A brief history of medicine

History of medicine: a scandalously short introduction
Jacalyn Duffin
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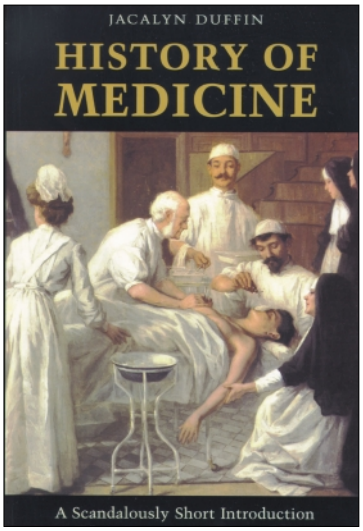
Don't be put off by the subtitle of Jacalyn Duffin's *History of Medicine: a Scandalously Short Introduction*, for this book is neither a superficial nor a simplified history. Rather, its 400 pages provide a vista, with a Canadian outlook, on medicine. A practising hematologist with a doctorate in history from the Sorbonne, Duffin draws upon a wide and thorough knowledge of the literature in writing this survey, which is based on her course for medical students at Queen's University. She has also chosen excellent illustrations; after all, physicians believe with Heraclitus that "More faithful witness are eyes than ears."

The last chapter, "Sleuthing and science: how to research a question in medical history," gives invaluable advice for those of us who love to dabble in history. It also provides a plot for the book itself. As with a good "who-done-it," one can read this chapter first to appreciate the others. The preceding chapters, mainly organized around the traditional medical specialisms, proceed from a chronological account of the major events in each discipline to brief and stimulating discourses on today's issues. Philosophical concepts at the heart of medicine are addressed. For instance, in the chapter on physiology the debate between the materialists and the vitalists is introduced. This made me reflect on prions: are they simply matter, or are they alive?

The essential message of the book is that the truth of history can mean many things to many people. Our own experience and biases influence our interpretation of what at first sight are the facts of history. Readers will, in various ways, relish this book, reflect on it and profit from it. Male readers will be forced to consider the history of paternalistic beneficence in obstetrics and gynecology, a chronicle of benign neglect, ignorance and arrogance. We like to think that such attitudes are now behind us, perhaps because women (whose efforts to join the profession are recorded) are now fully represented in medical schools. However, history must stimulate us to consider what physicians of both sexes are doing wrong now. Are we too parental toward young patients? Do we still think of children as too immature to make the difficult ethical decisions that their illnesses pose? Is it their own interest or the ethos of "no baby, no nation" that makes us legally force treatment on them?



The first readers of this *History of Medicine* should be medical students. As the director of a history of medicine program I welcome this book, for at last I have a good textbook to recommend, one that follows the principles of education and fits the curricula of Canadian medical schools in substance and spirit. It should be bought by, or better still, presented to each Canadian medical student as a reward for acceptance into medical school. Its easy style and entertaining narration will keep students reading. It imparts our scientific origins and conveys the traditions of our profession. Students will savour the essence of medicine and be inspired by its heritage. They will also learn to question what they are taught: as Billings warned, "your new textbooks will be antiquated in five years." The motto of the Karolinska Institute's Web site on the history of medicine is, "The farther backward you can look, the farther forward you can see." Students need such education, for they will practise medicine in ways undreamed by us.

Other readers should be physicians like me who need regular brain dusting. We believe that we practise better medicine than our predecessors did, but history teaches us that any superiority we enjoy was built on their shoulders. History is also humbling in that it reminds us that we are probably wrong in many of our own concepts and therapies. We deride our predecessors' use of bleeding and antimony to treat inflammation for, if nothing else, these treatments produced fatigue, nausea, vomiting and collapse. But will the same be said one day of chemotherapy for cancer? This book also reveals the sources of the currents that sweep us forward and so often buffet our lives, such as the aspirations and problems of the Canadian health care system.

Amateur historians will find this a model for scholarly work and a source of important further reading, including the Web sites that lead to the great libraries. Several times I wondered if my own areas of interest would be addressed and was pleased to

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find the appropriate references listed. And Canadians will appreciate Duffin's perspective. Too often we overlook our country's solid achievements. Sir William Osler put it best in his introductory lecture to medical students in 1882: "Canada yields to no country in practical work and the average of its attainments."

Finally, I have to debate Duffin's argument that blood, that passive carrier of oxygen, is particularly special. Blood, we are told, is mentioned 460 times in the Bible and the lungs not at all. As a respirologist I must point out that without the breath of life man would be but dust and, without man, there would have been no rib. And then we, whatever our background, would not be here to enjoy this history of medicine.

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One thousand words

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World War I soldiers, probably Canadians, suffering from fractured femurs, at the No. 7 Canadian General Hospital, Etaples, France, 1917

Room for a view

Being Frank

It was long, long ago in a galaxy far, far away. I was leaving the hospital close to midnight on a Sunday, after attending one of my patients in childbirth. The quickest way back to my car was through the emergency room, and I was glad to be going home in time for a good night's sleep before the working week began again. The emergency room seemed quiet, but I wasn't surprised when the nurses asked me to see a patient, since I was there anyway.

Art Explosion

A middle-aged man had come in complaining of upper anterior chest pain and palpitations, absolutely convinced there was something seriously wrong with his heart. By the time I saw him he was attached to a cardiac monitor and breathing oxygen through nasal cannulae. The pain had settled down. I listened to his concerns, asked a few questions and examined him. His chest pain didn't sound cardiac, but he was certainly frightened. He appeared to be in good condition, and I found nothing abnormal. I'm just an ordinary doctor who can barely spell supraventricular tachycardia and who thinks that aberrant conduction should get an orchestra a new leader, but his electrocardiogram looked fine and the squiggly lines on the monitor were good enough for me. I reassured him about the benign nature of his symptoms, asked him to come back if his symptoms recurred, and recommended that he call his own family doctor in the morning.

I was about to leave when one of the nurses took me aside and told me that the patient didn't have a family doctor and had been coming in several times a week for the last month or two, always late at night, always with the same complaint and afraid that he was going to die. "What he needs," the nurse said emphatically, "is a family doctor who will take an interest in him." She seemed to mean me. I was busy enough at the time, but not so busy that I couldn't take an extra patient or two. So I gave him my office address and suggested that he call for an appointment in the morning.

I got to the office a little early the next day, at half-past eight. My receptionist looked a bit put out. "Frank's here to see you," she said. "He's a strange one." Frank? It was the patient from the previous evening. I went into the consulting room. He was prowling up and down, pausing to inspect my