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## Max Weber, historiography, medical knowledge, and the formation of medicine

Fran M. Collyer

### Abstract

This paper applies Max Weber's proposition regarding the differences between the 'sciences' to the 'historicist controversy': the problems emerging from opposing approaches to understanding the past. The historiography in question is the development of the 'biomedical model' of health and disease, and the rise of 'medicine' in the course of 19<sup>th</sup> century Europe and Britain. While Weber's theoretical framework does not answer the questions posed by present-day scholars about specific historical events, it enables a critique of the process through which history is 'constructed', and offers an alternative approach to the 'transformation' of 19<sup>th</sup> century medicine.

### Introduction

In lectures and correspondence during the latter decades of the 19<sup>th</sup> century, Max Weber entered the debate over the 'sciences' (that is, branches of knowledge including the 'natural' and 'social' sciences), arguing their differences were of values, context and theoretical orientation rather than subject matter. Weber's involvement culminated, many decades later, in *The Methodology of the Social Sciences*, in which he announced only a 'hairline' separates 'science from faith' (1949:110). Weber's position was not entirely unique, nor was it the first thesis on the nature of knowledge; yet it has significance because it can be placed in late 19<sup>th</sup> century Europe, a period of significant rivalry between intellectuals, each seeking to foster the institutionalisation of a form of knowledge as a distinct discipline within the university system. Between 1860 and 1870, a new generation of physiologists sought to redefine the nature of science (Veit-Brause, 2001:40); in the 1890s, various groups campaigned for the recognition of a new discipline of biology (Pauly, 1984); and others claimed for psychology the subject of mental phenomena or 'psychic facts' (Chimisso, 2000:58). Between 1870 and 1900 was also a crucial period for the formation of sociology. Various scholars including Durkheim, argued sociology 'needed its own specific object, method and space as an autonomous discipline' (Chimisso, 2000:56).

Weber's *Methodology* was both polemical and ideological, appropriate at a time of fierce competition for student enrolments and academic appointments: an environment he considered harmful to scholarship, hindering the promotion of those of intellectual worth (cf: Weber, 1964:132-3). However *The Methodology* is equally a scholarly critique, directed in turn at each of the sciences; including what are now regarded as the 'natural' sciences (Weber, 1949:80), plus economics, biology (1949:85), psychology (1949:74), vitalism and physiology (1949:75). All, according to Weber, 'take out history' and reduce their gaze to 'universal laws' which are not 'reality' but merely tools to understand reality (1949:85;

also 1964:140-145). Moreover, *The Methodology* is both a defence of the discipline of history, and a critique of historiography; that is, of how historians interpret and 'construct' the past. (Within Weber's text, the term 'historian' denotes not only those within the discipline of history, but many who would now be regarded as sociologists: for these also produce 'history'). Debates about the 'construction' of history and the nature of knowledge were not new, but the relationship between 'the historical' and 'the social' became significantly problematic toward the end of the 19<sup>th</sup> century with the increasing prominence of positivistic forms of science (Mandalios, 2000:389); and, it may be suggested, with the strengthening of 'medicine' as an institutional form. For although much of this fervour took place within the university system, it was necessarily part of a much broader sphere of social action in which physiologists, physicians, surgeons, laboratory workers and others were organising politically to establish claims for specific orientations to the understanding of reality, and to the ownership of effective methods for the rational administration, not just of hospitals and health care services, but of industrial societies as a whole (Sturdy and Cooter, 1998:448).

In this paper it is suggested the problematic relationship between 'the historical' and 'the social' resurfaced in the late 20<sup>th</sup> century in debates within historiography: a set of problems Seidman (1985:13) has termed the 'historicist controversy'. While the 'controversy' has attracted considerable attention (e.g. Jones, 1974; Seidman, 1983,1985; Skinner, 1969; Patterson, 1998), it has not previously been considered with reference to Weber's analysis of the sciences, nor his theories of history and knowledge. This paper employs Weber's ideas to examine the historiography of the emergence of the 'biomedical model' of health and disease, and of the rise of 'medicine' during the 19<sup>th</sup> century in Europe and Britain. It is proposed that Weber's insights into the difference between the 'sciences', despite being formed over a century ago, have continuing relevance, offer a more coherent and compelling form of historiography, and provide the means to move beyond the 'historicist controversy'.

## Europe and Britain in the 19<sup>th</sup> century

For historians, the first half of the 19<sup>th</sup> century is often characterised by political and cultural struggle between a plethora of groups with varying orientations toward therapy and practice, and competing theories of health and disease (e.g. French, 2003; Saks, 2003). Though some argue for heterogeneity and uncertainty as a feature of medical practice throughout the 19<sup>th</sup> century and until the 1920s (e.g. Marks, 2006; Lawrence, 1985), the more prevalent view is one of 'transformation' after mid-century, with the emergence of an homogenous form of medical knowledge (the 'biomedical model'), and the development of the institution of 'medicine' (e.g. Porter, 1993; Saks, 2003; Johnson, 1972; Cockerham, 2007:190-1). Some of the contributions of this substantial literature are examined in this paper according to two criterion: theoretical orientation toward medical knowledge, and theory of historical change. For this purpose a typology has been constructed, with examples provided to explain each category. It needs to be noted that, as with all typologies, the selection of examples is open to interpretation: these are offered as illustrative of a genre or approach, and not intended as criticism of individuals scholars. Moreover, readers are urged to forgive the reduction of often complex arguments in order to analyse the historiography of the 19<sup>th</sup> century.

### *Category One: Medical Histories Without Medical Knowledge*

The first category in the typology includes studies where medical knowledge plays only a marginal role in the 19<sup>th</sup> century 'transformation' of medicine. These theorise the formation of the medical profession primarily as a consequence of *class-based alliances* between medical and other elites. Within this Marxist schema, the *content* of the profession's knowledge base is largely irrelevant, for it is the prevalence of a belief in the

possession of 'expert' knowledge which enables the profession to claim a mandate to control their own work, and that of others. Thus, it is argued, the growing dominance of medicine was not primarily an outcome of new medical knowledge nor new knowledge relationships, but the result of an historical struggle over occupational territory and task domains (cf: Willis, 1983:4; see also Johnson, 1972; Freidson, 1970). In these studies, the relations of power are the driving force of historical change. Medical knowledge is secondary to the determining forces of capitalism and merely an *effect* of social structure.

A related set of theories within this group, though less explicitly Marxist, are more open to the notion of medical knowledge as a feature of historical change. These focus on the interests and claims-making processes of 'factions' of healer-practitioners during the 19<sup>th</sup> century, when alliances were formed between some groups (for instance apothecaries and surgeons) to oppose others (such as city-based physicians or acupuncturists). In these theories, 'medical knowledge' is treated as a tradable market 'product', and it is its *ownership* which is relevant to the outcome of the struggle for status and power (e.g. Saks, 2005). Claims for a 'scientific' form of medicine for instance, might, in some contexts, lend the claim more authority. Alternatively, theories of health and disease operate as a means to challenge the social order. For instance, Ackerknecht (1948) argues the debate over contagionism constituted an attack by certain groups on the social order, its social institutions and class rule. In these studies the *content* of medical knowledge is not as relevant as its ownership and how it is used in the political context, the status of the individual or group making the claim, and the nature of alliances formed.

*Category Two: Medical Knowledge as Scientific 'Truth' and History as 'Progress'*

An additional group of theories can be added to the typology. In this second category, the ideational realm is given a more central role. Here, some forms of medical knowledge are assumed to be more valid, true, and effective, and as a consequence, became more prevalent. Some historians argue this form of historical narrative has become less common within histories of medicine, for historiography has become increasingly critical and gives greater emphasis to social context (e.g. Patterson, 1998:6; Warner, 1995:174). Despite these protestations, many 'histories' continue to assert the 'scientific' basis of 19<sup>th</sup> century set medicine apart from other forms of knowledge (e.g. Porter, 1993:50), differentiated 'medical' practitioners from 'quacks' (e.g. Smith, 1985), and brought about the rise of 'medicine' through increasing clinical effectiveness (e.g. Hardy, 2001; Rosen, 1963; French, 2003:231). Within this group may also be placed others, which, although generally more critical, occasionally 'default' to a positivist conception of medical knowledge and 'normal science'. For example, Turner (2000:17) argues 'the advances of medical science made possible the growth of the medical profession as a "learned profession"'; Cockerham (2007:189-190) places Pasteur's germ theory and Koch's bacillus as fundamental to the 19<sup>th</sup> century professionalisation of doctors; and Siegrist (2000:102) proposes past theories of disease (such as miasmas), were 'misconceived' and thus inhibited 'progress'. These contributions illustrate a *positivist* approach to medical knowledge and history. If past theories of health and disease conform to the 'truth' of biomedicine, they are 'rational', if not, they are 'false' and 'incomplete'. Historical change is a product of the progressive 'discovery' of 'truth'.

Other studies relevant to this category not only envisage the rising status of medicine during the 19<sup>th</sup> century as an outcome of 'true discovery' and increasingly effective practice, but invest in the 'Great Men and Great Deeds' approach to history. These rely on the selection of a series of individuals, each 'representative' of a particular epoch, and a list of theories or 'discoveries' as evidence of historical change and 'medical progress' (e.g. Porter, 1993; Garrison, 1966). This is the *presentist* approach to history. Individuals are selected as *exemplars* of an epoch or the instigators of a particular medical theory, even though evidence suggests most 'discoveries' are shared efforts, and few individuals pursued only one form of practice or invested in one theory of disease. William Harvey, for

instance, immortalised by medical historians for his 'discovery' of the circulation of the blood and use of 'scientific method', relied regularly upon astrology to treat patients and determine the appropriate therapeutic dosage. Similarly, the French clinicians of the early to mid 19<sup>th</sup> century, widely regarded today as critical to the development of anatomical-pathological medicine (a forerunner of the 'bio-medical model'), propounded an eclectic mix of theories of disease including vitalism and galenism. Cabanis, celebrated in the medical literature as a prominent member of the Paris 'school' which over-turned classificationism and brought anatomical-pathological medicine to Europe (e.g. Foucault, 1973; Waddington, 1973), offered an approach to disease which was, in many ways, contradictory to the emerging anatomical-pathological medicine; for Cabanis regarded chemistry, physics, and the 'discoveries' of Harvey as irrelevant to medicine; saw Hippocrates as the 'greatest physician of all time'; and believed progress in medicine would come not from 'discoveries' but the perfection of the classification system (cf. Ackerknecht, 1967:5-7).

The *presentist* approach to history disregards this heterogeneity, and selectively focuses on an aspect of an individual's practice or knowledge base which conforms to present-day notions of medicine. Moreover, the resultant 'histories' often rely on a narrow selection of individuals, events and ideas from the past: a choice determined by the employment of a 20<sup>th</sup> or 21<sup>st</sup> century definition of medicine to ascertain past relevance. Hence a 'typical history of medicine' will include the 'discoveries' of Harvey or Pasteur, but ignore the contributions of Farr, Snow or the Webb's, for these are in turn relegated to 'histories' of public health or epidemiology. Such 'discipline-based histories' are said by Camic (1979:517) to be 'constructed' histories, in which historians trawl the past for evidence of current concerns, identifying 'relevant' prior scholarship and presenting these as part of a coherent continuum leading toward the present. Rather than a 'history', these narratives are criticised merely as mythological constructions (Skinner, 1969:12-25).

#### *Category Three: Medical Knowledge and History as Products of 'Medicine'*

In this third category might be included studies with a more critical orientation to both medical knowledge and history; where knowledge is produced within a social context and taken into consideration within the processes of historical change. In these studies however, 'medical knowledge' is not fully theorised as a social product. It is *shaped* by social forces and has an *effect* on social practices and organisation, but at its core is a 'technical' or 'theoretical' element largely independent of 'the social', and medical knowledge is produced *internally* within the confines of medicine itself. An example comes from the work of Jewson (1974), who tells us that medical knowledge in the 18<sup>th</sup>-19<sup>th</sup> centuries resulted primarily from the doctor-patient relationship. Medical knowledge during the period of 'bedside medicine' reflected the aspirations, values and attitudes of the elite, who were the patrons of elite medical practitioners. A second example can be found in Waddington (1973), where new forms of medical knowledge 'emerged' in Paris in the 19<sup>th</sup> century with the demise of patronage and the rise of a hospital-based system. The new and more powerful role of the hospital doctor 'facilitated' a transformation in medical knowledge, for it provided doctors with the possibility for experimentation rather than just the observation of the processes of disease, and gave them full access to the body. This new 'freedom' from patient demands enabled practitioners to develop theories of disease according to 'professional judgement'. A third example comes from Rosen (1963:22), who argues that 'favourable conditions' enabled practitioners to apply the discoveries of science to medical practice and knowledge. In all three examples, medical knowledge is produced 'within' medicine and given impetus by 'appropriate' social conditions. This is the *internalist* approach to history, and shares with *presentism* a focus on 'medicine' rather than the wider social sphere. It is a 'sterilised history', constructed from a narrow selection of past historical events. Significantly, studies within this category also regard at least some aspects of 'medical knowledge' as a 'black box' which can be inhibited or

propelled into existence through 'correct' social circumstances.

*Category Four: Medical Knowledge and History Without Norms or the Relations of Power*

The fourth group of studies offer a perspective on the formation of medicine during the 19<sup>th</sup> century which is neither presentist nor positivist, for medical knowledge is not a 'black box', nor does the past merely *unfold* toward the present. Instead, knowledge and social practices are historically located and outcomes historically contingent. The focus is the historical individual and their 'choices' and practices within a specified social context. An example of this approach is offered by Hamlin (1998), who examines the theoretical debates over contagionism: whether poverty or 'dirt' might be the source of disease. He shows how these theories were played out in political conflict between those who sought to ameliorate disease through cleaning up the physical environment via sewerage and drainage, and opponents who campaigned for the elimination of poverty. For Hamlin (1998:9-10,337-8), the outcome of the debates over the cause of disease and the means of its elimination was historically contingent, not predetermined, for history *could* have been different.

Hamlin examines history from an *historicist* position. For the historicist, knowledge is historically located (Seidman, 1983:85): the historian seeks to place an event or text in its social context, and to 'understand the past, completely as possible, in its own terms' (cf: Jones, 1974:355). Moreover, the key to understanding the past and producing 'authentic history' can be found within the text itself and through the 'discovery' of the motivations and intentions of the author. The weakness in the *historicist* approach results not from the presumption of knowledge as historically located, but *how* it is so located. For the historicist, knowledge is pertinent only to a particular problem and intention (cf: Skinner, 1969:50). All knowledge is, in a sense, 'new', and there are no enduring social problems (Seidman, 1983:85). It is not possible, or legitimate, from an historicist approach, to discover the 'history' of a particular idea, nor explore the historical contingencies which 'led particular theories to be established at the expense of others' (Camic, 1997:6). One of the reasons for this restricted theory of the role of knowledge in social change is that historicism underestimates the role a text might play in shaping future action, regardless of the original intention of the author or of its originating context (Seidman, 1983). Another reason is that historicism takes the autonomous, non-social individual as the key to the meaning of history, and largely discounts the possibility that the actor's 'choices' may be shaped by enduring structural relations of power (such as class or gender), the 'norms' of culture, or institutional processes. For instance, Hamlin (1998:339) argues the British government threw its efforts into drainage and sewerage in the first few decades of the 19<sup>th</sup> century rather than the amelioration of poverty (even though there was ample evidence of the relationship between disease and poverty at that time) because of the 'choices' made by key individuals. As a consequence of this exclusive attention on the 'historical moment' itself, the autonomous individual and *their* pivotal role in history, the historicist approach cannot adequately explain the formation and continuance of bodies of knowledge, nor why one theory or body of knowledge might be marginalised whilst another becomes dominant.

*Category Five: Medical History and Knowledge Without Power*

This fifth group of theories about the rise of medicine link medical knowledge to cultural norms and hence take into account a significant mechanism through which knowledge might be transmitted over time. However these do not link the ideational sphere to systemic relations of power. In this group may be placed the work of Starr (1983), who theorises the 'birth of scientific medicine' in terms of the wide public acceptance of the claims of medicine to specialised knowledge and skill. Starr's framework emphasises the role of values, beliefs and attitudes in historical change, but neglects the structures of power and the socio-political context which give shape and substance to the claims of the

profession. The work of Mechanic may also be included here. Mechanic (1978:89) views the emergence of medicine as an outcome of societal needs, values and system 'goals': for here, health care systems are constructed over time *in order to* provide for the sick. Medical knowledge is an inherent element of this theoretical framework; though only as a resource orienting social action within the system. While theories within this group are cognisant of cultural norms, and thus offer a challenge to historicism, the neglect of the relations and structures of power reduce their capacity to explain the 'transformations' of 19<sup>th</sup> century medicine.

*Category Six: Medical History and Knowledge Without Actors*

The sixth group is reserved for the work of Foucault (1970,1973), for it offers a unique perspective on both knowledge and history. Foucault's 'archaeology' of the 19<sup>th</sup> century emphasises the historical shift from classificationist to anatomical-pathological medicine. The central focus is not specific theoretical frameworks, ideas or concepts as 'drivers' of historical change, nor the actions of specific individuals or groups, but the underlying framework or 'episteme'. For Foucault, an episteme is a framework of *possibility* for the production of knowledge: producing and giving coherency to a form of 'knowing' qualitatively different from that of previous epistemes. Although Foucault offers an approach to history which is not presentist, it is nevertheless problematic. It is, after all, a 'history of medicine' which takes place without actors: no actors to produce, argue or struggle over different theories and possible forms of action. Moreover, it is a framework which does not readily allow for alternative forms of discourse and other theories of disease arising within a given episteme: for all knowledge is the outcome of a single discursive process, unique to an historical epoch. And given Foucault's focus on epistemes rather than concepts and theories, it cannot provide insight into the role specific theories of health and disease might play in historically shaping social relations and practices. In this sense, and in this sense only, Foucault's approach might be considered to offer an ideational approach to history. That is, a history which does not theorise the relations between the ideational and the material aspects of social reality in terms of social practices, political struggle, or forms of organisation. As a consequence, it cannot offer a theory of history in which specific notions of disease, nor particular social actors, contributed to the historical changes of the 19<sup>th</sup> century.

*Category Seven: Medical Knowledge As Constituted By, and Constitutive of, History*

The final group of studies in the typology fully theorise the relationship between theories of health and disease, social practices, systemic forms of social power, and the social context. As such, they are able to account for the formation and transmission of knowledge over time, as well as the increasing dominance of medicine after the end of the 19<sup>th</sup> century. As will become clear in the next section, studies comprising this group apply a theoretical framework compatible with Weber's own. In this category we might include the work of Figlio (1985:159-160), for whom 'disease' is not an unproblematic, objective 'fact' which 'breaks into human life as a falling boulder', but a socially constructed, socio-clinical entity within a given social space. Moreover, medical knowledge is not a product of 'medicine' itself, for a clinical diagnosis is equally a *social* diagnosis, expressing the social anxieties of the period (Figlio, 1985:137-8,141). As such, medical knowledge is always in a relationship with the social structure, for it is generated in specific historic contexts, and does not just reflect but contains within it social forces such as class dynamics (Figlio, 1985:135). The study of the crowded, competitive medical market-place of 19<sup>th</sup> century by Lawrence (1994) can also be included in this category. This author considers the proliferation of anatomical-pathological medicine in connection with the rising social power of surgeons, proposing the new view of disease as a surgical, rather than physicians' epistemology. The new form of medicine replaced the physicians' employment of theoretical reasoning and knowledge of the individual patient, with a new mission: locating the cause of disease in the underlying, hidden knowledge of the body's structure.

For the surgeon and anatomical-pathologist, medical knowledge could be ‘discovered’ through looking, touching and listening. As such, the new form of medical knowledge did not arise within a void, but from shifts in social practice and the relations of power. Within this approach to history, new epistemologies and theories of disease are fundamentally tied in with social practices and new structural relationships. Medical knowledge is not separate from other discourses: it is not a ‘technical’ realm distinct from the social, for even epistemological shifts are socially produced. Moreover, social change is a process involving both the ideational and material realms: these are inter-linked developments. As Cooter (1982:100) argues, any body of knowledge is ‘mutually constitutive with the historical conditions that gave rise to the social context in which the knowledge was called forth’.

Weber’s approach to knowledge challenges all but the last of these theories of knowledge, history and historical change; and provides a reflexive, critical analysis of the processes of historiography. It is to these challenges and analysis which we shall now turn.

## Weber’s Historical, Theoretical Critique

For most historians, the actor from the past is central to the analysis of the past. In Weber’s approach to history however, there are two social actors. In addition to the actor from the past, involved in creating, putting forward, refuting or supporting theories (including those of health and disease), there is a second actor who, in the current or recent context, analyses history. For Weber, both sets of actors are historically located, for knowledge is never created in the abstract, and their actions are social, oriented toward meaning (cf: Weber, 1968). These two principles - the historical location of all actors and their orientation toward meaning - are central to Weber’s theoretical framework, as is a third: that of the ‘construction’ of knowledge. Rejecting the proposition that science is directly able to capture ‘objective’ reality in a process of ‘discovery’, Weber ascribes to the Neo-Kantian position of conceptual phenomena as the ‘creation’ of human reason (Månson, 2000:79; Weber, 1949:106). With these principles in hand, Weber attends to the process through which actors produce knowledge: whether as actors from the past interpreting and ‘constructing’ knowledge, or actors in the present making sense of, and ‘constructing’ these past acts. Weber’s concern with this process of ‘knowledge-making’ places his work directly within the terms of the ‘historicist controversy’, and hence calls for a close examination of his theories of knowledge and history.

## Reductionism

Weber’s approach to knowledge explicitly rejects reductionist and mono-causal explanations of history (Zaret, 1980:1189), and therefore challenges histories of the 19<sup>th</sup> century where the growth of medical occupations are theorised as the outcome of their ‘sources of power and authority and the ways in which they use them’ (cf: Johnson, 1972:18). For Weber (1949:71), neither knowledge nor systems of authority are sufficient in themselves to produce historical change. In their stead, he places an emphasis on a multiplicity of causal forces, including various social orders such as the economy, the family, law and religion, as well as historical events and ideas (Kalberg, 1997:232). Although Weber’s *The Protestant Ethic and the Spirit of Capitalism* explores the role of ideas in the emergence of capitalism in Europe, in its introduction (and also elsewhere, 1949:71), he describes the book as an antidote to prevailing theories which reduce history to materialistic forces, and argues it is not intended to be a ‘complete’ historical analysis, but rather an exploration of the role of the ideational realm in historical change.

Weber’s approach is therefore at odds not only with economic reductionist accounts of

historical change, but with any analysis which negates the relevance of the ideational realm in the processes of historic change. As such, it is not compatible with Marxist or Neo-Marxist accounts of professionalisation, nor with 'interest group' approaches, where the ideational realm is deemed relevant to history only in as far as it represents a 'product' upon which claims can be made for authority and status. For Weber, ideas and knowledge are not the *product* of interest group formations or class positions which are then 'selected' and applied according to social 'needs'. Rather, ideas and knowledge are 'constructed' within social action, they can, in themselves be influential and enduring across historical time, and may, in particular contexts, independently produce historical effects (cf: Weber, 1968:519; Kalberg, 1997:229).

## Internalism and Presentism

An internalist history of the 19<sup>th</sup> century offers 'medicine' as a present and past field of knowledge, practice and organisation, independent of other social arenas, in which there is a dynamic of development *internal* to medicine itself. It is akin to the *presentist* approach to history, for both rely upon the analytic construction of a concept of 'medicine' as an independent, bounded field of knowledge and practice. *Presentist* 'histories of medicine' impose 20<sup>th</sup> or 21<sup>st</sup> century definitions of 'medicine' onto the past, thus including only ideas, technologies and practices considered pertinent to this field. This process thereby narrows the field of possible selections from an empirical past which, according to Weber (1949:78), is 'infinite'. The result is a 'discipline-based' history: an abstract 'construction', organised according to the modern discipline of medicine, its boundaries and defining characteristics. Like other disciplinary histories, it is open to the criticism of being a 'mythological history' within which the causal relations between scholars, texts and ideas are not empirically established and where imputed forms of social action did not, in fact, take place (cf: Seidman, 1985:14).

The category 'medicine', employed in these histories, can be regarded as an 'ideal type'. Although Weber (1949:105-7) considers the ideal type a useful analytic device, he argues it is necessarily one-sided and unable to capture the 'infinite richness' of reality. In light of this, and in contrast to both internalism and presentism, Weber's historical analyses demonstrate the inter-connectivity of ideas and attitudes *across* various spheres of social action. *The Protestant Ethic* reveals ideas and attitudes apparently central to one sphere of social life, (such as asceticism, discipline and orderliness, as found in the Calvinist religion), to be also an organising principle of another (such as the accruing of wealth through hard work in the economic sphere). Weber's approach then, is to make use of the ideal type to explore a sphere of social action, but remain cognisant of the artificial boundaries analytically created. Weber objects to historians who assume the creation of categories, classifications and concepts are reality itself, and forget these are only tools: for 'concepts are primarily analytical instruments for the intellectual mastery of empirical data and can be only that' (Weber, 1949:106).

Weber's approach to history is therefore at odds with both internalism and presentism. While Weber uses the ideal type to explore the possibility of a causal pathway through history, he cautions against the uncritical acceptance of these 'histories' as anything other than artificial, narrow, 'constructed' selections of past 'significant' events. As a consequence, Weber's mode of analysis challenges presentist histories which reify categories such as 'disease', 'medicine' and 'medical knowledge' and lend them a universality and constancy across time. In this, Weber's approach to history is in agreement with historicism, for both argue against the imposition of current assumptions onto the past and seek to ascertain the uniqueness of past ideas and forms of social action.



## 'Whiggism' and Historicism

'Whiggism' is a mode of historical analysis which evaluates the past according to present categories of adequacy and understanding (as found in Hardy, 2001; Porter, 1993; Cockerham, 2007; Garrison, 1966). *Historicist's* caution against this historiographic approach, particularly the practice of condemning the past as 'irrational' or 'misguided', and suggest the past be considered as 'rational' with regard to its social context (cf: Jones, 1974:355). This means past conceptualisations of health and disease need to be understood as attempts at self-understanding within the prevailing conditions of the period, and not evaluated against the knowledge claims of the 20<sup>th</sup> or 21<sup>st</sup> century biomedical sciences. Weber's mode of comparative-historical analysis suggests a compatibility with this aspect of historicism, for in studies of various traditions including those of ancient Judaism and Calvinism; past ideas and practices are not evaluated as 'inferior' but regarded as unique, plausible, and meaningful within their own contexts.

In other ways though, Weber's methodological approach stands in sharp contrast to *historicism*, for his historian is not merely an interpreter of past events, but a social actor acting with regard to what is meaningful and significant. As such, *values* are the central organising principle of historiographic procedure. The historian, as a social actor, faces an infinite empirical context, and in seeking to build knowledge about this context, must select aspects of it to create a view, theory and perspective (Weber, 1949:78). For Weber, it is values which direct an actor toward what is culturally significant, *narrowing* the field and enabling the individual to 'make sense' of the empirical context (Zaret, 1980:1183). Weber's placement of the historian as a social actor, undertaking a process of value-construction, is premised on a particular methodological stance which, unlike historicism, problematises the notions of objectivity and subjectivity. On the one hand, the historians' 'construction' of historical reality is a subjective process: 'Every meaningful *value-judgement* about someone else's *aspirations* must be a criticism from the standpoint of one's own *Weltanschauung*; it must be a struggle against *another's* ideals from the standpoint of one's *own*' (Weber, 1949:60). On the other hand, historical analysis is *not subjective*, for, according to Weber, the categories created by the historically located historian, reflect prevailing evaluative ideas (1949:83-4), disciplinary knowledges, and the experience and analytical training of the historian (1949:79-80). This notion of 'subjectivity' differs from that implied by historicism, where 'objectivity' occurs when an analysis 'captures reality' through a position of value-neutrality. Weber (1949:60) however, insists that an '*attitude of moral indifference* has no connection *with scientific* "objectivity"'. Thus the historiographic process is 'subjective' in the sense that historians' categories *are* evaluations, but is not subjective in the sense that the categories are 'valid' only for each individual (Weber, 1949:83-4).

Weber's theories of history and knowledge also offer an alternative to historicism's insistence on the 'objectivity' of historical 'fact'. For Weber, because views, understandings and theories are formed in a process of value-construction, actors do not just *select* whether to understand a subject or issue in a particular way, but actively construct social 'facts'; that is, the possible empirical objects of analysis (Zaret, 1980:1183). This means historians, when faced with the same empirical, historical past, may construct different 'objects of analysis' (Zaret, 1980:1184), and hence offer opposing 'interpretations' of historical events and historical change. For Weber, the 'historical fact has both objective and subjective aspects. 'Historical facts' are 'objective' in the sense they are the result of rigorous efforts to contextualise and comprehend the past in its *difference* from the present, but 'subjective' in as far as the past is 'knowable' only through the 'value-ideas' constructed 'in our minds': for 'we comprehend reality only through a chain of intellectual modifications' (cf: Weber, 1949:80,94).

Weber's proposition then, is that historians, as historically located actors, 'construct'

history according to that which is of prevailing and personal significance, for ‘there is nothing in the things themselves to set some of them apart as alone meriting attention’ (Weber, 1949:78). Hence it is perhaps not surprising, given the widespread importance attributed to the institution of medicine in most societies during the 20<sup>th</sup> century, that historians have taken such a keen interest in the events of 19<sup>th</sup> century Europe.

## Developmentalism and Evolutionism

Many histories of 19<sup>th</sup> century medicine demonstrate an initial similarity to Weber’s comparative histories, for both offer categories which describe the character of a specific period, and appear to function as historical ‘phases’. Common categories in medical histories include pre-scientific, and rational or scientific medicine (French, 2003); bedside, hospital, and laboratory medicine (Jewson, 1976); and galenism, classificatory, and anatomical-pathological medicine (Foucault, 1973; Ackerknecht, 1967). In Weber’s studies can be found categories representing, for instance the differing historical forms of rulership, perhaps charismatic, patriarchal, feudal, patrimonial and bureaucratic. The difference however, lies in how Weber applies these categories in his analyses of historical dynamics. Weber’s analytical mode begins with the construction of *ideal types* or ‘mental constructions’ (Weber, 1949:101-3), produced through a close interweaving of empirical study and the use of theory, which reveal the *unique* patterns of social action (but not its average character) in a given historical context. Weber then uses ideal types to pose questions about causal social forces, for though ideal types may include significant social action, they do not, and cannot, exhaust the forms of possible social action of an epoch (Kalberg, 1997:222; Weber, 1949:72-3,170-2). Weber’s view then, is that the ideal type does not *capture* the intrinsic nature of reality, but is merely an ‘ideal’ *depiction* which is partial, distorted, and logically extreme. This means, for Weber, ideal types cannot themselves provide the means to *demonstrate* causality (Weber, 1949:102; Kalberg, 1997:222-3). From Weber’s perspective, categories such as ‘hospital’ or ‘laboratory medicine’ cannot reveal the empirical factors which *caused* changes in health practices, knowledge and organisation, but serve only as reference points for further empirical and historical analysis.

Histories of medicine offer two principle approaches to the analysis of historical change. On the one hand history is regarded in *evolutionary and developmental* terms. History is essentially linear, displaying progressive tendencies according to a set of ‘laws’ or ‘principles’ which determine an historical trajectory of inevitable advancement and maturation. This approach underpins Marxist studies of history (e.g. Johnson, 1972), an approach Weber was particularly critical of, for he argued these historians identify a number of characteristic ‘features’ of an era, and present them as ‘phases’ in the ‘transformation’ of history according to universal and inevitable ‘laws’ (cf. Kalberg, 1997:223; Weber, 1949:102-3). Yet these ‘laws’ of history, for Weber, are themselves ideal types. As such they are neither empirically valid nor express actual forces in reality, but merely a means to understand reality. Weber’s critique also has relevance for non-Marxist but otherwise *evolutionary and developmental* approaches to history. Both presentist and ‘whig’ medical histories display this approach, for these regard past practices and knowledges of healing *as if* they were, in a sense, predetermined to proceed, according to a set of ‘laws’ or ‘principles’ on an unfolding trajectory toward ‘biomedical truth’ (e.g. Hardy, 2001; Porter, 1993). On the other hand, some medical histories offer an historicist approach which contrasts with evolutionism, for here history is characterised by fundamental discontinuity and cleavage, with entire reorganisations of knowledge, attitudes, and ideas (e.g. Foucault, 1970, 1973). This historicist approach, in which each historical ‘moment’ is entirely unique, divorced from the past, would be an anathema for Weber, for he ‘never views social life as an “endless drift” of solitary and unconnected

action-orientations' (Kalberg, 1997:216).

Weber's theory of history is therefore neither presentist nor historicist. Instead, history is partially pre-determined and partially open-ended, and contains both historical continuities and discontinuities. His analysis of 'rationalisation', for instance, implies a linearity to historical change, and is suggestive of accumulative intellectual progress, but is tempered by an insistence on the multiplicity of social forces shaping the social sphere and on historical contingency. As such, Weber allows for both the entrenchment of patterns of social action over time, and the occasions when regular patterns of action are disrupted and institutional trajectories disintegrate. It is an approach to history in which the present is never entirely free of the past (cf: Weber, 1968:29; Kalberg, 1997:224).

For Weber, then, history cannot be understood through the lens of a particular doctrine about historical change, but through an examination of the multiplicity of social forces which shape particular historical events and individual actions. This necessitates the use of both empirical research and theory. While it is the historian's task to explain *empirically* why a phenomenon became 'historically so and not otherwise' (Weber, 1949:72), Weber also relies on the analytic construction of 'ideal types' and 'societal orders' to isolate significant causal patterns of action (Kalberg, 1997:217-221). Moreover, in order to explain *patterns* of regularity over time, rather than resorting to historical laws or tendencies, Weber offers the concept of 'social carriers', such as status groups, class, and organisations (Kalberg, 1997:227). Weber's theoretical framework is therefore opposed to historicism, for the comprehension of the past requires a focus not just on the social action *within* a specific social context, but on the 'social carriers' which shape those actions, transmit these across time, and influence subsequent social orders. In this way, Weber's approach to history allows for the possibility of both continuities and discontinuities of knowledge and practice across historical time.

## Conclusion

This paper has demonstrated the relevance of Weber's critique of the sciences to the 20<sup>th</sup> century 'historicist controversy', for both are concerned with how there can be knowledge of the past, and how the relationship between 'the social' and 'the historical' can, and should, be theorised. Consideration of the controversy from the perspective of Weber's theoretical framework indicated problems with reductionism, idealism and presentism, for these explicitly disengage from 'historical empirical reality' in order to explicate the history of a particular discipline or field of action. As a consequence, such approaches to history produce only partial views of the past, based on an abstract chain of imputed causality in which historical development is an inevitable, linear, progression from past to present. While Weber's analysis revealed no valid role for 'whig' approaches to history, it suggested reductionism, idealism and presentism as useful analytic tools: provided their limitations are openly acknowledged by the historian.

Historicism, which has to date received relatively less criticism in the 'historicist controversy', is significantly challenged by the application of Weber's theories of history and knowledge. While there is a concordance between the approaches of Weber and the historicist regarding the need to understand the past within its socio-temporal context, Weber's alternative analytic undermines historicism's insistence on the historian as a neutral conduit through which the past can be 'discovered', and on historiography as an 'objective' process directly capturing historical 'reality'. In theorising the process of historiography as a *social* rather than technical process, the historian as a *social* actor, and *all* avenues to understanding the past as value-oriented and thus partial and selective; Weber proposes the past cannot be 'discovered', nor can we produce an 'objective' history which directly captures 'reality', even through attention to the past social context. 'Objective' knowledge of the past is only that which is 'subjectively'

produced but given validity through a shared, social process of rigorous empirical and theoretical labour.

Weber's theoretical orientation toward history and historical change therefore provides an alternative to both presentism and historicism. Rather than history as either inevitably linear, progressive and predetermined, or irrevocably fragmented, random, and open-ended, we are presented with a theoretical framework which accounts for the occurrence of both historical discontinuity and continuity. This draws from Weber's inclusion not only of historical 'events' but value-oriented social action and 'social carriers' as historical 'objects', for all influence the course of history. As a consequence, Weber's theoretical framework is able to explain how it is that ideas, knowledge and values can be transmitted across time, and why the past may be part of the present.

Weber's theories of history and knowledge also have a significance beyond that of a critique of historiographic practice. The concept of the historian-sociologist as an historically located, social actor applies equally to Weber and ourselves as historian-sociologists. Weber's immediate location within a specific socio-temporal context, and his partial and selective perspective as a *social* actor, narrowed his concerns to the improvement of scholarship and a place for history and the cultural sciences in the developing university system. He could not, and did not, envisage his work as a contribution to a much broader sphere of social action where efforts to re-define the sciences and re-order the hierarchy of knowledge were marginalising the cultural sciences and effectively positioning 'medicine' and the experimental sciences as the means to both define and solve social problems.

Historian-sociologists of the 21<sup>st</sup> century, are, like Weber, both privileged and handicapped as historically located social actors. One of the *privileges* of their location within the 21<sup>st</sup> century is a capacity to reflect on 19<sup>th</sup> century events as critical to the eventual formation of the historicist and presentist approaches to history. Historicism, with its principles of value-neutral 'objective' knowledge, had an ancestor in the surgeon, seeking to discover knowledge through looking and touching; while presentism, with its intentional disengagement from 'empirical reality', is the progeny of the physician, whose approach to healing was through theoretical reasoning. One of the *handicaps* of the 21<sup>st</sup> century historian-sociologist however, is that, in a context explicitly favouring the empirical sciences, it is difficult to even envisage a social order in which problems and solutions might be sociologically, rather than medically or scientifically defined; as they may have been, given different events during the 19<sup>th</sup> century. Equally difficult is the possibility of regarding 'medicine' as anything other than a unique and ontologically given body of knowledge and homogenous field of social action.

Yet the lesson which must be taken from Weber is to see 'medicine' as a mere abstraction (albeit a 'mental construction' with deep historical roots and maintained through vested interests) and work to challenge, rather than sustain its boundaries. One of the consequences of not doing so is evident within most histories of medicine. These explain the current dominance of medicine as a process of 'transformation' during the 19<sup>th</sup> century from an heterogeneity of healing practices to homogeneity, from pluralistic to professional control, from fragmentation to coherency in medical knowledge, and non-science to science. Weber's theoretical framework suggests the need to critically re-examine not only the notion of historical linearity within these histories, but the constructs themselves. It may be the 19<sup>th</sup> century 'transformation' of medicine is an exaggeration which reflects not empirical reality, but the profession's 'own view of itself'. Despite the new hierarchical order of the sciences, 'medicine', in the 21<sup>st</sup> century, may have continued as a fragmented field of diverse practices and occupational groupings, and 'medical knowledge', with its icon the 'biomedical model', may be less homogenous and coherent than commonly characterised. Rather than 'empirical reality', 'medicine' may have been given its unity in large part through the historian's categories. This, as Weber

would insist, is a question for further empirical analysis.

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