the field, progress in medicine was an account of advances and ‘that which saves the most lives.’ In these studies, as Philip van der Eijk explained in 2011, Graeco-Roman medicine became the ‘cradle’ of the Western medical tradition, though these same studies often emphasised stagnation in the medieval period before highlighting how the sixteenth century saw a period of renewed progress.⁶ In such a narrative, the Scientific Revolution, the Enlightenment, and the nineteenth century were periods of innovation associated with turning points in ideas and practices on the path to modern medicine. For many of those Western historians of medicine writing in the 1950s and 1960s, the start of modern scientific medicine was to be found in eighteenth-century Europe, with the nineteenth century seeing the inevitable triumph of surgery, the hospital, and the laboratory. Such accounts put forward a ‘singularity’ model of medical development based on a Western conception of modernity, an approach that resonated with the confidence placed in the power of biomedicine in the 1950s and 1960s.⁷

Initially controversial, what was labelled the ‘new’ social history of medicine in the 1970s offered European and North American academics an innovative way of writing medical history. On the surface, narratives of progress became out of step with how they

⁵ See, for example, Frank Huisman and John Harley Warner, ed., *Locating Medical History. The Stories and their Meanings* (Baltimore: John Hopkins University Press, 2004).

⁶ Philip van der Eijk, ‘Medicine and Health in the Graeco-Roman World’, in Mark Jackson, ed., *Oxford Handbook for the History of Medicine* (Oxford: Oxford University Press, 2011), 21-39, 21.

⁷ See, for example, Richard Shryock, *Development of Modern Medicine: An Interpretation of the Social and Scientific Factors Involved* (New York: Alfred A. Knopf, 1947), 151.

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conceptualised medicine's past as a messy, conflicted, and negotiated process of development. A new generation of scholars drew on wider trends in historical writing and turned to the social and cultural history of medicine to assert the importance of considering class, gender, race, conflict, and continuities in their challenge to a top-down, doctor-centred approach. Although many continued to position their work in relation to an understanding of turning points in the history of medicine, in problematising the development of Western medicine, they saw the process of modernisation as anything but smooth. As they explored the production of medical knowledge, the institutional and political dynamics of health care, and how social and cultural expectations and experiences structured disease and sickness, changes in medicine became tied to their socio-economic, cultural, racial, and political contexts. One consequence of these shifts was more pessimistic readings of existing chronologies of progress.

Social and cultural historians since the 1990s have not unthinkingly fallen victim to modernising accounts. Questioning discontinuities and the monolithic nature of medicine now forms an essential part of scholarship. As Mark Jackson explained in 2011, historians of medicine have come to 'offer critical reflections on the validity and stability of many historical assumptions about both the past and the present.'⁸ Earlier ideas about medicalisation as a collaboration between experts and modern states linked to professionalisation, bureaucratisation, and industrialisation were refined to draw out the complex historical relationships between a biomedical perspective and the liberal (and neoliberal) state. Regional and local variations from a grand narrative of development -- as evident in writing on medicine in the southern United States, for example -- and the extent to

⁸ Mark Jackson, 'Introduction', in Jackson, ed., *Oxford Handbook*, 10.

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which regions or locales connect to national or transnational processes have been stressed.⁹ Informed by subaltern positions, and influenced by an awareness of the politics of knowledge production, social historians of medicine have become expert at exploring medical pluralism whether they are looking at the divergences in Greek and Chinese medicine or writing about colonial medical encounters where the notion of hybridisation offered a way to question chronologies and types of modernity. Models, such as the medical marketplace, for all their limitations, provided ways of thinking through complex processes, such as the medical pluralism of seventeenth-century Europe. Other historians, informed by cultural approaches, urged those in the field to write about medicine and meaning. Social constructionism or Charles Rosenberg's advocacy later in his career of 'framing', for example, were held up as methodological frameworks that provided scope for more nuanced readings to 'conceptualise, explain and interpret' the contexts and processes that informed medical ideas and practices.¹⁰ Yet other historians turned to medicalisation, biopower, and more recently to governmentality to critique ideas of progress. Whether framed as transnational, connected, or global history, the importance of the transmission of knowledge and practices across social, culture, and geographical boundaries is increasingly stressed.¹¹

⁹ See, for example, Peter McCandless, *Slavery, Disease, and Suffering in the Southern Lowcountry* (New York: Cambridge University Press, 2012); Deidre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynaecology* (Athens: University of Georgia Press, 2017).

¹⁰ Ludmilla Jordanova, 'The Social Construction of Medical Knowledge', *Social History of Medicine*, 1995, 8, 361-81.

¹¹ For the challenges of writing global medical histories, see Sarah Hodges, 'Second Opinion: The Global Menace', *Social History of Medicine*, 2011, 25, 719-28.

‘CANNOT HELP BUT WRITE A TALE OF THE GRADUAL BUT INEVITABLE
TRIUMPH OF TRUTH OVER ERROR’

Notwithstanding these intellectual shifts, how to interrogate what we mean about tradition, progress, and modernity continues to pose problems for students and scholars alike working on medicine in Britain, Europe and North America. This problem is not a new one for the discipline. Writing in *Medical History* in 1973, John Hutchinson warned that if the social historian of medicine assumed that medicine means ‘modern scientific medicine, he cannot help but write a tale of the gradual but inevitable triumph of truth over error.’¹² Thirteen years later, Paul Weindling wondered ‘whether this very diversity and complexity [of social life; of medicine] can really be encompassed by such opaque categories as “traditional” or “modern”.’¹³ Of course, few would now think in terms of the inevitable triumph of, for example, germ theory. Instead, they would draw on a rich literature that sees a contested history to explore the complex linkages that exist between ideas about germs, practices, institutions, disease, society, culture, politics, and medical practitioners.¹⁴ Yet enduring assumptions about the development of modern medicine reinforce associations between traditional, indigenous, and scientific medicine. Ironically, even those swayed by

¹² John F. Hutchinson, ‘Historical Method and the Social History of Medicine’, *Medical History*, 1973, 17, 342-51.

¹³ Paul Weindling, ‘Medicine and Modernisation: The Social History of German health and Medicine’, *History of Science*, 1986, 24, 277-301, 293.

¹⁴ See for example, Nancy Tomes, *The Gospel of Germs. Men, Women, and the Microbe in American Life* (Harvard: Harvard University Press, 1999) or Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900* (Cambridge: Cambridge University Press, 2000)

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poststructuralism retained categories of tradition and modernity in their writing. The result is that not only are national histories often variations of a metanarrative of professionalisation, institutionalisation, the laboratory, and state intervention, but also that modernist notions remain embedded in writing about, for example, the Enlightenment or the growth of what is often presented as scientific, rational medicine in the nineteenth century. Where older medical views are detected as persisting – such as around beliefs about humours and holistic approaches in North America in the nineteenth century – they are characterised, as Ruth Rogaski suggests, as ‘transitional moments, as lag times between a traditional past and an inevitable achievement of medical modernity’.¹⁵

Equally telling is how histories of medicine in Europe and North America reinforce the modernist assumption that the centuries between 1500 and 1800 were a period of transition from the medieval to the modern world. For instance, while scholars are sensitive to the centrality of religion in structuring fluid attitudes to medicine and the body in the sixteenth and seventeenth centuries, work on eighteenth- and nineteenth-century European medicine implicitly accepts the seeming separation of the religious and secular during the Enlightenment, and how the growth of scientific rationality reinforced this separation.¹⁶ This propensity is despite the fact that religion remained at the centre of the Enlightenment and that religious concerns informed the thinking of figures commonly associated with advancing medical thinking, such as René Laennec or Charles Darwin. It likewise marginalises how

¹⁵ Ruth Rogaski, *Hygienic Modernity: Means of Health and Disease in Treaty-Port China* (Berkeley: University of California Press, 2004), 6-7.

¹⁶ For an excellent review of historical debates about secularisation, see J.C.D. Clark, ‘Secularisation and Modernisation: The Failure of a “Grand Narrative”’, *Historical Journal*, 2015, 55, 161-194.

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religious institutions remained crucial to the delivery of healthcare in the nineteenth and twentieth centuries; for instance, in structuring healthcare in colonial settlements or in how sectarian debates influenced twentieth-century medicine in France.¹⁷

Periodisation and a degree of chronological chauvinism that sees certain periods associated with greater progress than others likewise create problems. In earlier writing, scholars working on Britain or Europe often wrote off particular periods, linking them with stagnation, such as the medieval period. Instead they concentrated on, for example, Renaissance anatomy, post-Revolutionary Paris, or nineteenth-century bacteriology, as emblematic of progress. Scholars in the 1980s and 1990s challenged this periodisation of stagnation and progress, but in doing so, they often replaced a narrative of stagnation with one that pointed to change or difference. Work on eighteenth-century medicine is a good example of this approach. Whereas earlier historians wrote about stagnation and confusion, scholars now see the eighteenth century as a crucial period; important in terms of evolving professional structures, the formation of new medical knowledge, growing institutionalisation, and the medicalisation of societies.¹⁸ Yet, work still characterises periods in particular ways -- such as the association of the eighteenth century with quackery -- and by doing so reinforce ideas about a common path to modern medicine.

Where problems exist with periodisation, some of the models used to represent wider processes in writing medical history -- professionalisation, medicalisation, institutionalisation -- implicitly endorse ideas of progress. The best example of this is how medical historians

¹⁷ See, for example, Biswamoy Pati and Mark Harrison, ed., *Society, medicine and politics in Colonial India* (London: Routledge, 2018).

¹⁸ For an overview of these ideas, see Mary Lindemann, *Medicine and Society in Early Modern Europe* (Cambridge: Cambridge University Press, 2010 [2nd edn.]).

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have drawn on sociological ideas of professionalisation, which sees the medical profession as a modern creation that emerged out of the processes of economic and political revolution in Europe and the growth of modern industrialised societies. Those working on the rich range of practitioners that offered medical care in the past have done much to refine approaches to professionalisation. They have questioned chronologies, often writing about evolving patterns of professionalisation, but many still privilege professionalisation as a key historical process. They might frame the medical profession as insecure, divided, or opposed but they still look for, and talk about, the rise of a medical profession. They continue to write about male doctors' growing authority, even if they offer nuanced readings of agency, identity, gender, and ideology, and widely recognise the contested nature of male medical authority.¹⁹ At the same time, the very sites associated with the emergence of a modern medical profession -- the hospital and the laboratory -- are in locations -- towns and cities -- that historians also present as places of progress that materially and symbolically embodied modernity.

Are such deeply embedded assumptions about modernity surprising? Perhaps not. If historians have become skilled at examining how medical ideas and practices were constructed, contested, and represented, as C.A. Bayly shows in *The Birth of the Modern World*, perceptions of what is 'modern', and what people viewed as 'progress', embedded in the sources historians use were often not abstractions.²⁰ Modernisers, conservatives, and

¹⁹ See, for example, Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c.1760-1850* (Manchester: Manchester University Press, 2011) or Alannah Tomkins, *Medical Misadventure in an Age of Professionalization, 1780-1890* (Manchester: Manchester University Press, 2017).

²⁰ C.A. Bayly, *The Birth of the Modern World, 1780-1914* (Oxford: Oxford University Press, 2004), 10.

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traditionalists were all constantly engaged in the discourses of modernity. ‘Nominally’ modern societies initially articulated the concept of modernity to revere self-referential values tied to notions of inclusion, identity, and power. What was modern and what signified progress in medicine intimately connected with concrete beliefs about different types or styles of medicine. Communities constructed, as Robert Gildea suggests in his work on French history, myths about progress ‘in such a way as to serve the political claims of that community’.²¹ The writings of medical practitioners, policy makers, or commentators often used to shape our understanding of medicine can be similarly interpreted. Since the sixteenth century, ideas of modernity and progress were used to make professional, political, and clinical claims. From the eighteenth century onwards, the traditional / modern dichotomy recurred as a trope in medical writing to illustrate the superiority of analytical over (past) descriptive approaches. By the mid-nineteenth century, all things modern captivated European culture and politics, with modernity not only symbolising an idea, but a way of thinking. Notions of modernity reinforced claims for the exclusion of other types of practitioner; for example, as seen in the abusive term *Kurpfuscher* (quack or charlatan) in Germany to attack a wide range of unorthodox practitioners. A belief in modernity seemed to have a magnetic attraction for medical reformers, policymakers, administrators, and hospital architects in the twentieth century. Social historians of medicine might therefore do more to recognise the political valance of the term ‘modern’ and ideas about modernity to produce a greater sensitivity to how consciousness of, or a language of modernity, often arose most sharply where and when what we see as modern trends in medicine were most contested or problematic.

²¹ Robert Gildea, *The Past in French History* (New Haven: Yale University Press, 1994), 10.

NORMATIVE MODERNITY AND BACKWARDNESS

Problematising progress and modernity also necessitates thinking about how backwardness is employed. No matter what the historical context, claims of modernity and progress often imply other assumptions that equate the diachronic with the synchronic; for instance, that certain forms of medicine, practitioners, regions, peoples, or institutions were traditional or backward. Social historians of medicine are, of course, familiar with ideas of backwardness and primitiveness through their use in, for example, discussions about indigenous medicine, or in twentieth-century eugenic discourses. While they have approached these ideas critically, in historical writing, narratives of backwardness act as a way of understanding comparative progress. More often, backwardness became a way to account for why some countries or regions, particularly non-European societies, did not follow a perceived path to modernity or to explain how they were modernised by their encounters with Western medicine.

Scholarship on economic development, notably in responses to Gerschenkron's ideas about relative backwardness and European industrialisation, framed backwardness in comparison to perceived development elsewhere.²² This 'elsewhere' was northern Europe. Backwardness or backward countries became associated with primitiveness, stagnation, under-development, and dependency. Evolutionary and functionalist anthropologist and sociologists in the 1950s and 1960s equally employed backwardness in their writings, equating it with primitive (traditional) societies, to account for different patterns of social and economic development. If backwardness is a comparative judgement -- extending from the economic to the political, social, and cultural -- since the publication of Edward Said's *Orientalism* in 1978 and the growth of postcolonial critiques, historians are sensitised to how

²² Alexander Gerschenkron, *Economic Backwardness in Historical Perspective* (Cambridge: Belknap Press, 1962).

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Western statements of superiority and advancement are premised on a particular European prejudices of Asia, Africa, or Latin America as backward and stagnating. By the 1990s, historical analysis highlighted how regions once viewed as colonial peripheries were active sites of scientific and medical knowledge production. Postcolonial scholarship revealed, as Chakrabarty explains, the need to write in the ‘ambivalences, contradictions, the use of force, and the tragedies and ironies’ that attended the history of modernity.²³

Whereas important work on Asia and Africa drew attention to complex patterns of colonial medicine and, as discussed below, raised key questions about how we should approach modernity, ideas of backwardness continue to be applied in other contexts. Although scholars have come to reject notions of a German *Sonderweg* or ‘special path’ to modernity, certain European states remain associated with backwardness, especially those considered to be on the periphery in terms of geography, industrialisation, or the creation of a modern state. A prime example of this is how historians have written about Spain. They claim that Spanish doctors fell behind in embracing science in the nineteenth and twentieth centuries as part of a wider narrative that framed Spain within ‘a paradigm of backwardness.’²⁴ Similarly, southern Italy and Norway have been portrayed as medical latecomers; European Russia as a prototype of medical under-development. Such assessments are often both spatial -- in terms of their geography and distance from an imagined ‘centre’ -- and temporal.

²³ Dipesh Chakrabarty, *Provincialising Europe: Postcolonial Through and Historical Differences. New Edition* (Princeton, 2008), 43.

²⁴ Monica Burguera and Christopher Schmidt-Nowara, ‘Introduction: Backwardness and its Discontents’, *Social History*, 2004, 29, 279-83.

If countries could be backward, so too were rural areas, with those countries viewed as predominantly rural conceptualised as inherently backward. Just as state-controlled, public health initiatives directed at rural areas in Europe, Scandinavia, or South America built on assumptions that they needed to be modernised, in concentrating on the urban, historians too have associated the countryside with ‘traditional’ medicine and restricted access to ‘modern’ medicine. While more work is needed on the boundaries between the urban and rural, which could be more symbolic than real, to highlight inter-connections as Rawson does in his work on municipal water supplies in Boston, evidence of opposition to medicine in rural communities has often been characterised as irrational.²⁵ Often the countryside has been viewed as a place of backwardness and tradition associated with stasis because it did not seemingly reflect urban patterns of modernity, involve the mobility of ideas and people, or share in a process of medicalisation.²⁶ Such a characterisation is notwithstanding the fact that there is often little evidence that rural populations were any more hostile or resistant to professional medicine than those living in towns. As evidence from mainly rural regions in

²⁵ For a discussion of the problematic nature of rural-urban distinctions, see ‘Rural American in an Urban Society’, *Annual Review of Sociology*, 2011, 37, 565-592; Michael Rawson, *Eden on the Charles: The Making of Boston* (Cambridge: Harvard University Press, 2010).

²⁶ Astri Andresen, Josep L. Barona, and Steven Cherry, ‘Introduction: “Rural Health” as a European Historical Issue’, in Astri Andresen, Josep L. Barona, and Steven Cherry, ed., *Making a New Countryside: Health Policies and Practices in European History c.1860-1950* (Frankfurt am Main: Peter Lang, 2010), 11-24.

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Britain suggests, just like their urban counterparts, people in villages and market towns often embraced medical and sanitary reform, just in different ways or at a different pace.²⁷

Assumptions about backwardness and the labelling of certain forms of medicine as traditional are made because they reproduce contemporary views and interests. Much of the evidence of backwardness and tradition comes from those writing about the region from a geographical (and often cultural) distance or from an imagined distance of medical superiority and power. This relative remoteness made various prejudices or reformist pronouncements easier to sustain. For instance, late-eighteenth century French writers conceived of southern and rural France as an ‘abyss of barbarism’ because they had little contact with the people who lived there. European observers had a confused idea of Indian medicine because it seemed so distant and different, while in the 1950s, cultural anthropologists of mental disorders turned to ideas of backwardness to suggest that non-Westerners experienced an impoverished form of depression visible not through complex psychological symptoms but through bodily malaise.²⁸ Equally, labelling forms of medicine as traditional, rather than backward, presents other problems. Historians are attuned to the invented nature of traditions and how institutions or practices seen as traditional were often nineteenth-century European (or more recent) creations. They have come to recognise how ‘tradition’ denotes clusters of practices and values fashioned at particular historical moments to serve specific purposes, such as to sanction reform or to promote a common identity. Yet, traditions are also far from static, especially at a regional level as Eugen Weber showed in his

²⁷ Keir Waddington, “‘It might not be a nuisance in a country cottage’”: Sanitation Conditions and Images of Health in Victorian Rural Wales’, *Rural History*, 2012, 23, 185-204.

²⁸ For example, J.C. Carothers, ‘Frontal Lobe Function and the African’, *Journal of Mental Science*, 1951, 12-48.

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1976 book *Peasants into Frenchman*. Thinking of certain forms of medicine as traditional does not allow for varieties within and between different medical traditions. Western perceptions of medicine in Africa is the perfect example of why such thinking is problematic. Not only is 'Africa' usually a conflation born of European constructions of modernity rather than a complex entity, but also the label 'traditional medicine' in Africa was often employed without sensitivity to how it conceals a dynamic array of healing practices and theories or how healing practices were the subject of complex cultural and political brokerages. Furthermore, Western assessments often overlooked how African medicine was just as concerned with ideas of balance, pharmacopeia, and environment as Islamic or European medicine. Given these problems, we might ask ourselves what would the social history of medicine look like if it began from the rural or from regions normally considered to be on the periphery rather than from the urban or Western Europe?

Take the example of rural water supplies. The nineteenth century saw an outpouring of writing on hygiene and sanitation produced by people who lived in urban environments, but by shifting the focus it becomes possible to see how urban modernising narratives break down outside of large towns. The history of rural water supplies does not match how historians characterise the creation of networks of piped-water and the gradual shift to high-pressure constant supplies in the nineteenth and early-twentieth century. Many villages and market towns continued to get their water from rivers, streams, and shallow wells in the first decades of the twentieth century. Does this make them backward? For contemporary urban commentators, it would. However, if practices in rural regions could be different to those expressed in urban culture, evidence from nineteenth- and early twentieth-century Wales suggests how we need to rethink these categories. Many English commentators considered the Principality as the epitome of backwardness, but the dangers of polluted water alarmed people living in Welsh villages and market towns just as much as their urban counterparts.

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They equally insisted on access to clean, regular water supplies. Rural authorities actively responded to these pressures with efforts to improve existing supplies. However, they did so within a context of limited funding, often difficult terrain, technological limitations, and the problems posed by isolation or access to clean water supplies, which could be some miles away. These factors often made small-scale solutions to local problems the only viable option, even if many of these did not match metropolitan sanitary orthodoxy.²⁹ Hence, rather than being backward, the dynamics of rural water supplies until the 1920s need to be understood as revealing a different history. This history is one where topography, geology, climate, varying resources, distance, and access were crucial determinants in efforts to supply clean water. It highlights how neither ideas of backwardness nor tradition, or urban models of modernity, are useful in enhancing our understanding of medicine in rural regions.

FROM MULTIPLE TO ‘BLENDED MODERNITIES’

So far, more problems in thinking about modernity, progress, and tradition have been raised than answers offered. This could be because, as Roger Cooter claimed, social historians of medicine have not ‘set medicine in the framework of any generalised understanding of modernity’.³⁰ Even with more sophisticated approaches to the social or cultural history of medicines’ pasts, scholars working on Western medicine have not always engaged with wider historical debates about the meaning of modernity. One way in which social historians of medicine working on Europe or North America might do this is to engage more actively with

²⁹ Keir Waddington, “‘I should have thought that Wales was a wet part of the world’:

Drought, Rural Communities and Public Health, 1870-1914’, *Social History of Medicine*, 2016, 30, 590-611.

³⁰ Roger Cooter, ‘Medicine and Modernity’, in Jackson, ed., *Oxford Handbook*, 100.

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a wealth of scholarship on Asia, Africa, and global medicine and the important critiques they offer of the inherently normative aspects of modernity.

Since the 1990s scholars of the history of health, medicine and science in non-European societies have, in the words of Ruth Rogaski, placed ‘meanings of health and disease at the centre’ of experiences of modernity while being sensitive to how ‘imperialism inexorably altered both the terms and conditions of life’.³¹ As David Arnold insightfully summarized, rather than medicine in India or China being ‘imperfect copies of a Western ideal’, a wealth of studies since 1990 highlighted the violent displacements and interventions that resulted from European approaches to health and healing brought to indigenous societies. Historians of global medicine and science demonstrated that modernity, and even the Enlightenment, are hybrid historical, social and cultural experiences, drawing attention to the role of confrontation, appropriation, refashioning, and nationalist politics to re-evaluate modernity and the global spread of Western models of science and technology.³²

³¹ Rogaski, *Hygienic Modernity*, 1.

³² David Arnold, *The New Cambridge History of India, Volume 3, Part 5: Science, Technology and Medicine in Colonial India* (Cambridge: Cambridge University Press, 2000), 15. Examples of such excellent historical work since 2010 include monographs by Madhuri Sharma, *Indigenous and Western Medicine in Colonial India* (New Delhi: Foundation Books, 2012); Rachel Berger, *Ayurveda made Modern: Political Histories of Indigenous Medicine in North India* (New York: Palgrave MacMillian, 2013); Bridie Andrews, *The Making of Modern Chinese Medicine 1859-1960* (Vancouver: UBC Press, 2014); Sean Hsainh-Lin Lei, *Neither Donkey nor Horse: Medicine in the Struggle over China’s Modernity* (Chicago: University of Chicago Press, 2014).

For many scholars working on Africa, China, India, and the Ottoman empire the notion of multiple modernities initially offered an attractive way to explore different trajectories of modernity.³³ If some studies of European medicine have begun to employ the idea of multiple modernities -- such as Corinna Treitel's account of paranormal practices, therapeutic interventions, and scientific materialism -- thinking in terms of 'multiple' or alternative paths to modernity does not offer unproblematic solutions.³⁴ As Frederick Cooper argues in *Colonialism in Question*, by multiplying modernities -- alternative, parallel, vernacular, colonial -- we run the risk of exhausting the concept of modernity of meaning as he explains how there are as many modernities as there are modern societies.³⁵ Equally problematic is how post-Enlightenment Europe has been used as the reference point for these alternative modernities. Whilst a *histoire croisée* approach is intrinsic to the literature on multiple modernities, sensitive is needed to resist a conventional telos of the move to a

³³ Shmuel N Eisenstadt, 'Multiple Modernities', *Daedalus*, 2000, 129, 1-29; Björn Wittrock 'Modernity: One, None, or Many? European Origins and Modernity as a Global Condition', *Daedalus*, 2000, 129, 31-60.

³⁴ Corinna Treitel, *A Science for the Soul: Occultism and the Genesis of the German Modern* (Baltimore: John Hopkins University Press, 2004).

³⁵ Frederick Cooper, *Colonialism in Question: Theory, Knowledge, History* (Berkeley: University of California Press, 2005), 127. On the multiplying of modernity, see Bruce M. Knauft, ed., *Critically Modern: Alternatives, Alterities, Anthropologies* (Bloomington, IN: Indiana University Press, 2002); *Multiple Modernities*, Special Issue, *Daedalus*, 2000, 129; Projit Mukharji, 'Vernacular Modernity' in Sanjay Seth, ed., *Subject Lessons* (Durham, NC: Duke University Press, 2007).

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modern, capitalist society.³⁶ Seeing modernity in plural terms has the potential to preserve existing frameworks; for example, of seeing the social history of medicine at the boundaries or beyond Europe as a variety on a theme of how we get to the dominance of biomedicine.³⁷ Nor does it recognise how even within European nations substantially different patterns could exist as demonstrated by northern and southern Italy, or how those medical practices characteristically identified as modern only recently became widespread in the West.

The idea of ‘blended modernities’ put forward by Carol Gluck might offer a template for conceptualising progress and modernity. ‘Blended modernities’ is not another version of hybridity. It draws on ideas put forward by cognitive scientists to stress the emergence of conceptual structures which are not an imitation but possess characteristics not present in the original components. In Gluck’s words, although an imperfect metaphor, the notion of ‘blended modernities’ draws attention ‘away from singularity to the plural inflections of the modern experience, which is importantly diverse but not endlessly multiple’. It highlights the need to consider how theory and practice were transformed through the exchange of ideas -- either trans-regionally or transnationally -- to create a ‘blend’ that was different or new.

Gluck uses Andrew Bernstein’s work on cremation practices in nineteenth- and twentieth-century Japan to illustrate what ‘blended modernities’ offers as an interpretative model. In the 1870s, Shinto nativists supported burial against what they perceived as the foreign and ritualistic practices of Buddhism, with the government banning cremation as inhumane and hazardous to health in 1873 in an anti-Buddhist move. However, cremation was also associated with Western practices. Bernstein explores how the hygienic factor -- or

³⁶ Sheldon Pollock, ‘Pretextures of Time’, *Historical Theory*, 2007, 46, 366-83.

³⁷ Gurdminder Bhambra, ‘Historical Sociology, Modernity, and Postcolonial Critique’, *American Historical Review*, 2011, 116, 653-662.

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what might be seen as new rituals based around notions of hygiene -- became increasingly prominent in debates about cremation. These debates led Buddhists to adapt their practices to stress hygiene more than ritual. By the mid-twentieth century, nearly all Japanese were cremated to create a modern Japanese way of death that blended Buddhist and Western practices, rather than create a hybrid of the two, which was different from their original characters.³⁸ In *Neither Donkey nor Horse* Sean Hsainh-Lin Lei likewise presents a fine grained analysis to highlight the value of thinking through what he calls ‘mongrel’ practices to create more diversified modernities. He shows a blended form of modernity shaped by reciprocal interactions and surprising alliances between Chinese medicine and Western biomedicine. For Lei the result was the emergence of a new and different Chinese medicine (*xinzhongyi*) that was an essential part of the Chinese exploration of modernity.³⁹

This idea of ‘blending’ is not just useful of thinking about medicine outside Europe. A process of ‘blending’ can be seen in other contexts. For instance, in fourteenth-century Islamic medicine, which blended old customs associated with magic and incantation with humoral physiology epitomised in the medicine of the Prophet. It was equally visible in early nineteenth-century America where practitioners blended medical practices from Britain, France, and Germany as well as incorporated indigenous practices. Thinking about how medical ideas, practices, and policies are ‘blended’, rather than as hybrids, might help us get

³⁸ Gluck, ‘End of Elsewhere’, 676-87. For an account of cremation debates, see Andrew Bernstein, *Modern Passings: Death Rites, Politics and Social Change in Imperial Japan* (Honolulu: University of Hawaii Press, 2006), 67-90.

³⁹ Hsainh-Lin Lei, *Neither Donkey nor Horse*.

at a different way of approaching modernity by tracing ‘commonalities across time and space’.⁴⁰

THE SOCIAL HISTORY OF MEDICINE AND THE EVERYDAY

Thinking about the everyday offers a further corrective to the spectacularising discourse of modernity to draw attention to the mundane, the unnoticed, the local, the contingent, and the previously unobserved in medicine. ‘History from the bottom up’ was integral to new directions in the social history of medicine in the 1970s and 1980s, but in the last few decades the everyday has become an influential category invoked by social historians to get at what the anthropologist Georges Perec refers to as the background noise of history.⁴¹ In *Everyday Life in the Modern World*, Henri Lefebvre explained how through the everyday, with its repetition and routines, we can understand the incomplete nature of modernity and counteract grand narratives. Doreen Massey takes up this idea. She argues that the mundane activities of the everyday act as a useful counter to a technologically determinist approach.⁴² Here the everyday is not just what lags behind the modern, a mere description of the quotidian or the experiences of ‘ordinary’ people as a re-working of ‘history from below’. Rather, as an analytical category the everyday provides opportunities for other readings of agency and the multiplicity and complexity of lived experiences. As the social historian Joe Moran shows in his work on the spaces, practices, and mythologies of European life, the everyday is a route into understanding a range of rituals, quotidian practices, and hidden politics that people are

⁴⁰ Gluck, ‘End of Elsewhere’, 676.

⁴¹ Georges Perec, *L’Infra-ordinaire* (Paris: Editions du Seuil, 1989), 11-12.

⁴² Henri Lefebvre, *Everyday Life in the Modern World* trans. Sacha Sabinovitch (London: Allen Lane, 1971); Doreen Massey, ‘A Place Called Home’, *Formations*, 1992, 17, 3-15.

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only half-aware of as they go about their lives.⁴³ It reveals the importance of often overlooked routines, habits, and what was happening away from major urban centres or in the case of the history of medicine, away from capital cities, metropolitan hospitals, and high-profile laboratories and universities. The everyday hence becomes a way into, as the historian of Japan Harry Harootunian explains, ‘the site of unevenness’, not an unproblematic or transparent realm.⁴⁴

Early modernists have offered valuable insights into everyday practices through their work on experiences of illness, the medical marketplace, and medicine in the home, but how do we use the everyday as a possible route out of the spectacularising discourse of modernity? How might we think about the everyday as both dynamic and static that does not conflate the problematic of ‘the ordinary’ with the everyday and vice versa? In *The Practice of Everyday Life*, Michel de Certeau outlines one conceptual approach. In contrast to Foucault, de Certeau (like Lefebvre) characterises the everyday as that which is external to (or eludes) the discourses and techniques of power. He draws attention to the micro-structures of the everyday and the need to consider what Andrew Blauvelt calls the ‘arts of doing’; how people individualise culture, altering things from utilitarian objects to rituals, laws, and language to re-appropriate them and make them their own in everyday situations. In rejecting the possibility of a totalising account, and in making distinctions between strategies and

⁴³ See Joe Moran, *Reading the Everyday* (London: Taylor and Francis, 2005).

⁴⁴ Harry Harootunian, *History’s Disquiet: Modernity, Cultural Practice and the Question of Everyday Life* (New York: Columbia University Press, 2000), 56.

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institutions and how people acted, de Certeau shows how through the everyday we expose how practices are adapted or challenged, either clandestinely or tactically.⁴⁵

While de Certeau concentrates on mass culture in the twentieth century, drawing on his approach offers a way to re-consider narratives of modernity beyond thinking about a quotidian or ‘average’ existence. It encourages us to further reflect on co-production, collusion, and adaption, on the problematic gap between professional ideology and practice, and about everyday acts of resistance and how we might define resistance, which might include passivity. By drawing on some of the techniques used by early modernists in interrogating anecdotal or peripheral material, the everyday encourages us to pay more attention to the contingent, mundane, and routine of individual and family lives in the nineteenth and twentieth centuries. Such an approach is aided by the popularisation of diaries and journal keeping in Europe and the United States with their textual and visual conventions and messy, gap-ridden writing. Consideration of the everyday can equally provide insights into what constituted the day-to-day workings of institutions be they hospitals or government departments, into material and mundane objects or, for example, into how landscape, transport networks, or weather configured and re-configured lived experiences of medicine or medical institutions. For instance, weather and climatic events changed how people viewed and used water supplies on a day-to-day level, or episodically during summers when water sources could dry up. These practices often ran counter to sanitary advice, revealing a different dynamic to what health officials believed or wanted.

The everyday might equally help us to reflect on how institutional cultures enabled or acted as barriers to changes normally associated with modernity. It might help reveal how

⁴⁵ Michel de Certeau, *L’Invention du quotidien 1: Arts de faire* (Paris, 1980), trans. Steven Rendall, *The Practice of Everyday Life* (Berkeley: University of California Press, 1984).

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existing spaces, such as the operating theatre or laboratory, were modified, and how practitioners used, adapted, or individualised these spaces. Thinking about such spaces through the everyday can help us consider how, for example, anatomical dissections became routine, mundane events in the eighteenth century or how bacteriological laboratory work contained everyday practices for those who worked in them but were not ‘ordinary’ in a universal sense. What the everyday offers therefore is a phenomenological approach based on the history of experience that if not novel, in and of itself, is theoretically more challenging than simply making a plea to ‘think about the ordinary’ in the social history of medicine.

‘TO WALK OUT OF THE DEEP COLLUSION’: CONCLUSIONS

As Dipesh Chakrabarty commented in 1992, ‘it is not possible to simply walk out of the deep collusion between “history” and the modernising narrative(s).’⁴⁶ Rather than blaming social historians of medicine for how they use modernist assumptions, this essay suggests that whatever country, topic, or period they study, those working on Britain, Europe, and North America need to be more self-conscious of the common ‘grammar of modernity’ that continues to influence their writing. While theories of modernity offer other routes into examining similarities and differences, social historians of medicine need to remain sensitive to using terms such as modern and modernity, tradition and backwardness, especially as they imply judgements in an understanding of ‘the normative modernity’ from which that judgement issues.⁴⁷ Although the de-centring of authority is one of the fundamental features of social history of medicine, no matter how sophisticated the historian, it is hard for them to

⁴⁶ Dipesh Chakrabarty, ‘Postcoloniality and the Artifice of History: Who Speaks for ‘Indian’ Pasts?’, *Representations*, 1992, 37, 1-26, 19.

⁴⁷ Dipesh Chakrabarty, ‘The Muddle of Modernity’, *American Historical Review*, 2011, 116, 663-75, 673.

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escape from these judgments and an implicit framework of modernity when they talk about medicine in the past.

One way of countering this is to interrogate more openly the history we are writing and for whom. Through that process we can be more sensitive to how things and practices are never homogeneous but are assembled out of a multitude of traditional and modern forms, and how the common ‘grammar of modernity’ conceals the circuitous routes taken or the dead ends. We need to think more about the geographical, cultural, political, and temporal constructions of both backwardness and tradition. Thinking about ‘blended modernities’, or considering the everyday, may help us break down a progressive narrative of modernity and rethink existing chronologies and the scale of enquiry. Both suggest how a focus on institutions or published texts can overlook how and why things developed as they did on the ground, often in ways not intended by authorities or by the authors of manuals and articles. While we need to be aware of the micro-spatiality of the everyday, its performative aspects, and avoid placing too much analytical power in the everyday, it does offer one way to rethink the ambiguities and ambivalences that helped structure medicine in the past to reveal the practical challenges people faced when it came to the adoption and application of the new knowledges or practices we associated with modernity. However, this awareness of the everyday should not lose sight, as Marc Bloch realised in his two-volume *Feudal Society* (1939–40), of the need to move ‘back and forth between micro- and macrohistory, between close-ups and extreme long shots.’⁴⁸ Nor should the everyday just become a way of highlighting contingency and variability when thinking multi- or trans-regionally. Yet by being more sensitive to the plurality of modernity and progress, by considering how

⁴⁸ G. Levi. ‘On Microhistory’, in Peter Burke, ed., *New Perspectives on Historical Writing* (Cambridge: Polity Press, 1991), 93-113.

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discourses of modernity are embedded in sources and archives, and by thinking about everyday practices, social history of medicine working on Britain, Europe, and North America can move closer to uncovering the type of richer medical world that lies at the heart of the social history of medicine.