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The Patient's View Meets the Clinical Gaze

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Summary. Roy Porter's 1985 article on 'The Patient's View' is the starting point for a methodological and historical reflection on the patient in medical history. This article gains its inspiration from the fact that to the present day, the history of patients as an intellectual project has not found much reflection. Old categories, such as patient, knowledge and disease, all need to be revisited and rethought. It sketches out several arenas where this debate will have to take place and contrasts Porter's patient's view with David Armstrong's writings on the constructed patient. It goes on to discuss the project of social history of medicine to begin to place Porter in the context of the discipline and closes with some comments on the political context of patients' history in the 1980s which coincided with the start of governmental reforms in the NHS intended to strengthen the patient's role.

Keywords: patients; disease; knowledge; Foucault; Porter; intellectual history; power; politics

Introduction

In 1985, Roy Porter, the doyen of the social history of medicine, published his seminal article entitled 'The Patient's View: Doing Medical History from Below'.[1] This was not the first time Porter had written about the patient, but in this manuscript his ideas on patients and their history came through in the clearest way. He called for a change of perspective in order to rewrite fundamentally the history of medicine from 'the patient's view'. Most history of medicine, he argued, had been written as stories of scientific progress, knowledge and countless breakthroughs. But he felt that patients were equally important 'for it takes two to make a medical encounter'.[2] Surely Porter's article has become a modern day classic in the field and virtually every chapter, article or monograph on medical practice published since 1985 seems to refer back to it.[3]

At the time, several subsequent studies responded to the general call to arms by Porter with well-researched empirical analyses incorporating aspects of the history of the patient.[4] With the increased availability of computer technology and the discovery of patient notes, it seemed at the time that empirical projects would soon reveal much more about the patient.[5] However, it is clear that we know a great deal more about patients today compared to the mid-1980s. Several survey publications document how much progress there has been since Porter.[6] But the notion of the patient and his or

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[1]Porter 1985*a*.
[2]Porter 1985*a*, p. 175.
[3]Stolberg 2003, p. 9.
[4]Risse 1986; Risse 1999 for the wider perspective; Beier 1987; Pickstone 1985; Marland 1987.
[5]Risse in Porter and Wear (eds) 1987; Dupree 1992.
[6]Ernst in Bröer (ed.) 1999.

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her history is still very much driven by the empirical perspective according to which the interpretation of autobiographies still predominate prespective. There has been little methodological innovation and database construction. There can be no doubt that the empirical side of writing the patient's history has been much enriched in recent years.[7] But issues of how to write the patient's history, how to deal with subjectivity, experience and perhaps even choice is still very much uncharted territory for historians of medicine.

One does not need to go as far as Roger Cooter and declare the end of social history of medicine to understand that we cannot take the trusty old categories for granted anymore.[8] Thus the categories of knowledge, soon followed by diseases and causes of death, began to be subjected to anti-presentist approaches.[9] It is surprising to note that after more than 20 years, Porter's article remains the main source of inspiration for the history of patients and is still so widely quoted. Conceptually, it appears to this author, that the history of the patient's view is as undeveloped now as it was back in the mid-1980s when it seemed that patients' history could turn into the new paradigm for writing history of medicine. While it is true that the patient has been getting more attention since Porter, it is also undoubtedly true that mainstream historiography has not incorporated the radical change of perspective for which Porter argued.

This article aims to revisit Porter and engage with it conceptually, empirically and perhaps even politically to see what has become of patients' history in these past 20 years. The author would like to note at this point that this is not intended to be a comprehensive review essay of patients' history, but an attempt to take up Porter's challenge at long last and explore concepts, ideas and limitations of the history of patients which he had so radically proposed in his article.[10] I concentrate first on the fundamental debate over whether there is any 'real' patient to study. The argument will then proceed to engage more fully with the social history project within recent historiography before concluding with an analysis of the idea of a medical history from below. All this will be summarized in the form of a brief sketch about what a useful history of patients might look like in the future.

The Patient's View versus the Clinical Gaze

Let us start this investigation with a closer look at Porter's article. Simple questions of time, place and context reveal a great deal about the shaping of modern patients' history as Porter published his article in an interesting location and at an important time. The journal *Theory and Society*, according to its publisher's website, 'is a forum for the international community of scholars that publishes theoretically-informed analyses of social processes'.[11] Leaving aside the intriguing question of what it might entail to understand the patient's history as a process, the editorial statement is at odds with the fact that Porter himself did not make much use of theory to phrase his

[7]Wright 1997.
[8]Cooter in Huisman and Warner (eds) 2004.
[9]Jordanova 1995; Condrau and Worboys 2007.
[10]Profound apologies go to all those scholars engaged in writing the history of patients whose work I have not quoted.
[11]http://www.jstor.org/journals/springer.html

argument at all. Widespread enthusiasm for concepts, terms and arguments borrowed from social science had perhaps already peaked in the 1970s.[12] Social science, perhaps a little less so in Anglo-Saxon historiography with its empiricist focus, was still quite an important source of inspiration for medical historians. And there was no shortage of interesting ideas and hypotheses around to find inspiration for patients' history.

One of the most useful theoretical concepts might have been Arthur Kleinman's notion of cultural systems of health and illness.[13] He argued very much in a Parsonian tradition that medicine can be understood as a cultural system within which norms and behaviour as well as social structures and arenas are organised. The term 'system' is the key because it suggests that all aspects of health care, medicine, health and illness are part of an integral system and contribute substantially to its functioning. The crux of this idea is that it allows one to understand all actors, structures and forms of knowledge as being part of the same system. Looking at patients or studying all partners in the clinical encounter was therefore an obvious, perhaps even ideal, avenue to study these cultural systems as it allowed a fresh perspective to be developed at least partly independent of the history of medical sciences. The notion of systems, going back to Talcott Parsons, enjoyed a brief revival in Western post-Marxist theorising.[14] The application of functionalist systems theories has not caught on with many historians, but Kleinman's work became influential in German history of medicine, where the notion of 'medical cultures' (*medikale Kulturen*) has been successfully used to examine systems of beliefs, assumptions, knowledge and behaviour connected to health and illness.[15] Within the study of these medical cultures, the emphasis is on such cultural values regarding health and illness in all classes of society, which implies that Porter's call for an equal attention to patients and their doctors would, at least conceptually, have been fulfilled straightaway.[16] Kleinman's later work on illness narratives has found more attention amongst Anglo-Saxon historians and seems to be the major methodological refinement of patient's history.[17] When Kleinman writes that 'illness is the lived experience of monitoring bodily processes' he differentiates between medical disease categories and patient experience told through illness narratives.[18]

But the real minefield for the history of patients is to begin to make sense of Foucault. Foucaultian history emphasises why marginalisation happened and how the discourse of power created all these categories of marginalisation in the first place.[19] It is particularly concerned with the history of the body and how body politics or biopolitics have engaged structures of power, knowledge and embodiment.[20] Thus, in many ways a Porteresque history of the patient's view and a Foucaultian analysis of discourse and power leaves

[12]Evans in Cannadine (ed.) 2002, p. 2.
[13]Kleinman 1978, 1980.
[14]Mayhew 1982; Parsons and Bales 1956.
[15]Roelcke in Paul and Schlich (eds) 1998.
[16]For empirical studies using German autobiographies, see Lachmund and Stollberg 1995; Stollberg 1993.
[17]Kleinman 1988.
[18]Kleinman 1988, p. 4.
[19]Jones and Porter (eds) 1994.
[20]Cooter 2007. I am very happy to refer the reader to Roger Cooter's contribution to this anniversary issue for a sophisticated analysis of Foucault's influence on history of medicine.

us with the paradoxical relation of a mainly empirical view 'from below' and a theoretically informed account of how the patient gets constructed through discourse, knowledge and power. Porter concedes the point to Foucault that modern 'patients' are a result of the 'medical gaze' but turns around to say that this is often just ahistorical retrospective sociology.[21] Elsewhere, he calls the Foucaultian position 'extremely misleading, the more so, perhaps, the farther back into historical time one searches'.[22] But what is it then? Either the patient is an independent partner in the medical encounter akin to the formula that it takes two to tango or the patient is a result of the medical gaze, with no opportunity to tango. Sitting on the fence to agree with Foucault whilst effectively denouncing it as retrospective sociology (what is so wrong with that anyway?) seems an interesting position. Perhaps a thorough analysis of Porter's view of Foucault ought to be left for another occasion, but a simple word search for the name of the French philosopher on the Roy Porter Legacy Website at the University College London reveals interesting statements.[23] In one particularly striking paragraph, Porter refers to one of Foucault's key statements about lunatic asylums as a 'fantasy'.[24] Hence it appears that what Porter had in mind (to study the medical encounter and give voice and recognition to the patient) was not so easily reconcilable with discourses of power and the creation of knowledge according to Foucault.

Or was it? Porter was not the only author at the time writing conceptual pieces interested in the history of patients. For instance, there was the medical sociologist David Armstrong's iconic article on 'the patient's view'.[25] Written as the 'modern' version to complement Porter's take and delivered in the same seminar series at the Wellcome Trust in London, Armstrong's paper could not be more different in aim, method and material. According to Armstrong, 'the patient's view . . . was a technique demanded by medicine'.[26] It cannot come as a surprise that a medical sociologist would present the case in a different way compared to an early modernist. But featuring in the same seminar series, devoted to two different chronological periods, giving it almost the same title but operating with an almost completely different methodology makes for an interesting contrast. While Porter chose *Theory and Society*, which cannot have been the most prominent of outlets for his work, Armstrong chose *Social Science and Medicine*, perhaps the best regarded journal of medical sociology. The former quickly gained the status as the masterpiece of patients' history which has since been abundantly quoted by historians interested in patients, while the latter has been almost forgotten and finds very little readership among historians, particularly outside the UK, despite waves of interdisciplinary scholarship.

As it is, they have almost nothing in common except the title. Porter reflected on Samuel Pepys' seventeenth-century diary to argue for a fundamental historiographic shift to patients and their views. Armstrong argued, with Foucault, that the patient is a

[21] Porter 1985*a*, p. 182.
[22] Porter 1985*b*, p. 2.
[23] http://www.ucl.ac.uk/histmed/publications/roy-porter-bibliography/index.html
[24] Porter 1983.
[25] Armstrong 1984.
[26] Armstrong 1984, p. 739.

medical construct rather than an entity in its own right. But he did so by concentrating on a rather specific type of patient in the medical encounter. And Armstrong was by no means alone. Nicholas Jewson had written in 1976 about the 'Disappearance of the Sick-Man from Medical Cosmology' and argued that the transition from the old medical market place to the modern medical world has implied a disappearance of the sick person's voice from the medical bargaining table.[27] Merging Jewson's and Armstrong's arguments, Mary Fissell acknowledged that the patient's narrative has lost its importance in favour of hospital medicine that in turn relied much more on medical expertise and laboratory results.[28] She argued that with the invention of hospital medicine during the eighteenth century, 'doctors begin to sound like doctors, and patients' voices disappear'.[29] Here a consensus appears to emerge that clinical notes do indeed reveal a great deal about doctors and their perception of the patient, while not necessarily being terribly useful sources for examining the patient's view.[30] It becomes increasingly clear that taking a patient's medical history results in a medical construct based on information coming from the patient, while being clearly governed by perceptions, categories and the language of medicine. The patient, rather than an independent partner in the medical encounter, becomes according to this view an integral part of modern biomedicine, which is of course precisely what Armstrong argued. Perhaps one could say with Warner, then, that such clinical notes and whatever they say about patients are primarily useful for exploring medical practice.[31] Warner's optimism that 'more discursive hospital records' also reveal patients' stories and allow us to hear about beliefs and self-help brings us right back to Porter's empirically-based call to arms and reminds us of the optimism of the late 1980s and early 1990s that modern IT and the discovery of patient notes would soon allow historians to reveal everything about the patient.[32]

Thus the patient's point of view remains enigmatic. On the one hand, there is a call to consider the patient in history of medicine as an important partner, voice, subject, object or whatever you like to name it with the ultimate aim of rewriting the history of medicine according to the patient's view. On the other hand, we have statements that the patient has actually disappeared from the medical narrative or is merely a by-product of medicine. A full debate between these two positions—that the patient's view can be unearthed from the sources against the statement that the patient is a construct of the medical gaze—has, to my knowledge, never taken place.

The conspicuous absence of such a debate becomes particularly noteworthy in Michael Stolberg's fascinating book *Homo Patiens*.[33] His account of the early modern patient mentions Porter in the introduction's first reference and then turns much more towards a history of health, illness and the body. The book discusses not so much the patient and his perspective in the medical encounter but rather focuses on the experience of health and illness in the past. In many ways, it appears that Stolberg provides the

[27]Jewson 1976.
[28]Fissell in French and Wear (eds) 1991.
[29]Fissell in French and Wear (eds) 1991, p. 99.
[30]Gillis 2006.
[31]Warner 1999, p. 101.
[32]Warner 1999, p. 106; Risse and Warner 1992; Dupree 1992.
[33]Stolberg 2003.

answers to most questions that Porter raised in that he maps the patient's experience, perhaps even the patient's view in early modern Germany, and expertly analyses an impressively rich body of primary sources. It goes beyond other comparable attempts, such as Duden's classic study of the female body, in that it largely rejects doctors' notes about patients and bases the argument on primary sources coming from those who experience health and illness themselves.[34] I understand that a full English translation of the book is currently in preparation.[35] The chapter sequence suggests that conceptually the book's main aim is archival. It selects its topics and presents its arguments in a way that is largely driven by the available sources. Disease categories such as cancer might raise more fundamental questions than the book wants to engage with.

Social History and the Patient

Looking at the chronology of Porter's original article can bring us a little bit closer to understanding the sudden surge in attempts to map the patient's view in the mid-1980s. At the time, social history of medicine had been taking hold of the discipline as the innovative way of writing medical history.[36] One of McKeown's all-time best one-liners linked Trevelyan's old social history and the then new social history of medicine: he said that 'if social history is history with the politics left out, the social history of medicine is medical history with the public interest put in'.[37] Few quotes are so ambiguous and have such far-reaching implications. Social historians have long disagreed that theirs is a non-political history and I assume that there might be a distinct shortage of social historians of medicine who define themselves predominantly through the public interest. A wider definition of social history might cast it as a historical sub-discipline looking at groups, classes, structures and their relations within society.[38] Social history of medicine could therefore be classified accordingly: to study groups, classes and structures related to health and illness. Taking this further, one might also argue that the characteristic of social history of medicine was at least partially to ignore medicine in the scientific sense of the word.[39] The debate about the reasons for the mortality decline was in full swing at the time and provided a welcome battleground for social historians because it allowed a framing of the history of health and illness as at least partly independent from the history of medical knowledge.[40] It cannot be a coincidence that so much social history of medicine has been written about the early modern period and the nineteenth century and it seems hardly surprising to note how little of this historiography concentrated on the time after 1945.[41] And it is perhaps equally unsurprising that in the debate between established history of medicine and the then new social historians, harsh words were spoken, arguing that precisely this separation of health and illness

[34]Duden 1987.
[35]Stolberg in De Blécourt and Usborne (eds) 2004.
[36]Porter 1995.
[37]McKeown 1970, p. 342.
[38]Hobsbawm in Gilbert and Graubard (eds) 1972; Lloyd 1991.
[39]Shortt 1980; Imhof and Larsen 1977.
[40]To give but two references: McKeown 1976; Szreter 1988.
[41]Take Germany as an example: Spree 1981.

from medicine rendered the new social history of medicine suspect and dubious in scholarly terms.[42]

Justifying his call for paying attention to the patient's point of view, Porter argued that it was nonetheless understandable that 'medicine' was writing its history as a series of scientific and medical achievements.[43] When surveying the historiography of the social history of medicine in its heyday, it is rather difficult to substantiate this statement and I am tempted to claim the opposite—how else to explain Abel-Smith's hospitals, Wrigley and Schofield's population history or the McKeown debate?[44] If one wanted to make a claim similar to Porter's, the analysis of the medical profession would have to be chosen to exemplify the point: perhaps here was a critical historiography that nonetheless underlined the very same dominance of academic medicine which it wanted to criticise. Highly regarded amongst social historians, Eliot Freidson's theory of the medical profession quickly achieved methodological cult status.[45] Surprisingly little has been made in the UK of the rather formalised way of exploring the medical profession, despite the fact that the key term is widely used.[46] This avenue of enquiry proved to be much more popular and quite fruitful in German-language historiography, which simply serves as an example here.[47] If the theory of medical professions has not found significant popularity, the decline of this concept went even further under the radar. Even though Britain with its NHS could perhaps serve as the ideal counter-example against the theory of professions, the discussion about de-professionalisation was not taken up by historians at all.[48] Porter argued that to speak about the medical profession implied a dominance of medicine that could not be assumed in centuries past.[49] However, this was never assumed by the advocates of such concepts, so Porter might actually have been guilty of fighting phantoms.

What seems with hindsight to be even more interesting is the fact that Porter, as so many others before and after him in the Anglo-Saxon historiography, did not fully engage with the concept of medicalisation.[50] Much has been written about one of the most popular, yet unexplored terms in the history of medicine. The most developed critique of modern medicine, the nemesis of medicine by Ivan Illich, presented the shortfalls of medicine through a historical analysis of medicalisation.[51] Coupled with Michel Foucault's writings, this term gained a quick surge in popularity and was used to complement the analysis of the medical profession's dominance in a growing medical market place.[52] While the precise interpretation has always been debated, the fundamental aim of the term is to provide a framework to tackle how academic medicine claimed expert

[42]Reverby and Rosner in Huisman and Warner (eds) 2004, p. 174.
[43]Porter 1985*a*, p. 175.
[44]McKeown 1976; Wrigley and Schofield 1981; Abel-Smith 1964; Woodward 1974.
[45]Freidson 1970.
[46]Peterson 1978.
[47]Huerkamp 1985*a*; Brändli 1990.
[48]Hafferty 1988.
[49]Porter 1985*b*, p. 3.
[50]Burney in Bivins and Pickstone (eds) 2007.
[51]Illich 1976.
[52]Foucault in Foucault *et al.* (eds) 1976.

status for a range of social issues, whilst at the same time bringing a growing proportion of society under its control.[53] Popular initially in France and soon in Germany as well, medicalisation became one of those key terms we all use, but which we can never adequately define. Nikolas Rose even declares it a 'cliché of social analysis'.[54] The most sophisticated albeit very critical analysis of the term I have seen was provided by Franzisca Loetz whilst studying empirical material of the German province of Baden in the early nineteenth century.[55] Other, more positive applications of the idea were provided with a particular emphasis on the history of smallpox vaccination.[56]

But the question as to what brought about medicalisation and whether or not it is actually a useful category to study the history of patients is as yet unclear. Nancy Tomes notes critically that 'in the new era of collaborative medicine, patients have nowhere to hide' and goes on to praise the collaboration between patient and doctor.[57] If medicalisation as an idea is to make sense in the context of this article then it has to be tested against the growing medical influence over the patient, which brings us right back to issues discussed above in relation to whether or not the patient exists outside of medical categories. References concerning the heated debates about medicalisation cannot have escaped Porter's notice at the time, yet he chose not to engage with them in his article on the patient's view. It appears to me that his was a different agenda. Rereading Porter today reveals how much emphasis he placed on the patient's agency. It was this, perhaps more than the patient's view, that he wanted to unearth. In a discussion about what he saw as unfortunate connotations of the term 'patient' amongst contemporary observers, he argued that 'it is probably preferable to speak historically of "sufferers" or "the sick", some of whom *opted* [his italics] to put themselves into relations with medical practitioners'.[58]

This is precisely the intellectual context for Edward Shorter's *Bedside Manners*, which was later reprinted as *Doctors and their Patients*.[59] Shorter takes the reader on a whirlwind journey through medical history, fills it with the best of anecdotes and provides an entertainment value that I doubt many other academic books can match. Shorter opens the reprint and sets the tone perfectly by saying that 'since this book was written in 1985, all the problems it describes have become worse'.[60] This dialogue between history and perceived contemporary problems remains the book's major strength and despite all its shortfalls, it will remain popular in the teaching of the history of the patient. Its more recent title, *Doctors and their Patients*, is not a coincidence as the focus is very firmly on the polarity of the medical encounter. Shorter's book owes perhaps more to McKeown than to Porter, in that it looks to history to provide answers for the contemporary world, but it is to my knowledge the only such work taking into account the patient's view in the style of a grand narrative with all its entertaining and at times enlightening advantages as well as all its obvious intellectual disadvantages.

[53]Goubert 1982.
[54]Rose 2007, p. 700.
[55]Loetz 1993; Stolberg in Paul and Schlich (eds) 1998.
[56]Huerkamp 1985*b*.
[57]Tomes 2007, p. 698.
[58]Porter 1985*b*.
[59]Shorter 1985; 1991.
[60]Shorter 1991, p. 9.

Medical History from Below?

There is a potential explanation for Porter's quest to find and scrutinize the patient's agency to be found in the subtitle of his article. 'Doing medical history from below' is depicted as the *practice* required to analyse successfully the patient's view.[61] As straightforward as it sounds, this promise is actually rather puzzling as history from below implies power struggles, resistance and perhaps even a popular movement. Porter extensively quotes from Samuel Pepys' diary to exemplify his point. But surely a member of parliament and civil servant is not the ideal source to document the feelings of the society as a whole? The scarcity of his references confirms that he did not see the need to fully engage with histories from below. Rather, he used this well-known catch-phrase almost by analogy: if understanding the poor cannot be achieved through the study of social policy, so surely making sense of medicine by concentrating on doctors would be similarly impossible.[62] Porter's intention was to give a voice to an unheard class of people engaged in the medical encounter, patients. It seems that his patients were mainly underprivileged by historians, not by the doctors of their time.

However helpful a rhetorical construct it may have been, the analogy to histories from below appears to be difficult for two reasons: first, it over-emphasises polarity. Porter's patients stand against doctors—there is not much room for the social or local environment. The family or, lo and behold, other occupational groups such as nurses and midwives play only a minor role in such an account if they even appear at all. This is of course extremely problematic as, throughout history, patients have in fact rarely encountered doctors and were looked after by their families, nurses or perhaps even left to their own devices.[63] It appears that this has long been one of the fundamental weaknesses of the historiography of medical institutions. Very much akin to Porter, they appear to suggest that the great bulk of care was undertaken in institutions, which we know has hardly ever been the case. In my field, the history of tuberculosis, the majority of the sufferers were not looked after in institutions all the time, yet the majority of historical studies tackle the sanatoriums, hospitals and Poor Law infirmaries.[64] If one wants to write medical history from below, the doctor–patient polarity is detrimental to the cause, obscuring rather than enhancing the analysis. Since Porter's article, the history of nursing has made great strides.[65] Similarly, the history of midwifery has been taken up by 'mainstream' historians challenging the medical model.[66] The UK Centre for the History of Nursing at the University of Manchester provides a very useful gateway between nurses' activism and historical scholarship even if the history of nursing and midwifery is still somewhat neglected in mainstream history of medicine and the curricula of leading history of medicine centres in this country.

Empirically I can see no good reason for this polarity and my own research on tuberculosis patients confirms the view that doctors, patients, nurses and even technical staff

[61] Jordanova 2000.
[62] Porter 1985*a*, p. 185.
[63] Horden and Smith (eds) 1997.
[64] Condrau in Henderson and Horden (eds) 2007.
[65] Dingwall, Rafferty and Webster 1988; Rafferty 1996.
[66] Marland and Rafferty (eds) 1997.

have a role to play in the medical encounter.[67] If history from below has to do with power structures, then patients appear to be the least likely group to challenge medical power and influence. For example, take the medicalisation of birth. Of course, there is a complex story to be told that requires careful analysis before jumping to conclusions.[68] But there can be no denying that since 1945, birthing women have largely welcomed the hospital and have voiced no fundamental, large-scale opposition to the medicalisation of birth and its experience.[69] In Porter's early modern world as well as in the contemporary world of the postmodern patient according to Shorter, patients are not simply dominated by their doctors. They seek them out, they follow or disregard their advice as often as they please, they negotiate on the early-modern market for health care as much as they are engaged in health care consumerism in the more contemporary world.[70] Perhaps they are indeed becoming 'The Rosetta Stone in the Crisis of Medicine', the main actors rather than a disempowered group.[71] This is hardly the material for a history from below.

The second, rather fundamental difficulty in connection with medical history from below has to do with the fact that most histories from below were driven by a political interest. Women's history is inconceivable without the feminist movement of the 1960s and 1970s. Black history would not have gained any attention at all without the civil rights movement.[72] Indeed, history from below has been equated with the history of social protest as giving voice to those for whom being 'below' has always implied challenging the ruling classes who are above.[73] A comparable political background for patients is not easy to unearth. The Patient's Association in the UK, founded in 1963 in response to ethical debates about clinical research, can hardly claim to be an organisation of radical protest.[74] The same would be true for the consumer movement, with the caveat that much of this depends on structures of the welfare state and raises difficult questions of nation-states as opposed to transnational history.[75]

Long before Porter, a veritable intellectual crisis of medicine had unfolded in the 1970s with authors challenging the logic of modern western medicine. Illich, at that time perhaps its best-known protagonist, wrote about the perils of hospitals as medical factories and fought against the disappropriation of health.[76] According to his logic, medicine and its allies, the nation state and industrialists, had cunningly tricked humanity into submission without any real benefit to show for it. The patient, it has to be said, does not get much voice in Illich's account and is relegated to the oft-repeated role of the object without any agency. In the history of psychiatry, radical criticism was often voiced against institutions. Erving Goffman spoke of medical institutions as total institutions in which the

[67] Condrau 2001.
[68] Beier 2004.
[69] Hanson 2004.
[70] Tomes in Stevens, Rosenberg and Burns (eds) 2006.
[71] Wildes 2005.
[72] Bennet 1989; Wright 2002.
[73] Krantz (ed.) 1988.
[74] Hazelgrove 2002.
[75] Hilton 2003.
[76] Illich 1976.

reconstruction of patient identity became the main aim.[77] For Goffman, most mental institutions never really attempted medical treatment for the benefit of the patient. Rather, he sought to explain their 'real' aim of getting into the patient's mind to shape a new identity. Being cured, in Goffman's eyes, would imply getting a new self—it had nothing to do with modern bio-scientific intervention or effective medical therapy. Similarly, Thomas Szasz argued that institutions create the pathology they pretend to cure.[78] As a psychiatrist, he questioned the categories of mental illness and was vividly aware of psychiatrists' powers to define, which have ceased to lie with the patient. But most of these rather politically minded writers focused on coercive institutionalisation rather than on patients of all kinds. Perhaps the key to this is to question the category 'patient' itself and to begin to understand that diverse arenas such as anti-psychiatry, feminism and disability would need to be taken into account to formulate a critique of medicine from below.

What is stunning and certainly meriting further investigation is an entirely different type of politics which is usually associated with Margaret Thatcher.[79] Patient's history became popular in many countries at more or less the same time as her political reign. Those who are familiar with the NHS's history in post-war Britain cannot fail to see how well Porter's agenda of patients' agency fitted with the NHS reforms begun in 1974 and culminating in the recent announcements concerning a patient-led NHS.[80] How absolutely fascinating that this context, the increased importance a patient as consumer would play in contemporary policy-making, was left totally untouched by Porter and so many other authors at the time. Perhaps McKeown was not so far off after all when he argued that 'perhaps the most successful social historian would be one who does not particularly care for history, but turns to it because he considers it indispensable to an understanding of contemporary problems'.[81] He certainly hit the tone of the time, asserting the contemporary political interest that was supposed to drive historical inquiry. With the benefit of hindsight—and this benefit is of course substantial—one cannot be but baffled by the fact that the policy shift towards internal markets in health, patient representation in decision-making, and ultimately patient choice in health care politics has not been linked to Porter's call to arms for patient's history. The timing is not quite right of course: the government white papers outlining the relevant reforms were not published before 1989, with the National Health Service and Community Care Act (in England) proposing internal markets from 1990.[82] Through this, however, another kind of patient begins to emerge who is a political entity, perhaps a politically constructed one and for that very reason well worth further historical investigation.

Conclusion

This article reveals that there is a debate to be had between largely empirically driven accounts of the history of patients and a more Foucaultian perspective which emphasises

[77]Goffman 1961.
[78]Szasz 1961.
[79]Webster 1998; Rivett 1998.
[80]Creating a Patient-led NHS: Delivering the NHS Improvement Plan, London: Department of Health 2005.
[81]McKeown 1970, p. 342.
[82]Working for Patients, London: Department of Health 1989.

the patient as a construct of the medical sciences. It appears to me that the former, whilst providing extremely interesting case studies and adding much required detail, sometimes even a fresh perspective to the established historical account, have difficulty overcoming what I like to call the 'charm of the sources'. Reading patients' diaries, first-hand accounts of hospital experiences and autobiographical material, and perceiving such medical encounters from the patient's view, adds a lot of colour and can often help make quite different points about the history of health and illness. But Porter wanted more. He wanted to add the patient to the fundamental categories of the social history of medicine project. Unlike other areas of research, such as the history of medical sciences or the history of disease, not much further methodological reflection has taken place and this has left the history of patients intellectually less stimulating than other research fields. The battles of the discipline, it seems to me, are fought elsewhere.

By going back to Porter, this article has argued on two distinct levels. The first has to do with the fact that the history of patients, written and studied by so many fine historians since Porter, has always suffered from a lack of methodological inspiration. With so much at stake, going back to Porter often seemed enough to justify the perspective chosen. But using the good and great of our field leaves out their own motives and limitations and perhaps hinders innovation. What made Porter write his article, what made him consider the patient in that specific way and what were the historiographical, political and empirical contexts in which he developed the call for the patient's view? It seems to me that looking to Porter for inspiration ought, in the first place, to be coupled with a critical analysis of his work. The article goes some way towards providing this. The second major objective this article has aimed to achieve is to engage with the patient's history to sketch potential ways out of this methodological dilemma. Rather than siding either with Porter and studying the patient's agency through time, or with Armstrong's patient's view as a medical construct, the article suggests giving up the master narrative of a patient's history from Plato to Nato and replacing it with carefully contextualised analyses of 'patients'. This is not a call for more case studies, of which of course there can never really be enough, but a plea to define arenas of 'patients' and to understand that the sum of these arenas may not reveal the real patient.

I am sure that Porter would agree that his patients and Armstrong's have nothing much in common. They operate, quite literally, in different worlds. This, then, I suggest, is the way forward for patients' history: to engage with debates that have raged elsewhere and to claim intellectual, empirical and theoretical importance in a field that has been for long enough dominated by empirical, perhaps even descriptive, case studies. The patient in the twenty-first century may well be postmodern, to take up one of Shorter's key terms, but the analysis of the patient also increasingly suffers from boundary problems. What the term means needs to be defined very carefully and this definition will largely depend on the arena in which such clarification is sought.

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