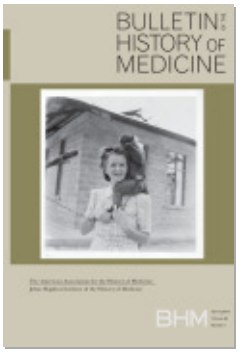
The Fielding H. Garrison Lecture: Great Doctor History:

Barron H. Lerner



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Great Doctor History: A Personal Journey

Barron H. Lerner

SUMMARY: For decades, physicians wrote much of the history of medicine, often "great man" histories that celebrated their colleagues' accomplishments as part of a celebratory historical narrative. Beginning in the 1970s, social historians challenged this type of scholarship, arguing that it was Whiggish, omitted the flaws of the medical profession, left patients out of the story, and ignored issues of gender, race, and class. This Garrison Lecture revisits this history through the prism of my recent book, *The Good Doctor: A Father, a Son, and the Evolution of Medical Ethics*, which is essentially a biography of my physician father, Phillip Lerner, and an autobiography. In the talk I ask whether there is true historical value to biography or whether it should serve only as an adjunct to "real" social history. I also historicize my own career, something I chose not to do in the book.

KEYWORDS: medical ethics, patient autonomy, paternalism, historiography, microhistory, clinical judgment, great man history, biography, autobiography.

One of the enduring topics in the history of medicine—and at meetings for the American Association for the History of Medicine—is that of great doctor history. Most historians agree that the early historiography of medicine was dominated by this genre: books and articles often written by physicians who chronicled and praised the careers of earlier physicians, some of whom had been their professors.

Things changed dramatically beginning in the 1970s, however, when professionally trained historians, many with Ph.D. degrees, brought the new "social history" to the history of medicine. These scholars argued that the old history—with its "Whiggish" emphasis on the accomplishments of largely male physicians and medical progress—ignored not only

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patients but gender, race, class, and unethical behaviors on the part of the medical profession. Not a few AAHM Clinician-Historian breakfasts have debated the value and validity of these two competing approaches to understanding medicine's past.

I recently had occasion to revisit these issues on a firsthand basis. My latest book, titled *The Good Doctor: A Father, a Son, and the Evolution of Medical Ethics*, is a historical account of my father's career as an infectious diseases physician during the second half of the twentieth century. I begin with my father's Orthodox Jewish childhood and education through medical school in Cleveland, move to his fellowship and training in infectious diseases in Boston, proceed to his decades back in Cleveland as a consultant and professor at Case Western Reserve University, and conclude with his retirement, illness, and eventual death from Parkinson's disease. Along the way, I discuss how he exemplified the humanistic and paternalistic physician of this era, including taking on the emerging profession of bioethics, which was challenging his authority.

But the book is also autobiographical, as I compare my father's training and practice with those of my own, which began with my entrance into medical school in the 1980s. I reached back to my own childhood in a secular Jewish home, and then described my education and training as both an internist and a historian of medicine. Among the issues I studied extensively as a historian was the evolution of bioethics. I largely rejected the paternalism of my father in favor of patient autonomy, while trying to practice my own brand of patient-centered medicine. Although my book is thus both biography and autobiography, my training in history was as a social historian. So I also sought to place the careers of my father and myself in their proper historical context and within the existing historical literature on clinical practice, medical ethics, and death and dying in the middle to late twentieth century.

Did I succeed? You can read the book and decide for yourselves. But what I did not do in the book was to spend a large amount of time exploring the historiographic implications of my effort. Was my book a work of "great doctor history" reminiscent of a bygone era? If so, does it suffer from some of the flaws noted by critics of this approach? Is it possible to merge biography and autobiography with social history, or does my personal involvement with the subject matter somehow jeopardize my historical scholarship? Finally, what does my book say about the long-standing debate between biographers and social historians? Are their approaches truly distinctive, or are they complementary ways to conduct satisfactory historical research?

So at the risk of exposing you to an hour or more than you would likely care to know about me and my family, I will forge ahead and try to answer some of these questions.

Figure 1. Phillip Lerner (with cigarette), the author's father, in medical school, 1958. Courtesy of Ronnie Lerner.

What should first be noted is, as well-described by Peter Novick in *That Noble Dream: The "Objectivity Question" and the American Historical Profession*, that early historical writing generally made little distinction between history and biography. That is, chronicling the lives of important historical figures was equated with telling the histories of the eras in which they had lived. History, moreover, was a literary genre and the author's role in shaping the narrative was expected and appreciated. Things changed in the late nineteenth century with the emergence and professionalization of American historians. As Novick describes, these scholars argued that history, if conducted properly, was an "objective science" that enabled discovery of a "true" past.[1] In this new milieu, biographical and autobiographical works that either explicitly or implicitly included judgments about historical events and specific individuals became suspect. Biographies came to be seen less as works of history themselves than potential sources for "real" historical inquiry.

In some sense, the history of medicine did not conform to this historical change. For one thing, these new academic historians wrote political, labor, financial, and military history but not medical history. As such, physicians—who were almost exclusively amateur historians—continued

1. Peter Novick, *That Noble Dream: The "Objectivity Question" and the American Historical Profession* (Cambridge: Cambridge University Press, 1988), 31.

to dominate the field with biographical works.[2] These books had a common trajectory, beginning with the subject's birth and then progressing through his education, professional achievements, marriage, family life, participation in great discoveries and events, and, in most cases, his death.[3] (Physicians were overwhelmingly male in the nineteenth and early twentieth centuries.) In contrast to academic biographies of, say, political figures, these works tended to be largely hagiographic, chronicling the contributions of these great doctors to medical progress. Typical was a 1948 book on the origins of the Johns Hopkins School of Medicine by a Hopkins physician, Bertrand M. Bernheim. He unabashedly termed the prominent founders of the school—William Osler, William Welch, William Halsted, and Howard Kelly—"the four saints."[4] Similarly, Harvey Cushing's magisterial 1925 biography of Osler, which won the Pulitzer Prize, was largely a hagiographic account of Osler's career, achievements, and wisdom.[5]

Of note, beyond their efforts to document the historical record and praise their medical ancestors, physicians promoted the history of medicine for another, often forgotten, reason. Learning about the history of medicine, they believed, was a way to humanize modern medicine, especially as its scientific and technological prowess was on a steep incline.[6] In this manner, the accomplishments and professionalism of past physicians could serve to inspire generations of students and young doctors in training.

Rejection of the history of medicine as a Whiggish success story of the medical profession did not only result from the revisionist works of social historians. By the early 1970s, several research scandals, such as Tuskegee and Willowbrook, had called into question the ethics of the medical profession.[7] Meanwhile, critics, such as the sociologist Erving Goffman,

2. This should not imply that there was no social history of medicine written before the 1970s. But physicians dominated the AAHM and publication in the field.

3. It is worth mentioning the distinction between biography and memoir here. In short, biographies (and autobiographies) generally cover the entirety of their subject's life and involve research to document events. Memoirs, in contrast, focus on specific aspects of an individual's life and commonly rely on the memories of the person writing the book.

4. Bertrand M. Bernheim, *The Story of the Johns Hopkins: Four Great Doctors and the Medical School They Created* (New York: Whittlesey House, 1948).

5. Harvey Cushing, *The Life of Sir William Osler* (Oxford: Clarendon, 1925). See also Michael Bliss, *William Osler: A Life in Medicine* (New York: Oxford University Press, 1999). Bliss half-joked to his more critical readers that he had been unable to find anything negative to say about Osler.

6. John Harley Warner, "The Humanizing Power of Medical History: Responses to Biomedicine in the 20th-Century United States," *Proc. Soc. Behav. Sci.* 77 (2013): 322–29.

7. David J. Rothman, "Were Tuskegee and Willowbrook 'Studies in Nature?,'" *Hastings Cent. Rep.* 12, no. 2 (1982): 5–7; Barron H. Lerner and Arthur L. Caplan, "Judging the Past: How History Should Inform Bioethics," *Ann. Intern. Med.* 164, no. 8 (2016): 553–57.

the historian Michel Foucault, and the philosopher Ivan Illich, published books suggesting that physicians and medical institutions often did more harm than good. And certain women with breast cancer, misleadingly told by male surgeons that they had to get disfiguring radical mastectomies in order to survive, began a very public revolt.[8]

But it was the social historians Susan Reverby and David Rosner, in the introductory chapter of their edited 1979 volume *Health Care in America: Essays in Social History*, titled "Beyond the Great Doctors," who called into question not only the history of medicine but the historiography of medicine. Drawing on similar critiques of other fields of history, in which Novick had identified "substantially and systematically 'oppositional' historiographical tendencies," Reverby and Rosner argued that the predominant focus on white male doctors ignored a vast amount of information and experiences—the "total" history of medicine. Almost entirely absent were patients and their experiences of illness, which would later lead the historian of medicine Roy Porter to champion medical history "from the ground up" instead of the reverse.[9] So, too, aside from occasional mentions of famous physicians who had cared for the poor, issues of class were also invisible. Several essays in Reverby and Rosner's volume explicitly contained the word "social" in their titles, such as "The Social Meaning of Personal Health: The Ladies' Physiological Institute of Boston and Vicinity in the 1850s" and "The Loomis Trial: Social Mores and Obstetrics in the Mid-Nineteenth Century."

Health Care in America led to a series of celebrated interchanges between the old and new guard. Those defending doctor-driven history, viewing the vast output of social histories of medicine, were genuinely baffled at the absence of famous doctors, famous discoveries, and the "march of progress" that necessarily ensued. The new work, they charged, was "medical history without medicine." Continuing their critique of work that described generations of physicians and their accomplishments, social historians spoke of a "medical history without history."[10]

As with many ideological arguments, this one remained highly polarized. Rather than exploring the complementary aspects of the two historical approaches, the differences were emphasized, leading to what the

8. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961); Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Pantheon, 1973); Ivan Illich, *Medical Nemesis: The Expropriation of Health* (New York: Pantheon, 1976); Barron H. Lerner, *The Breast Cancer Wars: Hope, Fear and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001).

9. Susan M. Reverby and David Rosner, eds., *Health Care in America: Essays in Social History* (Philadelphia: Temple University Press, 1979), 3–16.

10. For an account of this episode, see David Rosner, "Medical History: A Tempest in a Test Tube," *Radical Hist. Rev.* 26 (1982): 166–71.

historian of medicine Beth Linker has termed an "artificial duality."[11] For example, supposedly hagiographic history was not always so. In his book on the four Hopkins "saints," for example, Bernheim had some very unkind words to say about Harvey Cushing, another Hopkins luminary and someone with whom he had worked. Among the adjectives Bernheim used to characterize Cushing were sarcastic, inconsiderate, impatient, ruthless, and domineering. He told a story of how Cushing once ripped up a paper he had written. But even more important, Bernheim described in fairly great detail (admittedly uncritically) the large amount of mortality that had accompanied the early pioneering neurosurgical operations developed by Cushing. Discussions of the perils of experimentation—and the ethical conflicts they engendered—would become a cornerstone of the new social history of medicine. Yet here was the topic in print in 1948.[12]

Similarly, a more recent work of great doctor history, the autobiographical *Life of the Clinician* by New York City gastroenterologist Michael Lepore, published posthumously in 2002, also contained information that would have fit well in traditional social histories. For example, Lepore offered a firsthand account of anti-Semitic and anti-Italian sentiments expressed at medical schools during the mid-twentieth century. There is also an interesting discussion of Lepore's complicated experiences at the Rockefeller Institute in the years just after the publication of Sinclair Lewis's *Arrowsmith*.[13]

Another parallel between social history and biography is their use of sources. One tends to think of social historians as mining archival sources such as the records of organizations, personal correspondence, and newspapers. But good social history also uses diaries, oral histories, and interviews that often recount the lives and opinions of specific historical figures. Why should two different books that obtain their narratives from predominantly the same sources reflexively be seen as good history in one case and unacceptable history in the other?

11. Beth Linker, "Resuscitating the 'Great Doctor': The Career of Biography in Medical History," in *The History and Poetics of Scientific Biography*, ed. Thomas Soderqvist (Aldershot: Ashgate, 2007), 221–39, quotation on 225.

12. Bernheim, *Story of the Johns Hopkins* (n. 4), 85–89. On the social history of human experimentation, see Renée C. Fox and Judith P. Swazey, *Courage to Fail: A Social View of Organ Transplants and Dialysis* (Chicago: University of Chicago Press, 1974); David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (New York: Basic Books, 1991); Susan E. Lederer, *Subjected to Science: Human Experimentation in America before the Second World War* (Baltimore: Johns Hopkins University Press, 1995).

13. Michael J. Lepore, *Life of the Clinician* (Rochester, N.Y.: University of Rochester Press, 2002), 51–54.

Finally, another way in which social history resembles great doctor history, it has been argued, is in its presentism. "The past we know or experience," historian David Lowenthal writes, "is always contingent on our own views, our own perspective, above all our own present."[14] To put this argument another way, all history is to some degree autobiographical because it incorporates the writer's perspectives and prejudices—even if the author does not appear at all in the narrative. Looked at in this manner, for example, a social historian's desire to unearth early examples of feminist movements might color the manner in which he or she characterizes the efforts of a particular group of past women. In describing her historical account of her mother's life, the historian Carolyn Steedman wrote that "the usefulness of the biographical and autobiographical core of the book lies in the challenge it may offer to much of our conventional understanding of childhood, working-class childhood, and little-girl hood."[15] There is nothing wrong with this, of course, as long as the historical research is of good quality. But it would be unfair to imply that the inclination of physician-historians to emphasize scientific progress is by definition flawed when social historians may have their own agendas.

Recently, serious scholars have tried to move past the polarized discourse and really contemplate the value of great doctor history. Several commentators have partially rehabilitated it, using the argument that biographies and autobiographies of physicians can play an important role as a "litmus test" for social history. That is, these works can corroborate—or contradict—the more comprehensive social histories that detail events and draw conclusions about medical practice during the time periods in which their subjects lived and practiced. For the medical historian Charles Rosenberg, biography can serve as a "sampling device" to "enhance a more collective history."[16]

A good example of this phenomenon is provided by two biographical works by the historian of medicine Jacalyn Duffin. In her biography of Rene Laennac, the inventor of the stethoscope, some of Duffin's findings contradicted the standard historical account. Although social historians of medical technology had cited Laennac as embodying the positivist spirit of nineteenth-century French medicine, Duffin revealed that her subject was

14. David Lowenthal, *The Past Is a Foreign Country* (Cambridge: Cambridge University Press, 1985), 216.

15. Quoted in Jeremy D. Popkin, *History, Historians and Autobiography* (Chicago: University of Chicago Press, 2005), 253.

16. Quoted in Thomas Söderqvist, "No Genre of History Fell under More Odium Than That of Biography: The Delicate Relations between Twentieth Century Scientific Biography and Historiography of Science," in Soderqvist, *History and Poetics of Scientific Biography* (n. 11), 241–62, quotation on 256–57.

actually more of a vitalist than a materialist. Similarly, Duffin's other biographical subject, nineteenth-century Canadian physician James Langstaff, demonstrated behaviors, most notably his support of women's rights, that other historians had not identified among male physicians of the era.[17]

But is the role of biography limited to this type of "fact checking" of social history? Those who answer "no" to this question have used two related terms to describe a more synthetic work that is at once biographical and historical: "social biography" and "microhistory." Scholars have employed social biography more commonly in the history of science than the history of medicine, although the term could surely apply to the two books by Duffin mentioned above. The idea behind social biography is to explore the social and cultural context within which the life of a physician—or another historical figure—unfolded. Social biography, according to historian Edmund Burke III, makes historically visible "the role of world historical processes in human lives."[18] The best of these works would exemplify what historian of science Thomas Hankins calls an individual's "scientific, philosophical, social and political ideas,"[19] as well as historiographic considerations, such as the accuracy of primary sources and reviews of the existing literature.

Perhaps the best-known history of medicine book generally termed a social biography is Gerald Geison's *The Private Science of Louis Pasteur*. Geison's book is absolutely a traditional biography in the sense that it begins with Pasteur's youth and training and uses the chronology of his life as an organizing strategy. But it then calls into question the previously accepted version of Pasteur as the brilliant French scientist who had discovered the germ theory of disease and was thoroughly revered in both his native country and throughout the world. Geison, through an extensive examination of Pasteur's journals, discovered that the scientist had engaged in unethical behaviors, such as generating questionable statistics, using his rival's data and lying about the experiments he had performed. The book was thus not only a biography but an exploration of academic advancement, fraud, and memorialization.[20]

17. Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993); Jacalyn Duffin, *To See with a Better Eye: A Life of R.T.H. Laennec* (Princeton, N.J.: Princeton University Press, 1998).

18. Edmund Burke III, "How to Write a Social Biography," https://mafiadoc.com/writing-a-social-biography_59a036971723dd0e40b1a478.html (accessed on November 19, 2017).

19. Thomas Söderqvist, "Introduction: A New Look at the Genre of Scientific Biography," in Söderqvist, *History and Poetics of Scientific Biography* (n. 11), 1–16, quotation on 8.

20. Gerald L. Geison, *The Private Science of Louis Pasteur* (Princeton, N.J.: Princeton University Press, 1995).

Social biographies are one example of an approach that has come to be called "microhistory." While there are multiple definitions of the term, it generally refers to an intensive investigation of group, event, or person that sheds light on larger historical themes and processes. In general, subjects of microhistories have been neither ordinary or extraordinary but individuals whose lives and careers provide what Jacalyn Duffin has termed a "window" into an era and what historian Jeremy Popkin believes are insights into the sensibilities, values, and interpretations that "constructed reality" for a specific generation.[21] One of the best-known and successful microhistories is Harold Cook's *Trials of an Ordinary Doctor*, which tells the story of the late seventeenth-century Dutch physician Johannes Groenevelt. Groenevelt, who spent most of his medical career in England, actually had some renown due to a legal proceeding in which he was charged with malpractice for his use of cantharides (Spanish Fly) for urinary problems. But Cook saw Groenevelt's story, which had largely been forgotten, as a unique way to explore medical practices of the era and to also learn about the society in which Groenevelt lived and worked—what he called the "tendencies of an age."[22] As I will argue, my microhistory of the two Lerner doctors provides insights into the evolution of bioethics that would have been harder to capture in a traditional social history.

Have all great doctor histories been about white men? Given that until recently, most physicians—and their physician-biographers—were white and male, most have been. But there have certainly been biographies of early women physicians, such as Elizabeth Blackwell and Marie Zakrzewska,[23] which use the hagiographic approach familiar to the narratives of great male physicians.

However, because the subjects of these works were women who composed a tiny minority of the profession, it was difficult for authors to write Whig histories that ignored issues—such as sexism—that permeated the experiences of these pioneers. Moreover, once social historians began to study women physicians, it was only logical that issues of gender would come to the forefront.[24] Yet while these authors convincingly argued that early women physicians faced enormous obstacles and were often "victims"

21. Popkin, *History* (n. 15), 20.

22. Harold J. Cook, *Trials of an Ordinary Doctor: Johannes Groenevelt in Seventeenth-Century London* (Baltimore: Johns Hopkins University Press, 1994).

23. Agnes C. Vietor, *A Woman's Quest: The Life of Marie E. Zakrzewska, M.D.* (New York: D. Appleton, 1924); Dorothy Clarke Wilson, *Lone Woman: The Story of Elizabeth Blackwell, the First Woman Doctor* (Boston: Little, Brown, 1970).

24. See, for example, Ellen S. More, Elizabeth Fee, and Manon Perry, eds., *Women Physicians and the Cultures of Medicine* (Baltimore: Johns Hopkins University Press, 2008).

of discrimination, they did not whitewash their subjects. For example, as historian Regina Morantz-Sanchez showed in *Sympathy and Science*, many women physicians showed a particular affinity for the eugenics movement. And when historian Arleen Tuchman wrote her mostly laudatory version of the life of Marie Zakrzewska, she emphasized how her subject had a difficult personality and gave mixed messages about whether women practiced medicine differently than their male counterparts.[25]

So, too, with the gradual increase of minorities in medicine in the late twentieth century, books began to appear that documented the stories of African American and other minority physicians. As with women physicians, the pioneering achievements of these doctors shared space with stories of how they faced frequent discrimination. A good example is journalist and historian Spencie Love's biography of Charles Drew, who helped revolutionize the use of blood transfusions. Recently, a young African American physician named Damon Tweedy has written an autobiography documenting his experiences in the largely white world of medicine.[26]

So whether one calls it "social biography" or "microhistory," what can this type of research add to the historical enterprise? Scholars have made several claims. Most notable is that the study of individuals or groups of individuals captures what historian Arthur O. Lovejoy termed the "ideas and feelings that have moved men."[27] That is, nodding to intellectual history, we need to know more than just what historical figures did and the social and cultural forces that caused them to do so. History is also about getting into their heads, so to speak. Biography, according to historian Mary Jo Nye, reveals the "ambitions, passions, disappointments and moral choices that characterize a scientist's life." The British historian Keith Thomas agreed, seeing biography not as the chronicling of great men's achievements but a powerful way to learn about human agency and its constraints.[28]

25. Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985); Arleen Marcia Tuchman, *Science Has No Sex: The Life of Marie E. Zakrzewska, M.D.* (Chapel Hill: University of North Carolina Press, 2006).

26. Spencie Love, *One Blood: The Death and Resurrection of Charles R. Drew* (Chapel Hill: University of North Carolina Press, 1996); Damon Tweedy, *Black Man in a White Coat: A Doctor's Reflections on Race and Medicine* (New York: Picador, 2015). See also Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920–1945* (New York: Oxford University Press, 1995) and Vanessa Northington Gamble, "'Outstanding Services to Negro Health': Dr. Dorothy Boulding Ferebee, Dr. Virginia Alexander and Black Women Physicians' Health Activism," *Amer. J. Pub. Health* 106, no. 8 (2016): 1397–1404.

27. Quoted in Cook, *Trials* (n. 22), xvi.

28. Mary Jo Nye, "Scientific Biography: History of Science by Another Means?," *Isis* 97, no. 2 (2006): 322–29, quotation on 322; Thomas quoted in Constantinos C. Frangos, "Towards a Realistic Approach to Medical Biography," *J. Med. Biog.* 18, no. 1 (2010), http://journals.sagepub.com/doi/full/10.1258/jmb.2009.009006 (accessed July 27, 2017).

These types of arguments make sense for an important reason. If a major goal of history is to historicize, and thus understand events in their specific historical context, biography—if done well and with adequate primary sources—can show what it was like to be "living in history." Readers, Lowenthal has written, can re-experience "what led men of the past to think, feel and act as they did."[29] Although writing about oral history, historian of medicine Nancy Tomes concurs, stressing the importance of restoring human agency to the sometimes name-free pages found in histories of medicine and health care. If modern historians, even as they try not to, still have a tendency to judge historical figures in retrospect (since we know what eventually happened), the possibility of "experiencing choices as they occurred" is especially valuable. To quote the famous British historian Herbert Butterfield, historians who uncovered how past individuals approached and made choices were able to "transcend hindsight."[30]

Of course, as mentioned above, it is possible to get at these types of historical crossroads through more traditional social history, but the biographer who has "lived" with his or her subject for years has the potential to vividly characterize historical moments. Having said this, we should always be careful when asserting that we knew what people were thinking. Lowenthal gives examples of writers who have argued that historical fiction, which can provide "imaginative empathy with the past," is more "trustworthy" than actual history.[31] This line of reasoning, which would likely make most historians uncomfortable, should serve a reminder that writing compelling historical narratives should not be a substitute for ascertaining what actually occurred.

More obviously, biography, especially if written by students or colleagues, has another potential advantage: the author may have been present during the events that he or she is describing. This type of knowledge is a potential double-edged sword; memories of events, particularly those from many years before, are notoriously unreliable.[32] But to the degree that they are "true," they may be able to corroborate the historical record far better than a work of social history written by a "stranger." One example of this phenomenon occurred in the Bernheim book on the four Johns Hopkins physicians, when he tells the story of the controversial 1905

29. Lowenthal, *The Past* (n. 14), 226.

30. Quoted in ibid., 227. See also Nancy Tomes, "Oral History in the History of Medicine," *J. Amer. Hist.* 78 (1991): 607–17.

31. Lowenthal, *The Past* (n. 14), 225. The *New York Times*' book review of Ron Hansen's novel *Hitler's Niece* proclaimed that "Hansen succeeds in conjuring Hitler as he probably was"; http://www.nytimes.com/books/99/10/03/reviews/991003.03louriet.html?mcubz=3 (accessed October 20, 2017).

32. See Marita Sturken, *Tangled Memories: The Vietnam War, the AIDS Epidemic and the Politics of Remembering* (Berkeley: University of California Press, 1997); Mark Roseman, *A Past in Hiding: Memory and Survival in Nazi Germany* (New York: Picador, 2000).

speech in which William Osler argued that older members of society were not productive and mentioned Anthony Trollope's book, *The Fixed Period*, which advocated euthanizing people over age sixty. Bernheim asserted to his readers that there was no doubt that Osler was being satirical, although press coverage at the time suggested otherwise.[33]

My book on the careers of my father and myself demonstrates some of the advantages of biography. The portion focusing on my dad might be termed a microhistory of a consulting physician from the 1960s to the 1990s. My father obtained a modicum of fame early in his career, being the lead author of a four-part 1966 series on infective endocarditis in the prestigious *New England Journal of Medicine*. And he achieved great renown among his colleagues in infectious diseases and other fields in the Cleveland hospitals in which he practiced. Not extraordinary, he was not likely to warrant a biography from someone other than his son. Yet, he was not ordinary either. As a hospital-based consultant—someone who saw other doctors' patients—his career provides a window onto a number of aspects of late twentieth-century medical practice that more traditional histories might not have discovered.

This is not to say that my book upends the standard historical take on American medicine during the decades in question. My father's career emerged during what has been called the "golden age of American medicine" and, to some degree, confirms this historical interpretation.[34] My dad chose infectious diseases in part due to the exciting cures that penicillin and the other new antibiotics began to produce beginning in the late 1930s. In turn, he experienced the "cultural authority" enjoyed by the postwar medical profession.[35] Particularly after the passage of Medicare in 1965, my father and his peers happily practiced high-technology, fee-for-service medicine, liberally ordering tests for patients without much regard to cost.

And my father was an unabashed paternalist, which was the norm for physicians of this era. He felt entirely comfortable making decisions for patients, routinely keeping them in the dark and at times actively misleading them.[36] "Doctor knows best" was his philosophy and he genuinely believed that patients who followed all of his advice would do better.

33. Bernheim, *Story of the Johns Hopkins* (n. 4), 77.

34. John C. Burnham, "American Medicine's Golden Age: What Happened to It?," *Science* 215, no. 4539 (1982): 1474–79; Allan M. Brandt and Martha Gardner, "The Golden Age of Medicine?," in *Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (Amsterdam: Harwood, 2000), 21–37.

35. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 3–29.

36. Barron H. Lerner, *The Good Doctor: A Father, a Son, and the Evolution of Medical Ethics* (Boston: Beacon, 2014), 31–33.

My father also participated in a number of other activities that the fledgling profession of bioethics found objectionable and used to justify its existence beginning in the 1970s. For example, when he was an infectious diseases fellow, he and his colleagues performed research without consent at an institution for mentally disabled children.[37] True, all they were doing was injecting antibiotics and then measuring blood levels, something that was relatively safe compared to some of the more outrageous examples of human experimentation after World War II. Nevertheless, such experiments were hardly risk-free and victimized an already vulnerable population.

Similarly, my dad worked very closely with the pharmaceutical industry, particularly Eli Lilly, which funded his research as a fellow and a young professor. I vividly remember his bringing home various gifts that he had received from drug company representatives, presumably in exchange for promoting the use of their particular drugs. In 1983, Lilly gave him between five and ten thousand dollars for a trip to China in exchange for his mentioning Lilly agents in his lectures.[38] These stories all corroborated what I had learned about my father's generation of physicians as I studied history and medical ethics: they saw themselves as somehow above issues that others believed—or were beginning to believe—were essential, such as avoiding conflict of interest and promoting patients' rights and informed consent.

But at the same time, my examination of my father's career—mostly through his journals but also my memories and interviews with his colleagues and my family—revealed things unlikely to be found in more traditional social history. And what I found, I believe, is real "history"—the sort of contingent knowledge a historian should try to discover when he or she writes an account of medical practice and health care in a particular era and place. To quote historian Jeremy Popkin, this was my effort to move from "initial memories and discoveries to the construction of a deeper, more critical narrative." It was a "search for understanding."[39]

For one thing, my dad's "problematic" behaviors emanated from a devotion to the care of patients that was almost all-consuming for him. Much ink has been spilled on the loss of humanism among physicians as medicine became more bureaucratic and specialized in the twentieth century. That is, the great diagnosticians and wise professors, beginning with William Osler and continuing with Soma Weiss, Paul Beeson, and

37. Ibid., 109–10.
38. Ibid., 110–11.
39. Popkin, *History* (n. 15), 256.

Edmund Pellegrino, have been replaced by physicians who are too reliant on technology and clinical guidelines.[40]

Although I generally agree with this hypothesis, and have read the historical literature that discusses it, it was not until I immersed myself in my dad's clinical practices that I really "got" what this past practice of medicine could look like. My father routinely gave out our home phone number to patients and kept in almost constant contact with his house staff and infectious diseases fellows during our family vacations (although he was careful to let them run the cases). He even kept in touch during his and my mother's annual summer peregrinations to France in the 1980s and 1990s. My family was permitted to go on vacation only during the last two weeks of a month—once my dad would have had enough time to indoctrinate his new monthly team and make sure they knew the patients intensely.

It was not until 1993, twenty years after he became the chief of infectious diseases at Cleveland's Mount Sinai Hospital, that my father took on an infectious diseases colleague. That meant that, in essence, he was on call every day and night for twenty years. Of course, it is not as if he got constant phone calls at night and on the weekends. But he got called a lot, and he was always the one who dealt with the most complicated infections. In addition, my dad's journals are filled with instances in which he went the extra mile for patients, comforting a young woman with an ulcer just discharged from the intensive care unit, reassuring a patient with cancer that his case was not "hopeless," and accompanying worried patients to the radiology suite or operating room. In a small number of difficult cases, in which patients with chronic diseases developed a series of infections over many years, he became their de facto physician, intensely monitoring their care to keep them alive and in good health. This was the case with a number of the first HIV patients in Cleveland, whom he often visited at their homes when they were too weak to travel.

In addition to his being such a strong patient advocate, another aspect of my father's medical practice hearkened back to an earlier time: his use of "clinical experience" to guide his diagnostic and therapeutic endeavors. Thanks to his fellowship under the renowned Louis Weinstein, one of the "fathers" of infectious diseases, my dad had seen an enormous amount

40. Perhaps the most eloquent spokesperson for this opinion is Abraham Verghese. See, for example, Denise Grady, "Physician Revives a Dying Art: The Physical," *New York Times*, October 11, 2010, www.nytimes.com/2010/10/12/health/12profile.html (accessed June 20, 2017). The Arnold P. Gold Foundation, which financed some of my early work, has made the restoration of humanism in medicine its primary mission: see www.humanism-in-medicine.org.

of infectious diseases cases—both common and rare. He also had seen Weinstein and other masters of the field practice their craft on complicated patients who did not fit cleanly into specific diagnostic categories or were not responding to the usual type of antibiotics. As a result, my father felt comfortable trying clinical maneuvers that did not exist in standard textbooks and even at times contradicted the results of randomized controlled trials. These interventions did not always work, but sometimes they did, and alleviated difficult problems. This type of effort might best be called the "art of medicine." After he successfully prescribed an unapproved antileukemia drug for a woman with shingles involving her eye, he wrote: "This is really a minutia type of therapeutic maneuver and can only come about through word of mouth and personal experience."[41]

Finally, I learned what practicing clinicians of my father's era thought about the bioethics revolution that was spreading in medicine during the years in which he practiced. In contrast to the received history, perhaps, my dad and his colleagues were *not* blind to issues such as the misuse of technology and mismanagement of death and dying. Indeed, as an infectious diseases specialist, my father had a front row seat when it came to end-stage patients, often with dementia or cancer, and frequently from nursing homes, who were admitted and readmitted to the hospital with infection after infection that needed treatment. After therapy was completed, these sad individuals returned to their poor quality of life, either no better or worse. In such instances, doctors rarely spoke to the patients or families about issues such as prognosis and palliation.

Plain and simple, here was the crux of medical ethics for my father and those of his peers who were also upset at what they were seeing: these doctors believed that, in such cases, they were actively doing harm and thus violating the Hippocratic injunction that they had taken as medical students and physicians. The rampant misuse of technology in such cases was "criminal," my dad wrote. "I've participated in the horrible and cruel prolongation of a biologic life, of a person whose disease process is totally irreversible—irretrievably so—but sustainable by inappropriate technology."[42]

What we historians and bioethicists thought my father's generation should have cared about—Tuskegee, Willowbrook, and the other research scandals involving inadequate consent practices—were not of immediate concern to them. When I asked my father, somewhat incredulously, about

41. Lerner, *Good Doctor* (n. 36), 27. On clinical experience, see also Naomi Rogers, *Polio Wars: Sister Kenny and the Golden Age of American Medicine* (New York: Oxford University Press, 2013).

42. Lerner, *Good Doctor* (n. 36), 115.

the antibiotic research he had done, he shrugged his shoulders and said, "We did things you could never do now."[43]

But doing harm to the very people he was caring for? That was an outrageous violation of medical ethics. Indeed, my dad invoked the Nazi analogy not with respect to human experimentation but in regard to his colleagues who would not let their dying patients die. "I jokingly tell some of my associates," he wrote, "that when the Nuremberg trials are reconvened, I will submit their names as 'war criminals'—but I am not entirely joking."[44]

Perhaps my father's best proclamation of his philosophy came after he did something extremely provocative and irregular—physically placing his body over a miserable, bed-bound, incurable woman who had just died in order to prevent his colleagues from doing cardiopulmonary resuscitation. He had acted, he wrote, "in the name of common, ordinary humanity" and based on his "30+ years as a physician responsible for caring and relieving the pain of my patients who can't be cured."[45]

This type of thinking has parallels with conclusions reached in a recent book, *Death before Dying*, by the historian of medicine Gary Belkin. Belkin argues that much of the deliberations of the famous Harvard "Brain Death" Committee drew on the amassed clinical knowledge of its members, particularly the committee chairman, Henry Beecher. Brain death, Belkin argues, was a pragmatic approach to a problem that had emerged due to the ability of ventilators to maintain the circulation of patients who had no chance of survival. Belkin regrets that the committee's work became seen as validating the need for bioethicists to provide a new language of values to the practice of medicine.[46] In the same way, my father's response to what ethicists eventually termed "medical futility" came out of a tradition of tough medical decisions that my father believed that he and his more responsible doctor-colleagues were more than qualified to make by themselves. Although I will not have time to address this issue in my talk, my father made similar claims for the ability of infectious diseases physicians to be leaders in discussions about the emergence of antibiotic resistance and the possibility of regulating or rationing the use of such agents.

43. Ibid., 109.

44. Ibid., 117.

45. Ibid., 122.

46. Gary S. Belkin, *Death before Dying: History, Medicine and Brain Death* (New York: Oxford University Press, 2014). See also Emily K. Abel, *The Inevitable Hour: A History of Caring for Dying Patients in America* (Baltimore: Johns Hopkins University Press, 2013).

So, to the degree that my book succeeded, I tried to capture a slice of medical practice distinctive to my father but also emblematic of an era: one of physician authority; patient passivity; rapidly expanding fee-for-service medicine; exciting scientific advances; but also harbingers of the downsides of technological advances and the growth of patients' rights. Readers of my book, to use a phrase from the historian Shirley Leckie, were able to "encounter a person from a different time and place" (although admittedly not so long ago).[47] I would also like to think, per Jacalyn Duffin, that I, as the biographer, had an "honest interaction" with my father as my subject.[48] Finally, and here I feel most confident, I believe I was able to use biography to tell a good story, one that not only health professionals, historians, and ethicists—but members of the broader public—might be interested to read.

But how realistic is this assessment? Can my account of my father's life and career in any way be considered "objective" or "good history"? As the biographer Ira Nadel has written, biography is inevitably self-reflexive and self-referential, reflecting the interests and concerns of the biographer—as opposed to necessarily getting the facts right. Biographers, to again quote Popkin, use "elaborate authorial strategies."[49] This may be even more true when the biographer is the subject's son. As Alice Wexler suggested in *Mapping Fate*, her book on her family's struggles with Huntington's disease, other relatives—let alone strangers—writing a similar book might have told the history in a completely different manner.[50]

Perhaps the best example of how I told my story in a certain way was my fealty to my father's diaries. For the most part, unless I found contradictory information, I took what I read at face value. I made very few attempts to corroborate the nature of events my father described—for example, trying to interview people who were present at the time. Diaries and journals are notoriously unreliable and "never constitute a pure,

47. Quoted in Lloyd E. Ambrosius, ed., *Writing Biography: Historians and Their Craft* (Lincoln: University of Nebraska Press, 2004), viii.

48. Jacalyn Duffin, "'*La Mauvaise Herbe*': Unwanted Biographies Both Great and Small," in Söderqvist, *History and Poetics of Scientific Biography* (n. 11), 187–97, quotation on 196.

49. Ira B. Nadel, *Biography: Fiction, Fact and Form* (New York: Palgrave Macmillan, 1984), 21, 120. See also James Olney, ed., *Studies in Autobiography* (New York: Oxford University Press, 1988). On teaching this type of material to students, see Ann K. Warren, "Biography and Autobiography in the Teaching of History and Social Studies," *Perspect. Hist.* 30, no. 1 (January 1992); https://www.historians.org/publications-and-directories/perspectives-on-history/january-1992/biography-and-autobiography-in-the-teaching-of-history-and-social-studies (accessed October 20, 2017).

50. Alice R. Wexler, *Mapping Fate: A Memoir of Family, Risk and Genetic Research* (Berkeley: University of California Press, 1996).

unstructured account of their authors' thoughts and actions."[51] Thus, my father surely picked certain events, perhaps those that put him in a better light, to include in his journals. He also—either on purpose or inadvertently—likely shaded the details of certain events to make a point. To the degree that I purport to be giving an accurate history of my father's life and career, my unwillingness to scrutinize the validity of my source material calls my mission into question.

Similarly, I also did very selective interviews, mostly with former colleagues of my father's and a few relatives and friends. I mostly chose them out of convenience rather than systematically tracking folks down. Indeed, after the manuscript was complete, I happened to speak to someone who had been an infectious diseases fellow with my father who provided me with new information that I wish I could have included in the book. People who worked alongside my father for years may have found his behaviors more problematic than I did.

I also, in at least one instance, took something for granted that perhaps was unwarranted. When speaking with a physician about my possibly giving grand rounds at his institution, I provided him with a description of my book. In it, I described my father as a revered clinician renowned for his clinical judgment, a characterization I had entirely taken for granted. After all, almost every physician-colleague I had spoken with described my father using that type of language. But this physician wrote back to me: "Renowned for his clinical judgment—makes me wonder, what defines better or worse clinical judgment—the process, the outcome, both—the flare, the charisma—hmmmm."[52] It was a bit humbling, to say the least, to be reminded of my potential historical bias by a non-historian. But I decided not to challenge this image of my dad, at least in the book. Deconstructing such a central tenet of my thesis—even if warranted from the perspective of accuracy—would have resulted in a very different book.

In addition, I made pointed decisions about what to include in the book and what to leave out. My editor and agent had strong opinions on this topic as well. Many of these choices were done for the sake of creating a strong narrative that would appeal to a broad readership. For example, we all agreed that it made sense for me to suggest that reading my father's journals had been a type of epiphany for me, in which I was forced to revisit many assumptions I had made about his career. In truth, I had read portions of his journals in the past, and had long seen him as a complicated person with both virtues and flaws. I also had an agenda of sorts: to use my father's career to celebrate a vanishing era of patient-

51. Novick, *That Noble Dream* (n. 1), 71.

52. Harlan Krumholz to the author, August 27, 2013.

centered medical practice. In this spirit, I selected anecdotes from his journals that seemed to validate this notion.

It is not hard to find clever quotations indicting biographers for these exact types of choices. Facts may be "entirely excluded," Oscar Wilde said, "on the general ground of dullness." Sigmund Freud believed that a biographer necessarily "binds himself to lying, to concealment, to flummery." Perhaps the pithiest critique comes from Philip Roth's own inventive autobiography, sarcastically titled *The Facts*. "We always tell," Roth wrote, "in order not to tell."[53]

Despite these caveats, I did try to historicize my father's career. But what about my own career? If biography is a way to tell a story about a historical figure, autobiography is telling a story about oneself. An autobiographer, according to Jeremy Popkin, is a "historian whose subject matter is his own life." As a result, the French critic Georges Gusdorf wrote in a famous 1956 article, an autobiography is "a work of personal justification." To literary critic Wallace Fowlie, it is "the recycling of memories, both conscious and unconscious," to create a personal myth.[54] The danger, of course, is that events that are fictional get reported as the truth, and subsequently repeated by others as the truth. To the degree these cautionary statements are true, it is reasonable to ask the question: how can autobiography in any way be seen as reliable history?

The answer to this question, it might be argued, is not that autobiography corrupts history but that history has become more like autobiography. After all, if one shares Peter Novick's skepticism about the objectivity of history in the first place, the search to distinguish truth from untruth becomes somewhat less important. Seen in this light, autobiography, with its explicit use of the first person and selective inclusion of information, is more real, what Popkin terms an "answer to positivism."[55] Or to paraphrase French historian Pierre Nora, the biographer's or autobiographer's evident connections to the historical material—and his or her motives in writing a book—become not an obstacle, but a means of understanding.[56]

53. Wilde is quoted in Ruth Franklin, *A Thousand Darknesses: Lies and Truth in Holocaust Fiction* (New York: Oxford University Press, 2011), 237. Freud quoted in Richard Pollak, *The Creation of Dr. B.: A Biography of Bruno Bettleheim* (New York: Simon & Schuster, 1997), 15. Philip Roth, *The Facts: A Novelist's Autobiography* (New York: Vintage Books, 1988), 164.

54. Popkin, *History* (n. 15), 19, 25. Wallace Fowlie, *Sites: A Third Memoir* (Durham, N.C.: Duke University Press, 1987), 5. For an erudite take on the topic of autobiography, see Paul Theroux, "The Trouble with Autobiography," *Smithsonian Magazine* 41, no. 9 (January 2011): 76–88.

55. Popkin, *History* (n. 15), 75.

56. Quoted in ibid., 75.

One of the more clever attempts to deal with this potential blurring of history and autobiography occurs in Roth's *The Facts*. Aside from having changed some names of past girlfriends and acquaintances, his book is a seemingly straightforward autobiography. The text focuses on five episodes in Roth's life, including his years in college and the circumstances surrounding his writing *Goodbye, Columbus* and *Portnoy's Complaint*. Many of the events described seem valid, jibing closely with nonfictional accounts of Roth's life. To underscore this point, in a preface, he tells the reader that he is exhausted with the "masks, disguises, distortions and lies" that were present in his fiction.[57]

Roth, however, is messing with us. The book's preface is written by "Roth," presumably Philip Roth, to his fictional alter-ego Nathan Zuckerman. But when the fictional Zuckerman "replies" to Roth, after having "read the manuscript twice," he is thoroughly unconvinced with the book's reliability. First, Zuckerman accuses Roth of purposely leaving out facts that he knows should have been included. The book, he says, is a "fictional autobiographical projection of a partial you." The problem, Zuckerman concludes, is with autobiography itself. "With autobiography there's always another text, a countertext, if you will, to the one presented," he writes. "It's probably the most manipulative of all literary forms."[58]

The reader is thus left with a conundrum. What should he or she believe about what Roth has written about his life? It's a fascinating intellectual exercise, to be sure, but as a reader, it is frustrating. As a historian interested in what actually happened to Roth, how he became a writer, or his childhood in Newark in the 1940s and early 1950s, it can be exasperating.

I would like to think that throughout my book, I told the "truth." I can assure you that the part about my not having any dates in high school was accurate. But I certainly actively included and omitted items to construct a particular story. In the case of my dad, it was relatively easy to include his controversial behaviors since he has died, as have many of his peers and mentors. I did not embarrass them, nor can they refute me. In the case of my own history, however, I was much more careful not to "name names." For example, I tell the story of a private Columbia cardiologist who refused to help my medical student and me during my internship when one of my ward team's patients had a massive heart attack and I could not get in touch with my junior resident. In this type of scenario,

57. Roth, *Facts* (n. 53), 6.
58. Ibid., 172.

one could argue that the story, and what it signifies about doctoring and medical ethics, is more important than the name of the particular doctor.[59]

But it is harder to justify another type of omission I made. Twice during my career, individuals involved in medical ethics and/or the medical humanities have taken away my academic jobs due to considerations of politics and money—as opposed to my performance.

Given that my book discusses these fields at length, and praises many people who I have encountered in these areas, it could be argued that my exclusion of these two anecdotes represents an important omission from the historical record. That is, future historians should know that in at least two instances, this is the sort of thing that happened—and was tolerated by many—at academic medical centers.

I am far from the only academic to keep quiet about this type of thing. Erving Goffman found that success at work often meant ignoring the discrepancies between the stated goals and actual behaviors of one's colleagues.[60] Nor does the topic often emerge when historians write autobiographies. Few of them, Popkin notes, "have been willing to acknowledge . . . the part that personal feuds and struggles against powerful older figures in the profession often play in academic careers." What results, he continues, is a "stylized" history that omits "much of what actually shaped an individual's life and gave it drama" and paints individual careers and organizations in a more positive light than they should.[61] To the degree that good historical research is comprehensive, this type of work is thus subpar history, even if it makes for a good narrative and a peaceful workplace. In my own case, I believed that such stories would be both hard to "prove" and would deflect the reader from the more important themes of the book. As far as my decision to discuss these issues here, this talk is historiographical so I felt that I could not really omit them. Plus, I felt that the Garrison audience would be a mature one and able to keep this information in its proper context, although we will see if this is so at the reception.

Finally, if I did succeed in historicizing my father's career in my book, I did so much less when it came to my career. Once again, my choices reflected my desire for a smooth narrative. An autobiography that scrutinizes the historical context of every action would not be much fun to read. Plus, extracting historical lessons from one's own life is a tall task.[62]

59. For a perceptive discussion of writing about living subjects, see Vassiliki Betty Smocovitis, "*Pas de Deux*: The Biographer and the Living Biographical Subject," in Söderqvist, *History and Poetics of Scientific Biography* (n. 11), 207–19.

60. Erving Goffman, *The Presentation of Self in Everyday Life* (New York: Anchor, 1959).

61. Popkin, *History* (n. 15), 152, 160, 281.

62. Ibid., 60.

One of the best examples of a historian choosing to historicize his own actions is Joel Braslow's chapter, "Timeless Desperation and Timely Measures," in Jacalyn Duffin's *Clio in the Clinic*. Braslow vividly describes the day that he realized that his use of neuroleptic drugs to sedate mentally ill patients—rather than spending the time to possibly reach them through some type of talk therapy—was analogous historically to the neurosurgeons he had researched (and criticized) who had performed lobotomies on institutionalized patients in the years after World War II. In other words, Braslow was able to see himself as future historians might when researching the treatment of mental illness in the pharmaceutical era.[63]

So, too, I might have historicized my own career path, which took me into history and bioethics. Having studied in medical school and graduate school with a historian and an ethicist, David Rothman and Albert Jonsen, respectively, who were early participants in bioethics and later wrote histories of the field, my take on the topic was not surprising. I readily accepted the hypothesis that the medical profession, as evidenced by its willingness to lie to cancer patients, participate in unethical human experimentation, misuse new technologies, and not communicate effectively with patients, had somehow lost its bearings and needed to be rescued by the practitioners of the new field of bioethics. I also became a fervent proponent of patients' rights when on the wards and when serving on ethics committees, consistently challenging colleagues—generally older than I—who dared to propose paternalistic interventions that excluded patients and families from the decision-making process.

A telling anecdote occurred in the 1990s when David Rothman and I were coteaching a class on informed consent. As part of the session, we did a role-playing exercise in which I was the doctor and one of the students was the patient. At issue was whether the patient should and would undergo some type of invasive treatment. We role-played for several minutes and after the student indicated his willingness to have the procedure, I said something to him along the lines of "So we will forge ahead then."

Rothman's hand immediately shot up. "What do you mean by 'We'?" he perceptively asked. "The patient is undergoing the test, not you."

What was remarkable here was not that I used the word "we" or that Rothman challenged its use. What was striking was my response, which was to immediately apologize for what I had done, essentially agreeing with Rothman that my use of this word somehow compromised the patient's informed consent.

63. Joel T. Braslow, "Timeless Desperation and Timely Measures," in *Clio in the Clinic: History in Medical Practice*, ed. Jacalyn Duffin (New York: Oxford University Press, 2005), 251–68.

Looking back, what was much more important was the way the student got to the decision and how I assisted in that process. I suspect that experts in informed consent, especially those who promote a shared decision-making model, would have approved of what had transpired. But as a reflexive devotee of strict patient autonomy, I could not see this at the time. It is reasonable to suggest that many others who trained in bioethics during the 1990s were also likely influenced by the historical moment to adopt a similarly narrow perspective on some of the issues at hand. I left most of this analysis out of my book, preferring to underscore the differences between my father's paternalism and my devotion to autonomy. But autobiography, if historicized, provides a unique way to understand what was occurring in a society at a particular time and why.

In sum, I have tried to suggest how great doctor history, either biographical or autobiographical, need not be presentist and hagiographic Whig history but can be done from a "truly historicist point of view." It can provide information about individual practitioners or medical groups that may be difficult to obtain by more traditional social historical approaches—generating stories, to quote the historian Peter Gay, that may be "lost amid the clamor of historical events."[64] Popkin concurs, arguing that past experience can be a "kind of penumbra to history, a zone of the past where historical narrative does not shine its beams."[65] Or, to again quote Thomas Hankins, biography lets the historian "tie together the parallel currents of history at the level where events and ideas occur."[66] Perhaps it is fitting that I end this article by quoting Hankins, who, while serving ably on my dissertation committee, practiced a type of history that I was mostly being taught to ignore.

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Barron H. Lerner is a professor of medicine and population health at New York University, where he directs bioethics education for medical students, teaches history of medicine to undergraduates, and is a practicing internist. His book, *The Breast Cancer Wars: Hope, Fear and the Pursuit of a Cure in Twentieth-Century America*, won the William H. Welch Medal of the American Association for the History of Medicine in 2006.

64. Peter Gay, *My German Question: Growing Up in Nazi Berlin* (New Haven, Conn.: Yale University Press, 1999), 22.

65. Popkin, *History* (n. 15), 244–45.

66. Quoted in Söderqvist, "Introduction" (n. 19), 8.