Starting out in History

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What can you study?

What *can't* you study historically!

What can you study

- Social
- Cultural
- Intellectual
- Transnational
- Global
- *Medical*
- Science
- Technology

Some common threads

- Individuals (Joseph Lister?)
- Institutions (Guy's and St Thomas's; the BMA; the medical profession)
- Big sweeping movements (germ theory? humoral theory?)
- Gender & Race
- Intellectual histories
- Pandemics
- Diseases
- Traditional medicines
- Global health
- And the list goes on….

When can you study?

- Ancient (from about 500 BCE to 500 CE)
- Medieval (500-1400)
- Early modern (ca 1400-1800)
- Modern (ca 1800-2000)
- Contemporary (2000-present)
- (*Microhistories and deep or ‘big’ history)

Where can you study?

- Anywhere, within practical limits
- Is there an archive available (whether in physical or digital form?)
- Do you speak the language or are there sufficient sources in translation?
- Do you know enough about cultural, intellectual differences to undergird your study?
- Transhistorical narratives; global health narratives

How do you study?

- Primary Sources
- Secondary Sources
- Background reading
- Context
- Analysis
- Imagination?

How do you study

Context *and* Analysis *and* Imagination

It’s not really about what the facts are, because the facts are sometimes impossible or difficult to come by.

It’s how you interpret the facts, and how you build out the context that makes those facts make sense in the first place.

Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children

A J Wakefield, S H Murch, A Anthony, J Linnell, D M Casson, M Malik, M Berelowitz, A P Dhillon, M A Thomson, P Harvey, A Valentine, S E Davies, J A Walker-Smith

Summary

Background We investigated a consecutive series of children with chronic enterocolitis and regressive developmental disorder.

Methods 12 children (mean age 6 years [range 3–10], 11 boys) were referred to a paediatric gastroenterology unit with a history of normal development followed by loss of acquired skills, including language, together with diarrhoea and abdominal pain. Children underwent gastroenterological, neurological, and developmental assessment and review of developmental records. Ileocolonoscopy and biopsy sampling, magnetic-resonance imaging (MRI), electroencephalography (EEG), and lumbar puncture were done under sedation. Barium follow-through radiography was done where possible. Biochemical, haematological, and immunological profiles were examined.

Findings Onset of behavioural symptoms was associa[ted] by the parents, with measles, mumps, and rub[ella] vaccination in eight of the 12 children, with measl[es] infection in one child, and otitis media in an[other]. All 12 children had intestinal abnormalities rangi[ng] from lymphoid nodular hyperplasia to an[ore]xoid ul[cer]ation. Histology showed patchy chronic inflam[mat]ion i[n] in 11 children and reactive ileal lymphoi[d] hyperplasia in seven, but no granulomas. Be[hav]ioural disor[ders] included autism (nine), disintegrative psych[osis] (one), a[nd] possible postviral or vaccinal encephalitis (two). There were no focal neurological ab[nor]malities and MRI and EEG tests were normal. Abnor[mal] laboratory results were significantly raised urinary methylmalonic acid compared with age-matched control[s] (p=0·003), low haemoglobin in four children, and low s[erum] IgA in four children.

Interpretation We identified associated gastrointestinal disease and developmental regression in a group of previously normal children, which was generally associated in time with possible environmental triggers.

Lancet 199[8]; **351:** 637–41
See Commentary page

Introduction

We saw several children who, after a period of apparent normality, lost acquired skills, including communication. They all had gastrointestinal symptoms, including abdominal pain, diarrhoea, and bloating and, in some cases, food intolerance. We describe the clinical findings, and gastrointestinal features of these children.

Patients and methods

12 children, consecutively referred to the department of paediatric gastroenterology with a history of a pervasive developmental disorder with loss of acquired skills and intestinal symptoms (diarrhoea, abdominal pain, bloating and food intolerance), were investigated. All children were admitted to the ward for 1 week, accompanied by their parents.

Clinical investigations

We took histories including details of immunisations and exposure to infectious diseases, and assessed the children. In 11 cases the history was obtained by the senior clinician (JW-S). Neurological and psychiatric assessments were done by consultant staff (PH, MB) with HMS-4 criteria.[1] Developmental assessments included a review of prospective developmental records from parents, health visitors, and general practitioners. Four children did not undergo psychiatric assessment in hospital; all had been assessed professionally elsewhere, so these assessments were used as the basis for their behavioural diagnosis.

After bowel preparation, ileocolonoscopy was performed by SHM or MAT under sedation with midazolam and pethidine. Paired frozen and formalin-fixed mucosal biopsy samples were taken from the terminal ileum; ascending, transverse, descending, and sigmoid colons, and from the rectum. The procedure was recorded by video or still images, and compared with images of the previous seven colonoscopies in paediatric colonoscopies (four normal colonoscopies and three on children with ulcerative colitis), in which the reported normal appearances in the terminal ileum. Barium follow-through radiography was possible in some.

Also under sedation, cerebral magnetic-resonance imaging (MRI), electroencephalography (EEG) including brainstem auditory, and sensory evoked potentials were done (MRI made these possible), and lumbar puncture.

Laboratory investigations

Thyroid function, serum cerebrospinal-fluid lactate and causes of childhood methylmalonic acid were

Primary versus Secondary Sources

Early report

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How to read and write in history?

- What are the constituent parts of a scientific paper?

Title
Authors and Affiliation
Abstract
Introduction
Methods
Results
(Figures & Tables)
Discussion
Conclusion
Acknowledgments
Literature Cited

Or something like that!

How to read and write in history?

- What are the constituent parts of a historical research paper?
  - Title
  - Author & Affiliation
  - Abstract (maybe)
  - Introduction
  - Argument evidenced by archival and historiographical sources
  - Conclusion

Ultimately….

‘When we remember – as psychologists so often tell us – we don’t reproduce the past, we create it. Surely, you may say – some truths are non-negotiable, the facts of history guide us. And the records do indeed throw up some facts and figures that admit no dispute. But the historian Patrick Collinson wrote: “It is possible for competent historians to come to radically different conclusions on the basis of the same evidence. Because, of course, 99% of the evidence, above all, unrecorded speech, is not available to us.

Evidence is always partial. Facts are not truth, though they are part of it – information is not knowledge. And history is not the past – it is the method we have evolved of organising our ignorance of the past. It’s the record of what’s left on the record. It’s the plan of the positions taken, when we to stop the dance to note them down. It’s what’s left in the sieve when the centuries have run through it – a few stones, scraps of writing, scraps of cloth. It is no more “the past” than a birth certificate is a birth, or a script is a performance, or a map is a journey. It is the multiplication of the evidence of fallible and biased witnesses, combined with incomplete accounts of actions not fully understood by the people who performed them. It’s no more than the best we can do, and often it falls short of that.

--Hilary Mantel, 2017.